STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275120	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Billings Rehabilitation and Nursing LLC	600 S 27th St Billings, MT 59101

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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. Based on interview and record review, the facility failed to report allegations of abuse to the State Survey Agency (SSA) within the required timeframe of an allegation of sexual abuse for 1 (#73); and failed to report the investigative findings for allegations of abuse for 4 (#s 10, 46, 67 and 76) of 25 sampled residents. Findings include:1. Review of resident #73's Behavior Progress Note, dated 12/14/25, showed: Resident has repeatedly been removed from female resident rooms. Resident has also been rubbing legs of other female residents. Resident has been repeatedly corrected by staff and educated on inappropriate behavior. During an interview on 2/24/26 at 4:51 p.m., staff member A stated they were reviewing a former resident's chart (resident #73) who wanted to return to the facility. Upon the review, they noted a progress note which should have been a reportable event, sent to the State Survey Agency, but had not been reported. Staff member A stated they did not know of the incident before the review and would be making a late report to the State Survey Agency regarding the incident. Staff member A stated a staff member noticed resident #73 had his hand on resident #46's thigh while he was assisting the resident to eat. He stated the aide (staff member N) who witnessed the incident and asked the resident to remove his hand from the resident's thigh, which he did, and the aide reported the incident to the nurse on duty (staff member O). Staff member A stated staff member O did not report the incident. He stated the expectation was for staff to report allegations of resident-to-resident abuse or inappropriate contact immediately or within two hours of the incident. During an interview on 2/24/26 at 5:05 p.m., staff member N stated she witnessed resident #73 assisting resident #46 with eating. She stated resident #73 had his hand on resident #46's thigh. She said she did not feel that it was appropriate for resident #73 to have his hand on her thigh, and she asked the resident to keep his hands to himself. Staff member N stated the resident removed his hand from the resident #46's thigh, but he did place his hand again on her thigh. Staff member N stated she asked resident #73 to remove his hand again from resident #46's thigh, which he did. Staff member N stated she did not feel it was appropriate and reported the behavior to the nurse on duty, staff member O. During an interview on 2/25/26 at 11:21 a.m., staff member O stated he was informed by staff member N that resident #73 kept placing his hand on resident #46's thigh while he was assisting her with eating. Staff member O stated he did not observe the behavior but did not feel the behavior was sexual or predatory in nature. He stated he made a note of it in the resident's behavior charting but did not report the incident. He stated he had received Relias training on the different forms of abuse and when and to whom to report any concerns or incidents. 2. Review of a facility reported event dated 1/7/26, showed residents #10 and #76 were involved in a verbal altercation. Investigation findings were due to the State Survey Agency on 1/14/26. The (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility reported the investigation findings late on 1/15/26. During an interview on 2/25/26 at 2:58 p.m., staff member A stated the facility had an Administrator in Training who was submitting reportable events and investigation findings to the State Survey Agency. Staff member A stated the investigation findings for the facility reported event on 1/7/26 were due on 1/14/26. Staff member A stated the investigation findings were submitted on 1/15/26. Staff member A stated he received alerts when findings were due and reminded the facility of the due dates. Staff member A did not know why the findings were submitted late. 3. Review of a facility reported event, dated 2/2/26, showed that resident #67 reported verbal abuse by a staff member. Investigation findings of the verbal abuse event were due to the State Survey Agency on 2/9/26. The facility reported the investigation findings late on 2/10/26. During an interview on 2/25/26 at 2:58 p.m., staff member A stated the facility had an Administrator in Training who was submitting reportable events and investigation findings to the State Survey Agency. Staff member A stated the investigation findings for the facility reported event on 2/2/26 were due on 2/9/26. Staff member A stated the investigation findings were submitted on 2/10/26. Staff member A did not know why the findings were submitted late. Review of a facility policy titled, Abuse, Neglect, and Exploitation, implemented 4/11/25, showed: . VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. . B. The Administrator will follow up with government agencies, during business hours, to confirm the report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. Based on interview and record review, the facility failed to complete Quarterly MDS assessments in the required timeframe of 14 days after the ARD for 6 (#s 5, 7, 9, 10, 11, and 55) of 25 sampled resident assessments. Findings include:During an interview on 2/26/26 at 8:48 a.m., staff member M stated he started covering as the MDS Coordinator at the end of December 2025. Staff member M stated he believed the facility had Quarterly MDS's that were late when he started. Staff member M stated he was not sure why they were late.