STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185208	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Manor	100 Carmel Manor Road Fort Thomas, KY 41075

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

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the facility's investigation, and review of the facility's policy, the facility failed to take steps to prevent sexual abuse from occurring for 2 of 15 sampled residents, Resident (R) 2 and R3.R2 and R3, two cognitively impaired residents, were observed having intercourse. Instead of separating the residents, staff were told to close the resident's door and provide the cognitively impaired residents privacy. Staff stated the residents were not assessed to have the ability to consent to the sexual activity, and interviews with staff revealed they did not know what to do for R2 and R3.The facility's failure to have an effective system in place to ensure residents were protected from sexual abuse is likely to cause serious injury, impairment, or death if immediate action is not taken. Immediate Jeopardy (IJ) was identified on 07/17/2025 at 42 CFR 483.12 Freedom From Abuse, Neglect, and Exploitation (F600) at the highest Scope and Severity (S/S) of a J. Substandard Quality of Care (SQC) was identified at 42 CFR 483. 12 Freedom from Abuse, Neglect, and Exploitation (F600). The IJ was determined to exist on 06/30/2025. The facility was notified of IJ on 07/17/2025. An acceptable IJ Removal Plan was received on 07/24/2025, which alleged removal of the IJ on 07/24/2025. The State Survey Agency (SSA) validated the IJ was removed on 07/24/2025, prior to exit on 07/24/2025. Non-compliance remained in the area of 42 CFR 483.12 Free from Abuse, Neglect, and Exploitation (F600) at a S/S of a D while the facility monitors the effectiveness of systemic changes and quality assurance activities.The findings include:Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated 03/31/2025, revealed an immediate investigation was warranted when suspicion or reports of abuse, neglect, or exploitation occurred. Further review revealed efforts would be made to ensure all residents were protected from physical and psychological harm as well as additional abuse during and after the investigation. Review of the State Survey Agency, intake Information, titled Entity Self-Reported allegation of Resident/Patient/Client Abuse, with category listed as sexual, was reported on 07/01/2025 at 5:09 PM via E-mail. Further review revealed two residents with cognitive impairment were found disrobed under blankets. Continued review of the intake information revealed the residents were immediately separated and one resident was placed on 1:1; and initial assessment of both residents found no evidence of any injury. Review of the final report Facility Internal Investigation [FII], dated 07/07/2025 at 4:45 PM, initial report dated 07/01/2025 at 5:00 PM, revealed on 06/30/2025, no time given, staff and the Administrator became aware of the incident between R2 and R3, and the physician and the families were notified on 07/01/2025, no time given. Additional review of the FII indicated no other notifications were made on 06/30/2025. The findings of the FII revealed both residents were found disrobed under blankets; they were immediately separated; R2 was then placed on 1:1 monitoring; and R2 and R3 had no injuries. Further review revealed the FII findings concluded sexual abuse did not occur based on staff interviews, stating the residents were able to voice understanding and consequences of their activity. The State Survey Agency (SSA), however, determined through observation, interviews, and record review that R2 and R3 were observed on 06/30/2025, earlier during the day, to be holding hands, hugging, and kissing on each other and was redirected by staff throughout the day. Later in the evening, staff found R2 in R3's room and they were observed having sex. Instead of separating the residents, LPN5 told staff to let them finish, clean them up, and provide supervision later. The residents were allowed to continue for another 15 minutes before STNA13 separated the residents. Though R2 was placed on 1:1 supervision, the supervision did not last and had not been cared planned, which placed R2 and other residents at risk for continued abuse. The facility's report addresses the residents being able to consent, however, there was no documentation to support the residents were assessed to be capable of consenting. Further, the facility waited two days before reporting the allegations to State Agencies, which should have occurred immediately, but no later than two hours.Review of taped audio conversation sent to the SSA by the facility's staff [STNA13] via text on 07/21/2025 at 7:49 AM revealed, the DON's instructions to staff related to their statements. The DON stated this was an open investigation. The DON stated staff could not speak to anyone, and it was serious. The DON stated not to make any assumptions and give nothing but facts. During continued listening of the taped audio conversation, one employee asked if she should put in the comment from the nurse telling them to shut the door and let them finish. The DON stated, absolutely not. The DON stated this was a dementia unit, and staff was to keep residents safe and provide a safe environment. The DON stated if staff placed that in their statement it would open another can of worms. 