STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225318	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Town Health and Rehabilitation	22 Maple Street Amesbury, MA 01913

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on records reviewed and interviews, for two of three sampled residents (Resident #2 and Resident #3), who were both severely cognitively impaired, unable to formulate consent and found engaged in touching in a sexual manner, the Facility failed to ensure staff consistently implemented and followed their abuse policy related to reporting abuse allegations, when on 03/04/26 although Certified Nurse Aide #2 immediately reported to Nurse #1 that Resident #2 and Resident #3 were witnessed engaging in sexual behavior, Administration however, was not made aware until on 03/05/26 (the following morning), and failed to ensure their abuse policy aligned with the requirement for allegations of abuse to be reported to their State Agency within two hours.Findings include:Review of the Facility Policy titled Investigation of Resident Abuse, Neglect, Mistreatment, Misappropriation of Resident Property Complaints/Allegations, dated June 2022, indicated any complaint, observation, or suspicion of resident abuse, neglect, mistreatment or misappropriation of resident property is reported to the Massachusetts Department of Public Health, Division of Health Care Quality and other appropriate agency as deemed appropriate in accordance with state and federal law. The Policy indicated the Unit Manager/Supervisor will notify the Director of Nurses and the Administrator within two hours (or sooner), after the allegation if there is abuse or bodily harm. The Policy's reporting requirements indicated that the Administrator and Director of Nursing will be notified immediately, (based on the time frames set forth by Centers for Medicare and Medicaid Services and State Regulatory Agency), upon receipt of an allegation of resident abuse, neglect, mistreatment or misappropriation of resident property. The Policy indicated that additionally, if abuse is suspected or confirmed, a report will be made within 24 hours to the Department of Public Health.Review of the report submitted by the Facility via the Health Care Facility Reporting System, dated as created on 03/05/26 at 1:29 P.M., indicated [on 3/04/26 during the evening shift] that evidently Resident #2 wandered into Resident #3's room, sat on his/her bed, and both cognitively impaired Residents were found touching each other in a sexual manner. Review of Resident #2's clinical record indicated that his/her diagnoses included dementia, aphasia, conversion disorder and post-traumatic stress disorder.Review of Resident #2's annual Minimum Data Set (MDS) assessment, dated 02/25/26, indicated he/she rarely/never made himself/herself understood or understood others, and had severely impaired cognitive skills for daily decision making. Review of Resident #2's Care Plan Report, dated 03/03/26, indicated he/she wandered aimlessly, and may significantly intrude on the privacy of others or activities. Care Plan Interventions include to distract with pleasant diversions and structured activities.Review of Resident #3's clinical record indicated that his/her diagnoses included vascular dementia.Review of Resident #3's quarterly MDS assessment, dated 02/17/26, indicated he/she usually made himself/herself understood and usually understood others, and during a brief interview for mental status had severely impaired cognitive patterns.Review of Resident #3's Care Plan Report, reviewed and renewed with his/her most recent MDS, indicated he/she had impaired cognitive function or impaired thought processes due to dementia. Interventions include to cue, reorient and supervised as needed.During a telephone interview on 03/26/26 at 2:35 P.M., Certified Nurse Aide (CNA) #2 said Resident #2 was known to wander throughout the secure unit. CNA #2 said on 3/04/26, she recalled seeing Resident #2 in the dining room at 6:00 P.M. as she (continued on next page)

