STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395289	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wecare at South Hills Rehabilitation and Nrsg Ctr	201 Village Drive Canonsburg, PA 15317

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 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observation and staff interview, it was determined that the facility failed to post complete and current contact information for the Grievance Officer in the facility on three of three nursing units (Bird Room (Main area near dining room), Solarium C and Solarium E).Findings include:During an observation completed 8/21/25, through 8/22/25, of the Bird Room (common area), the facility failed to reveal the address and email contact information for Adult Protective Services and the Office of the State Long-Term Care Ombudsman program along with the Grievance Officer for the facility, observations revealed in Solarium C and Solarium E common areas, the facility failed to reveal the correct contact information for the Grievance Officer.During an interview on 8/22/25, at approximately 2:50 p.m., the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to post complete contact information for Adult Protective Services, State Long-Term Care Ombudsman, and the Grievance Officer as required in one resident common area and failure to list an updated contact for Grievance Officer in two of two common areas.28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(e) Management.

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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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on review of facility documentation, clinical records, staff interviews and resident interviews it was determined the facility failed to submit, document and/or follow-up on concerns/grievances presented by staff and residents (staff and residents wished to remain anonymous).Finding include:Review of Federal Regulation 483.10(i)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatments which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.Review of facility policy, Skilled Nursing Facility Grievance Policy dated 1/27/25, revealed the facility is committed to maintaining transparent, fair, and accessible grievance process. Every grievance will be addressed promptly and appropriately, in accordance with federal and state regulations. Residents and their representative must be assured that: They can submit grievances orally or in writing; Their concerns will be investigated and responded to promptly; They will not face discrimination, reprisal, or retaliation; They will receive written notice of grievance outcomes within required timeframes.Review of the last six months of grievances revealed only three grievances filed. One grievance from March was from a visitor that sent negative feedback for a smell and T.V. and controller not working. In April a Grievance form was completed that should have been an incident report with an investigation done due to resident not receiving medication or vitals as ordered. The last Grievances were from July regarding a resident accusing another resident of physical harm (running over toes and ankle with wheelchair) which led to an investigation. The second grievance was a son that called in asking for records to be sent to an attorney, the attorney had not sent in a request and would need to do so. These grievances were resolved.Interview on 8/21/25, at 10:30 a.m. with Resident R8 and R9 revealed that they had filed both verbal and written grievances about another resident (male) being aggressive towards female residents and no actions were taken, did not receive a written confirmation that anything was being done and were threatened by staff to stop filing grievances and to quit complaining. Resident R8 and R9 revealed that at one point there were no forms at the grievance boxes to fill out, thus the grievances could not remain anonymous because they had to be submitted verbally. Interview on 8/21/25, at 10:43 a.m. with Employee E4 and E5 revealed that they had attempted to file grievances about a resident and were told that if they continued there would be consequences to them, that they would lose their jobs. Employee E4 and E5 stated that they started to refuse to file grievances for residents because they were afraid, they would be accused of complaining too much.During an interview on 8/22/25, at 2:50 p.m. the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to address concerns from staff and residents.28 Pa. Code 201.29(a) Resident Rights.