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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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 0607 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, review of the facility's investigation, review of the facility's job descriptions, and review of the facility's policy, the facility failed to develop and implement policies and procedures to prohibit and prevent abuse and failed to establish policies and procedures to thoroughly investigate allegations of abuse for 2 of 15 residents, Resident (R) 2 and R3. R2 and R3, both cognitively impaired, were observed having sexual intercourse.Additionally, the facility failed to promote a culture of safety and open communication in the work environment through prohibiting retaliation against an employee for reporting abuse. The facility's failure to have an effective system in place to ensure residents were protected from sexual abuse is likely to cause serious injury, impairment, or death if immediate action is not taken. Immediate Jeopardy (IJ) was identified on 07/17/2025 at 42 CFR 483.12 Freedom From Abuse, Neglect, and Exploitation (F607) at the highest Scope and Severity (S/S) of a J. Substandard Quality of Care (SQC) was identified at 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F607). The IJ was determined to exist on 06/30/2025. The facility was notified of IJ on 07/17/2025. An acceptable IJ Removal Plan was received on 07/24/2025, which alleged removal of the IJ on 07/24/2025. The State Survey Agency (SSA) validated the IJ was removed on 07/24/2025, prior to exit on 07/24/2025. Non-compliance remained in the area of 42 CFR 483.12 Free from Abuse, Neglect, and Exploitation (F607) at a S/S of a D while the facility monitors the effectiveness of systemic changes and quality assurance activities.Cross-reference F600The findings include:Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated 03/31/2025, revealed an immediate investigation was warranted when suspicion or reports of abuse, neglect, or exploitation occurred. Further review revealed efforts would be made to ensure all residents were protected from physical and psychological harm as well as additional abuse during and after the investigation. Additional review revealed the procedures included reporting all alleged violations to the Administrator, state agency, adult protective services (APS), and other required agencies, such as law enforcement, immediately but not later than two hours after the allegation was made.Review of the facility's job description Nursing Assistant Job Description and Performance Appraisal, revision date 07/2023, revealed staff would strive for excellence in performance and adherence to professional and regulatory standards. Further review revealed the job summary included to ensure the highest degree of quality resident care was delivered to residents, including recognition and reporting a resident's change of condition. The nursing assistant job duties included reporting all allegations of abuse, neglect, mistreatment, and misappropriation, and making any required reports and statements within required timeframes while keeping residents safe. The job description revealed the nurse aide worked within the scope of practice for the state of practice and followed established policies and procedures at all times. Review of the facility's document, Job Description and Performance Appraisal Administrator, dated 03/2023, revealed the Administrator was responsible for assuring the highest degree of quality resident care was delivered at all times. Further review revealed the Administrator maintained responsibility for all accident and incident report investigations and reviewed and ensured timely reporting when necessary to maintain the effectiveness of the facility's risk management program. Additional review revealed the Administrator was to act with integrity and honesty in all matters and demonstrated uncompromising adherence to ethical principles and organizational values.Review of the facility's final report Facility Internal Investigation (FII), dated 07/07/2025 at 4:45 PM, the initial report was dated 07/01/2025 at 5:00 PM, revealed the date staff and the Administrator was made aware of the incident between R2 and R3 was 06/30/2025, no time given. Per the report, the physician and families were notified 07/01/2025, no time given. Additional review indicated no other notifications were made on 06/30/2025. The report revealed both residents were found disrobed under blankets, they were immediately separated, R2 was then placed on 1:1 supervision, and R2 and R3 had no injuries. Per the report, it concluded sexual abuse did not occur based on staff interviews, stating the residents were able to voice understanding and consequences of the activity. Additional review revealed both residents willingly engaged in the activity and had the ability to consent as determined by the Interdisciplinary team (IDT), Nurse Practitioner (NP), and counselor [therapist]. Continued review revealed the resident representatives agreed and consented to participation in an intimate relationship, and the facility would re-evaluate the residents' capacity to consent as needed. Per the report, the reporting party was the Administrator, and the residents' care plans were to be reviewed and updated. The State Survey Agency (SSA), however, determined through observation, interviews, and record review

