STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105262	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Lake Post Acute	991 E New York Ave Deland, FL 32724

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42442 Based on observations, a review of resident and facility records, interviews with staff, and a review of job descriptions and facility policies and procedures, the facility failed to protect the resident's right to be free from sexual abuse from a resident. This resulted in sexual contact for one resident who was unable to consent to sexual activity (Resident #1) of three residents reviewed for abuse. The facility failed to develop and implement interventions necessary to protect Resident #1 from sexual contact by Resident #2, who had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 possible points, indicating moderate cognitive impairment, and who was independently ambulatory with the use of a cane. This created a likelihood that Resident #1 could be abused again, or any other vulnerable resident could be sexually assaulted and suffer serious psychosocial and/or physical harm from Resident #2. Resident #1 was unable to consent to sexual activity due to severely impaired cognition. She had a likelihood to suffer serious psychosocial harm not yet realized, because of her inability to consent to sexual activity. Other residents also could suffer the same outcome if Resident #2 were to sexually abuse them. This diminished their self-worth and self-respect. Immediate Jeopardy (IJ) at a scope and severity of J (isolated) was identified on April 7, 2025 at 3:50 p.m. On April 1, 2025, at 6:55 p.m., Immediate Jeopardy began. On April 8, 2025, at 6:15 p.m., the Administrator was notified of the IJ determination and was provided with Immediate Jeopardy Templates. Immediate Jeopardy was ongoing as of the survey exit on April 8, 2025. The findings include: Cross reference F610, F835, and F867. 1. A review of Resident #1's medical record revealed an admitted [DATE]. Her diagnoses included, but were not limited to, metabolic encephalopathy (brain dysfunction leading to altered consciousness, cognitive decline and other neurological symptoms), attention and concentration deficit following cerebral infarction (stroke); extended-spectrum beta-lactamase resistance (ESBL - bacterial infection resistant to antibiotics); dementia in other diseases classified elsewhere, unspecified severity with agitation; general anxiety disorder; schizoaffective disorder; and need for assistance with personal care. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the resident's 3/2/25 physician's orders revealed: - Donepezil Oral tablet 10 milligrams (mg) - give 1 tablet by mouth at bedtime for dementia. - Quetiapine (antipsychotic) Fumarate Oral tablet 50 mg - give 1 tablet by mouth one time a day for anxiety. - Quetiapine Fumarate Oral tablet 50 mg - give 3 tablets by mouth at bedtime for anxiety. - Alprazolam (benzodiazepine - slows the nervous system) oral tablet 0.5 mg - give 1 tablet by mouth every morning and at bedtime for anxiety. - Sertraline HCL (hydrochloride) (selective serotonin reuptake inhibitor - can be used to treat depression, obsessive compulsive disorder, posttraumatic stress disorder, social anxiety disorder and/or panic disorder) oral tablet 100 mg - give 1 tablet by mouth one time a day for depression. - 1:1 monitoring every shift - discontinued on 3/7/25. Additional physician's orders included: - 3/7/2025 - 30-minute monitoring for behaviors, (This order, 30-minute monitoring, was discontinued on 3/19/25). No documentation for increased/frequent monitoring was found from 3/19/2025 through 4/1/2025. - 3/24/2025 - Ciprofloxacin HCL (antibiotic) oral tablet 500 mg - give 500 mg by mouth two times a day for urinary tract infection (UTI) for 14 days. - 4/1/2025 - One-on-one monitoring for behaviors - every shift. A review of the Psychotropic Evaluation nursing note dated 3/2/2025, revealed that Resident #1 had behaviors (e.g. combativeness, verbal disruptions) that were harmful to self or others or limited participation in activities. Increased in acuteness. She could be aggressive with staff. Resident has anxiety or nervousness that impairs his/her quality of life or limits participation in activities. A review of a Behavior Note dated 3/3/2025 revealed: Resident has pulled out her peripherally inserted central catheter (PICC) line from her right upper arm. Some bleeding was observed, pressure applied and Tegaderm (transparent, waterproof, sterile medical dressing) placed after it stopped. Resident remains aggressive, attempting to bite several staff members and kick. New order for Haldol (antipsychotic) intramuscularly (IM) given per Advanced Practice Registered Nurse (APRN) - Ineffective, continues to walk around yelling and screaming. Redirected as staff walks along with her. A review of the Provider Encounter dated 3/14/25 revealed that the resident wandered and attempted to hit and bite staff. She continued to refuse clothing changes as needed. Psychiatry was consulted to see resident and schedule next week. The Haldol order remained in place for behavioral management. (Psychiatry notes were requested but not provided during the survey.) (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An Encounter note dated 3/20/25 recommended that the resident continue with 30-minute behavior checks for safety monitoring. (The order was not implemented. Copies obtained) An Encounter note dated 4/2/25 revealed that Resident #1 was seen for a behavioral follow up. She was found in a male resident's bed last night with what appears to be inappropriate touching and sexual behavior. Resident was returned to one-on-one (1:1) care. A Nursing Progress note dated 4/2/25 read, Resident is up pacing around in her room, up and down in her bed, difficult to redirect, very aggressive with staff, swinging at them, screaming out loud, cursing, knocked over everything on her bedside table, attempted to get in a bed with a resident in the bed, displayed aggressive behavior when trying to redirect. New order given to administer Haldol 0.5 mg IM (intramuscularly - in the muscle) due to aggressive behavior. She remains on 1:1 care. A review of the Admission 5-day minimum data set (MDS) assessment with a reference date of 3/6/25, revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 01 out of 15 possible points, indicating severe cognitive impairment. The resident was noted to be delusional, and physically and verbally aggressive with wandering behavior. She received antipsychotic, antianxiety, antidepressant, and antibiotic medications during the assessment period. A review of the Care Plan (initiated 4/1/25, revised 4/1/25) revealed that the resident had Impaired Cognitive Function/Dementia or Impaired Thought Processes related to dementia, schizoaffective disorder, difficulty making decisions and psychotropic drug use. The resident will be able to communicate basic needs on a daily basis. The care plan noted that the resident had a behavior problem of making inappropriate sexual advances to other residents, aggression and other inappropriate behaviors with a history of UTIs, pacing, wandering, disrobing, inappropriate response to verbal communication, violence, aggression towards staff/others. Pulled out PICC line. Pulled out Foley (urinary) catheter. Resident will have fewer episodes of undesired behaviors. The resident will have no evidence of behavior problems. 1:1 care (downgraded, failed attempt) frequent checks 1:1 caregiver reinitiated 4/1. Move to a room away from patient she appears to favor. Resident #1 was admitted on [DATE]. The following comprehensive care plans were initiated: 3/3/2025 - Nutrition/Hydration Risk 3/4/2025 - Depression 3/8/2025 - Urinary Tract Infection The incident with Resident #2 occurred on 4/1/25. The following comprehensive care plans were initiated on 4/1/25: 4/1/2025 - Dementia 4/1/2025 - Skin Integrity 4/1/2025 - Activities 4/1/2025 - Incontinence (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4/1/2025 - Fall Risk 4/1/2025 - Infection 4/1/2025 - Psychotropic Use 4/1/2025 - Anxiety 4/1/2025 - Elopement Risk 4/1/2025 - Dehydration 4/1/2025 - Behaviors 4/1/2025 - Advance Directives 4/1/2025 - Anticoagulant Therapy 4/1/2025 - Cardiovascular 4/1/2025 - Gastrointestinal 4/1/2025 - ADL Self-Care Performance Deficit 2. A review of Resident #2's medical record revealed an admitted [DATE] and a discharge date of [DATE]. His diagnoses included dysphagia (difficulty swallowing) following cerebral infarction (stroke), type 2 diabetes mellitus (DM), difficulty walking, lack of coordination, and hypertension (HTN). No psychiatric diagnoses/mental health disorders were noted. A review of Resident #2's 3/18/25 physician's orders revealed: - Occupational therapy (OT) - Resident to be seen 5 times a week for 60 days with a focus on therapeutic exercises, therapeutic activity, self-care management, neuromuscular re-education training, group treatment when appropriate, and wheelchair management. - Skilled physical therapy (PT) services following hospitalization for 5 times a week for 4 weeks for therapeutic exercises, therapeutic activities, neuromuscular re-education, gait training, group therapy and manual. - Clopidogrel bisulfate (inhibits blood clotting) 75 mg via percutaneous endoscopic gastrostomy (PEG) tube (feeding tube passed into a resident's stomach through the abdominal wall) one time a day (QD) for deep vein thrombosis (DVT). - Amlodipine 10 mg via PEG QD for HTN. - Ezetimibe (cholesterol medication) 10 mg via PEG at bedtime for hyperlipidemia. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Lantus (insulin) 100 unit/ml (units per milliliter) inject 16 units subcutaneously (beneath the skin) at bedtime for DM. There was no physician's order for one-on-one (1:1) supervision. (Copies obtained) A review of Resident #2's Admission 5-day MDS, with a reference date of 3/24/25, revealed that the resident had a BIMS score of 12 out of 15 possible points, indicating moderate cognitive impairment. No behaviors were noted. He reported feeling depressed with little to no interest in doing things. He ambulated with a cane and required partial to moderate assistance with transfers. He did not receive psychotropic medications during the assessment period. A review of Resident #2's Care Plan, initiated on 4/3/25, revealed that the resident had a focus area for Behavior related to hypersexuality and was noncompliant with dietary restrictions. Interventions included the following: 1. Administer medications as ordered. Monitor side effects and effectiveness. 2. Caregivers to provide opportunity for positive interaction, attention. Stop and talk to him/her as passing by. 3. If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. 4. Monitor behavior episodes and attempt to determine the underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. 5. Praise any indication of the resident's progress/improvement in behavior. All interventions were initiated on 4/3/25, two days after the event. There was no intervention for increased supervision for Resident #2 from the care plan initiation date through his transfer to the sister facility on 4/6/25. (Copy obtained) The Care Plan revealed a focus area for Impaired Cognitive Function/Dementia or Impaired Thought Processes related to impaired decision making, initiated on 4/1/25. Interventions included, but were not limited to, the following: 1. Administer medications as ordered. Monitor/document for side effects and effectiveness. 2. Ask yes/no questions in order to determine the resident's needs. 3. Communicate with the resident/family/caregivers regarding resident's capabilities and needs. 4. Cue, reorient and supervise as needed. 5. Monitor/document and report PRN (as needed) any changes in cognitive function, specifically changes in decision making ability, memory, recall, and general awareness, difficulty expressing self, and difficulty understanding others. There was no intervention for increased supervision for Resident #2 after the 4/1/25 incident through the resident's transfer to the sister facility on 4/6/25. (Copy obtained) Resident #2 was admitted on [DATE]. The following comprehensive care plan was initiated on 3/24/2025 - Nutrition/Hydration Risk. The incident with Resident #1 occurred on 4/1/25. The following comprehensive care plans were initiated on 4/1/25 and later: 4/1/2025 - History if CVA (cardiovascular accident)/Stroke 4/1/2025 - Advance Directives 4/1/2025 - Diabetes 4/1/2025 - Cardiovascular (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4/1/2025 - Cognitive Deficit 4/1/2025 - Pain 4/1/2025 - Activities 4/1/2025 - Anticoagulant Use 4/1/2050 - Hypertension 4/1/2025 - Elopement Risk 4/1/2025 - Fall Risk 4/1/2025 - G Tube (feeding tube) 4/1/2025 - Noncompliance with Dietary Restrictions and Activities of Daily Living. 4/3/2025 - Behavior (hypersexuality) - Two days after the incident with Resident #1. On 4/6/25, Resident #2 was transferred to the sister facility. On 4/7/25 and later, he was care planned for the following: 4/7/2025 - Nutritional/Hydration Risk 4/7/2025 - Tube Feeding 4/8/2025 - Risk for Falls related to gait/balance problem. 4/8/2025 - Behaviors/Sexual Advances related to hypersexuality. Interventions did not include close supervision or supervision at all. Many interventions called for specific information that was left blank. There was no care plan for Impaired Cognition. A Physician's Note dated 4/2/25, revealed that the resident was seen for behavioral follow-up status post incident with resident. Female resident was found in the resident's bed with likely inappropriate touching or sexual behavior noted. The female resident is quite confused. He (Resident #2) was placed on one-on-one care for observation. He was told about the inappropriateness of his behavior. He appeared to be slightly confused but is aware of inappropriate behavior. On 4/7/25 at 1:25 p.m., the Administrator confirmed that Resident #2's one-on-one (1:1) supervision was discontinued because Resident #1 was the resident who initiated the sexual behavior. