

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Northfield Retirement Communities Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 Circle Drive Scottsbluff, NE 69361	
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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Licensure Reference Number 175 NAC 12-006.04(B)(ii)(1) Based on record review and interview, the facility failed to ensure 2 of 5 sampled Nurse Aides completed 12 hours of ongoing in-service training and at least 4 hours of dementia care training. This had the potential to affect all residents who resided within the facility. The facility identified a census of 60. Findings Are: A record review of the Facility Assessment Tool, last updated on 7/3/26 revealed that Nurse Aides (NA) must complete no less than 12 hours of in-service training per year and the training would include dementia management training. The in-service training would address areas of weakness as determined in NA's performance reviews and facility assessment and may address the special needs of residents as determined by the facility staff. A record review of an undated and untitled facility-provided document revealed NA-B was hired on 3/6/23 and NA-D was hired on 7/2/25. A record review of NA-B's Training Hours dated 7/7/26 revealed NA-B had completed 11.8 hours of ongoing training and 2.25 hours of dementia care training. A record review of NA-D's Training Hours dated 7/7/26 revealed NA-d had completed 6.3 hours of ongoing training and 1.25 hours of dementia care training. An interview on 7/7/26 at 2:23 PM with Licensed Practical Nurse (LPN)-U confirmed there was no evidence of NA-B or NA-D completed any additional ongoing training or dementia care training.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 285271	Facility ID: 285271 If continuation sheet Page 1 of 14

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(D)&(E) Based on record review and interview, the facility failed to ensure residents or their representatives were informed in advance of the risks and benefits of a medication, the treatment alternatives or other options prior to the use of psychotropic medication for 7 (Residents 2, 8, 10, 24, 54, 57, and 62) of 7 sampled residents. The facility identified a census of 60. Findings are: Record review of psychotropic medication use policy with a revision date February 2025 revealed: Prior to initiating psychotropic medication, the staff will obtain documented consent from the resident or representative. A. Record Review of Resident 2's Face sheet dated 7/9/26 revealed an original admission date of 12/5/25 with the following relevant diagnosis: -Dementia in other diseases classified elsewhere, unspecified severity, with agitation. Record review of Resident 2's Medications Administration History dated 6/10/26 through 7/9/26 revealed an order for: risperidone tablet 0.5milligrams (mg); take one tablet by mouth twice a day (BID) as needed (PRN) for agitation. The start date on this order was 6/9/26. The order was discontinued on 7/8/26. Record review of Resident 2's Medication Order with a start date of 6/5/2026 revealed an order for fluoxetine capsule, 20 mg, take 1 capsule by mouth once a day for dementia with agitation. There was no end date listed for this order. Record review of Resident 2's Medications Administration History from 6/10/26-7/9/26 revealed that Resident 2 received 6 doses of the PRN risperidone. Record review of Resident 2's paper chart and electronic medical record revealed there was no informed consent signed by the Resident or their Representative before the risperidone and fluoxetine medications were started. A document received from the facility on 7/7/26 labeled psychotropic medication consent revealed the names of the medications ordered (risperidone and fluoxetine), the name of the Resident's representative, with a date written as 7/7/26, and an unidentified staff signature with a date written as 7/7/26. This document also revealed that the consent was received by the representative via phone. An interview on 7/7/26 at 2:57 PM with the Director of Nursing (DON) confirmed there was no informed consent completed before 7/7/26 for Resident 2's Risperidone or Fluoxetine orders. B. Record review of Resident 8's face sheet dated 7/7/26 revealed an original admission date of 2/6/26 with the following relevant diagnoses: (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; -Depression, unspecified; -Anxiety disorder, unspecified. Record review of Resident 8's medication orders revealed an order for escitalopram oxalate (an SSRI antidepressant prescribed to treat major depressive disorder and generalized anxiety disorder) tablet, 20mg, take 1 tablet by mouth once a day. This order started on 2/6/26. There was an additional order for: Vraylar capsule, 1.5mg, take 1 capsule by mouth once a day