STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245596	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Shores of Worthington	1307 South Shore Drive Worthington, MN 56187

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 observation, interview, and record review, the facility failed to protect 1 of 10 residents (R1) reviewed for sexual abuse, from sexual abuse by another resident (R2) who had a known history of sexually inappropriate behaviors. This resulted in an Immediate Jeopardy (IJ) when R1, who had severe cognitive impairment was sexually abused by R2 and was unable to independently protect herself from unwanted sexual contact. The IJ began on 2/5/26, when staff found R2 in a resident common area with his hand under R1's shirt touching her breast while she was resting in a recliner. R2 was placed on 1:1 supervision on 2/6/26; however, he was removed from 1:1 supervision on 2/11/26 and placed on 30-minute safety checks. The removal of continuous supervision left female residents vulnerable to R2's ongoing and escalating sexually inappropriate behaviors without sustained and consistent interventions to prevent reoccurrence. The Administrator, director of nursing (DON), social services, vice president of clinical services (via phone), and chief operations officer (via phone) were notified of IJ on 2/19/26 at 4:11 p.m. The citation was issued as at past non-compliance when the facility implemented a sustainable plan of correction which removed the immediacy on 2/7/26. Findings include R2's prior facility referral/screening record faxed to the facility on 8/19/25, included a face sheet dated 8/12/25. The records faxed from the previous facility also included R2's care plan, progress notes, and current medications. R2's progress notes dated 8/3/25 indicated R2 displayed behaviors of urinating in public and following and trying to touch/rub another resident's arm. Progress notes on 8/4/25 indicated between 8:49 a.m. to 10:03 a.m. R2 required staff redirection after he demonstrated repeated behaviors of rubbing female residents' shoulders and/or arms. Progress note at 10:49 a.m. indicated an incident had occurred that was reported to the State Agency and the family member was notified (incident was not defined). The prior facility had revised R2's care plan on 8/4/25 identified R2 had displayed inappropriate sexual advances towards female resident(s) with intervention to have 1:1 supervision to prevent behavior on 8/4/25. Progress notes between 8/5/25 through 8/18/25 indicated R2 was on 1:1 supervision with no further behaviors of touching female residents documented. R2's Family Medicine Visit dated 8/28/25, identified R2 was seen for a physical for potential transfer. R2 had been 1:1 supervision since 8/5/26. R2 can be easily redirected. R2's face sheet dated 2/19/26, identified R2's admission date to [NAME] of Worthington on 8/28/26 with diagnoses that included of vascular dementia, unspecified severity, with other behavioral disturbances, mixed obsessional thoughts and acts, and depression. R2's Behavioral Health visit note dated 8/6/25 scanned to [NAME] of [NAME] on 8/28/26 at 2:30 p.m. included Staff report that the patient is easily redirectable and will stop behaviors when told to. State report this week when he was noted by staff to be touching women shoulders and one woman's breast. Staff reports he touches himself in public and will pee in different public areas of the building. R2's Social Service-Resident Vulnerability and Susceptibility to Abuse assessment dated [DATE], Identified R2 had cognitive and communication (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	impairments, and wandered into other resident rooms/belongings. Additionally identified R2 was a vulnerable adult unable to report, but no signs of abuse or neglect present. The box that was not checked (indicating not present) included Inappropriate sexual comments/or behavior. Section A1. If other, describe was blank. The assessment did not include R2's history of sexually inappropriate behaviors. R2's care plan dated 9/11/25, identified a focus of Impaired Social Interaction with nterventions dated 10/17/25, monitor R2's level of social interaction. Observe R2's interactions with others. R2 is allowed to stand and look at people. When/if R2 reaches out to touch other residents, intervene and offer staff companionship. Guardian states the only thing R2 wanted in life was to have a home and get married. R2 never did marry and seeks out companionship. If staff is unable to sit with him, redirect him to another area. Intervene when R2 attempts to touch peers without permission. R2 does not seem to understand personal space. Help guide him. Provide safety not judgement. R2's care plan was updated on 10/9/25, with a focus of Behavior Management: taking others food or drink. Interventions included: utilize diversion techniques as needed, provide verbal feedback to R2 regarding behavior, establish boundaries and limits with R2. Review of R2's care plan between 8/28/25 through 11/7/26 did not identify R2's history of sexually inappropriate behaviors as described in the referral documents (touching of woman's breast and rubbing women's shoulders) nor interventions that identified prevention measures and/or any known potential triggers to monitor to mitigate