STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Connersville	1029 E 5th Street Connersville, IN 47331

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 - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility failed to ensure residents remained free from sexual abuse from Resident C towards Resident B and Resident G, resulting in Resident B experiencing anxiety and fear for 3 of 6 residents reviewed for sexual abuse (Resident C, Resident B and Resident G). Findings include:1a. The clinical record for Resident C was reviewed on 10/27/25 at 10:45 a.m. The diagnoses included, but were not limited to, vascular dementia, depression, anxiety, hypertension, heart failure and epilepsy. The Quarterly Minimum Data Set (MDS) assessment for Resident C, dated 8/22/25, indicated the resident was severely cognitively impaired for daily decision making. The resident was independent with ambulation. The clinical record of Resident C indicated the resident resided on the memory care unit from 4/8/25 until 6/30/25. The resident was moved to the Long Term Care unit on 6/30/25. A progress note for Resident C, dated 6/29/25 at 6:12 p.m., indicated the resident was found with his left hand inside a female resident's shirt and had her right breast in his hand and was physically moving his hand around her breast. The facility staff immediately intervened and separated the residents. Resident C was placed on 15-minute checks and responsible parties were notified. The safety checks for Resident C, dated 10/5/25 through 10/9/25, indicated the resident was being monitored every 15 minutes for sexually acting out. There was no further documentation in the resident's clinical record pertaining to any behaviors that led to the 15 minute checks being initiated. The safety checks for Resident C, dated 10/15/25 through 10/16/25, indicated the resident was being monitored every 15 minutes for sexually acting out. A progress note for Resident C, dated 10/15/25 at 8:11 p.m., indicated a female resident reported to staff that Resident C reached over her shoulder and touched her chest when they were coming inside from a smoke break. Resident C was walking behind the female resident who was in a wheelchair propelling herself. Another resident witnessed the incident and also reported the incident to the staff. Certified Nurse Aide (CNA) 4 had taken residents out to smoke and was inside the door holding it for other residents and did not witness what happened but was immediately alerted once residents were all inside. The nurse immediately alerted the Director of Nursing (DON) and the Nurse Practitioner (NP). Resident C was placed on 15-minute checks and would walk back and forth by a staff member during smoking times. The progress note was electronically signed by Licensed Practical Nurse (LPN) 2. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 - Actual harm Residents Affected - Few	The NP note for Resident C, dated 10/15/25, indicated the resident had increased anxiety and was sexually acting out. The note indicated the medication Lexapro (antidepressant) would be increased to 20 milligrams (mg). The NP note for Resident C, dated 10/16/25, indicated the resident groped a female resident's breast. The facility was to continue to monitor the resident and keep residents separate. The plan of care for Resident C, dated 10/16/25, indicated the resident had a history of approaching female resident and touching inappropriately related to the diagnosis of vascular dementia. The interventions included, but were not limited to, administering medications as ordered, psychiatric (psych) NP to follow as needed, redirect the resident if he attempted to approach a peer while in the wheelchair back to their room, resident needed supervision during supervised smoke breaks and in the dining room, the resident was to be taken out for smoke breaks separate from other residents (dated 10/25/25), and was to be one-on-one supervision at all times (dated 10/25/25). During an interview with Registered Nurse (RN) 1 on 10/27/25 at 11:40 a.m., she indicated she was the nurse, on 10/6/25, and Resident C was on 15-minute checks. RN 1 was unsure why the resident was on 15-minute checks and was unable to find any further documentation besides the 15-minute check sheet for Resident C. During an interview with the DON on 10/27/25 at 1:40 p.m., she indicated, on 10/5/25, it was reported to her that Resident C may have been doing something he should not have been doing. The DON indicated another resident reported that Resident C was being inappropriate with female residents. Resident G might have been one of them. The Social Services Director (SSD) talked with Resident G, and she denied anything happened. There were no further interviews or investigation conducted regarding an allegation pertaining to Resident C. During an interview with LPN 2 on 10/27/25 at 6:40 p.m., she indicated she was the nurse on 10/15/25. LPN 2 indicated Resident B reported to her that Resident C grabbed her chest and it was not the first time he had done this. Resident J also reported the incident as he had witnessed it. LPN 2 indicated she called the DON and reported it; and the DON had LPN 2 put Resident C on 15-minute checks and 1-on-1 supervision during smoke breaks. Resident B reported she