STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185232	A. Building B. Wing	01/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Health Center Corbin	116 South Commonwealth Avenue Corbin, KY 40702

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policies, the facility failed to ensure that one (Resident (R) 93) of 13 sampled residents reviewed for abuse was free from abuse by another resident (R12). The facility was aware that R12 exhibited escalating behaviors toward staff and other residents, including entering other residents' rooms, physical sexual contact, and aggression since at least 08/2025. Despite documented identification of R12's ongoing behaviors, the facility failed to develop a comprehensive care plan to reflect the behaviors, so as to implement consistent behavioral interventions to protect other residents. On 01/05/2026, R12 touched and physically restrained R93 in her bed, causing R93 psychosocial harm with emotional distress and fear. The facility's failure to protect residents from abuse by promptly recognizing, assessing, and intervening to address known behaviors, resulted in Immediate Jeopardy as the deficient practice created a situation likely to cause serious harm to residents. Immediate Jeopardy (IJ) was identified on 01/17/2026 at 42 CFR S483.12 (Free from Abuse and Neglect -F600). The IJ at F600 also constituted Substandard Quality of Care (SQC) at 42 CFR 483.12. The IJ was determined to exist on 01/05/2026 when Licensed Practical Nurse (LPN) 1 observed R12 in R93's room, positioned over R93, with one hand holding the resident's hands down and the other hand placed on the resident's left shoulder, pushing her back into her bed while attempting to get on top of her. On 01/17/2026, the Executive Director (ED), Director of Nursing (DON) and Social Services Director (SSD)/Assistant ED were provided a copy of the Centers for Medicare and Medicaid Services (CMS) Immediate Jeopardy (IJ) Template and was notified of the failure to ensure each resident was free from abuse is likely to cause serious injury, harm, impairment, or death to a resident. The facility provided an acceptable IJ removal plan on 01/19/2026. This plan alleged the IJ was removed on 01/19/2026. An Extended Survey was conducted on 01/18/2026-01/19/2026. During this survey, on 01/19/2026, the State Survey Agency (SSA) validated the immediacy of the IJ, which was removed on 01/19/2026 as alleged. The deficient practice remained at a scope and severity of Level 2 - Isolated (D) following the removal of the immediate jeopardy.Findings include:Review of the facility's policy titled Abuse Reporting and Prevention, reviewed 07/2025, revealed abuse included physical, verbal, mental, and sexual abuse, involuntary seclusion, and mistreatment and applied to abuse perpetrated by any individual, including other residents. Further review of this policy revealed that it defined sexual abuse as nonconsensual sexual contact of any type with the resident. The policy further noted that the facility must evaluate if the resident has the capacity to consent to physical intimacy/sexual activity. Per the policy, this evaluation must be documented in the nurses' notes, clearly outlining how a decision of intimacy was determined. A review of the facility's Resident-to-Resident Altercation Guidelines, included within the Abuse Reporting and Prevention policy, revealed the policy categorized resident-to-resident altercations as mental/verbal conflict, sexual contact, and physical altercations, and identified specific circumstances that are (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: 185232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/19/2026
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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	considered reportable. The policy states that under physical altercations, Any willful act that results in physical injury, mental anguish and/or pain was reportable. The policy further states that A resident-to-resident altercation should be reviewed as a potential situation of abuse, and cautions staff to not automatically assume that abuse did not occur, especially in cases where either or both residents have a cognitive impairment or mental disorder. The policy also states that Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions. The policy further revealed when behaviors related to a resident-to-resident altercation were present, An assessment of the resident and care planned interventions must be conducted. The policy revealed Redirection alone is not a sufficiently protective response to a resident who will not be deterred from targeting other residents for abuse once he/she has been redirected. The policy further revealed staff should monitor for and respond to any behaviors that may provoke a reaction by residents or others, including verbally aggressive behavior, physically aggressive behavior, sexually aggressive behavior, taking or rummaging through others' property, and wandering into other residents' rooms or space.Review of the Electronic Medical Record (EMR) revealed the facility admitted R12 on 09/25/2024 with multiple diagnoses, including schizophrenia. A review of R12's annual (comprehensive) Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 08/27/2025, revealed R12 had a Brief Interview for Mental Status (BIMS) score of 9/15, which indicated R12 had moderate cognitive impairment. The MDS documented that the resident had diagnoses including schizophrenia, anxiety, and depression. Per this MDS, the resident had no physical or verbal behavioral symptoms directed toward others. In addition, the MDS showed no hallucinations, delusions, or any other type of behaviors, such as rejection of care, wandering, or behaviors not directed towards others during the seven-day look back period ending on 08/27/2025. Section V of the MDS, which included the care planning summary, documented that behavioral symptoms did not trigger and this care area was not care planned.Review of R12's comprehensive care plan created in response to the 08/27/2025 MDS confirmed that a problem of behaviors was not care planned at the time of the annual comprehensive assessment.Although the 08/27/2025 MDS documented no behaviors and this area was not care planned, review of facility documentation revealed that the facility was aware of ongoing behaviors prior to this assessment. These included:a. Review of a Psychiatric Evaluation, Date of Service 08/15/2025, documented R12 had a known history of sexually inappropriate behavior and aggression, with staff reporting that R12 has a history of sexual inappropriate behavior and aggression and continued to display psychiatric symptoms including psychosis, delusions, paranoia, irritability, and agitation. The evaluation included a treatment plan directing staff to notify providers of any inappropriate sexually acting out behaviors in which redirection was unsuccessful and potentially put others at risk for harm.b. A review of a Psychiatric Periodic Evaluation, Data of Service 08/22/2025 (during the MDS look-back period), documented R12 had a history of impulsive behavior including sexually inappropriate behavior, increased aggression toward staff and other residents, yelling, physical contact with other residents, and attempts to enter other residents' rooms. Staff were noted to have attempted redirection, which was often ineffective.c. A review of a Behavioral Nursing Note, dated 08/24/2025 (during the MDS look-back period) revealed R12 was noticed by nurse to be pushing a female resident down the hallway to the female resident's room, and the nurse rerouted the residents to the dining room to sit. The residents then were found following one another back down the hallway, attempting to go back to the female resident's room together.After the failure to identify and care plan behaviors in response to annual Resident Assessment Instrument (RAI) conducted in 08/2025, R12 continued to display