

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2025
NAME OF PROVIDER OR SUPPLIER Montana Veterans Home N H		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Veterans Dr Columbia Falls, MT 59912	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to recognize and prevent sexual abuse and neglect, and identify the residents' ability to consent to sexual activity, for 9 (#s 9, 12, 17, 44, 61, 77, 78, 80, and 89) of 28 sampled residents. This deficient practice resulted in residents participating in sexual activities who were unable to make their own decisions, which increased the risk of sexual abuse and psychosocial harm for residents, and this was identified to be an Immediate Jeopardy situation; and, based on observation, interview, and record review, the facility failed to ensure a resident was free from physical abuse by a staff member, which resulted in a skin tear on the resident's left hand for 1 (#20) of 28 sampled residents. On [DATE] at 9:58 a.m., the Administrator and facility management team were notified that an Immediate Jeopardy existed in the area of F600. related to the failure to address sexual activity amongst the residents. The Severity and Scope identified for the Immediate Jeopardy were identified to be at the level of a K, and when the immediacy was removed, lowered to an E. The facility provided a plan to remove the immediacy, which was accepted by the State Survey Agency and the CMS Kansas/Denver Regional Office, and the facility carried out the plan which was verified onsite on [DATE] at 12:52 PM. Findings include:1. Resident #17:</p> <p>During an interview on [DATE] at 11:37 a.m., staff member H stated there were many residents in the facility who participated in sexual activity with other residents. Staff member H stated resident #17, who resided in the SCU, had been with many other male residents and was "sucking on their penis, with multiple residents." Staff member H stated they felt this behavior was wrong between the residents, as they were unable to consent for themselves. Staff member H stated they reported the sexual abuse to staff member B, but staff member B had told them the family was aware and had given consent on behalf of the residents.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 1:57 p.m., staff member L stated all the staff members knew about the sexual relationships between the residents, and staff member L stated, "Gosh I feel bad." Staff member L stated resident #17 had been on another unit, and there had been a complaint from resident #77. The complaint was that resident #17 had said words that were inappropriate and with sexual innuendos towards him. Staff member L stated resident #17 was then moved to the SCU unit because it was a smaller unit and staff could keep a closer eye on him. Staff member L stated they had later received a report of an incident with resident #89 and resident #17, where resident #89 had no clothes on and resident #17 was on top of resident #89 performing oral sex. They stated this occurred about four months ago. Staff member L stated the POA was notified and moved resident #89 out within a few weeks. Staff member L stated about three weeks ago, resident #17 had went into resident #9's room. Staff member L stated resident #17 had resident #9 on the bed with resident #9's pants around his ankles and the brief open. Staff member L stated staff walked in just before sexual contact had been made. Staff member L stated resident #17 seemed like he attempted to lure other residents into his room. Staff member L stated the residents residing on the SCU were unable to consent for sexual activity for themselves.</p> <p>Review of resident #17's chart showed the following nursing notes:</p> <p>-[DATE] - "alleged accusation of [Resident #17] wandering into neighbors room [Resident #77] and laying in his bed, accusations of sexual innuendos. The resident stated he felt harassed, and he was teary during the interaction. The staff advised the house supervisor, who was staff member D. The documentation did not show actions taken at that time to ensure the resident's safety.</p> <p>-[DATE] - Staff member D and staff member B met with resident #77, and he stated he felt unsafe with #17. The notes showed, [Resident #17] has gone into [Resident #77's] room multiple times thinking it's his room asking why he is in his bed. It was determined that [Resident #17] will move to SCU today. &hellip; [sic]</p> <p>-[DATE] - "[Resident #17's] POA" made aware of new roommate &hellip; [sic]</p> <p>-[DATE] - "[Resident #17] was found by CNA performing oral sexual activity to roommate [Resident #89] on roommate's bed &hellip; Voicemail left to [Staff member B] &hellip; [sic]</p> <p>-[DATE] - "[Staff member D] explained the situation to [Resident #17's] POA" who was shocked, but stated if parties consenting he just wants his [resident] to be happy. &hellip; [sic]</p> <p>-[DATE] - "CNA found other res. in [Resident #17's] rm laying with pants down & brief partially down. [Resident #17] was in the process of bending over his peri area without contact with