STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115522	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Health and Rehabilitation	1321 Pulaski School Road Pulaski, GA 30451

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on interviews, record reviews, and review of the policy titled, Abuse Prohibition, the facility failed to ensure one cognitively impaired resident (R48) was free from sexual and physical abuse from one resident (R121) who had a history of sexually inappropriate behaviors, and history of being agitated and hostile. The sample size was 36. On 3/31/2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The Senior Director of Clinical Standards, Director of Quality and Regulatory Services, Director of Nursing (DON), and Assistant Administrator were informed of the Immediate Jeopardy (IJ) on 3/31/2025 at 10:45 am. The noncompliance related to the IJ was identified to have existed on 9/28/2024 when R121 sexually and physically abused R48 inside her room. A Credible Allegation of Compliance was received on 3/31/2025. Based on observations, record review, resident and staff interviews, and review of facility policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice were removed as of 4/1/2025. The facility remains out of compliance while the facility continues management level oversight as well as continuing to develop and implement a Plan of Correction. (POC). This oversight process included the analysis of facility staff's conformance with the facility's policies and procedures. In-service materials and records were reviewed. Interviews were conducted with staff to ensure they demonstrated knowledge of facility Policies and Procedures related to Abuse, Neglect, and Exploitation, and the behavioral health needs of residents. Findings include: (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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility policy titled Abuse Prohibition, undated, stated it is the intent of this center to actively protect each patient's right to be free from mistreatment, neglect, abuse, or misappropriation of patient property. We believe that each patient has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. 3. Sexual abuse includes, but is not limited to sexual harassment, sexual coercion, or sexual assault. 4. Physical abuse includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment. Once an injury or event is identified as suspicious and may constitute abuse, the center will follow the investigation procedures. Identification of patients whose behavior is abusive to other patients. If a patient is identified in one of the following categories, a thorough assessment will be completed to include any identified situations or factors that triggers abusive behavior. Patients whose personal histories render them at risk for abusing other patients. Patients who have displayed abusive behavior toward other patients. ii. From the assessment, intervention strategies will be developed on the care plan or behavior management plan to prevent occurrences including monitoring for factors that trigger abusive behavior for this patient. 1.Record review of the Electronic Medical Record (EMR) for R48 revealed the following diagnoses, but not limited to, schizoaffective disorder, bipolar disorder, Alzheimer's, and major depressive disorder. Record review of the prior Significant Change Minimum Data Set (MDS) assessment for R48 dated 10/2/2024 assessed a Brief Interview Mental Status Score (BIMS) of seven, which indicates moderate cognitive impairment (a score of seven out of 15). R48 was also assessed on the MDS assessment as being independent for ambulation, requiring supervision to partial moderate assistance for Activities of Daily Living (ADLs). R48 resided on B Hall in the facility. Record review of a skin assessment for R48 completed on 9/30/2024 revealed a bruise to the right hip. 2. Record review of the EMR for R121 revealed that he had diagnoses that included, but were not limited to, anxiety disorder, unspecified, and mild intellectual disabilities. A new diagnosis of hypersexuality was identified on 10/23/2023 by the Nurse Practitioner (NP). Record review of the Quarterly MDS Assessment for R121 dated 7/13/2024 revealed that a BIMS score was assessed as a three, which indicates severe cognitive impairment (a BIMS score of three out of 15) and being independent and/or being provided with supervision for ADLs, including ambulation. However, during a psychiatric follow-up visit on 8/21/2024, the physician transcribed a BIMS of seven on this day. R121 resided on C Hall in the facility. A review of Nurse's notes for R121 dated 10/21/2023 revealed, Resident up yelling and going door to door trying to exit. Impulsive, approaching staff stating What you doing? What's your name? I love you! I wanna {sic} make love to you! Trying to enter other resident's rooms. Manic laughing. Is currently standing at nurse station window yelling and laughing stating I wanna {sic) go home! I'm crazy about you! I wanna {sic} make love!. On call nurse notified and she ordered 0.5 mg IM (0.5 milligram intramuscular) Ativan q 6 hours (every six hours). Med pulled from e (emergency)-kit and administered to left glute; resident tolerated well but so far is not effective. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the NP Progress Notes for R121 dated 10/23/2023, documented diagnosis of hypersexuality. The recommendation documented stated hormone treatment, and the R121 is currently receiving Ativan. Record review of Progress Notes dated 12/10/2023 documented Certified Nursing Assistant (CNA) went into R121 room to get the patient up/ R121 got up and punched the CNA in the stomach. Record review of the care plan for R121 last reviewed 6/5/2024, documented an identifying problem of inappropriate sexual Behaviors, verbal behavioral symptoms directed toward others /wandering. The intervention noted was to assess patterns of behavior with behavior monitoring. A review of a psychiatric behavior consult note for R121, dated 8/21/2024, documented an incident of inappropriate, sexually aggressive behaviors displayed by R121. The note stated, staff requested a visit today, staff reports that resident was talking inappropriately in a sexual manner, towards staff, this morning, aeb {sic} wanting sex, trying to kiss a staff member, and stating that he was going to rape her, staff reports that he was hit the nurse in the head, and started kicking her. Recommendation to monitor sexual behaviors and new diagnoses of hypersexuality. A review of a Facility Incident Report Form, dated 9/28/2024, that documented an allegation of resident-to-resident abuse had occurred on 9/28/2024 at 8:40 pm. The form included that the Licensed Practical Nurse (LPN) CC reported an inappropriate act between R121 and R48, with R121 listed as the perpetrator. A further review of the form revealed that the LPN CC heard a scream from R48 room, she entered the room, observed R48 on the floor and R121 on top of her. R121 was observed holding his hands over R48 's mouth and his hands in her brief. She separated the resident, and skin assessments were completed on both residents with no injuries noted. The physician, the responsible parties, and law enforcement were notified. A review of the accompanying investigation that included employee and resident interviews, police reports, and the facility's follow-up summary conclusion revealed evidence that the allegation had occurred. A review of the hospital records for R48 dated 9/28/2024 documented a reported sexually assaulted; she was fondled (contact, hand on the vaginal area. No penetration). The patient complains of mild pain. No blow to the head, loss of consciousness, or alcohol consumed. Not dazed. The patient reports that another nursing home resident pushed her off her bed onto the floor. He placed himself on top of her. He then covered her mouth with his hand and contacted the outer area of her vagina with his opposite hand. SANE evaluation completed on 9/28/2024 at 11:54 pm. Clinical impression: confirmed sexual assault and assault by bodily force. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the local police Incident Report dated 9/28/2024 revealed that an officer responded to the facility at approximately 9:30 pm in reference to an aggravated sexual battery. R48's roommate explained that R121 came into their room, grabbed R48, and pushed her down. R48 stated, he stuck his finger up my vagina, and R121 was holding his hand over her mouth. The roommate explained that staff removed R121, but he returned to get his shoe, and staff removed him from the room again before retrieving his shoe. The officer documented the shoe beside the roommate's bed. LPN CC stated to the officer that she witnessed R121 on top of R48 with his hand in the area of her vagina and explained that she then pulled R121 off her. The officer asked R121 several basic questions to assess his mental capabilities, and R121 replied several more times with I don't know. The nursing staff at the facility indicated that they believed R121 was pretending to be mentally incompetent. The Director of Nursing (DON) informed the officer that R121 was on probation. However, the officer later discovered that R121 was on parole. The DON additionally explained that she had been getting reports from staff that R121 had been threatening to rape them over the past couple of weeks. R121 was arrested on 9/28/2024. The officer did respond to the hospital, where he met the SANE nurse, and she explained she had performed a sexual assault exam. At that time, the SANE nurse turned over the sexual assault exam evidence to the officer. Continued review of the EMR for R121 revealed that he was considered a parolee with the Department of Corrections and had the potential to be returned to the Department of Corrections, once determined by the parole board. Interview on 3/25/25 at 12:27 pm with R48 reported that man came into her room and threw her down on the floor and stuck his hand into her diaper and her vaginal area. She stated that the police were called. The man is no longer here, and she couldn't remember his name. R48 stated the man was a resident at the facility. Interview on 3/28/2025 at 12:35 pm with R121's parole officer revealed the resident was sent back to prison after the 9/28/2024 violation. He stated that he was not made aware of any previous incidents with R121, and if made aware, he would have put risk interventions into place. The parole officer stated that facility staff informed him that R121 was doing fine during visits and phone calls. Interview on 3/26/2025 at 2:10 pm with the Administrator reported that she cannot recall the incident with R121 and R48 in detail. She remembers reporting the incident to the State based on what the nurse told her. The nurse reported that resident, R48 stated that R121 had his hand in her vagina. The Administrator further revealed that she thinks what their investigation revealed was not actually the truth. She