behaviors. These included:Review of a Psychiatric Periodic Evaluation, Date of (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Service 09/05/2025, documented R12 was being monitored for impulsive behavior, including sexually inappropriate behavior. The history of present illness noted that R12 continued to experience sexually inappropriate behavior at times, despite pharmacological interventions, and staff reported ongoing behavioral concerns. The Nurse Practitioner (NP)13 recommended staff to monitor for changes in mood and behaviors.Review of a behavioral nursing note, dated 09/21/2025, revealed that when a Certified Nurse Aide (CNA) entered R12's room, the resident got a hold of the CNAs arm and tried to put his arms around her. The CNA backed away from the resident and went out of the room. Then R12 came out in hallway without his walker, trying to get the CNA to come back into his room. R12 got upset when CNA would not go back to his room.A review of a Psychiatric Periodic Evaluation, Date of Service 10/03/2025, documented R12 continued to experience sexually inappropriate behavior at times, requiring ongoing monitoring.A review of R12's quarterly MDS assessment, with an ARD of 10/19/2025, revealed the facility continued to document R12 as having no behavioral symptoms. Review of R12's comprehensive care plan revealed that it continued to not address resident behaviors. A review of the facility's Behavior Review Committee documentation for R12 revealed the facility was aware of ongoing behavioral concerns. Documentation dated 11/18/2025 identified R12 with diagnoses including schizophrenia, anxiety, and dementia, and documented behaviors described as episodes of touching female caregivers inappropriately, with triggers identified as touching female caregivers during personal care. The documentation reflected that R12 was reviewed by the Behavior Committee and that recommendations included remind [R12] his behavior is inappropriate, redirect, and encourage activities and choices. However, the documentation did not include evidence of increased supervision, care approach modifications, staff assignment changes, or other protective interventions implemented to prevent further targeting of others. Additionally, the documentation did not reflect evaluation of the effectiveness of the interventions or revision of the care plan when behaviors persisted.A review of a Psychiatric Periodic Evaluation, Date of Service 11/21/2025, revealed R12 continues to exhibit episodes of aggressive behavior along with ongoing mood instability, irritability and psychotic symptoms. The evaluation further documented R12 was at risk for sexually acting out. The evaluation noted that information was obtained from chart review and nursing staff.Review of a written statement by the DON, dated 12/29/2025, revealed R12 went across the hall and stated he was just going to talk to the resident. Continued review revealed R12 entered R93's room, and R93 advised that R12 had entered her room before. Although facility documentation revealed staff knowledge for R12's behaviors over a multi-month period, review of the R12's Care Plan revealed the facility failed to develop a comprehensive care plan regarding R12's inappropriate behaviors until 01/09/2026, after R12 abused R93 and physically restrained her in bed on 01/05/2026. (Refer to F656.)Review of the EMR for R93 revealed the resident was admitted to the facility on [DATE] with diagnoses including dementia and anxiety disorder. Review of R93's quarterly MDS, with an ARD of 10/28/2025, revealed R93 had a BIMS score of 6/15, which indicated R93 was severely cognitively impaired. Review of R93's nurses notes revealed no evidence that the resident was assessed, per facility policy, for the ability to consent to sexual contact, and no such determination was recorded. Review of R93's comprehensive care plan, effective 02/19/2025 through present, also revealed no evidence that the severely cognitively impaired resident was assessed or care planned as able to provide informed consent for sexual contact.A review of a nursing progress note dated 01/05/2026, authored by LPN1, reflected R93 and the resident's family member (FM)2, had ongoing concerns regarding resident safety and fear related to another resident. The note documented that R93 was observed to be very anxious and crying, stating that there were three men outside her door on a rock who were there to harm her. The resident required reassurance that No man would be (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	coming into her room to harm her. FM2 reported that each time R12 walked by, R93 would state He's here, he's here to hurt me. LPN2 documented that the resident was made to feel uncomfortable and scared by R12, and the concern was reported to the social worker. The documentation did not reflect implementation of immediate protective interventions, supervision measures, or environmental controls to prevent continued distress or potential harm.A review of an undated written statement authored by LPN1 revealed that while administering medications in another resident room, CNA1 alerted her that R12 was attempting to enter another resident's room and had been redirected. LPN1 then observed R12 in R93's room, positioned over R93, with one hand holding the resident's hands down and the other hand placed on the resident's left shoulder, pushing her back into the bed while attempting to get on top of her. LPN1 reported that when she asked R12 what he was doing, he did not respond, and she instructed him to leave the room. LPN1 advised R12 he was not allowed in R93's room, at which time he stated, Ok, I know, and returned to his room.A review of a written statement authored by the SSD/Assistant ED, dated 01/05/2026, documented an interview conducted with R12 regarding his entry into a female resident's (R93) room. The SSD/Assistant ED documented R12 admitted entering the female resident's room, stated he touched the resident's arm, and acknowledged that the resident had a startled reaction as a result. The statement further noted that R12 had previously visited the female resident, and although he denied sexual intent, the intervention implemented consisted of verbal instruction advising R12 not to enter female residents' rooms, especially at bedtime.A review of a Behavior Note dated 01/07/2026 at 10:29 AM, entered by LPN2, revealed R93 was observed to be very upset and crying, stating she needed to leave the facility and go home. When asked the reason for her distress, R93 stated she was fearful of that man coming into her room again, referring to R12. R93 further stated she felt uncomfortable and no longer wanted to stay at the facility. LPN2 documented that nursing staff attempted to redirect and reassure R93 by sitting with her and assuring her that no one would enter her room; however, the redirection was only temporarily effective, lasting a few minutes before R93 began crying again. A review of a Psychiatric Periodic Evaluation for R93, Date of Service 01/07/2026, revealed the resident was experiencing increased anxiety and emotional distress following the incident involving R12. Although R93 appeared calm during the evaluation, staff and family reported worsening emotional symptoms since the prior visit, including increased tearfulness, nervous behaviors, heightened anxiety, and emotional lability, particularly in the evenings and when separated from family. The evaluation further documented staff observations of increased crying, sensitivity, and anxiety over the past several weeks.Review of a Behavior Note, dated 01/16/2026, by LPN2 revealed R93 was very anxious, crying several times and stated that she need to go home and had to get out of this place.A review of Social Services documentation for R93 dated between 01/05/2026 and 01/19/2026 revealed repeated staff interventions related to emotional distress, fear, confusion, and anxiety following the incident involving