R2's risk of re-current inappropriate sexual touching behaviors. During an interview on 2/19/26 at 11:05 a.m., social worker (SW)-A felt R2's behaviors at the prior facility were directed at only one woman, was mutual in nature, and the woman had consented until the woman did not. When R2 first admitted , the sexual behaviors were not happening with female residents so historic sexual behaviors were not incorporated into the care plan upon admission. The care plan was updated when new behaviors were identified. Any nurses or management can update care plans when the need arises. Care plans represent how to care for the residents. Staff should always go to the charge nurse if they see a behavior. Staff could always go to management when they were uncertain if behavior was reportable or not. R2's quarterly MDS dated [DATE], identified R2 had severe cognitive impairment, no issues with hearing or speech, sometimes socially isolated. R2 had other behavioral symptoms not directed towards other (e.g. physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds.) R2 used a walker, needed partial assistance with dressing, setup or clean-up assistance with toileting, and was independent with walking in facility. R2 had a wander/elopement alarm. Between 11/4/25 and 2/1/26, progress notes repeatedly documented R2 hand holding and/or rubbing hands with female residents, rubbing/grabbing/attempting to touch female residents' arms/hands, standing over/in front of/standing by female residents and/or staring in dayroom settings, approaching/going toward female residents despite redirection, behavior involving breasts/chest, public sexual behavior (hands down pants), and agitation/anger/yelling/cussing associated with redirection; redirection/reminders/education were documented across the period with variable effectiveness documented. The following progress notes are representative excerpts from the record and are not an exhaustive listing of all entries reviewed during the period. R2's progress note dated 11/4/25, identified R2 sat at a table during breakfast holding a female residents hand. R2 then started rubbing her hand up and down with his hand. Nurse removed R2 and had him sit in the dayroom. Couple minutes later, R2 was up from recliner and standing over same resident. R2 stood over resident for almost 15 minutes before sitting back down in recliner. During evening hours R2 continued holding another female residents' hands, R2 would be asked to sit down, sit down and within 2-3 minutes, R2 would be standing next to resident (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	holding her hand. R2 did this for almost an hour. R2's progress note dated 11/5/25, R2 had been observed rubbing arms of several female residents. Easily redirected each time, but behavior persisted throughout shift. R2's progress notes dated 11/6/25, identified R2 has been getting and staying close to the ladies. Approaching them in an inappropriate manner. Stopped by staff before he touched a resident on her breasts. Has a hard time with redirection. Continues to stand around women. Tried to touch several woman residents, however, staff were able to redirect. R2 will stand in one spot and stare at female residents and this does make some of them uncomfortable. Psychiatric doctor notified of increased inappropriate behaviors. POA called and stated she wanted staff to keep ahead of any incident, be very firm and set boundaries with R2. During the evening, R2 walked to a resident that was sitting in a recliner and held her hand and rubbed her hand up and down. R2 was advised not to touch people without permission and R2 stated she touched me. This was not true as R2 walked to her and that resident is unable to move herself. R2 would be told to leave her alone and he would turn around and when staff were not looking would go to resident again. The woman did not understand why R2 was holding her hand but did hold his hand back. R2 is very fast and will walk across the room back to the resident after being told to sit down. R2's care plan was updated 11/7/25, included Behavior Management: touching of other residents. Interventions included: provide verbal feedback to R2 regarding behavior. Remind R2 we are not to touch other residents. Establish boundaries and limits with R2. Redirect R2 away from other's things to his own. Offer R2 alternative objects/snacks/drinks. Try to pass R2's tray first. Do not allow physical contact with other residents. Intervene and direct R2 away from resident of interest or walk with him to his room. Although the care plan directed staff to not allow R2 physical contact, R2's record between 11/7/25 and 2/5/26 identified multiple instances staff did not prevent R2 from having physical contact with female residents. --removed bolded R2's progress note dated 11/9/25, identified R2 had been trying to hold hands with a female resident while she was sleeping. R2 had to be redirected more than 25 times. R2 is very quick and with three staff in the room, will be found standing over the female resident moments after staff seen him in a chair across the room. Female resident had to be moved to be near staff as it was too hard to keep R2 away. R2's progress note dated 11/12/25, identified R2 had been standing in front of female resident or sat next to them and