STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115697	A. Building B. Wing	08/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountainview Ctr for Alzheimer	2631 North Druid Hills Road N E Atlanta, GA 30329

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy titled, Abuse, Neglect, and Exploitation, the facility failed to ensure residents were free from sexual abuse for three of six residents reviewed for abuse (Resident (R) 2, R3, and R6). Specifically, R1 displayed inappropriate sexual behaviors towards others on 6/20/2025 when she grabbed a male housekeeper's private area (groin) and buttocks. The resident's inappropriate sexual behavior towards staff members progressed to resident's on the South Pavillion unit sustaining sexual abuse. Even though the facility was aware of R1's inappropriate sexual behavior and her abuse of other residents, the facility failed to implement any interventions to protect the residents who resided on the unit. The facility's failure to ensure residents were free from abuse had caused or was likely to cause serious injury, harm, impairment, or death to a resident. An Immediate Jeopardy was identified on 8/15/2025 and was determined to exist on 6/20/2025. The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy on 8/15/2025 at 9:00 am. The facility was notified that an acceptable plan of removal had been accepted on 8/16/2025 at 4:11 pm. The Surveyor validated the full implementation of the facility's removal plan, and the Administrator was notified on 8/17/2025 at 9:31 am that the Immediacy had been removed.Findings include:Review of the facility's policy titled, Abuse, Neglect, and Exploitation, revised 1/23/2023 revealed the definition of sexual abuse as non-consensual sexual contact of any type with a resident. The policy also revealed Employee Training.C. Training topics will include: .2. Identifying what constitutes abuse.III. Prevention of Abuse, Neglect and Exploitation. The facility will implement policies and procedure to prevent and prohibit all types of abuse.A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, such as the identify when, how, and by whom determinations of capacity to consent to sexual contact will be made and where this documentation will be recorded.The facility will have written procedures to assist staff in identifying the different types of abuse.sexual abuse.Review of R1's undated admission Record, located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder, bipolar type, unspecified dementia, and delusional disorders.Review of R1's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/18/2025 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of two out of 15 which indicated the resident was severely cognitively impaired. The MDS also indicated the resident was assessed to have exhibited other behavioral symptoms directed towards others (e. g., physical symptoms such as.public sexual acts, disrobing in public, and verbal/vocal symptoms. and also assessed that the behaviors significantly impacted others care or living environment during the assessment period.Review of R1's Nursing Progress Note, dated 6/20/2025 and located in the resident's EMR under the Progress Notes tab revealed .At approximately 11:30 am a male housekeeper was observed running away from the resident, with the resident chasing after him. The housekeeper reported that the resident had just grabbed his private area and touched him on his buttocks. The resident had to be redirected several times in order to stop her from chasing after the male housekeeper.Review of R1's Nursing Progress Note, dated 6/24/2025 and located in the resident's EMR under the Progress Notes tab revealed Resident inappropriately fondled narrator. When passing in hall Narrator attempted to say good morning to resident in which she said, Hello to you too and grabbed narrators vagina.Review of R1's Nursing Progress Note, dated 6/25/2025 and located in the resident's EMR under the Progress Notes tab revealed .CNA reported to this nurse that client [resident] walked towards her rolling her hips and thrusting her pelvis toward sher [sic] .then client reached out and started rubbing CNA's right breast.when CNA asked client not ot touch her like that, client responded 'you do not like doing that' .Review of R1's Nursing Progress Note, dated 6/25/2025 and located in the resident's EMR under the Progress Notes tab revealed Resident observed attempting to take male resident into another resident's room stating, 'Want to do it?' Narrator was informed by a visitor that was on site visiting another resident. Both residents separated and easily redirected without issues.Review of R1's Nursing Progress Note, dated 6/28/2025 and located in the resident's EMR under the Progress Notes tab revealed The resident was observed following a particular male resident throughout the shift. She held his hands and attempted to sit in his lap on several occasions. The resident required frequent redirections. Staff continued to intervene, attempted to separate this resident from the male resident, and distract her with