R12. Documentation reflected R93 intermittently reported fear of individuals entering her room, expressed a desire to leave the facility and go home, and required frequent reassurance from Social Services staff. While some entries documented periods in which R93 appeared calm or without tearfulness, the repeated need for staff intervention, reassurance, and monitoring demonstrated ongoing emotional impact and psychological distress following the incident involving R12.During an interview on 01/07/2026 at 3:20 PM, FM2 stated that on 01/05/2026, R12 repeatedly approached R93's room, stood at the doorway, and looked inside before returning to his room across the hall. FM2 stated that R12 was also observed pacing up and down the hallway while looking into R93's room, which made FM2 feel uncomfortable. FM2 stated that she reported these concerns to LPN1 and requested that R12 be kept out of R93's room. FM2 stated that LPN1 assured her that R12 would be (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	kept out of R93's room.During an interview on 01/07/2026 at 7:37 PM, LPN1 stated that on 01/05/2026, R12 had been exhibiting unusual behavior throughout the day, including repeatedly standing in his doorway and pacing the hall while looking into R93's room before returning to his room. LPN1 stated that R93's family member observed this behavior and requested that staff ensure R12 did not enter R93's room after the family member departed. LPN1 further stated that after being notified by CNA1 that R12 entered R93's room, she immediately exited the room she was in and went to R93's room. LPN1 stated that upon entering the room, she observed R12 physically positioned over R93, with one leg raised onto the bed and actively pushing R93 down into the bed. LPN1 stated that she notified the Social Services Director (SSD) and the DON of the incident and was told the situation was speculation and advised not to make a mountain out of a molehill. LPN1 further reported that CNA1 observed R12 running rapidly across the hallway toward R93's room immediately prior to the incident, describing his movement as purposeful and urgent.During an interview on 01/07/2026 at 6:45 PM, LPN2 stated she had been informed of the incident involving R12 and R93 that occurred on 01/05/2026. LPN2 stated that on 01/06/2026, she observed R93 exit her room, appearing visibly distressed and stating that that man was in her room, referring to R12. LPN2 stated that R93 had not been observed in this level of distress previously and reported that R93 expressed that she was no longer comfortable remaining in the facility due to fear of R12. LPN2 stated that while R93 has had crying episodes in the past, the behavior observed on 01/06/2026 was different and represented a new fear response. During this interview, LPN2 further stated that multiple staff members had reported to her that R12 touched staff inappropriately, including touching buttocks and breasts and making sexual advances. LPN2 stated that although she had heard these reports on multiple occasions, she was not aware of actions taken by the administrative team to address these behaviors.During an interview on 01/09/2026 at 3:45 PM, CNA 6 stated R12 had grabbed her legs and buttocks numerous times during 12/2025, while she was providing resident care for R12's roommate. CNA 6 stated she would move R12's roommate's bed out of R12's reach to ensure R12 was not able to touch her while she was providing care to R12's roommate. CNA 6 stated the DON implemented a buddy system for female staff when entering R12's room; however, it was not documented anywhere to notify staff; was not included in the CNA Kardex (a care plan summary used by nursing staff and nurse aides as a quick reference tool for resident's care and needs); and interventions were not developed to address behaviors toward other residents.During an interview on 01/10/2026 at 12:27 PM, Speech Language Pathologist (SLP) 1 stated that while she was in R12's room, sitting in his recliner in December of 2025, R12 came out of the restroom, and walked toward her. SLP1 stated she started to stand up but was unable to because R12 was leaning over her and kissed her face. She stated she notified the Unit Manager, and, after the incident, she did not enter R12's room alone.During an interview on 01/13/2026 at 2:54 PM, R12 stated he had gone into R93's room on Thanksgiving, Christmas, and a few other times after it had gotten dark. R12 stated that when facility staff would see him in R93's room they would tell him to go back to his house.During an interview on 01/07/2026 at 1:35 PM, FM1 stated R93 and her roommate had been telling the family for several months that a man had been coming into their room. During an interview with R93's FM2 on 01/07/2026 at 3:20 PM, she stated R93 has had increased episodes of crying and asking to leave the facility because she did not feel safe because of that man. FM2 stated that R93 became more upset when R12 walked past her room. During an interview with the SSD/Assistant ED on 01/14/2026 at 4:33 PM, she stated the facility's policy for suspected abuse was to gather the information, discuss it as a team, and then decide if it should be reported to the Office of Inspector General (State Survey Agency). The SSD stated that the ED, SSD, and DON decided that the incident regarding R12 and R93 did not need to be reported (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to the appropriate agencies because they did not feel it met the definition of abuse.(Refer to F609.) Interview with the SSD/Assistant ED revealed her belief that R93, who was severely cognitively impaired, could consent to being touched.Interview with the ED, on 01/07/2026 at 2:10 PM, revealed that R12 was placed on 1:1 supervision after the incident on 01/05/2026. During an additional interview with the ED on 01/15/2026 at 5:24 PM, she stated she was the facility's abuse coordinator. She stated that she, the SSD/Assistant ED, and the DON were responsible for conducting the facility's abuse investigations. The ED stated the facility's policy included if abuse was suspected, the facility had 2 hours to report allegations to state agencies. However, she continued, there had not been any recent incidents that required reporting to the appropriate agencies, as she, the DON, and SSD/Assistant ED had not determined that abuse had occurred. Further interview with the ED revealed she was aware of different types of abuse, including physical, mental, and sexual. However, she continued, they had decided the 01/05/2026 did not rise to the level of abuse because R93 had consented to R12 being in her room, Further interview with the ED revealed the belief that R93, who was assessed as severely cognitively impaired, could consent to the male resident (R12) coming into her room and touching her. However, she could provide no evidence to support this belief. During an interview with the DON on 01/16/2026 at 1:40 PM, the DON stated behavioral care plans were expected to be reviewed and revised when an incident was reported. The DON stated that it would have been important for the facility to have a behavioral care plan in place for R12 so that staff would be aware of his care needs and behavioral risks. The DON further stated that the facility failed to document R12's behaviors in the Kardex to protect staff and residents. The DON stated she assumed the Unit Manager was updating R12's care plan and Kardex but acknowledged that she did not review either and stated that she should have. The DON stated she did not know how it was possible that R12 did not have a behavioral care plan until 01/09/2026. Further interview with the DON revealed that she had not identified this incident as abuse because of her belief that the severely cognitively impaired resident could consent to being touched.