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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 observation, interview, record review, review of the facility's job descriptions, review of the facility's investigation, and review of the facility's policy, the facility failed to ensure, in response to an incident of witnessed sexual abuse, it had evidence of a thorough investigation, to include reporting the incident to the state agency timely, and protecting the residents during and after the investigation for 2 of 15 sampled residents, Resident (R) 2 and R3. On 06/30/2025, R2 and R3 were found by staff in R3's bed naked. The residents were not separated immediately, and based on interview, the room door was closed. Review of medical records and interviews revealed immediate assessments had not been performed. Additional review and interview revealed the families and medical providers of R2 and R3, authorities, and state agencies had not been contacted immediately on 06/30/2025.The facility's failure to have an effective system in place to ensure residents were protected from sexual abuse is likely to cause serious injury, impairment, or death if immediate action is not taken. Immediate Jeopardy (IJ) was identified on 07/17/2025 at 42 CFR 483.12 Freedom From Abuse, Neglect, and Exploitation (F610) at the highest Scope and Severity (S/S) of a J. Substandard Quality of Care (SQC) was identified at 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F610). The IJ was determined to exist on 06/30/2025. The facility was notified of IJ on 07/17/2025. An acceptable IJ Removal Plan was received on 07/24/2025, which alleged removal of the IJ on 07/24/2025. The State Survey Agency (SSA) validated the IJ was removed on 07/24/2025, prior to exit on 07/24/2025. Non-compliance remained in the area of 42 CFR 483.12 Free from Abuse, Neglect, and Exploitation (F610) at a S/S of a D while the facility monitors the effectiveness of systemic changes and quality assurance activities.Cross reference F600The findings include:Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated 03/31/2025, revealed an immediate investigation was warranted when suspicion or reports of abuse, neglect, or exploitation occurred. Further review revealed efforts would be made to ensure all residents were protected from physical and psychological harm as well as additional abuse during and after the investigation. Additional review revealed the procedures included reporting all alleged violations to the Administrator, state agency, adult protective services (APS), and other required agencies, such as law enforcement, immediately but not later than two hours after the allegation was made. Review of the facility's investigation revealed R3's Incident Report [IR], dated 07/01/2025 at 9:30 AM, revealed a male resident [R2] came into R3's room, and both were found under the sheets. Further review revealed both residents were immediately assessed for injury and distress, and the male resident was placed on a 1:1 observation.Review of the facility's investigation revealed R2's IR, dated 07/01/2025 at 9:45 AM, revealed R2 was found in a female resident's [R3] bed under sheets, residents were separated and assessed for injuries, and R2 was then placed on 1:1 supervision.Review of the State Survey Agency, intake Information, titled Entity Self-Reported allegation of Resident/Patient/Client Abuse, with category listed as sexual, was reported on 07/02/2025 at 1:07 PM via E-mail. Further review revealed two residents with cognitive impairment were found disrobed under blankets. Continued review of the intake information revealed the residents were immediately separated and one resident was placed on 1:1; and initial assessment of both residents found no evidence of any injury.Review of the facility's final report, Facility Internal Investigation (FII), dated 07/07/2025 at 4:45 PM, the initial report was dated 07/01/2025 at 5:00 PM, revealed the date staff and the Administrator was aware of the incident between R2 and R3 was 06/30/2025, no time given. Per the report, the physician was notified on 07/01/2025, no time given. Additional review revealed no other notifications were made on 06/30/2025. Per the report, both residents were found disrobed under blankets, they were immediately separated. R2 was then placed on 1:1 supervision. The report determined sexual abuse did not occur based on staff interviews.However, review of the State Survey Agency (SSA) investigation, through observation, interviews, and record review, revealed the facility failed to conduct a thorough investigation. Interviews with staff revealed the residents were not separated immediately and though the facility's investigative documentation states R2 was provided 1:1 supervision during the investigation, additional staff was not provided to complete the 1:1 protection/supervision. Further, there was no documentation to support the residents were assessed for physical or psychosocial harm on 06/30/2025, after the incident was observed by staff. Further, the facility reported the allegation of abuse to the state survey agency on 07/01/2025 at 5:09 PM, approximately 1 day after the alleged abuse and should have reported immediately, but no later than two hours after learning of the abuse, as per the facility's policy