wrote exactly what R48 said in the Facility Reportable and the 5-Day Report. This was an actual quote, and the staff investigated the incident. The Administrator stated that she was informed that written reports to the State must be based on what the resident (R48) reveals. (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 3/27/2025 at 5:36 pm, the Medical Director (MD) verified being informed by staff of the incident between R48 and R121 on 9/28/2024. The MD confirmed that at the time of R121's admission in 2023, R121 displayed inappropriate sexual behaviors (inappropriate sexual statements towards staff) that had leveled out. The MD reported, I don't recall a time when he was not calm when I interacted with him. The MD reported that usually when they (residents) are on proper medication (med), they will be alright. MD continued to state that if we (referring to medical professionals) are aware of any ongoing sexual behaviors, then we would have to figure out the proper dose of medication because we want them to be their normal self and in control of their behavior. MD reported that an assessment would include trying to figure out the trigger (leading to sexual aggression/behaviors) before we (the medical professionals) add more medications. The MD revealed that the use of Zyprexa for R121 was for his schizophrenia, was not used for sexual aggression, and R121 was being monitored for hormone treatment because the doctor wanted to make sure it was appropriate before starting R121 on progesterone. The facility implemented the following actions to remove the IJ: 1. R48 was assessed for injury, changes in behavior, trauma, and pain on 9/28/2024. NP gave orders to send R48 to the Hospital for evaluation and treatment. The patient was sent to the hospital for evaluation and treatment. MD and family were notified. R48 was discharged back to the center on 9/29/2024 from the hospital. Center nurses began observation on the patient to ensure feelings of safety with no noted distress. Patient had a visit with behavioral health 011 10/1/2024 for a psychosocial support visit. Patient refused to see the behavioral health NP on 10/8/2024. Patient did have visit by hospice on 10/8/2024. Behavior health visit for the patient completed on 3/28/2025. 2. Rl21 was immediately removed from R48 room by the LPN Charge Nurse and placed on one-on-one observation by a CNA until police arrived at the center to test the patient. Patient R121 was arrested on 9/28/2024. 3. Skin audits were conducted on all residents 9/30/2024 to evaluate for any signs of abuse by the facility charge nurses and nurse managers. R48 noted with bruising to the thigh. No other adverse findings for other patients were audited. 4. Resident with BIMs of 10 and above were interviewed by licensed nursing staff on 9/30/2024. 5. In-service education was initiated on 9/29/2024 for staff and to include abuse prohibition, abuse reporting, burnout, and de-escalation for all staff of the facility. Education was provided by the Administrator, Director of Nursing (DON) Assistant Director of Nursing (ADON), Nurse Manager, or Social Services Director. 6. A Resident Council Meeting was held on 10/29/2024. Abuse & Neglect Prevention to include Residents Rights reviewed by Activities Director. R48 was in attendance at the meeting. 7. Interviews were completed on 28 of 28 residents who are interviewable to identify any concerns for abuse on 3/28/2025 by the Social Services Director, Director of Nursing (DON), Activity Director (AD), and Nurse Managers. All denied any type of abuse or neglect. 8. R48 was interviewed by the Administrator on 3/27/2025. Expressed no problems at this time and was happy and planning to attend activities. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. On 3/28/2025, a Root Cause Analysis was completed for the Abuse Prevention. Root Cause identified that the center failed to implement interventions to protect the residents as outlined on the behavior health visit. A communication tool was developed to improve the communication between the behavior provider and center to provide notification of any recommendations timely. The behavior provider will meet with the DON, ADON, and or nurse supervisor upon entrance and exit to make aware of any new recommendation and to receive report of new adverse events. Education of this process has been provided to the nurse leadership, SSD, and behavior provider on 3/31/2025 by the DON. 10. Education was provided to 28 of 28 cognitive residents regarding the Elder Justice Act and reporting of abuse by the Social Services Director and the Director of Social Services on 3/31/2025. 11. Education provided on 3/31/2025 to the center leadership team by the Governing Body on abuse prohibition policy to reviewing adverse events during Quality Assurance Performance Improvemen (QAPI), recognizing trends to create proactive measures to reduce further reoccurrences, and utilization of non-pharmacological interventions as warranted for patients to promote safety of all patients. 12. Re-education was completed on 3/29/2025 for staff and to include abuse prohibition, abuse reporting to include physical and sexual aggression, burnout, and de de-escalation for all staff of the facility. Education was provided by the Director of Nursing (DON) Assistant Director of Nursing (ADON), Nurse Manager, or Social Services Director. 11 of 11 RN, 9 of 9 LPN, 23 of 23 CNAs, 4 of 4 CMAs, l of 1 Maintenance, 1 of l Therapy, 2 of 2 Activities, 8 of 8 Dietary, 10 of 10 Housekeeping, Social Services Director 1 of l, 5 of 5 Administrative staff have been in serviced which totals l00%. No staff shall work until they have completed in-service education. No staff shall work until they have completed in-service education. Contract and newly hired associates will be educated upon hire on abuse prohibition, abuse reporting, burnout, and de-escalation by the Nurse Manager, DON, or ADON. 13. Audits started on 3/31/2025 by the social service director to interview 10 residents to ensure. They feel safe, and 10 associates' interviews have been completed to ensure they know the process for reporting and can identify abuse, including sexual and physical aggression. Any noncompliance identified will be addressed by the Administrator assistant and or [NAME] by written education, and incidents identified will be reported following the HFRD reporting protocol. 14. On 3/31/2025, the DON, Financial Controller, and Nurse Managers notified all current non-interviewable resident representatives via written notification on Abuse & Neglect Prevention Policy, and the Elder Justice Act and reporting. 15. An ADHOC QAPI meeting was held with the Medical Director, center leadership, and Governing Body on 3/31/2025 to notify of the deficiencies cited and the interventions implemented to ensure that the deficient practices do not reoccur. The Abuse Policy was reviewed with no needed revisions needed. The State Survey Agency (SSA) validated the facility's written IJ Removal Plan as follows: 1. Verified by: Record review of Licensed Practical Nurse (LPN) CC 's written statement stated nurse assessed resident, and no visible bleeding noted at this time. ROM (Range of Motion adequate to all extremities, and she could stand with full weight, v/s (vital signs 138/93, 97.6, pulse 107, O2 Sat 95 % (oxygen saturation 95 percentage) on room air. The Administrator and DON aware. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Verified by: The hospital record review revealed that R48 returned to the facility on [DATE]. Verified by: Record review of nurse written statement showed dates of each observation (consist of every 15 minutes checks per 12 hours shift) conducted by licensed nursing staff: Documentation revealed that staff observation included interview questions about the resident overall well beings. (Note: R48 returned back to the facility at 6:10 pm from the hospital). 9/29/2024 at 6:10 pm to 7 pm -Registered Nurse (RN) VVV 9/29/2024 at 7 pm to 7 am LPN CC 9/30/2024 at 9:30 am to 6:11 pm by Resident Care Coordinator/LPN HH & DON, 9/30/2024 at 6:11 pm to 7:00 pm, DON 9/30/2024 at 7pm to 7am, LPN CC & LPN DDDD 10/1/2024 at 8:40 am to 4:10 pm, Resident Care Coordinator/LPN HH, Interview with Resident Care Coordinator/LPN HH on 4/3/2024 at 2:08 pm verified that she did not clock out to 6:11 pm on 9/30/2025 and provided observations until 6:11 pm. She stated that Activities/SSD (Social Services Director) was in the room to continue monitoring of R48. She was not sure who provided the observation after she left. Interview with the DON on 4/3/2024 at 2:00 pm, the DON confirmed making observations to monitor resident for safety and welfare checks. Verified by: Record review of {Named} Behavioral Health note dated 10/1/2024 verified resident was seen by {Named} Nurse Practitioner (NP). Record review of email from {Named} Behavioral Health NP to Director of Nursing (DON). {Named} Behavioral Health NP stated in her email that R48 refused a follow up visit with her. Verified by: Record review of hospice agency documents documented behavior visits by the Chaplain Interview 4/2/2025 with Hospice Administrator [NAME] verified that R48 was seen by the Chaplain 10/2/2024, 11/20/2024, 12/05/2024, 1/15/2024, 2/20/2024, 3/17/2024. 2. Verified by: Record review of LPN CC written statement verified R121 was removed from the room. Record review of the written statement by Certified Nurse Assistant (CNA) EEEE documented that she provided observations on 9/28/2024. Record review of Police Report dated 9/20/2024. 3. Verified by: Record review of bath sheets and skin assessment forms dated 9/30/2024 documented R48 's skin assessments/bath sheet including the other facility residents based on the facility census. R48's bath sheet and skin assessment noted a bruise to resident 's thigh. 4. Record review of facility form titled Quality Improvement Data Collection GRID excel sheet documented the following question asked to the resident Have you had any encounter with any other resident that made you uncomfortable? A total of 40 residents were interviewed including resident R48. A list of 26 residents which included the same residents were also questioned by the Resident Care Coordinator LPN HH. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. Verified by: Record review of facility education form titled What is abuse dated 9/29/2024.The content of the training included a PowerPoint handout titled Preventing and Responding to Resident to Resident Mistreatment. 