tried to touch them if nobody was watching. R2's progress note dated 11/13/25, identified R2 was redirected various times to not touch another resident. R2 would walk up to the resident in the recliner and start massaging the resident's chest. Staff is on alert and will quickly redirect R2, trying to keep R2 away from female residents. R2 was looking around and then would walk to R1 and stand right by her, getting too close if no redirection. During a phone interview on 2/19/26 at 9:35 a.m., R2's guardian stated the facility knew all about R2's explained the escalation of sexual behaviors with female residents at both an Assisted Living and the nursing home he discharged from; both prior incidents started with obsessing over individual female residents, progressed to touching (like handholding) then resulted in touching female breasts before they accepted him to their memory care unit. The long-term care Ombudsman and guardian informed and discussed with the facility social worker (SW) R2's sexual behavioral history that had gone too far at two prior facilities R2 had resided at. Guardian informed SW of R2's sexual behaviors patterns including initial presentation and escalation and warned SW to not let anything start because it would go too far just like it had at the other two facilities. In response SW reassured Guardian that facility would be able to manage the behaviors. Not long after admission, Guardian was called because staff noticed R2 was rubbing ladies shoulders. Guardian stated R2 was easily redirectable, but his short-term memory was so short it did not take him long to forget what was just said- you cannot reason with [R2.] (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility staff were very aware to frequently redirect to stop R2 from rubbing shoulders. Memory care units should have the tricks of the trade for how to manage these behaviors but every time guardian had been at the facility R2 was sitting in the dayroom in a recliner facing R1, who was the lady R2 really liked. Guardian received a phone call from SW-A on 2/6/26, that R2 had gone under a female resident's shirt and touched her breast. Guardian felt the facility failed R2. During an interview on 2/19/26, at 9:08 a.m., licensed practical nurse (LPN)-A stated when R2 first admitted to facility, she was unaware of any behaviors. R2 was calm and redirectable. Staff knew as soon as R2 began eyeing them he would head in R1's direction, R2 had his attention always focused on R1. R2 began by just holding R1's hand but then it progressed to going up R1's arm. R1 and R2's care plans both reflected hand holding was permissible (however review of R2s care plan was not revised to include hand holding); staff were directed to redirect R2 from R1 and tell R2 to keep his hands to himself. During shift-to-shift report, the nurse would always report how much re-direction was given so the oncoming shift would be vigilant with R2's supervision. On 11/13/25, in the dayroom, LPN-A observed R2 standing over R1. R2 put his hand on the top of R1's chest by her neck area and rubbed the area. This was the first time LPN-A had witnessed R2 touch R1 someplace other than her hand. R2 was directed to keep his hands to himself and go to his recliner and sleep. R2's progress note dated 11/14/25, identified R2 kept going to R1 and attempted to touch her multiple times but was easily redirected with no behavior. R2's psychiatry visit note dated 11/14/25, identified chief complaint and staff concerns of increased inappropriate behaviors including touching women's breasts and rubbing and holding their hands. Behavioral concerns/inappropriate behaviors: start Brexpiprazole (antipsychotic medication) 0.5 milligrams (mg) daily for behavioral concerns likely secondary to dementia. R2 has had increasing inappropriate behaviors towards female residents and may benefit from low dose antipsychotic. Safety: staff to continue redirection, being very clear and direct with R2 when behaving inappropriately. R2 needs consistent redirection with clear expectations, which may include asking R2 to leave the day area when being inappropriate with other females. R2's care plan was not updated after psychiatry visit until 11/17/25. R2's progress notes dated 11/15/25, identified R2 was seen for a psychiatric visit by certified nurse practitioner (CNP)-A. Provide clear and direct redirection with R2. R2 was standing in front of female residents and tries to touch them. Staff have tried redirecting multiple times but ineffective. R2's Behavior Management care plan intervention updated 11/17/25, identified: Provide verbal feedback to R2 regarding behavior. Provide clear and direct redirection when R2 is acting inappropriately. R2 needs constant redirection with clear redirection, which may include asking R2 to redirect out of dayroom. R2's Nursing Note dated 11/19/25, identified director of nursing (DON) completed R2's assessment on phone call with guardian/power of attorney (POA)-A. Reviewed policies for Resident Sexual Expression, and resident to resident altercations. DON stated R2 was provided frequent monitoring while awake and firm re-direction when seeing this behavior. POA-A stated she wants to help facility prevent this from occurring, by maintaining communication with facility and psychiatry. R2's Resident