

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Regency Albany		STREET ADDRESS, CITY, STATE, ZIP CODE 805 19th Avenue SE Albany, OR 97321	

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 - 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. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview, and record review it was determined the facility failed to protect the resident's right to be free from sexual abuse by another resident for 1 of 3 sampled residents (#101) reviewed for abuse. This placed residents at risk for abuse. Findings include:Based on interview, and record review it was determined the facility failed to provide care and services to ensure the resident's right to be free from sexual abuse by another resident for 1 of 3 sampled residents (#101) reviewed for abuse. This placed residents at risk for abuse. Findings include:Resident 101 was admitted to the facility in 7/2025 with diagnoses including Alzheimer's dementia and stroke.On 9/24/25, Resident 101 had a score of 7 on a BIMS Evaluation which indicated severe cognitive impairment.Resident 101's 8/7/25 MDS CAA for Cognitive Loss/ Dementia indicated the resident had cognitive loss related to a diagnosis of Dementia, aphasia (a disorder that affects your ability to speak, understand, read, and write), a history of a recent stroke and reported inattention. Resident 101 was confused and sometimes struggled with understanding others and making herself/himself understood. Dementia and aphasia impeded the resident's ability to interact with others.A Facility Reported Incident (FRI) dated 9/22/25, indicated Resident 101 was found by Staff 3 (CNA) in the room of Resident 102 and they were having adult relations using Resident 101's hands. Resident 101 was redirected by Staff 3 to her/his room. Resident 101 had no memory of the interaction with Resident 102. Resident 101 has a diagnosis of dementia. On 9/24/25 at 11:34 PM, Resident 101 was interviewed regarding the incident with Resident 102. The resident did not remember the incident.On 9/24/25 at 2:11 PM, Staff 3 (CNA) stated she was Resident 101's CNA on the night of the incident on 9/19/25. Resident 101 was not in her/his room so she went to look and found the resident in Resident 102's room. Staff 3 stated Resident 101 was standing by the bed and her/his hands were on resident 102's private parts. Resident 102 wears adult briefs but he does not wear the briefs taped. Staff 3 stated she was positive what she saw and knew it was not right. Staff 3 said she took resident 101 out of the room and back to her/his own room. Staff 3 also stated when she got the resident back to her/his room Resident 101 was acting differently than normal. Resident 101 would not let her put a new brief on her/him and was going around the room naked, even standing on the bed naked. Staff 3 stated the resident had never behaved like that before and has not done so again since the incident. On 9/24/2025 at 12:47 PM, Resident 102 indicated she/he previously had a room on the 100 Hallway where she/he would see Resident 101 wandering the hallways. Resident 102 stated she/he would try to say hello and wave but Resident 101 did not respond. Resident 102 stated she/he was aware that Resident 101 had mental issues. Resident 102 stated she/he previously had a room on the 100 hallway and one day Resident 101 walked by and Resident 102 asked Resident 101 to come here. Resident 102 stated he was in bed with the door open and asked the resident her/his name but Resident 101 did not answer. Resident 102 went on to say she/he had the covers up to her/his waist and just a brief on. Resident 102 stated she/he was just trying to talk to the resident but could tell something was wrong with Resident 101 mentally. Resident 102 stated Resident 101 did not touch her/him. When asked about the CNA seeing him/her and then quickly trying to cover herself/himself up when she entered the room Resident 102 said she/he was putting her/his urinal in place. Resident 102 stated if anyone wanted to take advantage of me, she/he would let them. A review of Resident 101's medical record including the care plan and nursing progress notes, revealed no interventions were put in place to ensure the resident's safety directly following the incident and no interventions were put in place in the care plan, progress notes or alert charting related to Resident 102's behavior.On 9/25/25 at 1:49 PM, Witness1 (Family Member) stated the incident occurred on Friday evening and she was not informed about it until Monday at 4:00 PM. Witness 1 said she was a retired Nurse Practitioner and had just moved to Oregon to be closer to resident 101. Witness 1 also stated Resident 101 had never exhibited any behaviors of a sexual nature, and if the resident got naked after the incident, it was not a behavior she had ever seen or heard about previously. Witness 1 stated her main concern was that this incident should never happen again and her intention was to move the resident to a different facility with a memory unit.On 9/25/25 at 2:04 PM, Staff 1 (Administrator) acknowledged Staff 3 was a witness to the sexual contact between the residents, and Resident 101 did not have the mental capacity to consent to the sexual contact. The facility did not put appropriate interventions in place following the incident because it was not reported to her in a timely manner. On 9/25/25 at 5:32 PM, Staff 2 (LPN) stated when she came to work Resident 101 was already back to her/his room. Staff 3 told her what happened including that Resident 101's hands were on Resident 102's genitals. Staff 2 stated Resident 102 would frequently watch pornography on</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interviews and record review it was determined the facility failed to report an allegation of sexual abuse and an allegation of verbal abuse to the State Survey Agency within two hours of the allegations for 1 of 3 (#101) sampled residents reviewed for abuse. This placed residents at risk for further unreported abuse. Findings include: 1. Resident 101's FRI with an allegation of sexual abuse was received by the State Survey Agency on 9/22/25 at 2:51 PM. The incident of alleged sexual abuse occurred on 9/19/25 at 9:30 PM and should have been reported within the two hours of the incident date and time. 2. Resident 101's FRI with an allegation of verbal abuse was received by the State Survey Agency on 7/21/25 at 2:30 PM. The incident of alleged verbal abuse occurred on 7/19/25 at 12:41 PM and should have been reported within two hours of the incident date and time. On 9/25/25 at 2:04 PM, Staff 1 (Administrator) acknowledged the incident of alleged sexual and verbal abuse were not reported to the State Survey Agency in a timely manner.</p>		