

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2026
NAME OF PROVIDER OR SUPPLIER Sunview Respiratory and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 12207 North 113th Avenue Youngtown, AZ 85363	
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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical record, and review of facility policy and procedure, the facility failed to protect the resident's (#444) right to be free from sexual abuse by another resident (#3) on March 18, 2025 . when R3, an adult was found performing a sexual act on R444, a minor. The facility failed to specifically to (1) address R444's inappropriate interactions with staff; (2) provide supervision when the minor was noted to spend time with a cognitively impaired resident; and, (3) identify sexual contact between a minor and an adult as sexual abuse. When a minor has been the victim of molestation or statutory rape it has the potential to cause long lasting effects, psychological trauma and post traumatic stress disorder. As a result, the situation of Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified. Due to the potential for serious psychosocial harm an immediate jeopardy was called in the presence of the Administrator, Clinical Resource (staff #315) and Director of Operations (staff #316) on April 3, 2025 at 12:08 p.m.The facility's removal plan was accepted on April 3, 2026 at 5:29 p.m. and included the following actions taken:In-house review, assessment and checking against the Sex Offender Registry of their current residents;In-service training of all staff on Recognizing/Identifying, reporting, responding and implementing interventions for allegations abuse and neglect, EJA (Elder Justice Act), Recognizing/identifying inappropriate behaviors and Actions to take; and, Resident Rights; Review of current protocols for minors and justice involved residents admitted at the facility; Interviews conducted with all current interviewable residents regarding abuse;Review of their Grievance logs to identify any complaints from residents related to any inappropriate behaviors of staff and/or other residents.Multiple observations were conducted on April 3, 2026 and revealed the facility implementing their action plan to include conducting inservice training on recognizing/Identifying, reporting, responding and implementing interventions for allegations abuse and neglect, EJA (Elder Justice Act), recognizing/identifying inappropriate behaviors and Actions to take; and, Resident Rights with sign-in sheets of their staff, monitoring residents for inappropriate behaviors every shift and records of quiz on abuse completed by staff.Interviews with multiple staff were conducted on April 3, 2026 revealed that staff verbalized their understanding on how to identify/recognize abuse and inappropriate behaviors, what to do when they see or hear allegations of abuse or inappropriate behaviors, and actions to take to intervene/mitigate the situation. On April 3, 2026 at 6:35 p.m., IJ was removed but noncompliance remained at the lower scope and severity of isolated, actual harm that is not immediate.Findings include:A facility self-report dated May 19, 2025 submitted to the State Agency (SA) by the former Director of Nursing (DON/Staff #66) revealed that on May 19, 2025, a staff member overheard Resident #444 made a statement that suggested he received sexual acts from Resident #3. According to the report, both residents were determined to be cognitively intact and had a BIMS score of 15; and that, during separate interviews, each resident acknowledged the encounter, asserted it was consensual, and that it occurred on May 18, 2025. Further, the report included that staff had previously witnessed residents #444 and #3 together but reported that there was no inappropriate behavior at that time. The report revealed the police were notified and appropriate reporting to state (continued on next page)</p>		

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
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>was conducted on May 19, 2025 at approximately 6:26 p.m. with Resident #444 who confirmed that a sexual encounter occurred between and mutually consented by him and Resident #3. Per the documentation, Resident #444 reported that the incident occurred one time on May 18, 2025, and was interrupted by staff; and that, both Resident #444 and Resident #3 put their clothes on before staff entered the restroom.</p> <p>Continued review of the facility 5-day investigation revealed an interview was conducted on May 19, 2025 at 6:45 p.m. with Resident #3 who initially denied any incident; however, retracted and acknowledged that she and Resident #444 voluntarily engaged in the act; and that, Resident #444 requested for it. Per the documentation, Resident #3 reported that the encounter was interrupted by a staff.</p> <p>Further review of the facility investigation revealed an interview conducted on May 18, 2025 with the nurse on duty (LPN/Staff #312), who stated she observed Residents #444 and #3 together in one of the resident rooms, but, there was no inappropriate behavior noted at that time. The LPN reported that both residents reported that they were watching videos together and denied any misconduct; and, both were directed to return to their respective rooms. The report concluded that the facility was unable to substantiate that abuse occurred, and the incident occurred between two consenting individuals.</p> <p>The APS (Adult Protective Services) investigative report dated August 19, 2025, revealed that the allegation against the facility was neglect of a vulnerable adult, identified as Resident #3, and that the allegation was verified. The report revealed that Resident #3 was identified as a vulnerable adult due to having serious mental illness (SMI); and that, Resident #3 sexually assaulted Resident #444 while at the facility, and the case was verified because the sexual assault occurred.</p> <p>A phone interview with the legal guardian/family of Resident #444 was conducted on March 3, 2026, at 10:42 a.m. The legal guardian/family stated that she was the legal guardian of Resident #444 at the time of the incident; and that, a facility staff called and informed her several days before the incident that Resident #444 had developed an inappropriate relationship with another resident. She stated that she was asked by the facility staff to speak to Resident #444 about it. The legal guardian stated that she was unable to come to the facility; but that, Resident #444 was under the facility's care, and it was the facility's responsibility to handle the situation and ensure the resident's safety. The legal guardian stated that approximately two days after the initial phone call, staff called and informed her that there was an incident where a staff member caught Resident #444 receiving oral sex from another resident. She stated that Resident #444 should have been under staff supervision and all staff should have been aware that Resident #444 was a minor and required supervision; but that, the facility did not do an adequate job protecting Resident #444. Further, the legal guardian stated that Resident #444 had a negative psychosocial impact as a result of the incident that occurred.</p> <p>However, there was no evidence found in the clinical records that interventions were put in place to supervise or discourage Resident #444 and #3 from hanging out with each other; and, no evidence found of any actions or preventive measures taken such as increase supervision or monitoring of Residents #444 and #3.</p> <p>A phone interview was conducted with an LPN (Staff #179) on March 3, 2026, at 9:57 a.m. The LPN stated that prior to the incident, Resident #3 and Resident #44 were hanging out together a lot, and that staff had warned Resident #3 that Resident #444 was a minor. Regarding the incident, The LPN stated it occurred on the night shift; but, she was not sure if the sexual act was witnessed by anyone. (continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>that prior to the incident, Resident #444 was not supervised directly by staff, and had freedom to roam the facility without anyone directly watching. The CNA said that when she came to work for her shift on day shift, she was informed that there had been an incident between Resident #444 and Resident #3. She said that she was told that during the night shift, a nurse walked in the bathroom of another resident's room and found Resident #3 performing oral sex on Resident #444. She stated she was not sure whether or not the resident who was admitted to the room was in the room or not at the time the incident between Residents #444 and #3 occurred. The CNA stated that when she returned to work on day shift on May 20, 2025, she was informed that she was assigned to be the one on one sitter for Resident #444; and, during that shift, Resident #444 seemed sad or depressed. Further, the CNA said that later that day on May 20, 2025, Resident #444 was discharged to the hospital.</p> <p>During an interview with an LPN / unit manager (Staff #82) conducted on March 4, 2026, at 12:26 p.m., the unit manager stated that the facility accepts and admits pediatric residents; and, if the resident has a legal guardian, then healthcare decisions and consents are obtained from the resident's legal guardian. The unit manager stated that there would be no scenario where a child/minor could consent to have sex with an adult while in the facility, because the child would not be of consenting age. She stated that it would be considered sexual molestation or rape if an adult has a sexual act with a child who cannot legally consent; and, it would be important for facility staff to be able to identify possible situations of sexual abuse and rape in order to protect the residents. Regarding the incident between Resident #3 and Resident #444, the unit manager stated that prior to the incident, there was a fear amongst staff that something would happen between Resident #444 and Resident #3, because both residents were spending a lot of time together. She said that Staff #82 stated that prior to the incident, she called and informed the legal guardian of Resident #444, that Resident #444 was spending time with another resident and the facility did not want anything inappropriate to happen. She also said that she informed the legal guardian that Resident #444 had been instructed to stay within public areas in the facility; and she requested the legal guardian to speak to Resident #444 to encourage compliance. The unit manager said that the legal guardian told her that Resident #444 had a TBI that impaired the resident's judgment; and that, the resident had a lot of sexual urges and behaviors. The unit manager said that prior to the incident, the resident's TBI-related behaviors were noticeable, and the resident showed no remorse for his actions. Regarding the incident, the unit manager said that she was told that it occurred on night shift and a nurse walked in and saw the Residents #3 and #444 engaged in what appeared to be oral sex. The LPN said that both residents were separated, and the former DON (Staff #66) was the main person who conducted the investigation afterward. She stated that both Residents #3 and #444 initially denied the allegation; but later, Resident #444 admitted that oral sex occurred. A review of the clinical record was conducted with the unit manager who stated that Resident #444 was discharged to the hospital on May 20, 2025, in order to get a pediatric psychiatric evaluation, because the facility's psychiatric provider was not able to perform a pediatric psychiatric evaluation.