STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425129	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Andrews Operator, LLC	3514 Sidney Road Columbia, SC 29210

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure 3 of 5 residents reviewed for dignity (Resident (R)3, R4, and R5) were treated in a manner that maintained and promoted their dignity and sense of safety after reporting or witnessing a potential non-consensual sexual encounter involving a non-interviewable resident (R2). Cross-Reference: F600 §483.12 Freedom from Abuse, Neglect, and Exploitation. Findings include: Record review of facility policy titled Quality of Life Dignity last revised February 2020 revealed Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. Policy interpretation and implementation include residents are treated with dignity and respect at all times. The facility culture is one that supports and encourages humanization and individuation of residents, and honors resident choices, preferences, values, and beliefs. This begins with the initial admission and continues throughout the resident's facility stay. Resident's private space and property are respected at all times. Staff inform and orient residents to their environment. Procedures are explained before they are performed, and residents will be told in advance if they are going to be taken out their usual or familiar surroundings. Review of R3's Face Sheet revealed that he was admitted to the facility on [DATE], with diagnoses including but not limited to: cerebral palsy, muscle weakness, pain, abnormalities of gait and mobility, and major depressive disorder recurrent (mild). Review of R3's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/19/25, revealed that R3 has a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicates that he is cognitively intact. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with R3 on 04/24/25 at 2:10 PM, revealed on 04/17/25 around 7:00 AM, I overheard a staff member yelling at R] from R2's room; What are you doing in [R2's] room with the door closed? [R3] stated they heard a staff member yelling out to other staff to help assist her with removing R1 out of R2's room. During interview with R3 he stated that this was not the first time that R1 wandered into R2's room and he has observed R1 close the door while alone with R2 and could recall this incident happening two times prior. R3 stated that R1 was sent out to the hospital after being found in R2's room that morning but returned to the facility a few hours later and was returned to his room. R3 stated that they did not observe R2 being sent for evaluation. When R1 returned to the facility he was then placed on 1:1 supervision. R3 stated facility staff did not report this incident to R2's RR or call law enforcement but they could not allow this situation to go unreported out of fear for R2's safety because she is vulnerable due to her vegetative state. Further interview with R3 revealed that they have had conversations with R1 about the incident with R2 while outside smoking with staff and R1 stated, I wanted to touch some pussy. R3 stated that staff members have been retaliative towards him, and he has some fear of his future treatment/care by staff, I have had a staff member tell me that I shouldn't spread false rumors and that I should shut my mouth because I don't know what I am talking about. R3 did not feel comfortable identifying a specific staff member that had been retaliative towards him. Review of R4's Face Sheet revealed he was admitted to the facility on [DATE], with diagnoses including but not limited to: type 2 diabetes with diabetic neuropathy, acquired absence of left and right leg below knee, abnormalities of gait and mobility, major depressive disorder recurrent severe without psychotic features, and congestive heart failure. Review of R4's Quarterly MDS with an ARD date of 03/13/25, revealed that R4 had a BIMS score of 15 out of 15, which indicates that he is cognitively intact. During an observation and interview with R4 on 04/24/25 at 2:42 PM, revealed that they are currently roommates with R1 and overheard Certified Nursing Assistant (CNA)2 yelling at R1 to get out of R2's room. R4 further stated that they witnessed CNA2 bring R1 back into the room and yelling at other staff to call law enforcement because R1 was touching R2 in a non-consensual and sexually inappropriate manner. R4 further revealed, He has been living with me for a few weeks prior to the incident with R2, but R1 has always wandered and taken other resident's food/snacks. R1 would also at times relieve (defecate/urinate) in public areas. There have been times in the past when R1 eats others meal trays that have been left for clean up in the dining area. I always keep my foods/snacks on me and on the back of my wheelchair because I don't want R1 to take my food. During the daytime I stay out of my room because I don't feel comfortable being in the room with R1 and I also don't like now that it has to always have a sitter with him because the incident with R2. R4 stated that staff have been retaliative towards him because of this incident. Observation of R4 revealed several bags attached to the back of his wheelchair with food/snack items. R4 revealed that he was outside smoking with R1 after the incident on 04/17/25 and R1 was bragging about touching R2's vagina to R4, R3, and other residents and staff. One staff member even told R1 that he was being bad but R1 laughed it off. Review of R5's Face Sheet revealed she was admitted to the facility on [DATE], with diagnoses including but not limited to: muscle weakness, need for assistance with personal care, major depressive disorder recurrent, and generalized anxiety disorder. Review of R5's Quarterly MDS with an ARD of 04/17/25, revealed R5 had a BIMS score of 13 out of 15, which indicates that she is cognitively intact. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/24/25 at 3:30 PM, R5 revealed that R1 attempted to enter on 04/16/25 around midday. R5 stated that she yelled at R1, if you come in here, I will gouge out your eyes. R1 ran next door into R2's room and was in there for several minutes. R1 was then observed by a staff member in R2's room and ran out of R2's room and back into his room and closed his door. R5 stated that this was not the first incident of R1 attempting to enter female resident's room, and they have witnessed R1 enter R2's room at night over the last few weeks. R5 stated that they reported this to a nurse (unsure of name), but nothing was done about the situation, it was brushed off. R5 further stated that she does not feel safe at the facility because R1 is still located on the same hall, R5 also stated that she's frustrated that R1 is still 2 doors away from R2 as well. R5 finally stated that she has informed her family about the incident in the event anything should happen. R5 feels the facility is protecting R1 by allowing this behavior to continue.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to protect one non-interviewable, cognitively impaired Resident (R2) from a non-consensual sexual encounter with R1. Despite prior documentation of R1's inappropriate and unsafe behaviors toward female residents, the facility did not implement timely or adequate interventions to prevent further incidents. On April 25, 2025 at 5:26 PM, the Administrator and Director of Nursing (DON) were notified that the failure to protect Resident (R)2 from a non-consensual sexual encounter with R1 constituted Immediate Jeopardy (IJ) at F600. On April 25, 2025 at 5:26 PM, the survey team provided the Administrator and DON with a copy of the CMS IJ Template and informed the facility the IJ existed as of April 16, 2025. The IJ was related to §483.12 - Freedom from Abuse, Neglect, and Exploitation. On April 28, 2025, the facility provided an acceptable IJ Removal Plan. On April 28, 2025 at 12:00 PM, the survey team validated the facility's corrective action and removed the IJ. The facility remained out of compliance at F600 at a lower scope and severity of D. An extended survey was conducted in conjunction with the Complaint Survey for non-compliance at F600, constituting substandard quality of care. Findings include: Review of the facility's policy titled Abuse Prevention Program last revised December 2016, revealed, Our residents have the right to be free from abuse . This includes but is not limited . sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. As part of the resident abuse prevention, the administration will protect our residents from abuse by anyone including but necessarily limited to facility staff, other residents . Protect residents during abuse investigations. Sexual abuse is defined as non-consensual sexual contact of any type with a resident. Review of R1's Face Sheet revealed he was admitted to the facility on [DATE], with diagnoses including but not limited to: frontal lobe and executive function deficit, impulse disorder, dementia with behaviors, and psychoactive substance dependence in remission. Review of R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/05/25, revealed he had a Brief Interview of Mental Status (BIMS) score of 7 out of 15 which indicates that he had severe cognitive impairment. Review of R1's Electronic Medical Record (EMR) Nurses Note revealed a note dated 04/16/25 at 9:25 AM, which revealed, Resident was seen going into a female resident's room [R2] while Certified Nursing Assistant (CNA) was performing Activities of Daily Living (ADL) care. [R1] was directed to leave the room and not return. Female resident next door [R5] also stated that he went into the same resident's room last night and was attempting to come into her room as well. Female resident asked [R1] to leave and not come back. Management was notified of the behavior for possible room change. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R1's EMR Nurses Note dated 04/16/25 at 12:57 PM, revealed, Writer educated resident about entering another resident's room without their consent. Resident understood to not enter another resident's room. Plan of care is ongoing. Review of R1's Nurses Notes revealed a note dated 04/16/25 at 3:22 PM, which revealed 15-minute check was initiated at noon. Resident has been redirected out of female's rooms three times. Review of R1's EMR Situation Background Assessment Recommendation (SBAR) Summary dated 04/17/25 at 8:12 AM, revealed, Increased confusion . Resident is being sent to local hospital for evaluation and treatment, Resident Representative notified, primary care physician notified. Review of R1's EMR Nurses Note revealed a note dated 04/17/25 at 12:45 PM, 15-minute check reinitiated since return from hospital. Review of R1's EMR Nurses Note revealed a note dated 04/18/25 at 6:06 AM, 15-minute checks remain in place resident at rest with no behaviors noted plan of care ongoing. Review of R1's EMR Nurses Note revealed a note dated 04/18/25 at 1:02 PM, Resident remains on 1:1 monitoring, Medical Director (MD) and Resident Representative (RR) made aware, plan of care is ongoing. Review of R1's EMR Nurses Note revealed a note dated 04/18/25 at 6:04 PM, [R1] doing well has had 1:1 sitter all day no complaints voiced. Review of R1's EMR Physician