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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 - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility provided policies and documentation, clinical records, and resident, family, and staff interviews, it was determined that the facility failed to protect residents from resident-to-resident sexual abuse. This failure resulted in a resident with a known history of sexually inappropriate behavior touching non-consenting residents, which created an Immediate Jeopardy situation for five of 67 residents (Resident R2, R3, R4, R5, R6). Findings include:Review of facility Abuse and Neglect Policy reviewed 1/27/25, Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Neglect as defined as, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Sexual Abuse is defined as a non-consensual sexual contact of any type with a resident. Willful, as defined as, and as used in the definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2024, indicated that a Brief Interview for Mental Status (BIMS), is a screening test that aides in detecting cognitive impairment). The BIMS total score suggests the following distributions:13-15: cognitively intact8-12: moderately impaired0-7: severe impairmentReview of the clinical record indicated Resident R1 was initially admitted to the facility on [DATE], and readmitted on [DATE]. Review of Minimum Data Set (MDS - periodic review of resident needs) dated 6/3/25, included diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), history of a stroke, and a seizure disorder. Question C0500 BIMS Summary Score revealed Resident R1's score to be 1. Review of Resident R1's plan of care initiated on 7/10/24, indicated that Resident R1 was a registered sexual offender. The goal of this care plan was Will not exhibit inappropriate sexual behaviors towards others. Interventions listed were:-Counseling as indicated.-Life review with resident to identify triggers and coping. -Monitor resident's whereabouts, resident does have female friend, make sure residents are in common area. -Observe for wandering into other residents' rooms. Offer snacks to minimize wandering in search of food. -Provide consistent message from all IDT.-Psychology consult.-Report with Megan's Law (laws that mandate the creation of public registries of convicted sex offenders) as required.-Report inappropriate behavior towards others immediately to administration.Review of Resident R1's plan of care for Potential to be sexually inappropriate revealed it was not initiated until 7/30/25. The goal of this care plan was Resident will not harm self or others through the review date. Interventions listed were:-Administer medications as ordered. Monitor/document for side effects and effectiveness. -Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. No documentation that this was completed. -Monitor/document/report as needed any signs/symptoms of resident posing danger to self and others. -Psychiatric/psychogeriatric consult as indicated.-When resident becomes sexually inappropriate: Intervene before behavior escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive/ inappropriate, staff to ensure safety and walk calmly away, and approach later.Review of a physician order dated 8/18/25, indicated for Resident R1 to receive Fluoxetine (Prozac, an anti-depressant medication) 20 milligrams (mg) daily, for depression/sexually disinhibited behavior.During an interview on 8/29/25, at approximately 11:00 a.m. the Director of Nursing confirmed the medication adjustment was based on notification to the provider of increased sexual behaviors.Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE].Review of the MDS dated [DATE], included diagnoses of Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior), anxiety, and depression. Question C0500 BIMS Summary Score revealed Resident R2's score to be 3. Review of Resident R2's plan of care initiated 5/20/25, indicated Resident R2 was at risk of mood instability related to anxiety and bipolar disorder (mood disorder characterized by extreme shifts in mood, energy, and activity levels).During an observation on 8/21/25, at 10:40 a.m. Resident R1 was seen staring fixated at Resident R2. The surveyor observed Resident R2 roll her wheelchair backwards away from Resident R1

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Finding include:Review of the facility policy Abuse and Neglect-Clinical Protocol dated 1/27/25, previously reviewed 10/23/24, indicated abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical conditions, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.Review of the facility policy Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating dated 1/27/25, previously reviewed 10/23/24, indicates all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.Review of the facility policy Resident Right Guidelines for All Nursing Procedures dated 1/27/25, previously reviewed 10/23/24, indicates to provide general guidelines for residents while caring for the resident. Staff must have appropriate in-service training on resident rights, including preventing, recognizing and reporting resident abuse, resident dignity and respect, and resident access to information.Skilled Nursing Facility Grievance Policy dated 1/27/25, previously reviewed 10/23/24, indicates all residents, resident representatives, and responsible parties in the Skilled Nursing Facility (SNF) have the right to voice concerns, file grievances, and receive prompt, thorough, and impartial response without the fear of