</p> <p>In a phone interview with another CNA (Staff #221) conducted on March 4, 2026, at 1:29 p.m., the CNA stated she was informed the day after the incident occurred through verbal report from staff that an adult resident and a kid resident were found by a staff member having a sexual encounter in another resident's room. The CNA stated that prior to the incident, staff were trying to keep an eye on the minor resident (#444); and that, after the incident, the residents were kept separated.</p> <p>A phone interview was conducted on March 4, 2026, at 1:35 p.m. with another LPN (Staff #85) who stated that she was working on the night shift on May 18, 2025 when the incident occurred. She stated that earlier in the evening, Residents #3 and #444 were spending time together with another resident and were walking the halls together. The LPN said that while she was in the middle of (continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>evening medication pass, sometime around 7:00 p.m. &ndash; 9:00 p.m., nurse (Staff #312) from another unit came and asked her if either Resident #444 or Resident #3 was one of her assigned residents. She told the nurse (Staff #312) one of the residents was; and, the nurse (Staff #312) told her that there was an incident. The LPN said that the nurse (Staff #312) reported that when the nurse (Staff #312) walked into the room of another resident, the nurse (Staff #312), found Residents #444 and #3 together in the bathroom; and that, Resident #3 was on her knees in front of Resident #444 who was standing and had his pants down. The LPN said that the nurse (Staff #312) reported that Resident #444 quickly pulled his pants up when he saw the nurse (Staff #312); and that, the nurse told her that it looked like Resident #3 was performing oral sex on Resident #444. The LPN said that both she and the nurse (Staff #312) went to the room where both Residents #3 and #444 were found. The LPN stated that upon arriving to the room, the resident who stays in that room was very upset and told both nurses that he had no idea what was going on, and had no idea that a sexual encounter was going on in his bathroom. The LPN stated that Residents #3 and #444 were separated and reported the incident to the DON (staff #66) at that time. The LPN further stated that the police came to the facility the following day.</p> <p>During a phone interview with a Department of Child Services (DCS) staff conducted on March 4, 2026, at 2:58 p.m. the DCS staff stated that DCS only became involved with the incident when Resident #444 was discharged to the hospital; and the hospital reported the incident to them. The DCS staff stated that the facility did not inform DCS of the incident. The DCS staff said that Resident #444 reported that he was caught by a facility staff having oral sex with another resident. Further, the DCS staff stated that based on the resident's age, Resident #444 was not able to give consent.</p> <p>A phone interview was conducted with another LPN (Staff #102) on March 5, 2026, at 8:48 a.m. The LPN stated that she found out about the incident the day after the incident; and she was verbally informed through verbal report that Resident #444 and Resident #3 were visiting the room of another resident and both Residents #3 and #444 were seen by staff doing something inappropriate based on the residents' ages.</p> <p>A telephone interview with a DCS child safety specialist who was assigned to the case of Resident #444 was conducted on March 5, 2026, at 9:03 a.m. The DCS child safety specialist stated that prior to the incident, Resident #444 had suffered a brain injury that affected the resident's decision-making ability; and that, Resident #444 had maladaptive behaviors. The DCS child safety specialist stated that Resident #444 reported that Resident #3 had performed oral sex on him; and they had been cau</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to implement policies and procedures to prohibit and prevent abuse for one resident (R)444 when (1) Staff failed to identify non consensual sexual acts between R444 and R3 as sexual abuse; (2) Report the abuse within the time frame required by State law and federal requirements; and, (3) Conduct a thorough investigation. The failure of the facility to recognize non consensual sexual acts between minors and adults has the potential to put all minors in the facility at risk for serious psychosocial harm such as post traumatic stress disorder or psychological trauma. As a result, the situation of Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified. An immediate jeopardy was called in the presence of the Administrator, Clinical Resource (staff #315) and Director of Operations (staff #316) were notified of the Immediate Jeopardy on April 3, 2025 at 12:08 p.m. The facility's removal plan was accepted on April 3, 2026 at 5:29 p.m. and included the following actions taken: In-house review, assessment and checking against the Sex Offender Registry of their current residents; In-service training of all staff on Recognizing/Identifying, reporting, responding and implementing interventions for allegations abuse and neglect, EJA (Elder Justice Act), Recognizing/identifying inappropriate behaviors and Actions to take; and, Resident Rights; Review of current protocols for minors and justice involved residents admitted at the facility; Interviews conducted with all current interviewable residents regarding abuse; Review of their Grievance logs to identify any complaints from residents related to any inappropriate behaviors of staff and/or other residents. Multiple observations were conducted on April 3, 2026 and revealed the facility implementing their action plan to include conducting in-service training on recognizing/Identifying, reporting, responding and implementing interventions for allegations abuse and neglect, EJA (Elder Justice Act), recognizing/identifying inappropriate behaviors and Actions to take; and, Resident Rights with sign-in sheets of their staff, monitoring residents for inappropriate behaviors every shift and records of quiz on abuse completed by staff. Interviews with multiple staff were conducted on April 3, 2026 revealed that staff verbalized their understanding on how to identify/recognize abuse and inappropriate behaviors, what to do when they see or hear allegations of abuse or inappropriate behaviors, and actions to take to intervene/mitigate the situation. On April 3, 2026 at 6:35 p.m., IJ was removed but noncompliance remained at the lower scope and severity of isolated, actual harm that is not immediate. Findings include: A facility self-report dated May 19, 2025 submitted to the State Agency (SA) by the former Director of Nursing (DON/Staff #66) revealed that on May 19, 2025, a staff member overheard Resident #444 made a statement that suggested he received sexual acts from Resident #3. According to the report, both residents were determined to be cognitively intact and had a BIMS score of 15; and that, during separate interviews, each resident acknowledged the encounter, asserted it was consensual, and that it occurred on May 18, 2025. Further, the report included that staff had previously witnessed residents #444 and #3 together but reported that there was no inappropriate behavior at that time. The report revealed the police were notified and appropriate reporting to state regulatory authorities was completed.</p> <p>The report did not identify Resident #444 as a minor.</p> <p>-Resident #444 (alleged victim/minor) was admitted to the facility on [DATE], with diagnoses of traumatic brain injury, attention deficit hyperactivity disorder (ADHD), anxiety and depression.</p> <p>Review of the clinical record indicated that the resident was alert and oriented; however, all decisions and consents for Resident #444 were made by the resident's legal guardian/parent. (continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A care plan dated May 13, 2025 revealed Resident #444 was at risk for impaired cognitive function or impaired thought process due to recent hospitalization. Interventions included the resident needed supervision/assistance with all decision making, and to include resident-centered behavioral interventions.</p> <p>A daily skilled note dated May 18, 2025 at 10:16 p.m. revealed the resident was alert and oriented x 4 and had no active behavioral symptoms.</p> <p>A BIMS (Brief Interview for Mental Status) assessment dated [DATE] revealed Resident #444 had a score of 15 indicating intact cognition.</p> <p>A nursing note dated May 19, 2025 included that Resident #444 was placed on change of condition (COC) monitoring for psychosocial wellbeing for a reported event; and that, the resident, family, case manager, and provider were notified.</p> <p>A care plan initiated May 19, 2025 revealed Resident #444 had a potential for a psychosocial well-being problem due to a reported event. Interventions included for 1:1 staff initiated on May 19, 2025.</p> <p>However, there was no evidence found in the clinical record that interventions to protect Resident #444 from further abuse was put in place on May 18, 2025, the date the incident happened.</p> <p>A nursing note dated May 20, 2025 included the decision was to discharge Resident #444 back to the acute care hospital based on the family's request.</p> <p>A Nursing Home to Hospital Transfer Form revealed Resident #444 was transferred to acute hospital on May 20, 2025, for a pediatric psychiatric evaluation.</p> <p>-Resident #3 (alleged perpetrator) was admitted on [DATE] with diagnoses of ADHD, schizophrenia, and mood disorder.</p> <p>A care plan initiated May 10, 2025 revealed Resident #3 was at risk for impaired cognitive function or impaired thought process due to new environment, mental illness, and recent hospitalization. Interventions included to monitor, document, and report to the physician any changes in cognitive function, decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status.</p> <p>The nursing note dated May 19, 2025 revealed Resident #3 was placed on COC monitoring for psychosocial well-being for a reported event.</p> <p>A care plan initiated May 19, 2025 included that Resident #3 had potential for a psychosocial well-being problem due to a reported event. Interventions included for a psychiatric evaluation on May 19, 2025.