given for depression. This order started on 2/6/26. Record review of Resident 8's medications administration history from 2/6/26-3/6/26 revealed that Resident 8 received the escitalopram and the Vraylar every day between 7:00 and 10:00 AM. Record review of Resident 8's EMR and paper chart revealed no informed consent signed by the Resident or their representative before the escitalopram or Vraylar were started. A document received from the facility on 7/7/26 labeled psychotropic medication consent revealed the names of the medications ordered (Vraylar and escitalopram) and their doses, the name of the resident's representative with a date listed of 7/7/26, and two unidentified staff signatures with a date listed of 7/7/26. This document also revealed that the consent was received by the representative via phone. An interview at 2:57 PM on 7/7/26 with the DON confirmed there was no informed consent completed before 7/7/26 for Resident 8's Vraylar and escitalopram. C. Record review of Resident 10's face sheet dated 7/7/26 revealed an original admission date of 11/10/2023 with the following relevant diagnoses: - Anxiety disorder, unspecified; - Depression, unspecified. Record review of Resident 10's orders revealed an order for mirtazapine (atypical tetracyclic antidepressant. It is primarily used to treat major depressive disorder) tablet, 30mg, take 2 tablets by mouth, daily at bedtime. This order had a start date of 1/22/26. There was an order for: clonazepam (a prescription benzodiazepine used to treat panic disorders and certain seizure disorders) tablet, 1mg, take 1 tablet by mouth as needed, daily. This order had a start date of 5/14/26. There was an additional order for: clonazepam tablet, 1mg, take one tablet by mouth twice a day. This order had a start date of 5/29/26. Record review of Resident 10's medication administration history from 1/22/26-2/21/26 revealed that Resident 10 received their Mirtazapine medication every day between 7:00-10:00 PM. Continued (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	record review of Resident 10's administration records from 5/11/26-6/10/26 revealed that Resident 10 received their scheduled clonazepam daily as ordered, and they received their PRN clonazepam 3 times. Record review of Resident 10's EMR and paper chart revealed there was no informed consent signed by the resident before their mirtazapine and clonazepam were started. A document received by the facility labeled Psychotropic Medication Consent received from the facility on 7/7/26 revealed 1 of the Residents relevant medications order (mirtazapine), a note that reads: [gender]'s [gender] own person, no resident name or signature, and an unidentified staff signature with a date written as 6/10/25. An additional document received from the facility also lists the resident's medication (mirtazapine) with the resident's name written in and a date listed as 1/22/26, and an unidentified staff signature with a date written as 7/9/26 with a line through it. Another document received from the facility on 7/9/26 revealed one of the Residents medications (clonazepam 1mg twice a day and PRN) with the resident's name and a date written as 7/14/26 with the 7 marked out and a 5 written next to it, and an unidentified staff signature with a date written as 7/14/26 with the 7 marked out and a 5 written next to it. An interview with Resident 10 at 12:28 PM confirmed that they don't recall receiving the psychotropic medication consents, their signature is not on it, and the hand-written name is not in their own handwriting. D: Record review of Resident 54's admission face sheet revealed an original admission date to the facility on 3/6/24 with the following relevant diagnoses: Other sexual disorders; Unspecified dementia (a decline in cognitive function that intervenes with daily life, including memory, thinking, reasoning, and behavior). Record review of Resident 54's active orders printed 7/8/26 revealed an order for donepezil (medication used to treat dementia by improving memory, attention, and daily functioning) which was initiated 4/26/25, fluoxetine (medication used to treat certain mental health conditions) which was initiated 4/26/25, and paroxetine (medication used to treat conditions by increasing serotonin levels in the brain) which was initiated 06/17/2025. Record review of Resident 54's medication order revealed an order for haloperidol (an antipsychotic medication used to treat psychiatric conditions) which was initiated 7/2/26. Record review of Resident 54's paper chart and electronic health record (EHR) revealed there was no informed consent for donepezil, fluoxetine or paroxetine. An informed consent for haloperidol was identified with a date of 07/07/2026. Interview with DON 07/07/2026 at 2:57 PM confirmed there was no informed consent completed (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	before 07/07/2026. E: Record review of Resident 57's admission face sheet revealed an original admission date to the facility on [DATE] with the following relevant diagnoses: Unspecified dementia (a decline in cognitive function that interferes with daily life, including memory, thinking, reasoning, and behavior); Anxiety disorder (a mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life). Record review of Resident 57's orders printed 7/8/26 revealed an order for: donepezil (medication used to treat dementia by improving memory, attention, and daily functioning) which was initiated 1/20/26, quetiapine (an antipsychotic medication used to treat mental health conditions) which was initiated 4/4/26, and duloxetine (medication used to treat depression and anxiety) which was initiated 2/17/26. Record review of Resident 57's paper chart and EHR revealed there was no informed consent for donepezil. An informed consent for quetiapine and duloxetine was identified with a date of 07/07/2026. Interview with DON 07/07/2026 at 2:57 PM confirmed there was no informed consent completed before 07/07/2026. F. Record review of Resident 62's Resident Face Sheet dated 7/9/2026 revealed the resident was admitted to the facility on [DATE] and discharged from the facility on 4/17/2025. Record review of Resident 62's Order History printed 7/9/26 revealed an order for Lexapro (escitalopram oxalate) tablet once a day. This medication started on 3/21/2025 and discontinued 4/2/2025. Record review of Resident 62's Resident Progress Notes revealed a note dated 3/20/2025 regarding a medication review with a Nurse Practitioner for continued behaviors. The note revealed an order for Lexapro 10mg by mouth once a day and to discontinue Seroquel as needed (PRN). The note did not reveal the Power of Attorney (POA)/Legal Guardian was notified of this change and new medication. Further record review of Resident 62's Progress Notes revealed a note dated 4/1/2025 for a request for Lexapro to be discontinued due to refusals and the POA stated that Resident 62 did not want nor need that medication. Record review of Resident 62's electronic medical record revealed no evidence of the facility (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contacting the POA about starting Resident 62 on Lexapro. Interview with the Director of Nursing (DON) on 7/9/2026 at 12:25 PM confirmed the facility did not have any documentation notifying Resident 62's POA for starting Lexapro. G. A record review of Resident 24's Facesheet dated 7/9/26 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 24's Active Orders revealed the resident had the following psychotropic medication orders: -alprazolam (an anti-anxiety medication) 0.25 mg, to be given daily at bedtime. This medication had a start date of 1/7/26. -paroxetine (an antidepressant medication) 30 mg daily. This order had a start date of 6/5/26. -Zyprexa (an antipsychotic medication) 2.5 mg, to be given three times a day. This order had a start date of 5/8/26. A record review of a Psychotropic Medication Consent form for Resident 24 revealed the facility provided this form to the resident's representative with information on the risks and benefits of their paroxetine and Zyprexa via telephone on 7/7/26. A record review of Resident 24's medical records revealed no evidence of informed consent being obtained from the resident or their representative related to their alprazolam medication. There was also no evidence of informed consent being obtained from the resident or the representative prior to 7/7/26 for their paroxetine or Zyprexa. An interview on 7/7/26 at 2:57 PM with the DON confirmed there was no informed consent completed before 7/7/26.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm 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** Licensure Reference Number 175 NAC 12-006.05(H) Based on record review and interview, the facility failed to protect other residents from 1 (Resident 54) of 1 sampled resident's adverse behaviors. The facility identified a census of 60. Findings Are: A record review of the facility policy Abuse, Neglect, Exploitation, and Misappropriation Prevention Program with a revision date of April 2021 revealed Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The policy stated objectives to identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property and to protect residents from any further harm during investigations. A record review of Resident 54's Facesheet dated 7/8/2026 revealed the resident was admitted to the facility on [DATE] and had diagnoses of dementia (a usually progressive condition marked by the development of multiple cognitive deficits (such as memory impairment, aphasia, and the inability to plan and initiate complex behavior)) with behavioral disturbances, other sexual disorders, and