res., when CNA stopped him. &hellip; Later, [Resident #17] was found with arm around [Resident #44's] waist walking toward [Resident #17's] bedroom with him &hellip; [sic]</p> <p>-[DATE] - " [Resident #17] is A&Ox1 (self). BIMS score is 9/15. Score indicates moderately impaired cognition. Mood/behavior concerns include recent sexual behaviors toward other residents & increasing self pleasure. &hellip; [sic]</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>&ldquo;&hellip; [Staff member D] informed [NF2] of the situation that had occurred b/w [Resident #89] and his roommate. [NF2] was upset, stating her [family member] would never engage in such behaviors. [Staff member D] explained, based on notations from staff, [Resident #89] reports he wasn&rsquo;t injured and was okay. It was documented there appeared to be no struggle or resistance. [NF2] again said [Resident #89] would never, and has never, engaged in such activity. This writer asked about [Resident #89&rsquo;s] sexual orientation and stated maybe she wasn&rsquo;t aware of his attraction to men, in which she said &lsquo;Absolutely not.&rsquo; [Staff member D] informed [NF2] that [Resident #89] would be moved to another room within the unit and staff would monitor. &hellip;&rdquo; [sic]</p> <p>A review of an IDT progress note, dated [DATE] at 11:25 a.m., for resident #89 showed:</p> <p>&ldquo;IDT met for initial review of plan of care. [Resident 89, NF2, and NF3] present for care conference. Both [NF2 and NF3] expressed concerns Re: recent incident with [Resident #17]. &hellip;&rdquo; [sic]</p> <p>A review of a facility document titled &ldquo;Brief Interview for Mental Status (BIMS),&rdquo; dated [DATE], for resident #89, showed a score of 3 out of 15, reflecting the resident had severe cognitive impairment.</p> <p>A review of a facility document titled &ldquo;Mini-Mental State Examination (MMSE),&rdquo; for resident #89, dated [DATE], showed a score of 13 out of 30, reflecting severe cognitive impairment.</p> <p>3. Resident #80:</p> <p>During an interview on [DATE] at 11:37 a.m., staff member H stated resident #80 was currently on the 40-bed unit, had dementia, and had multiple sexual partners. Staff member H stated resident #80&rsquo;s current partner, resident #78, had behavioral issues, was suicidal, and was found to have a butter knife in his shoe one time. Staff member H stated they felt resident #78 was unsafe for staff and other residents. Staff member H stated staff member B was aware of both instances and had told staff member H the interaction between the residents was okay because both POAs had given consent. Staff member H stated if resident #80 was caught in the act of any sexual activity, staff member B had told staff members to let it continue and close the door. Staff member H stated they were told to, &ldquo;just keep an eye on them.&rdquo;</p> <p>Review of resident #78&rsquo;s chart showed the following incidents of aggression:</p> <p>-[DATE] &ndash; an email documentation which showed resident #78 was following a resident's family member out to their vehicles and was &ldquo;hiding in the bushes and watches people.&rdquo;</p> <p>-[DATE] &ndash; documentation of a timeline for resident #78 showed: &ldquo;8/3 PM Yelling at [Resident #80], pacing, going into rooms &hellip; 8/5 AM Bullying, took [another resident's] gloves and threw them&hellip;&rdquo;</p> <p>-A personal statement from staff showed: &ldquo;&hellip; His behavior was very disturbing.&rdquo;</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on [DATE] at 12:03 p.m., resident #80 was sleeping in bed and in her pajamas. There was a sign on her door reflecting female caregivers only for care. During the interview with resident #80, she was confused and unable to answer any questions.</p> <p>During an interview on [DATE] at 1:43 p.m., staff member K stated resident #80 was sexually active with other residents in the past, but had not for several months, and her partners varied. Staff member K stated resident #80 sought out the residents and would take them back to her room. Staff member K stated they would look very intently into resident #80's eyes and ask, "Do you want this person in this room?" Staff member K stated resident #80 would either say "yes" or "no" and the staff felt resident #80 was able to make her own decisions. Staff member K stated they would leave the door closed to provide privacy but would have to get resident #80 off the floor after their interaction. Staff member K stated it never caused any physical injury, so they thought the sexual acts were not a form of sexual abuse and were acceptable. Staff member K stated resident #80 had a relationship with resident #17 in the past. Staff member K stated they were worried about resident #80 and resident #78's current relationship advancing to sexual activities because of her dementia and his aggression and strength. Staff member K stated, "That's a hard problem," when referring to whether resident #80 was able to consent for sexual activity or not based on her cognitive ability. Staff member K stated staff member B, the POA, staff member D, and their physician were all aware of what was occurring. Staff member K stated, "I would not (feel comfortable if this was her family member in this situation)."