felt very uncomfortable, upset, and was fearful he was going to come into her bedroom while she was asleep. LPN 2 indicated she reassured Resident B that the staff would not let Resident C come into her room and provided her with anti-anxiety medication. During an interview with the Regional [NAME] President of Operations on 10/28/25 at 9:43 a.m., he indicated he was the Administrator of the facility, on 10/5/25, and the DON had texted him and said Resident C was touching a female resident and he was unsure who the female resident was. The SSD talked to Resident G, and she did not report anything happened. There were no other residents or staff interviewed. During an interview with the DON on 10/28/25 at 12:45 p.m., she indicated she was unsure why there was no documentation in Resident C's clinical record about the incident on 10/5/25. During an observation on 10/28/25 at 10:10 a.m., there were three female residents and two male residents smoking in the facility's smoking area. Resident C ambulated to the smoking area independently at 10:15 a. m. and sat next to a staff member. (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 0600 Level of Harm - Actual harm Residents Affected - Few	1b. During an interview with Resident J on 10/28/25 at 10:35 a.m., he indicated he had witnessed Resident C, on two different occasions, touching female residents inappropriately. Resident J indicated a few weeks ago, unsure of the date, he witnessed Resident C pushing Resident G's wheelchair and was rubbing her hair. Resident J indicated he was unable to see what else Resident C did because he was walking in front of him. Resident G told Resident J that if Resident C ever touched her like that again she would smack the s--t out of him. The other episode Resident J witnessed a couple weeks ago, unsure of date, was Resident C pushing Resident B in her wheelchair and he put his hands down her shirt and Resident J reported it to LPN 2. Resident J indicated Resident B was trying to push Resident C's hands away. Resident J indicated no one from management had interviewed him about these two incidents. The admission MDS assessment for Resident J, dated 8/5/25, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. During an interview with RN 1 on 10/28/25 at 10:47 a.m., she indicated she remembered, on 10/5/25, that Resident C was on 15-minute checks because he was sexually acting out towards female residents. RN 1 was unsure who the female residents were. During an observation and interview on 10/28/25 at 10:50 a.m., CNA 4 was sitting outside Resident C's room. CNA 4 indicated she was sitting 1-on-1 with Resident C, but she was unsure why the resident was on 1-on-1. During an interview with the CNA 4 on 10/28/25 at 12:04 p.m., she indicated she was working, on 10/15/25, when there was an allegation of sexual abuse with Resident C. CNA 4 indicated she had taken the residents out to smoke and was holding the door open for the residents to come back into the facility. CNA 4 indicated she did not witness Resident C touch Resident B. CNA 4 indicated Resident B and Resident J was mad and reported to LPN 2 that Resident C had touched Resident B's chest. CNA 4 indicated she was not aware that Resident C had a history of sexually inappropriate behaviors, but she did know he was moved from the memory care unit because he liked to girlfriend everyone. 1c. The clinical record for Resident B was reviewed on 10/27/25 at 1:30 p.m. The diagnoses included, but were not limited to, nicotine dependance, anxiety disorder, and major depressive disorder. A Significant Change MDS assessment, dated 9/19/25, indicated Resident B was moderately cognitively impaired. During an interview with Resident B on 10/27/25 at 11:38 a.m. Resident B indicated a couple weeks prior she was being wheeled back into the facility in her wheelchair after smoking by Resident C. Resident B indicated Resident C while standing behind her started rubbing her shoulder, then reached his hand down the front of Resident B's chest area. Resident B indicated she then swiped Resident C's hand away. Resident B indicated she then informed LPN 2 that Resident C had tried to touch her chest while wheeling her in her wheelchair back into the facility. (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 0600 Level of Harm - Actual harm Residents Affected - Few	A progress note, dated 10/15/25 at 8:30 p.m., indicated Resident B alerted staff that another resident had reached over her shoulder and touched her chest when coming inside from a smoke break. Resident B stated she swatted his hand away. Another resident witnessed this happen and also alerted staff of what he saw. The aide that had taken the residents out to smoke was inside the door holding it for others and did not witness what had happened but was immediately alerted once residents were all inside. The nurse immediately alerted the DON. An eCare Triage note, dated 10/16/25, indicated LPN reported that Resident B alerted staff that another resident groped her breast on the way inside from the 8:00 p.m. smoke break. Another resident witnessed the event. The DON was notified. The Medication Administration Record (MAR) indicated Resident B received buspirone HCL 5 mg (milligram) scheduled tablet at bedtime, on 10/15/25, for anxiety. 