Capacity to Consent to Sexual Activity dated 11/19/25, identified R2 is seeking companionship from a female resident per POA. R2 likes to socialize by placing hand on other female resident's hand. Noted to have been stopped by staff to move hand towards breast area. R2 easily redirectable but continues to touch residents' hands. R2 does not have the capacity to understand sexual options and the potential consequences of sexual choices. Precautions implemented to maintain resident safety including R2 has been on frequent monitoring while awake with frequent firm re-direction and reminders to not touch others without consent. R2 does not have any relationship with a resident. R2 is on a dementia unit. R2 is seeking companionship and wants to be affectionate. R2 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	urinating in public space. Interventions updated to include: utilize diversion techniques as needed. Likes to watch TV and color. POA supplies art supplies and other activities for R2 to do in his room. When resident is trying to touch another resident redirect to another area. Encourage R2 to sit in recliner to watch TV or go to room and work on art projects. Offer him a place at the table and offer a snack and beverage. Remind R2 that we cannot touch people without their permission. When wandering to others room or aimless-ask if he needs to use the bathroom and redirect him to his room. R2's psychiatry visit note dated 12/12/25, included behavioral concern/inappropriate behaviors and addressed changes to psychotropic medications as R2 is identifying inappropriate boundaries with peers, repetitive compulsions of stealing food and drink, restlessness, and anxiety. Discussed Naltrexone (medication to treat alcohol disorder) as guardian reports in the past this has improved R2's impulsivity, however, it is contraindicated due to elevated liver enzymes. Safety: staff to continue redirection, being very clear and direct with R2 when behaving inappropriately. R2 needs consistent redirection with clear expectations, which may include asking R2 to leave the day area when being inappropriate with other females. R2's progress note dated 12/13/25, identified R2 would go and stand over another resident while she was in the recliner, R2 had to be reminded numerous times to go and sit down and not stand over her. R2's progress note dated 12/15/25, identified R2 kept going to R1 and standing by her. When redirected would get upset and yell at staff. R2's progress note dated 1/1/26, identified R2 was found with his hand resting on shoulder of another resident after lunch. Easily redirected. R1's progress note dated 1/1/26, identified R2 had his hand on R1's shoulder. Nurse asked if resident was okay, and she stated yes. Asked if anyone hurt her or made her uncomfortable and R1 stated no. R2's progress note dated 1/12/26, identified R2 continued to approach female resident in her recliner and hold hands. Easily redirected but will continue to approach her over and over again. R2's progress note dated 1/17/26, identified R2 made multiple attempts to stand at the side of another resident's chair and hold her hands. Always easily redirected but redirection was required frequently. R2's progress note dated 1/30/26, identified R2 stood by a recliner chair around a female resident multiple times. After redirection, would go to another resident and put his hands on her shoulder. R2's progress note dated 2/1/26, identified R2 lifted his shirt up and stuck his hand down his pants while sitting with his legs spread over the top of the arms of the recliner in the dayroom. The facility reported incident (FRI) dated 2/6/26, identified yesterday morning (2/5/26), R1 was sitting in recliner resting and R2 had touched breast. During an interview on 2/18/26, at 11:40 a.m., NA-A stated when R2 first came to facility he did not have any issues. R2 stayed in his room mainly and would come to the dayroom and relax in a recliner. NA-A was unaware of any sexual history with R2, it had been okay for R2 to hold hands with female residents. A couple of months ago, R2 began touching R1's arm, standing beside her, watching her, and would move his chair to get closer to her. R1 would be asleep most of the time when R2 would do these things to her. On 2/5/26, between breakfast and lunch, NA-A returned to the dayroom and a resident was pointing towards R2 and R1. R2 was standing over R1, who was in a recliner, with his hand under her shirt touching her breast. NA-A told R2 to stop touching R1, back away from her, that it was inappropriate, and directed R2 to either go to his recliner or his room. R1 had been sleeping and woke up and said, what are you doing? NA-A stated she told the nurse to keep an eye on R2 because he had been constantly touching and staring at women and it literally takes half a second and he is up and out of that chair doing the same thing. During the rest of that shift (on 2/5/26), R2 was not just going towards R1 but also towards another resident, he touched her hand. Prior to the incident, R2 only had these behaviors with R1. After the incident R1 was moved out of the memory unit within one day. During an interview on 2/18/26 at 1:31 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	p.m., NA-B stated after her break on 2/5/26, probably around 9:30 a.m., NA-A