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/07/25 at 3:30 p.m., Registered Nurse (RN) A stated she had been employed by the facility for about a year as a floor nurse. In November 2024 she was promoted to evening supervisor. As of Friday (4/4/25), she was asked to be the interim Director of Nursing (DON) since the previous DON had resigned. When asked if she was familiar with Residents #1 and #2, she stated Resident #1 was confused, verbally and physically aggressive towards staff, and refused care and medications. She stated the resident had not had any sexually inappropriate behaviors before this incident with Resident #2. Resident #2 was alert and oriented times three (person, place and time). He had no behaviors except noncompliance with diet orders. She stated on 4/1/24 she was working on the floor on the 200 hall. At 5:30 p.m., Residents #1 and #2 were observed in the dining area watching television. She was at the nurses' station with Licensed Practical Nurse (LPN) C, and they were completing their daily documentation. She stated at approximately 6:00 p.m., Resident #1 was seated on Resident #2's walker. LPN C separated the two residents. The residents were again observed holding hands, and she approached both residents and explained to Resident #2 that he could not hold hands with resident #1 because she was not alert and oriented. The residents were separated again. She then left the area to attend to another resident and left LPN C at the nurses' station. She stated she was not present in Resident #2's room when the two residents were found there. A telephone interview was conducted on 4/7/25 at 3:50 p.m., with LPN B. She stated she had worked in the facility for about a year and on 4/1/25, she was coming in to work her 7:00 p.m. to 7:00 a.m. shift when the assigned nurse mentioned that Residents #1 and #2 were having behaviors. At that time, they noticed that neither Resident #1 nor Resident #2 were in the dining area. LPN B and LPN C then went to Resident #2's room together at approximately 6:55 p.m. looking for the residents. As they walked into Resident #2's room, they saw that his right hand was inside of Resident #1's pants. LPN B stated she and LPN C separated the residents and LPN C notified the Administrator (referring to the Administrator in Training (AIT). On 4/8/25 at 11:45 a.m., a visit was made to the sister facility where Resident #2 had been discharged after the incident. Resident #2 was observed in the bed adjacent to the window with his eyes closed. He was clean and appropriately dressed. There was a rollator walker and a cane at his bedside. He opened his eyes, and an interview was conducted at this time. Resident #2 stated he was a little sleepy. When asked if he was unwell, he replied, no. When he was asked when and why he was discharged to this sister facility, he said, They transferred me here a few days ago. I did not have a choice. When asked if he could recall the 4/1/25 incident in the other facility where a female resident was found in his bed, he replied, A female resident? Yes, she was in my bed. He declined to provide further details about the incident. He said, I don't want to answer any more questions. On 4/8/25 at 12:07 p.m., a joint interview was conducted with LPN L/MDS Nurse and Registered Nurse N/Director of Nursing (DON) at the sister facility. They both stated they were involved with the admission process. They both stated that a care plan was established from the resident's diagnoses, physician's orders, and any additional information from the medical record. When they were asked about Resident #2's functional status, LPN L stated Resident #2 had a BIMS score of 14 out of 15 possible points, indicating intact cognition was ambulatory with the use of a walker. They both stated Resident #2 was transferred from the sister facility because of a sexual encounter with another resident and the need for long-term care placement. When asked if they had established any behavior care plan for this resident, they stated the behavior care plan established was only related to non-compliance with the resident's diet. They added that they did not initiate a sexual behavior care plan because they were informed that the other female resident initiated the sexual act. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 4/8/25 at 1:43 p.m. with Resident #1's spouse. He stated he was contacted by the facility when the incident occurred. This was the first time anything like this had happened. He was asked how he felt his wife would have responded to the actions of Resident #2 if she was not cognitively impaired. He stated that in her previous life his wife was very modest. She would have been very upset over Resident #2's actions. A telephone interview was conducted on 4/8/25 at 5:37 p.m. with LPN C. She stated she had worked at the facility for about a year. She confirmed that she was assigned to Residents #1 and #2 on 4/1/25. She explained that she was sitting at the nurses' station at approximately 6:00 p.m. and observed Resident #1 rubbing Resident #2's shoulder and trying to pull him close to her while grabbing his hand. Resident #2 allowed her to do so after being told three times that Resident #1 was not as alert and oriented as him and he should not allow the behavior. This behavior went on over the course of 15 to 20 minutes. Resident #1 was also observed trying to sit on Resident #2's walker. Resident #2 was informed that he should not allow her to do that. Resident #1 was redirected and went back to the chair she was sitting in before - away from Resident #2. Both residents continued to watch television with the other residents. At approximately 6:30 p.m. , LPN C went to complete blood glucose monitoring on a resident near the dining room. When she came out of that resident's room, the night shift nurse had arrived (LPN B). LPN A noticed that the two residents (#1 and #2) were not in the dining room any longer. Together with the night nurse (LPN B) at approximately 6:55 p.m., LPN C quickly went to Resident #2's room and observed Resident #1 lying in his bed on her back fully clothed with her pants unbuttoned and her zipper down while Resident #2 stood to the right of her fully clothed with his right hand inside of Resident #1's pants. When he saw the nurses, he quickly pulled his hand out of her pants. Resident#1 was quickly assisted out of the room while Resident #2 remained in his room. LPN C confirmed that she and LPN B entered the room at the same time. She stated she notified the evening supervisor, the DON, and the Administrator. She stated both residents were placed on 1:1 supervision. She confirmed that she was not contacted by any administrative team member at facility about the 4/1/25 incident until 4/8/25. On 4/8/25, the Administrator contacted her and she explained to the Administrator what occurred exactly as she had in her previously written statement. A review of the job descriptions for Charge Nurse LPN/RN (both effective January 2025), revealed that the primary purpose of the Charge Nurse was to provide direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing or Unit Manager to ensure that the highest degree of quality care is maintained at all times. ESSENTIAL DUTIES AND RESPONSIBILITIES - Direct/supervise the day-to-day functions of the licensed nurses and nursing assistants in accordance with current rules, regulations, and guidelines that govern the long-term care facility. - Ensure that all assigned nursing personnel comply with the written policies and procedures established by the facility. - Make written and oral reports/recommendations concerning the activities of your shift as required. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Cooperate with other resident services when coordinating nursing services to ensure that the resident's total regimen of care is maintained. - Participate in the development maintenance, and implementation of the facility's quality assurance program for the nursing service department. - Periodically review the resident's written discharge plan. Participate in the updating of the resident's written discharge plan as required. - Assist in planning the nursing services portion of the resident's discharge plan as necessary. - Complete accident/incident reports as necessary. - Transcribe physician's orders to resident charts, Kardex, medication cards, treatment/care plans, as required. - Chart nurses' notes in an informative and descriptive manner that reflects the care provided to the resident, as well as the resident's response to the care. - Fill out and complete accident/incident reports. Submit to Director as required. - Chart all reports of accidents/incidents involving residents. Follow established procedures. - Fill out and complete transfer forms in accordance with established procedures. - Provide leadership to nursing personnel assigned to your unit/shift. - Receive telephone orders from physicians and record on the Physicians' Order Form. - Transcribe physicians' orders to resident charts, Kardex, medication cards, treatment/care plans as required. - Chart all reports of accidents/incidents involving residents. Follow established procedures. - Perform routine charting duties as required and in accordance with established charting and documentation policies and procedures. - Notify the resident's attending physician and responsible party when the resident is involved in an accident or incident. - Ensure that residents who are unable to call for help are checked frequently. - Monitor nursing care to ensure that all residents are treated fairly, and with kindness, dignity and respect. - Report and investigate all allegations of resident abuse and/or misappropriation of resident property. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Supervises RNs/LPNs/CNAs. A review of the Administrator's job description (effective January 2025), revealed that the primary purpose of the Administrator was to oversee, manage and direct the day-to-day functions and overall operations of the facility in accordance with current federal, state and local government regulations that govern long-term care facilities and the Operators requirements. The Administrator's focus is on maintaining the highest degree of quality care for the resident/patient while achieving the facility's business objectives. As the Administrator, you are delegated the Governing Body and administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. CUSTOMER SERVICE - Demonstrates positive customer service when performing the role of the Administrator, with residents, family members, internal and external staff. - Displays flexibility, team spirit, compassion, respect honesty, politeness and accountability when dealing with residents, family members and facility staff. - Demonstrates an awareness of and sensitivity for resident's rights in all interfaces with residents and family members. - Develops an environment that allows for creative thinking, problem solving and empowerment in the development of a facility management team. - Communicates effectively via open, straightforward communication, including the use of listening skills. - Seeks validation of knowledge base, quality, decision-making and skill level by actively questioning when necessary. - Utilizes survey information to address areas of importance as defined by our customers. ESSENTIAL DUTIES AND RESPONSIBILITIES - Leads facility management staff in developing and working from a business plan that focuses on all aspects of facility operations, including setting priorities and job assignments. - Serves on various committees of the facility (i.e., Infection Control, Quality Assurance & Assessment, etc.) Committee Functions: - Assist the Quality Assurance and Assessment Committee in developing and implementing appropriate plans of action to correct identified quality deficiencies. - Evaluate and implement recommendations from the facility's committees as necessary. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Lake Post Acute	991 E New York Ave Deland, FL 32724

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Consult with department directors concerning the operation of their departments to assist in eliminating/correcting problem areas, and/or improvement of services. Ensure that an adequate number of appropriately trained professional and auxiliary personnel are on duty at all times to meet the needs of the residents. MISCELLANEOUS - Ensure that all residents receive care in a manner and in an environment that maintains or enhances their quality of life without abridging the safety and rights of other residents. A review of the facility's Abuse, Neglect, and Misappropriation policy (effective 2/1/24, reviewed on 1/1/25), revealed: Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Sexual Abuse: Is defined as non-consensual sexual contact of any type with a resident. Training: a. Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation. b. Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property. c. Recognizing signs of abuse, neglect, exploitation, and misappropriation of resident property, such as physical or psychosocial indicators. d. Reporting abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources, and to whom and when staff and others must report their knowledge related to any alleged violation without fear of reprisal. e. Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect and how to respond. These symptoms include, but are not limited to, the following: - Aggressive and/or catastrophic reactions of residents. - Wandering or elopement-type behaviors. - Resistance to care. - Outbursts or yelling out. - Difficulty in adjusting to new routines or stakeholders. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Prevention: 1. Establishing a safe environment that supports, to the extent possible, a resident's safety. 2. Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur. 4. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect. Investigative Guidelines: 1. The facility Administrator will investigate all allegations, reports, grievances, and incidents that potentially could constitute allegations of abuse, injuries of unknown source, exploitation, or suspicions of crime as defined in this document. the facility Administrator retains the ultimate responsibility to oversee and complete the investigation, and to draw conclusions regarding the nature of the incident. 2. The investigation should include interviews of the involved persons, including alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. 3. To the extent possible and applicable, provide complete and thorough documentation of the investigation. 6. The facility Administrator will make reasonable efforts to determine the root cause of the alleged violation and will implement corrective action consistent with the investigative findings and take steps to eliminate any ongoing danger to the resident or residents. 7. Any affected resident's physician and family/responsible party will be informed of the result of the investigation. 8. Every substantiated allegation of abuse will be reviewed by the facility's Quality Assurance and Performance Improvement Committee to detect potential patterns or trends, and for consideration of further interventions or training opportunities. The Medical Director should be notified and involved. Protection: 2. If a stakeholder observes any form of abuse, the stakeholder will intervene immediately, remove and/or separate residents involved, and move them to an environment where the residents' safety can be assured. 