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 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 observation, interview, record review, and review of the facility's policies, the facility failed to develop person-centered care plan interventions for 4 of 7 sampled residents, Resident (R) 1, R2, R3, and R11. 1. The facility failed to follow interventions placed on R1's Comprehensive Care Plan [CCP] and Kardex to prevent an accident on 06/19/2025, resulting in a compound fracture of R1's right lower extremity, which required surgical intervention.2. The facility failed to develop R11's CCP with person-centered interventions to prevent falls for R11. On 07/14/2025, R11 fell out of bed and sustained a right shoulder fracture.3. The facility failed to develop R2's and R3's CCP with person-centered interventions to address the residents' behaviors, assessments, ability to consent to sexual activity, or supervision needs following the sexual encounter. R2 and R3, both cognitively impaired were found in bed naked on 06/30/2025 and engaging in sexual activity. Staff stated the residents were not assessed to have the ability to consent to the sexual activity, and interviews with staff revealed they did not know what to do for R2 and R3.The facility's failure to have an effective system in place to ensure residents' CCP were developed with person-centered interventions to protect them from sexual abuse is likely to cause serious injury, impairment, or death if immediate action is not taken. Immediate Jeopardy (IJ) was identified on 07/17/2025 at 42 CFRS483.21 Comprehensive Care Plans (F656) at the highest Scope and Severity (S/S) of a J. The IJ was determined to exist on 06/30/2025. The facility was notified of IJ on 07/17/2025. An acceptable IJ Removal Plan was received on 07/24/2025, which alleged removal of the IJ on 07/24/2025. The State Survey Agency (SSA) validated the IJ was removed on 07/24/2025, prior to exit on 07/24/2025. Non-compliance remained in the area of 42 CFRS483.21 Comprehensive Care Plans (F656) at a S/S of a G while the facility monitors the effectiveness of systemic changes and quality assurance activities.Cross reference F600 and F689The findings include: Review of the facility's policy titled, Comprehensive Care Plans, dated 02/09/2024, revealed the facility was to develop and implement a comprehensive person-centered care plan for each resident consistent with residents' rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in each resident's comprehensive assessment. Further review revealed guidelines included services would be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial wellbeing, and alternate interventions would be documented as needed. Additional review revealed the care plan could be prepared by any interdisciplinary team which included but was not limited to include registered nurses and nurse aides. Additional review revealed qualified staff responsible for carrying out interventions would be notified of their roles and responsibilities for carrying out interventions initially and when changes were made. Record review and interviews revealed Resident (R)2 and R3 resided on the Memory Care Unit (MCU) and were assessed to have severe cognitive impairment. On 06/30/2025, earlier during the day, staff reported redirecting the residents and separating the residents due to kissing, hugging, and mutual intentions. However, staff did not fully develop the residents' care plans to include increased supervision and monitoring. Later, that evening, R2 was found in R3's room, in her bed and was observed on top of R3 having sex. Licensed Practical Nurse (LPN)5 told staff to close the door and provide the residents privacy with agency nurse, LPN6 stating, Isn't that the way it is supposed to be, if residents want to have sex, I don't know what the big deal is. The residents' care plans failed to instruct staff on how to care for the cognitively impaired residents.Cross Reference F600 and F689Review of taped audio conversation sent to the State Survey Agency (SSA) surveyor by the facility's staff [STNA13] via text on 07/21/2025 at 7:49 AM revealed the Director of Nursing (DON) stated the residents were on a dementia unit and staff were to keep the residents safe and provide a safe environment. 1. a. Review of R2's Face Sheet, found in the electronic health record (EHR), revealed the facility admitted the resident on 05/30/2025 after his health declined, and his wife was unable to provide care with diagnoses to include Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and heart disease. Review of R2's Minimum Data Set [MDS], with an ARD of 06/04/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of four out of 15, which indicated the resident was severely cognitively impaired. Review of R2's 'Physician's Orders, dated 05/30/2025, revealed an order for staff to monitor behavior every shift, document, and notify physician as needed.Review of R2's Comprehensive Care Plan [CCP], dated 06/11/2025, revealed a focus was identified as R2 being at risk for behaviors related to depression, mood disorder, and Alzheimer's. Further review