told NA-B about the incident with R2 putting his hand on R1's breast. NA-A had said she told the nurse. For the rest of the day NA-B and NA-A tried to keep a close eye on R2 and kept having R2 go back to his room when he would go to the dayroom. R2 would wander a lot and go from recliner to recliner in the dayroom. NA-B had never seen R2 and R1 hold hands. R2's progress note dated 2/6/26 at 1:15 p.m., identified R2 was redirected to keep appropriate distance from other residents. At 3:00 p.m., due to new incident reported resident immediately placed on 1:1. R1's progress note dated 2/6/26, at 3:05 p.m., identified interdisciplinary team (IDT) met and discussed moving R1 to main area of facility. R1 moved to main area at 3:00 p.m. R1's physician order dated 2/6/26, identified to monitor any physical, emotional, or mental distress: document any findings or changes in R1's status for 14 days. R1's progress note dated 2/6/26, at 3:30 p.m., SW-A spoke with R1 around 11:00 a.m., while observing for behaviors and interactions with other residents. R1 has memory issues but able to speak freely when she wants to. Asked how R1 was doing, she nodded her head. Asked if she had any problems or concerns and if she felt safe. R1 looked at SW-A, smiled, and closed eyes. SW-A had an email conversation with guardian about moving R1 upstairs due to more behaviors of verbal outbursts and loud yelling on the memory unit and R1 no longer being an elopement risk. Decision made to move R1 sooner rather than later due to staff allegations of another resident inappropriately touching resident. Guardian notified of allegation and in agreement with course of action. R1's care plan dated 2/6/26, identified Safety General: Vulnerable Adult. Resident would remain safe in facility with interventions that include R1 was moved from memory care unit to new room immediately due to alleged abuse report. Monitor for any physical/mental/emotion signs of distress. R2's Behavior Management care plan updated 2/7/26, focus included impulsivity. Additional focus Safety General: Vulnerable Adult created on 2/7/26, with interventions that included R2 currently on 1:1 supervision with staff for safety. R2's fax cover sheet dated 2/7/26, to primary care physician, identified Vulnerable Adult (VA) filed due to R2 touched other resident inappropriately. No injury or issue noted. Do you have any order? Please advise? The fax was returned on 2/9/26, with a response to continue documenting behaviors and redirect R2. No medication changes at this time. Will be at facility on 2/13/26. R2's progress note dated 2/8/26, witnessed attempting to walk towards a dining table with female residents multiple times. Redirected successfully. 1:1 monitoring continues. R2's Behavior Management care plan updated 2/9/25, focus removed OCD and impulsivity. Interventions updated: have staff sit with R2 or visit. Help fulfil need of companionship. On 2/9/26, try to deter/stop physical contact from R2 with other residents. Have staff sit with him or visit. Help fulfill need of companionship. If wandering, ask him if he needs to use the bathroom and if so direct him to his bathroom. R2's progress note dated 2/11/26, identified R2 was on 1:1 for recent event. Removed from 1:1 after chart review and no action occurred, no concerns from staff. Continue on 30-minute safety checks at this time. R2's psychiatry visit note dated 2/13/26, identified chief complaint of more inappropriate behaviors. Last week, reportedly groped another resident. Will be transferring to an old man's nursing home. Staff continue redirection, being very clear and direct with R2 when behaving inappropriately. R2 was separated from female resident he was being inappropriate with. R2 will be transferring care next week to an all men's nursing home. During a continuous observation on 2/18/26 that began at 2:14 p.m. when R2 was sitting in a recliner in the common area eating ice cream; activity assistant (AA)-A was also in the common area. R2 then stood up turned his head toward staff and began slowly walking toward two female residents as AA-A began walking towards R2. When R2 reached the female residents, he asked how she was. AA-A asked R2 to sit in the recliner next to the female resident with a small side table separating them and asked if R2 (continued on next page)

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	245596	A. Building B. Wing	02/19/2026

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	wanted to play a game. RN-B redirected R2 back to his recliner across the room. At 2:19 p.m., R2 stood up from his recliner and began walking slowly to the female resident sitting across from him but then stopped and stared at her when he was halfway to her. NA-D walked up to R2 and asked if he wanted a drink or snack; R2 responded no. NA-D directed R2 to sit and then walked away. R2 remained standing where he was watching NA-D walk away. At 2:20 p.m., R2 moved closer to the female resident staring at her. NA-D watched from a distance. At 2:21 p.m., R2 stood in front of a different recliner staring at a female resident. R2 turned his walker and began walking toward the female in the recliner. RN-B went to R2 and told him to sit down. At 2:22 p.m., R2 went back to his recliner, turned around, and began walking back to the female resident. RN-B