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility documentation, the facility failed to immediately report allegations and incidents of potential abuse, as well as injuries of unknown origin, to appropriate external authorities, including law enforcement and/or the State Survey Agency (SSA), in accordance with facility policy and federal regulations. This failure involved eight (Resident (R) 12, R19, R30, R67, R84, R87, R90, R93) of 13 sampled residents reviewed for abuse. The failure to immediately report allegations as required included a witnessed incident on 01/05/2026 when R12, who had a history of sexual behaviors, physically restrained R93 in her bed, causing R93 psychosocial harm with emotional distress and fear. The facility's failure to immediately report all allegations of abuse resulted in Immediate Jeopardy as the deficient practice created a situation likely to cause serious harm to residents.Immediate Jeopardy (IJ) was identified on 01/17/2026 at 42 CFR S483.12 (Freedom from Abuse, Neglect, and Exploitation -F609) at the highest scope and severity S/S of a J. The IJ at F609 also constituted Substandard Quality of Care (SQC) at 42 CFR 483.12. The IJ was determined to exist on 01/05/2026 when the facility failed to immediately report an allegation of abuse when R12 was witnessed physically restraining R93 in her bed.On 01/17/2026, the Executive Director (ED), Social Services Director (SSD)/Assistant ED, and Director of Nursing (DON) were provided with a copy of the CMS IJ Template and notified that the failure to ensure allegations of abuse, as exhibited by the 01/05/2026 incident involving R12 and R93, were immediately reported to all required parties, constituted immediate jeopardy at F609.An Extended Survey was conducted on 01/18/2026 - 01/19/2026. The facility presented an acceptable plan for removal of the IJ on 01/19/2026. On 01/19/2026, the survey team validated the immediate jeopardy was removed on 01/19/2026 as alleged, following the facility's implementation of the plan for removal of the immediate jeopardy. The deficient practice remained at a D (isolated with potential for minimal harm) scope and severity following the removal of immediate jeopardy.Findings include:Review of the facility's policy titled Abuse Reporting and Prevention, reviewed 07/2025, revealed abuse includes physical, verbal, mental, and sexual abuse, neglect, involuntary seclusion, and mistreatment, and applies to abuse perpetrated by any individual, including other residents.Continued review of the facility's policy revealed that All facility staff are required to report any observation, suspicion or information otherwise obtained related to possible abuse to their supervisor, Department Head or Executive Director (ED), or designee, immediately. The policy further revealed This requirement relates to abuse of any kind by anyone. Additionally, the policy stated, The Executive Director, or designee, reports the incident to the appropriate state agencies and initiates an in-house investigation. The policy noted that, All alleged abuse (verbal, mental, sexual, and physical) must be reported within two hours of becoming aware of the incident or allegation.A review of the facility's Resident-to-Resident Altercation Guidelines, included within the Abuse Reporting and Prevention policy, revealed the policy categorizes resident-to-resident altercations as mental/verbal conflict, sexual contact, and physical altercations, and identified specific circumstances that were considered reportable. The policy stated that under physical altercations, Any willful act that results in physical injury, mental anguish and/or pain is reportable. 1. A review of an undated written statement authored by Licensed Practical Nurse (LPN) 1 revealed that she observed R12 (a male resident) in the room of R93 (a female resident assessed as severely cognitively impaired, per a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/28/2025). LPN1 stated R12 was positioned over R93, with one hand holding the resident's hands down and the other hand placed on the resident's left shoulder, pushing her back into the bed while attempting to get (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	on top of her. (Refer to F600.)Interview with LPN1, on 01/07/2026 at 7:37 PM, revealed that the incident described in the undated written statement occurred on 01/05/2026. According to LPN1, upon entry to R93's room, she observed R12 physically positioned over R93, with one leg raised onto the bed and actively pushing R93 down into the bed. LPN1 stated that she notified the SSD/Assistant ED and the DON of the incident and was told the situation was speculation and advised not to make a mountain out of a molehill. LPN1 stated when she reported behaviors of residents to facility management, she felt the concerns were swept under the rug, were not addressed, and were not reported to the appropriate agencies.Review of facility documentation and SSA records revealed no evidence that the allegation, which LPN1 witnessed and reported to the DON and SSD/Assistant ED was reported to any outside agencies, including law enforcement and/or the SSA.During an interview with the SSD/Assistant ED on 01/14/2026 at 4:33 PM, she stated the facility's policy for suspected abuse was to gather the information, discuss it as a team, and decide if it should be reported to the Office of Inspector General (SSA). The SSD/Assistant ED stated that the team, which also included the ED and DON, decided that the incident between R12 and R93 did not need to be reported to the appropriate agencies because they did not feel it met the definition of abuse, explaining her belief that R93, who was assessed as severely cognitively impaired, could consent to being touched.Interview with the ED, on 01/15/2026 at 5:24 PM, revealed she was the facility's abuse coordinator and was aware of different types of abuse, including physical, mental, and sexual. She stated that she, the SSD/Assistant ED, and the DON, were responsible for conducting the facility's abuse investigations. The ED stated the facility's policy included if abuse was suspected, the facility had 2 hours to report allegations to state agencies. However, she continued, there had not been any recent incidents that required reporting to the appropriate agencies, as she, the DON, and SSD/Assistant ED had not determined that abuse had occurred. Regarding the failure to report the allegation that R12 abused R93, the ED stated they had decided the 01/05/2026 incident did not rise to the level of abuse because R93 had consented to R12 being in her room. Further interview with the ED revealed the belief that R93, who was assessed as severely cognitively impaired, could form consent to the male resident (R12) coming into her room and touching her. However, she could provide no evidence to support this belief. During an interview with the DON on 01/16/2026 at 1:40 PM, the DON stated that she was unsure whether the incident involving R12 and R93 should have been reported to reporting agencies or law enforcement, explaining that she had not identified this incident as abuse because of her belief that the severely cognitively impaired resident could consent to being touched. However, after a review of the facility's Abuse and Reporting Policy, the DON stated that one of the facility leadership members (ED, DON, or SSD/Assistant ED) should have reported the incident. The DON confirmed that incidents involving alleged sexual misconduct between residents should be reportedDuring an additional interview on 01/17/2026 at 11:11 AM, the ED further stated she often reached out to corporate for direction.Interview on 01/17/2026 at 2:49 PM with the Director of Clinical Reimbursement (DCR - a corporate representative) revealed that if the facility feels they have an occurrence of abuse, they will contact the corporate team and ask their opinion. She further stated an allegation of abuse should be reported to state agencies within two hours; however, she was aware the facility would investigate and see what happened before reporting. The facility, with corporate input, determines what abuse is. Although the DCR confirmed that allegations of abuse were to be reported within two hours, the DCR indicated it was the next day (more than two hours) before the facility contacted the Chief Executive Officer for guidance about the alleged incident between R12 and R93. Per the DCR, at this time it was determined to not be a reportable allegation, adding, We did not see that any abuse had occurred.I would not consider it a (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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	reportable offense if it was just touching. 