retaliation, as required under CMS SOM Appendix PP, F585 and Pennsylvania Department of Health (DOH) regulations. The facility is committed to maintaining a transparent, fair. and accessible grievance process. Every grievance will be addressed promptly and appropriately, in accordance with federal and state regulations. Residents and their representatives must be assured that: they can submit grievances orally or in writing, their concerns will be investigated and responded to promptly, they will not face discrimination, reprisal, or retaliation, they will receive written notice of grievance outcomes within required timeframes. Non-retaliation clause states that residents and staff are protected from retaliation related to filing or assisting in grievances. Any allegation of retaliation will be investigated and addressed immediately.During an interview on 8/21/25, at 10:38 a.m. Licensed Practical Nurse (LPN) Employee E16 stated she has seen a male resident that wonders and has heard that he touches female resident, she was told to not talk about it. During an interview on 8/21/25, at 10:34 LPN Employee E8 stated that she has seen the male resident with a female resident and knows that they have a history, she can't say that she has seen him wandering but knows that he has a history of it. She was also instructed not to talk about it.During an interview on 8/21/25, at 10:30 a.m. LPN Employee E6 stated that she has seen the male resident wandering and has had to redirect him away from female residents. She revealed that she has reported it to management and was instructed to keep quiet about it, was threatened with repercussions if she discussed it with anyone.During an interview on 8/21/25, at 10:30 a.m. Certified Nursing Assistant (CNA) Employee E5 revealed that she has seen this male resident wandering all over and has had to redirect him, she has spoken to families that ask if he was in their family members room and was told to deny it, she herself has been told not to talk about it and knows other staff have also been told not to talk about it or talk to family members or risk being terminated. Staff were told not to file any grievancesDuring an interview on 8/22/25, at 2:50 p.m. the Nursing Home Administrator (NHA) and the Director of Nursing (DON) confirmed that the facility failed to protect female residents from the male resident wandering into their rooms with no grievances or investigations available to confirm that the facility was aware of the situation or that they were doing anything regarding his behavior. The NHA and DON also stated they failed to make the staff feel safe from retaliation of being threatened with termination if they spoke with family, filing a grievance or talking amongst themselves regarding the male resident.28 Pa. Code 201.14(a): Responsibility of licensee.28 Pa. Code 201.18(b)(1)(e)(1): Management.28 Pa Code: 201.20 (b): Staff development.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of state laws, facility policy and documents, clinical records, and staff interview, it was determined that the facility failed to implement policies and procedures to report allegations of abuse for four of 67 residents (Resident R2, R3, R5, and R6). This failure resulted in a resident with a known history of sexually inappropriate behavior touching non-consenting residents, which created an Immediate Jeopardy situation. Findings include:Review of the Older Adult Protective Services Act of 11/6/87, amended by Act 1997-13, Chapter 7, Section 701, requires any employee or administrator of a facility who suspects abuse is mandated to report the abuse. All reports of abuse should be reported to the local area agency on aging and licensing agencies. If the suspected abuse is sexual abuse, serious bodily injury, or suspicious death, the law requires additional reporting to the Department of Aging and local law enforcement.Review of facility policy Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigating dated 1/27/25, indicated The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies:The state licensing/certification agency responsible for surveying/licensing the facility. The local/state ombudsman. The resident's representative.Adult protective services (where state law provides jurisdiction in long-term care).Law enforcement officials. The residents attending physician. The facility medical director.Immediately is defined as:Within two hours of an allegation involving abuse or result in serious bodily injury; or Within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's Minimum Data Set (MDS - periodic review of resident needs) dated 6/3/25, included diagnoses of dementia (a group of symptoms that affect memory, thinking, and interferes with daily life), history of a stroke, and a seizure disorder. Question C0500 BIMS Summary Score revealed Resident R3's score to be 1. Review of an electronic communication dated 8/12/25, at 6:18 p.m. provided to both the facility administration and the state survey agency indicated, It has come to our family's attention in the last 2 weeks that my grandmother has been harassed (and touched at least twice) by a male resident at your facility for months. During an interview on 8/21/25, at 8:45 p.m. Resident R3's granddaughter confirmed that the electronic communication provided to the facility was the same electronic communication provided to the state survey agency and provided the name of the male resident spoken of in the electronic communication as Resident R1.Review of documentation submitted by the facility to the State Survey Agency failed to include a report of possible abuse to Resident R3.During an interview on 8/21/25, at approximately 3:40 p.m. the Director of Nursing confirmed that a report was not made to the State Survey Agency related to the allegation of possible abuse reported by Resident R3's family member on 8/12/25.Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE].Review of Resident R2's MDS dated [DATE], included diagnoses of Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior), anxiety, and depression. Question C0500 BIMS Summary Score revealed Resident R2 ' s score to be 3.During an interview completed during the survey, Employee E4 stated they have seen Resident R1 being sexually inappropriate. Kissing, touching. Tried to separate them and bring him back to his unit. Has seen Resident R1 recently with Resident R7 and here more recently with Resident R2. I've told 'em. Everybody knows it. It's everyday like, Oh I have had to get Resident R1 away from Resident R2. Oh, I just had to get Resident R1 away from whoever. Confirmed he wanders into other rooms, Oh yeah, he's everywhere. Real bad.Review of documentation submitted by the facility to the State Survey Agency failed to include a report of possible abuse to Resident R2.Review of the clinical record indicated Resident R5 was admitted to the facility on [DATE].Review of the MDS dated [DATE], included diagnoses of dementia, anxiety, and depression. Question C0500 BIMS Summary Score revealed Resident R5 ' s score to be 00, which indicated that Resident R5 is so severely cognitively impaired to not be able to complete the interview. During an interview completed during the survey, Employee E6 stated they have seen Resident R1 be inappropriate with residents. A lot in the dining room. When we separate them, he follows us and gets very combative. [Resident R5] was asleep in the dining room and [Resident R1] put his fingers in her mouth. We were told it's not inappropriate behavior. It really upset me. I was very uncomfortable. We were told, 'Do you kiss in your own home?' but yes, with consent.Review of documentation submitted by the facility to the State Survey Agency failed to include a report of possible abuse to Resident R5.Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE].Review of the MDS dated [DATE], included

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and documents, clinical records, and staff interview, it was determined that the facility failed to implement policies and procedures to investigate allegations of abuse for four of 61 residents (Resident R2, R3, R5, and R6). This failure resulted in a resident with a known history of sexually inappropriate behavior touching non-consenting residents.Findings include:Review of facility policy Abuse, Neglect, Exploitation or Misappropriation dated 1/27/25, indicated All allegations are thoroughly investigated. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE].Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 7/7/25, included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles) and physical debility. Review of Section C: Cognitive Patterns indicated Resident R3 was cognitively intact.Review of an electronic communication dated 8/12/25, provided to both the facility administration and the state survey agency indicated: It has come to our family's attention in the last 2 weeks that my grandmother has been harassed (and touched at least twice) by a male resident at your facility for months.During an interview on 8/21/25, at 8:45 p.m. Resident R3's granddaughter confirmed that the electronic communication provided to the facility was the same electronic communication provided to the state survey agency.Review of facility-provided investigation documents revealed an interview with Resident R3, but no interviews and/or observations with other residents to learn if a peer resident entering rooms and touching them was a concern to other facility residents. Review of Resident R3's clinical record indicated that from 8/1/25, through 8/18/25, Resident R3 had care documented as having been provided by eleven nurse aides (NA Employees E4, E15, E16, E17, E18, E19, E20, E21, E22, E23, and E24). Review of the facility-provided investigation documents revealed that only four of the eleven nurse aides who cared for Resident R3 from 8/1/25, through 8/18/25, were interviewed (NA Employees E21, E22, E23, and E24).Review of Resident R3's clinical record indicated that from 8/1/25, through 8/18/25, Resident R3 had care documented as having been provided by nine registered nurses (RNs) or licensed practical nurses (LPNs) (RN Employees E3, E14, E25, E26, E27, LPN Employees E28, E29, E30, and E31). Review of the facility-provided investigation documents revealed that only three of the nine RNs and LPNs who cared for Resident R3 from 8/1/25, through 8/18/25, were interviewed (RN Employees E4, E14, and E25).During an interview completed during the survey, Employee E4 stated they have seen Resident R1 being sexually inappropriate. Kissing, touching. Tried to separate them and bring him back to his unit. Has seen it recently with Resident R7 and here more recently with Resident R2. I've told 'em. Everybody knows it. It's everyday like, 'Oh I have had to get Resident R1 away from Resident R2. Oh, I just had to get Resident R1 away from whoever.' Confirmed he wanders into other rooms, Oh yeah, he's everywhere. Real bad.Review of the facility-provided incident list from March 2025, through August 22, 2025, failed to include documentation of an incident or