85% of the facility staff were interviewed during the abatement process. The staff was knowledgeable about abuse process and how to work with difficult residents. Also verified the above education by the following staff interview on 4/2/2025 at with Certified Nursing Assistant (CNA) II, Dietary JJ, Dietary KK, Dietary LL, Dietary MM, Dietary Manager, EVS PP, EVS QQ, EVS RR, Assistant Activity Director, Dietary [NAME] SS, Laundry TT, Floor Tech/EVS UU, Environmental Services (EVS) Supervisor, Health Care Navigator, CNA XX, CMA/CNA ZZ, Resident Care Coordinator WW, Unit Manager GG, LPN DDD, CNA BB, LPN Wound care nurse, RN charge nurse EEE, LPN charge nurse EE, LPN HHH, CNA FFF, CNA GGG, CNA III, 4/3/2025 at 8:15 pm LPN QQQ, LPN CC, CNA UUU, CMA/CNA LLL, RN/Charge nurse RRR, CMA/CNA NNN, CNA MMM, EVS TTT, EVS SSS, CNA OOO, RN KKK, CNA PPP, RN/Charge Nurse VVV, RN WWW, RN/Weekend Supervisor XXX, CNA YYY, CNA ZZZ, RN/Weekend Supervisor AAAA, RN/Charge Nurse BBBB, RN CCCC. 6. Record review of Resident Council Minutes dated 10/29/2024, documented questions were added and addressed to the residents Do you feel safe?. Do you know who to tell if you do not feel safe?, Do you know about physical, mental, and sexual abuse. The questions were reviewed with the residents in attendance. 7. 28 of 28 residents were interviewed by the above-mentioned staff. The form listed y (yes) or n (no). 8. Record review of handwritten document by Administrator documented a conversation conducted with R48 by the Administrator for 3/27/2025.The written statement documented Visited with R48 this morning. She told me about the incident and what the man did, and that she went to the hospital and he went to jail. She verbalized being safe here at the facility. She was eating her breakfast and had almost cleaned her plate, and drank her juice and other beverages. She seemed happy and was planning on attending activities. 9. The form list the 5 WHY's (1. Why -The center failed to implement nonpharmacological interventions that were recommended by the behavior health provider after behavior health visits. 2. Why. There was lack of communication with the behavioral health provider to identify the findings and recommendation of the visit to include any pharmacological and/or non-pharmacological interventions for behavioral management. This includes the recommendation for Gradual Dose Reduction (GDR)s for the patients that were approved by the provider. 3. The center changed behavioral health providers, and the process and expectation was not re-established for communication of visits. Root cause: 1. lack of process, 2. change in behavior health support (based on a new behavior provider that was onboard, there were a gap, familiar with the building systems, billing systems, and familiar with resident and their diagnoses/behaviors. 3. Recommendation for the GDRs for the population of the center (Ensure that GDR was effective in coordinating with the resident care/disease process, stabilizations). 10. Verified by: The list of residents revealed that training was provided to 28 residents. Residents' names and signatures are noted on the form. The content included was Elder Abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11. Verified by: Record review of the facility education form titled Abuse Prohibition/Abuse Investigation dated 3/28/2025. Also verified the above education by the following staff interview on 4/2/2025 with the DON, Administrator, ICP, Health Information Management (HIM), Director of Rehabilitation, Social Worker, Human Resources. 12. Verified by: 3/29/2025 for staff education and to include abuse prohibition, abuse reporting to include physical and sexual aggression, burnout, and de-escalation for all staff of the facility. Also verified the above education by the following staff interview on 4/2/2025 at with Certified Nursing Assistant (CNA) II, Dietary JJ, Dietary KK, Dietary LL, Dietary MM, Dietary Manager, EVS PP, EVS QQ, EVS RR, Assistant Activity Director, Dietary [NAME] SS, Laundry TT, Floor Tech/EVS UU, Environmental Services (EVS) Supervisor, Health Care Navigator, CNA XX, CMA/CNA ZZ, Resident Care Coordinator WW, Unit Manager GG, LPN DDD, CNA BB, LPN Wound care nurse, RN charge nurse EEE, LPN charge nurse EE, LPN HHH, CNA FFF, CNA GGG, CNA III, 4/3/2025 at 8:15 pm LPN QQQ, LPN CC, CNA UUU, CMA/CNA LLL, RN/Charge nurse RRR, CMA/CNA NNN, CNA MMM, EVS TTT, EVS SSS, CNA OOO, RN KKK, CNA PPP, RN/Charge Nurse VVV, RN WWW, RN/Weekend Supervisor XXX, CNA YYY, CNA ZZZ, RN/Weekend Supervisor AAAA, RN/Charge Nurse BBBB, RN CCCC. 13. Verified by: Audit contents 1. Abuse Types, Reporting, Audits dates 4/2/2025, 4/3/2025, 4/4/2025. 14. Verified by: Included a letter provided to residents defining abuse and how to report listing information, Administrator contact number, State and Local Agencies, and Confidential Reporting Channels. 15. Verified: Review of a form titled, QAPI Committee Attendance dated 3/31/2025 at 2:30 pm with signatures documented all staff in attendance for the QAPI meeting. The list included 17 facility staff and three corporate staff including the Senior Director of Clinical Standards, Divisional [NAME] President, and the Director of Quality & Regulatory Services. The signature page documented that the Medical Director attended via phone. Review of the signature page revealed there was no signature to indicate that the Activities Director or the Assistant Activity Director were in attendance. Review of a Resident List revealed 22 residents identified with sexually inappropriate behaviors were discussed, and documented two referrals were made for {Named} Behavioral Health services on 3/31/2025 and seen on 4/1/2025. confirmed attendance of the QAPI meeting held on Monday, 3/31/2025; LPN GG, LPN HH, Senior Director of Clinical Standards, Assistant Activities Director. All corrective actions were completed on 3/31/2025. The facility alleges IJ removal 4/1/2025.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Health and Rehabilitation	1321 Pulaski School Road Pulaski, GA 30451

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39786 Based on resident and staff interviews, record review, and review of the facility's policies titled, Behavior Health, and Abuse Prohibition, the facility failed to ensure one of eight residents (R) (R121) received behavioral health services that promoted psychosocial well-being, met the resident's needs, and included individualized approaches related to nonpharmacological interventions to address worsening sexual behaviors and sexual aggression. The deficit practice provided the opportunity for R121 to sexually and physically abuse R48. On 3/31/2025, a determination was made that the facility's noncompliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Senior Director of Clinical Standards, Director of Quality and Regulatory Services, Director of Nursing (DON), and Assistant Administrator were informed of the Immediate Jeopardy (IJ) on 3/31/2025 at 10:45 am. The noncompliance related to the IJ was identified to have existed on 9/28/2024 when R121 sexually abused R48 inside her room. An acceptable Removal Plan was received on 4/1/2025. Based on the validation of the Removal Plan, the State Survey Agency determined that the corrective plans and the immediacy of the deficient practice was removed on 4/1/2025. The facility remained out of compliance while the facility continued management level staff oversight as well as developed and implemented a Plan of Correction (POC). This oversight process included the analysis of facility staff's conformance with the facility's policies and procedures. In-service materials and records were reviewed. Interviews were conducted with staff to ensure they demonstrated knowledge of facility Policies and Procedures related to Abuse, Neglect, and Exploitation, and the behavioral health needs of residents. Findings included: Review of the facility's policy titled, Behavior Health, review date 12/27/2024 revealed, Intent: It is the intent of this center for each patient to receive the necessary behavioral health care and services to attain or maintain their highest practical physical, mental, and psychosocial well-being based on the comprehensive assessment and plan of care. Guidelines: The center will provide behavioral healthcare and services to include Pharmacological interventions are only used when non-pharmacological interventions are ineffective or when clinically indicated. Training to include .Implementing person-centered care approaches designed to meet the needs of the individual patient .Mental health and social service needs . Patients who display or who are diagnosed with a mental disorder, psychological adjustment difficulty . receive appropriate treatment and services to address the problem .concerns identified will be assessed and care planned; changes should be documented, including frequency of occurrence and potential triggers; concerns, follow-up assessment and potential modifications are discussed with the interdisciplinary team. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Abuse Prohibition, review date 12/27/2024 revealed, Intent: It is the intent of this center to actively preserve each patient's right to be from mistreatment, neglect, abuse . The purpose of these identified procedures is to assure that we are doing all that is within our control to create a standard of intolerance and to prevent any occurrences of any form of mistreatment, neglect, abuse . Guideline: Definitions: For the purposes of this policy, the following definitions apply . Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault. Identification of possible abuse, neglect or exploitation: Identification of injuries or events that are suspicious and may constitute abuse. In attempting to identify any type of abuse or neglect the following signs and symptoms of abuse will be examined as to whether it is suspicious and may constitute abuse . Sexual abuse: An at-risk adult's report . It will be the responsibility of any associate receiving the complaint of alleged abuse .to inform the administrator or designee immediately. The [NAME] will identify, correct and intervene in situations in which abuse, neglect . is more likely to occur. This will include an analysis of: The assessment, care planning, and monitoring of patients with specialty needs and behaviors which might lead to conflict or neglect, such as patients with a history of aggressive behaviors, patients who have behaviors . Review of the medical record revealed that R121 was admitted on [DATE] with diagnoses (Dx) of but not limited to catatonic schizophrenia and anxiety disorder. The primary psychiatric diagnosis was adjustment disorder with mixed disturbance of emotions and conduct. A new diagnosis of hypersexuality was identified on 10/23/2023 by the Nurse Practitioner (NP). There were no physician orders or interventions to monitor for sexual behaviors or sexual aggressiveness. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], Section C assessed R121 with a Brief Interview for Mental Status (BIMS) score of 03, indicating severe cognitive impairment. Section D-Mood was coded as little interest or pleasure in doing things, feeling down, depressed or hopeless, feeling tired or having little energy, and trouble concentrating on things. Section E-No behaviors exhibited Section I-Diagnoses included anxiety disorder, schizophrenia, and other included other sexual dysfunction. Review of the care plan revealed there was no problem/care area or interventions specific for sexual abuse, sexual aggression, or sexual behaviors. Inappropriate sexual behavior was only documented under the category for behaviors and under evidenced by. There were no interventions specific to sexual behaviors or sexual aggressiveness. There was no revision to the care plan after documentation of sexually aggressive behaviors identified. Review of the care plan, updated 8/23/2024, revealed R121 had a care area/problem for Behaviors related to catatonic schizophrenia, anxiety, and mild intellectual disability-onset 2/6/2024. The Behaviors care plan was updated 8/20/2024 related to psychosocial, activity and environmental factors. The Behaviors care plan evidenced by included but not limited to, inappropriate sexual behaviors, inappropriate vocalizations, impulsiveness, anxiety, and verbal behavioral symptoms directed toward others-onset 10/23/2023; Rejects care, treatments, and medication(s)-onset 10/28/2023; Level 2 PASRR-onset 12/18/2023; restlessness-onset 1/25/2024; agitation-onset 6/24/2024; pharmacological-onset 8/20/2024. Interventions for behaviors included: Provide activities of choice, redirect patient as needed, conduct behavior assessment as needed onset 10/23/2023, reviewed 6/5/2024. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide privacy for resident appropriate to maintain self-esteem-onset 10/25/2023, reviewed 6/5/2024. Analyze key times, places, circumstances, triggers, and what deescalates behavior-onset 1/18/2024, reviewed 6/5/2024. Administer medications for a clearly defined goal aimed at specific target behavior for which the drug is effective, assess patterns of behavior with behavior monitoring tool, be an active listener and allow for expression of feelings without censure, involve the person in the activities based on their preferences and cognitive functioning, maintain a tolerant, calm manner, remove patient from stressful situations-8/20/2024. Every 15-minute observation x 3 days-8/21/2024. Labs-onset 8/23/2024. Review of facility documentation, a written statement by LPN (Licensed Practical Nurse) QQQ, R121's nurse the night of the incident of alleged sexual abuse of R48 revealed, 9/28/2024 8:40-Event the nurse documented that she was summoned to [R48's] room and upon arrival noted R121 on top for a female resident (R48) fully clothed. Female resident (R48) yelling out help Instructed by LPN CC to get off that woman. Writer assisted R121 up and to his room and asked him why he was on that woman and in her room, [R121] stated I didn't know. At 8:50 pm [Named] (R121) was noted attempting to return to R48's room. A 1:1 monitoring CNA (Certified Nursing Assistant) posted outside R121's door for observation. The DON was notified and arrived at the facility. Local police were notified, and a deputy arrived at the facility. R121 was taken into custody and transported to jail. A review of documentation by the [Named] behavioral health services NP and visits confirmed by the DON revealed that R121 was seen on 12/8/2023, 3/5/2024, 6/4/2024, and 8/21/2024. The behavioral health visit note dated 8/21/2024 under the history of present illness and assessment, included R121's primary psychiatric diagnosis was adjustment disorder with mixed disturbance of emotions and conduct, and was documented as worsening. R121 was talking inappropriately in a sexual manner with staff, wanting sex, trying to kiss a staff member, and stated that he was going to rape her. Staff reports he hit a nurse in the head and was kicking, and he paces all the time. Past medical history included hypersexuality. Impulse control and insight/judgement were both poor. BIMS score was seven, and the psychotic symptoms were delusions. Under recommendations, it was documented that R121's parole officer had visited recently, and staff felt he may be a trigger because R121 had some behavioral issues after the last time his parole officer visited him. Recommendations included for staff to speak with the parole officer and ask if he could speak with the nurse instead of coming to the facility, since R121 is not appropriately able to answer questions. R121 was placed on q15 (every 15) minute checks. Also, an order was given to start Haloperidol 5 mg (milligram) po (by mouth/orally) q6hrs (every 6 hours) prn (as needed for) agitation x (for) 14 days. If he is displaying inappropriate behaviors, staff to try to redirect or distract him with an activity, staff to encourage communication with family unless this is distressing to him, staff to offer support and reassurance as needed. Staff to promote good sleep hygiene by dimming the lights, and reducing noise levels as able during bedtime hours, and discouraging daytime naps. If he becomes a danger to himself or others, send him to the Emergency Department (ER) for psychiatric evaluation. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of documentation revealed no evidence that nonpharmacological interventions for sexual behaviors were implemented or documented based on behavioral health services recommendations on 8/21/2024. Review of facility documentation of the Offence/Incident Report dated 9/28/2024 from 9:00 pm to 9:20 pm by the local county Sheriff's Office revealed a report of Aggravated Sexual Battery of a named victim [R48] by R121. Additional information included the complainant's name, subjects who were interviewed, and evidence. Further review revealed it was reported to the officers by the DON that R121 had been threatening to rape them over the past couple of weeks. An interview with LPN CC revealed that she responded after hearing a commotion and that she witnessed R121 on top of R48 with his hand in the area of her vagina. She explained that she then pulled R121 off R48. Interview with various licensed staff on 3/28/2025 from 11:30 am to 12:30 pm revealed examples of nonpharmacological interventions for sexual behaviors or sexual aggressiveness that staff gave included, try to redirect, watch them, increased monitoring, depends on the situation but keep an eye on the aggressor, remove the resident from the hall, involve in activities, try to calm them down, talk with them, notify family if available, maybe family could come visit and try to reach the resident, interventions are in the book, they ask residents their preference and don't force them or make them do something if they don't want to, separate residents, keep residents safe, notify the doctor, move to another unit/hall to get away from other residents to keep them safe and make sure the perpetrator did not have access to the victim, one-on-one monitoring/ supervision, and if not improving in 24 to 48 hours notify the physician, report to the nurse supervisor, social worker, Administrator, and/or DON. Care plans are not on the POC system. Therefore, CNAs don't have access to interventions, so the nurse lets the CNA know what the interventions are, what the resident needs to be monitored for, or if any revised or new interventions are added. The staff acknowledges what nonpharmacological interventions are for residents. However, these interventions were not implemented for R121. Interview on 3/27/2025 at 5:36 pm with the Medical Director revealed he recalled an event between R121 and R48, the male on top of the female, an actual assault or attempted rape by the male (R121). The interview revealed R121 was evaluated to determine why it happened, what was going on with him, must figure out the proper dosage of medication to be therapeutic at the same time have the resident function and be themselves, and try to figure out triggers before adding more medication (meds). The interview confirmed that he and the nurse practitioner reviewed behavioral health notes, the psychiatric team is responsible for dose-reducing meds, and they are discussed with facility staff. When asked if R121's meds were appropriate, and if olanzapine (Zyprexa) would increase R121's sexual drive. The interview revealed that the use of Zyprexa for R121 was for his schizophrenia, was not used for sexual aggression, and R121 was being monitored for hormone treatment because the doctor wanted to make sure it was appropriate before starting R121 on Progesterone. He confirmed the olanzapine (Zyprexa) was prescribed for the schizophrenia and not anything sexual. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 4/2/2025 at 11:42 am with the [Named] behavioral health NP confirmed R121 did have sexual behaviors, was sexually inappropriate and aggressive with a staff member, had made sexual comments to a nurse, attempted to kiss a nurse, and the sexual assault incident with R48. I'm very conservative with meds, we try nonpharmacological interventions first. I always try to start with nonpharmacological interventions first, and if they don't work, I start with the lowest dosage of medication. Recommended interventions include redirecting, discouraging the behavior, encouraging the resident to get involved in activities, trying to redirect with an activity, encouraging communication with family unless they are not involved or it is distressing to the residents, and offering support as needed. If they become verbally or physically aggressive, observe the source of the conduct. Encourage good hygiene, observe for hallucinations and delusions, allow safe space to pace, observe for pacing, manic, depression, and sexual aggression. Interview on 4/1/2025 at 9:58 pm, the DON confirmed behavioral health notes, confirmed that R121 was seen by the behavioral consultant on several scheduled visits to the facility, and non-pharmacological interventions were in place on the care plan. The facility implemented the following actions to remove the IJ: 1. R121 was discharged from the facility on 9/28/2024 and was arrested at 9:30 pm and did not return to the facility. 2. The Assistant Administrator, DON, Division [NAME] President, and the medical director reviewed the facility's policy titled Behavioral Health on 3/31/2025. No revisions were indicated through review. 3. On 3/31/2025 an audit was completed by DN (Divisional Nurse) for residents with sexual inappropriate behaviors complete of all patients. A review of the plan of care was completed to ensure that nonpharmacological interventions were captured for two of 21 residents that exhibited behaviors in past 30 days. A referral was initiated as appropriate by the DON. 4. In-service education was initiated on 3/31/2025 for RNs (Registered Nurse(s) and LPN(s) and was completed on 3/31/2025 and included identifying behavioral health needs, updating the plan of care and implementing interventions in the plan of care as outline in the facility's Behavioral Health Policy to include nonpharmacological interventions. CNAs provided education on abuse reporting to include sexual inappropriate behaviors on 3/31/2025. Education was provided by the DON, Assistant Director of Nursing (ADON), Nurse Manager, or Social Services Director. 