2. Review of a notepad document, with Investigation written on the page, which was dated 12/26/2025 at 12:30 PM and authored by the DON, revealed R90 was found in the floor in her room by a laundry aide. R90 stated that her roommate pushed her down.During an interview on 01/16/2026 at 11:14 AM with Laundry Aide (LA) 1, she stated that upon entering R90's room, R90 was lying on the floor between the bed and recliner. LA 1 stated she went to R90, who stated her roommate (R67) had pushed her down. LA1 stated she immediately reported to the nurse on duty.Review of facility documentation and SSA records revealed no evidence that R90's allegation of abuse by her roommate (R67) was reported to the SSA as required. 3. Review of R30's Face Sheet revealed she was admitted to the facility on [DATE] with diagnoses of delusional disorders, and spondylosis (age-related spinal degeneration). Review of R30's MDS, with an ARD of 11/04/2025, revealed a Brief Interview for Mental Status (BIMS) score of 7/15, which indicated severe cognitive impairment.Review of an incident report, dated 01/01/2026 at 2:07 PM, revealed R30 was noted to have dark, purple bruising to her inner left thigh down to her knee and a small bruise to the outer of her left thigh. R30 was unable to state the cause of the bruising. Review of facility documentation and SSA records revealed no evidence that this injury of unknown origin was reported to the SSA as required. 4. Review of R19's Face Sheet revealed she was admitted to the facility on [DATE] with diagnoses of dementia, cerebral infarct and contractures. Review of R19's MDS, with an ARD of 06/09/2025 revealed a BIMS score of 3/15, which indicated R19 was severely cognitively impaired.A review of a handwritten statement, dated 07/16/2025 and authored by the DON, revealed R19 had a bruise to the left outer knee, pale yellow in color. The statement noted an incident ten days earlier (07/06/2025) when R19 was aggressive with staff and hit her hand (not her knee) on the table. Registered Nurse (RN) 1 had noted that on 07/06/2025 during the incident, R19 had been kicking her legs but RN1 did not witness R19 kicking anything.Review of facility documentation and SSA records revealed no evidence that this injury of unknown origin was immediately reported to the SSA as required at the time it was first identified. 5. Review of R87's Face Sheet revealed he was admitted to the facility on [DATE] with diagnoses of Alzheimer's, atrial fibrillation and impulse disorder. Review of R87's Quarterly MDS, with an ARD of 09/09/2025, revealed staff assessed the resident as severely cognitively impaired.Review of a handwritten notepad document dated 12/12/2025 at 5:00 PM, with Investigation written on the page, revealed the DON was made aware of a bruise to R87's right eye/cheek area. Although the DON ultimately made the determination that the root cause was R87 was rubbing his face, review of facility documentation and SSA records revealed no evidence that R87's injury of unknown origin was immediately reported to the SSA as required at the time it was first identified. 6. Review of R84's Face Sheet revealed she was admitted to the facility on [DATE] with diagnoses of Parkinsons, contractures of the muscles and neurocognitive disorder with Lewy bodies.Review of a handwritten notepad document dated 01/12/2026 at 10:15 AM and authored by the DON, revealed staff reported to her that R84 had a bruise to left upper arm. Although the DON conducted interviews with staff and ultimately concluded no suspicion of abuse, review of facility documentation and SSA records revealed no evidence that R84's injury of unknown origin was immediately reported to the SSA as required at the time it was first identified. During an interview on 01/14/2026 at 4:33 PM with the SSD/Assistant ED, she stated that she, the ED, and DON, reviewed the incidents detailed in Examples #2- #6 (which included injuries of unknown origin and an allegation of resident-to-resident physical abuse) and determined they did not need to be reported to the appropriate agencies because they did not feel they met the definition of abuse.During an interview on 01/17/2026 at 10:20 AM, the DON stated that she was not aware that she was supposed to report allegations or suspicions of alleged abuse immediately to the appropriate State (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	agencies.interview on 01/07/2025 at 2:10 PM with the ED revealed the facility investigated incidents and if the facility substantiated the incident, they would report to the State Agency and document in the Electronic Medical Record (EMR). However, review of facility policy and federal regulations require that all alleged violations of abuse, including injuries of unknown origin, be immediately reported, rather than waiting to determine if the facility substantiated the allegation.An additional interview with the ED, on 01/15/2026 at 5:24 PM, revealed she was the facility's abuse coordinator. The ED stated the facility's policy included if abuse was suspected, the facility had two hours to report allegations to state agencies. The ED stated there had not been any recent incidents that required reporting to the appropriate agencies, adding that the decision to not report the incidents was determined by herself, the SSD/Assistant ED, and the DON. During an additional interview on 01/17/2026 at 11:11 AM, the ED further stated she often reached out to corporate for direction.Interview on 01/17/2026 at 2:49 PM with the DCR (corporate representative) confirmed if the facility feels they have an occurrence of abuse, they will contact the corporate team and ask their opinion. She further stated an allegation of abuse should be reported to state agencies within two hours. However, she continued, she was aware the facility would investigate and see what happened before reporting.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on interview, record review, and review of facility documentation and policies, the facility failed to conduct a thorough investigation in response to incidents of potential abuse and/or injuries of unknown origin involving six (Resident (R) 19, R30, R67, R84, R87, R90) of 13 sampled residents reviewed for abuse. The facility failed to thoroughly investigate alleged incidents and/or injuries of unknown origin so as to learn facts, determine if abuse had occurred, and identify actions to prevent the potential for further abuse.Findings include:Review of the facility's policy titled Abuse Reporting and Prevention, reviewed 07/2025, revealed that if abuse is reported by the resident, a full investigation of the allegation would be conducted by the Executive Director (ED), and/or designated facility staff. In addition, the policy noted that any resident injury of undetermined origin would be investigated in-house to rule out the possibility of physical abuse. Per the policy, as soon as possible, all information related to a report of abuse, et al, shall be obtained from all persons with knowledge of the reported incident. Pertinent interviews were to be conducted and put in writing, and may include the resident, if possible, the individual reporting the event, all staff on duty at the time of the event with any probable first-hand information, and other individuals present in the area at this time of the reported incident. Further review of the policy revealed upon receiving a verbal or written report of suspected or observed abuse, et al, the nursing home staff (Charge Nurse, Supervisor, Department Head, etc.) would immediately examine the resident for any sign of injury and inform the ED or designee. All statements during the course of the investigation were to be put in writing. 