- A review of resident #11's medical record showed a Quarterly MDS was scheduled with an ARD of 12/18/25. The Quarterly assessment was due to be completed on 1/1/26. The MDS was completed late on 1/8/26.- A review of resident #55's medical record showed a Quarterly MDS was scheduled with an ARD of 12/23/25. The Quarterly assessment was due to be completed on 1/6/26. The MDS was completed late on 1/8/26.- A review of resident #7's medical record showed a Quarterly MDS was scheduled with an ARD of 1/1/26. The Quarterly assessment was due to be completed on 1/15/26. The MDS was completed late on 1/19/26.- A review of resident #5's medical record showed a Quarterly MDS was scheduled with an ARD of 1/9/26. The Quarterly assessment was due to be completed on 1/23/26. The MDS was completed late on 2/2/26.- A review of resident #10's medical record showed a Quarterly MDS was scheduled with an ARD of 1/15/26. The Quarterly assessment was due to be completed on 1/29/26. The MDS was completed late on 2/2/26.- A review of resident #9's medical record showed a Quarterly MDS was scheduled with an ARD of 1/19/26. The Quarterly assessment was due to be completed on 2/2/26. The MDS was completed late on 2/4/26.A review of the Centers for Medicare & Medicaid Services' Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.20.1, effective 10/1/25, showed: . Chapter 2: Assessments For the Resident Assessment Instrument (RAI). Quarterly (Non-Comprehensive) . MDS Completion Date. No Later Than. ARD +14 calendar days.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to investigate an allegation of resident-to-resident inappropriate nonconsensual contact for 2 (#s 46 and 73) of 25 sampled residents. Findings include:Review of resident #73's Behavior Progress Note, dated 12/14/25, showed: Resident has repeatedly been removed from female resident rooms. Resident has also been rubbing legs of other female residents. Resident has been repeatedly corrected by staff and educated on inappropriate behavior. During an interview on 2/24/26 at 4:51 p.m., staff member A stated they were reviewing a former resident's chart (resident #73) who wanted to return to the facility. Upon the review, they noted a progress note for a reportable event that was not reported or investigated involving residents #'s 46 and 73. Staff member A stated they did not know of the incident before the review and would be sending a late report to the State Survey Agency regarding the incident and conducting an investigation (See F609 for details of allegation). Review of the facility's reported incidents, sent to the State Survey Agency, did not show that the incident between residents #46 and #73 was reported or investigated by the facility for the event on 12/14/25. Review of the facility's policy and procedure titled, Abuse, Neglect, and Exploitation, with an implementation date of 4/11/25, showed: V. Investigation of Alleged Abuse, Neglect and Exploitation: A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation . 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on interview and record review, the facility failed to complete a Comprehensive MDS assessment in accordance with the required timeframe of the 14th day of the residents stay for 1 (#67) of 25 sampled residents. The failure had the potential to prevent the resident from achieving their highest practicable level of function. Findings include:During an interview on 2/25/26 at 2:58 p.m., staff member A stated the previous MDS Coordinator left the position in late November 2025 or early December 2025, and there was a lapse in coverage of the position duties prior to the current MDS Coordinator starting. Staff member A stated this may have contributed to the MDS's that were completed late.During an interview on 2/26/26 at 8:48 a.m., staff member M stated he started covering as the MDS Coordinator at the end of December 2025. Staff member M stated he believed the facility had MDSs that were late when he started. Staff member M stated he was not sure why they were late.A review of resident #67's medical record showed an admission date of 1/8/26, and an admission MDS was scheduled with an ARD of 1/14/26. The admission MDS was due to be completed on 1/21/26. The MDS was completed late on 1/22/26.A review of the Centers for Medicare & Medicaid Services' Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.20.1, effective 10/1/25, showed: . Chapter 2: Assessments For the Resident Assessment Instrument (RAI). admission (Comprehensive). MDS Completion Date. No Later Than. 14th calendar day of the resident's admission (admission date +13 calendar days) .