</p> <p>The psychiatric provider note dated May 19, 2025, at 7:15 p.m. revealed that according to staff, Resident #3 had increased anxiety with pacing and worrying; and that, the resident reported increased anxiety about a recent event, but did not wish to discuss the details of the event. The documentation also included that the resident reported having feelings of excess worrying and nervousness. Diagnosis included anxiety. (continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The police report shows the incident was reported on May 19, 2025, at 6:49 p.m., which is nearly 24 hours after it happened on May 18, 2025. The call was classified as a sexual assault of a minor. The report synopsis revealed that on May 18, 2025, at approximately 9:00 p.m., Resident #3 sexually assaulted Resident #444 while at the facility. The police report included a witness statement from a Licensed Practical Nurse (LPN/staff #312) who reported she often observed Resident #444 and Resident #3 hanging out together and talking at the facility for approximately a week before the incident. The LPN reported that on May 18, 2025 at approximately 9:00 p.m., she went to utilize the mirror in another resident's room and opened the closed door. The LPN reported that she saw Resident #3 positioned on her knees, with Resident #444 in the bathroom. The LPN reported that she informed her supervisor of the incident; and, Resident #3 was placed in a separate wing of the facility. The police report revealed a statement from Resident #3 who reported that both Resident #3 and Resident #444 went into the bathroom in another resident's room; and that, Resident #3 reported that she performed oral sex for approximately 2 minutes on Resident #444, who had asked for it. The report also included that Resident #3 reported knowing how old Resident #444 was prior to engaging in sexual acts in the restroom. Further, the police report revealed Resident #444 reported he and Resident #3 were watching a movie in another resident's room. According to the report, Resident #444 asked Resident #3 for oral sex, proceeded to the bathroom, closed the door, and then Resident #3 conducted oral sex. Further, the police report revealed that the offense for Resident #3 included 1 count of completed statutory rape and sexual conduct with minor.</p> <p>A facility 5-day investigation report was signed by the former DON (Staff #66) and dated May 21, 2025 submitted to the State Agency revealed that on or about May 19, 2025 at approximately 6:15 p.m., Resident #444 who was alert and oriented to person, place, time, and event was overheard by a staff making statements that he allegedly had received sexual acts from Resident #3. According to the report, a comprehensive investigation was immediately initiated; and, both Residents #444 and #3 were instructed to refrain from spending time together or having any physical contact to mitigate the risk of further occurrence. It also included that visual safety monitoring was implemented for both residents while the investigation was ongoing. According to the report, both residents were determined to be cognitively intact and had a BIMS score of 15. The report revealed that an interview was conducted on May 19, 2025 at approximately 6:26 p.m. with Resident #444 who confirmed that a sexual encounter occurred between and mutually consented by him and Resident #3. Per the documentation, Resident #444 reported that the incident occurred one time on May 18, 2025, and was interrupted by staff; and that, both Resident #444 and Resident #3 put their clothes on before staff entered the restroom.</p> <p>Continued review of the facility 5-day investigation revealed an interview was conducted on May 19, 2025 at 6:45 p.m. with Resident #3 who initially denied any incident; however, retracted and acknowledged that she and Resident #444 voluntarily engaged in the act; and that, Resident #444 requested for it. Per the documentation, Resident #3 reported that the encounter was interrupted by a staff.</p> <p>Further review of the facility investigation revealed an interview conducted on May 18, 2025 with the nurse on duty (LPN/Staff #312), who stated she observed Residents #444 and #3 together in one of the resident rooms, but, there was no inappropriate behavior noted at that time. The LPN reported that both residents reported that they were watching videos together and denied any misconduct; and, both were directed to return to their respective rooms. The report concluded that the facility was unable to substantiate that abuse occurred, and the incident occurred between two consenting individuals. (continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Despite knowledge of Resident #444's minor status, the facility failed to include this information in its initial and 5-day reports to the State Agency. Moreover, the facility did not identify the incident between Resident #444 and Resident #3 as sexual abuse, instead describing it as an encounter between consenting individuals. The facility failed to initiate a thorough investigation; specifically, it did not interview the resident who was allegedly present in the room while the residents #444 and #3 were in the bathroom, nor did it interview other residents—particularly those identified as minors and admitted at the time. Additionally, the facility did not review all relevant circumstances surrounding the event, including how the incident may have occurred, as required by its policy. The facility's report included a list of staff members and residents who were interviewed; and, all staff interviewed reported not seeing or hearing any incident. The report did not indicate what the interviewed residents had seen or heard. Further, the report did not include any interview or a written statement from the nurse (staff #312) who entered the room and found Residents #444 and #3 on the night of the incident.</p> <p>The facility investigation also did not include appropriate corrective actions taken to protect residents from possible abuse such as assessment and monitoring of other residents at risk, and any interventions/supervision put in place to protect other residents at risk.</p> <p>There was no evidence found that the facility reported this incident to DCS (Department of Child Services) despite knowing that Resident #444 was identified as a minor.</p> <p>The APS (Adult Protective Services) investigative report dated August 19, 2025, revealed that the allegation against the facility was neglect of a vulnerable adult, identified as Resident #3, and that the allegation was verified. The report revealed that Resident #3 was identified as a vulnerable adult due to having serious mental illness (SMI); and that, Resident #3 sexually assaulted Resident #444 while at the facility, and the case was verified because the sexual assault occurred.</p> <p>A phone interview with the legal guardian/family of Resident #444 was conducted on March 3, 2026, at 10:42 a.m. The legal guardian/family stated that she was the legal guardian of Resident #444 at the time of the incident; and that, a facility staff called and informed her several days before the incident that Resident #444 had developed an inappropriate relationship with another resident. She stated that approximately two days after the initial phone call, staff called and informed her that there was an incident where a staff member caught Resident #444 receiving oral sex from another resident. She stated that Resident #444 should have been under staff supervision and all staff should have been aware that Resident #444 was a minor and required supervision; but that, the facility did not do an adequate job protecting Resident #444. Further, the legal guardian stated that Resident #444 had a negative psychosocial impact as a result of the incident that occurred.</p> <p>A phone interview was conducted with an LPN (Staff #179) on March 3, 2026, at 9:57 a.m. The LPN stated that prior to the incident, Resident #3 and Resident #444 were hanging out together a lot, and that staff had warned Resident #3 that Resident #444 was a minor. The LPN further stated that after the incident, Resident #444 told staff that Resident #3 had performed oral sex on him.</p> <p>An interview with the social services supervisor (SS/Staff #254) was conducted on March 3, 2026, at 2:28 p.m. Staff #254 stated that a pediatric resident can make simple choices such as food, clothing, and activity choices; however, healthcare decisions and consent would be obtained from the resident's parent or legal guardian. Staff #254 stated that it was inappropriate and was illegal for an adult resident and a pediatric/minor resident to have a sexual relationship while at the facility. Further, Staff #254 stated that she was not sure what supervision measures the facility implemented (continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>for pediatric/minor residents.</p> <p>In an interview with a CNA (Staff #123) conducted on March 4, 2026, at 12:00 p.m., the CNA stated that prior to the incident, Resident #444 was not supervised directly by staff, and had freedom to roam the facility without anyone directly watching. The CNA said that when she came to work for her shift on day shift, she was informed that there had been an incident between Resident #444 and Resident #3. She said that she was told that during the night shift, a nurse walked in the bathroom of another resident's room and found Resident #3 performing oral sex on Resident #444.</p> <p>During an interview with the unit manager (Staff #82) conducted on March 4, 2026, at 12:26 p.m., the unit manager stated that the facility accepts and admits pediatric residents; and, if the resident has a legal guardian, then healthcare decisions and consents are obtained from the resident's legal guardian. The unit manager stated that there would be no scenario where a child/minor could consent to have sex with an adult while in the facility, because the child would not be of consenting age. She stated that it would be considered sexual molestation or rape if an adult has a sexual act with a child who cannot legally consent; and, it would be important for facility staff to be able to identify possible situations of sexual abuse and rape in order to protect the residents. Regarding the incident between Resident #3 and Resident #444, the unit manager stated that prior to the incident, there was a fear amongst staff that something would happen between Resident #444 and Resident #3, because both residents were spending a lot of time together; and that, Resident #444's TBI-related behaviors were noticeable, and the resident showed no remorse for his actions. She said that prior to the incident, she called and informed the legal guardian of Resident #444, that Resident #444 was spending time with another resident and the facility did not want anything inappropriate to happen. She also said that she informed the legal guardian that Resident #444 had been instructed to stay within public areas in the facility; and she requested the legal guardian to speak to Resident #444 to encourage compliance. Regarding the incident, the unit manager said that she was told that it occurred on night shift and a nurse walked in and saw the Residents #3 and #444 engaged in what appeared to be oral sex. The LPN said that both residents were separated, and the former DON (Staff #66) was the main person who conducted the investigation afterward. She stated that both Residents #3 and #444 initially denied the allegation; but later, Resident #444 admitted that oral sex occurred.