</p> <p>During an interview on [DATE] at 7:56 a.m., staff member G stated the sign on resident #80's door was because the resident feels uncomfortable being exposed in front of men. Staff member G stated, The sign was not there when I first started, and I went into her room to care for her, and she did not like it; she didn't like me. If she is out of her room, I will care for her, and she is fine with that.</p> <p>4. Neglect - It was identified that the facility system to identify and address neglect of care and provide goods and services necessary to protect the residents. The concerns included:</p> <ul style="list-style-type: none"> -The Administrator and Director of Nursing were aware of the sexual activities and did not address them to ensure residents were not subjected to potential abuse, and ensure necessary steps were taken, per the facility policies and procedures, to address the actions and behaviors of the residents. -Residents engaging in or exhibiting sexual behaviors were not assessed for the ability to consent to the activities. -Resident care plans did not include personalized information related to sexual encounters, personal preferences, risks, goals, or interventions for staff to utilize to ensure abuse/neglect did not occur for those wishing to engage in sexual activities. -When sexual encounters occurred between the residents, the staff did not act to protect the resident(s) involved or address the actions at the time, or after for future prevention of potential abuse. -The facility abuse and neglect policy was not comprehensive and lacked information related to alleged or potential sexual abuse. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>-The facility staff did not attempt to identify if the events between the residents were abuse or neglect of care, and abuse events were not reported to the State Survey Agency as required. Refer to F609 - Abuse/Neglect Reporting.</p> <p>-The abuse/neglect training was not sufficient to address alleged or potential sexual abuse.</p> <p>During an interview on [DATE] at 4:44 p.m., staff member A stated he was aware of the sexual encounters and behaviors exhibited by the residents on the SCU. He stated staff members B and D were aware. All three staff were administrative.</p> <p>The interview with staff members D and E on [DATE] at 4:56 p.m. included:</p> <p>-Staff member D stated there were no residents having sex at this time. Staff member D stated that resident #80 was able to consent for herself in the past and had declined cognitively in the last six months. Staff member D stated all of the POAs had been reached out to regarding their family members' sexual activity, and the POAs had all said if the acts were consensual, then it was okay for the resident to continue. Staff member D stated resident #80 felt comfortable talking with staff member D. Staff member D stated psychosocial assistance was provided to resident #80 by communication between staff member D and resident #80. Staff member D stated these conversations were documented in the interdisciplinary notes in resident #80's chart.</p> <p>-Staff member D stated resident #17 had sexual relations with resident #12 two years ago, and resident #12 was able to consent for himself. Staff member D stated resident #80 also had relations with resident #61 in the past.</p> <p>-Staff member E stated resident #80 was started on Lexapro to decrease her libido. Staff member E stated the facility did not have a formal process (to address sexual activities), and residents having sexual activity was "a newer phenomenon"; Staff member E stated the facility never did any cognitive or physical assessments after the incidents. Staff member E stated there were young CNAs who were shocked by seeing the activities with the residents.</p> <p>Staff member E said resident #17 was moved to the SCU as he had exit-seeking behavior. Staff member E stated they thought resident #17 was showing sexual behaviors because his wife died, and he seemed to be looking for companionship. Staff member E stated that the incident with resident #17 and resident #89, was not a factor in #89's discharge, as resident #89 was only discharged to [Town Name] to be closer to family. Staff member E stated resident #17 then had another incident with resident #9, where resident #9's pants were down while resident #9 was on the bed, and resident #9's brief was open. Staff member E stated that after this incident, the facility implemented a bed alarm for resident #17. Staff member E stated the incident between residents #9 and #17 was not sexual abuse because there was no contact made between the residents.