1. During an interview on 01/16/2026 at 11:14 AM with Laundry Aide (LA) 1, she stated upon entering R90's room, R90 was lying on the floor between the bed and recliner. LA1 stated she went to R90, who stated her roommate (R67) had pushed her down. LA 1 stated she immediately reported this allegation of resident-to-resident abuse to the nurse on duty.Review of a notepad document, with Investigation written on the page, dated 12/26/2025 at 12:30 PM and authored by the Director of Nursing (DON), revealed R90 was found on the floor in her room by a laundry aide. R90 stated that her roommate pushed her down. Further review of the document revealed R67 stated R90 was upset because [Resident name] married me and not her. However, R67 stated she did not push her down. The document concluded that, based on a reenactment by staff, the allegation could not have happened as described by R90. However, review of the investigation revealed no evidence of a written statement from LA1, and there was no evidence that a skin assessment (to observe for signs of injury) was completed for either R90 or R67. 2. Review of a handwritten statement, dated 07/16/2025, authored by the Director of Nursing (DON), revealed R19 had a bruise on the left outer knee, pale yellow in color. Further review of the statement revealed that R19 had an incident on 07/06/2025 when R19 was aggressive with staff and hit her hand (not her knee) on the table. Registered Nurse (RN) 1 had noted that on 07/06/2025 during the incident, R19 was kicking her legs; however, RN1 did not witness R19 kicking anything. In this note, the DON also documented R19 often pulled her legs up in a scrunched position in the wheelchair. Review of the facility documentation revealed that it failed to include a thorough investigation into the injury of unknown origin, in accordance with facility policy. There was no evidence of witness statements, or any interviews from other staff who may have provided care to R19 on the incident date, or in the ten days after the 07/06/2026 incident to determine possible timing and etiology of the bruise/injury. There was no evidence that a skin assessment of R19 was completed. Further review of the investigation revealed the conclusion that the cause of the bruising was based on an incident that happened ten days prior was made without sufficient facts that supported the conclusion and without ensuring that no other possible scenarios were responsible for the injury of unknown origin. 3. During a review of an incident (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	report dated 01/01/2026 at 2:07 PM, Licensed Practical Nurse (LPN) 6 documented that R30 was noted to have dark, purple bruising on her inner left thigh down to her knee and a small bruise to the outer of her left thigh. R30 was unable to state the cause of the bruising. Review of the incident report revealed no skin assessment was completed and no statements from direct care staff were obtained to complete a thorough investigation into this injury of unknown origin. 4. Review of a notepad document with Investigation written on the page, on 12/12/2025 at 5:00 PM and authored by the DON, revealed the DON was made aware of a bruise to R87's right eye/cheek area. Staff interviews were conducted, and the DON determined the root cause was R87 was rubbing his face. There was no documented evidence of a thorough investigation as evidenced by a lack of written witness statements, or a complete skin assessment for R 87. 5. Review of a handwritten notepad document, dated 01/12/2026 at 10:15 AM and authored by the DON, revealed staff reported to her that R84 had a bruise to the left upper arm. The DON conducted interviews with staff and concluded no suspicion of abuse, determining R84 had contractures and the bruise happened during a gown change. There was no documented evidence that the incident was thoroughly investigated as evidenced by no written statements were obtained from staff that provided direct care and no evidence that a skin assessment was completed for R84. During an interview with the Social Services Director (SSD)/Assistant ED on 01/14/2026 at 4:33 PM, she stated the facility's policy for suspected abuse was to gather the information and discuss it as a team.During interview with the ED on 01/15/2026 at 5:24 PM, she stated she was the facility's abuse coordinator and that she, the SSD/Assistant ED, and the DON were responsible for conducting the facility's abuse investigations. The ED stated they interviewed staff and residents during their investigations.During an interview with the DON on 01/16/2026 1:40 PM, the DON stated that during the facility investigation, they determined how the injuries happened and therefore did not require any further investigation. The DON provided no further information to explain how these determinations were made when the facility investigations did not contain all information required by policy, nor why this information was not obtained.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interview, record review, and review of facility's documents, the facility failed to ensure that it was administered in an effective manner to meet the needs of each resident, in the areas of developing/implementing care plans, freedom from abuse, and immediate reporting of alleged incidents of abuse. This failure affected two (Resident (R) 12 and R93) of 13 sampled residents reviewed for abuse. The facility was aware that R12 exhibited escalating behaviors toward staff and other residents, including physical sexual contact and aggression, since at least 08/2025. Despite documented identification of these behaviors, the facility failed to develop and implement a comprehensive care plan to protect residents from the potential for abuse. On 01/05/2026, R12 touched and physically restrained R93 in her bed, causing R93 psychosocial harm with emotional distress and fear. This allegation of abuse was immediately reported to administrative staff by the staff person who witnessed it. However, the Administrative staff then failed to identify the reported incident as an allegation of abuse. In addition, the Administrative staff failed to report the allegation as required by facility policy and federal regulation, based on their determination that R93, a severely cognitively impaired resident, had consented to being touched. The failure to immediately report all allegations of abuse, as well as injuries of unknown origin, also affected six additional sampled residents reviewed for abuse (R19, R30, R67, R84, R87, R90). The facility's failure to be administered effectively so as to develop and implement comprehensive care plans, take affirmative steps to prevent abuse, and report all allegations of abuse resulted in Immediate Jeopardy as the deficient practice created a situation likely to cause serious harm to residents. Immediate Jeopardy (IJ) was identified on 01/17/2026 at 42 CFR S483.70 (Administration - F835). The IJ was determined to exist on 01/05/2026 when, after Administrative staff failed to ensure the development and implementation of a care plan in response to behaviors, and failed to prevent abuse, Licensed Practical Nurse (LPN) 1 observed R12 in R93's room, positioned over R93, with one hand holding the resident's hands down and the other hand placed on the resident's left shoulder, pushing her back into her bed while attempting to get on top of her. The IJ at F835 also included the failure of administrative staff to immediately report this allegation to all required authorities, including the State Survey Agency (SSA).On 