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure the residents' environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents for 3 of 3 residents reviewed for accidents, Resident (R)1, R7, and R11.1) On 06/19/2025, R1 sustained a compound fracture to right lower extremity during a transfer, requiring surgical interventions. However, review of the facility's investigation, they determined it was an injury of unknow origin and the cause was unable to be determined.2) On 07/14/2025, R11 was found in her room on the floor and was transferred to local hospital. Hospital records revealed R11 sustained a broken shoulder.3) On 07/09/2025, observation during an interview with R7 revealed a medication cup with 2 pills in it on the overbed table. Additional observation revealed one pill lying on the over bed table. During an immediate interview, Registered Nurse (RN)3 stated she had not given any medication to R7, they must have been left by the previous shift.The findings include: Review of the facility's policy titled, Comprehensive Care Plans, dated 02/09/2024, revealed the facility was to develop and implement a comprehensive person-centered care plan for each resident consistent with residents' rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in each resident's comprehensive assessment. Further review revealed guidelines included services would be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial wellbeing, and alternate interventions would be documented as needed. Additional review revealed the care plan could be prepared by any interdisciplinary team which included but was not limited to include registered nurses and nurse aides. Additional review revealed qualified staff responsible for carrying out interventions would be notified of their roles and responsibilities for carrying out interventions initially and when changes were made. Record review and interviews revealed Resident (R)2 and R3 resided on the Memory Care Unit (MCU) and were assessed to have severe cognitive impairment. On 06/30/2025, earlier during the day, staff reported redirecting the residents and separating the residents due to kissing, hugging, and mutual intentions. However, staff did not fully develop the residents' care plans to include increased supervision and monitoring. Later, that evening, R2 was found in R3's room, in her bed and was observed on top of R3 having sex. Licensed Practical Nurse (LPN)5 told staff to close the door and provide the residents privacy with agency nurse, LPN6 stating, Isn't that the way it is supposed to be, if residents want to have sex, I don't know what the big deal is. The residents' care plans failed to instruct staff on how to care for the cognitively impaired residents.Cross Reference F600 and F689Review of taped audio conversation sent to the State Survey Agency (SSA) surveyor by the facility's staff [STNA13] via text on 07/21/2025 at 7:49 AM revealed the Director of Nursing (DON) stated the residents were on a dementia unit and staff were to keep the residents safe and provide a safe environment. 1. a. Review of R2's Face Sheet, found in the electronic health record (EHR), revealed the facility admitted the resident on 05/30/2025 after his health declined, and his wife was unable to provide care with diagnoses to include Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and heart disease. Review of R2's Minimum Data Set [MDS], with an ARD of 06/04/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of four out of 15, which indicated the resident was severely cognitively impaired. Review of R2's 'Physician's Orders, dated 05/30/2025, revealed an order for staff to monitor behavior every shift, document, and notify physician as needed.Review of R2's Comprehensive Care Plan [CCP], dated 06/11/2025, revealed a focus was identified as R2 being at risk for behaviors related to depression, mood disorder, and Alzheimer's. Further review revealed the goal was for R2 to display reduction of cognitive behaviors. Further review of the resident's care plan revealed it had not been fully developed to include monitoring or supervision of the resident for his behaviors, as noted in the resident's physician's orders.Review of R2's Health Status Note, dated 06/30/2025 at 10:57 AM, in the progress notes, revealed LPN5 charted R2 was encouraged and redirected from a female resident, for mutual walks and sitting together. On the same day at 4:59 PM, LPN5 charted R2 was redirected from a female resident from walking and sitting together. Though staff redirected the resident from a female resident on 06/30/2025, his care plan was not fully developed to include increased supervision and monitoring of his observed behaviors. Review of R2's Behavior Note, dated 06/30/2025 at 9:25 PM, in the progress notes, revealed LPN6 charted that R2 was in his room at this time with a sitter on 1:1 supervision. The note stated there was an earlier incident with him going into a