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

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	left to provide another resident care. CNA #2 said at 6:15 P.M., as she walked out of that resident's room, she noticed Resident #3's door was ajar and Resident #2 seated on Resident #3's bed. CNA #2 said Resident #2 did not reside in Resident #3's room. CNA #2 said she immediately entered, saw Resident #3 lying in bed with no clothing covering his/her genital area. CNA #2 said Resident #2, while sitting next to Resident #3 on his/her bed, was touching Resident #3's genital area with one hand. CNA #2 said one of Resident #3's hands covered Resident #2's hand while the other hand touched Resident #2's chest under his/her shirt. CNA #2 said she removed Resident #2 from Resident #3's room and immediately reported the incident to Nurse #1.During an interview on 03/24/26 at 2:30 P.M., Nurse #1 said on 03/04/26 at about 6:15 P.M., CNA #2 reported Resident #2 was found to have wandered into Resident #3's bedroom and they were engaged in sexual activity. Nurse #1 said she reported the incident to Assistant Director of Nursing (ADON) either by telephone or email to receive guidance. Nurse #1 said she reported the incident to the Director of Nursing (DON) by text that night (on 03/04/26) sometime after 11:00 P.M. (around four hours after the alleged incident occurred). Nurse #1 said she should have immediately called to ensure the DON was notified after CNA #2 reported the incident to her. Nurse #1 said she was distracted by tasks such as, ensuring Resident #2 and Resident #3 remained separated, conducting their skin checks, investigating the incident, and ensuring the oncoming 11:00 P.M. to 7:00 A.M. shift received information on the incident.During an interview on 03/24/26 at 3:05 P.M., the ADON said she did not recall being contacted or informed of the incident involving sexual activity between Resident #2 and Resident #3 on 03/04/26, by staff.During an interview on 03/24/26 at 12:18 P.M., the Director of Nursing (DON) said she was unaware of the incident which occurred at 6:15 P.M. on 03/04/26 between Resident #2 and Resident #3 until she saw Nurse #1's text at about 5:00 A.M. on 03/05/26 (almost 11 hours after the alleged incident occurred). The DON said she then notified the Administrator by text that morning. The DON said an allegation of resident-to-resident sexual abuse should have been immediately reported to Administration, per Facility policy.During an interview on 03/24/26 at 3:15 P.M., the Administrator said he was not aware of the incident involving Resident #2 and #3, until the DON notified him of the allegation by text on 03/05/26, which was received as he was arriving to the Facility at 8:00 A.M. (almost 14 hours after the incident occurred).During a telephone interview on 04/03/26 at 2:20 P.M., the Administrator said it was determined based on review of the Facility's Policy titled Investigation of Resident Abuse, Neglect, Mistreatment, Misappropriation of Resident Property Complaints/Allegations, dated June 2022, that it had not been fully updated to accurately reflect current reporting requirements. The Administrator said allegations of abuse were expected to be reported immediately, not within two hours, to himself and the Director of Nurses, and that the report submitted by the Facility via the Health Care Facility Reporting System to the State Agency, regarding abuse allegations, must be submitted within two hours.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on records reviewed and interviews, for two of three sampled residents (Resident #2 and Resident #3), who were severely cognitively impaired and had been found by staff touching each other is a sexual manner, the Facility failed to ensure staff immediately reported an allegation of resident to resident sexual abuse to Administrative staff as required, so the Facility could report the incident to the State Survey Agency, within the two hour required time frame. On 03/04/26 although a staff member witnessed Resident #2 and Resident #3 engaging in sexual behavior with each other, it was not successfully reported to Administration until the following morning on 03/05/26, (almost 11 hours after the alleged incident occurred) and not reported to their State Agency until 1:29 P.M. that afternoon (more than 18 hours later).Findings include:Review of the Facility Policy titled Investigation of Resident Abuse, Neglect, Mistreatment, Misappropriation of Resident Property Complaints/Allegations, dated June 2022, indicated any complaint, observation, or suspicion of resident abuse, neglect, mistreatment or misappropriation of resident property is reported to the Massachusetts Department of Public Health, Division of Health Care Quality and other appropriate agency as deemed appropriate in accordance with state and federal law. Review of Resident #2's clinical record indicated that his/her diagnoses included dementia, aphasia, conversion disorder and post-traumatic stress disorder.Review of Resident #2's annual Minimum Data Set (MDS) assessment, dated 02/25/26, indicated he/she rarely/never made himself/herself understood or understood others, and had severely impaired cognitive skills for daily decision making. Review of Resident #3's clinical record indicated that his/her diagnoses included vascular dementia.Review of Resident #3's quarterly MDS assessment, dated 02/17/26, indicated he/she usually made himself/herself understood and usually understood others, and during a brief interview for mental status had severely impaired cognitive patterns.During a telephone interview on 03/26/26 at 2:35 P.M., Certified Nurse Aide (CNA) #2 said on 03/04/26 around 6:15 P.M., as she walked out of a resident's room she noticed Resident #3's door was ajar and Resident #2 seated on Resident #3's bed. CNA #2 said Resident #2 did not reside in Resident #3's room. CNA #2 said she immediately entered, saw Resident #3 lying in bed with no clothing covering his/her genital area. CNA #2 said Resident #2, while sitting next to Resident #3 on his/her bed, was touching Resident #3's genital area with one hand. CNA #2 said one of Resident #3's hands covered Resident #2's hand while the other hand touched Resident #2's chest under his/her shirt. CNA #2 said she removed Resident #2 from Resident #3's room and immediately reported the incident to Nurse #1.During an interview on 03/24/26 at 2:30 P.M., Nurse #1 said on 03/04/26 at about 6:15 P.M., CNA #2 reported to her that Resident #2 was found to have wandered into Resident #3's bedroom and they were engaged in sexual activity. Nurse #1 said she reported the incident to Assistant Director of Nursing (ADON) either by telephone or email to receive guidance. Nurse #1 said she reported the incident to the Director of Nursing (DON) by text that night (on 03/04/26) sometime after 11:00 P.M. (around four hours after the alleged incident occurred). Nurse #1 said she should have immediately called to ensure the DON was notified after CNA #2 reported the incident to her.During an interview on 03/24/26 at 3:05 P.M., the ADON said she did not recall being contacted and/or informed of the incident involving sexual activity between Resident #2 and Resident #3 on 03/04/26.During an interview on 03/24/26 at 12:18 P.M., the Director of Nursing (DON) said she was unaware of the incident that occurred at 6:15 P.M. on 03/04/26 between Resident #2 and Resident #3 until she saw Nurse #1's text at about 5:00 A.M. on 03/05/26 (11 hours later). The DON said she then notified the Administrator by text that morning. The DON said the allegation of resident to resident sexual abuse should have been immediately reported to Administration per Facility policy.During an interview on 03/24/26 at 3:15 P.M., the Administrator said he was not aware of the incident until the DON notified him of the allegation by text on 03/05/26, which was received as he was arriving to the Facility at 8:00 A.M. The Administrator said the incident was not reported to the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	State Agency within two hours as required, and that their report of the incident was not created or submitted via the Health Care Facility Reporting System until the afternoon on 03/05/26. Review of the report submitted by the Facility via the Health Care Facility Reporting System, in which they reported the incident of 03/04/26 with Resident #2 and Resident #3 (both cognitively impaired residents) were found touching each other in a sexual manner, indicated the Report was dated as created/submitted on 03/05/26 at 1:29 P.M. (more than 18 hours after the alleged incident occurred),