</p> <p>-Staff members D and E stated that only the incident on [DATE] could have been abuse, as there was physical contact. Both staff members D and E stated there had been an accident report, and the incident had been charted in each of the residents' charts. Staff member D stated that resident #80's sexual activity was consensual, and resident #9 did not show any signs of psychosocial stress. Staff members D and E stated the resident's giving consent was difficult, and "We try to prohibit this stuff from happening"; They stated resident #9 was unable to give consent.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 11:14 a.m., staff member E stated that sexual abuse was any sexual act done to anyone who does not consent. Staff member E stated no behavioral assessments, root cause analyses, or cognitive assessments were completed on the residents before the residents' involvement in sexual acts.</p> <p>During an interview on [DATE] at 3:02 p.m., staff member J stated all residents in the SCU were unable to give consent for sexual activity, and stated, they do not have a policy on it, and do not allow it anywhere in the facility. Staff member J stated the residents in the SCU had behaviors and may find a way to evade the nursing staff and begin sexual activity, but those were treated as behaviors. They stated the facility had effective measures to implement if the behaviors arose.</p> <p>Review of resident #9's chart showed a BIMS of 3 (severe cognitive impairment), dated [DATE].</p> <p>Review of resident #12's chart showed a BIMS of 15 (cognitively intact), dated [DATE].</p> <p>Review of resident #61's chart showed a BIMS of 4 (severe cognitive impairment), dated [DATE].</p> <p>Review of resident #17's chart showed a BIMS of 9 (moderate cognitive impairment), dated [DATE]; and a BIMS of 6 (severe cognitive impairment), dated [DATE].</p> <p>Review of resident #78's chart showed a BIMS of 12 (moderate cognitive impairment), dated [DATE].</p> <p>Review of resident #44's chart showed a BIMS of 3 (severe cognitive impairment), dated [DATE].</p> <p>Review of resident #80's chart showed a SLUMS of 6 (severe dementia), dated [DATE].</p> <p>Review of resident #77 chart showed a BIMS of 11 (moderate cognitive impairment), dated [DATE].</p> <p>5. Facility Reported Incident</p> <p>Review of a Facility-Reported Incident, for resident #20, submitted to the State Survey Agency, on [DATE], showed the facility reported a staff member squeezed a resident's hand and caused a skin tear while trying to retrieve Tylenol from the resident's hand. The resident had a history of caching medications and was to only take medication while in the presence of a nurse. The report showed the staff member was immediately removed from caring for the resident.</p> <p>Review of resident #20's investigative file, dated [DATE], showed the facility reported staff member R came in to assist staff member S with retrieving medications from resident #20, who was refusing to take them, and he had a history of caching medications. During this time, staff member R held resident #20's hand very tightly to get him to release the Tylenol. This caused a skin tear to resident #20's left hand. Resident #20 then refused treatment to the wound. The investigative file showed that staff members R and S were immediately removed from caring for resident #20.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on [DATE] at 9:05 a.m., resident #20 had bruising and a large yellow scab raised on his left hand. Resident #20 stated, "I don't care what happened to them (staff members R and S) as long as they don't take care of me anymore; I am happy with the outcome."</p> <p>The investigative file for resident #20, dated [DATE], showed staff members R and S were immediately suspended pending the completion of the investigation. The file also showed staff members R and S were both terminated. The file also showed staff and residents were interviewed, and no other concerns were identified. Resident #20's care plan was updated. The facility provided abuse training to all staff on [DATE].</p> <p>Review of a facility policy titled Abuse-Resident; with a revision date of [DATE], showed:</p> <p>"Policy:</p> <p>Each resident has the right to be free from abuse; Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals.</p> <p>Definitions of Abuse:</p> <p>Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.</p> <p>Sexual Abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault."</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review, the facility failed to thoroughly investigate allegations and resident actions of sexual abuse for 3 (#s 9, 17, and 89) out of 28 sampled residents. This deficient practice increased the risk of incidents occurring in the future for these residents, and others, and the residents were identified to be vulnerable and unable to consent to sexual activity. The facility staff did not identify the resident actions as potential abuse or protect them, and staff were aware of the resident actions but did not address the alleged potential abuse, reflecting the facility's abuse education program was not sufficient to ensure resident safety. Findings include: During an interview on 8/13/25 at 1:57 p.m., staff member L stated they received a report of an incident with resident #89 and resident #17, where