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	185208	A. Building B. Wing	07/24/2025

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Carmel Manor	100 Carmel Manor Road Fort Thomas, KY 41075

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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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, the facility failed to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable, physical, mental, and psychosocial well-being of each resident by failing to follow the abuse policy and procedures related to protecting residents and conducting a thorough investigation of abuse after two cognitively impaired residents were observed having sexual intercourse, Resident (R) 2 and R3.On 06/30/2025, R2 and R3 were found in R3's bed naked, engaging in sexual activity, and neither had been assessed for ability to consent to activity.The facility's failure to have an effective system in place to ensure residents were protected from sexual abuse is likely to cause serious injury, impairment, or death if immediate action is not taken. Immediate Jeopardy (IJ) was identified on 07/17/2025 at 42 CFR 483.70 Administration (F835) at the highest Scope and Severity (S/S) of a J. The IJ was determined to exist on 06/30/2025. The facility was notified of IJ on 07/17/2025. An acceptable IJ Removal Plan was received on 07/24/2025, which alleged removal of the IJ on 07/24/2025. The State Survey Agency (SSA) validated the IJ was removed on 07/24/2025, prior to exit on 07/24/2025. Non-compliance remained in the area of 42 CFR 483.70 Administration (F835) at a S/S of a D while the facility monitors the effectiveness of systemic changes and quality assurance activities.The findings include:Review of the facility document titled, Job Description and Performance Appraisal - Administrator, dated 03/2023, revealed the Administrator is responsible for assuring the highest degree of quality resident care is delivered at all times. Further review revealed the Administrator maintains responsibility for all accident and incident report investigations and reviews and ensures timely reporting when necessary to maintain the effectiveness of the facility's risk management program. Additional review revealed the Administrator is to act with integrity and honesty in all matters and demonstrate uncompromising adherence to ethical principles and organizational values.Review of the facility document titled, Job Description and Performance Appraisal - Director of Nursing (DON), dated 03/2023, revealed the DON is responsible for planning, organizing, developing, and directing the operations of the Nursing Services Department in accordance with local, state, and federal regulation and established home policies and procedures. Further review revealed job duties include overseeing resident accidents, incidents, and concerns and identifies potential indicators of abuse, neglect, or misappropriation daily and reports promptly to the Administrator and state agency and actively participates in a thorough investigation. Additional review revealed job duties included ensuring a robust education program that provides staff with necessary competencies.Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated 03/31/2025, revealed an immediate investigation was warranted when suspicion or reports of abuse, neglect, or exploitation occurred; and defining sexual abuse as non-consensual sexual contact of any type with a resident. Further review revealed efforts would be made to ensure all residents were protected from physical and psychological harm as well as additional abuse during and after the investigation. Additional review revealed the procedures included reporting all alleged violations to the Administrator, state agency, adult protective services (APS), and other required agencies, such as law enforcement, immediately but not later than two hours after the allegation was made. Continued review of facility policy revealed prevention measures for abuse, neglect, and exploitation included providing residents, representatives, and staff information on how and to whom they may report concerns, incidents, and grievances without the fear of retribution. Further review revealed the facility would promote a culture of safety and open communications in the work environment prohibiting retaliation against any employee who reports a suspicion of a crime. 1. Interviews and record review revealed staff were asked to change their statements when reporting allegations of abuse. Staff stated they changed their interviews out of fear of retaliation. During an interview with STNA14 on 07/11/2025 at 4:41 PM, she stated as she was rounding at the end of day shift and the beginning of her shift, on 06/30/2025, she found R2 and R3 naked in R3's bed with a sheet over them. She stated she reported to the nurses immediately. She stated once both nurses entered R3's room, LPN5 told staff to close the door and let them finish. She stated the door was closed, and the nurses went back to the nurses' station. She stated since she really did not know what to do, she did as the nurse told her. She stated the DON asked her to change her written statement and she changed her report out of fear of losing her job, adding, I just caved, cause I need a job. In an interview with STNA13 on 07/10/2025 at 12:41 PM , she stated she was told by the Director of nursing (DON) to change her statement. STNA13 stated during the