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility licensed nursing staff, assigned to complete treatments on a resident's burn, failed to provide services in accordance with professional standards of nursing practice related to wound assessments, treatments, and documentation of the wound details and current status, for 1 (#73) of 25 sampled residents. The failure placed the resident at elevated risk for the delayed identification of complications and or ineffective treatments not being addressed promptly, due to the lack of wound information in the resident's medical record. Findings include:During an interview on 2/24/26 at 11:12 a.m., staff member B stated resident #73 had obtained a burn injury to his lower abdomen, groin, and right hip on 10/30/25, after accidentally spilling hot soup onto himself. The right hip wound was a second-degree burn with blistering, and the lower abdomen and groin were first-degree burns. Staff member B stated wound treatments were initiated on the notification to the provider about the burns, which was on 10/30/25, and the burn treatments were completed as ordered until the wound healed.During an interview on 2/24/26 at 1:34 p.m., staff member G stated that the previous wound management nurse left the facility unexpectedly two weeks earlier. Staff member G stated she was unaware of the resident's wound until that time. Staff member G stated she assessed the wound for the first time on 11/21/25 and noted it had resolved. Staff member G stated a wound's progress (healing) should be assessed routinely by the nurse, who then documents the status and evaluation of the effectiveness of the wound treatments provided. Review of resident #73's nursing progress note, dated 10/30/25 at 2:31 p.m., showed: Resident sustained a burn to right upper thigh, groin, and low abdomen during early morning hours. Burn on thigh is 5 1/2 by 5 inches with a large blister which has since broken and drained serous fluid. The abdomen has several small burns the blistering to this area has resolved. The groin has 2 red areas without blistering. There are 41/2 by 2 3/4 inches and 2 1/4 by 1 1/2 inches. Burns had been covered with loose ABD dressings for protection from rubbing. Provider did evaluate and gave instruction to ADON for new orders. Dressing will be applied as instructed . [sic]Review of resident #73's nursing progress note, dated 11/1/25 at 5:36 a.m., showed: area of burn cleaned and Bacitracin applied- covered with abd- tolerated well-N/S of infection. [sic] Review of resident #73's nursing progress note, dated 11/3/25 at 2:25 a.m., showed: area of burn cleaned and Bacitracin applied- covered with abd- tolerated well-N/S of infection. [sic]Review of resident #73's nursing progress note, dated 11/6/25 at 12:54 a.m., showed: Bacitracin applied as ordered to burn on right hip. Resident tolerated well. Wound bed pink/red in color. No signs of infection. Minimal drainage noted. Dressing applied to area. Scant serous drainage noted. [sic]Review of resident #73's nursing progress note, dated 11/21/25 at 7:09 a.m., showed:Area to right hip checked- no open areas-clean dry and skin is intact-resolved. [sic]Review of resident #73's nursing progress notes failed to show a wound status note on 10/31/25, 11/2/25, 11/5/25, and 11/7/25 through 11/20/25, and the notes that were completed did not address all the areas of the burn(s), the status of the burns, location, classification, measurement, burn assessment, the status of the wound edges, if there was any odor, if the resident had pain or if there were signs of infection, or if the treatment at the time was beneficial or not. Review of resident #73's physician order, dated 10/30/25, showed: Adaptic or Optifoam dressing with daily dressing changes to right lateral hip burn site. One time a day for second degree burn of right lateral hip. Notify provider of any worsening. [sic]Review of resident #73's Medication Administration Record for November 2025 showed the dressing change was not documented as completed on eight out of 21 days.Review of a facility policy titled Wound Treatment Management, dated 4/11/25, showed: . 7. Treatments will be documented on the Treatment Administration Record or in the electronic health record .8. The effectiveness of treatments will be monitored through ongoing assessment of the wound .Review of a professional standard titled, Principles for Nursing Documentation, published by the American Nurses Association, accessed online on 3/2/26 at (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/ana-principles/, showed: Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview and record review, the facility failed to adhere to a resident's individualized plan of care regarding repositioning and elevation of the heels to prevent skin breakdown for 1 (#79) of 25 sampled residents. Findings include:During an observation and interview on 2/23/26 at 2:55 p.m., resident #79 was lying flat on her back with a pillow beneath her legs, but her heels and feet were still touching the bed. Resident #79 stated she was never repositioned by staff but would lie flat on her back very frequently. Resident #79 stated, They're (staff) supposed to not let my heels touch the bed, but stated the staff members would often forget to do this task.During an observation and interview on 2/24/26 at 2:12 p.m., resident #79 was lying on her back and had a pillow underneath her legs. Her heels were not elevated but were resting on the pillow's surface. Resident #79 stated she was dependent on staff for help and would rarely get out of bed for activities. During an observation on 2/25/26 at 2:28 p.m., resident #79 was lying on