</p> <p>A phone interview was conducted on March 4, 2026, at 1:35 p.m. with another LPN (Staff #85) who stated that she was working on the night shift on May 18, 2025 when the incident occurred. She stated that earlier in the evening, Residents #3 and #444 were spending time together with another resident and were walking the halls together. The LPN said that while she was in the middle of evening medication pass, sometime around 7:00 p.m. – 9:00 p.m., a nurse (Staff #312) from another unit came and asked her if either Resident #444 or Resident #3 was one of her assigned residents. She told the nurse (Staff #312) one of the residents was; and, the nurse (Staff #312) told her that there was an incident. The LPN said that the nurse (Staff #312) reported that when the nurse (Staff #312) walked into the room of another resident, the nurse (Staff #312), found Residents #444 and #3 together in the bathroom; and that, Resident #3 was on her knees in front of Resident #444 who was standing and had his pants down. The LPN said that the nurse (Staff #312) reported that Resident #444 quickly pulled his pants up when he saw the nurse (Staff #312); and that, the nurse told her that it looked like Resident #3 was performing oral sex on Resident #444. The LPN said that both she and the nurse (Staff #312) went to the room where both Residents #3 and #444 were found. The LPN stated that upon arriving to the room, the resident who stays in that room was very upset and told both nurses that he had no idea what was going on, and had no idea that a sexual encounter was going on in his bathroom. The LPN stated that Residents #3 and #444 were separated and reported the incident to the DON (staff #66) at that time. The LPN further stated that the police came to the (continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>facility the following day.</p> <p>A telephone interview with a DCS child safety specialist who was assigned to the case of Resident #444 was conducted on March 5, 2026, at 9:03 a.m. The DCS child safety specialist stated that Resident #444 reported that Resident #3 had performed oral sex on him; and they had been caught by a nurse at the facility. The DCS child safety specialist stated that the incident at the facility, including the ripple-effect aftermath, had a negative psychosocial effect on Resident #444.</p> <p>During a phone interview conducted with the former administrator (Staff #38) on March 5, 2026, at 12:46 p.m., the former administrator stated the facility staff knew that medical consents and healthcare decisions were needed to be obtained from the residents' families/legal guardian for pediatric residents/minors admitted at the facility. The former administrator stated that a child was not able to consent to have sex with an adult, because a minor is smaller than an adult and could be overpowered. He also said that the child's brain development is not fully there to be able to consent. The former administrator said that it was important for facility staff to be able to recognize possible instances of sexual abuse in order to prevent abuse from occurring; and, if staff sees/observes/has knowledge of an instance of possible sexual abuse, staff were expected to report the allegation to supervisors immediately, and then the facility would report to mandated entities within 2 hours. Regarding the incident between Resident #3 and Resident #444, the former administrator stated that he could not recall the details or when he had learned of it, but remembered that a nurse walked in and found Resident #3 positioned on her knees and Resident #444 was standing; and that, he was informed that Resident #3 had taken care of Resident #444 in a sexual way. The former administrator said that the former DON (Staff #66) had reported the incident right away, and led investigation of the incident. Regarding the outcome of the investigation, the former administrator said that he knew the incident was involving an adult and a minor, and that we assumed it happened. He further stated that he saw it as a crime, but did not know if it was sexual abuse.</p> <p>During a phone interview with the former DON (Staff #66) conducted on March 6, 2026, at 10:48 a.m., the former DON stated that the process for determining the necessary supervision level for each resident was by screening residents prior to admission and through nursing assessments; and that, this information would be communicated to staff typically through a care plan and a physician's order. Regarding consent, the former DON stated that consents would be obtained from the resident's parent or legal guardian for residents who were minors which was any resident under the age of 18. The former DON stated that any resident who was alert and oriented could consent to sexual decisions; and that, minors could consent to sexual activity with an adult. She also stated that she sees this happen all the time; and, she did not know the difference between assent and consent. The former DON stated that sexual abuse was unwanted sexual activity, and statutory rape was an instance where there was sexual conduct involving an adult and a minor that was not able to consent. She stated that there could be possible harm to a minor who was involved in a sexual encounter with an adult. Further, the former DON stated that the importance of staff being able to recognize possible instances of crimes or abuse would be so that staff could report it. She also said that if staff failed to recognize instances of abuse or crimes within the facility, then the risk of ongoing abuse or crimes to the residents. Regarding the incident between Resident #3 and Resident #444, the former DON stated that on May 18, 2025, Residents #3 and #444 were in another resident's room watching a movie together on a phone, and the nurse walked in to give the other resident evening medications when the nurse saw Residents #3 and #444 together watching the movie. The former DON stated that the nurse asked Resident #3 and Resident #444 to go back to their rooms, and the nurse reported the incident to her. The former DON stated that there was nothing going on other than watching movies; and that, she directed one of the night nurses to sit with Resident #444 all night. She said that the following day, a (continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Sunview Respiratory and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 12207 North 113th Avenue Youngtown, AZ 85363	
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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>staff overheard Resident #444 state that he asked Resident #3 to give him a sexual favor. The former DON stated that both Residents #3 and #444 were then interviewed by multiple staff and eventually one of the residents admitted that the act was started but never carried out. The former DON said that the incident was reported to mandated entities, was investigated, and the police came to the facility and conducted interviews. Further, the former DON further stated that she did not consider this incident as a case of sexual abuse because it could not be considered abuse if it was not unwanted. The former DON also said that Resident #444 could consent to have sexual activity with an adult.</p> <p>An interview was conducted with the facility's current Director of Nursing (DON / Staff #212) on March 6, 2026, at 11:29 a.m. The current DON stated that a minor would be considered a resident who was under the age of 18 and would need a parent or legal guardian to give consent for healthcare decisions. She stated that assent was an expression of agreement; and, consent was the legal ability to agree to something; and that, the importance of determining whether a resident can consent was to ensure the safety of residents. She stated that sexual abuse was a situation in which a resident was the recipient of unwanted sexual acts, or if the resident was a recipient of sexual acts and could not consent to those acts. She said that statutory rape was a case in which sex occurred between a minor who could not legally consent and an adult; and, if a resident was involved in a situation of statutory rape or sexual abuse then the outcome could be physical or psychological harm, and there could be other social implications as well. The current DON stated that it was not acceptable for an adult to sexually touch a minor who could not legally give consent. Regarding the incident between Resident #444 and Resident #3, the current DON said that she reviewed the facility's investigation and based on the investigation, the incident involved a minor and an adult and it appeared to be a crime. However, she stated that she could not speak directly to the details of the incident because she was not employed by the facility at that time. The current DON stated that this kind of incident required immediate reporting and investigation.</p> <p>During an interview conducted with the facility's current administrator (Staff #170) on March 6, 2026, at 1:43 p.m., the current administrator stated that it was extremely important for staff to be able to recognize possible instances of abuse or crimes within the facility in order to protect the residents. He said that if a staff failed to recognize abuse or crimes, then the abuse could be ongoing and detrimental to the health and wellbeing of the residents. The current administrator also said that if an allegation of abuse or a crime were suspected by staff, it was his expectation that staff would move the residents out of harm's way and to notify the administrator immediately. He said that the facility would then report the allegation to mandated entities within 2 hours. He stated that sexual abuse was any unwanted or non-consented sexual act from one person to another. Further, the current administrator stated that it was not acceptable for an adult to sexually touch or have sex with a minor who could not legally consent because the minor could experience psychological harm.