investigation related to possible abuse of Resident R2.During an interview completed during the survey, Employee E6 stated they have seen Resident R1 be inappropriate with residents. A lot in the dining room. When we separate them, he follows us and gets very combative. [Resident R5] was asleep in the dining room and [Resident R1] put his fingers in her mouth. We were told it's not inappropriate behavior. It really upset me. I was very uncomfortable. We were told, 'Do you kiss in your own home?' but yes, with consent.Review of the facility-provided incident list from March 2025, through August 2025, failed to include documentation of an incident or investigation related to possible abuse of Resident R5.During an interview completed during the survey, Employee E12 stated, I've heard of him touching other residents, I've never seen it. Employee E12 confirmed they had heard from both residents and staff that Resident R1 is sexually inappropriate. I feel like if this had been handled when this started, today (referring to incident with Resident R2) would never have happened. When asked about reporting, Employee E12 stated, The entire building knew. There was a lady who cannot communicate who he was touching inappropriately, [Resident R6] was her name.Review of the facility-provided incident from March 2025, through August 2025, list failed to include documentation of an incident or investigation related to possible abuse of Resident R6.During an interview completed during the survey, Employee E20 stated that Resident R1's behaviors have been going on for over a month, that he goes around touching women, up their pants, fingers in their mouth, and grabbing their breasts. Employee E20 stated that the incidents were reported verbally. Through other staff members, was told that, They are older people and allowed to touch. Review of the facility-provided incident list from March 2025, through

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of Resident Assessment Instrument (RAI) User's Manual, facility policy, clinical records, and staff interviews, it was determined that the facility failed to develop comprehensive care plans to meet resident care needs for residents to be in a relationship for four of 67 residents (Residents R1, R7, R21, and R35). Finding include:Review of the facility policy Care Planning/ Interdisciplinary Care Planning Team dated 1/27/25, previously reviewed 10/23/24, indicated the Care Planning/Interdisciplinary Team shall serve as the authority for overseeing resident care services. The committee shall function as an advisory committee to the Quality Assessment and Assurance Committee. A comprehensive, person-centered care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessments.Review of Resident R1's admission record indicated he was admitted to the facility on [DATE] and readmitted [DATE].Review of the Minimum Data Set (periodic assessment of resident care needs) dated 6/3/25, included diagnoses of dementia (a group of thinking and social symptoms that interferes with daily functioning), high blood pressure, dysphagia (difficulty swallowing), and muscle weakness. Question C0500 BIMS Summary Score revealed Resident R1's score to be 1, severe impairment.Review of Resident R1's care plan dated 6/9/25 did not reveal a plan of care developed for a consensual romantic relationship with Resident R7. Within Resident R1's plan of care for Registered Sex Offender included the intervention initiated 3/6/25, of Resident does have a female friend, make sure residents are in common area.Review of Resident R1's Progress Notes revealed no documentation made to the guardian that he wished to be in a relationship with Resident R7. Review of Resident R7's admission record indicated that she was admitted on [DATE].Review of the MDS dated [DATE], included diagnoses Alzheimer's (a progressive disease that destroys memory and other important mental function), high blood pressure, muscle weakness, and dysphagia. Question C0500 BIMS Summary Score revealed Resident R7's score to be 3, severe impairment.Review of Resident R7's care plan dated 5/26/25, does not reveal that she was care planned to be in a consensual romantic relationship with Resident R1.Review of Resident R7's progress notes revealed that her guardian was contacted on 8/4/25, Writer spoke with son and son made me aware that his mom is dating Resident R1 and that he does not have a problem with them holding hands and kissing. Everyone needs some affection and at this point in her life it doesn't bother me at all, and it doesn't bother her either. This writer informed son that we had to ensure that he was made aware. Son thanked writer for call.Review of Resident R21's admission record indicated that she was initially admitted on [DATE] and readmitted on [DATE].Review of the MDS dated [DATE], included diagnoses of Parkinsonism (group of neurological disorders characterized by tremors, stiffness, slowness of movement, and difficulty maintaining balance), bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), and a seizure disorder. Question C0500 BIMS Summary Score revealed Resident R21's score to be 8, moderately impaired.Review of Resident R21's care plan initiated 12/13/21, does not reveal that she was care planned to be in a consensual romantic relationship with Resident R35.Review of a nurse practitioner progress note created on 8/21/25, at 4:14 p.m. indicated, Patient is involved in consensual romantic relationship with another resident which seems to improve her countenance; she has capacity as does