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, and review of the facility's policy, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 2 sampled residents, Resident (R) 27 and R28The findings include:Review of the CDC's guidelines titled, Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated 04/12/2024, revealed hand hygiene should be performed immediately before providing resident care and after care is completed. Further review revealed to ensure proper selection and use of personal protective equipment (PPE) based on the nature of the patient interaction and potential for exposure to blood, body fluids, and/or infectious materials.Review of the facility's policy titled, Infection Prevention and Control Plan, undated, revealed the facility maintained an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections per CDC guidelines. The policy stated its goal was to limit unprotected exposure to pathogens through the use of hand hygiene and PPE isolation precautions and improving compliance within work practices. Additionally, the policy stated that it would limit the transmission of infections associated with the use of medical equipment devices and supplies through the cleaning and disinfection of equipment.1. Review of R27's admission Record revealed the facility admitted R27 on 07/23/2025 with diagnoses that included COVID-19, epilepsy, and chronic kidney disease. R27 did not have a Brief Interview for Mental Status (BIMS) assessment as he was a new admit.Review of R27's baseline Care Plan Report, dated 07/23/2025, revealed the facility care planned the resident for a COVID-19 infection. Goals included the infection would be resolved without complications. Interventions included placing R27 in droplet isolation precautions. Additional interventions included that the resident would be redirected back to her room if she wandered out while in isolation.Review of R27's physician Order Summary Report, revealed R27 was placed in droplet isolation precautions on 07/23/2025 for COVID-19. Observation of R27's room on 07/23/2025 at 11:48 AM revealed there was no CDC signage displayed on the entrance door indicating the resident was under droplet isolation precautions. Outside of the room, there was a container holding PPE. Additionally, R27, who was diagnosed with COVID-19, was not in her room; R27 was self-ambulating in her wheelchair in the living room area and was not wearing a mask. Staff were walking in the area but did not redirect the resident back to her room until the SSA surveyor asked why the resident was not in her room.During an interview with State Tested Nursing Assistant (STNA12) on 07/24/2025 at 11:25 AM, she stated that R27 tested positive for COVID-19 and was currently in isolation in a single room. However, the STNA stated there was no droplet isolation precaution sign on the door to indicate the type of transmission-based precautions (TBP) in place. STNA12 stated she served breakfast to R27 without wearing PPE because there were no signs on the door indicating droplet precautions were in effect. Additionally, she stated that the nursing staff provided reports at the beginning of each shift, but the reports were often not detailed enough, making it difficult to get a complete understanding of the resident's status. STNA12 stated that during her orientation, she received training on infection prevention and control practices (IPCP), which included instructions for wearing gowns and gloves when providing direct care for residents under enhanced barrier (EBP) and TBP. She stated full PPE was required to enter the room of residents who were under droplet precautions.During an interview with STNA1 on 07/24/2025 at 4:49 PM, she stated she had received IPCP training upon hire and periodically throughout the year. The STNA stated that there should be a PPE bin outside all TBP rooms. She stated that she had observed there was neither a PPE container nor a sign on R27's door yesterday when the resident was admitted . She confirmed there was still no sign on the door today. Additionally, STNA1 stated R27 should remain in the room with the door closed and should not be allowed to ambulate in the hallway. When asked how she knew it was a droplet isolation room without the required CDC signage, she stated, Usually, the nurse would stop you before you entered. However, she also stated that yesterday, if the nurse had not been present, she would have entered the room because there was no sign on the door or PPE container outside of the room.During an interview with LPN2 on 07/24/2025 at 11:55 AM, she stated R27 should not be out of her room. She stated the resident had to be educated on staying in her room while she was under droplet isolation precautions. LPN2 stated staff were given report every morning on each resident's status, and all staff were made aware that R27 was