1d. The clinical record for Resident G was reviewed on 10/28/25 at 9:40 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, generalized anxiety disorder, and depression. The Quarterly MDS assessment, dated 9/19/25, indicated Resident G was moderately cognitively impaired. During an interview with Resident G on 10/27/25 at 1:55 p.m., Resident G indicated a couple weeks prior that she was wheeling herself in her wheelchair down the hallway when Resident C came up behind her and started pushing the wheelchair for her. Resident G indicated Resident C took his hand and started sliding it down the front of her chest. Resident G indicated she swiped his hand away and told him to cut it out. Resident G indicated she had told a couple of staff members. Resident G indicated these sexual behaviors keep happening outside when residents were coming back in from the smoking area with Resident C, but no one ever sees it. Resident G indicated the DON had not come in to speak with her about this event. An Abuse, Mistreatment, Neglect, Exploitation and Misappropriation policy was provided by the DON on 10/27/25 at 11:00 a.m. It indicated .Sexual abuse is a non-consensual sexual contact of any type with a resident .C. Prevention & Identification (b.) identifying, correcting, and intervening in situations in which abuse is more likely to occur .D. Protect the Resident (b.)3) The facility will ensure other residents are protected This citation is related to Intake 2644466. 3.1-27(a)(1)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report an allegation of sexual abuse to the Indiana Department of Health (IDOH) for 2 of 6 residents reviewed for sexual abuse (Resident C and Resident G). Findings include:1. The clinical record for Resident C was reviewed on 10/27/25 at 10:45 a.m. The diagnoses included, but were not limited to, vascular dementia, depression, anxiety, hypertension, heart failure and epilepsy. The Quarterly Minimum Data Set (MDS) assessment for Resident C, dated 8/22/25, indicated the resident was severely cognitively impaired for daily decision making. The resident was independent with ambulation. The safety checks for Resident C, dated 10/5/25 through 10/9/25, indicated the resident was being monitored every 15 minutes for sexually acting out. There was no further documentation in the resident's clinical record pertaining to any behaviors that led to the 15-minute checks being initiated. During an interview with Registered Nurse (RN) 1 on 10/27/25 at 11:40 a.m., she indicated she was the nurse, on 10/6/25, and Resident C was on 15-minute checks. RN 1 was unsure why the resident was on 15-minute checks and was unable to find any further documentation besides the 15-minute check sheet for Resident C. During an interview with the Director of Nursing (DON) on 10/27/25 at 1:40 p.m., she indicated, on 10/5/25, it was reported to her that Resident C may have been doing something he should not have been doing. The DON indicated another resident reported that Resident C was being inappropriate with female residents. Resident G might have been one of them. The DON indicated the incident was not reported to IDOH. During an interview with the Regional [NAME] President of Operations on 10/28/25 at 9:43 a.m., he indicated he was the Administrator of the facility, on 10/5/25, and the DON had texted him and said Resident C was touching a female resident and he was unsure who the female resident was. The allegation was not reported to IDOH. During an interview with RN 1 on 10/28/25 at 10:47 a.m., she indicated she remembered, on 10/5/25, that Resident C was on 15-minute checks because he was sexually acting out towards female residents. RN 1 was unsure who the female residents were. During an interview with the DON on 10/28/25 at 12:45 p.m., she indicated she was unsure why there was no documentation in Resident C's clinical record about the incident on 10/5/25. 2. The clinical record for Resident G was reviewed on 10/28/25 at 9:40 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, generalized anxiety disorder, and depression.The Quarterly MDS assessment, dated 9/19/25, indicated Resident G was moderately cognitively impaired. During an interview with Resident G on 10/27/25 at 1:55 p.m., Resident G indicated a couple weeks ago that she was wheeling herself in her wheelchair down the hallway when Resident C came up behind her and started pushing the wheelchair. Resident G indicated Resident C took his hand and started sliding it down the front of her chest. Resident G indicated she swiped his hand away and told him to cut it out. Resident G indicated she had told a couple of staff members but were unsure of their names. Resident G indicated these sexual behaviors keep happening outside when residents were coming back in from the smoking area with Resident C, but no one ever sees it. Resident G indicated the DON had not spoken with her about this event.The abuse policy was provided by the DON on 10/27/25 at 11:00 a.m. The policy indicated if there was an allegation of abuse the Administrator would notify the IDOH. This citation relates to Intake 2644466. 3.1-28(c)