6. The Administrator will identify, intervene and correct situations in which reported abuse, neglect, exploitation, or misappropriation of resident property may occur.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42442 Based on interviews and record review, the facility failed to ensure that all alleged violations related to abuse were reported immediately, but not later than two hours after the allegation was made, to officials (including the State Survey Agency). The facility also failed to report the results of the investigations to the State Survey Agency within five working days of the incidents. This involved three (Residents #1, #2, and #3) of three residents reviewed for abuse, from a total survey sample of eight residents. Reporting requirements under this regulation are based on real (clock) time, not business hours. The findings include: 1. A review of Resident #3's medical record revealed an admitted [DATE]. His diagnoses included acute respiratory failure with hypoxia (condition where the respiratory system is unable to deliver enough oxygen to the blood, resulting in low blood oxygen levels); congestive heart failure (condition where the heart's pumping action is not strong enough to supply the body's needs, leading to fluid buildup in the lungs and other tissues); Type 2 diabetes mellitus (chronic condition where the body either doesn't produce enough insulin, or the body's cells become resistant to insulin, leading to high blood sugar levels); morbid obesity (severe form of obesity (accumulation of excess body fat) characterized by a Body Mass Index (BMI) of 40 or higher, or a BMI of 35 or higher with obesity-related health complications); diverticulitis of the large intestine (condition where pouches in the large intestine (colon) become inflamed or infected); non-ST segment elevation myocardial infarction (NSTEMI) (type of heart attack where there is a partial blockage of a coronary artery, leading to reduced blood flow to the heart muscle); atrial fibrillation (irregular heartbeat); and chronic kidney disease - stage 3 (moderate loss of kidney function). A review of the 5-day Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident #3 scored 11 out of 15 possible points on the Brief Interview for Mental Status (BIMS) assessment, indicating moderate cognitive impairment. An interview was conducted with the Administrator on 4/7/25 at 1:26 p.m. He stated he received an allegation from the son of Resident #3 stating that a certified nursing assistant (CNA) came in to answer the call light and was rude and too rough helping him get on the bed pan. The Administrator stated the resident's son said the incident occurred during the 11:00 p.m. to 7:00 a.m. shift on Friday (4/4/25). An interview was conducted on 4/8/25 at 9:41 a.m. with the Social Services Director (SSD). She advised that she was new and had been employed in the facility for about a week. When asked, she stated she was familiar with the incident involving Resident #3. She stated she had just begun employment in the facility, and she immediately completed a grievance form related to the incident once she was informed of it. When asked if there had been more than one incident involving Resident #3, the SSD stated the incident in question was the only incident she was aware of since she started working in the facility. She confirmed the incident involving Resident #3 was originally reported to her by the family as an allegation of abuse due to the staff member being rough with the resident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Resident #3 on 4/8/25 at 10:47 a.m. The resident was advised of the purpose for the interview. When asked if he recalled the date of the incident, he stated it was at the end of last month (March) or the beginning of this month (April). When asked to describe the details of the grievance submitted by his son, the resident explained that he pressed his call light because he needed assistance with toileting. When the staff member came into his room, she was angry and aggressive. While attempting to turn him onto his left side, she forcefully pushed his right leg near the knee area. The resident confirmed that he did not report the incident to the staff; instead, he informed his son about it. An interview was conducted with the son and daughter of Resident #3 on 4/8/25 at 3:07 p.m. The resident's son stated the incident did not occur on 4/4/25 as the Administrator had previously informed the survey team. The resident's daughter stated Resident #3 was admitted to the facility on [DATE] and the incident occurred on 3/28/25 or 3/29/25. She stated Resident #3 had initially advised her of the incident by phone and she told him that she would report it to the facility. She did so on 3/31/25. She stated the resident reported that he felt bad and humiliated. She stated in less than 24 hours they were informed by the facility that the staff member involved had been terminated. The SSD asked if she could close the grievance since the staff member had been terminated. She advised her no because her brother, Resident #3's son, was also involved and they believed things were looking suspicious. She stated this occurred on 4/1/2025. When the family realized the facility wasn't taking the incident seriously, they went on the State Survey Agency website to learn how the incident should be handled. They confronted the facility Administrator with what they had discovered, and that was when the facility filed the official report. A follow-up interview was conducted with the SSD on 4/8/25 at 5:30 p.m. She was shown the facility's Grievance Checklist (photographic evidence obtained) and asked if she had completed a grievance form. She stated she had not and that was the first time she had seen the form. She was asked about the incident involving Resident #3. She stated her understanding of the incident was that it was related to how the certified nursing assistant (CNA) changed the resident after a bowel movement. She stated the daughter of Resident #3 was very upset when she came to her, so she wrote the grievance on 3/31/25. Another interview was conducted on 4/8/25 at 6:21 p.m. with the Administrator. He was asked about the actual date of the incident with Resident #3. He stated there was only one incident. He stated it was initially reported as a customer service issue because the staff was rude. He stated the report was initially filed on 3/31/25. He again stated that the facility didn't file an abuse report because it was a customer service issue. A record review revealed that on 3/31/25, a grievance was filed by the daughter of Resident #3. The facility's Social Services Director completed the grievance form. Per the grievance form, [Resident #3] uses a bed pan. He had to have a bowel movement. Assigned aide came in and was visibly angry. Reported that when she had to clean him, she was not gentle enough with his leg. Results of action taken: Staff educated. Per the facility's grievance form, the grievance was resolved. Resident notified of results and education. The method used to notify the resident and/or representative of the resolution was listed as: Telephone and one-to-one conversation. Both the date of the resolution and the date of notification were 4/2/25. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident #1's medical record revealed an admitted [DATE]. Her diagnoses included, but were not limited to, metabolic encephalopathy (brain dysfunction leading to altered consciousness, cognitive decline and other neurological symptoms), attention and concentration deficit following cerebral infarction (stroke); extended-spectrum beta-lactamase resistance (ESBL - bacterial infection resistant to antibiotics); dementia in other diseases classified elsewhere, unspecified severity with agitation; general anxiety disorder; schizoaffective disorder; and a need for assistance with personal care. An Encounter note dated 4/2/25 revealed that Resident #1 was seen for a behavioral follow up. She was found in a male resident's bed last night (4/1/25) with what appears to be inappropriate touching and sexual behavior. A review of Resident #2's medical record revealed an admitted [DATE] and a discharge date of [DATE]. His diagnoses included dysphagia (difficulty swallowing) following cerebral infarction (stroke), type 2 diabetes mellitus (DM), difficulty walking, lack of coordination, and hypertension (HTN). No psychiatric diagnoses/mental health disorders were noted. A Physician's Note dated 4/2/25, revealed that the resident was seen for behavioral follow-up status post incident with resident. Female resident was found in the resident's bed with likely inappropriate touching or sexual behavior noted. The female resident is quite confused. He (Resident #2) was placed on one-on-one care for observation. He was told about the inappropriateness of his behavior. He appeared to be slightly confused but is aware of inappropriate behavior. A telephone interview was conducted on 4/7/25 at 3:50 p.m., with LPN B. She stated she had worked in the facility for about a year and on 4/1/25, she was coming in to work her 7:00 p.m. to 7:00 a.m. shift when the assigned nurse mentioned that Residents #1 and #2 were having behaviors. At that time, they noticed that neither Resident #1 nor Resident #2 were in the dining area. LPN B and LPN C then went to Resident #2's room together at approximately 6:55 p.m. looking for the residents. As they walked into Resident #2's room, they saw that his right hand was inside of Resident #1's pants. LPN B stated she and LPN C separated the residents and LPN C notified the Administrator (referring to the Administrator in Training (AIT). During a joint interview on 4/8/25 at 2:19 p.m., the Administrator and the Administrator in Training confirmed that the 5-day federal report for the 4/1/25 incident was submitted on 4/7/25. The Administrator stated he had five business days to submit the report, therefore it was submitted timely. When asked if that was the facility's policy, he replied, We have always done it like that. A review of the facility's Abuse, Neglect, and Misappropriation policy (effective 2/1/24, reviewed 1/1/25), revealed: Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Sexual Abuse: Is defined as non-consensual sexual contact of any type with a resident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	G. Reporting/Response: 1. Every Stakeholder shall immediately report any allegation of abuse, injury of unknown origin, or suspicion of a crime, as those terms are defined above, to the facility Administrator or designee as assigned by the facility Administrator in his/her absence. Failure to report an allegation of abuse, injury of unknown origin or suspicion of crime may result in disciplinary action, including termination of employment, and/or further legal or criminal action against any person who is required to, but fails to make such a report. Reporting Guidelines: Any abuse allegation must be reported to within two hours from the time the allegation was received. Any reasonable suspicion of a crime with serious bodily injury must be reported to the State and Police. Any allegation of neglect, exploitation, mistreatment or misappropriation of resident property must be reported to the State Regulatory Agency within 24 hours. In the case of neglect, exploitation, mistreatment, or misappropriation resulting in serious bodily injury, it must be reported to the State Regulatory Agency and Police within two hours.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42442 Based on staff interviews, resident and facility record reviews, and a review of facility policies and procedures, the facility failed to thoroughly investigate sexual abuse for one (Resident #1) of three residents reviewed for abuse. Failure to investigate sexual abuse thoroughly, put the facility's female residents at a likelihood for suffering sexual abuse, which could result in serious psychosocial harm, which would diminish their self-worth and self respect. Immediate Jeopardy (IJ) at a scope and severity of J (isolated) was identified on April 7, 2025 at 3:50 p.m. On April 1, 2025, at 6:55 p.m., Immediate Jeopardy began. On April 8, 2025, at 6:15 p.m., the Administrator was notified of the IJ determination and was provided with Immediate Jeopardy Templates. Immediate Jeopardy was ongoing as of the survey exit on April 8, 2025. The findings include: Cross reference F600, F835, and F867. 1. A review of Resident #1's medical record revealed an admitted [DATE]. Her diagnoses included, but were not limited to, metabolic encephalopathy (brain dysfunction leading to altered consciousness, cognitive decline and other neurological symptoms), attention and concentration deficit following cerebral infarction (stroke); extended-spectrum beta-lactamase resistance (ESBL - bacterial infection resistant to antibiotics); dementia in other diseases classified elsewhere, unspecified severity with agitation; general anxiety disorder; schizoaffective disorder; and a need for assistance with personal care. A review of the resident's 3/2/25 physician's orders revealed: - Donepezil Oral tablet 10 milligrams (mg) - give 1 tablet by mouth at bedtime for dementia. - Quetiapine (antipsychotic) Fumarate Oral tablet 50 mg - give 1 tablet by mouth one time a day for anxiety. - Quetiapine Fumarate Oral tablet 50 mg - give 3 tablets by mouth at bedtime for anxiety. - Alprazolam (benzodiazepine - slows the nervous system) oral tablet 0.5 mg - give 1 tablet by mouth every morning and at bedtime for anxiety. - Sertraline HCL (hydrochloride) (selective serotonin reuptake inhibitor - can be used to treat depression, obsessive compulsive disorder, posttraumatic stress disorder, social anxiety disorder and/or panic disorder) oral tablet 100 mg - give 1 tablet by mouth one time a day for depression. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- 1:1 monitoring every shift - discontinued on 3/7/25. Additional physician's orders included: - 3/7/2025 - 30-minute monitoring for behaviors, (This order, 30-minute monitoring, was discontinued on 3/19/25). No documentation for increased/frequent monitoring was found from 3/19/2025 through 4/1/2025. - 3/24/2025 - Ciprofloxacin HCL (antibiotic) oral tablet 500 mg - give 500 mg by mouth two times a day for urinary tract infection (UTI) for 14 days. - 4/1/2025 - One-on-one monitoring for behaviors - every shift. A review of the Psychotropic Evaluation nursing note dated 3/2/2025, revealed that Resident #1 had behaviors (e.g. combativeness, verbal disruptions) that were harmful to self or others or limited participation in activities. Increased in acuteness. She could be aggressive with staff. Resident has anxiety or nervousness that impairs his/her quality of life or limits participation in activities. A review of a Behavior Note dated 3/3/2025 revealed: Resident has pulled out her peripherally inserted central catheter (PICC) line from her right upper arm. Some bleeding was observed, pressure applied and Tegaderm (transparent, waterproof, sterile medical dressing) placed after it stopped. Resident remains aggressive, attempting to bite several staff members and kick. New order for Haldol (antipsychotic) intramuscularly (IM) given per Advanced Practice Registered Nurse (APRN) - Ineffective, continues to walk around yelling and screaming. Redirected as staff walks along with her. A review of the Provider Encounter dated 3/14/25 revealed that the resident wandered and attempted to hit and bite staff. She continued to refuse clothing changes as needed. Psychiatry was consulted to see resident and schedule next week. The Haldol order remained in place for behavioral management. (Psychiatry notes were requested but not provided during the survey.) An Encounter note dated 3/20/25 recommended that the resident continue with 30-minute behavior checks for safety monitoring. (The order was not implemented. Copies obtained) An Encounter note dated 4/2/25 revealed that Resident #1 was seen for a behavioral follow up. She was found in a male resident's bed last night with what appears to be inappropriate touching and sexual behavior. Resident was returned to one-on-one (1:1) care. A Nursing Progress note dated 4/2/25 read, Resident is up pacing around in her room, up and down in her bed, difficult to redirect, very aggressive with staff, swinging at them, screaming out loud, cursing, knocked over everything on her bedside table, attempted to get in a bed with a resident in the bed, displayed aggressive behavior when trying to redirect. New order given to administer Haldol 0.5 mg IM (intramuscularly - in the muscle) due to aggressive behavior. She remains on 1:1 care. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Admission 5-day minimum data set (MDS) assessment with a reference date of 3/6/25, revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 01 out of 15 possible points, indicating severe cognitive impairment. The resident was noted to be delusional, and physically and verbally aggressive with wandering behavior. She received antipsychotic, antianxiety, antidepressant, and antibiotic medications during the assessment period. A review of the Care Plan (initiated 4/1/25, revised 4/1/25) revealed that the resident had Impaired Cognitive Function/Dementia or Impaired Thought Processes related to dementia, schizoaffective disorder, difficulty making decisions and psychotropic drug use. The resident will be able to communicate basic needs on a daily basis. The care plan noted that the resident had a behavior problem of making inappropriate sexual advances to other residents, aggression and other inappropriate behaviors with a history of UTIs, pacing, wandering, disrobing, inappropriate response to verbal communication, violence, aggression towards staff/others. Pulled out PICC line. Pulled out Foley (urinary) catheter. Resident will have fewer episodes of undesired behaviors. The resident will have no evidence of behavior problems. 1:1 care (downgraded, failed attempt) frequent checks 1:1 caregiver reinitiated 4/1. Move to a room away from patient she appears to favor. 2. A review of Resident #2's medical record revealed an admitted [DATE] and a discharge date of [DATE]. His diagnoses included dysphagia (difficulty swallowing) following cerebral infarction (stroke), type 2 diabetes mellitus (DM), difficulty walking, lack of coordination, and hypertension (HTN). No psychiatric diagnoses/mental health disorders were noted. A review of Resident #2's 3/18/25 physician's orders revealed: - Occupational therapy (OT) - Resident to be seen 5 times a week for 60 days with a focus on therapeutic exercises, therapeutic activity, self-care management, neuromuscular re-education training, group treatment when appropriate, and wheelchair management. - Skilled physical therapy (PT) services following hospitalization for 5 times a week for 4 weeks for therapeutic exercises, therapeutic activities, neuromuscular re-education, gait training, group therapy and manual. - Clopidogrel bisulfate (inhibits blood clotting) 75 mg via percutaneous endoscopic gastrostomy (PEG) tube (feeding tube passed into a resident's stomach through the abdominal wall) one time a day (QD) for deep vein thrombosis (DVT). - Amlodipine 10 mg via PEG QD for HTN. - Ezetimibe (cholesterol medication) 10 mg via PEG at bedtime for hyperlipidemia. - Lantus (insulin) 100 unit/ml (units per milliliter) inject 16 units subcutaneously (beneath the skin) at bedtime for DM. There was no physician's order for one-on-one (1:1) supervision. (Copies obtained) (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #2's Admission 5-day MDS, with a reference date of 3/24/25, revealed that the resident had a BIMS score of 12 out of 15 possible points, indicating moderate cognitive impairment. No behaviors were noted. He reported feeling depressed with little to no interest in doing things. He ambulated with a cane and required partial to moderate assistance with transfers. He did not receive psychotropic medications during the assessment period. A review of Resident #2's Care Plan, initiated on 4/3/25, revealed that the resident had a focus area for Behavior related to hypersexuality and was noncompliant with dietary restrictions. Interventions included the following: 1. Administer medications as ordered. Monitor side effects and effectiveness. 2. Caregivers to provide opportunity for positive interaction, attention. Stop and talk to him/her as passing by. 3. If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. 4. Monitor behavior episodes and attempt to determine the underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. 5. Praise any indication of the resident's progress/improvement in behavior. All interventions were initiated on 4/3/25, two days after the event. There was no intervention for increased supervision for Resident #2 from the care plan initiation date through his transfer to the sister facility on 4/6/25. (Copy obtained) The Care Plan revealed a focus area for Impaired Cognitive Function/Dementia or Impaired Thought Processes related to impaired decision making, initiated on 4/1/25. Interventions included, but were not limited to, the following: 1. Administer medications as ordered. Monitor/document for side effects and effectiveness. 2. Ask yes/no questions in order to determine the resident's needs. 3. Communicate with the resident/family/caregivers regarding resident's capabilities and needs. 4. Cue, reorient and supervise as needed. 5. Monitor/document and report PRN (as needed) any changes in cognitive function, specifically changes in decision making ability, memory, recall, and general awareness, difficulty expressing self, and difficulty understanding others. There was no intervention for increased supervision for Resident #2 after the 4/1/25 incident through the resident's transfer to the sister facility on 4/6/25. (Copy obtained). A Nursing Progress note dated 4/2/25, revealed that Resident #2's family member was notified that the resident could be transferred to the sister facility on Friday (4/4/25). The family member stated he would think everything over because he was not in agreement. The administrator would follow up with him. A Physician's Note dated 4/2/25, revealed that the resident was seen for behavioral follow-up status post incident with resident. Female resident was found in the resident's bed with likely inappropriate touching or sexual behavior noted. The female resident is quite confused. He (Resident #2) was placed on one-on-one care for observation. He was told about the inappropriateness of his behavior. He appeared to be slightly confused but is aware of inappropriate behavior. A Physician's Note dated 4/4/25, revealed that Resident #2 was evaluated for discharge. He will be discharged to another skilled nursing facility, as he had a sexual encounter with another resident at this facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105262	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Lake Post Acute	991 E New York Ave Deland, FL 32724

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/7/25 at 1:25 p.m., the Administrator and the Administrator in Training (AIT) were interviewed regarding the timeline of events as related to the 4/1/25 incident between Residents #1 and #2. The Administrator stated on 4/1/25 at approximately 6:00 p.m., Residents #1 and #2 were in the dining room area. Resident #1 was observed tapping Resident #2's shoulder. The assigned nurse, Licensed Practical Nurse (LPN) C, who was at the nurses' station, separated the residents. Approximately five minutes later, Resident #1 was observed attempting to sit on Resident #2's walker. Again, the residents were separated and put at different ends of the dining area. Resident #2 was educated and voiced understanding. At approximately 6:30 p.m., LPN C went to conduct blood glucose monitoring for another resident and walked away from the dining area. When she returned, she noticed that both Resident #1 and Resident #2 were not in the dining area. LPN C walked to Resident #2's room and found both residents (#1 and #2). Resident #1 was observed in Resident #2 's bed lying supine, fully clothed, with her pants unbuttoned and her zipper down. Resident #2 stood to the right of her. He was fully clothed with his hand inside of Resident #1's pants. He quickly pulled his hand out of her pants when the nurse walked in. The Administrator stated during the investigation, however, the assigned nurse, LPN C, could not determine if Resident #2's hand was actually inside Resident #1's pants. The Administrator further stated Resident #2 may have had the intention of placing his hand in Resident #1's pants, but he had not actually done it. He just pulled his hand away when the nurse walked into the room. Resident #1 was taken back to her room. When the Administrator was asked if there were any other witnesses to the event, he replied that Registered Nurse (RN) A/Weekend Supervisor, was the only witness present at the time and she also wrote a statement. During an interview on 4/07/25 at 3:30 p.m., Registered Nurse (RN) A stated she had been employed by the facility for about a year as a floor nurse. In November 2024 she was promoted to evening supervisor. As of Friday (4/4/25), she was asked to be the interim Director of Nursing (DON) since the previous DON had resigned. When asked if she was familiar with Residents #1 and #2, she stated Resident #1 was confused, verbally and physically aggressive towards staff, and refused care and medications. She stated the resident had not had any sexually inappropriate behaviors before this incident with Resident #2. Resident #2 was alert and oriented times three (person, place and time). He had no behaviors except noncompliance with diet orders. She stated on 4/1/24 she was working on the floor on the 200 hall. At 5:30 p.m., Residents #1 and #2 were observed in the dining area watching television. She was at the nurses' station with Licensed Practical Nurse (LPN) C, and they were completing their daily documentation. She stated at approximately 6:00 p.m., Resident #1 was seated on Resident #2's walker. LPN C separated the two residents. The residents were again observed holding hands, and she approached both residents and explained to Resident #2 that he could not hold hands with resident #1 because she was not alert and oriented. The residents were separated again. She then left the area to attend to another resident and left LPN C at the nurses' station. She stated she was not present in Resident #2's room when the two residents were found there. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview was conducted on 4/7/25 at 3:50 p.m. with LPN B who stated she had worked in the facility for about a year and on 4/1/25, she was coming in to work her 7:00 p.m. to 7:00 a.m. shift when the assigned nurse (LPN C) mentioned that Residents #1 and #2 were having behaviors. At that time, they noticed that neither Resident #1 nor Resident #2 were in the dining area. LPN B and LPN C then went to Resident #2's room together at approximately 6:55 p.m. looking for the residents. As they walked into Resident #2's room, they saw that his right hand was inside of Resident #1's pants. LPN B stated she and LPN C separated the residents and LPN C notified the Administrator (referring to the AIT). LPN B explained that she completed a witness statement and pushed it under the Administrator's door. When asked if the written statement was in addition to/followed by a telephone interview, she replied, No one called me. I typed up my observations. She provided a copy of her statement. A follow-up interview was conducted on 4/7/25 at 4:31 p.m. with the Administrator who was asked for any surveillance videos. He stated the surveillance video cameras were not working. When asked again if there was another witness to the incident, he said, There were no other witnesses. He was asked about the witness noted in the federal incident report. The Administrator stated she was another nurse who was assisting with a respiratory program. He further stated this other nurse was asked by LPN C (assigned nurse) if she had seen the residents. LPN C and this other nurse then both walked into Resident #2's room. The Administrator stated this other nurse/witness entered Resident #2's room after the assigned nurse (LPN C) and did not witness what happened. When asked if he had a witness statement from this second nurse, the Administrator stated he might not have put it in the investigative file that had been provided to the surveyor. He stated he would provide it. At 4:53 p.m., the Administrator provided a statement indicating that a phone interview was conducted on 4/1/25 with LPN I, whose name was on the statement. The statement indicated that LPN I did not witness the incident. When asked why LPN I was not on the schedule for 4/1/25, the Administrator stated the staffing person may have forgotten to add LPN I since she was not working a medication cart. He further stated he would provide an updated schedule. The reprinted schedule provided for review did not match the name of LPN B (who witnessed the incident with LPN C) or LPN I; it indicated LPN J. A review of the employee roster printed on 4/7/25 revealed that there was no employee by the name of LPN I, who was noted in the witness statement, on the facility's roster. Another interview was conducted with the Administrator on 4/7/25 at 5:08 p.m. He was asked about the differing names on the federal incident report, the witness statement he provided, and the schedule for 4/1/25. He stated LPN B went by LPN J's name. When asked why the schedule had a different name (LPN J), he walked out of the room stating he would clarify with the staffing department. A follow-up interview was conducted with LPN B on 4/8/25 at 5:18 p.m. She confirmed her full name as well as her [NAME]. She stated the name on the statement the Administrator had provided for review was her sister's name. She added that her sister, who also worked in the facility, would not have been able to make a statement regarding the incident involving Residents #1 and #2, because she was not working on the day of the incident, 4/1/25. LPN B stated she and LPN C entered Resident #2's room at the same time on 4/1/25 and again confirmed they both witnessed Resident #2 with his hand under the zipper and inside the pants of Resident #1. LPN B again confirmed that her sister was not in the facility at the time of the incident, and that she did not have an [NAME]. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Another follow up interview was conducted on 4/7/25 at 5:50 p.m. with the Administrator who stated he contacted LPN B, and she confirmed that she entered the room at the same time with LPN C and witnessed Resident #2 removing his hand from Resident #1's pants. He stated he had contacted LPN C and was unable to reach her. He added that with the new information he would close the investigation and substantiate the abuse allegation. On 4/8/25 at 11:45 a.m., a visit was made to the sister facility where Resident #2 had been discharged after the incident. Resident #2 was observed in the bed adjacent to the window with his eyes closed. He was clean and appropriately dressed. There was a rollator walker and a cane at his bedside. He opened his eyes, and an interview was conducted at this time. Resident #2 stated he was a little sleepy. When asked if he was unwell, he replied, no. When he was asked when and why he was discharged to this sister facility, he said, They transferred me here a few days ago. I did not have a choice. When asked if he could recall the 4/1/25 incident in the other facility where a female resident was found in his bed, he replied, A female resident? Yes, she was in my bed. He declined to provide further details about the incident. He said, I don't want to answer any more questions. On 4/8/25 at 12:07 p.m., a joint interview was conducted with LPN L/MDS Nurse and Registered Nurse N/Director of Nursing (DON) at the sister facility. They both stated they were involved with the admission process. They both stated that a care plan was established from the resident's diagnoses, physician's orders, and any additional information from the medical record. When they were asked about Resident #2's functional status, LPN L stated Resident #2 had a BIMS score of 14 out of 15 possible points, indicating intact cognition was ambulatory with the use of a walker. They both stated Resident #2 was transferred from the sister facility because of a sexual encounter with another resident and the need for long-term care placement. When asked if they had established any behavior care plan for this resident, they stated the behavior care plan established was only related to non-compliance with the resident's diet. They added that they did not initiate a sexual behavior care plan because they were informed that the other female resident initiated the sexual act. During an interview on 4/8/25 at 2:19 p.m., the Administrator and the AIT where asked if there were any identified opportunities for improvement. The Administrator stated there was a missed opportunity for Resident #1 regarding her behaviors. He further stated there were opportunities on 4/1/25 when Resident #1 had behaviors and staff could have provided more supervision, but they walked away. When asked if they had identified opportunities for improving their abuse investigation and reporting, the Administrator replied, What exactly? He was reminded that he had mentioned on 4/7/25 that the allegation could not be verified, and then at the end of the day he stated that the allegation was substantiated. He said that per LPN C they could not verify the allegation. He confirmed that he did not obtain a statement from Resident #2. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview was conducted on 4/8/25 at 5:37 p.m. with LPN C. She stated she had worked at the facility for about a year. She confirmed that she was assigned to Residents #1 and #2 on 4/1/25. She explained that she was sitting at the nurses' station at approximately 6:00 p.m. and observed Resident #1 rubbing Resident #2's shoulder and trying to pull him close to her while grabbing his hand. Resident #2 allowed her to do so after being told three times that Resident #1 was not as alert and oriented as him and he should not allow the behavior. This behavior went on over the course of 15-20 minutes. Resident #1 was also observed trying to sit on Resident #2's walker. Resident #2 was informed that he should not allow her to do that. Resident #1 was redirected and went back to the chair she was sitting in before - away from Resident #2. Both residents continued to watch television with the other residents. At approximately 6:30 p.m. , LPN C went to complete blood glucose monitoring on a resident near the dining room. When she came out of that resident's room, the night shift nurse had arrived (LPN B). LPN A noticed that the two residents (#1 and #2) were not in the dining room any longer. Together with the night nurse (LPN B) at approximately 6:55 p.m., LPN C quickly went to Resident #2's room and observed Resident #1 lying in his bed on her back fully clothed with her pants unbuttoned and her zipper down while Resident #2 stood to the right of her fully clothed with his right hand inside of Resident #1's pants. When he saw the nurses, he quickly pulled his hand out of her pants. Resident#1 was quickly assisted out of the room while Resident #2 remained in his room. LPN C confirmed that she and LPN B entered the room at the same time. She stated she notified the evening supervisor, the DON, and the Administrator. She stated both residents were placed on 1:1 supervision. She confirmed that she was not contacted by any administrative team member at facility about the 4/1/25 incident until 4/8/25. On 4/8/25, the Administrator contacted her and she explained to the Administrator what occurred exactly as she had in her previously written statement. A review of the facility's Abuse, Neglect, and Misappropriation policy (effective 2/1/24, reviewed 1/1/25), revealed: Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Sexual Abuse: Is defined as non-consensual sexual contact of any type with a resident. E. Investigation Guidelines 1. The facility Administrator will investigate all allegations, reports, grievances, and incidents that potentially could constitute allegations of abuse, injuries of unknown source, exploitation, or suspicions of crime as defined in this document. the facility Administrator retains the ultimate responsibility to oversee and complete the investigation, and to draw conclusions regarding the nature of the incident. 2. The investigation should include interviews of the involved persons, including alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. 3. To the extent possible and applicable, provide complete and thorough documentation of the investigation. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. The investigation should be documented, and any specific forms required by the State, or as otherwise instructed by legal counsel use (if applicable). The documentation will be kept in the facility Administrator or Director of Nursing's office in a secure administrative file marked confidential, or as otherwise instructed by legal counsel (if applicable). If any written statements or notes relating to the investigation are prepared, they should not be placed in any Stakeholder's personnel files. 5. All investigation documents and materials are to be held in strict confidence and cannot be shared with any unauthorized person. 6. The facility Administrator will make reasonable efforts to determine the root cause of the alleged violation and will implement corrective action consistent with the investigative findings and take steps to eliminate any ongoing danger to the resident or residents. 7. Any affected resident's physician and family/responsible party will be informed of the result of the investigation. 8. Every substantiated allegation of abuse will be reviewed by the facility's Quality Assurance and Performance Improvement Committee to detect potential patterns or trends, and for consideration of further interventions or training opportunities. The Medical Director should be notified and involved. 9. If the investigation substantiates an allegation of abuse or suspicion of crime by a Stakeholder, the facility Administrator will inform the applicable state licensure authority or Aide Abuse Registry pursuant to such agency's reporting procedures and as required by state or federal law. 10. The Governing Body will be informed of the receipt of allegations of abuse, neglect, exploitation, or misappropriation and the results of the investigation via the QAPI (Quality Assurance and Performance Improvement) process.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42442 Based on staff interviews, resident and facility record reviews, and a review of job descriptions, the facility's administration failed to ensure that staff provided appropriate supervision to protect vulnerable residents from sexual abuse for one (Resident #1) of three residents reviewed for abuse. The facility administration failed to ensure that staff developed and implemented interventions necessary to protect Resident #1, who was unable to consent, from sexual contact by Resident #2. Resident #2 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 possible points, indicating moderate cognitive impairment, and was independently ambulatory with the use of a cane. This created a likelihood that Resident #1 or any other vulnerable resident could be sexually assaulted and suffer serious psychosocial and/or physical harm from Resident #2. Immediate Jeopardy (IJ) at a scope and severity of J (isolated) was identified on April 7, 2025 at 3:50 p.m. On April 1, 2025, at 6:55 p.m., Immediate Jeopardy began. On April 8, 2025, at 6:15 p.m., the Administrator was notified of the IJ determination and was provided with Immediate Jeopardy Templates. Immediate Jeopardy was ongoing as of the survey exit on April 8, 2025. The findings include: Cross reference F600, F610, and F867. 1. A review of Resident #1's medical record revealed an admitted [DATE]. Her diagnoses included, but were not limited to, metabolic encephalopathy (brain dysfunction leading to altered consciousness, cognitive decline and other neurological symptoms), attention and concentration deficit following cerebral infarction (stroke); extended-spectrum beta-lactamase resistance (ESBL - bacterial infection resistant to antibiotics); dementia in other diseases classified elsewhere, unspecified severity with agitation; general anxiety disorder; schizoaffective disorder; and a need for assistance with personal care. A review of the resident's 3/2/25 physician's orders revealed: - Donepezil Oral tablet 10 milligrams (mg) - give 1 tablet by mouth at bedtime for dementia. - Quetiapine (antipsychotic) Fumarate Oral tablet 50 mg - give 1 tablet by mouth one time a day for anxiety. - Quetiapine Fumarate Oral tablet 50 mg - give 3 tablets by mouth at bedtime for anxiety. - Alprazolam (benzodiazepine - slows the nervous system) oral tablet 0.5 mg - give 1 tablet by mouth every morning and at bedtime for anxiety. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Sertraline HCL (hydrochloride) (selective serotonin reuptake inhibitor - can be used to treat depression, obsessive compulsive disorder, posttraumatic stress disorder, social anxiety disorder and/or panic disorder) oral tablet 100 mg - give 1 tablet by mouth one time a day for depression. - 1:1 monitoring every shift - discontinued on 3/7/25. Additional physician's orders included: - 3/7/2025 - 30-minute monitoring for behaviors, (This order, 30-minute monitoring, was discontinued on 3/19/25). No documentation for increased/frequent monitoring was found from 3/19/2025 through 4/1/2025. - 3/24/2025 - Ciprofloxacin HCL (antibiotic) oral tablet 500 mg - give 500 mg by mouth two times a day for urinary tract infection (UTI) for 14 days. - 4/1/2025 - One-on-one monitoring for behaviors - every shift. A review of the Psychotropic Evaluation nursing note dated 3/2/2025, revealed that Resident #1 had behaviors (e.g. combativeness, verbal disruptions) that were harmful to self or others or limited participation in activities. Increased in acuteness. She could be aggressive with staff. Resident has anxiety or nervousness that impairs his/her quality of life or limits participation in activities. A review of a Behavior Note dated 3/3/2025 revealed: Resident has pulled out her peripherally inserted central catheter (PICC) line from her right upper arm. Some bleeding was observed, pressure applied and Tegaderm (transparent, waterproof, sterile medical dressing) placed after it stopped. Resident remains aggressive, attempting to bite several staff members and kick. New order for Haldol (antipsychotic) intramuscularly (IM) given per Advanced Practice Registered Nurse (APRN) - Ineffective, continues to walk around yelling and screaming. Redirected as staff walks along with her. A review of the Provider Encounter dated 3/14/25 revealed that the resident wandered and attempted to hit and bite staff. She continued to refuse clothing changes as needed. Psychiatry was consulted to see resident and schedule next week. The Haldol order remained in place for behavioral management. (Psychiatry notes were requested but not provided during the survey.) An Encounter note dated 3/20/25 recommended that the resident continue with 30-minute behavior checks for safety monitoring. (The order was not implemented. Copies obtained) An Encounter note dated 4/2/25 revealed that Resident #1 was seen for a behavioral follow up. She was found in a male resident's bed last night with what appears to be inappropriate touching and sexual behavior. Resident was returned to one-on-one (1:1) care. A Nursing Progress note dated 4/2/25 read, Resident is up pacing around in her room, up and down in her bed, difficult to redirect, very aggressive with staff, swinging at them, screaming out loud, cursing, knocked over everything on her bedside table, attempted to get in a bed with a resident in the bed, displayed aggressive behavior when trying to redirect. New order given to administer Haldol 0.5 mg IM (intramuscularly - in the muscle) due to aggressive behavior. She remains on 1:1 care. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Admission 5-day minimum data set (MDS) assessment with a reference date of 3/6/25, revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 01 out of 15 possible points, indicating severe cognitive impairment. The resident was noted to be delusional, and physically and verbally aggressive with wandering behavior. She received antipsychotic, antianxiety, antidepressant, and antibiotic medications during the assessment period. A review of the Care Plan (initiated 4/1/25, revised 4/1/25) revealed that the resident had Impaired Cognitive Function/Dementia or Impaired Thought Processes related to dementia, schizoaffective disorder, difficulty making decisions and psychotropic drug use. The resident will be able to communicate basic needs on a daily basis. The care plan noted that the resident had a behavior problem of making inappropriate sexual advances to other residents, aggression and other inappropriate behaviors with a history of UTIs, pacing, wandering, disrobing, inappropriate response to verbal communication, violence, aggression towards staff/others. Pulled out PICC line. Pulled out Foley (urinary) catheter. Resident will have fewer episodes of undesired behaviors. The resident will have no evidence of behavior problems. 1:1 care (downgraded, failed attempt) frequent checks 1:1 caregiver reinitiated 4/1. Move to a room away from patient she appears to favor. 2. A review of Resident #2's medical record revealed an admitted [DATE] and a discharge date of [DATE]. His diagnoses included dysphagia (difficulty swallowing) following cerebral infarction (stroke), type 2 diabetes mellitus (DM), difficulty walking, lack of coordination, and hypertension (HTN). No psychiatric diagnoses/mental health disorders were noted. A review of Resident #2's 3/18/25 physician's orders revealed: - Occupational therapy (OT) - Resident to be seen 5 times a week for 60 days with a focus on therapeutic exercises, therapeutic activity, self-care management, neuromuscular re-education training, group treatment when appropriate, and wheelchair management. - Skilled physical therapy (PT) services following hospitalization for 5 times a week for 4 weeks for therapeutic exercises, therapeutic activities, neuromuscular re-education, gait training, group therapy and manual. - Clopidogrel bisulfate (inhibits blood clotting) 75 mg via percutaneous endoscopic gastrostomy (PEG) tube (feeding tube passed into a resident's stomach through the abdominal wall) one time a day (QD) for deep vein thrombosis (DVT). - Amlodipine 10 mg via PEG QD for HTN. - Ezetimibe (cholesterol medication) 10 mg via PEG at bedtime for hyperlipidemia. - Lantus (insulin) 100 unit/ml (units per milliliter) inject 16 units subcutaneously (beneath the skin) at bedtime for DM. There was no physician's order for one-on-one (1:1) supervision. (Copies obtained) (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #2's Admission 5-day MDS, with a reference date of 3/24/25, revealed that the resident had a BIMS score of 12 out of 15 possible points, indicating moderate cognitive impairment. No behaviors were noted. He reported feeling depressed with little to no interest in doing things. He ambulated with a cane and required partial to moderate assistance with transfers. He did not receive psychotropic medications during the assessment period. A review of Resident #2's Care Plan, initiated on 4/3/25, revealed that the resident had a focus area for Behavior related to hypersexuality and was noncompliant with dietary restrictions. Interventions included the following: 1. Administer medications as ordered. Monitor side effects and effectiveness. 2. Caregivers to provide opportunity for positive interaction, attention. Stop and talk to him/her as passing by. 3. If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. 4. Monitor behavior episodes and attempt to determine the underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. 5. Praise any indication of the resident's progress/improvement in behavior. All interventions were initiated on 4/3/25, two days after the event. There was no intervention for increased supervision for Resident #2 from the care plan initiation date through his transfer to the sister facility on 4/6/25. (Copy obtained) The Care Plan revealed a focus area for Impaired Cognitive Function/Dementia or Impaired Thought Processes related to impaired decision making, initiated on 4/1/25. Interventions included, but were not limited to, the following: 1. Administer medications as ordered. Monitor/document for side effects and effectiveness. 2. Ask yes/no questions in order to determine the resident's needs. 3. Communicate with the resident/family/caregivers regarding resident's capabilities and needs. 4. Cue, reorient and supervise as needed. 5. Monitor/document and report PRN (as needed) any changes in cognitive function, specifically changes in decision making ability, memory, recall, and general awareness, difficulty expressing self, and difficulty understanding others. There was no intervention for increased supervision for Resident #2 after the 4/1/25 incident through the resident's transfer to the sister facility on 4/6/25. (Copy obtained) A Physician's Note dated 4/2/25, revealed that the resident was seen for behavioral follow-up status post incident with resident. Female resident was found in the resident's bed with likely inappropriate touching or sexual behavior noted. The female resident is quite confused. He (Resident #2) was placed on one-on-one care for observation. He was told about the inappropriateness of his behavior. He appeared to be slightly confused but is aware of inappropriate behavior. A Physician's Note dated 4/4/25, revealed that Resident #2 was evaluated for discharge. He will be discharged to another skilled nursing facility, as he had a sexual encounter with another resident at this facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105262	A. Building B. Wing	04/08/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/7/25 at 1:25 p.m., the Administrator and the Administrator in Training (AIT) were interviewed regarding the timeline of events as related to the 4/1/25 incident between Residents #1 and #2. The Administrator stated on 4/1/25 at approximately 6:00 p.m., Residents #1 and #2 were in the dining room area. Resident #1 was observed tapping Resident #2's shoulder. The assigned nurse, Licensed Practical Nurse (LPN) C, who was at the nurses' station, separated the residents. Approximately five minutes later, Resident #1 was observed attempting to sit on Resident #2's walker. Again, the residents were separated and put at different ends of the dining area. Resident #2 was educated and voiced understanding. At approximately 6:30 p.m., LPN C went to conduct blood glucose monitoring for another resident and walked away from the dining area. When she returned, she noticed that both Resident #1 and Resident #2 were not in the dining area. LPN C walked to Resident #2's room and found both residents (#1 and #2). Resident #1 was observed in Resident #2 's bed lying supine, fully clothed, with her pants unbuttoned and her zipper down. Resident #2 stood to the right of her. He was fully clothed with his hand inside of Resident #1's pants. He quickly pulled his hand out of her pants when the nurse walked in. The Administrator confirmed that Resident #2's one-on-one (1:1) supervision was discontinued because Resident #1 was the resident who initiated the sexual behavior. During an interview on 4/07/25 at 3:30 p.m., Registered Nurse (RN) A stated she had been employed by the facility for about a year as a floor nurse. In November 2024 she was promoted to evening supervisor. As of Friday (4/4/25), she was asked to be the interim Director of Nursing (DON) since the previous DON had resigned. When asked if she was familiar with Residents #1 and #2, she stated Resident #1 was confused, verbally and physically aggressive towards staff, and refused care and medications. She stated the resident had not had any sexually inappropriate behaviors before this incident with Resident #2. Resident #2 was alert and oriented times three (person, place and time). He had no behaviors except noncompliance with diet orders. She stated on 4/1/24 she was working on the floor on the 200 hall. At 5:30 p.m., Residents #1 and #2 were observed in the dining area watching television. She was at the nurses' station with Licensed Practical Nurse (LPN) C, and they were completing their daily documentation. She stated at approximately 6:00 p.m., Resident #1 was seated on Resident #2's walker. LPN C separated the two residents. The residents were again observed holding hands, and she approached both residents and explained to Resident #2 that he could not hold hands with resident #1 because she was not alert and oriented. The residents were separated again. She then left the area to attend to another resident and left LPN C at the nurses' station. She stated she was not present in Resident #2's room when the two residents were found there. A telephone interview was conducted on 4/7/25 at 3:50 p.m. with LPN B who stated she had worked in the facility for about a year and on 4/1/25, she was coming in to work her 7:00 p.m. to 7:00 a.m. shift when the assigned nurse (LPN C) mentioned that Residents #1 and #2 were having behaviors. At that time, they noticed that neither Resident #1 nor Resident #2 were in the dining area. LPN B and LPN C then went to Resident #2's room together at approximately 6:55 p.m. looking for the residents. As they walked into Resident #2's room, they saw that his right hand was inside of Resident #1's pants. LPN B stated she and LPN C separated the residents and LPN C notified the Administrator (referring to the AIT). LPN B explained that she completed a witness statement and pushed it under the Administrator's door. When asked if the written statement was in addition to/followed by a telephone interview, she replied, No one called me. I typed up my observations. She provided a copy of her statement. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A follow-up interview was conducted on 4/7/25 at 4:31 p.m. with the Administrator who was asked for any surveillance videos. He stated the surveillance video cameras were not working. When asked again if there was another witness to the incident, he said, There were no other witnesses. He was asked about the witness noted in the federal incident report. The Administrator stated she was another nurse who was assisting with a respiratory program. He further stated this other nurse was asked by LPN C (assigned nurse) if she had seen the residents. LPN C and this other nurse then both walked into Resident #2's room. The Administrator stated this other nurse/witness entered Resident #2's room after the assigned nurse (LPN C) and did not witness what happened. When asked if he had a witness statement from this second nurse, the Administrator stated he might not have put it in the investigative file that had been provided to the surveyor. He stated he would provide it. At 4:53 p.m., the Administrator provided a statement indicating that a phone interview was conducted on 4/1/25 with LPN I, whose name was on the statement. The statement indicated that LPN I did not witness the incident. When asked why LPN I was not on the schedule for 4/1/25, the Administrator stated the staffing person may have forgotten to add LPN I since she was not working a medication cart. He further stated he would provide an updated schedule. The reprinted schedule provided for review did not match the name of LPN B (who witnessed the incident with LPN C) or LPN I; it indicated LPN J. A review of the employee roster printed on 4/7/25 revealed that there was no employee by the name of LPN I, who was noted in the witness statement, on the facility's roster. Another interview was conducted with the Administrator on 4/7/25 at 5:08 p.m. He was asked about the differing names on the federal incident report, the witness statement he provided, and the schedule for 4/1/25. He stated LPN B went by LPN J's name. When asked why the schedule had a different name (LPN J), he walked out of the room stating he would clarify with the staffing department. Another follow up interview was conducted on 4/7/25 at 5:50 p.m. with the Administrator who stated he contacted LPN B, and she confirmed that she entered the room at the same time with LPN C and witnessed Resident #2 removing his hand from Resident #1's pants. He stated he had contacted LPN C and was unable to reach her. He added that with the new information he would close the investigation and substantiate the abuse allegation. On 4/8/25 at 11:45 a.m., a visit was made to the sister facility where Resident #2 had been discharged after the incident. Resident #2 was observed in the bed adjacent to the window with his eyes closed. He was clean and appropriately dressed. There was a rollator walker and a cane at his bedside. He opened his eyes, and an interview was conducted at this time. Resident #2 stated he was a little sleepy. When asked if he was unwell, he replied, no. When he was asked when and why he was discharged to this sister facility, he said, They transferred me here a few days ago. I did not have a choice. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/8/25 at 12:07 p.m., a joint interview was conducted with LPN L/MDS Nurse and Registered Nurse N/Director of Nursing (DON) at the sister facility. They both stated they were involved with the admission process. They both stated that a care plan was established from the resident's diagnoses, physician's orders, and any additional information from the medical record. When they were asked about Resident #2's functional status, LPN L stated Resident #2 had a BIMS score of 14 out of 15 possible points, indicating intact cognition was ambulatory with the use of a walker. They both stated Resident #2 was transferred from the sister facility because of a sexual encounter with another resident and the need for long-term care placement. When asked if they had established any behavior care plan for this resident, they stated the behavior care plan established was only related to non-compliance with the resident's diet. They added that they did not initiate a sexual behavior care plan because they were informed that the other female resident initiated the sexual act. During an interview on 4/8/25 at 2:19 p.m., the Administrator and the AIT were asked if there were any identified opportunities for improvement. The Administrator stated there was a missed opportunity for Resident #1 regarding her behaviors. He further stated there were opportunities on 4/1/25 when Resident #1 had behaviors and staff could have provided more supervision, but they walked away. When asked if they had identified opportunities for improving their abuse investigation and reporting, the Administrator replied, What exactly? He was reminded that he had mentioned on 4/7/25 that the allegation could not be verified, and then at the end of the day he stated that the allegation was substantiated. He said that per LPN C they could not verify the allegation. He confirmed that he did not obtain a statement from Resident #2. A telephone interview was conducted on 4/8/25 at 5:37 p.m. with LPN C. She stated she had worked at the facility for about a year. She confirmed that she was assigned to Residents #1 and #2 on 4/1/25. She explained that she was sitting at the nurses' station at approximately 6:00 p.m. and observed Resident #1 rubbing Resident #2's shoulder and trying to pull him close to her while grabbing his hand. Resident #2 allowed her to do so after being told three times that Resident #1 was not as alert and oriented as him and he should not allow the behavior. This behavior went on over the course of 15-20 minutes. Resident #1 was also observed trying to sit on Resident #2's walker. Resident #2 was informed that he should not allow her to do that. Resident #1 was redirected and went back to the chair she was sitting in before - away from Resident #2. Both residents continued to watch television with the other residents. At approximately 6:30 p.m. , LPN C went to complete blood glucose monitoring on a resident near the dining room. When she came out of that resident's room, the night shift nurse had arrived (LPN B). LPN A noticed that the two residents (#1 and #2) were not in the dining room any longer. Together with the night nurse (LPN B) at approximately 6:55 p.m., LPN C quickly went to Resident #2's room and observed Resident #1 lying in his bed on her back fully clothed with her pants unbuttoned and her zipper down while Resident #2 stood to the right of her fully clothed with his right hand inside of Resident #1's pants. When he saw the nurses, he quickly pulled his hand out of her pants. Resident#1 was quickly assisted out of the room while Resident #2 remained in his room. LPN C confirmed that she and LPN B entered the room at the same time. She stated she notified the evening supervisor, the DON, and the Administrator. She stated both residents were placed on 1:1 supervision. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Administrator's job description (effective January 2025), revealed that the primary purpose of the Administrator was to oversee, manage and direct the day-to-day functions and overall operations of the facility in accordance with current federal, state and local government regulations that govern long-term care facilities and the Operators requirements. The Administrator's focus is on maintaining the highest degree of quality care for the resident/patient while achieving the facility's business objectives. As the Administrator, you are delegated the Governing Body and administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. CUSTOMER SERVICE - Demonstrates positive customer service when performing the role of the Administrator, with residents, family members, internal and external staff. - Displays flexibility, team spirit, compassion, respect honesty, politeness and accountability when dealing with residents, family members and facility staff. - Demonstrates an awareness of and sensitivity for resident's rights in all interfaces with residents and family members. - Develops an environment that allows for creative thinking, problem solving and empowerment in the development of a facility management team. - Communicates effectively via open, straightforward communication, including the use of listening skills. - Seeks validation of knowledge base, quality, decision-making and skill level by actively questioning when necessary. - Utilizes survey information to address areas of importance as defined by our customers. ESSENTIAL DUTIES AND RESPONSIBILITIES: - Leads facility management staff in developing and working from a business plan that focuses on all aspects of facility operations, including setting priorities and job assignments. - Serves on various committees of the facility (i.e., Infection Control, Quality Assurance & Assessment, etc.) Committee Functions: - Assist the Quality Assurance and Assessment Committee in developing and implementing appropriate plans of action to correct identified quality deficiencies. - Evaluate and implement recommendations from the facility's committees as necessary. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Consult with department directors concerning the operation of their departments to assist in eliminating/correcting problem areas, and/or improvement of services. Ensure that an adequate number of appropriately trained professional and auxiliary personnel are on duty at all times to meet the needs of the residents.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42442 Based on staff interviews, resident and facility record reviews, and a review of facility policies and procedures, the facility's Quality Assessment and Quality Assurance Committee (QAA) failed to develop and implement appropriate plans of action to correct identified quality deficiencies, particularly those that caused adverse outcomes. This resulted in a lack of improvement of their systems and processes. This failure contributed to the sexual abuse of one (Resident #1) out of three residents reviewed for abuse. It also placed all other vulnerable female residents at a likelihood for serious adverse outcomes related to potential sexual abuse from Resident #2. Immediate Jeopardy (IJ) at a scope and severity of J (isolated) was identified on April 7, 2025 at 3:50 p.m. On April 1, 2025, at 6:55 p.m., Immediate Jeopardy began. On April 8, 2025, at 6:15 p.m., the Administrator was notified of the IJ determination and was provided with Immediate Jeopardy Templates. Immediate Jeopardy was ongoing as of the survey exit on April 8, 2025. The findings include: Cross reference F600, F610, and F835. A review of Resident #1's medical record revealed an admitted [DATE]. Her diagnoses included, but were not limited to, metabolic encephalopathy (brain dysfunction leading to altered consciousness, cognitive decline and other neurological symptoms), attention and concentration deficit following cerebral infarction (stroke); extended-spectrum beta-lactamase resistance (ESBL - bacterial infection resistant to antibiotics); dementia in other diseases classified elsewhere, unspecified severity with agitation; general anxiety disorder; schizoaffective disorder; and a need for assistance with personal care. A review of the resident's 3/2/25 physician's orders revealed: - Donepezil Oral tablet 10 milligrams (mg) - give 1 tablet by mouth at bedtime for dementia. - Quetiapine (antipsychotic) Fumarate Oral tablet 50 mg - give 1 tablet by mouth one time a day for anxiety. - Quetiapine Fumarate Oral tablet 50 mg - give 3 tablets by mouth at bedtime for anxiety. - Alprazolam (benzodiazepine - slows the nervous system) oral tablet 0.5 mg - give 1 tablet by mouth every morning and at bedtime for anxiety. - Sertraline HCL (hydrochloride) (selective serotonin reuptake inhibitor - can be used to treat depression, obsessive compulsive disorder, posttraumatic stress disorder, social anxiety disorder (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and/or panic disorder) oral tablet 100 mg - give 1 tablet by mouth one time a day for depression. - 1:1 monitoring every shift - discontinued on 3/7/25. Additional physician's orders included: - 3/7/2025 - 30-minute monitoring for behaviors, (This order, 30-minute monitoring, was discontinued on 3/19/25). No documentation for increased/frequent monitoring was found from 3/19/2025 through 4/1/2025. - 3/24/2025 - Ciprofloxacin HCL (antibiotic) oral tablet 500 mg - give 500 mg by mouth two times a day for urinary tract infection (UTI) for 14 days. - 4/1/2025 - One-on-one monitoring for behaviors - every shift. A review of the Psychotropic Evaluation nursing note dated 3/2/2025, revealed that Resident #1 had behaviors (e.g. combativeness, verbal disruptions) that were harmful to self or others or limited participation in activities. Increased in acuteness. She could be aggressive with staff. Resident has anxiety or nervousness that impairs his/her quality of life or limits participation in activities. A review of a Behavior Note dated 3/3/2025 revealed: Resident has pulled out her peripherally inserted central catheter (PICC) line from her right upper arm. Some bleeding was observed, pressure applied and Tegaderm (transparent, waterproof, sterile medical dressing) placed after it stopped. Resident remains aggressive, attempting to bite several staff members and kick. New order for Haldol (antipsychotic) intramuscularly (IM) given per Advanced Practice Registered Nurse (APRN) - Ineffective, continues to walk around yelling and screaming. Redirected as staff walks along with her. A review of the Provider Encounter dated 3/14/25 revealed that the resident wandered and attempted to hit and bite staff. She continued to refuse clothing changes as needed. Psychiatry was consulted to see resident and schedule next week. The Haldol order remained in place for behavioral management. (Psychiatry notes were requested but not provided during the survey.) An Encounter note dated 3/20/25 recommended that the resident continue with 30-minute behavior checks for safety monitoring. (The order was not implemented. Copies obtained) An Encounter note dated 4/2/25 revealed that Resident #1 was seen for a behavioral follow up. She was found in a male resident's bed last night with what appears to be inappropriate touching and sexual behavior. Resident was returned to one-on-one (1:1) care. A Nursing Progress note dated 4/2/25 read, Resident is up pacing around in her room, up and down in her bed, difficult to redirect, very aggressive with staff, swinging at them, screaming out loud, cursing, knocked over everything on her bedside table, attempted to get in a bed with a resident in the bed, displayed aggressive behavior when trying to redirect. New order given to administer Haldol 0.5 mg IM (intramuscularly - in the muscle) due to aggressive behavior. She remains on 1:1 care. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Admission 5-day minimum data set (MDS) assessment with a reference date of 3/6/25, revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 01 out of 15 possible points, indicating severe cognitive impairment. The resident was noted to be delusional, and physically and verbally aggressive with wandering behavior. She received antipsychotic, antianxiety, antidepressant, and antibiotic medications during the assessment period. A review of the Care Plan (initiated 4/1/25, revised 4/1/25) revealed that the resident had Impaired Cognitive Function/Dementia or Impaired Thought Processes related to dementia, schizoaffective disorder, difficulty making decisions and psychotropic drug use. The resident will be able to communicate basic needs on a daily basis. The care plan noted that the resident had a behavior problem of making inappropriate sexual advances to other residents, aggression and other inappropriate behaviors with a history of UTIs, pacing, wandering, disrobing, inappropriate response to verbal communication, violence, aggression towards staff/others. Pulled out PICC line. Pulled out Foley (urinary) catheter. Resident will have fewer episodes of undesired behaviors. The resident will have no evidence of behavior problems. 1:1 care (downgraded, failed attempt) frequent checks 1:1 caregiver reinitiated 4/1. Move to a room away from patient she appears to favor. 2. A review of Resident #2's medical record revealed an admitted [DATE] and a discharge date of [DATE]. His diagnoses included dysphagia (difficulty swallowing) following cerebral infarction (stroke), type 2 diabetes mellitus (DM), difficulty walking, lack of coordination, and hypertension (HTN). No psychiatric diagnoses/mental health disorders were noted. A review of Resident #2's 3/18/25 physician's orders revealed: - Occupational therapy (OT) - Resident to be seen 5 times a week for 60 days with a focus on therapeutic exercises, therapeutic activity, self-care management, neuromuscular re-education training, group treatment when appropriate, and wheelchair management. - Skilled physical therapy (PT) services following hospitalization for 5 times a week for 4 weeks for therapeutic exercises, therapeutic activities, neuromuscular re-education, gait training, group therapy and manual. - Clopidogrel bisulfate (inhibits blood clotting) 75 mg via percutaneous endoscopic gastrostomy (PEG) tube (feeding tube passed into a resident's stomach through the abdominal wall) one time a day (QD) for deep vein thrombosis (DVT). - Amlodipine 10 mg via PEG QD for HTN. - Ezetimibe (cholesterol medication) 10 mg via PEG at bedtime for hyperlipidemia. - Lantus (insulin) 100 unit/ml (units per milliliter) inject 16 units subcutaneously (beneath the skin) at bedtime for DM. There was no physician's order for one-on-one (1:1) supervision. (Copies obtained) (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #2's Admission 5-day MDS, with a reference date of 3/24/25, revealed that the resident had a BIMS score of 12 out of 15 possible points, indicating moderate cognitive impairment. No behaviors were noted. He reported feeling depressed with little to no interest in doing things. He ambulated with a cane and required partial to moderate assistance with transfers. He did not receive psychotropic medications during the assessment period. A review of Resident #2's Care Plan, initiated on 4/3/25, revealed that the resident had a focus area for Behavior related to hypersexuality and was noncompliant with dietary restrictions. Interventions included the following: 1. Administer medications as ordered. Monitor side effects and effectiveness. 2. Caregivers to provide opportunity for positive interaction, attention. Stop and talk to him/her as passing by. 3. If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. 4. Monitor behavior episodes and attempt to determine the underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. 5. Praise any indication of the resident's progress/improvement in behavior. All interventions were initiated on 4/3/25, two days after the event. There was no intervention for increased supervision for Resident #2 from the care plan initiation date through his transfer to the sister facility on 4/6/25. (Copy obtained) The Care Plan revealed a focus area for Impaired Cognitive Function/Dementia or Impaired Thought Processes related to impaired decision making, initiated on 4/1/25. Interventions included, but were not limited to, the following: 1. Administer medications as ordered. Monitor/document for side effects and effectiveness. 2. Ask yes/no questions in order to determine the resident's needs. 3. Communicate with the resident/family/caregivers regarding resident's capabilities and needs. 4. Cue, reorient and supervise as needed. 5. Monitor/document and report PRN (as needed) any changes in cognitive function, specifically changes in decision making ability, memory, recall, and general awareness, difficulty expressing self, and difficulty understanding others. There was no intervention for increased supervision for Resident #2 after the 4/1/25 incident through the resident's transfer to the sister facility on 4/6/25. (Copy obtained) A Physician's Note dated 4/2/25, revealed that the resident was seen for behavioral follow-up status post incident with resident. Female resident was found in the resident's bed with likely inappropriate touching or sexual behavior noted. The female resident is quite confused. He (Resident #2) was placed on one-on-one care for observation. He was told about the inappropriateness of his behavior. He appeared to be slightly confused but is aware of inappropriate behavior. (continued on next page)