</p> <p>An interview with the former DON (Staff #66) was conducted on April 3, 2026 at 11:52 a.m. The former DON stated abuse could be physical, emotional, physical, sexual, verbal and financial. She stated that she was the DON at the time of the incident between Resident #444 and #3. She stated that Resident #444 who was under the age of eighteen, was not identified as a minor in the facility reported incident to the State Agency, because when they discussed the incident, it was determined after conducting interviews with Residents #444 and #3 that the act was consensual between Residents #444 and #3; and that, Resident #444 sought out the sexual act. The former DON said that the facility did not identify that Resident #444 was a minor in their 5-day report because she entered the date of birth of Resident #444 in complaint portal; but, was not able to give a reason as to why the resident was not described as a minor in their reports. She stated a minor cannot give consent for sexual activity; and, if there are allegations involving a minor at the facility, the incident will be reported to (continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>the State Agency, APS (Adult Protective Services), and Department of Public Safety. She stated that mandatory reports included healthcare workers, the administrator, social workers and herself. Regarding Resident #444, the former DON stated that the resident's family called and informed APS of the incident. Staff #66 said she called to verify that the report was made to APS. She said that after reviewing the notification laws, CPS (Child Protective Services) should have been notified of the incident as soon as possible.</p> <p>Review of the facility policy titled Abuse: Prevention of and Prohibition Against, revised October 2022, revealed it is their policy that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Sexual abuse is non-consensual sexual contact of any type with a resident. All personnel, residents, visitors, etc. are encouraged to report incidents and grievances without the fear of retribution. Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the Facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations. The facility will act to protect and prevent abuse and neglect from occurring within the facility by:</p> <p>Supervising staff to identify and correct any inappropriate or unprofessional behaviors; -Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship, and the resident's right to establish a relationship with another individual; which may include the development of or the presence of an ongoing sexually intimate relationship;</p> <p>Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur, to include validating that the facility has deployed the correct number of competent staff on each shift to meet the needs of the residents;</p> <p>Identifying, assessing, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as: (a) verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating; physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects; and, sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing.</p> <p>Continued review of the policy included that the facility staff with knowledge of an actual or potential violation of this policy must report the violation to his or her supervisor or the Facility administrator immediately. The Facility will assist staff in identifying abuse, neglect, and exploitation of residents, and misappropriation of resident property. This includes identifying the different types of abuse-mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services.</p> <p>Further, the policy included all allegations of abuse, neglect, misappropriation of resident property, and exploitation will be promptly and thoroughly investigated by the Administrator or his/her designee. The investigation will include the following:</p> <p>An interview with the person(s) reporting the incident;</p> <p>An interview with the resident(s);</p> <p>Interviews with any witnesses to the incident, including the alleged perpetrator, as appropriate; (continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A review of the resident's medical record;</p> <p>An interview with staff members (on all shifts) who may have information regarding the alleged incident;</p> <p>Interviews</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, staff interviews, and review of facility policy and procedure, the facility failed to ensure an allegation of sexual abuse was reported in accordance with federal requirements when the facility failed to (1) Report the allegation of abuse to the State Agency, local law enforcement, adult protective services and department of children services immediately but no later than within 2 hours; (2) Failed to provide an accurate 5 day report; and, (3) Take appropriate corrective actions for one of one resident (R)#444 investigated for alleged sexual assault. The deficient practice resulted in the facility putting residents at for further abuse and placed the residents at risk for harm. Findings include: A facility self-report dated May 19, 2025 submitted to the State Agency (SA) by the former Director of Nursing (DON/Staff #66) revealed that on May 19, 2025, a staff member overheard Resident #444 made a statement that suggested he received sexual acts from Resident #3. According to the report, both residents were determined to be cognitively intact and had a BIMS score of 15; and that, during separate interviews, each resident acknowledged the encounter, asserted it was consensual, and that it occurred on May 18, 2025. Further, the report included that staff had previously witnessed residents #444 and #3 together but reported that there was no inappropriate behavior at that time. The report revealed the police were notified and appropriate reporting to state regulatory authorities was completed. However, the report did not identify Resident #444 as a minor.-Resident #444 (alleged victim/minor) was admitted to the facility on [DATE], with diagnoses of traumatic brain injury, attention deficit hyperactivity disorder (ADHD), anxiety and depression. A nursing note dated May 19, 2025 included that Resident #444 was placed on change of condition (COC) monitoring for psychosocial wellbeing for a reported event; and that, the resident, family, case manager, and provider were notified. However, the document did not include what the reported event was about.-Resident #3 (alleged perpetrator) was admitted on [DATE] with diagnoses of ADHD, schizophrenia, and mood disorder. The nursing note dated May 19, 2025 revealed Resident #3 was placed on COC monitoring for psychosocial well-being for a reported event. However, the document did not include what the reported event was about. The police report shows the incident was reported on May 19, 2025, at 6:49 p.m., which is nearly 24 hours after it happened on May 18, 2025. The call was classified as a sexual assault of a minor. The report synopsis revealed that on May 18, 2025, at approximately 9:00 p.m., Resident #3 sexually assaulted Resident #444 while at the facility. The police report included a witness statement from a Licensed Practical Nurse (LPN/staff #312) who reported she often observed Resident #444 and Resident #3 hanging out together and talking at the facility for approximately a week before the incident. The LPN reported that on May 18, 2025 at approximately 9:00 p.m., she went to utilize the mirror in another resident's room and opened the closed door. The LPN reported that she saw Resident #3 positioned on her knees, with Resident #444 in the bathroom. The LPN reported that she informed her supervisor of the incident; and, Resident #3 was placed in a separate wing of the facility. The police report revealed a statement from Resident #3 who reported that both Resident #3 and Resident #444 went into the bathroom in another resident's room; and that, Resident #3 reported that she performed oral sex for approximately 2 minutes on Resident #444, who had asked for it. The report also included that Resident #3 reported knowing how old Resident #444 was prior to engaging in sexual acts in the restroom. Further, the police report revealed Resident #444 reported he and Resident #3 were watching a movie in another resident's room. According to the report, Resident #444 asked Resident #3 for oral sex, proceeded to the bathroom, closed the door, and then Resident #3 conducted oral sex. Further, the police report revealed that the offense for Resident #3 included 1 count of completed statutory rape and sexual conduct with minor. A facility 5-day investigation report was signed by the former DON (Staff #66) and dated May 21, 2025 submitted to the State Agency revealed that on or about May 19, 2025 at (continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>approximately 6:15 p.m., Resident #444 who was alert and oriented to person, place, time, and event was overheard by a staff making statements that he allegedly had received sexual acts from Resident #3. According to the report, a comprehensive investigation was immediately initiated; and, both Residents #444 and #3 were instructed to refrain from spending time together or having any physical contact to mitigate the risk of further occurrence. It also included that visual safety monitoring was implemented for both residents while the investigation was ongoing. According to the report, both residents were determined to be cognitively intact and had a BIMS score of 15. The report revealed that an interview was conducted on May 19, 2025 at approximately 6:26 p.m. with Resident #444 who confirmed that a sexual encounter occurred between and mutually consented by him and Resident #3. Per the documentation, Resident #444 reported that the incident occurred one time on May 18, 2025, and was interrupted by staff; and that, both Resident #444 and Resident #3 put their clothes on before staff entered the restroom. Continued review of the facility 5-day investigation revealed an interview was conducted on May 19, 2025 at 6:45 p.m. with Resident #3 who initially denied any incident; however, retracted and acknowledged that she and Resident #444 voluntarily engaged in the act; and that, Resident #444 requested for it. Per the documentation, Resident #3 reported that the encounter was interrupted by a staff. Further review of the facility investigation revealed an interview conducted on May 18, 2025 with the nurse on duty (LPN/Staff #312), who stated she observed Residents #444 and #3 together in one of the resident rooms, but, there was no inappropriate behavior noted at that time. The LPN reported that both residents reported that they were watching videos together and denied any misconduct; and, both were directed to return to their respective rooms. The report concluded that the facility was unable to substantiate that abuse occurred, and the incident occurred between two consenting individuals. Despite knowledge of Resident #444's minor status, the facility failed to include this information in its initial and 5-day reports to the State Agency. Moreover, the facility did not identify the incident between Resident #444 and Resident #3 as sexual abuse, instead describing it as an encounter between consenting individuals. As a result, the facility did not take appropriate corrective actions to protect residents from possible abuse such as assessment