high risk heterosexual behaviors. A record review conducted on 7/8/2026 of Resident 54's Care Plan revealed the resident had physical and verbal behavioral symptoms toward others; this had a start date of 3/25/2024. There was additional information stating that on 5/6/2026, the resident had grabbed another resident and forcefully tried to put the other resident's hand in their crotch and that staff had intervened. There were no other resident-to-resident incidents listed in the care plan. The interventions for this area were: -Assess whether the behavior endangers the resident and/or others, intervene if necessary. This had a start date of 3/25/2026. -Maintain a calm environment and approach to the resident. This had a start date of 3/25/2026. -When Resident 54 has physical or verbal behaviors, keep distance between resident and others (e.g. staff, other residents, visitors). This had a start date of 3/25/2026. -Notify Resident 54's provider as needed. This had a start date of 5/9/2026. A record review of Resident 54's Observations revealed the following Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) scores: -On 11/4/2025 the resident had a score of 12/15, indicating the resident had moderately impaired cognition. -On 2/2/2026 the resident had a score of 12/15, indicating the resident had moderately impaired cognition. -On 5/1/2026 the resident had a score of 11/15, indicating the resident had moderately impaired cognition. A record review of Resident 54's Progress Notes from June 2025 through July 8, 2026, revealed the following resident to resident incidents documented: -On 6/3/2025 this resident and another resident were whispering to each other at the dining room table. Resident 54 was holding onto the other resident's forearms and the nurse witnessed Resident 54 grope the other resident's breasts. The nurse reported the incident to the Director of Nursing (DON), Adult Protective Services (APS) and the Power of Attorney (POA) were notified, and staff were to keep the residents separated at all times. -On 6/4/2025, Resident 54 continued to make contact with and hold the hands of the resident from 6/3/2025. -On 6/5/2025, the facility contacted Resident 54's provider and requested a psychiatric consultation for the resident's sexual behaviors. -On 6/6/2025, the facility received an order for Resident 54 to be evaluated by the psychiatric provider as soon as possible. Scheduling had been notified of this order. -On 6/8/2025, another resident went to sit by Resident 54. Resident 54 yelled, Get up at the other resident while giving them dirty looks. The other resident got up and left the area upset. The nurse told Resident 54 (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that this wasn't kind, and to be nice and leave the other resident alone when they aren't bothering anyone.-Later in the day on 6/8/2025, Resident 54 was being assisted to their room when they saw another resident, who asked them, where are you going? This resident replied, I am going to bed, you should come to bed with me. Staff documented the charge nurse was aware.-On 6/9/2025, the facility was notified that Resident 54 would be seen by the psych provider at the facility on 6/17/2025.-On 6/17/2025, Resident 54 was seen by the psych provider and the facility received orders to discontinue their fluoxetine (an antidepressant medication) and to start paroxetine (an antidepressant medication) 40 milligrams (mg) daily for inappropriate sexual behaviors such as touching other residents' breasts. The resident was to see the provider again in one month.-On 8/22/2025, Resident 54 was seen by a psych provider. The progress note stated the resident was started on gabapentin (an anticonvulsant medication) 10mg in 4/2024 which was not effective. Then was placed on fluoxetine, then switched to paroxetine 40 mg, which was not effective. The facility was to do a gradual dose reduction of the paroxetine and reduce it to 20 mg every morning and add medroxyprogesterone (a synthetic form of the hormone progesterone) 5 mg for management of inappropriate sexual behaviors.-On 9/6/2025, Resident 54 wheeled themselves over to another resident and attempted to grab/touch them. Staff redirected Resident 54, took them to their room, and told them it is not appropriate to touch other residents.-On 11/7/2025, Resident 54 was seen by their provider with no changes made to their medication regimen.-On 11/23/2025, Resident 54 was making inappropriate gestures towards another resident. Resident 54 was removed from the area, and staff discussed the importance of appropriate communication with other residents. The staff also discussed the incident with other staff, so they were aware of the situation and this resident's placement near other residents.