11 of 11 RNs, nine of nine LPNs, 23 of 23 CNAs, and four of four CMAs (Certified Medication Tech) have been in serviced which totals 100%. No staff shall work until they have completed in-service education. No new hires as of 3/31/2025. 5. An audit tool was developed by DON on 3/31/2025 to review patients with inappropriate behaviors to ensure they have a non-pharmacological intervention noted on care plan. Any noncompliance noted will be addressed through written education by assistant administrator and/or DON. The State Survey Agency (SSA) validated the facility's written IJ Removal Plan as follows: (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Verified by review of the electric health record (EHR) showed R121's status was discharge. Review of the MDS schedule reported a Discharge return not anticipated assessment dated [DATE]. Interview with staff, the DON, and review of documentation confirmed R121 was removed from the facility in handcuffs by the Sheriff's deputy on 9/28/2025. Observations during the survey period confirmed R121 was not in the facility. An interview on 3/27/2025 at 2:00 pm with the Administrator revealed the Parole Officer confirmed R121 was back in prison because of probation violation. 2. Verified by review of documentation revealed a QAPI (Quality Assurance Performance Improvement) meeting was held on 3/31/2025, and the sign-in sheet had signatures of the Assistant Administrator, DON, Division [NAME] President indicating they were in attendance. Interview on 4/3/2025 at 1:55 pm with the Senior Director of Clinical Standards confirmed the DN attended; and the Medical Director attended via phone. The Behavior Health policy was reviewed, and no revisions were made to the policy. Interview with the DON on 4/3/2025 at 4:20 pm confirmed attendance of Assistant Administrator, DON, Division [NAME] President, and the Medical Director via phone and the policy was reviewed with no revisions. 3. Verified by review of a list of residents revealed 12 residents on a list receiving [Named] Behavioral Health Services. Ten residents were seen for routine visits, and two residents had acute episodes with referrals made on 3/31/2025 for [named] behavioral health. Interview on 4/3/2025 at 4:20 pm with the DON confirmed all care plans of residents identified with sexual behaviors were checked for non-pharmacological interventions. She had made referrals for [named] behavioral health services on 3/31/2025 for two residents with acute episodes in the past 30 days, and they were seen by the [named] behavioral health NP on Tuesday 4/1/2025. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Review of documentation revealed a list of 20 nursing staff with their title and confirmed inservice education with licensed nurse staff, RN's and LPN's on 3/31/2025 and included review of the Behavior Health guidelines, and identifying behaviors for patients, updating the care plan, implementing interventions, and non-pharmacological interventions. A list of nursing staff with their title was included and verified 20 licensed practical or Registered nurses. Review of documentation confirmed CNA inservice education completed on 3/31/2025 and included review of the behavior health guidelines, and identifying behaviors for patients, updating the care plan, implementing interventions, and non-pharmacological interventions. A list of nursing staff with their title was included. Verified: Review of documentation revealed a list of 20 nursing staff with their title and confirmed licensed nurse staff received inservice education on 3/31/2025 and included review of the behavior health guidelines, and identifying behaviors for patients, updating the care plan, implementing interventions, and non-pharmacological interventions. Interview on 4/3/2025 at 1:55 pm with the Senior Director of Clinical Standards confirmed the education was completed, audits were completed, and she had reviewed them. Interview with the DON on 4/3/2025 at 4:20 pm confirmed education had been completed with all staff, no staff will be able to work until they complete inservice education on abuse, confirmed abuse was already included in orientation, and on Work-Day training on Relias, and confirmed there was no new hires staff. Also verified the above education by the following staff interview on 4/2/2025 at with Certified Nursing Assistant (CNA) II, Dietary JJ, Dietary KK, Dietary LL, Dietary MM, Dietary Manager, EVS PP, EVS QQ, EVS RR, Assistant Activity Director, Dietary [NAME] SS, Laundry TT, Floor Tech/EVS UU, Environmental Services (EVS) Supervisor, Health Care Navigator, CNA XX, CMA/CNA ZZ, Resident Care Coordinator WW, Unit Manager GG, LPN DDD, CNA BB, LPN Wound care nurse, RN charge nurse EEE, LPN charge nurse EE, LPN HHH, CNA FFF, CNA GGG, CNA III, 4/3/2025 at 8:15 pm LPN QQQ, LPN CC, CNA UUU, CMA/CNA LLL, RN/Charge nurse RRR, CMA/CNA NNN, CNA MMM, EVS TTT, EVS SSS, CNA OOO, RN KKK, CNA PPP, RN/Charge Nurse VVV, RN WWW, RN/Weekend Supervisor XXX, CNA YYY, CNA ZZZ, RN/Weekend Supervisor AAAA, RN/Charge Nurse BBBB, RN CCCC. 5. Verified by review of an audit tool titled, Quality Improvement Date Collection Grid assessed/monitored four areas: 1. Any noted sexual inappropriate behavior. 2. If so, were non-pharmacological interventions implemented. 3. Care plan updated. 4. Was change in condition completed? Review of completed audit tools titled, Quality Improvement Date Collection Grid confirmed audits were completed on 4/1/2025, 4/2/2025, 4/3/2025. Four areas were assessed with no non-compliance identified. Review of a list of residents revealed 12 residents on a list receiving {Named} Behavioral Health Services. Ten residents were for routine visits, and two residents had acute episodes, referrals were made on 3/31/2025 and seen by CHE on Tuesday 4/1/2025. (A previous interview with NP (Nurse Practitioner) FFFF revealed she made visits every Tuesday). Interview with the DON on 4/3/2025 at 4:20 pm confirmed audits were initiated and ongoing. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. Verified by review of a form titled, QAPI Committee Attendance dated 3/31/2025 at 2:30 pm with signatures documented all staff in attendance for the QAPI meeting. The list included 17 facility staff and three corporate staff including the Senior Director of Clinical Standards, the Divisional [NAME] President, and the Director of Quality & Regulatory Services. The signature page documented that the Medical Director attended via phone. Review of the signature page revealed there was no signature to indicate that the Activities Director (AD) or the Assistant Activity Director were in attendance. Review of a Resident List revealed 22 residents identified with sexually inappropriate behaviors were discussed, and documented two referrals were made for [named] behavioral health services on 3/31/2025 and seen on 4/1/2025. Interview on 4/3/2025 at 1:30 pm with the Assistant Activities Director revealed the AD was out on Monday, March 31, 2025, the day the QAPI meeting was held, and confirmed she attended the QAPI meeting in the AD's place. She revealed they discussed residents with sexual behaviors, reviewed a list of residents, and discussed their behaviors and the policy for Behavioral Health. Interview on 4/3/2025 at 1:55 pm with the Senior Director of Clinical Standards confirmed they reviewed the Behavioral Health policy and revealed they did not make any changes to the policy. Further interview confirmed all steps in the plan of correction had been initiated and further audits were scheduled as indicated. Interview on 4/3/2025 at 2:06 pm with LPN HH confirmed attendance of the QAPI meeting held on Monday, 3/31/2025, and verified attendance and her name on the sign-in page. Further interview confirmed they discussed the Behavioral Health policy and confirmed the list of residents on the form titled Resident List was reviewed related to sexual behaviors. She revealed how they came up with the names on the list. They were not all current or new residents, but also included residents who had sexual behaviors in the past. She confirmed all the residents (22) on the list were reviewed/discussed for sexually inappropriate behaviors, documented if they had behavior monitoring in place or not, two new referrals were made on 3/31/2025, and revealed both were seen by the [named] behavioral health NP on Tuesday, 4/1/2025. Interview on 4/3/2025 at 2:10 pm with LPN GG confirmed attendance of the QAPI meeting held on Monday 3/31/2025 and verified attendance and her name on the sign-in page. She also confirmed they reviewed the Behavioral Health policy, discussed all the residents on the list, and two new referrals were made 3/31/2025. Both residents were seen 4/1/2025 by [named] behavioral health service NP. All corrective actions will be completed on 3/31/2025. The immediate jeopardy will be removed on 4/1/2025. Cross-reference F600

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Health and Rehabilitation	1321 Pulaski School Road Pulaski, GA 30451

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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	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 50941 Based on record review, staff interviews, review of the Administrator and Director of Nursing job descriptions, and review of the policy titled Abuse Policy, the facility Administration failed to provide protective oversight to attain the highest practicable physical and psychosocial well-being of the residents. Specifically, the Administration failed to take appropriate action on allegations of resident-to-resident physical and sexual abuse for resident (R) R48 by resident (R) R121; and failed to establish and implement written policies and procedures for feedback, data collection, and monitoring, including adverse event monitoring for Quality Assurance Performance Improvement (QAPI). The failures of the Administration to take appropriate action are likely to lead to future allegations of abuse not being identified. The facility census was 161. On 3/31/2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The Senior Director of Clinical Standards, Director of Quality and Regulatory Services, Director of Nursing (DON), and Assistant Administrator were informed of the Immediate Jeopardy (IJ) on 3/31/2025 at 10:45 am. The noncompliance related to the IJ was identified to have existed on 9/28/2024 when R121 sexually and physically abused R48 inside her room. A Credible Allegation of Compliance was received on 4/1/2025. Based on observations, record review, resident and staff interviews, and review of facility policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice were removed as of 4/1/2025. The facility remains out of compliance while the facility continues management level oversight as well as continuing to develop and implement a Plan of Correction. (POC). This oversight process included the analysis of facility staff's conformance with the facility's policies and procedures. In-service materials and records were reviewed. Interviews were conducted with staff to ensure they demonstrated knowledge of facility Policies and Procedures related to Abuse, Neglect, and Exploitation, and the behavioral health needs of residents. Findings include: Review of job summary for the Administrator revealed, responsible for day-to-day functions of the Nursing Center in accordance with current federal, state, and local regulations that govern long-term care centers, and as may be directed by the Regional [NAME] President, to provide appropriate care for our patients. Operates the Nursing Center in accordance with the established guidelines of the organization and in compliance with federal, state, and local regulations. Enforces the Nursing Center guidelines. Maintains a working knowledge of current licensure standards and the survey process. Acts as a liaison between the Nursing Center and regulatory agencies, patient advocacy groups, and fiscal intermediaries. Assumes responsibility for procedural guidelines relative to the prevention and reporting of patient abuse. Reviews, investigates, and arbitrates patient complaints and grievances, and makes available to the supervisor written reports of action taken. Contributes to the work of committees, workgroups, project management, and other collaborative efforts of the System. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of job summary for DON revealed responsible for planning, organizing, developing and directing the overall operation of our Nursing Services Department in accordance with current federal, state, and local regulations governing our nursing center, and as may be directed by the Administrator and/or the Medical Director, to provide appropriate care. Directs, evaluates, and supervises patient care and initiates corrective action as necessary. Evaluates patient care as related to individualized patient needs, family involvement, and the physician's plan of care for the patient. Maintains a working knowledge of current licensure standards and the survey process. Reports problems to the Administrator, conducts daily patient rounds, and initiates corrective action as necessary. Directs and provides implementation of educational programs, quality assurance program, and infection control program Operates the nursing department in accordance with the organization established guidelines, and in compliance with federal, state, and local regulations, demonstrates appropriate/effective supervisory skills that include fair and uniformly applied corrective actions administered without regard to race, color, creed, national origin, age, sex, religion, handicap or marital status. 1. Administration failed to protect resident (R) 48's right to be free from sexual assault by not monitoring, supervising, and effectively addressing the sexually aggressive behavior of R121, a resident who had been displaying sexually aggressive behaviors. This deficient practice resulted in R48 being sexually and physically assaulted. Cross-reference: F600 2. Administration failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for one of seven residents (R) (R121) reviewed for behavioral care services. Specifically, the facility did not complete a thorough investigation (monitoring) of residents with inappropriate behaviors to ensure they have a non-pharmacological intervention implemented. Cross-reference: F740 3. Administration failed to ensure concerns were identified and QAPI plans implemented related to the abuse prevention system, including resident-to-resident physical and sexual abuse, and implementing all components of the abuse policies. Cross-reference: F867 (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 local police Incident Report dated 9/28/2024 revealed that an officer responded to the facility at approximately 9:30 pm in reference to an aggravated sexual battery. R48's roommate explained that R121 came into their room, grabbed R48, and pushed her down. R48 stated, he stuck his finger up my vagina, and R121 was holding his hand over her mouth. The roommate explained that staff removed R121, but he returned to get his shoe, and staff removed him from the room again before retrieving his shoe. The officer documented the shoe beside the roommate's bed. LPN CC stated to the officer that she witnessed R121 on top of R48 with his hand in the area of her vagina and explained that she then pulled R121 off her. The officer asked R121 several basic questions to assess his mental capabilities, and R121 replied several more times with I don't know. The nursing staff at the facility indicated that they believed R121 was pretending to be mentally incompetent. The Director of Nursing (DON) informed the officer that R121 was on probation. However, the officer later discovered that R121 was on parole. The DON additionally explained that she had been getting reports from staff that R121 had been threatening to rape them over the past couple of weeks. R121 was arrested on 9/28/2024. The officer did respond to the hospital, where he met the SANE nurse, and she explained she had performed a sexual assault exam. At that time, the SANE nurse turned over the sexual assault exam evidence to the officer. Interview on 3/25/2025 at 12:27 pm with R48 reported that man came into her room and threw her down on the floor and stuck his hand into her diaper and her vaginal area. She stated that the police were called. The man is no longer here, and she couldn't remember his name. R48 stated the man was a resident at the facility. Interview on 3/26/2025 at 2:10 pm with the Administrator reported that she cannot recall the incident with R121 and R48 in detail. She remembers reporting the incident to the State based on what the nurse told her. The nurse reported that the resident, R48 stated that R121 had his hand in her vagina. The Administrator further revealed that she thinks what their investigation revealed was not actually the truth. She wrote exactly what R48 said in the Facility Reportable and the 5-Day Report. Further interview with the Administrator on 3/28/2025 at 1:44 pm revealed that the QAPI team did not change any procedures after months of abuse allegations, but did tell nursing staff to report immediately to the Director of Nursing (DON) and Administrator. The Administrator stated that her phone number is posted on the nursing station wall if she is not at the facility for the night shift. The Administrator revealed there are several sexual abuse allegations, resident-to-resident and staff-to-resident, but at this time, no other processes or procedures were changed after resident R121 sexually abused resident R48. Interview on 4/1/2025 at 9:58 pm, the DON confirmed behavioral health notes, confirmed that R121 was seen by the behavioral consultant on several scheduled visits to the facility, and non-pharmacological interventions were in place. However, there was no evidence that nonpharmacological interventions for sexual behaviors were implemented or documented. The facility implemented the following actions to remove the IJ: 1. Police was notified by DON regarding the incident for R121 and an arrest was made on 9/28/2024 at 9:30 pm. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. On 03/31/2025- Ad hoc QAPI and performance improvement plan (PIP) was developed and initiated by the Director of Quality and Regulatory Services (DOQRS). The meeting discussion included plan development and citations issued for F-835, F-867, F-600, and F-740. In attendance to the meeting were: Division vice president, Administrator, Division nurse, Director of nursing, licensed nurse, Medical director, Social Service, Financial controller, Maintenance Director, Resident assessment instrument nurses, Wound care nurse, Environmental services director, Activity director, health information manager Environmental/ laundry supervisor, Admission nurse, HR Partner service, scheduler, for the accident. The Medical Director was made aware on 3/31/2025 by the Director of Nursing. The existing Abuse policies were reviewed and concluded no revisions were needed. 3. On March 28, 2025, the 2025 Division [NAME] President provided education to the Administrator on job description to include roles, responsibilities, and duties to ensure the safety of all residents. Education provided on the abuse prohibition policy to include reviewing adverse events during QAPI, recognizing trends to create proactive measures to reduce further reduce reoccurrences to ensure the safety of all residents. Administrator 1 of 1. 4. Corrective action for other residents having the potential to be affected by the same deficient practice. 5. All residents who reside in the center have the potential to be impacted by the deficient practice. 6. Systemic changes were made to ensure that the deficient practice would not recur. 7. Starting on March 25, 2025, oversight was provided by the Divisional Nurses {DN), Program Director of SSD, and Divisional [NAME] President (DVP) to ensure the Administrator and the DON were informed about and adhered to the Abuse policy in their day-to-day operations. On 3/28/2025, the administrator was placed on administrative leave pending investigation, and oversight was provided by the Senior Director of Clinical Services (SRDCS). On March 31, 2025, oversight was provided by the Senior Director of Clinical Services (SRDCS), Program Director of SSD, and Director of Quality and Regulatory Services (DQRS). Education was provided to Administrator Assistant on 3/31/2025 by DVP to ensure the day to day operations were being followed to include adhering to the Abuse policy, QAPI education was also provided to the leadership team to include monitoring and follow-up for adverse events and being proactive by tracking and trending to identified what resources are needed to be proactive when inappropriate behavior is noted by Director of Quality and Regulatory Services and Sr Director of Clinical Standards. DVP, Sr. DCS, and DORQ confirmed that education had been completed with staff on abuse, including intervening to protect a patient from further abuse. On March 31, 2025, DVP and/or DN completed a review to ensure that audits were completed for F600, F867, and F740, ensuring that patients were safe, and that staff understood the education on non-pharmacological interventions for inappropriate sexual behavior, and QAPI review completed as indicate on reportable for trends. Audits will continue until the removal of IJ. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8.Quality Assurance Plans were implemented on 3/31/2025 to monitor facility performance, ensuring that corrections are implemented and remain permanent. An audit tool was developed and initiated by the Assistant Administrator and is being used daily to monitor the implementation of the Plan of Correction. The Assistant Administrator, Director of Nursing, or Assistant Director of Nursing will be responsible for ensuring the completion of this tool. The audits will be validated by the Governing body to include DVP, SrDCS, DOQR, and/or DN. The results of the monitoring completed under this plan of correction will be submitted monthly to the QAPI committee for review and further follow-up. The Audit tool will continue until the QAPI committee deems it is no longer necessary. Any noncompliance noted will be addressed through written education by the Divisional [NAME] President. The State Survey Agency (SSA) validated the facility's written IJ Removal Plan as follows: 1.Verified by Record Review on 4/3/2025 at 12:47 pm. Offense/Incident Report revealed that the DON called the local county sheriff's office regarding the incident. It stated that the local sheriff reported to the facility and that R121 was arrested for aggravated sexual battery on 9/28/2024 at 9:30 pm. There were no concerns identified. 2.Verified by interview and record review. On 4/3/2025 at 1:10 pm the record review revealed that a Quality Assurance/Performance Improvement (QAPI) meeting was held on 3/31/2025 at 2:30 pm and the Skilled Nursing Services: Abuse Prohibition - Reporting and Investigating was reviewed on 3/28/2025. Review of the sign-in The sheet revealed that a certain staff member's signature was not listed. Interview at 1:20 pm with the Senior Director of Clinical Standards, stated that she and Director of Regulatory and Quality wrote version the removal plan and made some mistakes. She stated that the removal plan state that the administrator did not attend the meeting; however, the assistant administrator attended the meeting in her place. She stated that the Division Nurse was herself; however, Division Nurse attended the meeting on the phone. Interview with Assistant Activities Director, verified that she attended the meeting in the place of the Activities Director and did not sign into the meeting. Interview at 2:08 pm with LPN GG and LPN HH, stated that they attended the QAPI meeting on 3/31/2025, verified their signature on the sign-in sheet, and were educated on the Abuse Policy. Interview on 4/3/2025 at 2:35 pm with the Assistant Administrator stated that she attended the QAPI meeting and verified her signature. She stated that the abuse policy was reviewed, and they found no changes needed to be made to the policy. 3.Verified by interview and record review. Interview on 4/3/2025 at 2:35 pm with the assistant Administrator stated that she attended the Administrator's in-service and education which was held on 3/28/2025. She stated that the Divisional [NAME] President gave the in-service education and explained to the Administrator everything that she needs to do regarding investigating and reporting. She stated that the Divisional [NAME] President went off the facility's policy. Record review revealed that an in-service Quality Assurance/Performance Improvement (QAPI) meeting was held on 3/31/2025 at 2:30 pm and the Skilled Nursing Services: Abuse Prohibition - Reporting and Investigating was reviewed on 3/28/2025. Review of the sign-in sheet revealed that a certain staff member's signature was not listed. Interview at 1:20 pm with Senior Director of Clinical Standards, stated that she and Director of Regulatory and Quality wrote Version the removal plan and made some mistakes. She stated that the removal plan state that the administrator did not attend the meeting; however, the assistant administrator attended the meeting in her place. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4.Verified by Interview and Record Review on 4/3/2025. Interview at 2:08 pm with LPN GG and LPN HH, stated that they have Quality Improvement Data Collection Grid to use as the corrective action to monitor residents that may have been potentially affected by the incident. Record review revealed that all the residents had been monitored and tracked using the Quality Improvement Data Collection Grid. The Administrator, the DON (3/28/2025), and Administrator Assistants (3/31/2025) were informed about and adhered to the day-today operations of monitoring and reporting abuse to ensure residents were safe. 5.Verified by Interview and Record Review on 4/3/2025. Interview at 2:08 pm with LPN GG and LPN HH, stated that they have Quality Improvement Data Collection Grid to use as the corrective action to monitor residents that may have been potentially affected by the incident. Record review revealed that all the Residents were monitored using the Quality Improvement Data Collection Grid. The Administrator, the DON (3/28/2025), and Administrator Assistant (3/31/2025) were informed about and adhered to the day-today operations of monitoring and reporting abuse to ensure residents were safe. 6.Verified by Interview and Record Review on 4/3/2025. Interview at 2:08 pm with LPN GG and LPN HH, stated that they have Quality Improvement Data Collection Grid to use as the corrective action to monitor residents that may have been potentially affected by the incident. Record review at 3:40 pm revealed that the systematic changes that were made to ensure that deficient practices would not occur were the following: Quality Improvement Grid; Baseline Review - nonpharmacological interviews; and monitoring and tracking of residents with inappropriate behaviors. 7.Verified by Interview and Record Review on 4/3/2025. Interviewed the DON and ADON at 4:25 pm revealed that they were informed and implemented the Abuse policy in their day-to-day operations. They stated that they are completing the Quality Improvement Data Collection Grid every day to monitor, track, and followup inappropriate behaviors and submit the form to the assistant Administrator. They stated that after receiving the form, the assistant Administrator will submit it to the Senior Director of Clinical Services. They stated that the educate the staff on abuse individually or by a group. They stated that if they educate them as a group, they would have it in the morning or in the afternoon located in the lobby. They stated that they have three different shifts, so staff is educated around the clock. They stated that they monitor the residents by reviewing any initial events, notes or change in conditions during the clinical meeting and will complete the proper assessment if needed. Interview at 4:55 pm with the Senior Director of Clinical Services revealed that the Administrator and the DON were informed about and adhered to the Abuse policy in their day-to-day operations. She confirmed that on 3/28/2025, the Administrator was placed on administrative leave pending investigation. She confirmed that education was provided to the Administrator (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Assistant on 3/31/2025 to ensure the day-to-day operations were followed, including adhering to the Abuse policy. She confirmed that QAPI education was also provided to the leadership team to include monitoring and follow-up for adverse events by tracking and trending for inappropriate behavior. She confirmed that education had been completed with staff on abuse, including intervening to protect a patient from further abuse. She also confirmed that on March 31, 2025, a review was completed to ensure that audits were completed for F600, F867, and F740, ensuring that patients were safe, and that staff understood the education on nonpharmacological interventions for inappropriate sexual behavior. She confirmed that audits will continue until the removal of IJ. Review if the records at 4:05 pm revealed that the Quality Improvement Data Collection Grid is completed daily. It revealed that on 3/28/2025, the administrator was placed on administrative leave pending investigation. Record review revealed that all the residents had been monitored using the Quality Improvement Data Collection Grid. Record review revealed that an in-service Quality Assurance/Performance Improvement (QAPI) meeting was held on 3/31/2025 at 2:30 pm, and the Skilled Nursing Services: Abuse Prohibition - Reporting and Investigating was reviewed on 3/28/2025. A record review revealed that an audit was completed to ensure that audits were completed for F600, F867, and F740. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8.Verified by Interview and Record Review on 4/3/2025. Interviewed the DON and ADON at 4:25 pm revealed that they were informed and implemented the Abuse policy in their day-to-day operations. They stated that they are completing the Quality Improvement Data Collection Grid every day to monitor, track, and follow-up inappropriate behaviors and submit the form to the Assistant Administrator. They stated that after receiving the form, the Assistant Administrator will submit the form to the Senior Director of Clinical Services. They stated that they educate the staff on abuse individually or in a group. They stated that if they educated them as a group, they would have it in the morning or the afternoon, located in the lobby. They stated that they have three different shifts, so staff are educated around the clock. They stated that monitor the residents by reviewing any initial events, notes, or changes in conditions during the clinical meeting and will complete the proper assessment if needed. Interview at 4:55 pm with the Senior Director of Clinical Services revealed that the Administrator and the DON were informed about and adhered to the Abuse policy in their day-to-day operations. She confirmed that on 3/28/2025, the Administrator was placed on administrative leave pending investigation. She confirmed that education was provided to the Administrator Assistant on 3/31/2025 to ensure the day-to-day operations were being followed to include adhering to the Abuse policy. She confirmed that QAPI education was also provided to the leadership team to include monitoring and follow-up for adverse events by tracking and trending for inappropriate behavior. She confirmed that education had been completed with staff on abuse, including intervening to protect a patient from further abuse. She also confirmed that in March 31, 2025, a review was completed to ensure that audits were completed for F600, F867, and F740, ensuring that patients were safe, and that staff understood the education on non-pharmacological interventions for inappropriate sexual behavior. She confirmed that audits will continue until the removal of IJ. On 4/3/2025 verified by record review of an audit titled, Quality Improvement DATA Collection Grid. Indicators: 1. Any noted sexually inappropriate behavior. 2. If so, were non-pharmalogical interventions implemented 3. Care Plan updated. 4. Was change in conditions completed? This tool will indicate whether the indicator was met, three residents were identified no to all indicators and was implemented on 4/3/2025, 4/2/2025, and 4/1/2025. On 4/3/2025 verified by interview with DON that audits will be continued until QAPI committee deems to no longer need audits. DON also confirmed that audits are implemented daily and reported to Administrator Assistance. She explained that the IJ tags are audited based on expectations of monitoring for tracking of residents with inappropriate behavior. All corrective actions were completed on 3/31/2025. The facility alleges that the IJ was removed on 4/1/2025.