and monitoring of other residents at risk, and any interventions/supervision put in place to protect other residents at risk. There was no evidence found that the facility reported this incident to DCS despite knowing that Resident #444 was a minor. The APS (Adult Protective Services) investigative report dated August 19, 2025, revealed that the allegation against the facility was neglect of a vulnerable adult, identified as Resident #3, and that the allegation was verified. The report revealed that Resident #3 was identified as a vulnerable adult due to having serious mental illness (SMI); and that, Resident #3 sexually assaulted Resident #444 while at the facility, and the case was verified because the sexual assault occurred. A phone interview was conducted on March 4, 2026, at 1:35 p.m. with another LPN (Staff #85) who stated that she was working on the night shift on May 18, 2025 when the incident occurred. She stated that earlier in the evening, Residents #3 and #444 were spending time together with another resident and were walking the halls together. The LPN said that while she was in the middle of evening medication pass, sometime around 7:00 p.m. - 9:00 p.m., a nurse (Staff #312) from another unit came and asked her if either Resident #444 or Resident #3 was one of her assigned residents. She told the nurse (Staff #312) one of the residents was; and, the nurse (Staff #312) told her that there was an incident. The LPN said that the nurse (Staff #312) reported that when the nurse (Staff #312) walked into the room of another resident, the nurse (Staff #312), found Residents #444 and #3 together in the bathroom; and that, Resident #3 was on her knees in front of Resident #444 who was standing and had his pants down. The LPN said that the nurse (Staff #312) reported that Resident #444 quickly pulled his pants up when he saw the nurse (Staff #312); and that, the nurse told her that it looked like Resident #3 was performing oral sex on Resident #444. The LPN said that both she and the nurse (Staff #312) went to the room where both Residents #3 and #444 were found. The LPN stated that upon arriving to the room, the resident who stays in that room was very upset and told both nurses that he had no idea what was going on, and had no idea that a sexual encounter was (continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>going on in his bathroom. The LPN stated that Residents #3 and #444 were separated and reported the incident to the DON (staff #66) at that time. The LPN further stated that the police came to the facility the following day. During a phone interview with a Department of Child Services (DCS) staff conducted on March 4, 2026, at 2:58 p.m. the DCS staff stated that DCS only became involved with the incident when Resident #444 was discharged to the hospital; and the hospital reported the incident to them. The DCS staff stated that the facility did not inform DCS of the incident. The DCS staff said that Resident #444 reported that he was caught by a facility staff having oral sex with another resident. Further, the DCS staff stated that based on the resident's age, Resident #444 was not able to give consent. In another telephone interview with a DCS child safety specialist who was assigned to the case of Resident #444 was conducted on March 5, 2026, at 9:03 a.m. The DCS child safety specialist stated that Resident #444 reported that Resident #3 had performed oral sex on him; and they had been caught by a nurse at the facility. The DCS child safety specialist stated that the incident at the facility, including the ripple-effect aftermath, had a negative psychosocial effect on Resident #444. During a phone interview conducted with the former administrator (Staff #38) on March 5, 2026, at 12:46 p.m., the former administrator stated it was important for facility staff to be able to recognize possible instances of sexual abuse in order to prevent abuse from occurring; and, if staff sees/observes/has knowledge of an instance of possible sexual abuse, staff were expected to report the allegation to supervisors immediately, and then the facility would report to mandated entities within 2 hours. Regarding the incident between Resident #3 and Resident #444, the former administrator stated that he was informed that Resident #3 had taken care of Resident #444 in a sexual way. The former administrator said that the former DON (Staff #66) had reported the incident right away, and led investigation of the incident; however, he stated that he could not answer questions related to discrepancies on when it was reported to him as the incident happened long time ago. Regarding the outcome of the investigation, the former administrator said that he knew the incident was involving an adult and a minor, and that we assumed it happened. He further stated that he saw it as a crime, but did not know if it was sexual abuse. During a phone interview with the former DON (Staff #66) conducted on March 6, 2026, at 10:48 a.m., the former DON stated that the facility staff investigated the incident between Residents #444 and #3. The former DON said that a thorough investigation included conducting staff interviews during and surrounding the incident, and from staff who were familiar with the residents involved. She further stated that she conducted an interview with the other resident present in the room of the restroom where both Resident #3 and Resident #444 were found; however, the interview was not documented in their facility investigative report. An interview was conducted with the facility's current Director of Nursing (DON/Staff #212) on March 6, 2026, at 11:29 a.m. The current DON stated that she reviewed the facility's investigation on the incident between Resident #444 and #3 and based on the investigation, the incident involved a minor and an adult and it appeared to be a crime. However, she stated that she could not speak directly to the details of the incident because she was not employed by the facility at that time; but, this kind of incident required immediate reporting and investigation. She said that based on the facility investigation, she could not determine details of the incident such as what room the incident happened, whether or not there was anyone else was present during the incident, if assessments were conducted for Residents #444 and #3 and whether or not DCS was notified since the incident involved a minor. During an interview conducted with the facility's current administrator (Staff #170) on March 6, 2026, at 1:43 p.m., the current administrator stated that it was extremely important for staff to be able to recognize possible instances of abuse or crimes within the facility in order to protect the residents. He said that if a staff failed to recognize abuse or crimes, then the abuse could be ongoing and detrimental to the health and wellbeing of the residents. The current administrator also said that if an allegation of abuse or a crime were suspected by staff, it was his expectation that staff would move the residents out of harm's way and to notify the administrator immediately. He said that the facility would then report the allegation to mandated entities within 2 hours. He stated that (continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>sexual abuse was any unwanted or non-consented sexual act from one person to another. Further, the current administrator stated that it was not acceptable for an adult to sexually touch or have sex with a minor who could not legally consent because the minor could experience psychological harm.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical record, and review of facility policy and procedure, the facility failed to ensure an allegation of sexual abuse was thoroughly investigated for two residents (#444 and #3). The deficient practice could result in an allegation of sexual abuse not being investigated timely and/or possible ongoing abuse of a resident. Findings include: A facility self-report dated May 19, 2025 submitted to the State Agency (SA) by the former Director of Nursing (DON/Staff #66) revealed that on May 19, 2025, a staff member overheard Resident #444 made a statement that suggested he received sexual acts from Resident #3. According to the report, both residents were determined to be cognitively intact and had a BIMS score of 15; and that, during separate interviews, each resident acknowledged the encounter, asserted it was consensual, and that it occurred on May 18, 2025. Further, the report included that staff had previously witnessed residents #444 and #3 together but reported that there was no inappropriate behavior at that time. The report revealed the police were notified and appropriate reporting to state regulatory authorities was completed. The report did not identify Resident #444 as a minor. -Resident #444 (alleged victim/minor) was admitted to the facility on [DATE], with diagnoses of traumatic brain injury, attention deficit hyperactivity disorder (ADHD), anxiety and depression. A nursing note dated May 19, 2025 included that Resident #444 was placed on change of condition (COC) monitoring for psychosocial wellbeing for a reported event; and that, the resident, family, case manager, and provider were notified. However, the document did not include what the reported event was about. A care plan initiated May 19, 2025 revealed Resident #444 had a potential for a psychosocial well-being problem due to a reported event. Interventions included for 1:1 staff initiated on May 19, 2025. However, there was no evidence found in the clinical record that interventions to protect Resident #444 from further abuse was put in place on May 18, 2025, the date the incident happened. -Resident #3 (alleged perpetrator) was admitted on [DATE] with diagnoses of ADHD, schizophrenia, and mood disorder. The nursing note dated May 19, 2025 revealed Resident #3 was placed on COC monitoring for psychosocial well-being for a reported event. The document did not include what the reported event was about. A care plan initiated May 19, 2025 included that Resident #3 had potential for a psychosocial well-being problem due to a reported event. Interventions included for a psychiatric evaluation on May 19, 2025. The psychiatric provider note dated May 19, 2025, at 7:15 p.m. revealed that according to staff, Resident #3 had increased anxiety with pacing and worrying; and that, the resident reported increased anxiety about a recent event, but did not wish to discuss the details of the event. The documentation also included that the resident reported having feelings of excess worrying and nervousness. There was no evidence found that appropriate actions were taken on May 18, 2025 to protect all residents including Resident #444 from further abuse by resident #3. The police report shows the incident was reported on May 19, 2025, at 6:49 p.m., which is nearly 24 hours after it happened on May 18, 2025. The report synopsis revealed that on May 18, 2025, at approximately 