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. (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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview, record review, review of the Centers for Medicare & Medicaid Services (CMS), Center for Clinical Standards and Quality/Quality, Safety & Oversight Group's 'QSO-21-19-NH Memo'", and review of the facility's policy, the facility failed to maintain documentation of screening, education, offering, and current Coronavirus Disease 2019 (COVID-19) vaccination status for 3 of 4 sampled staff, Registered Nurse (RN) 7, Licensed Practical Nurse (LPN) 11, and LPN12.The findings include:Review of the CMS Center for Clinical Standards and Quality/Quality, Safety & Oversight Group's QSO-21-19-NH Memo, dated 05/01/2021, revealed Long-term Care (LTC) facilities must offer staff vaccination against COVID-19 when vaccine supplies were available to the facility. LTC's must screen staff prior to offering the vaccination for prior immunization, medical precautions, and contraindications to determine whether they were appropriate candidates for vaccination. Per the guidance, the vaccine might be offered and provided directly by the LTC facility or indirectly, such as through an arrangement with a pharmacy partner, local health department, or other appropriate health entity.Review of the facility's policy titled, Infection Prevention and Control Plan, undated, revealed the facility would implement and maintain an active organization wide program for the prevention control and investigation of infections and communicable diseases to reduce the risk of infections in residents, and health care workers. Per the policy, the employee health program would include education and monitoring of staff for COVID-19 immunizations to minimize the risk of acquiring transmitting disease. 1. Review of RN7's employee file revealed no documented evidence noting RN7 was offered the COVID-19 vaccination. Additionally, there was no documentation that education regarding the benefits, risks, and potential side effects of the vaccine was provided to the employee. RN7 was unavailable for interview.2. Review of LPN11's employee file revealed no documented evidence the facility had provided LPN11 with education regarding the benefits, risks, and potential side effects of the COVID-19 vaccination. LPN11 was unavailable for interview.3. Review of LPN12's employee file revealed no documented evidence the facility had provided LPN12 with education regarding the benefits, risks, and potential side effects of the COVID-19 vaccination.LPN12 was unavailable for interview.During an interview with State Tested Nursing Assistant (STNA) 12 on 07/24/2025 at 11:25 AM, she stated she had not been educated about or asked regarding her COVID-19 vaccination status. She further stated she had not signed any forms related to this issue and was not required to present a COVID-19 vaccination card or sign any documentation.During an interview with the Medical Director on 07/24/2025 at 1:00 PM, she stated it was only her second day in the facility and that she could not answer questions without further reviewing the policies. However, she stated following CDC guidelines was important for the safety and well-being of residents and staff.During an interview with the Interim Director of Nurses (IDON)/Infection Preventionist (IP) on 07/22/2025 at 10:48 AM, she stated the facility followed the recommendation of the Centers for Disease Control and Prevention (CDC) for all immunizations and vaccines but had not provided education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine immunization education to all its employees. Furthermore, she stated she did not have documentation for staff related to the employee's COVID-19 vaccine education documentation. The IDON/IP stated it was important for the facility to educate staff about and offer the COVID-19 vaccine. Additionally, the IDON/IP stated the facility should maintain documentation of each staff member's immunization status or their decision to decline the vaccine in their personnel files. She stated the importance of adhering to the CDC's guidelines for infection prevention and control to help prevent the spread of diseases and infections.During an interview with the Interim Administrator on 07/24/2025 at 7:28 PM, she stated it was important that the facility maintained the appropriate documentation to reflect that it provided the required COVID-19 vaccine education to employees to comply with CDC recommendations and adhere to the facility's infection control program. She stated the IP Nurse was responsible for infection control oversight, but everyone must follow policies. She stated further that following policy and CDC guidelines was important for the safety of residents and staff.