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy titled, Abuse, Neglect, and Exploitation, the facility failed to complete a thorough investigation which included interviewing and/or assessing other residents who resided on the South Pavillion unit and interviewing staff who worked on the unit for two of two abuse investigations involving residents (Resident (R) 1, R2, and R3). Also, during the facility's investigation, the Administrator who was the Abuse Coordinator failed to thoroughly investigate and identify Certified Nurse Aide (CNA) 2's failure to protect R3 when she discovered R3 in R1's room with his pants off; instead of intervening, the CNA left the resident's room and reported her observations to the nurse. Additionally, the facility failed to protect all residents who resided on the unit when R1's level of supervision (LOS) was not assessed or increased when R1 started engaging in inappropriate sexual behaviors towards other residents which was determined to be sexual abuse. These failures led to the continued abuse of the vulnerable residents who resided on the South Pavillion unit. (Cross reference F600 Free from Abuse and Neglect and F657 Care Plan Timing and Revision)The facility's failure to implement their abuse policy and procedures to complete thorough abuse investigations and the failure of implementing interventions to protect all residents of the unit from sustaining abuse from R1 was likely to cause serious injury, harm, impairment, or death to a resident. An Immediate Jeopardy was identified on 8/15/2025 and was determined to exist on 6/20/2025. R1 attempted to take an unidentified male resident to a room to engage in sexual activity. The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy on 8/15/2025 at 9:00 am. The facility was notified that a plan of removal had been accepted on 8/16/2025 at 4:11 pm. The Surveyor validated the implementation of the facility's removal plan, and the Administrator was notified on 8/17/2025 at 9:31 am that the Immediacy had been removed. Findings include:Review of the facility's policy titled, Abuse, Neglect, and Exploitation, revised 1/23/2023 revealed .Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: .b. Establish policies and procedures to investigate any such allegations.The components of the facility abuse prohibition plan are discussed herein: . B. Prospective residents will be screened to determine whether the facility has the capability and capacity to provide the necessary care and services for each resident admitted to the facility. 1. An assessment of the individuals mood/behavioral status, medical acuity, and special needs will be reviewed prior to admission. 2. The facility will make individual determinations in consideration of current staffing patterns, staff qualifications, competency and knowledge, clinical resources, physical environment, and equipment.III. Prevention of Abuse, Neglect and Exploitation. The facility will implement policies and procedures to prevent and prohibit all types of abuse.A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, such as the identify when, how, and by whom determinations of capacity to consent to sexual contact will be made and where this documentation will be recorded.B. Identifying, correcting and intervening in situations in which abuse.is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents.V. Investigation of Alleged Abuse, Neglect, and Exploitation. A. An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse.occur.4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations.6. Providing complete and thorough documentation of the investigation.VI. Protection of Resident. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation.C. Increased supervision of the alleged victim and residents.Review of R1's undated admission Record, located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder, bipolar type, unspecified dementia, and delusional disorders.Review of R1's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/18/2025 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of two out of 15 which indicated the resident was severely cognitively impaired. The MDS also indicated the resident was assessed to have exhibited other behavioral symptoms directed towards others (e. g., physical symptoms such as public sexual acts, disrobing in public, and verbal/vocal symptoms, and also

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy titled, Comprehensive Care Plans, the facility failed to revise the resident's care plan with nonpharmacological interventions for inappropriate sexual behavior for one of nine sampled residents (Resident (R) 1). This failure led to multiple residents on the South Pavillion unit being victims of sexual abuse by R1. Cross Reference: F600 Free from Abuse and Neglect.The facility's failure to ensure R1's care plan was revised with interventions protecting residents from sexual abuse had caused or was likely to cause serious injury, harm, impairment, or death to a resident. An Immediate Jeopardy was identified on 8/15/2025 and was determined to exist on 6/20/2025. R1's care plan focus was revised to identify the problem of the resident engaging in inappropriate sexual behavior; however, there were no revisions to the interventions for R1's inappropriate sexual behavior. The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy on 8/15/2025 at 9:00 am. The facility was notified that an acceptable plan of removal had been accepted on 8/16/2025 at 4:11 pm. The Surveyor validated implementation of the facility's removal plan, and the Administrator was notified on 8/17/2025 at 9:31 am that the Immediacy had been removed.Findings include:Review of the facility's policy titled, Comprehensive Care Plans, dated 9/1/2023 revealed Policy: It is the policy of [Facility's Name] to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 6. The comprehensive care plan will include measurable objectives and time frames to meet the resident's needs as identified in the resident's comprehensive assessment.Alternative interventions will be documented as needed.The policy did not entail a process related to revision of care plans outside of the comprehensive and quarterly MDS assessment. Review of R1's undated admission Record, located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder, bipolar type, unspecified dementia, and delusional disorders.Review of R1's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/18/2025 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of two out of 15 which indicated the resident was severely cognitively impaired. The MDS also indicated the resident was assessed to have exhibited other behavioral symptoms directed towards others (e.g., physical symptoms such as. public sexual acts, disrobing in public, and verbal/vocal symptoms. and also assessed that the behaviors significantly impacted others care or living environment during the assessment period.Review of R1's Care Plan, initiated on 6/13/2025 and located in the resident's EMR under the Care Plan tab revealed a Focus of Resident exhibits behavioral episodes as evidenced by wandering. The Care Plan interventions for the Focus included Administer behavior medications as ordered, Allow opportunity to make choices and participate in care if able, Allow resident to calm and reapproach as needed, Approach from the front in a calm, unhurried manner, Assess for signs/symptoms of infection, constipation, or pain that may be causing delirium or increased behavioral episodes, Assist to quiet area with less distractions if behaviors observed and difficult to redirect, Elicit family input for best approach(es) to resident, Ensure safety of resident and others, Make sure resident can see you before you touch or move them, monitor for side effects of medications, provide diversional activities as indicated, Provide small group activities to decrease distraction, and Talk in calm voice when behavior is disruptive. Review of R1's Nursing Progress Note, dated 6/20/2025 and located in the resident's EMR under the Progress Notes tab revealed .At approximately 11:30 am a male housekeeper was observed running away from the resident, with the resident chasing after him. The housekeeper reported that the resident had just grabbed his private area and touched him on his buttocks. The resident had to be redirected several times in order to stop her from chasing after the male housekeeper. Review of R1's Care Plan, revised 6/20/2025 and located in the resident's EMR under the Care Plan tab