STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235626	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Troy	925 W South Blvd Troy, MI 48085

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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 - Minimal harm or potential for actual harm Residents Affected - Some	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** This citation relates to Intake 2655900. Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from physical and sexual abuse by one Resident, R108, towards two residents, R103 and R104, and by R106, towards two residents, R109 and R110, of six residents reviewed for abuse. Findings include:Review of a Complaint reported to the State Agency, received on 10/29/25, alleged R108 (a male resident) went into R103's (female resident) room naked, got into bed with R103, and touched her breast, and then R103 hit R108 with her shoe. The complaint further alleged R108 attempted to get into R103's roommates' bed, R104 (a second female resident), however did not touch them. The complainant conveyed safety and supervision concerns related to facility residents.Further review of same complaint (dated 10/29/25) alleged a second resident to resident incident occurred on 10/25/25, when R106 (a second male resident) was using other residents' bathrooms, pulled his pants down, and exposed himself to an unnamed female resident who screamed in response.Review of a Facility Reported Incident (FRI), received by the State Agency on 11/01/25, revealed on 11/01/25, R106 (the second male resident) was witnessed by staff allegedly pulling R110's hair, and putting his hands down R109's shirt (a female resident). The report revealed both incidents occurred within the same time frame.Review of a FRI, received by the State Agency on 11/06/25, revealed on 10/28/25, R104 reported R108 (first male resident) came into their room, attempted to get into their bed, and then exposed and fondled himself next to R104 in her room. The report revealed a police report was made. The report showed the Nursing Home Administrator (NHA) stated R104 made no comment to the police. R108:Review of an Accident and Incident Report, dated 10/28/25 at 3:30 p.m., revealed R108 (first male resident) was observed trying to enter other residents' beds (unnamed). The report showed when staff intervened, the resident became combative during redirection and described R104's roommates' bed was unoccupied at the time of the incident. Staff reportedly provided verbal redirection and ensured the safety of all the residents (unnamed) in the area and removed R108 from the environment. The report did not specify the details of the incident, which residents were involved, or any resident outcomes. On 11/05/25 at 11:10 a.m., R103 was observed in their room, dressed and seated in a chair, holding a Styrofoam cup, with a baby doll on her bed. R103 agreed to the interview by nodding. R103 appeared peaceful and content. No bruising or skin concerns were observed.On 11/05/25 at 11:11 a.m., R103 was asked yes/no questions. R103 denied care concerns or abuse concerns, however, Surveyor could not ascertain R103's accuracy due to communication impairment. R103 was oriented to herself only at that time and had no communication board or tool to ascertain her level of communication. R103 responded with a couple words and gestures and by nodding or shaking their head no. Review of R103's MDS (Minimum Data Set) assessment, dated 9/05/25, revealed she was admitted to the facility on [DATE], with diagnoses including hypertensive encephalopathy (brain metabolic disorder), dementia, and aphasia (communication impairment). The assessment showed R103 required assistance with self-care and had cognitive and communication impairment.On 11/05/25 at 11:15 a.m., R104 was observed in the same room in their hospital bed in the same room. On 11/05/25 at 11:15 a.m., R104 reported an (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incident when R108 attempted to climb into her bed when she was in her bed, about a week ago. R104 said she yelled at R108 to stop, and then R108 stood about four feet away from her next to the bed and fondled himself while exposed. R104 described R108 was only wearing a T-shirt. R104 stated she pushed her call light for assistance and waited 5 to 10 minutes for her call light to be answered by staff, which was too long for her. R104 reported six staff came into the room, including the Nursing Manager (Licensed Practical Nurse (LPN) E), who responded and said the facility needed a memory care unit. R104 explained the incident made her feel scared when it occurred but she was doing fine during the interview. R104 was fully oriented, and able to tell time on her wall clock and on her phone. Review of R104's MDS assessment, dated 10/16/25, showed she was readmitted [DATE], with diagnoses including lung disease and generalized anxiety disorder. The assessment revealed that R104 required maximal assistance for transfers and bed mobility and R104 was cognitively intact.On 11/05/25 at 12:00 p.m., R108 (first male resident) was observed in his bed, sleeping, wearing a sweat outfit and