the other resident.Review of Resident R35's admission record indicated that he was initially admitted on [DATE] and readmitted on [DATE].Review of the MDS dated [DATE], included diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), arthritis (inflammation of one or more joints, causing pain and stiffness), and lung cancer. Question C0500 BIMS Summary Score revealed Resident R35's score to be 14, cognitively intact.Review of Resident R35's care plan initiated 7/2/25, does not reveal that he was care planned to be in a consensual romantic relationship with Resident R21.During an interview on 8/29/25, Resident R21 referred to Resident R35 as my man. Resident R35 stated that Resident R21 is going to be my wife.During an interview on 8/29/25, at approximately 4:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed the facility failed to develop and implement comprehensive care plans to meet resident care needs for four of 67 residents.28 Pa. Code 211.11(d) Resident Care Plan

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical records, observations, and resident and staff interview, it was determined that the facility failed to provide necessary supervision of a resident with known sexually inappropriate behaviors. This failure resulted in an immediate jeopardy situation for five of 67 residents (Resident R2, R3, R4, R5, R6,).Findings include:Review of the facility, Resident Supervision Policy & Procedures effective 2/1/25, indicated, It is the policy of this facility to ensure that all residents receive appropriate levels of supervision based on their individual needs, as identified through comprehensive and ongoing assessment. The goal of this policy is to promote resident safety, maintain dignity, and prevent accidents, neglect, or adverse events. Review of the facility, Behavior Management Policy revised 2/2/25, indicated, Patients exhibiting behavioral symptoms will be individually evaluated. The interdisciplinary team will identify underlying medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes that contribute to the resident's behavior(s). Review of the Resident Assessment Instrument 3.0 User's Manual, effective October 2024, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:13-15: cognitively intact8-12: moderately impaired0-7: severe impairmentReview of the clinical record indicated Resident R1 was initially admitted to the facility on [DATE], and readmitted on [DATE].Review of Minimum Data Set (MDS, periodic review of resident needs) dated 2/12/23, included diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), history of a stroke, and a seizure disorder. Question C0500 BIMS Summary Score revealed Resident R1's score to be 1 severe impairment.Review of Resident R1's plan of care initiated on 7/10/24, indicated Resident R1 was a registered sexual offender. The goal of the care plan was Will not exhibit inappropriate sexual behaviors towards others. Interventions listed included: Counseling as indicated. Life review with resident to identify triggers and coping. No documentation Monitor resident ' s whereabouts, resident does have female friend, make sure residents are in common area. Observe for wandering into other residents ' rooms. Offer snacks to minimize wandering in search of food. Provide consistent message from all IDT. Psychology consult. Report with Megan's Law (laws that mandate the creation of public registries of convicted sex offenders) as required. Report inappropriate behavior towards others immediately to administration. Review of Resident R1's plan of care for Potential to be sexually inappropriate revealed it was not initiated until 7/30/25. The goal of the care plan was Resident will not harm self or others through the review date. Interventions listed were: Administer medications as ordered. Monitor/document for side effects and effectiveness. (Medications administered, no documentation of effectiveness). Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. No documentation that this was completed. Monitor/document/report as needed any signs/symptoms of resident posing danger to self and others. Minimal documentation completed. Psychiatric/psychogeriatric consult as indicated. When resident becomes sexually inappropriate: Intervene before behavior escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive/inappropriate, staff to ensure safety and walk calmly away, and approach later. Review of Resident R1's physician's orders dated 4/1/25, included behavior monitoring related to psychotropic medication use. Review of Resident R1's Treatment Administration Record (TAR) for April 2025, through August 2025, failed to include the option for monitoring for sexually inappropriate behavior. Listed behaviors to monitor for included unstable mood, signs and symptoms of changes, tearfulness, adjustment difficulty, withdrawal. Review of as needed nurse aide behavior monitoring revealed that the options for types of behavior that occurred were: Frequent Crying, Repeats Movement, Yelling/Screaming, Kicking/Hitting, Pushing, Grabbing, Pinching/Scratching/Spitting, Biting, Wandering, Abusive Language, Threatening Behavior, Sexually Inappropriate, Rejection of Care, None of the above observed. Review of the behavior monitoring documentation completed from 3/1/25, through 8/22/25, revealed the following: 3/22/25: Repeated movements, wandering.6/15/25: None of the above observed.8/19/25: None of the above observed.Review of Resident R1's psychiatry evaluation completed on 3/8/25, indicated, Requested by DON (Director of Nursing) to assess the patient's level of awareness, as he has been inappropriate with female peer in the facility and has a h/o (history of) these behaviors.Review of Resident R1's psychiatry evaluation completed on 8/12/25, indicated, Per the Director of Nursing, the patient has displayed sexually disinhibited behavior, specifically attempting to kiss staff. On interview, he endorsed depressed mood Review of