01/17/2026, the Executive Director (ED), Director of Nursing (DON), and Social Services Director (SSD)/Assistant ED were provided a copy of the Centers for Medicare and Medicaid Services (CMS) Immediate Jeopardy (IJ) Template and was notified that the failure to administer the facility in an effective manner to meet each resident's needs is likely to cause serious injury, harm, impairment, or death to a resident. The facility provided an acceptable IJ removal plan on 01/19/2026. This plan alleged the IJ was removed on 01/19/2026. An Extended Survey was conducted on 01/18/2026-01/19/2026. During this survey, on 01/19/2026, the State Survey Agency (SSA) validated the immediacy of the IJ was removed on 01/19/2026, as alleged. The deficient practice remained at a scope and severity of Level 2 - Isolated (D) following the removal of the immediate jeopardy. Findings include:Review of the facility's document, titled Position Identification: Executive Director, revised 01/2023, revealed the ED was responsible for taking all reasonable steps to ensure optimal quality of care was delivered to the residents; responsible and accountable for functions and activities of the entire staff while appropriately integrating these activities with all other departments in the facility that contribute to resident care; plan and organized systems of care, objectives, policies, procedures, staffing patterns, and staff development based on the needs of the facility within the framework of the established budget while maintaining compliance with all applicable laws, and regulatory and organizational standards. Furthermore, the ED was responsible for the day-to-day operations to include quality, safety, (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	occupancy, resident satisfaction, expense management, and compliance. Additionally, the ED performed job duties without posing a significant risk of substantial harm to the health or safety of himself/herself or others while maintaining compliance with all policies and procedures of the facility and within the parameters of the organization's mission, vision, and values. Review of the facility's document, titled Position Identification: Director of Nursing, revised 08/2025, revealed the DON was responsible for the overall direction of an effective, ongoing nursing program to assess, measure, and improve quality of nursing care delivered to residents by directing staff and other assigned professionals while maintaining compliance with all applicable laws, and regulatory and organizational standards. Additionally, the DON performed job duties without posing a significant risk of substantial harm to the health or safety of himself/herself or others while maintaining compliance with all policies and procedures of the facility and within the parameters of the organization's mission, vision, and values. Review of the facility document, titled Position Identification: Social Services Director, revised April 2021, revealed the SSD was responsible for evaluating prospective residents by performing on-site clinical and financial assessments to determine appropriateness of admission ensuring an efficient admission process by working with the residents and their families initially, while maintaining compliance with all applicable laws, regulatory, and organizational standards. Additionally, the SSD performed job duties without posing a significant risk of substantial harm to the health or safety of himself/herself or others while maintaining compliance with all policies and procedures of the facility and within the parameters of the organization's mission, vision, and values. 1. Refer to F656 - Failure to develop and implement care plans.Review of the Electronic Medical Record (EMR) revealed the facility admitted R12 on 09/25/2024 with multiple diagnoses, including schizophrenia. A review of R12's annual (comprehensive) Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 08/27/2025, revealed the facility failed to identify that R12 displayed documented behavioral symptoms towards others, including sexually inappropriate behavior and aggression. This documentation was noted in Documentation from Psychiatric Evaluations, with Dates of Service of 08/15/2025 and 08/22/2025 , as well as a Behavioral Nursing Note, dated 08/24/2025 (during the MDS look-back period). Section V of the MDS, which included the care planning summary, documented that behavioral symptoms did not trigger and this care area was not care planned. Review of R12's comprehensive care plan, created in response to the 08/27/2025 MDS, confirmed that a problem of behaviors was not care planned at the time of the annual comprehensive assessment.After the failure to identify and care plan behaviors in response to annual Resident Assessment Instrument (RAI) conducted in 08/2025, R12 continued to display behaviors. Documentation included a Psychiatric Periodic Evaluation, Date of Service 09/05/2025, Behavioral nursing note, dated 09/21/2025, Psychiatric Periodic Evaluation, Date of Service 10/03/2025, Behavior Review Committee documentation dated 11/18/2025, and Psychiatric Periodic Evaluation, Date of Service 11/21/2025, which revealed R12 continues to exhibit episodes of aggressive behavior along with ongoing mood instability, irritability and psychotic symptoms. The evaluation further documented R12 was at risk for sexually acting out.Although facility documentation revealed staff knowledge for R12's behaviors over a multi-month period, review of R12's care plan revealed the facility failed to develop a comprehensive care plan regarding R12's inappropriate behaviors until 01/09/2026, after an incident on 01/05/2026. Per interview with LPN1 on 01/07/2026 at 7:37 PM, on 01/05/2026, she was in R93's room and witnessed R12 physically positioned over R93, with one leg raised onto the bed and actively pushing R93 down into the bed. Review of facility documentation, including a Behavior Note dated 01/07/2026 at 10:29 AM, a Psychiatric Periodic Evaluation for R93 for Date of Service 01/07/2026, a Behavior Note, dated 01/16/2026, and Social Services (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	documentation for R93 dated between 01/05/2026 and 01/19/2026 revealed that after the 01/05/2026 incident, R93 was very upset and crying, fearful, uncomfortable and no longer wanted to be at the facility, displaying increased anxiety and emotional distress, and/or displayed worsening emotional symptomsInterview with the Unit Manager (UM) on 01/11/2026 at 5:35 PM, confirmed that R12 did not have a behavioral care plan prior to the 01/05/2026 incident between R12 and R93. She stated that she, as well as the DON, should have been updating the care plan; however, they did not. The UM stated that the DON asked her to not document resident behaviors, and if she did, the documentation was changed, explaining that this was also some of the reason that she did not create a behavioral care plan for R12.During an interview with the DON on 01/16/2026 at 1:40 PM, the DON stated behavioral care plans were expected to be reviewed and revised when an incident is reported. The DON stated that it would have been important for the facility to have a behavioral care plan in place for R12 so that staff would be aware of his care needs and behavioral risks. The DON further stated that the facility failed to document R12's behaviors in the Kardex (an informal document used by nursing staff and nurse aides as a quick care plan reference tool for resident's care and needs) to protect staff and residents.) The DON stated she assumed the Unit Manager was updating R12's care plan and Kardex but acknowledged that she did not review either and stated that she should have. The DON stated she did not know how it was possible that R12 did not have a behavioral care plan until 01/09/2026, four days after the incident occurred on 01/05/2026, and two days after the SSA began its investigation of the incident.Interview on 01/17/2026 