socks.On 11/05/25 at 1:25 p.m., Social Worker (SW) B reported they learned there was an incident when they returned to work recently, when R108 was taking off his clothes, was going into patient's rooms, and was attempting to get into bed with female patients. SW B said R103's Family Member, FM C, learned of it and described to them a male patient was taking off his clothes and was masturbating and said they did not know his name, and said R104 also had concerns (which were unspecified as they said they could not recall the details). SW B said FM C told them this on 10/27/25, prior to the 10/28/25 incident. SW B reported they notified the Director of Nursing (DON) about the incident and were not involved in any investigation beyond reporting. SW B was asked why the incident was not documented in their notes and there was no social services follow-up. SW B acknowledged the incident on 10/28/25 and said there should have been follow-up completed and FM C's call documented. SW B said, Normally there would have been a concern form completed, at a minimum. SW B denied any declines in physical or emotional status for R103 and R104. SW B indicated R104 was a credible reporter and fully oriented. Review of R104's concern forms showed no resident-to-resident incidences, and there were no concerns forms provided for R103. Review of R108's Provider Psychiatry note, dated 10/30/25 at 12:43 p.m., revealed, .(R108) is alert and oriented x 2 (spheres) with intermittent episodes of confusion and able to make his needs known . Behavioral concerns have emerged since the last visit with no identified trigger x 1. (R108) has been displaying sexually inappropriate behaviors towards patients and staff, has been getting into the beds of other residents, and has episodes of combativeness. UA (urinalysis) was collected and resulted negative.Review of R108's SW B's progress note, dated at 10/29/25 at 12:36 p.m., revealed, SW follow up (on) 2/2 reports of (R108) displaying inappropriate sexual behaviors. The note revealed referral to psychiatry, neurology, and preferred activities. No behavioral interventions were noted.Review of R108's Minimum Data Set (MDS) assessment, dated 9/08/25, showed R108 was admitted on [DATE], with diagnoses including Alzheimer's disease, anxiety, and depression. The assessment showed that R108 transferred and walked with supervision and cueing and had cognitive impairment and wandering behaviors.Review of R108's progress note, dated 10/28/25 at 3:26 p.m., showed R108 displayed sexually inappropriate behaviors to patients and staff, getting into other residents' beds and combativeness. Resident were not specified.Review of R108's Care Plan, accessed 11/05/25, showed a behavioral Care Plan dated 10/29/25, which showed R108 wandered into other residents' rooms, made sexual remarks, and had a behavior of being unclothed.On 11/06/25 at 9:32 a.m., the 200 floor Unit manager, Licensed Practical Nurse, LPN E, was asked about R104 reporting they were among the staff who responded when R104 reported R108 fondled himself next to her (R104) when she was in her hospital bed on 10/28/25. LPN E denied any awareness of abuse or exposure by R108 towards R104 or other residents. LPN E said they only heard R104 scream and responded when R108 was in her room and made sure R108 was removed. LPN E said R108 was found in R103's bed fully clothed and was removed from room and said R103 was not present. On 11/06/25 at 11:12 a.m., CNA H was asked about the resident-to-resident incident reported involving (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R108. CNA H reported they witnessed an incident perpetrated towards R108 towards R103, R104's roommate, on 10/28/25. CNA H described R103 observed R108 in R103's room in R103's bed, sitting there with his pants off, while R103 stood by her bed. R103 then reportedly popped R108 on his head with her house shoe. CNA H said they pulled R103 away from R108, as R103 was upset R108 was in their bed. R103 reported CNA L assisted them removing R108 from the room, and LPN E was in the room as well. CNA H said they were not aware of the incident prior between R108 and R104 or with other facility residents. R106 (second perpetrator):On 11/05/25 at 12:30 p.m., R106 was observed in his room, wearing a sweatshirt and pants, with a hard plastic boot on their leg. Certified Nurse Aide (CNA) A was seated in a chair in R106's room. R106 agreed to be interviewed.On 11/05/25 at 12:32 p.m., R106 said they were doing good and everything was fine. R106 denied any resident-to-resident incidents or abuse towards him or to other residents. R106 was oriented to himself and his surroundings.On 11/05/26 at 12:34 p.m., CNA A reported they were supervising R106 on a 1:1 supervision.On 11/05/25 at 3:09 p.m., SW B was asked about the incidences between R106 and R109 and R110. SW B confirmed the abuse incidents occurred as reported to the State Agency on 11/01/25. SW B stated R110 was only oriented to herself and did not recall the incident. SW B confirmed they had followed up with R109 today (11/05/25) and said they should have followed up sooner. SW B shared R109 was interviewed and had a