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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 - Actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	Based on interview and record review, the facility failed to complete a thorough investigation and ensure protection from further allegations of sexual abuse resulting in a second allegation of abuse where the resident experienced anxiety and fear for 3 of 6 residents reviewed for sexual abuse (Resident C, Resident B, and Resident G).Findings include:1. The clinical record for Resident C was reviewed on 10/27/25 at 10:45 a.m. The diagnoses included, but were not limited to, vascular dementia, depression, anxiety, hypertension, heart failure and epilepsy. The Quarterly Minimum Data Set (MDS) assessment for Resident C, dated 8/22/25, indicated the resident was severely cognitively impaired for daily decision making. The resident was independent with ambulation. The safety checks for Resident C, dated 10/5/25 through 10/9/25, indicated the resident was being monitored every 15 minutes for sexually acting out. There was no further documentation in the resident's clinical record pertaining to any behaviors that led to the 15-minute checks being initiated. The safety checks for Resident C, dated 10/15/25 through 10/16/25, indicated the resident was being monitored every 15 minutes for sexually acting out. A progress note for Resident C, dated 10/15/25 at 8:11 p. m., indicated a female resident reported to staff that Resident C reached over her shoulder and touched her chest when they were coming inside from a smoke break. Resident C was walking behind the female resident who was in a wheelchair propelling herself. Another resident witnessed the incident and also reported the incident to the staff. Certified Nurse Aide (CNA) 4 had taken the residents out to smoke and was inside the door holding it for other residents and did not witness what happened, but was immediately alerted once residents were all inside. The nurse immediately alerted the Director of Nursing (DON) and the Nurse Practitioner (NP). Resident C was placed on 15-minute checks and would walk back and forth by a staff member during smoking times. The progress note was electronically signed by Licensed Practical Nurse (LPN) 2. During an interview with Registered Nurse (RN) 1 on 10/27/25 at 11:40 a.m., she indicated she was the nurse, on 10/6/25, and Resident C was on 15-minute checks. RN 1 was unsure why the resident was on 15-minute checks and was unable to find any further documentation besides the 15-minute check sheet for Resident C. During an interview with the DON on 10/27/25 at 1:40 p.m., she indicated, on 10/5/25, it was reported to her that Resident C may have been doing something he should not have been doing. The DON indicated another resident reported that Resident C was being inappropriate with female residents. Resident G might have been one of them. The Social Services Director (SSD) talked with Resident G, and she denied anything happened. There were no further interviews or investigation completed regarding the allegation. During an interview with LPN 2 on 10/27/25 at 6:40 p.m., she indicated she was the nurse on 10/15/25. LPN 2 indicated Resident B reported to her that Resident C grabbed her chest and it was not the first time he had done this. Resident J also reported the incident as he had witnessed it. LPN 2 indicated she called the DON and reported it. The DON had LPN 2 put Resident C on 15-minute checks and 1-on-1 during smoke breaks. Resident B reported she felt very uncomfortable, upset, and was fearful he was going to come into her bedroom while she was asleep. LPN 2 indicated she reassured Resident B that the staff would not let Resident C come into her room and provided her with anti-anxiety medication. During an interview with the Regional [NAME] President of Operations on 10/28/25 at 9:43 a.m., he indicated he was the Administrator of the facility, on 10/5/25, and the DON had texted him and said Resident C was touching a female resident and he was unsure who the female resident was. The SSD talked to Resident G, and she did not report that anything happened. There were no other residents or staff interviewed regarding the allegation. During an interview with Resident J on 10/28/25 at 10:35 a.m., he indicated he had witnessed Resident C on two different occasions touching female residents inappropriately. Resident J indicated a few weeks ago, unsure of the date, he witnessed Resident C pushing Resident G's wheelchair and was rubbing her hair. Resident J indicated he was unable to see what else Resident C did because he was walking in front of him. Resident G told Resident J that if Resident C ever touched her like that again she would smack the s--t out of him. The other episode Resident J witnessed a couple weeks ago, unsure of date, was Resident C pushing Resident B in her wheelchair and he put his hands down her shirt and Resident J reported it to LPN 2. Resident J indicated Resident B was trying to push Resident C's hands away. Resident J indicated no one from management had interviewed him about these two incidents. The admission MDS assessment for Resident J, dated 8/5/25, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. During an interview with RN 1 on 10/28/25 at 10:47 a.m., she indicated she remembered, on 10/5/25, that Resident C was on 15-minute checks because he was sexually acting out