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F 0744 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 dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record and facility document review and staff interview, it was determined that the facility failed to provide the necessary services to meet the psychosocial needs resulting in the commitment of resident-to-resident sexual abuse for one of two residents with unmonitored hypersexual behaviors (Resident R1). Findings include:Review of the facility, Behavior Management Policy revised 1/27/25, indicated, Patients exhibiting behavioral symptoms will be individually evaluated. The interdisciplinary team will identify underlying medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes that contribute to the resident's behavior(s).Review of the Resident Assessment Instrument 3.0 User's Manual, effective October 2024, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact8-12: moderately impaired0-7: severe impairmentReview of the clinical record indicated Resident R1 was initially admitted to the facility on [DATE] and readmitted on [DATE].Review of Minimum Data Set (MDS, periodic review of resident needs) dated 2/12/23, included diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), history of a stroke, and a seizure disorder. Question C0500 BIMS Summary Score revealed Resident R1's score to be 1, severe impairment. Review of Resident R1s plan of care initiated on 7/10/24, indicated that Resident R1 was a registered sexual offender. Review of Resident R1s plan of care for Potential to be sexually inappropriate revealed it was not initiated until 7/30/25. Review of Resident R1s physicians orders dated 4/1/25, included behavior monitoring related to psychotropic medication use. Review of Resident R1s treatment administration record (TAR) for April 2025, through August 2025, failed to include the option for monitoring for sexually inappropriate behavior. Listed behaviors to monitor for included unstable mood, signs and symptoms of changes, tearfulness, adjustment difficulty, withdrawal.Review of facility submitted information dated 3/4/25, indicated, Housekeeper observed residents, [Resident R7] and [Resident R1], kiss in the hallway. Residents were separated. Neither of them can recall.Review of Resident R1s psychiatry evaluation completed on 3/8/25, indicated, Requested by DON (Director of Nursing) to assess the patient's level of awareness, as he has been inappropriate with female peer in the facility and has a h/o (history of) these behaviors.Review of a physician order dated 3/26/25, through 8/18/15, indicated for Resident R1 to received fluoxetine (Prozac, a medication to treat depression) 10 mg daily, for depression.Review of as needed nurse aide behavior monitoring revealed that the options for types of behavior that occurred were: Frequent Crying, Repeats Movement, Yelling/Screaming, Kicking/Hitting, Pushing, Grabbing, Pinching/Scratching/Spitting, Biting, Wandering, Abusive Language, Threatening Behavior, Sexually Inappropriate, Rejection of Care, None of the above observed.Review of this behavior monitoring completed from 3/1/25, through 8/22/25, revealed the following:3/22/25: Repeated movements, wandering.6/15/25: None of the above observed.8/19/25: None of the above observed. Review of a progress note dated 8/4/25, at 2:11 p.m. indicated, This writer spoke with [Resident R7s] son, and son made me aware that his mom is dating [Resident R1] and that he does not have a problem with them holding hands and kissing. Everyone needs some affection and at this point in her life it doesn't bother me at all, and it doesn't bother her either. This writer informed son that we had to ensure that he was made aware. Son thanked writer for call.Review of a physician order dated 8/18/25, indicated for Resident R1 to receive fluoxetine 20 mg daily, for depression/sexually disinhibited behavior.Review of a progress note dated 8/21/25, at 2:00 p.m. indicated, reported to this writer that resident was observed in an un-occupied room rubbing the leg of another resident. Resident was immediately removed and placed on 1:1. Review of a progress note dated 8/21/25, at 3:37 p.m. indicated, this writer and Director of Nursing placed call to [Resident R1s] contact. Updated [contact] on allegation of Resident R1 inappropriately touching a female resident and actions taken, including police notification and potential to have to refer Resident R1 to an alternate facility. Stated we would keep her updated, she expressed understanding.Review of confidential staff interviews completed on 8/21/25, and 8/22/25, revealed the following: Confidential Employee E3: Never personally witnessed, has heard from other staff that he (Resident R1) is sexually inappropriate. Has observed Resident R1 touching others, more it a patting sense. Confidential Employee E4: Stated they have seen Resident R1 sexually inappropriate. Kissing, touching. Tried to separate them and bring him back to his unit. Has seen it recently with Resident R7 and here more recently with Resident R2. I've told em. Everybody knows it. Its everyday like. Oh I have had to get Resident R1 away from Resident R2. Oh. I just had to get