BIMS (Brief interview for mental status) score of 9/15, which showed cognitive impairment, and said there had been no changes in mood/behavior since the incident for either resident R109 and R110. SW B reported R106 was moved to another floor, had 1:1 supervision, and denied the staff had awareness of any concern with R106 prior to the incident.Review of R106's nursing progress note, by Registered Nurse (RN) K, dated 11/01/25 at 2:58 p.m., revealed the writer overheard commotion at the 200 unit, and staff reported R106 pulled R110's hair, at approximately 2:00 p.m. An unnamed CNA reported R106 had attempted to put their hand down R109's shirt, which had occurred earlier at 11:40 a.m R106 was removed from the victim, R110. The police were notified, a 1:1 supervision was initiated for R106, who stated, I won't do it again.On 11/05/25 at 3:33 p.m., Registered Nurse, RN D, reported R106 was known to enter other resident's rooms and disrobed in their bathrooms to use their toilet prior to the incident. RN D reported they had observed R106 grabbing staff's arms or grabbing them by their pants. RN D described one incident when R106 grabbed R103 on their arm and by their pants and reported they had reported the incidents to LPN E. On 11/06/25 at 9:36 a.m , LPN E was asked about the incident when R106 perpetrated abuse towards R109 and R110 and any concerns with R106's behaviors prior to the incident. LPN E reported they had redirected R106 when they went into other residents' room to use their bathrooms prior to the 11/01/25 incident and acknowledged (unnamed) residents had screamed when R106 was using their bathrooms, so they intervened when this occurred. On 11/06/25 at 11:33 a.m., CNA H reported they were present when R109 was seated at the nurse's station on 11/01/25 and R106 reached over R109's bedside table and touched R109's breast under her shirt. R109 reportedly said, Oh, sh@t. CNA H reported they intervened and immediately moved R109 to her room. CNA H said the police were called and R109 could not specifically recall what occurred. CNA H reported R106 thought it was funny and said they believed R106 understood what occurred, as he had been grabbing staff prior.On 11/06/25 at approximately 11:40 a.m., CNA H described a second incident which was observed after lunch on 11/01/25, between R106 and R110. CNA H described R110 was seated at the nurse's station when R106 pulled R110's hair and would not let go. CNA H explained two staff attempted to assist and R106 would not let go and R110 was crying and cried for 30 minutes after the incident. CNA H reported they removed R106 from the scene and took them downstairs to another floor, and the police were notified and arrived after the incident.Review of CNA I witness statement, undated, showed CNA I was charting at the desk when they witnessed a kitchen aide remove R106's hand from R110's hair. CNA I reported the kitchen aide told R106 to let go, and R106 did not let go right away. Review of LPN J's witness statement, dated 11/01/25, revealed when they returned from break the floor staff let LPN J know an assault had occurred, when R106 assaulted another resident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(R110) by pulling her hair with a tight grip.Review of CNA P s witness statement showed R106 grabbed R110 by the hair forcefully and would not let to go, and then R110 started to cry. CNA P intervened however they could not get R106 to let go, and R106 pulled harder, until additional staff intervened. CNA clarified the incident happened on 11/01/25 at 1:00 p.m. by the nurse's station.On 11/06/25 at 1:50 and 1:55 p.m., R108 was observed walking on the 200 hall, where he resided, wearing a sweat outfit, with nursing staff supervising them. R108's mood was calm. On 11/06/25 at 2:05 p.m., R109 was observed dressed in her upright recline wheelchair in her room and agreed to be interviewed.On 11/06/25 at 2:07 p.m., R109 said she did not recall the details, and she believed a man touched her. R109 added, I don't remember. I know the police were here. R109 denied any injury or being upset about the incident during the interview. R109 reported they felt safe. On 11/06/25 at 2:10 p.m. R110 was observed dressed, seated at the nurse's station in a Geri (positional lounge) chair. R110 appeared comfortable and calm. R110 could not answer questions and was unable to be interviewed. R110 was directly supervised by LPN E during the observation.R106 and R108:On 11/06/25 at 2:30 p.m., CNA H was asked if R108 had any resident-to-resident incidents prior to 10/28/25, and they reported there were no concerns or similar behaviors per their awareness.On 11/07/25 at 9:33 a.m., the NHA (Nursing Home Administrator) reported they were unaware of R104's concerns until Surveyor reported them, and had followed up with R104 yesterday, who shared the same incident description. The NHA stated they followed up on the concerns of R103 also and understood four staff members responded to R104 yelling on 10/28/25 in her room and found R108 without his brief on R103's bed, with a CNA (unnamed) already in the room, and said they knew of no further incident. The NHA reported