resident #89 had no clothes on, and resident #17 was on top of resident #89 performing oral sex. This had occurred four months prior, and approximately three weeks ago, resident #17 went into resident #9's room, and staff found resident #9 in the bed. Resident #9's pants were around his ankles, and his brief was open. Staff member L stated staff walked in on the two residents just before sexual activity occurred. Staff member L stated the residents on the SCU were not able to consent to sexual activity due to cognitive deficits. During an interview on 8/13/25 at 4:43 p.m., staff member A stated he was aware of some resident sexual relations between the residents, but not aware of the extent of the resident sexual relationships. Staff member A was to be notified of all alleged or potential abuse for the facility. During an interview on 8/13/25 at 4:56 p.m., staff members D and E stated the sexual acts between the residents were not considered sexual abuse due to no physical contact being made between the residents. Staff member E stated the facility never completed a root cause analysis investigating why the events were occurring or to identify concerns related to them and the facility did not identify or address any behavioral assessments for #17 related to his sexual advances and activities. The staff did not identify the sexual acts between the two residents as alleged abuse and did not ensure protective measures were implemented to prevent potential abuse. During an interview on 8/19/25 at 9:13 a. m., staff member O stated resident #17 never should have been given a roommate due to his behaviors. Staff member O stated there were more instances of sexual activities with resident #89, as he had been at the facility for about a month. The facility moved resident #17 to an area of the facility where there were vulnerable residents, without addressing the risk factors related to #17's sexual behaviors, or the behavior of those on the SCU. A request was made on 8/14/25 for documentation of the Facility Reported Incidents and investigations with resident #17's sexual behavior towards other residents. None were provided by the end of the survey, as the facility did not identify the events as potential or alleged abuse. The facility did not follow the abuse reporting requirements or thoroughly investigate the events. During an interview on 8/19/25 at 8:37 a.m., staff member C stated the facility did not contact law enforcement, Adult Protective Services, or the State Survey Agency regarding any sexual abuse with resident #17. It was identified the facility did not respond to alleged or potential sexual abuse allegations and have evidence that all alleged violations were thoroughly investigated, and report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 275100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2025
NAME OF PROVIDER OR SUPPLIER Montana Veterans Home N H		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Veterans Dr Columbia Falls, MT 59912	
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on interview and record review, the facility failed to ensure the care plan contained a care area and interventions regarding sexual behaviors and interactions between residents, for 2 (#s 17 and 80) of 28 sampled residents. Findings include: During an interview on 8/13/25 at 11:37 a.m., staff member H stated there were many residents who participated in sexual activity who were unable to consent. A review of resident #17's care plan problem, goals, and interventions, all undated, showed the resident had a history of sexual behaviors that were exhibited towards other residents. There was no information for if he was a risk to other residents or himself. The goal was documented as the resident would have fewer episodes, but the goal did not show what episodes would be fewer or how this would be measured. The goal did not include information about the residents' safety. The interventions listed did not include any interventions related to protecting other residents from potential sexual abuse, or if the resident was able to consent to the sexual activities. During an interview on 8/13/25 at 4:52 p.m., staff member D stated resident #80 was able to consent for sexual activity for herself. Staff member D stated, I don't know if we ever put it on there, when referring to #80's care plan, and if sexual behaviors and preferences were added to the plan. Review of resident #80's care plan, dated 7/21/25, showed under the ADLs that she preferred female caregivers, and the care plan did not show other areas, concerns, or interventions related to the resident's sexual behaviors or the ability to consent. A request was made on 8/13/25 for all the care plans for residents who displayed sexual interactions towards others. The care plans provided by the facility were updated with new information for the residents' sexual interaction history and provided on 8/18/25. The updates did not occur until the facility completed a plan to remove immediacy for the Immediate Jeopardy situation identified in F600 - Abuse and Neglect.</p>		