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to implement individualized interventions for a resident with dementia who exhibited behaviors of being sexually inappropriate towards female residents for 3 of 6 residents reviewed for abuse (Resident C, Resident B and Resident G). Findings include:A.) The clinical record for Resident C was reviewed on 10/27/25 at 10:45 a.m. The diagnoses included, but were not limited to, vascular dementia, depression, anxiety, hypertension, heart failure and epilepsy. The Quarterly Minimum Data Set (MDS) assessment for Resident C, dated 8/22/25, indicated the resident was severely cognitively impaired for daily decision making. The resident was independent with ambulation. A progress note for Resident C, dated 6/29/25 at 6:12 p.m., indicated the resident was found with his left hand inside a female resident's shirt and had her right breast in his hand and was physically moving his hand around her breast. Writer immediately intervened and separated the residents. Resident C was placed on 15-minute checks. The clinical record of Resident C indicated the resident resided on the memory care unit from 4/8/25 until 6/30/25. The resident was moved to the Long-Term Care unit on 6/30/25.The safety checks for Resident C, dated 10/5/25 through 10/9/25, indicated the resident was being monitored every 15 minutes for sexually acting out. There was no further documentation in the resident's clinical record regarding behaviors that prompted the initiation of 15-minute checks for Resident C. The safety checks for Resident C, dated 10/15/25 through 10/16/25, indicated the resident was being monitored every 15 minutes for sexually acting out. A progress note for Resident C, dated 10/15/25 at 8:11 p.m., indicated a female resident reported to staff that Resident C reached over her shoulder and touched her chest when they were coming inside from a smoke break. Resident C was walking behind the female resident who was in a wheelchair propelling herself. Another resident witnessed the incident and also reported the incident to the staff. Certified Nurse Aide (CNA) 4 had taken the residents out to smoke and was inside the door holding it for other residents and did not witness what happened, but was immediately alerted once all residents were inside. The nurse immediately alerted the Director of Nursing (DON) and the Nurse Practitioner (NP). Resident C was placed on 15-minute checks and would walk back and forth by a staff member during smoking times. The progress note was electronically signed by Licensed Practical Nurse (LPN) 2. The NP note for Resident C, dated 10/16/25, indicated the resident groped a female resident's breast. The facility was to continue to monitor the resident and keep residents separate. The plan of care for Resident C, dated 10/16/25, indicated the resident had a history of approaching female residents' and touching residents' inappropriately related to the diagnosis of vascular dementia. The interventions included, but were not limited to, administering medications as ordered, psychiatric (psych) NP to follow as needed, redirect the resident if he attempted to propel a peer while in the wheelchair back to their room, resident needed supervision during supervised smoke breaks and in the dining room, the resident was to be taken out for smoke breaks separate from other residents (dated 10/25/25), and was to be one-on-one supervision at all times (dated 10/25/25). The Kardex for Resident C provided by the Regional Nurse Consultant, on 10/29/25 at 11:10 a.m., indicated no documentation or alert for sexually inappropriate behaviors. During an interview with Registered Nurse (RN) 1 on 10/27/25 at 11:40 a.m., she indicated she was the nurse, on 10/6/25, and Resident C was on 15-minute checks. RN 1 was unsure why the resident was on 15-minute checks and was unable to find any further documentation besides the 15-minute check sheet for Resident C. During an interview with the Director of Nursing (DON) on 10/27/25 at 1:40 p.m., she indicated, on 10/5/25, it was reported to her that Resident C may have been doing something he should not have been doing. The DON indicated another resident reported that Resident C was being inappropriate with female residents. Resident G might have been one of them. The Social Services Director (SSD) talked with Resident G, and she denied anything happened. There were no further interviews nor investigation being completed. During an interview with LPN 2 on 10/27/25 at 6:40 p.m., she indicated she was the nurse on 10/15/25. LPN 2 indicated Resident B reported to her that Resident C grabbed her chest and it was not the first time he had done this. Resident J also reported the incident as he had witnessed it. LPN 2 indicated she called the DON and reported it. The DON had LPN 2 put Resident C on 15-minute checks and 1-on-1 during smoke breaks. Resident B reported she felt very uncomfortable, upset and was fearful Resident C was going to come into her bedroom while she was asleep. LPN 2 indicated she reassured Resident B that the staff would not let Resident C come into her room and provided her with anti-anxiety medication. During an interview with the Regional [NAME] President of Operations on 10/28/25 at 9:43 a.m., he indicated he was the Administrator of the facility, on 10/5/25, and