her back and had her heels resting on the pillow's surface. During an observation and interview on 2/25/26 at 3:39 p.m., resident #79 was lying on her back. Staff member L stated resident #79's heels were boggy1. The resident's heels were observed to be slightly red, her entire back was red, and her left arm and fingers were noticeably swollen. Staff member L stated resident #79's left arm needed to be elevated to help reduce swelling and stated, We need to get that (resident #79's arm) up. Review of resident #79's Care Plan, initiated 7/15/25, showed, . Please use heel bilateral suspension boots to float heels while in bed . Staff will assist resident to turn/reposition regularly to offload pressure points . The boots were not observed when the resident was in bed. References:1According to a CMS document, titled Pressure Ulcer/Injury Coding Stages, soft or boggy heels could indicate a concern for a deep tissue injury. Deep tissue injuries can result from prolonged pressure and reduced circulation.Centers for Medicare and Medicaid Services. (2021, November 10). Pressure Ulcer/Injury Coding Stages. Retrieved from Centers for Medicare and Medicaid Services: https://www.cms.gov/files/document/pocket-guidepressure-ulcers-and-injuries-stages-and-definitions.pdf

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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. Based on interview and record review, the facility failed to thoroughly investigate an unavoidable accident to the level necessary to ensure appropriate measures were implemented to prevent recurrences for 1 (#73) of 25 sampled residents. The resident spilled soup on himself, causing burn(s), but it was unclear (upon watching video footage) who the person was who provided the resident with the hot soup, and or what action was taken to investigate the incident further in an attempt to prevent future recurrences of this nature. The facility treated the resident's burn(s), which did heal. Findings include: During an interview on 2/24/26 at 10:20 a.m., staff member B stated resident #73 sustained a burn injury after spilling hot soup onto himself on 10/30/25. Staff member B stated NF3 reported he had reviewed the facility's video footage of the incident and observed a tall male visitor in street clothes handing resident #73 a container. Staff member B stated NF3 did not offer any additional information on the investigation, including whether there had been a review of video footage near the nourishment room to determine if the visitor accessed the facility microwave or how the soup was heated. Staff member B stated NF3 had determined the burn was not reportable based on the surveillance footage reviewed, and no additional investigative documentation was located for this incident, although it was not clear who exactly provided the resident with the hot soup. During an interview on 2/24/26 at 2:12 p.m., staff member E stated the microwave used to heat resident food was located inside a locked nourishment room, and staff were expected to obtain and document food temperatures when heating food for residents. Staff member E stated she treated resident #73's wound, but did not know exactly how it occurred, stating, I don't know any details, but it blistered and burned.During an interview on 2/24/26 at 3:44 p.m., staff member A stated the facility's video surveillance footage was overwritten approximately every two weeks, and the facility was unable to retrieve or review video footage from the 10/30/25 burn incident involving resident #73. Staff member A stated the facility identified the concerns related to the resident's burn during a chart review three weeks after the incident.During an interview on 2/24/26 at 4:23 p.m., staff member F stated she did not know how a visitor would obtain access to the facility microwave, as the door was secured with a keypad lock. Visitors should not have had access to the locked room. During an interview on 2/26/26 at 9:15 a.m., staff member C stated no additional information was available regarding resident #73's accidental burn. Review of resident #73's physician note, dated 10/31/25, showed, . (Resident #73) was seen today for follow-up at the request of nursing staff for what they report to be burn wound from hot soup. When asked if he had dropped hot soup on himself he did nod yes. [sic]Review of resident #73's physician notes, provider notes, and facility investigative notes for the incident on 10/30/25, showed no documented determination of how or if the visitor accessed the locked nourishment room, whether staff heated the soup, or if the soup came into the facility at the hot temperature, or whether supervision for the resident at the time of the incident was adequate for the resident's safety.Review of a facility policy titled Incidents and Accidents, dated 4/11/25, showed: It is the policy of this facility for staff to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. Assuring that appropriate and immediate interventions are implemented to prevent recurrences and improve the management of resident care. Conducting root cause analysis to ascertain causative/contributing factors as part of Quality Assurance Performance Improvement (QAPI) to avoid further occurrences . Meeting regulatory requirements for analysis and reporting of incidents and accidents .