during their investigation they became aware during the survey R108 had a behavior of disrobing in his bed and in the facility prior to the incident, reported to them on 11/06/25 by LPN E and CNA L. The NHA clarified if they had known, they would have followed up. The NHA said they would have expected to have been made aware by facility staff so they could have put a plan in place, and the behavior should have been reported. The NHA clarified R108 was not in bed with R103 or R104 per their interviews and they learned R103 tried to [NAME] R108 out of her bed with a shoe. The NHA clarified the aide, CNA L , who was present, said they did not witness any contact by R108 with either R103 or R104. The NHA confirmed the incident was reported to the State Agency on 11/06/25, and to the police.On 11/07/25 at 9:45 a.m., the NHA was asked about their investigation conclusions regarding the abuse incident reported to the State Agency on 11/01/25 involving R106, R109, and R110. The NHA confirmed they understood the abuse related concerns and R106 was placed on a 1:1 supervision since 11/01/25, and no other incidents had occurred. They denied awareness of R106's inappropriate behaviors prior to the 11/01/25 incident. On 11/07/25 at 11:38 a.m., R103's Family Member, (FM) C, was available by phone, after earlier surveyor attempts. FM C reported they were not directly aware or had not been notified of any incidents between R103 and facility residents. However, they had observed R103 not wanting to go into her bedroom recently and said R103 wanted to stay in the day room and kept the day room door shut. FM C said R103 didn't want to lay in their bed and said this was all a new behavior. FM C said they never determined what happened, and no staff had told them if any incident occurred. FM C shared they reported their concerns to the facility and said facility staff were aware R103 did not want to lay in their bed, which staff had encouraged. On 11/07/25 at 11:40 a.m., FM C further described an incident involving them as a visitor two weeks prior, when they observed R106 wheeling by them in his wheelchair, with his pants down. FM C said R106 grabbed their arm, which upset them. FM C said a nearby staff member said, He (R106) does this all the time,. and intervened. FM C stated whenever R106 wheeled by R103, R103 would become aggressive and start yelling No, but they did not know if an incident occurred or if R103 was afraid of R106, as R103 had communication impairment. When asked if R103 was fearful, FM C said they were initially after admission, however believed R103 had adjusted to the facility now. On 11/07/25 at 12:22 p.m., CNA L was asked during a phone interview about any resident incidents with R108. CNA L reported on 10/25/25 around 2:00 p.m., they had just finished rounds and heard a (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	potential employees and prospective residents. Training new and existing staff on prohibiting, preventing, and identifying abuse, neglect, exploitation, mistreatment, and misappropriation of resident property, reporting procedures, dementia and behavior management. Prohibiting, Preventing, and Identifying abuse, neglect, mistreatment, exploitation, and misappropriation of resident property. Reporting any allegations of abuse, neglect, mistreatment, exploitation, and misappropriation or resident property including reporting a reasonable suspicion of a crime to the State Survey Agency and other officials in accordance with state law. Investigating allegations of abuse, neglect, misappropriation, mistreatment, and exploitation to include protecting residents during the investigation, and taking necessary actions as a result of the investigation. Establishing coordination with the QAPI (Quality Assurance Performance Improvement) program. The facility will provide ongoing oversight and supervision of staff in order to ensure that its policies are implemented as written. Training:The facility will educate its staff upon hire, annually, and as needed, which will include, but not necessarily be limited to, the following topics: Prohibiting and preventing all forms of abuse, neglect, mistreatment, exploitation, and misappropriation of resident property. Identifying what constitutes abuse, neglect, mistreatment, exploitation, and misappropriation of resident property. Residents right to privacy and confidentiality to include the unauthorized taking of pictures or recordings of residents and sharing them in any manner, including social media or the use of technology. Recognizing signs of abuse, neglect, mistreatment, exploitation, and misappropriation of resident property. Reporting process for suspicions or allegations of abuse, injuries of unknown origin, neglect, exploitation, mistreatment, and misappropriation of resident property without fear of reprisal or retaliation. Reporting reasonable suspicion of a crime by covered individuals without fear of reprisal or retaliation. Content will include but is not limited to: what is reportable as a reasonable suspicion of a crime, each covered individual's obligation to report a reasonable suspicion of a crime against a