stated R2 needed to sit by NA-D at the dining room table. DON asked R2 if he wanted to go to his room and R2 began following DON down the hall. At 2:34 p.m., R2 was back in dayroom with SW-B following him. SW-B placed a blanket on R2 and sat in a chair next to him in his recliner. SW-B walked away from R2 to talk to DON and RN-B at medication cart. At 3:16 p.m., R2 began sitting forward in his chair. At 3:16 p.m., R2 was looking towards the medication cart and staff. At 3:18 p.m., R2 began sitting up in recliner and sat back down when he saw RN-B, DON, and SS-B were watching him. SW-B returned to the chair next to R2. R2's progress note dated 2/18/26, identified at 3:06 p.m., call placed to behavioral health to update on current behaviors. Progress note at 3:19 p.m., nurse brought forward concern of R2 attempting to seek female residents after lunch. Nurse kept R2 on 1:1 until notifying DON. Redirectable but placed on 1:1 for safety at this time. Progress note at 4:34 p.m., behavioral health returned call. R2 had been attempting to approach two ladies that have been resting in dayroom recliners. Has required multiple redirection attempts and has been a 1:1 since before lunch. Easily redirected but will reattempt in a matter of a few minutes. Order for Olanzapine (antipsychotic) 5mg as needed provided. R2 has been sent to room on several attempts for a distraction attempt, given snack and drinks, offered activity and declined. Watching TV in both his room and dayroom, will fall asleep and when wakes up will reattempt to approach ladies again. Has been diverted away before reaching them. Progress note at 6:45 p.m., R2 has made multiple attempts to approach female resident in recliner. Immediately redirected by NA and other staff providing 1:1. Easily redirected with no behaviors but requires frequent redirection. R2's Behavior Management care plan interventions updated 2/19/26, identified 1:1 with staff with escalation of behavior of trying to touch others. During an interview on 2/18/26 at 3:15 p.m., DON stated RN-B informed her that R2 had st

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. Based on interview and document review the facility failed to designate a physician to serve as Medical Director. This deficient practice had the potential to affect all 52 residents currently residing at the facility.Findings include Findings include:During an interview on 2/18/26 at 10:07 a.m., director of nursing (DON) stated the former Medical Director (MD) retired in June or July and the position has yet to be filled. During a follow-up interview on 2/19/26 at 2:58 p.m., DON stated she was the only person that reviewed clinical trends, participated in Quality Assurance Performance Improvement (QAPI) clinical review.During an interview on 2/19/26 at 3:18 p.m., Administrator stated the MD position had been vacant since July 2025. Administrator indicated that the medical physician group in town would not contract physicians with the facility. The facility has attempted two other medical groups and currently is working on contract negotiations with an MD from one of the groups. Administrator had informal conversations with physicians when they would round at facility. There was no notification to the Governing Body but they are aware I talk to ownership every day. Administrator was unsure how physician-level oversight, contractual obligations, and compliance with federal requirements were achieved since July 2025.The facility Medical Director policy reviewed 3/2/25, identified: Implementation of Resident Care Policies and Procedures:admission policies and care practices.Availability, qualifications and clinical functions of staff to meet resident needs.Advance Directives and end of life care.Provisions to enhance resident decision making.Communicating/resolving medical care issues.Procedures/guidance related to practitioner notification. Coordination of Medical Care:Ensure primary/ backup physician coverage.Ensure that physician services are available to attain and maintain highest level of functioning.Address and resolve issues between physicians, practitioners and facility staff.Input to the FacilityFacilitating feedback to physicians and practitioners regarding performance/practices.Review individual resident cases as requested.Review consultant recommendations.Discuss and intervene when medical care is inconsistent with current standards of practice. The Medical Director shall meet all other responsibilities of a qualified physician, as set forth in Federal and State law and will provide copies of current licenses as necessary to the facility.To develop written by-laws, rules and regulations, which are to be approved by the governing authority and which include delineation of the responsibilities of the attending physicians.To maintain liaison with the attending physicians to ensure that orders are written by them in a timely manner (as dictated by state code and facility policy) upon admissions/readmission of a residentTo periodically evaluate the adequacy and appropriateness of the health care professionals and supportive staff and servicesTo review incidents and accidents that occurs on the premises in order to identify hazards to health and safety.To give appropriate information to the Administrator in order to ensure a safe and sanitary environment for residents, visitors and staff.To be responsible for the execution of resident care policies.Ongoing service as requested. Additional Responsibilities to include preparation of: The standards and procedures for granting and withdrawing physician appointments and privileges.A plan for medical board meetings.The provision for the required initial and periodic medical examination for all residents.The requirements for clinical recordsPresenting and attending the Quality Assurance Performance Improvement meetings