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of job descriptions, clinical records and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to protect residents from resident-to-resident sexual abuse. This failure resulted in a resident with a known history of sexually inappropriate behavior touching a non-consenting resident, which created an Immediate Jeopardy for five of 67 residents (Resident R2, R3, R4, R5, R6).Findings include:Review of the facility-provided Nursing Home Administrator (NHA) job description indicated, The primary purpose of the job position is to manage the Facility in accordance with current applicable federal, state, and local standards, guidelines, and regulations that govern long-term care facilities. To follow all facility policies and apply them uniformly to all employees. To ensure the highest degree of quality care is provided to our residents at all times.Review of the facility-provided Director of Nursing (DON) job description indicated, To plan, organize, develop and direct the overall operation of the Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern the facility, and as may be directed by the Administrator and the Medical Director, to ensure that the highest degree of quality care is maintained at all times.Based on findings identified in this report, the facility failed to prevent the failed protect residents from resident-to-resident sexual abuse. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed.During an interview on 8/21/25, at approximately 3:45 p.m. the NHA and DON confirmed that they failed to effectively manage the facility to protect residents from resident-to-resident sexual abuse, which created an Immediate Jeopardy for five of 67 residents.28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on review of facility documentation, cited deficiencies from previous surveys, review of plan of correction documentation, and staff interview, it was determined that the facility's Quality Assurance and Performance Improvement (QAPI) program failed to correct previously cited deficiencies. This has the potential to affect 5 of 67 residents.Finding include:Review of the facility policy Quality Assurance and Performance Improvement (QAPI) Program dated 1/27/25, indicated objectives of the QAPI program include providing a means to measure current and potential indicators for outcomes of care and quality of life; establish and implement performance improvement projects to correct identified negative or problematic indicators; reinforce and build upon effective systems and processes related to the delivery of quality care and services; and establish systems through which to monitor and evaluate corrective actions.Review of the facility's deficiencies and plan of corrections for the State Survey and Certification (Department of Health) survey ending 2/3/25, revealed the facility developed a plan of correction that included quality assurance systems to ensure that the facility-maintained compliance with cited nursing home regulations.Review of the plan of correction for survey ending 2/3/25, revealed the following:-Charts will be updated to reflect current status, guardians will be updated regarded any suspected abuse.-House review has been completed to ensure no other residents have been identified as abused, neglected or exploited.-All staff will be in-serviced via [outside consulting company] for freedom from abuse/neglect with focus on sexual abuse.-24-hour report, progress notes, grievance reports will be reviewed at morning clinical meeting to ensure investigation is completed for any incidents, accidents or grievances if warranted.-Director of Nursing/designee will educate all staff on facilities policy and procedure of abuse/neglect.-Director of Nursing/designee will monitor 24-hour report, progress notes for any instances that fall into this category at clinical meeting.-Director of Nursing/designee will audit weekly x2, monthly x2 progress notes and 24-hour report.-Results of in-service, monitoring and audits will be submitted to the Quality Assurance Improvement Committee.The results of the current survey, ending 9/12/25, identified a repeated deficiency related to sexual abuse for five of five residents.During the survey process the following was revealed:-Resident R2 was found in a bed with her pants around her ankles, brief off and perpetrator standing over her, had been observed with his hand on her hip.-Resident R3's guardian filing a complaint with CMS regarding the perpetrator coming into her room, touching her and knocking things off her wall and table. Guardian was interviewed in the evening during the survey process.-Resident R4's guardian was interviewed and stated that the resident had told him that the perpetrator comes into the resident's room and has touched her.-Resident R5 was observed by other residents in the hallway and dining room with perpetrator sticking his fingers in her mouth, grabbing her breasts and touching her groin.-Staff stated Resident R1 had attempted to get to Resident R5 and R6.During an interview on 8/21/25 at approximately 3:30 p.m. the Nursing Home Administrator and Director of Nursing confirmed the facility failed to maintain an effective Quality Assurance Committee to ensure that the concerns related to sexual abuse were identified, with potential to affect 5 of 67 residents.42 CFR 483.75 (a)(2)(h)(i) QAPI Program/Plan, Disclosure/Good Faith Attempt.28 Pa. Code 201.18(e)(1) Management.28 Pa. Code 201.18(e)(2)(3)(4) Management.