resident to the administrator immediately as well as the State Survey Agency and Law Enforcement, and the timeframe requirements of reporting. This may include but not limited to: placing a notification in the employee handbook, in-service education, notification letters, notification provision in a service contract. Understanding and ways to deal with behavioral symptoms of residents that may increase the risk of abuse and neglect such as: Aggressive behaviors and/or catastrophic reactions of residents. Wandering or elopement-type behaviors. Resistance to care. Outbursts or yelling out. Difficulty in adjusting to new routines or staff. How to recognize signs of burnout, frustration, and stress that may lead to abuse. Identification: The facility will educate the staff in identifying abuse (mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services), neglect, exploitation, mistreatment, and misappropriation of resident property. Possible indicators of abuse include, but are not limited to: Resident, representative, or staff reports of abuse. Suspicious or unexplained injuries such as bruises or patterned appearances such as a handprint, belt or ring mark on a resident's body. Resident, representative, or staff reports of theft or missing property. Verbal abuse of a resident overheard. Physical abuse of a resident observed. Psychological abuse of a resident observed. Failure to provide care needs such as feeding, bathing, dressing, turning & positioning. Evidence of photographs or videos of a resident that are demeaning or humiliating in nature of whether the resident provided consent and regardless of the resident's cognitive status. Sudden or unexplained changes in behaviors and/or activities such as fear of a person or place, or feelings of guilt or shame. Demonstration of catastrophic reactions. Protection: The facility will attempt to coordinate with State and Local law enforcement annually and as needed to determine which crimes are reportable other than those listed in the definition of Crime. Abuse against residents can be perpetrated by various people within the facility. The facility supports and protects patients, family members, and staff from harm during an investigation of alleged abuse including retribution and retaliation. Protective actions depend upon the people involved. Any allegation of abuse must be immediately reported to the supervisor and the Abuse Prevention Coordinator. The Administrator initiates investigating any (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	allegation of abuse against a patient. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to: Immediately removing the resident from contact with the alleged abuser. Evaluation of the physical and psychosocial condition of the resident and providing emotional support to the patient during and after the investigation as needed. Providing a safe and secure environment for all patients If a staff member is the alleged perpetrator, that staff member should be immediately removed from the facility and the schedule pending the outcome of the investigation. If a non-staff person (visitor, family member, etc.) is the alleged perpetrator, that non-staff person should be immediately removed from the facility, prevented access to the resident pending the outcome of the investigation, and/or referring the matter to the appropriate authorities as indicated. If a resident is the alleged perpetrator, the facility will ensure other residents are protected as determined by the circumstances, which may include but are not limited to resident room changes, increased supervision, or immediate transfer or discharge, if indicated. Notification to the resident's attending physician and resident representative of the incident or allegation of abuse.Sexual abuse: Non-consensual sexual contact of any type with a resident including but not limited to unwanted touch especially breasts or perineal area, coerced nudity.forced observation of masturbation.

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	235626	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Troy	925 W South Blvd Troy, MI 48085

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. This citation relates to Intake 2655900. Based on interview and record review, the facility failed to report a physical and sexual abuse incident for three residents (R103, R104, and R108) of six residents reviewed for abuse. Findings include:Review of a Complaint reported to the State Agency, received on 10/29/25, alleged R108 (a male resident) went into R103's room naked, got into bed with them, and touched her on her breast, and then R103 hit them with her shoe. The complaint further alleged R108 attempted to get into R103's roommates' bed, R104 (a second female resident), and did not touch them. Review of a FRI (Facility reported incident), received by the State Agency on 11/06/25, revealed on 10/28/25, R104 reported R108 came into their room, attempted to get into their bed, and then exposed and fondled themselves next to her in her room. On 11/05/25 at 11:15 a.m., R104 reported a resident-to-resident incident during an interview, which revealed R108 attempted to