at 11:11 AM with the ED revealed that the DON and Nursing team were responsible for care plans. She said that having correct and updated care plans was important for residents to ensure their needs were being met. 2. Refer to F600 - Failure to ensure residents are free from abuse.A review of an undated written statement authored by LPN1 revealed that she observed R12 (a male resident) in the room of R93 (a female resident assessed as severely cognitively impaired, per a quarterly MDS with an ARD of 10/28/2025). LPN1 stated R12 was positioned over R93, with one hand holding the resident's hands down and the other hand placed on the resident's left shoulder, pushing her back into the bed while attempting to get on top of her.Interview with LPN1, on 01/07/2026 at 7:37 PM, revealed that the incident described in the undated written statement occurred on 01/05/2026. According to LPN1, upon entry to R93's room, she observed R12 physically positioned over R93, with one leg raised onto the bed and actively pushing R93 down into the bed. LPN1 stated that she notified the SSD/Assistant ED and the DON of the incident and was told the situation was speculation and advised not to make a mountain out of a molehill. LPN1 stated when she reported behaviors of residents to facility management, she felt the concerns were swept under the rug, were not addressed, and were not reported to the appropriate agencies.During an interview with the SSD/Assistant ED on 01/14/2026 at 4:33 PM, she stated that she, the ED, and DON decided that the incident regarding R12 and R93 did not feel the witnessed incident on 01/05/2026 (in which R12 held R93 down, pushing her back into her bed while attempting to get on top of her), met the definition of abuse. Further interview with the SSD/Assistant ED revealed her belief that R93, who was assessed as severely cognitively impaired, could consent to being touched.Interview with the ED, on 01/15/2026 at 5:24 PM, revealed she was the facility's abuse coordinator. She stated that she, the SSD/Assistant ED, and the DON were responsible for conducting the facility's abuse investigations. The ED stated that, regarding the 01/015/2026 incident between R12 and R93, she, the DON, and SSD/Assistant ED had not determined that abuse had occurred. Further interview with the ED revealed she was aware of different types of abuse, including physical, mental, and sexual. However, she continued, they had decided the 01/05/2026 did not rise to the level of abuse because R93 had consented to R12 being in her room. Further (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/19/2026
NAME OF PROVIDER OR SUPPLIER Christian Health Center Corbin		STREET ADDRESS, CITY, STATE, ZIP CODE 116 South Commonwealth Avenue Corbin, KY 40702	

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	interview with the ED revealed the belief that R93, who was assessed as severely cognitively impaired, could consent to R12 coming into her room and touching her. However, she could provide no evidence to support this belief. During an interview with the DON on 01/16/2026 at 1:40 PM, the DON revealed that she had not identified this incident as abuse because of her belief that the severely cognitively impaired female resident (R93) could consent to being touched by the male resident (R12). 3. Refer to F609 - Failure to immediately report all allegations of abuse, including injuries of unknown origin.a. Review of facility documentation and SSA records confirmed that the 01/05/2026 allegation of abuse of R93 by R12, which LPN1 witnessed and reported to the DON and SSD/Assistant ED, was not reported to any outside agencies, including law enforcement and/or the SSA.During an interview with the SSD/Assistant ED on 01/14/2026 at 4:33 PM, she stated the facility's policy for suspected abuse was to gather the information, discuss it as a team, and decide if it should be reported to the Office of Inspector General (SSA). The SSD/Assistant ED stated that the team, which also included the ED and DON, decided that the incident between R12 and R93 did not need to be reported to the appropriate agencies because they did not feel it met the definition of abuse, explaining her belief that R93, who was assessed as severely cognitively impaired, could consent to being touched.Interview with the ED, on 01/15/2026 at 5:24 PM, revealed the facility's policy included if abuse was suspected, the facility had 2 hours to report allegations to state agencies. Regarding the failure to report the allegation that R12 abused R93, the ED stated they had decided the 01/05/2026 incident was not reportable as it did not rise to the level of abuse because R93 had consented to R12 being in her room and could form consent to the male resident (R12) coming into her room and touching her.During an interview with the DON on 01/16/2026 at 1:40 PM, the DON stated that she was unsure whether the incident involving R12 and R93 should have been reported to reporting agencies or law enforcement, explaining that she had not identified this incident as abuse because of her belief that the severely cognitively impaired resident could consent to being touched. However, after a review of the facility's Abuse and Reporting Policy, the DON stated that one of the facility leadership members (ED, DON, or SSD/Assistant ED) should have reported the incident. The DON confirmed that incidents involving alleged sexual misconduct between residents should be reportedDuring an additional interview on 01/17/2026 at 11:11 AM, the ED further stated she often reached out to corporate for direction on reporting requirements.Interview on 01/17/2026 at 2:49 PM with the Director of Clinical Reimbursement (DCR - a corporate representative) revealed that if the facility feels they have an occurrence of abuse, they will contact the corporate team and ask their opinion. Although the DCR confirmed that allegations of abuse were to be reported within two hours, the DCR indicated it was the next day (more than the two hours required for immediate reporting to the SSA) before the facility contacted the Chief Executive Officer for guidance about the alleged incident between R12 and R93. Per the DCR, at this time the allegation was determined to not be a reportable allegation, adding, We did not see that any abuse had occurred.I would not consider it a reportable offense if it was just touching. b. Further review of facility investigations revealed that additional allegations of abuse or injuries of unknown origin, which did not rise to the level of IJ, were also not immediately reported to the SSA. These included allegations of resident-to-resident abuse of R90 by R67 on 12/26/2025, and injuries of unknown origin identified for R30 on 01/01/2026, R19 on 07/16/2025, R87 on 12/12/2025, and R84 on 01/12/2026.During an interview with the DON on 01/17/2026 at 10:20 AM, she stated that she was not aware that she was supposed to report allegations or suspicions of alleged abuse immediately to the appropriate State Agencies.During an interview with the ED, on 01/15/2026 at 5:24 PM, she stated there had not been any recent incidents that required reporting to the appropriate agencies. The ED stated (continued on next page)

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	185232	A. Building B. Wing	01/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Health Center Corbin	116 South Commonwealth Avenue Corbin, KY 40702

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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	that she, the SSD/Assistant ED, and the DON make the decisions to not report incidents. During an additional interview on 01/17/2026 at 11:11 AM, the ED further stated she often reached out to corporate for direction.Interview on 01/17/2026 at 2:49 PM with the DCR revealed that an allegation of abuse should be reported to state agencies within two hours; however, she was aware the facility would investigate and see what happened before reporting.