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	105262	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Lake Post Acute	991 E New York Ave Deland, FL 32724

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/07/25 at 3:30 p.m., Registered Nurse (RN) A stated she had been employed by the facility for about a year as a floor nurse. In November 2024 she was promoted to evening supervisor. As of Friday (4/4/25), she was asked to be the interim Director of Nursing (DON) since the previous DON had resigned. When asked if she was familiar with Residents #1 and #2, she stated Resident #1 was confused, verbally and physically aggressive towards staff, and refused care and medications. She stated the resident had not had any sexually inappropriate behaviors before this incident with Resident #2. Resident #2 was alert and oriented x3 (person, place and time). He had no behaviors except noncompliance with diet orders. She stated on 4/1/24 she was working on the floor on the 200 hall. At 5:30 p.m., Residents #1 and #2 were observed in the dining area watching television. She was at the nurses' station with Licensed Practical Nurse (LPN) C, and they were completing their daily documentation. She stated at approximately 6:00 p.m., Resident #1 was seated on Resident #2's walker. LPN C separated the two residents. The residents were again observed holding hands, and she approached both residents and explained to Resident #2 that he could not hold hands with resident #1 because she was not alert and oriented. The residents were separated again. She then left the area to attend to another resident and left LPN C at the nurses' station. She stated she was not present in Resident #2's room when the two residents were found there. On 4/7/25 at 1:25 p.m., the Administrator confirmed that Resident #2's one-on-one (1:1) supervision was discontinued because Resident #1 was the resident who initiated the sexual behavior. During an interview on 4/07/25 at 3:30 p.m., Registered Nurse (RN) A stated she had been employed by the facility for about a year as a floor nurse. In November 2024 she was promoted to evening supervisor. As of Friday (4/4/25), she was asked to be the interim Director of Nursing (DON) since the previous DON had resigned. When asked if she was familiar with Residents #1 and #2, she stated Resident #1 was confused, verbally and physically aggressive towards staff, and refused care and medications. She stated the resident had not had any sexually inappropriate behaviors before this incident with Resident #2. Resident #2 was alert and oriented x3 (person, place and time). He had no behaviors except noncompliance with diet orders. She stated on 4/1/24 she was working on the floor on the 200 hall. At 5:30 p.m., Residents #1 and #2 were observed in the dining area watching television. She was at the nurses' station with Licensed Practical Nurse (LPN) C, and they were completing their daily documentation. She stated at approximately 6:00 p.m., Resident #1 was seated on Resident #2's walker. LPN C separated the two residents. The residents were again observed holding hands, and she approached both residents and explained to Resident #2 that he could not hold hands with resident #1 because she was not alert and oriented. The residents were separated again. She then left the area to attend to another resident and left LPN C at the nurses' station. She stated she was not present in Resident #2's room when the two residents were found there. A telephone interview was conducted on 4/7/25 at 3:50 p.m., with LPN B. She stated she had worked in the facility for about a year and on 4/1/25, she was coming in to work her 7:00 p.m. to 7:00 a.m. shift when the assigned nurse mentioned that Residents #1 and #2 were having behaviors. At that time, they noticed that neither Resident #1 nor Resident #2 were in the dining area. LPN B and LPN C then went to Resident #2's room together at approximately 6:55 p.m. looking for the residents. As they walked into Resident #2's room, they saw that his right hand was inside of Resident #1's pants. LPN B stated she and LPN C separated the residents and LPN C notified the Administrator (referring to the Administrator in Training (AIT). (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/8/25 at 11:45 a.m., a visit was made to the sister facility where Resident #2 had been discharged after the incident. Resident #2 was observed in the bed adjacent to the window with his eyes closed. He was clean and appropriately dressed. There was a rollator walker and a cane at his bedside. He opened his eyes, and an interview was conducted at this time. Resident #2 stated he was a little sleepy. When asked if he was unwell, he replied, no. When he was asked when and why he was discharged to this sister facility, he said, They transferred me here a few days ago. I did not have a choice. When asked if he could recall the 4/1/25 incident in the other facility where a female resident was found in his bed, he replied, A female resident? Yes, she was in my bed. He declined to provide further details about the incident. He said, I don't want to answer any more questions. On 4/8/25 at 12:07 p.m., a joint interview was conducted with LPN L/MDS Nurse and Registered Nurse N/Director of Nursing (DON) at the sister facility. They both stated they were involved with the admission process. They both stated that a care plan was established from the resident's diagnoses, physician's orders, and any additional information from the medical record. When they were asked about Resident #2's functional status, LPN L stated Resident #2 had a BIMS score of 14 out of 15 possible points, indicating intact cognition was ambulatory with the use of a walker. They both stated Resident #2 was transferred from the sister facility because of a sexual encounter with another resident and the need for long-term care placement. When asked if they had established any behavior care plan for this resident, they stated the behavior care plan established was only related to non-compliance with the resident's diet. They added that they did not initiate a sexual behavior care plan because they were informed that the other female resident initiated the sexual act. In an interview on 4/8/25 at 12:30 p.m., the facility's Medical Director stated he conducted rounds at the facility every Tuesday and Thursday, and during each visit, he asked the Administrator if there was anything to report. He stated he had just left the sister facility and was informed that surveyors were in the facility for a complaint investigation, but he was not provided details. He said that he contacted the facility Administrator to ask him whether he needed to make him aware of anything. When the Administrator then notified the Medical Director of the 4/1/25 incident between Residents #1 and #2, the Medical Director asked, What is this about? I am not aware. The Medical Director stated a brief overview of the incident was provided by the Administrator. He stated he told the Administrator, I'm not aware. I just came back from that facility and was not notified. As the Medical Director and QAPI committee member, I should be made aware. The Medical Director stated he would not comment on the incident because he had to review the documentation first. He stated he was not informed that Resident #2 had been transferred to the sister facility, but he would visit the resident after this interview. An interview was conducted on 4/8/25 at 1:43 p.m. with Resident #1's spouse. He stated he was contacted by the facility when the incident occurred. This was the first time anything like this had happened. He was asked how he felt his wife would have responded to the actions of Resident #2 if she was not cognitively impaired. He stated that in her previous life his wife was very modest. She would have been very upset over Resident #2's actions. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/8/25 at 2:19 p.m., the Administrator and the Administrator in Training stated they had identified areas of improvement related to failure to provide enough supervision to Resident #1 after several observations of new behaviors. It was confirmed with the Administrator that an ad hoc QAPI (Quality Assurance and Performance Improvement) meeting had not been held. When the Administrator was asked why an ad hoc QAPI meeting was not conducted, he replied that there was no reason to do so. When he was asked if the Medical Director was notified of the incident after it occurred, he said that he tried to contact him, but was unable to reach him, so he notified the Medical Director's Advanced Practice Registered Nurse (APRN). He confirmed that he did not follow up with the Medical Director. A telephone interview was conducted on 4/8/25 at 5:37 p.m. with LPN C. She stated she had worked at the facility for about a year. She confirmed that she was assigned to Residents #1 and #2 on 4/1/25. She explained that she was sitting at the nurses' station at approximately 6:00 p.m. and observed Resident #1 rubbing Resident #2's shoulder and trying to pull him close to her while grabbing his hand. Resident #2 allowed her to do so after being told three times that Resident #1 was not as alert and oriented as him and he should not allow the behavior. This behavior went on over the course of 15-20 minutes. Resident #1 was also observed trying to sit on Resident #2's walker. Resident #2 was informed that he should not allow her to do that. Resident #1 was redirected and went back to the chair she was sitting in before - away from Resident #2. Both residents continued to watch television with the other residents. At approximately 6:30 p.m. , LPN C went to complete blood glucose monitoring on a resident near the dining room. When she came out of that resident's room, the night shift nurse had arrived (LPN B). LPN A noticed that the two residents (#1 and #2) were not in the dining room any longer. Together with the night nurse (LPN B) at approximately 6:55 p.m., LPN C quickly went to Resident #2's room and observed Resident #1 lying in his bed on her back fully clothed with her pants unbuttoned and her zipper down while Resident #2 stood to the right of her fully clothed with his right hand inside of Resident #1's pants. When he saw the nurses, he quickly pulled his hand out of her pants. Resident#1 was quickly assisted out of the room while Resident #2 remained in his room. LPN C confirmed that she and LPN B entered the room at the same time. She stated she notified the evening supervisor, the DON, and the Administrator. She stated both residents were placed on 1:1 supervision. She confirmed that she was not contacted by any administrative team member at facility about the 4/1/25 incident until 4/8/25. On 4/8/25, the Administrator contacted her, and she explained to the Administrator what occurred exactly as she had in her previously written statement. A review of the facility's policy titled Quality Assurance and Performance Improvement Policy for Skilled Nursing Center (effective 2/1/24, reviewed 1/1/25), revealed: Policy Statement: The purpose of Quality Assurance and Performance Improvement (QAPI) is to continually take a proactive approach to assure and improve the way we provide care and engage with our patients, employees, and other stakeholders so that we may fully realize our vision, mission, and commitment to caring pledge. Procedure: (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All employees and contracted staff are responsible for the quality of care and services within their respective departments and are expected to participate in the QAPI Program. Each center must develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care, quality of life, and resident choice. It is the expectation of the SNF (skilled nursing facility) QAPI Program that the center will follow the established QAPI process to guide and direct the operations of the location. The executive leadership sets the expectation and provides the resources for implementation. Quality Assurance Performance Improvement (QAPI) information flows up and down the organization in an organized format. The center culture supports the premise that knowledge is shared, and information flows freely. Improvements in processes or outcomes as a result of the QAPI Program are communicated throughout the center and to stakeholders (residents, families and vendors). When improvement opportunities are identified through quality assessment activities, the center takes action to improve performance, including education, modification of systems and processes, or formal Performance Improvement Projects. IV. PERFORMANCE IMPROVEMENT PROJECTS (PIPs): As part of its QAPI Program, the SNF develops, implements, and evaluates performance improvement projects. - The facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the center must reflect the scope and complexity of the facility's services and available resources. - The center must set priorities for its performance improvement projects based on the results of quality monitoring that consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.