9:00 p.m., Resident #3 sexually assaulted Resident #444 while at the facility. The police report included a witness statement from a Licensed Practical Nurse (LPN/staff #312) who reported she often observed Resident #444 and Resident #3 hanging out together and talking at the facility for approximately a week before the incident. The LPN reported that on May 18, 2025 at approximately 9:00 p.m., she went to utilize the mirror in another resident's room and opened the closed door. The LPN reported that she saw Resident #3 positioned on her knees, with Resident #444 in the bathroom. The LPN reported that she informed her supervisor of the incident; and, Resident #3 was placed in a separate wing of the facility. The police report revealed a statement from Resident #3 who reported that both Resident #3 and Resident #444 went into the bathroom in another resident's room; and that, Resident #3 reported that she performed oral sex for approximately 2 minutes on Resident #444, who had asked for it. The report also included that Resident #3 reported knowing how old Resident #444 was prior to engaging in sexual acts in the restroom. Further, the police report (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>revealed Resident #444 reported he and Resident #3 were watching a movie in another resident's room. According to the report, Resident #444 asked Resident #3 for oral sex, proceeded to the bathroom, closed the door, and then Resident #3 conducted oral sex. Further, the police report revealed that the offense for Resident #3 included 1 count of completed statutory rape and sexual conduct with minor. A facility 5-day investigation report was signed by the former DON (Staff #66) and dated May 21, 2025 submitted to the State Agency revealed that on or about May 19, 2025 at approximately 6:15 p.m., Resident #444 who was alert and oriented to person, place, time, and event was overheard by a staff making statements that he allegedly had received sexual acts from Resident #3. According to the report, a comprehensive investigation was immediately initiated; and, both Residents #444 and #3 were instructed to refrain from spending time together or having any physical contact to mitigate the risk of further occurrence. It also included that visual safety monitoring was implemented for both residents while the investigation was ongoing. According to the report, both residents were determined to be cognitively intact and had a BIMS score of 15. The report revealed that an interview was conducted on May 19, 2025 at approximately 6:26 p.m. with Resident #444 who confirmed that a sexual encounter occurred between and mutually consented by him and Resident #3. Per the documentation, Resident #444 reported that the incident occurred one time on May 18, 2025, and was interrupted by staff; and that, both Resident #444 and Resident #3 put their clothes on before staff entered the restroom. Continued review of the facility 5-day investigation revealed an interview was conducted on May 19, 2025 at 6:45 p.m. with Resident #3 who initially denied any incident; however, retracted and acknowledged that she and Resident #444 voluntarily engaged in the act; and that, Resident #444 requested for it. Per the documentation, Resident #3 reported that the encounter was interrupted by a staff. Further review of the facility investigation revealed an interview conducted on May 18, 2025 with the nurse on duty (LPN/Staff #312), who stated she observed Residents #444 and #3 together in one of the resident rooms, but, there was no inappropriate behavior noted at that time. The LPN reported that both residents reported that they were watching videos together and denied any misconduct; and, both were directed to return to their respective rooms. The report concluded that the facility was unable to substantiate that abuse occurred, and the incident occurred between two consenting individuals. This report was signed by the former DON (staff #66). Despite knowledge of Resident #444's minor status, the facility failed to include this information in its initial and 5-day reports to the State Agency. Moreover, the facility did not identify the incident between Resident #444 and Resident #3 as sexual abuse, instead describing it as an encounter between consenting individuals. The facility failed to initiate a thorough investigation; specifically, it did not interview the resident who was allegedly present in the room while the residents #444 and #3 were in the bathroom, nor did it interview other residents-particularly those identified as minors and admitted at the time. Additionally, the facility did not review all relevant circumstances surrounding the event, including how the incident may have occurred, as required by its policy. The facility's report included a list of staff members and residents who were interviewed; and, all staff interviewed reported not seeing or hearing any incident. The report did not indicate what the interviewed residents had seen or heard. Further, the report did not include any written statement from the nurse (staff #312) who entered the room and found Residents #444 and #3 on the night of the incident. In their investigation, the facility included a statement regarding an interview with the nurse (staff #312) conducted during their investigation. The facility reported that the nurse (#312) reported seeing resident #444 and #3 together in one of the resident rooms but noted no inappropriate behavior at the time. Because of their failure to recognize the incident as a potential allegation of abuse, the facility did not initiate a thorough investigation to include: (1) Taking appropriate corrective actions taken to protect residents from possible abuse; (2) Assessment and monitoring of other residents at risk; Notification of the alleged violation to local law enforcement and DCS (Department of Child Services); and, any interventions/supervision put in place to protect other residents at risk. This placed residents at risk for harm. There was no evidence found that the facility reported this incident to DCS (Department of (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Child Services) despite knowing that Resident #444 was identified as a minor. Review of staff schedules and punch details revealed that none of the 6 staff members interviewed in their investigation worked during the night shift of the incident on May 18, 2025. The APS (Adult Protective Services) investigative report dated August 19, 2025, revealed that the allegation against the facility was neglect of a vulnerable adult, identified as Resident #3, and that the allegation was verified. The report revealed that Resident #3 was identified as a vulnerable adult due to having serious mental illness (SMI); and that, Resident #3 sexually assaulted Resident #444 while at the facility, and the case was verified because the sexual assault occurred. A phone interview was conducted with an LPN (Staff #179) on March 3, 2026, at 9:57 a.m. The LPN stated that prior to the incident, Resident #3 and Resident #44 were hanging out together a lot, and that staff had warned Resident #3 that Resident #444 was a minor. The LPN further stated that after the incident, Resident #444 told staff that Resident #3 had performed oral sex on him. However, there was no evidence found in the clinical records that interventions were put in place to supervise or discourage Resident #444 and #3 from hanging out with each other; and, no evidence found of any actions or preventive measures taken such as increase supervision or monitoring of Residents #444 and #3. In an interview with a CNA (Staff #123) conducted on March 4, 2026, at 12:00 p.m., the CNA stated that prior to the incident, Resident #444 was not supervised directly by staff, and had freedom to roam the facility without anyone directly watching. A phone interview was conducted on March 4, 2026, at 1:35 p.m. with another LPN (Staff #85) who stated that the incident to the DON (staff #66) at that time of the incident; but, the police came to the facility the following day. During a phone interview with a Department of Child Services (DCS) staff conducted on March 4, 2026, at 2:58 p.m. the DCS staff stated that DCS only became involved with the incident when Resident #444 was discharged to the hospital; and the hospital reported the incident to them. The DCS staff stated that the facility did not inform DCS of the incident. During a phone interview conducted with the former administrator (Staff #38) on March 5, 2026, at 12:46 p.m., the former administrator stated it was important for facility staff to be able to recognize possible instances of sexual abuse in order to prevent abuse from occurring; and, if staff sees/observes/has knowledge of an instance of possible sexual abuse, staff were expected to report the allegation to supervisors immediately, and then the facility would report to mandated entities within 2 hours. The former administrator said that the former DON (Staff #66) had reported the incident right away, and led investigation of the incident; however, he stated that he could not answer questions related to discrepancies on when it was reported to him as the incident happened long time ago. During a phone interview with the former DON (Staff #66) conducted on March 6, 2026, at 10:48 a.m., the former DON stated that on May 18, 2025, Residents #3 and #444 were in another resident's room watching a movie together on a phone, and the nurse walked in to give evening medications to the other resident (in the room where both Resident #3 and #444 was found). The former DON said that the nurse then saw Residents #3 and #444 together watching the movie; and the nurse Resident #3 and Resident #444 to go back to their rooms, and nurse reported the incident to her. The former DON stated that there was nothing going on other than watching movies; and that, she directed one of the night nurses to sit with Resident #444 all night. She stated the incident was not reported or investigated until the following day, May 19, 2025, when a staff overheard Resident #444 state that he asked Resident #3 to give him a sexual favor. The former DON stated that both Residents #3 and #444 were then interviewed by multiple staff and eventually one of the residents admitted that the act was started but never carried out. The former DON said that the incident was reported the following day to mandated entities, was investigated, and the police came to the facility and conducted interviews; and that, she did not consider this incident as a case of sexual abuse because it could not be considered abuse if it was not unwanted and this was why it was not reported on May 18, 2025. She further stated that Resident #444 could consent to have sexual activity with an adult. The former DON also said that the facility conducted a thorough investigation; and that, a thorough investigation included conducting staff interviews during and (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>surrounding