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and document review the facility failed to incorporate a Medical Director into the Quality Assurance Performance Improvement (QAPI) committee. This deficient practice had the potential to affect all 52 residents currently residing at the facility.Findings include:Review of QAPI from July 2025-Januaray 2026, identified no Medical Director was in attendance for QAPIDuring an interview on 2/18/26 at 10:07 a.m., director of nursing (DON) stated the former Medical Director (MD) retired in June or July and the position has yet to be filled. During a follow-up interview on 2/19/26 at 2:58 p.m., DON stated she was the only person that reviewed clinical trends, participated in Quality Assurance Performance Improvement (QAPI) clinical review.During an interview on 2/19/26 at 3:18 p.m., Administrator stated the MD position had been vacant since July 2025. The former MD was a quarterly attendee for QAPI and he last attended in June 2025. This would only be the second quarter the facility was missing a MD. Administrator was unsure how physician-level oversight, contractual obligations, and compliance with federal requirements were achieved since July 2025.The facility QAPI plan undated, identified:This facility shall develop, implement, and maintain an ongoing, facility-wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems.Policy Interpretation and ImplementationThe objectives of the QAPI Plan are to:Provide a means to identify and resolve present and potential negative outcomes related to resident care and services;Reinforce and build upon effective systems and processes related to the delivery of quality care and services;Provide structure and processes to correct identified quality and/or safety deficiencies;Establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome;Help departments, consultants, and ancillary services that provide direct or indirect care to residents to communicate effectively, and to delineate lines of authority, responsibility, and accountability;Provide a means to centralize and coordinate comprehensive QAPI activities in order to meet the needs of the residents and the facility; andEstablish systems and processes to maintain documentation relative to the QAPI Program, as a basis for demonstrating that there is an effective ongoing program.AuthorityThe owner and/or governing board (body) of our facility shall be ultimately responsible for the QAPI Program.The Administrator is responsible for assuring that this facility's QAPI Program complies with federal, state, and local regulatory agency requirements.ImplementationThe QAPI Committee shall oversee implementation of our QAPI Plan. A QAPI Coordinator shall coordinate QAPI Committee activities, including documentation.This committee shall meet monthly to review reports, evaluate the significance of data, and monitor quality-related activities of all departments, services, or committees.The QAPI Committee shall oversee and authorize QAPI activities, including data-collection tools, monitoring tools, and the basis for and appropriateness and effectiveness of QAPI activities.The committee shall approve any corrective actions, including changes in policies and/or procedures, employment practices, standards of care, etc., and shall also monitor all corrective activities for appropriateness and/or the need for alternative measures.The committee may recommend ways to reinforce and expand identified positive approaches and outcomes to various departments or services.Individual departments or services shall develop quality indicators for programs and services in which they are involved and which affect their function.Information regarding QAPI activities is confidential and may be disclosed only in accordance with applicable laws and regulations.Departments, services, and committees shall submit their reports to the QAPI Committee as directed by the committee.EvaluationThe facility shall evaluate the effectiveness of its QAPI Program at least annually and shall present their conclusions to the owner/governing board for review.The QAPI Committee, Administrator, and the (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	governing board shall review and approve a summary of problems and corrective measures.CoordinatorThe QAPI Coordinator shall attend and/or review minutes of meetings of other committees or departments as needed.The QAPI Coordinator will help other committees, individuals, departments, and/or services develop quality indicators, monitoring tools, criteria, and assessment methodologies, and help them identify and evaluate concerns impacting resident care and safety.The QAPI Coordinator will act as a liaison among committees, individuals, services, and/or departments regarding QAPI activities