STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335850	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Hamptons Center for Rehabilitation and Nursing	64 County Road 39 South Hampton, NY 11968

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during the abbreviated survey (Intake # 2660131) the facility failed to ensure that residents were free from alleged sexual abuse for two (2) of eight (8) residents reviewed. Specifically, Resident#1 and Resident #2, both with intact cognition, reported allegations of sexual abuse. Resident #1 alleged on 08/25/2025 that Certified Nursing Assistant #1 made a sexually inappropriate comment while providing care. Resident #2 alleged Certified Nursing Assistant #1 touched and rubbed their genital area on 08/21/2025 that made them feel unsafe in the facility. Certified Nursing Assistant #1 was suspended for three (3) days without a thorough investigation and returned to work and had access to all 248 residents in the facility. This resulted in Immediate Jeopardy.The findings are:The facility policy titled Abuse Prevention dated 11/02/2022 reviewed 07/2025 documented sexual abuse is the non-consensual sexual contact of any type with a resident and this may include touching intimate body parts. It is a violation of personal rights when anyone interacts with a resident in an inappropriate sexual manner. Residents can be abused without the occurrence of physical injury or sexual penetration.Resident #1 was admitted to the facility on [DATE] with diagnoses that include multiple sclerosis(a chronic autoimmune disease that affects the brain and spinal cord), protein calorie malnutrition (a condition where the body does not receive enough protein and calories) and pseudobulbar affect (a neurological condition that causes sudden, frequent and uncontrollable outburst of crying and laughing that are disproportionate to the situation).The Minimum Data Set (a resident assessment tool) dated 10/03/2025 documented a Brief Interview for Mental Status score of 15 indicating intact cognition.A Grievance Report dated 08/25/2025, documented that on 08/21/2025, Resident #1 told Certified Nursing Assistant #1 they wanted a female certified nursing assistant to give them care, not a male, but then resident #1 told a female certified nursing assistant they were okay with Certified Nursing Assistant #1. Certified Nursing Assistant #1 changed Resident #1's brief and put cream on their vagina and ass and told Resident #1 they never took care of a resident with a shaved vagina. The grievance concluded that Resident #1's family member was made aware that the facility would document in the Electronic Medical Record for Resident #1 not to have male caregivers and Resident #1 would be a two (2)-person approach. There is no documented evidence that an investigation was initiated regarding the incident with Certified Nursing Assistant #1 and Resident #1 on 08/25/2025 when the facility staff became aware. There is no documented evidence that Resident #1 was assessed, or a psychosocial evaluation conducted after they expressed fear due to the incident.During a telephone interview on 11/07/2025 at 4:51 PM, with Resident #1 and Family Member #1, they stated that on 08/21/2025, a day shift male aide, Certified Nursing Assistant #1, asked Resident #1 if they wanted cream on their vagina. Resident stated that Certified Nursing Assistant #1 started to put cream on their buttocks. Certified Nursing Assistant #1 stated that they do not see many women with a shaved vaginal area in the nursing home. Resident #1 stated they waited until their family member came to visit and told them about the incident because they felt embarrassed. Resident #1 stated they were afraid Certified Nursing Assistant #1 would be sexually inappropriate again after the incident. Resident #1 stated they did not agree with allowing the male aide to care for them and told this to Certified Nursing Assistant #1 before they provided care. Resident #1 stated that Certified Nursing Assistant #1 went to get the nurse who told Resident #1 that there was not documentation in their chart that they could not be cared for by a male caregiver. Resident #1 stated they did not feel safe and is no longer in the facility. Family Member #1 stated they shaved Resident#1's genital area for hygiene about a week or two before the incident. They stated they often shave the resident for hygienic purposes since they are unable to do it for themselves. Family Member #1 stated Resident #1 reported the incident to them on 08/25/2025 because the resident felt embarrassed. Family member #1 stated they told the Assistant Director of Nursing about the incident on 08/25/2025. Family Member #1 stated the Assistant Director of Nursing assured them they will take Certified Nursing Assistant #1 off the schedule and start an investigation. Family Member #1 stated they never heard anything regarding the results of the investigation. Family Member #1 stated Resident #1 never felt comfortable staying at the facility and felt they would retaliate against them.A Treatment Administration Record dated 08/21/2025 documented Silvadene 1% topical cream ordered to be applied to the sacrum after cleanse with sterile water and mixed with lidocaine cream followed by abdominal pads and secured with medical tape daily and as needed.There was no documented evidence in Resident #1's electronic medical record of a cream that needed to be applied in the vaginal area. During an interview with Certified Nursing