-On 11/26/2025, staff documented that Resident 54 was having an increase in inappropriate sexual behaviors and a referral was made to their provider. Later that same day, the provider wrote an order for paroxetine 30 mg daily for inappropriate sexual behaviors.-On 12/26/2025, Resident 54 was observed going up to another resident and grabbing the other resident's breasts. The nurse advised Resident 54 to stop and keep hands to self.-On 1/8/2026, staff documented Resident 54 was seen by the psych provider and that the resident would be monitored for two months.-On 2/3/2026, Resident 54 was observed during an activity holding hands with another resident. Staff separated the residents and then while the staff was telling Resident 54 it was inappropriate to hold other residents' hands, the resident reached up and grabbed the staff's breast. The resident was removed from the situation and educated.-On 2/18/2026, Resident 54's psych provider wrote a new order for Provera (a synthetic form of the hormone progesterone) 5mg twice daily for sexual disinhibition.-On 3/4/2026, Resident 54 was in a resident of the opposite gender's room while the other resident was sleeping, looking at the other resident. Staff removed Resident 54 from the room.-On 3/26/2026, facility staff contacted Resident 54's psych provider as this resident had placed their hands on another resident's buttocks and attempted to grab another resident. The provider placed an order for Depakote (a mood stabilizing medication) 125 mg twice daily.-On 4/4/2026, Resident 54 was seen by the psych provider and received an order to increase the Depakote to three times a day for sexual disinhibitions.-On 4/27/2026, Resident 54 grabbed another resident's hand and attempted to place their hand on Resident 54's genital area. Staff intervened and separated the residents. Staff explained to Resident 54 that they are not allowed to touch staff or other residents, the resident responded stating Oh, why? I like it. The nurse explained to Resident 54 that this is a violation and sexual assault and if they continued, legal action may be taken. Resident 54 stated but I like to touch. The nurse reinforced the education and alerted the DON and Social Services. The note then stated the plan of care was ongoing and the resident was watching television (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with their spouse in the south living room. Later this same morning, Resident 54 saw another resident walking by and attempted to touch them. Staff intervened, removed the other resident, then took this resident to activities.-Later on 4/27/2026, Resident 54 was attempting to grab another resident's breast, making a squeezing action. Staff intervened, took Resident 54 to their room, and educated the resident about appropriate behavior. Resident 54 did not believe they had done anything wrong stating that is not exactly what I was doing. The resident then stated to another resident Let me see your (breasts). The nurse again took Resident 54 to their room and educated them on appropriate behavior.-On 4/28/2026, the facility documented that on 4/27/2026, the facility contacted law enforcement and had the police officer meet with Resident 54 regarding their inappropriate physical contact with others. The officer spoke with the resident, who stated they understood the concern and would keep their hands to themselves going forward. Resident 54's POA was also contacted and the POA requested the facility contact the resident's psych provider.-On 4/28/2026, the facility received orders from a provider to discontinue Resident 54's finasteride (an androgen inhibitor medication), gabapentin, singulair (a cold medication), and Myrbetriq (a medication used to treat overactive bladder). Later that day, the facility received orders from Resident 54's psych provider to reduce their Depakote over the following 8 days, then discontinue; and to increase their medroxyprogesterone to 10 mg twice daily.-On 4/30/2026, Resident 54 was sitting in the commons area and stated come here so I can rub your tummy to another resident as they walked past. Staff intervened and removed the resident from the situation. A short time later, the same resident walked in front of Resident 54 in the dining room and Resident 54 yelled get (gender) out of here.-Later on 4/30/2026, Resident 54 was sitting in the commons area with their hand in their pants, touching their genitals. The nurse told the resident to remove their hand from their pants, which the resident did.