climb into her bed about a week prior, when R104 was in her bed. R104 said she yelled at R108 to stop, and then R108 stood about four feet away from their bed and exposed and fondled himself. R104 described R108 wearing only a T-shirt when the incident occurred. R104 stated they pushed their call light for assistance, which took five to ten minutes to be answered. R104 reported six staff came into the room, including Licensed Practical Nurse (LPN) E. R104 said the incident made her feel scared when it occurred. On 11/05/25 at 1:25 p.m., Social Worker (SW) B reported they learned there was an incident when they were off work recently, when R108 was taking his clothes off and was going into patient's rooms and was attempting to get into bed with female patients. SW B said R103's daughter learned of it and described to them a male patient was taking his clothes off and masturbating and said they did not know his name. SW B shared Family Member C told them this on 10/27/25, as well as R104, but said they could not recall what R104 told them exactly. SW B reported they notified the Director of Nursing (DON) about the incident. SW B indicated R104 was a credible reporter. Review of R108's Provider Psychiatry note, dated 10/30/25 at 12:43 p.m., revealed, .(R108) is alert and oriented x 2 (spheres) with intermittent episodes of confusion and able to make his needs known. Behavioral concerns have emerged since the last visit with no identified trigger x 1. (R108) has been displaying sexually inappropriate behaviors towards patients and staff, has been getting into the beds of other residents, and has episodes of combativeness. UA (urinalysis) was collected and negative.Review of R108's SW B's progress note, dated at 10/29/25 at 12:36 p.m, revealed, SW follow up 2/2 (secondary to) reports of (R108) displaying inappropriate sexual behaviors.Review of R108's Care Plan showed a behavioral Care Plan 10/29/25, which showed R108 wandered into other residents' rooms, made sexual remarks and found unclothed. On 11/06/25 at 11:12 a.m., CNA H reported they witnessed an incident perpetrated towards R108 towards R103, R104's roommate, on 10/28/25. CNA H described R103 observed R108 in their room in R103's bed, sitting with his pants off, while R103 stood by their bed. R103 then popped R108 in their head with her house shoe, and they pulled R103 away from R108, as R103 was upset R108 was in their bed. R103 reported CNA L assisted them removing R108 from the room, and LPN E was in the room as well. On 11/07/25 at 9:33 a.m., the Nursing Home Administrator (NHA) acknowledged the concerns related to R108 being found without their brief on R103's bed, with CNA L in their room. The NHA denied staff awareness of the exposure incident of R108 towards R104.The NHA reported during their investigation they discovered CNA L and LPN E were aware R108 had been disrobing in his bed and in the facility prior to the incident. The NHA said they should have been made aware so they could have put appropriate interventions in place. The NHA reported they concluded no contact was made between R108 and R103 and R104, although R103 shewed R108 away with a shoe, but denied any physical contact was made. The NHA reported the incident(s) to the State Agency and the police on 11/06/25, after learning about the incident(s). On 11/07/25 at 12:22 p.m,. CNA L was asked during a phone interview about any resident incidents with R108. CNA L reported on 10/28/25 around 2:00 p.m., they had just finished rounds and heard a (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	coworker yell for them to come to R103 and R104's room. They observed R108 in their room, standing by the curtain area (middle of room), looking confused with their pants down and brief removed. CNA L reported R108 then sat on R104's bed, and R103 approached R108, who became combative, and R10 began shewing him away with their house shoe. CNA L reported LPN E and CNA H were present when the incident occurred. Review of a police report, dated 11/06/25, revealed on 11/06/25 at 5:08 p.m., a suspicious circumstances incident was determined, when the NHA reported an incident on 10/28/25, when R108 walked into R104's room, opened his gown, dropped his underwear, and began fondling himself. Review of the policy, Abuse, updated 5/24/2023, revealed, .Residents have the right to be free from abuse, neglect, exploitation, mistreatment, and misappropriation of resident property.The facility will develop and implement written policies and procedures that include: Reporting any allegations of abuse, neglect, mistreatment, exploitation.including reporting a reasonable suspicion of a crime to the State Survey Agency and other officials in accordance with state law.Initial reporting: The facility will ensure that all allegations involving abuse, neglect, exploitation, mistreatment, injuries of unknown source.and crimes are reported immediately to the Administrator and: Reported to the State Agency immediately but not later than two hours after the allegation is made if the allegation involves abuse or results in serious bodily injury and to other officials (including adult protective services and/or law enforcement when applicable, OR reported to the State Survey Agency no later than 24 hours if the allegation does not involve abuse and does not result in serious bodily injury to the State Survey Agency and to other officials.Assuring the reporters are free from retaliation or reprisal. Conclusion reporting: The facility will ensure the results of the investigation are reported to the Administrator and a final report will be submitted to the State Survey Agency no later than five working days after the discovery of the incident. Any knowledge it has of any actions by a court of law which indicate an employee is unfit for service is reported to the State nurse aide registry or licensing authorities.