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop an individualized care plan reflecting a resident's past trauma, did not address his desire for sexual activities on the individualized care plan, or initiate behavior monitoring for potential sexual behaviors; and the facility did not identify the need for additional mental health trauma-based services timely for 1 (#73) of 25 sampled residents. This deficient practice increased the resident's risk of negative outcomes and or behaviors continuing to be unaddressed or unmonitored, which could affect 2 residents (#s 22 and 46). Findings include:During an interview on 2/24/26 at 5:05 p.m., staff member N stated she witnessed resident #73 assisting resident #46 with eating. She stated resident #73 had his hand on resident #46's thigh. She said she felt it was inappropriate and asked resident #73 to remove his hand. Staff member N stated she was not aware if resident #73 had a care plan or was to be monitored for any sexual behaviors.During an interview on 2/25/26 at 11:21 a.m., staff member O stated he was informed by staff member N that resident #73 kept placing his hand on resident #46's thigh while he was assisting the resident with eating. Staff member O stated he was not aware if resident #73 had a care plan or was to be monitored for any sexual behaviors.Review of resident #73's Psychosocial admission Assessment, dated 5/30/25, showed, The resident has a current BIMS of 9, indicating that there was moderate cognitive impairment. The resident has some confusion and forgetfulness but is usually oriented to person and place. The resident is able to communicate, he at times has difficulty finding words or using correct words but is able to make his needs known and can understand and follow conversation. The assessment showed the following psychosocial categories for which the resident had identified concerns/needs as: Mental health conditions for trauma/PTSD, substance abuse, behavioral issues, self-efficacy deficits, and lack of coping skills, and .desire for physical/sexual intimacy while in the facility. Social Factors that have been identified to affect the resident, showed, The resident made a comment to [social services] that he was engaged to a fellow resident. Does the resident express desire to engage in sexual activity with others, was checked as yes, and complete the Sexual Activity Capacity to Consent Assessment.Review of resident #73's EMR did not show the Sexual Activity Capacity to Consent Assessment was completed by the facility. A facility request for the Sexual Activity Capacity to Consent Assessment was submitted to the facility on 2/24/26 at 5:00 p.m., no additional documentation was provided by the end of the survey on 2/26/26.Review of resident #73's Social Services Progress Note, dated 6/2/25, showed, During a conversation between [social services] and the resident, the resident was telling [social services] that he is recently engaged. When [social services] asked the resident who he was engaged to, he couldn't remember the name but kept looking around him trying to find someone. [Social services] asked if he was engaged to someone in the facility and he said yes. The resident said she lives down B hall - [social services] asked the resident if it was a specific resident to which the resident said 'yes! Yes that's her!' Staff will monitor any increased behaviors relating to this statement from the resident. [sic]Review of resident #73's Behavior Progress Note, dated 12/14/25, showed: Resident has repeatedly been removed from female resident rooms. Resident has also been rubbing legs of other female residents. Resident has been repeatedly corrected by staff and educated on inappropriate behavior.Review of resident #73's Social Services Progress Note, date 12/24/25, showed, [Social services] was informed by staff that the resident reported plans to marry another resident the next day. [Social services] followed up with the resident, who stated that a minister had been arranged to conduct a wedding ceremony on Christmas Eve at the facility with his partner. [Social services] staff identified the minister as another resident currently residing in the facility. Following discussion with management and both residents involved, it was determined that the wedding would not and could not (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275120	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Billings Rehabilitation and Nursing LLC	600 S 27th St Billings, MT 59101

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

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	take place in relation to state refollowing. All parties verbalized understanding of the decision. The resident displayed no signs of distress, however, he did express concern regarding his partner's feelings and stated that he wanted her to know that everything was going to be okay. Admin, DON and resident's brother were all notified. [sic]Review of resident #73's Care Plan, failed to show the facility developed a comprehensive care plan to address the resident's past-trauma history and potential for sexual behaviors.Review of resident #73's TAR and Behavioral Monitoring, from 5/30/25 to 2/26/26, failed to show resident #73's potential for sexual behaviors was monitored by staff.Review of resident #73's Initial Psych Evaluation, dated 12/22/25, showed, . Chief Complaint: Initial psychiatric evaluation History of Present Illness: [AGE] year-old male seen for initial psychiatric evaluation with concerns of moderate recurrent