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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** 49681 Based on staff interview, facility document review, and review of the facility policy titled, Quality Assurance/Performance Improvement, the facility staff failed to maintain an effective Quality Assurance/Performance Improvement (QAPI) program regarding the facility's Performance Improvement Plan (PIP) for Sexual Abuse. This had the potential to affect all residents of the facility. On 3/31/2025, a determination was made that the facility's noncompliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Senior Director of Clinical Standards, Director of Quality and Regulatory Services, Director of Nursing (DON), and Assistant Administrator were informed of the Immediate Jeopardy (IJ) on 3/31/2025 at 10:45 am. The noncompliance related to the IJ was identified to have existed on 9/28/2024 when R121 sexually abused R48 inside her room. An acceptable Removal Plan was received on 4/1/2025. Based on the validation of the Removal Plan, the State Survey Agency determined that the corrective plans and the immediacy of the deficient practice was removed on 4/1/2025. The facility remained out of compliance while the facility continued management level staff oversight as well as developed and implemented a Plan of Correction (POC). This oversight process included the analysis of facility staff's conformance with the facility's policies and procedures. In-service materials and records were reviewed. Interviews were conducted with staff to ensure they demonstrated knowledge of facility Policies and Procedures related to Abuse, Neglect, and Exploitation, and the behavioral health needs of residents. Findings include: Review of the facility policy titled, Quality Assurance/Performance Improvement Plan Revised April, 2,2001 revealed, The Center's Quality Assurance - Performance Improvement (QAPI) Process is a systemic organized approach to quality assurance and performance improvement. The process is designed to be systematic, comprehensive, data-driven, proactive approach to performance management and improvement utilizing the five elements of QAPI of 1) design and scope 2) governance and leadership 3) feedback, data analysis and systematic action. The QAPI Process supports the center's mission and vision. It is the aim of the QAPI Process to take a consistent, proactive approach to continually improving the way our center cares for and engages with our patients, associates and other customers so that we may realize our vision to be the leader in long term care by improving the care and services to enhance the quality of life of the patients we serve. On April 1, 2025, a record review of a section of the policy titled, Governance and Leadership revealed that the facility failed: 4. To identify and prioritize problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. To implement an Action Plan addressing gaps in systems, and are evaluated for effectiveness; and 6. To create clear expectations that are set around safety, quality, rights and choice, and respect. On March 28, 2025, a record review of QAPI minutes revealed on June 28, 2024, July 31, 2024, August 26, 2024, October 15, 2024, December 19, 2024, and January 15, 2025 allegations of some form of sexual abuse/ abuse were made to the facility for resident to resident or staff to resident. At the bottom of the listed meeting minutes, notes state, QAPI team, no noted changes in procedure. A record review on March 28, 2025, titled Performance Improvement Projects (PIP) revealed, PIPs are charted and implemented through the QAPI committee based on priority as aligned with key customer expectations, center strategic objectives, and resource availability. At least annually, a PIP that focuses on high-risk or problem areas should be charted. Concurrent PIPs team should include a PIP Project Leader to lead the team, contain scope, focus on PIP objective and manage within available timeframe, PIP team members should include representatives from various departments/units'/ shifts as affected and associates who work with system/process on daily basis. During the PIP team charter, each PIP project leader will be charged with leading the team in the root cause analysis to determine the underlying causes of issues, rather than applying quick fixes that address symptoms only. The PIP Team leader is responsible for documenting the work of the PIP team, which should include highlights of the teamwork progress made and lessons learned. PIP documents will be maintained as part of the QAPI records. The PIP team leader should provide updates on PIP's work to the QAPI committee. The copy committee retains the right to recharter or discontinue PIPs. The Administrator is responsible for ensuring that PIP team members are enabled to meet and carry out PIP team functions for performance improvement purposes. On March 28, 2025, a record review of the facility's PIP dated November 11, 2024, December 12, 2024, and December 10, 2024, provided by the facility revealed a problem with residents inappropriate touching, resident to resident abuse, and resident staff abuse. Documentation was found on March 31, 2025. The PIP consisted of the problem statement and the root cause, with goals identified, no baseline data, or barriers established. Completion date marked as ongoing. No further information was provided to the survey team. Residents were not identified in the PIP on the Quality Assurance Event form. An interview on March 28, 2025, at 1:44 pm with the Administrator revealed that the QAPI team did not change any procedures after months of abuse allegations, but did tell nursing staff to report immediately to the DON and the Administrator. The Administrator stated that her phone number is posted on the nursing station wall if she is not at the facility for the night shift. Further, interview revealed that staff do not begin reporting until it is discussed with the DON and Administrator, so that they can get facts. There are several sexual abuse allegations between residents and staff to residents but at this time, no other processes or procedures have been changed after resident R121 sexually abused resident R48. The procedure for handling sexual abuse is to notify the police, ambulance, family, and physician. We have not changed any procedures. Cross-reference: F600, F740, and F835 The facility implemented the following actions to remove the IJ (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115522	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Health and Rehabilitation	1321 Pulaski School Road Pulaski, GA 30451

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

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The QAPI committee met on 3/31/2025 and reviewed the reportable adverse events from February 27, 2025, to March 31, 2025, to determine if any trends were identified. During the meeting the center did note that some behaviors were a result of GDRs and established a conununication tool to provide to the behavioral health provider upon entrance and to schedule an exit meeting after the visit to include review of GDRs. 2. An ad hoc meeting was held by the Director of Quality and Regulatory to review F-835, F-867, F-740, and F-600, and a performance improvement plan was developed. For F600 the policy for abuse education was reviewed to include response to sexual abuse, Non-Pharmacological Interventions to manage behaviors, Patient interviews completed on 3/31/2025 by social service director to interviewIO residents to ensure they feel safe and IO associates interviews to ensure they know process for reporting and can identify abuse to include sexual and physical aggression. Audit will continued until IJ removed. F867 - QAPI education was provided to include trending RCA to analyze resources needed to decrease or prevent reoccurrence. Communication tool was developed and implemented on 3/31/2025 by DON to improve the communication between the behavior provider and center to provide notification of any recommendations timely. The behavior provider will meet with the DON, ADON, and/or nurse supervisor upon entrance and exit to make aware of any new recommendation and to receive report of new adverse events. Nurse Managers will update the patient care plan with any non-pharmacological interventions to the patient care plan. For F740 an audit tool was developed by DON on 3/31/2025 to review patients with inappropriate behaviors to ensure they have a non-pharmacological interventions noted on care plan. Audit will continued until IJ removed. Education of this process has been provided to the nurse leadership and behavior provider on 3/31/2025 by the DON. Any noncompliance will be brought back through QAPI process and addressed tlu [NAME] the PDSA framework to identify RCA tlu-[NAME] the QAPI committee. For F835 a daily review for oversight will be completed by the Divisional [NAME] president and/or Senior Director of Clinical Standards to ensure that audits were completed for F600, F867, and F740, ensuring that patients were safe and that staff understood the education on non pharmacological interventions for inappropriate sexual/physical behavior, and QAPI review completed as indicate on reportable for trends. Any noncompliance noted will be addressed through written education by the Divisional [NAME] President. The State Survey Agency (SSA) validated the facility's written IJ Removal Plan as follows: 1. On 4/3/2025 at 12:55 pm verified by record review of a 5-way tool was used during QAPI meeting that held on (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3/31/2025 at 2:30 pm. The tool determined that root causes were a result Gradual Dose Reduction (GDR)s of some behaviors. They established a communication tool with titled {Named} Visits Communication dated 4/1/2025. The tool is broken into 4 identified components routine visits, acute episode, GDR and Added to PAR. {Named} visit. On 4/3/2025 verified by interview with facilities Management Supervisor who revealed that he attended the QAPI meeting on 3/31/2025 at 2:30pm. On 4/3/2025 at 1:48 pm DON revealed that she was in the QAPI meeting that was held on 3/31/2025 and a discussion of all IJ tags and they discussed behaviors and GDR reviews. On 4/3/2025 at 3:45 pm verified by record review of QAPI minutes were reviewed along with attendees sign in sheets all QAPI committee was present except for Administrator. On 4/3/2025 at 3:45 pm verified by record review revealed that on March 28,2025, the governing body held in service education to the Administrator, the divisional vice president, educated her on the process to follow when reporting abuse, the QAPI role, responsibilities, and her duties as the Administrator to ensure the safety of the patients. On 4/3/2025 at 2:27 pm LPN GG confirmed that she attended QAPI meeting during the meeting they discussed the IJ tags. On 4/3/2025 at 2:27 pm LPN HH confirmed that she attended QAPI meeting they discussed the communication tool that they will be utilizing with {Named} Behavioral Health monitor residents with sexual behaviors and behaviors. 2. On 4/3/2025 at 2:02 pm verified by record review of an education titled, Behavior Health Process dated 3/31/2025, presented by Senior Director of Clinical Standards. On 4/3/2025 at 2:08 pm Licensed Practical Nurse (LPN) GG confirmed that she was educated on the process of an audit that will be conducted as the {Named} Behavioral Health enters and exits the facility. In further interview she revealed that they will identify residents that are acute episode and routine visits. The communication between {Named} Behavioral Health and nursing staff will increase to ensure that residents are being identified if medications are changed or if interventions are added for sexual behaviors or behaviors. On 4/3/2025 at 2:27 pm LPN HH confirmed that she attended QAPI meeting and she was educated on 3/31/2025 titled, Behavior Health Process presented by Senior Director of Clinical. In further interviews she revealed that this audit has been conducted since 4/1/2025 the indicators: 1.Were there any self-reportable for sexually inappropriately behaviors submitted? 2. If so, was there an RCA completed to identify trends? LPN GG revealed that no reports were reported to nursing leadership on 4/1/2025, 4/2/2025, or 4/3/2025. A record review conducted on 4/3/2025 at 2:47 pm of the Quality improvement Data Collection Grid was implemented by nursing staff submitting information to assistant Administrator and reviewed by Senior Director for 4/1/2025, 4/2/2025 and 4/3/2025.The results self-reportable for sexually inappropriate behaviors were submitted no reports. On 4/3/2025 Certified Nursing Assistant (CNA) BB revealed that she is aware that they must report any sexual abuse behaviors for all residents she works on the memory unit. An observation was conducted on 4/3/2025 at 3:33 pm on memory unit residents were singing and calm in TV room no sexual behaviors were seen or heard. Staff were involved with residents and CNAs and Nursing staff are monitoring residents. Residents were observed in TV room CNAs were in room observing residents. On Hall C residents were seen in halls chatting with one another no sexual abuse seen or heard on halls. Residents are communicating with each other no issues found. Nursing staff are visible and monitoring and interacting with residents. On 4/3/2025 at 3:53 pm an audit of reportable in the last 30 days has been identified on 3/31/2025 of 6 residents that were identified with the date of incident and nature of incident. All corrective actions were completed on 3/31/2025. The Facility alleges IJ Removal 4/1/2025.