-On 5/6/2026, Resident 54 was walking to the dining room, approached a resident of the opposite gender, and forcefully grabbed their hand and attempted to place the other resident's hand between (gender) crotch. A nurse aide hollered no and stopped Resident 54 from placing the other resident's hand on them. Staff separated the two residents and moved Resident 54 to a different room for closer observation. Messages left for Resident 54's provider and POA. DON and Social Services were made aware. This incident was reported to the State. -On 5/8/2026, Resident 54 was seen by their psych provider and orders were received to discontinue their Aricept (a medication used to treat dementia), medroxyprogesterone, and paroxetine. A new order was received to start cimetidine (a medication that reduces stomach acid production) 200 mg four times a day.-On 5/18/2026, Resident 54 was found by staff attempting to lift up another resident's shirt. Staff intervened and Resident 54 stated, What, I was just trying to feel them up. Resident was removed from the room, and the nurse attempted to explain why this behavior was inappropriate, to which the resident stated, I just can't help myself.-On 5/28/2026, Resident 54 was reaching for a resident of the opposite gender, got ahold of the resident's hands and attempted to pull the resident closer to them. Staff intervened and asked Resident 54 what they were doing. The resident replied, I wanted to touch (gender) (breasts). The other resident was moved away from this resident.-On 6/5/2026, Resident 54 was seen by their psych provider. The provider wrote to discontinue the cimetidine, medroxyprogesterone, and to start trazodone (an antidepressant medication) 50 mg four times a day. The provider also wanted a valproic acid level drawn and would follow up in 1 month.-On 6/27/2026, Resident 54 was moved away from another resident due to Resident 54 rubbing their hands on the other resident's breast. Resident 54 was talked to about keeping their hands to themselves and the charge nurse was notified.-On 6/28/2026, Resident 54 had been making sexual comments to staff and other residents. The resident was also making attempts to grab staff's buttocks and breasts. The resident was educated about being appropriate, redirected, and (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Northfield Retirement Communities Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 Circle Drive Scottsbluff, NE 69361	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	distraction interventions were used which was successful at the time of the incident(s). Resident 54 stated they did not understand why they could not touch people or make comments. The resident was educated again and continued to have sexual behaviors. Later this same day, Resident 54 was moved to their room to watch television due to sexual comments being made to staff and other residents. Resident 54 had also been reaching to touch another resident. Resident 54 was educated, their POA and the administrator were notified.-On 6/30/2026, Resident 54 had been trying to follow another resident around even after Resident 54 was told the other resident did not want followed. Resident 54 was not easily redirected.-On 7/7/2026, Resident 54 was seen by their psych provider. The resident was to continue their current medication regimen, and they would add Haldol (an antipsychotic medication) 5 mg twice a day. The provider would follow up with the resident in 1 month.An interview on 7/8/26 at 4:45 PM with the facility Administrator confirmed educating a resident with cognitive impairment, like Resident 54, was not an effective intervention for resident-to-resident behaviors. The Administrator also confirmed the facility had no further information aside from the Progress Notes regarding Resident 54's resident-to-resident incidents or interventions over the prior year. An interview on 7/9/26 at 8:00 AM with the facility Administrator confirmed the medication changes were not working to mitigate Resident 54's behaviors toward other residents. An interview on 7/9/2026 at 8:00 AM with the Director of Nursing revealed we would be calling State three times a day if we called each time Resident 54 had a behavior.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(H) Based on record review and interview, the facility failed to notify Adult Protective Services (APS) of alleged resident-to-resident abuse for Resident 54. failed to notify APS within the required timeframe of an injury of unknown origin for Resident 6, and failed to submit an investigation report to the State Agency within the required timeframe for Residents 54 and 6. The sample size was 4 and the facility identified a census of 60. A record review of the facility policy Abuse, Neglect, Exploitation, or Misappropriation-Reporting and Investigating with a revision date of July 2026 revealed all allegations of resident abuse (including injuries of unknown source), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations). A. A record review of Resident 54's Facesheet dated 7/8/2026 revealed the resident was admitted to the facility on [DATE] and had diagnoses of dementia (a usually progressive condition marked by the development of multiple cognitive deficits (such as memory impairment, aphasia, and the inability to plan and initiate complex behavior)) with behavioral disturbances, other sexual disorders, and high risk heterosexual behaviors. A record review of Resident 54's Progress Notes from June 2025 through July 8, 2026, revealed the following resident to resident incidents documented: -On 6/3/2025 this resident and another resident were whispering to each other at the dining room table. Resident 54 was holding onto the other resident's forearms and the nurse witnessed Resident 54 grope the other resident's breasts. The nurse reported the incident to the Director of Nursing (DON), Adult Protective Services (APS) and the Power of Attorney (POA) were notified, and staff were to keep the residents separated at all times. -On 6/4/2025, Resident 54 continued to make contact with and hold the hands of the resident from 6/3/2025. -On 6/8/2025, another resident went to sit by Resident 54. Resident 54 yelled, Get up at the other resident while giving them dirty looks. The other resident got up and left the area upset. The nurse told Resident 54 that this wasn't kind, and to be nice and leave the other resident alone when they aren't bothering anyone. -Later in the day on 6/8/2025, Resident 54 was being assisted to their room when they saw another resident, who asked them, where are you going? This resident replied, I am going to bed, you should come to bed with me. Staff documented the charge nurse was aware. -On 9/6/2025, Resident 54 wheeled themselves over to another resident and attempted to grab/touch them. Staff redirected Resident 54, took them to their room, and told them it is not appropriate to (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	touch other residents. -On 11/23/2025, Resident 54 was making inappropriate gestures towards another resident. Resident 54 was removed from the area, and staff discussed the importance of appropriate communication with other residents. -On 12/26/2025, Resident 54 was observed going up to another resident and grabbing the other resident's breasts. The nurse advised Resident 54 to stop and keep hands to self. -On 3/26/2026, facility staff contacted Resident 54's psych provider as this resident had placed their hands on another resident's buttocks and attempted to grab another resident. -On 4/27/2026, Resident 54 grabbed another resident's hand and attempted to place their hand on Resident 54's genital area. Staff intervened and separated the residents. Staff explained to Resident 54 that they are not allowed to touch staff or other residents, the resident responded stating Oh, why? I like it. The nurse explained to Resident 54 that this is a violation and sexual assault and if they continued, legal action may be taken. Resident 54 stated but I like to touch. The nurse reinforced the education and alerted the DON and Social Services. The note then stated the plan of care was ongoing and the resident was watching television with their spouse in the south living room. Later this same morning, Resident 54 saw another resident walking by and attempted to touch them. Staff intervened, removed the other resident, then took this resident to activities. -Later on 4/27/2026, Resident 54 was attempting to grab another resident's breast, making a squeezing action. Staff intervened, took Resident 54 to their room, and educated the resident about appropriate behavior. Resident 54 did not believe they had done anything wrong stating that is not exactly what I was doing. The resident then stated to another resident Let me see your tittys. The nurse again took Resident 54 to their room and educated them on appropriate behavior. -On 4/30/2026, Resident 54 was sitting in the commons area and stated come here so I can rub your tummy to another resident as they walked past. Staff intervened and removed the resident from the situation. A short time later, the same resident walked in front of Resident 54 in the dining room and Resident 54 yelled get (gender) out of here. -On 5/6/2026, Resident 54 was walking to the dining room, approached a resident of the opposite gender, and forcefully grabbed their hand and attempted to place the other resident's hand between (gender) crotch. A nurse aide hollered no and stopped Resident 54 from placing the other resident's hand on them. Staff separated the two residents and moved Resident 54 to a different room for closer observation. Messages left for Resident 54's provider and POA. DON and Social Services were made aware. This incident was reported to the State. -On 5/18/2026, Resident 54 was found by staff attempting to lift up another resident's shirt. Staff intervened and Resident 54 stated, What, I was just trying to feel them up. Resident was removed from the room, and the nurse attempted to explain why this behavior was inappropriate, to which the resident stated, I just can't help myself. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 5/28/2026, Resident 54 was reaching for a resident of the opposite gender, got ahold of the resident's hands and attempted to pull the resident closer to them. Staff intervened and asked Resident 54 what they were doing. The resident replied, I wanted to touch (gender) titties. The other resident was moved away from this resident. -On 6/27/2026, Resident 54 was moved away from another resident due to Resident 54 rubbing their hands on the other resident's breast. Resident 54 was talked to about keeping their hands to themselves and the charge nurse was notified. -On 6/28/2026, Resident 54 had been making sexual comments to staff and other residents. The resident was also making attempts to grab staff's buttocks and breasts. The resident was educated about being appropriate, redirected, and distraction interventions were used which was successful at the time of the incident(s). Resident 54 stated they did not understand why they could not touch people or make comments. The resident was educated again and continued to have sexual behaviors. Later this same day, Resident 54 was moved to their room to watch television due to sexual comments being made to staff and other residents. Resident 54 had also been reaching to touch another resident. Resident 54 was educated, their POA and the administrator were notified. An interview on 7/8/26 at 4:45 PM with the facility Administrator confirmed the facility had no further information aside from the Progress Notes regarding Resident 54's resident-to-resident incidents over the prior year. An interview on 7/9/26 at 8:10 AM with the facility Administrator confirmed the resident-to-resident incidents documented in Resident 54's Progress Notes on 6/8/2025, 9/6/2025, 11/23/2025, 12/26/2025, 3/26/2026, 4/27/2026, 4/30/2026, 5/18/2026, 5/28/2026, 6/27/2026, and 6/28/2026 should have been reported to the State and were not. A record review of a facility provided fax document revealed the facility attempted to fax an Investigation Report for Resident 54's resident-to-resident sexual behaviors that occurred on 5/6/2026, on 5/8/2026. The document stated the fax was not sent, the result: Communication failed because the line is busy at the fax destination, etc. Wait a moment, then try again. There was no evidence provided of the facility attempting to re-fax or send the document through another means. An interview on 7/8/26 at 12:00 PM with the facility Administrator revealed the facility was not able to locate evidence of their investigative report for the resident-to-resident incident that occurred on 5/6/26 being successfully sent to the State Agency as required. B. Record Review of Resident 6's Resident Face Sheet dated 7/7/2026 revealed the resident was admitted to the facility on [DATE] with a diagnosis of Dementia with Behavioral Disturbance (a usually progressive condition marked by the development of multiple cognitive deficits [such as memory impairment, aphasia, and the inability to plan and initiate complex behavior] with non-cognitive symptoms like agitation, aggression, wandering, and hallucinations). (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 6's Resident Progress Notes revealed a note dated 10/8/2025 at 1:19 PM regarding a bruise noted to Resident 6's right forearm. The bruise was dark purple in color and measured 10 centimeters (cm) by (x) 10 cm. The note revealed Resident 6 was unable to state what happened and the nursing staff member stated Resident ambulates throughout facility, may have bumped gender arm somewhere. The note revealed that a referral was made to the Nurse Practitioner and a message left for Resident 6's Power of Attorney (POA). Further record review of Resident 6's Progress Notes revealed a note dated 10/18/2025 at 2:22 PM a bruise on right lower arm (RLA) of Resident 6 and was measured to be 11x12 cm and still has purple, blue, and green bruising to area. Record review of Resident 6's NRC Weekly Skin Observation dated 10/18/2025 at 3:57 PM revealed Resident 6's bruise was purple, blue, and had some yellow which indicated healing. Unknown how pt (resident) received bruise to RLA as pt is unable to report how (gender) received it. Record review of Adult Protective Services (APS) Intake Worksheet with date received at 10/20/2025 at 2:49 PM revealed the facility reported Resident 6's bruise of unknown origin that measured about 11x12cm, with purple and green hues, on right lower arm. The report revealed that Resident 6 was unable to tell the reporter where Resident 6 got the bruise due to their cognitive impairment. Interview with Administrator (ADM) on 7/9/2026 at 9:31 AM confirmed that the initial bruise was 10/8/2025, and the report was made to APS on 10/20/2025. ADM confirmed that this was past the two hours to report.		