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during the abbreviated survey (Intake #2660131) the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source, and misappropriation of resident property, were reported immediately, but not later than two (2) hours after the allegation is made. This was identified for two (2) of eight (8) Residents (Resident #1 and Resident #2). Specifically, Resident #1 reported an allegation that Certified Nursing Assistant #1 stated to them they did not see many women with a shaved vaginal area in the nursing home and this made Resident #1 not feel safe. Resident #2 reported an allegation that Certified Nurse Assistant #1 touched and rubbed their genital area in a manner that made them feel violated. There was no documented evidence the alleged abuse was reported to local law enforcement or the New York State Department of Health. This resulted in Immediate Jeopardy. The findings are:The facility policy titled Abuse Prevention dated 11/02/2022, reviewed 07/2025 documented: Any case in which abuse neglect mistreatment of a resident has been identified via the investigation or abuse cannot be ruled out, it will be reported promptly to the New York State Department of Health for further investigation. Sexual abuse includes; but it's not limited to sexual harassment or sexual assault residents may be abused by facilities staff this may include touching Intimate body parts, or the clothing covering intimate body parts or the examination of the resident or treatment of the resident for other than [NAME] fide, medical purposes or observation residence can be abused without the occurrence of physical injury or sexual penetration, we must appreciate and recognize residence as a victims when sexual abuse occurs. There was no documented evidence the facility policy contained information regarding reporting to local law enforcement for abuse and reasonable suspicion of a crime.Resident #1 was admitted to the facility on [DATE] with diagnoses that include multiple sclerosis (a chronic autoimmune disease that affects the brain and spinal cord), protein-calorie malnutrition (a condition where the body does not receive enough protein and calories) and pseudobulbar affect (a neurological condition that causes sudden, frequent and uncontrollable outburst of crying and laughing that are disproportionate to the situation). The Minimum Data Set (a resident assessment tool) dated 10/03/2025 documented a Brief I for Mental Status score of 15, indicating intact cognition.A Grievance Report dated 08/25/2025 documented that on 08/21/2025, Resident #1 told Certified Nursing Assistant #1 they wanted a female certified nursing assistant to give them care, not a male, but then told a female certified nursing assistant #2 they were okay with Certified Nursing Assistant #1. Certified Nursing Assistant #1 changed Resident #1's brief and put cream on their vagina and ass and told Resident #1 they never took care of a resident with a shaved vagina. The grievance concluded that Resident #1 and Family Member #1 were made aware that they would document in the Electronic Medical Record for Resident #1 not to have male caregivers, and Resident #1 would be a two (2)-person approach. During a telephone interview on 11/07/2025 at 4:51 PM with Resident #1 and Family Member #1, they stated that on 08/21/2025, a day shift male aide, (Certified Nursing Assistant #1), entered Resident #1's room. Resident #1 stated they requested a female aide but was not provided one. Resident #1 stated Licensed Practical Nurse #1 stated to the resident that Certified Nurse Assistant #1 could care for them because there was not documentation in their chart that they could not be cared for by a male caregiver. During care, Certified Nurse Assistant #1 asked Resident #1 if they wanted cream on their vagina, Resident #1 stated they (Resident #1) could put cream on their own vagina, but Certified Nurse Assistant #1 proceeded to put the cream on Resident #1's buttocks. Resident #1 stated Certified Nursing Assistant #1, said to them that they did not see many women with a shaved vaginal area in the nursing home. Resident #1 stated they did not report the incident until 08/25/2025 because they were embarrassed. Family Member #1 stated they shaved Resident #1 (for hygiene) about a week or two before the incident. Resident #1 reported the incident to them on 08/25/2025. Family Member #1 then made the Assistant Director of Nurses ware on the same day (08/25/2025). Resident #1 stated they did not feel safe because of (Certified Nursing Assistant #1) Resident #1 is no longer residing in the facility. A Treatment Administration Record dated 08/19/2025 through 08/31/2025 documented apply Silvadene (a cream to protect skin during incontinence) followed by abdominal pad to the sacrum and right buttocks daily. During an interview with the Director of Nursing on 11/10/2025 at 4:54 PM, they stated they made the decision not to report this allegation for Resident #1 because they did not feel that this was sexual abuse because Resident #1's vaginal area had not been shaved as per female Certified Nursing Assistance #3 who cared for Resident #1 on 08/22/2025, but