major depressive disorder and inappropriate sexual behaviors in the facility setting . Patient exhibits inappropriate sexual behaviors including entering female residents' rooms and inappropriate touching, requiring frequent staff redirection but is typically easily redirectable . The facility failed to timely ensure a behavioral health evaluation was completed for resident #73 at the time of his admission on [DATE]. During an Interview on 2/24/26 at 3:49 p.m., NF1 stated resident #73 no longer resided at the facility, but while he was there, she started seeing him in December of 2025 for mental health services. NF1 stated resident #73 had been in and out of group homes and had been admitted to the facility when his level of care became too much for the group home. NF1 stated resident #73 was flirtatious and a bit of a ladies' man but was not aware of any inappropriate interactions. She stated she noted hypersexuality for resident #73, not because of any inappropriate touching or behavior, but because the staff had noted that he had a girlfriend, identified as resident #22, and they would hold hands and spend time together. She stated residents #'s 22 and 73 were not to be left unattended together since neither resident was capable of providing sexual consent due to their cognition. NF1 stated it would be appropriate to develop a care plan for resident #73 to address his sexual behaviors and provide interventions as well as ensuring behavior monitoring occurred for the behavior.During an interview on 2/25/26 at 11:44 a.m., staff member K stated the Sexual Activity Capacity to Consent Assessment for resident #73 was not completed. She stated it was the expectation that the assessment would be completed during an IDT meeting to determine a resident's ability to consent to sexual activities. She stated residents #'s 22 and 73 were both not able to provide sexual consent. She stated the facility also did not develop a comprehensive care plan to address the resident's past trauma and potential for sexual behaviors. Staff member K stated they also did not include behavioral monitoring for resident #73's potential sexual behaviors.A review of the facility policy and procedure titled, Behavioral Health Services, with an implementation date of 4/1/25, showed, 2. The facility will consider the acuity of the resident population. This includes residents with mental disorders, psychosocial disorders, or substance use disorders (SUDs), and those with a history of trauma and/or post-traumatic stress disorder (PTSD), as reflected in the facility assessment.3. The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.7. The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. The assessment and care plan will include goals that are person-centered and individualized to reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.12. The Social Services Director shall serve as the facility's contact person for questions regarding behavioral services provided by the facility and outside sources such as physician, psychiatrists, or neurologists .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure medications to be administered matched the dose on the medication administration record for 2 (#s 14 and 51), and failed to ensure the medication, Voltaren gel, was measured appropriately for 1 (#14) of 25 sampled residents. This deficient practice resulted in a medication error rate of 10.34%. Findings include:1. During an interview and observation on 2/24/26 at 7:32 a.m., staff member I prepared the morning medications for resident #14. Staff member I stated the MAR and the medication bottle did not match for resident #14's glucosamine chondroitin. Staff member I stated the bottle was half empty and facility staff members had most likely been giving this medication in the past. The medication bottle showed Glucosamine Chondroitin Complex and had the following substances: Vitamin C 30 mg, Manganese 2.5 mg, Sodium 20 mg, Potassium 28 mg, Glucosamine Sulfate 250 mg, and Chondroitin Sulfate 200 mg. The MAR failed to show any other substances were ordered by the physician.Review of resident #14's EHR showed a physician order: Glucosamine-Chondroitin Oral Tablet 250-200 MG .2. During an observation on 2/24/26 at 7:49 a.m., staff member I entered resident #14's room with the medication, diclofenac sodium external gel (Voltaren gel). Staff member I squeezed approximately one tablespoon amount of gel into their gloved hands and rubbed the gel onto resident #14's knees. Staff member I did not measure the Voltaren gel.Review of resident #14's EHR showed a physician's order: . apply 2 gm to both knees 3 times a day. 3. During an observation and interview on 2/24/26 at 8:01 a.m., staff member H was preparing the morning medications for resident #51. Staff member H took out the medication magnesium chloride with calcium. On the back of the bottle it showed a serving size of two tablets: calcium 238 mg and magnesium 143 mg. Staff member H stated, The dose does not match up. Staff member H showed the dose on the MAR did not match the dose on the bottle of the medication. Staff member H stated pharmacy was very easy to contact but instead they used ChatGPT to verify if the dose was correct. ChatGPT showed staff member H could give the medication because the dosage was correct. When staff member H calculated the dosage on paper, the dose for one tablet was 119 mg of calcium and 71.5 mg of magnesium. Review of resident #51's EHR showed a physician order: Slow magnesium/calcium oral tablet delayed release 70-117 mg .