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is based on complaint: 2655900. Based on observation, interview and record reviews the facility failed to provide adequate supervision for a resident with medical issues and physical limitations which makes client unsafe to leave the facility alone and cognitive function and awareness concerns, for one (R105) of four residents reviewed for supervision/accidents. This resulted in the facility's failure to ensure the necessary supervision for R105 was provided. Findings include:A review of a complaint submitted to the State Agency (SA) documented concerns of R105 to have eloped from the facility. A review of the medical record revealed R105 was admitted to the facility on [DATE] with diagnoses that included: unsteadiness on feet, dysphagia, anxiety disorder, chronic obstructive pulmonary disease, hypertension and alcoholic cirrhosis of liver. A Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. A review of a Physician Statement of Capacity for Medical Treatment and Decisions documented R105 . lacks the capacity to make reasoned medical decisions and/or provide informed consent for their medical affairs. The specific cause and/or contributing diagnosis to support this decision. signs & symptoms involves cognitive function & awareness . The capacity assessment was signed by the attending Physician on 8/1/25 and signed by a second clinician on 8/3/25. On 11/5/25 at 12:04 PM, R105 was observed sitting in bed watching his cellphone. When asked about him leaving the facility, R105 stated . I got out. I missed my family. I went down the street and all the staff grabbed me and came back.A review of the medical record revealed no documentation of R105 to have eloped from the facility. Review of the Physician orders revealed the following: . Start 8/19/2025. Resident to wear wander alert bracelet. Every shift check placement on resident. Document placement RA=right arm, LA=Left arm, RL= right leg, LL= left leg, OTH=other AND every night shift check function of wander guard. If not functioning please place new wander guard and enter expiration date. End Indefinite. This order was created by the Director of Nursing (DON). A review of R105's care plans revealed an Exit seeking / elopement risk related to: cognitive loss implemented on 8/19/25. A review of a Elopement Risk Evaluation assessment dated [DATE] at 4:01 PM, documented a score of 16. The evaluation noted . If elopement evaluation score is 12 or greater the resident is considered and <sic> elopement risk.A review of the progress notes revealed the following: On 7/30/25 at 3:32 PM, a Social Work (SW) note documented, . Referral made to (behavioral group name) and (third party company name) for competency eval (evaluation) and petition for guardianship. SW (social worker) to follow up and review.On 8/1/25 at 12:00 PM, a Psychology Note documented, . I certify that my clinical findings support that this client. is facility bound due to: medical issues and physical limitations which makes client unsafe to leave the facility alone and illness requiring supportive devices/special transportation/assistance of another person in order to leave their residence. Facility SW requested psychologist to evaluate mental health, cognition, and determine capacity to make reasoned medical decisions and provide informed consent.On 10/11/25 at 11:03 AM, a Nurse Practitioner (NP) note documented, . discharge was cancelled. This is likely due to patient being deemed incompetent making medical decisions. Chart updated to noted that patient will be here long-term.On 10/13/25 at 10:39 AM, a Social Work note documented, . Guardianship court hearing is scheduled for 10/22/25.On 10/17/25 at 11:46 AM, a Social Work note documented, . Resident is currently his own representative. GA (guardianship) hearing scheduled on 10/22/25. He has strong support from his sister.As of the date of survey (11/7/25- exit date), the facility had not updated the medical record regarding the guardianship hearing outcome. On 11/5/25 at 1:11 PM, the DON was interviewed and asked about their note regarding R105 to have a wanderguard placed on 8/19/25 and asked why an elopement assessment was completed on that date for R105. The DON replied the resident kept saying they wanted to leave. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was asked why the resident was unable to leave if they were their own responsible party and the DON stated they were told the resident had a guardian. The DON stated they were told R105's sister was the resident's guardian. The DON was then asked specifically if R105 eloped from the facility on 8/19/25 and the DON stated they would have to look into their notes. The DON was asked where their notes were documented, as the medical record contained no documentation of the resident to have left the facility unsupervised and the DON stated they keep notes in their office and requested to look into it and follow back up. At 2:03 PM, the DON returned and stated the resident did leave the facility when they were allowed outside to smoke, so a wanderguard was placed on the resident. The DON stated the resident currently is able to go out to smoke with the supervision of a staff member, since the incident on 8/19/25. The nurse assigned to R105 at the time of the incident was identified as Licensed Practical Nurse (LPN) P. LPN P was interviewed on 11/6/25 at 8:42 AM and asked if they remembered the incident with R105 to have left the facility unsupervised and LPN P stated they did. LPN P stated that residents who smoke get LOA (leave of absence) passes. LPN P stated they believed it was the front receptionist that called them that day to inform them that R105 was walking away from the facility. LPN P stated they went to retrieve the resident with Unit Manager (UM) Q, who was no longer employed at the facility. On 11/6/25 at 10:08 AM, UM Q was interviewed and asked about the incident with R105 to have left the facility unsupervised and stated R105 would go outside to smoke. UM Q stated they received a call telling them that R105 was walking up the street. UM Q stated they got in the car with LPN P and drove around to find R105. UM Q stated they found R105 and got them into the car and brought them back to the facility. UM Q stated R105 could only go out to smoke with the supervision of a staff member after the incident. When asked, UM Q stated they were not informed of R105 to have been deemed incompetent to make medical decisions until they were informed after the incident by the DON.On 11/5/25 at 2:17 PM, the Administrator was interviewed and asked about the incident with R105 and stated the resident signed themselves out LOA to go and smoke (the facility is not a smoking facility). The receptionist saw that R105 was walking and informed the staff. The Administrator stated . he was his own responsible party. The Administrator stated they directed staff to go and get R105. The Administrator was asked why they directed staff to obtain R105 to bring them back to the facility if they were their own responsible party and had signed out on a LOA, and the Administrator stated that R105 was their own responsible party at the time and they should have not brought the resident back to the facility.A review of a facility policy titled Leave of Absence revised 5/17/24, documented in part . Any resident who leaves the facility. will have a Leave of Absence order and be signed out on the Leave of Absence form at their nurses' station. A leave of absence may include but is not limited to: going to a medical appointment, a non-medical leave (such as going shopping, to a family gathering, a home visit etc.) going on a facility activity outing, etc. The resident must have a physician's order to go on a leave of absence. The physician may place parameters on the resident's leave of absence which may include whether the resident can take their medications with them on LOA. If the resident is their own responsible party, they may sign themselves out on the Leave of Absence Form. If they cannot make their own decisions and has a legal representative, the representative signs the resident out on the Leave of Absence Form.A review of R105's record revealed no physician's order ever implemented for a leave of absence.On 11/6/25 at 12:20 PM, the Administrator was recalled for a second interview and asked about R105 to be deemed to lack the capacity for medical treatment and decisions per the capacity document that noted cognitive function and awareness concerns. The Administrator was asked why they considered R105 to be their own responsible party when they were deemed to lack the capacity for medication treatment and decisions as of 8/3/25. At that time the Administrator acknowledged the concern. The Administrator was then asked how the facility allowed R105 to leave on LOA when they did not have a physician's order as noted in their policy and the Administrator acknowledged the concern. At 1:17 PM, the Administrator returned and stated interventions were put in place (staff accompanying resident for smoke breaks) once the incident with R105 and at the time (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they believed R105 were their own responsible party as a guardian had not been assigned to R105 at the time of the incident. When asked about the current status of R105's guardianship, the Administrator stated they were informed that R105's sisters were appointed guardianship over R105, however they were waiting for the documents to be sent to the facility. No further explanation or documentation was provided.