the incident, and from staff who were familiar with the residents involved. She further stated that she conducted an interview with the other resident present in the room of the restroom where both Resident #3 and Resident #444 were found; however, the interview was not documented in their facility investigative report. An interview was conducted with the facility's current Director of Nursing (DON / Staff #212) on March 6, 2026, at 11:29 a.m. The current DON stated that a minor would be considered a resident who was under the age of 18 and would need a parent or legal guardian to give consent for healthcare decisions. She stated that assent was an expression of agreement; and, consent was the legal ability to agree to something; and that, the importance of determining whether a resident can consent was to ensure the safety of residents. She stated that sexual abuse was a situation in which a resident was the recipient of unwanted sexual acts, or if the resident was a recipient of sexual acts and could not consent to those acts. She said that statutory rape was a case in which sex occurred between a minor who could not legally consent and an adult; and, if a resident was involved in a situation of statutory rape or sexual abuse then the outcome could be physical or psychological harm, and there could be other social implications as well. The current DON stated that it was not acceptable for an adult to sexually touch a minor who could not legally give consent. Regarding the incident between Resident #444 and Resident #3, the current DON said that she reviewed the facility's investigation and based on the investigation, the incident involved a minor and an adult and it appeared to be a crime. However, she stated that she could not speak directly to the details of the incident because she was not employed by the facility at that time. The current DON stated that this kind of incident required immediate reporting and investigation. During an interview conducted with the facility's current administrator (Staff #170) on March 6, 2026, at 1:43 p.m., the current administrator stated that it was extremely important for staff to be able to recognize possible instances of abuse or crimes within the facility in order to protect the residents. He said that if a staff failed to recognize abuse or crimes, then the abuse could be ongoing and detrimental to the health and wellbeing of the residents. The current administrator also said that if an allegation of abuse or a crime were suspected by staff, it was his expectation that staff would move the residents out of harm's way and to notify the administrator immediately. He said that the facility would then report the allegation to mandated entities within 2 hours. He stated that sexual abuse was any unwanted or non-consented sexual act from one person to another. Further, the current administrator stated that it was not acceptable for an adult to sexually touch or have sex with a minor who could not legally consent because the minor could experience psychological harm. Review of the facility policy titled Abuse: Prevention of and Prohibition Against, revised October 2022, revealed it is their policy that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Sexual abuse is non-consensual sexual contact of any type with a resident. All personnel, residents, visitors, etc. are encouraged to report incidents and grievances without the fear of retribution. Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the Facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations. The policy included all allegations of abuse, neglect, misappropriation of resident property, and exploitation will be promptly and thoroughly investigated by the Administrator or his/her designee. The investigation will include the following: An interview with the person(s) reporting the incident; An interview with the resident(s); Interviews with any witnesses to the incident, including the alleged perpetrator, as appropriate; A review of the resident's medical record; An interview with staff members (on all shifts) who may have information regarding the alleged incident; Interviews with other residents to whom the accused employee provides care or services or who may have information regarding the alleged incident; An interview with staff members (on all shifts) having contact with the accused employee; and, A review of all circumstances surrounding the incident. The policy continued that if an allegation of abuse, neglect, misappropriation of resident property, or exploitation is reported, discovered or suspected, the Facility will take the following steps to protect all residents from physical and psychosocial harm (continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>Based on interviews, records, and policy review, the facility's QAPI program did not show it is actively addressing all care and services for residents. Specifically, the facility failed to: (1) Conduct a root cause analysis to identify why the sexual abuse incident between residents occurred; (2) Clearly define the problem or outline specific actions to fix it, including measurable goals, timelines, how effectiveness would be evaluated, and who is responsible; (3) Identify specific changes to policies, procedures, or practices that were or will be put in place; and, (4) Set up ongoing monitoring with clear baselines, target goals, and timelines. Because of these gaps, the facility did not implement clear corrective actions or provide appropriate staff training, which may lead to weak systems for identifying, assessing, and responding to potential sexual abuse incidents. Findings include: Review of the Quality Improvement Plan/Action Plan dated May 20, 2025 revealed the item/problem identified was that minors were admitted to the facility. Causal factor included lack of communication to the facility's IDT (interdisciplinary team) regarding admission of minors. Interventions included monitoring of date of birth daily on each admission, in-service training of admission and marketing staff on the new process for admission of minors, review of census in daily stand-up meetings and complete a full house review of the date of birth of all current residents. However, the plan did not look into the root cause of the sexual abuse incident between the two residents or show that the facility fully investigated why it happened. Aside from general monitoring, the QAPI plan did not include a clear plan to fix the issue. It was missing details like goals, timelines, specific actions to correct the problem, who is responsible for each step, how the facility will check if the actions are working. The facility's QAPI plan showed that staff training focused on a new process for admitting minors, not on the abuse-related deficiency. The plan also did not include key details about the training, such as the content, who will be trained, the timeline for completion, and how the training will be documented and verified. In addition, the plan did not include any system-wide changes made or planned in direct response to the abuse incident. During an interview with the Administrator on April 2, 2026 at 3:40 p.m., he stated that the facility holds QAPI (Quality Assurance and Performance Improvement) meetings monthly, but at least quarterly. These meetings are attended by the Administrator, DON, IDT team, medical director or family representative, and staff. He explained that the purpose of QAPI is to identify areas of concern. He stated that a QAPI meeting was held at the time of the incident involving Residents #444 and #3, during which the facility discussed admitting residents under the age of eighteen. The Administrator said the facility decided not to admit any residents under eighteen going forward. He further stated that after the incident between Resident #444 and #3, the facility initiated and continued to provide training on Abuse, Neglect and Exploitation during their monthly all staff meeting. The administrator said since the investigation which occurred earlier this month the facility has not admitted anyone under the age of 18. He stated the facility was waiting for the 2567 to be sent out to determine what policies and procedures might needed to be implemented. An interview with the Clinical resource was conducted on April 3, 2026 at 8:50 a.m. The clinical resource stated that QAPI meeting is usually held every month at a minimum; and, they discuss all the identified areas of concerns, trends, action plans in place. She stated that the actions in place are monitored to ensure that it is being implemented and were reviewed whether they are effective or not. In another interview with the Administrator conducted on April 3, 2026 at 9:43 a.m., he stated that the issues were identified during the monthly QAPI meeting which are attended by the administrator, DON and the IDT team. He stated that staff can also bring up quality concerns to their managers who would then share with him and the QAPI committee. He stated that the QAPI committee will then come up with systems in place to address the issue and have specific plans to correct the issue. He said that the action plans will then be implemented and audits are conducted to ensure that staff were following the intervention that is in place. The quality concern will stay in QAPI for 90 days or longer to ensure that it is working. He said that the tools that they use to correct the identified quality (continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>concern includes in-service training of staff, audits, and data collection/analysis if needed; and if the action in place is not working, the QAPI will reevaluate and revise or put and implement new actions to take and monitor implementation to address the identified quality issue. Review of the facility policy titled Abuse: Quality Assessment and Performance Improvement, revised September 2020, revealed it is their policy that the facility will prioritize through identification of high risk, high volume, or problem-prone areas; and that, the facility may utilize the following established Performance Improvement tools/Processes. The members of the QAPI committee functions include: QAPI plan, identifying and prioritizing PIPs, implementing actions to correct quality issues, and monitoring to ensure the corrective action implemented is being sustained. The QAPI Plan will include (1) Design and scope; (2) Governance and leadership; (3) Feedback, data systems, and monitoring; (4) Performance improvement projects (QITs); and, (5) Systemic analysis and systemic action. Identification of, and prioritizing of, PIPs through: (1) Open-door policy for staff reporting of quality problems; (2) Staff meetings; (3) Resident Council; (4) Grievances; (5) Systematic review of facility data, data sources, and comparative data, from market, state, and national sources; and, (6) Prioritizing through identification of high-risk, high volume, or problem-prone issues.</p>		