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during the abbreviated survey (Intake #2660131), the facility failed to ensure that an investigation of alleged sexual abuse was thoroughly and timely investigated to prevent further potential abuse, neglect, exploitation, or mistreatment. This was identified for two (2) of eight (8) residents (Resident #1 and Resident #2) reviewed for accidents/incidents. Specifically, Resident #1 and Resident #2 alleged Certified Nursing Assistant #1 was sexually inappropriate which made them feel unsafe in the facility. There was no documented evidence that an investigation to rule out abuse, neglect, or mistreatment was initiated. This resulted in Immediate Jeopardy.The findings are: The facility policy titled Abuse Prevention dated 11/02/2022 and reviewed 07/2025 documented all allegations of abuse must be immediately reported to the administrator and no later than two (2) hours to the other officials (including to the State Survey Agency) after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury. The facility will investigate all incidents of alleged and actual abuse, complaints/grievances, misappropriation and injury of unknown origin. The investigative process will include statements from staff, witness, residents, interviews with staff, witness, residents, medical record review if applicable, review of employee records. Resident #1 was admitted to the facility on [DATE] with diagnoses that include multiple sclerosis (a chronic autoimmune disease that affects the brain and spinal cord), protein-calorie malnutrition (a condition where the body does not receive enough protein and calories) and pseudobulbar affect (a neurological condition that causes sudden, frequent and uncontrollable outburst of crying and laughing that are disproportionate to the situation). The Minimum Data Set (a resident assessment tool) dated 10/03/2025 documented a Brief Interview for Mental Status score of 15 indicating intact cognition.A Grievance Report dated 08/25/2025 documented that on 08/21/2025, Resident #1 told Certified Nursing Assistant #1 they wanted a female Certified Nursing Assistant to give them care, not a male, but then told a female certified nursing assistant [KN1] [HC2] [KO3] they were okay with Certified Nursing Assistant #1. Certified Nursing Assistant #1 changed Resident #1's brief and put cream on their vagina and ass and told Resident #1 they never took care of a resident with a shaved vagina. The grievance concluded that Resident #1 and their mother were made aware that they would document in the Electronic Medical Record for Resident #1 not to have male caregivers, and Resident #1 would be a two (2)-person approach. During a telephone interview on 11/07/2025 at 4:51 PM with Resident #1 and Family Member #1, they stated that on 08/21/2025, a day-shift male aide, (Certified Nursing Assistant #1), entered Resident #1's room. Resident #1 stated they requested a female aide but was not provided one. Resident #1 stated that Licensed Practical Nurse #1 stated to the resident that Certified Nurse Assistant #1 could care for them because there was no documentation in their chart that they could not be cared for by a male caregiver. During care Certified Nurse Assistant #1 asked Resident #1 if they wanted cream on their vagina, Resident #1 replied they could put cream on their own vagina, but Certified Nurse Assistant #1 proceeded to put the cream on Resident #1's buttocks. Resident #1 stated Certified Nursing Assistant #1 said to them that they did not see many women with a shaved vagina in the nursing home. Resident #1 stated they did not report the incident until 08/25/2025 because they were embarrassed.During a telephone interview on 11/07/2025 at 4:51 PM, Family Member #1 stated they shaved Resident #1 (for hygiene) about a week or two (2) before the incident. Resident #1 reported the incident to them on 08/25/2025. Family Member #1 then made the Assistant Director of Nursing aware on the same day (08/25/2025). Resident #1 stated they did not feel safe because of Certified Nursing Assistant #1. Resident #1 is no longer residing in the facility. During an interview with the Assistant Director of Nursing on 11/10/2025 at 4:28 PM they stated they initiated a grievance report, but they did not feel this was sexual abuse because they believed the resident was making up stories. The Assistant Director of Nursing stated the allegation did not need to be investigated any further. During an interview with the Administrator on 11/10/2025 at 5:43 PM, they stated the facility conducted a grievance investigation and determined within two (2) hours there was no evidence of abuse. They stated for Resident #1 they ruled within two (2) hours that there was no harm because the family member told them they did not shave Resident #1 ‘s vaginal area.Resident #2 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus (where the body becomes resistant to insulin and eventually may not produce enough), depression (mental disorder that negatively affects how you feel, think, act, and perceive the world) and anxiety disorder (anxiety that does not go away). The Minimum Data Set assessment dated