Progress Notes dated 04/17/25 at 1:30 PM, revealed, [R1] seen today for management of acute or chronic conditions to avoid decline while in Skilled Nursing Facility (SNF), per staff patient altered mental status now wandering into opposite sexes room two days. Per Nurse Practitioner sent to emergency room (ER). No pain noted, no skin issues reported, staff has no concerns at this time. Assessment/Plan - altered mental status increased for two day and now wandering into opposite sex rooms, sent out for evaluation. Review of R1's EMR Physician Progress Note dated 04/18/25 at 1:30 PM, revealed [R1] being seen today for management of acute or chronic conditions to avoid decline while in SNF. Patient being seen for follow up from ED visit, per staff, no new orders or findings from ED report. No pain noted, no skin issues reported, staff has no concerns at this time. Assessment/Plan - altered mental status increased for two days and now wandering into opposite sexes rooms, sent out for evaluation . Facility made [R1] 1:1 supervision until resident seen by psychiatric services. Review of R1's EMR Psychiatry Initial Consult dated 04/18/25, revealed, Assessment and Plan - dementia, BIMS 15 out of 15, moderate symptoms of cognitive impairment, sexual inappropriate behaviors reported, intrusive behavior, symptoms will progress as dementia progress. Start Divalproex ER 250mg tablet extended related 24 hours, take one tablet by mouth once a day. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R1'S Care Plan revised on 04/24/25 (during survey) revealed, [R1] exhibits severe cognitive impairment and memory loss. He is alert and oriented to self only. R1 has a diagnosis of frontal lobe and executive deficit following cerebral infraction and diagnosis of dementia with behaviors. Damage to the frontal lobe can cause executive dysfunction affecting ability to perform everyday tasks. R1 has trouble with planning, starting tasks, remembering things, and shifting plans. He may also experience behavioral changes, mood swings, and loss of interest in activities. He also has a history of psychoactive substance abuse in remission. Strengths include [R1] appears to understand what is said to him, answers simple questions and make needs/wants known, and is pleasantly confused and cooperative with staff. He was poor hygiene and poor safety awareness at times. Toilets in inappropriate areas, wanders on unit at times. Interventions include 1:1 due to increased confusion/wandering; explain all procedure to [R1]; give [R1] simple choices to increase sense of autonomy and reduce the stress of decision making; monitor for any changes or decline in [R1] cognitive status; notify nurse/MD of any changes in mental status. Review of R1's Notification of Room Change/Notification of Roommate document dated 04/25/25 revealed, Staff reported that [R1's] roommate watches adult entertainment on his phone/tablet and plays it out loud. To avoid any triggers for [R1] he is being moved to another unit. [R1] agreed to the room change. He is familiar with 300 Hall and was previously in a room on that unit. Said he'd be glad to move back to the 300 Unit. Review of R2's Face Sheet revealed that she was readmitted to the facility on [DATE], with diagnoses including but not limited to: muscle wasting atrophy, weakness, contracture of muscle, cognitive communication deficit, and paraplegia. Review of R2's Quarterly MDS with and an ARD of 03/12/25, revealed that R2 is in a vegetative state, no BIMS score was record. Further review of the Quarterly MDS revealed that R2 is dependent on staff for all ADLs. Review of R2's EMR Nurses Notes for April 2025, revealed no notes related to this incident. Review of R2's EMR Assessments revealed a Head-to-Toe Skin Check dated 04/17/25 at 7:05 AM, status was still in progress on 04/24/25 at 1:53 PM. Further review of the Head-to-Toe Skin Check revealed that it was incomplete/blank. During an observation and an attempted interview on 04/24/25 at 10:17 AM, with R1 was unsuccessful. The resident at this time was asleep. Further observation and interview revealed Certified Nursing Assistant (CNA)1 sitting outside of R1's door and providing 1:1 supervision for R1. During an observation and attempted interview on 04/24/25 at 10:17 AM, with R2 was unsuccessful, as R2 is in a vegetative state. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 04/24/25 at 11:44 AM, R2's Resident Representative (RR) in R2's room revealed, On Easter Sunday (04/20/25) I was informed by a resident that they overheard on 04/17/25 a staff member yelling at [R1], What are you doing in here . you should not be in [R2's] room with the door closed. The staff member escorted [R1] out of [R2's] room and was yelling about [R1] touching [R2] inappropriately in her room to other staff and attempting to get other staff to call law enforcement. R2's RR further stated that when this resident reported this information to her she was in shock because they were not informed by the facility staff of any incident occurring with R2 and was told by the resident that law enforcement never came to the facility and R2 was never sent out to the hospital for evaluation, only R1. R2's RR was also informed by the resident that this was the third time that he witnessed/overheard R1 entering R2's room without consent and having to be redirected by staff out of her room and this has been happening ever since R2's former/more cognitively intact roommate discharged from the facility a few weeks ago. The resident told R2's RR that R1 was sent to the hospital but returned to the facility the same day and was placed back in the same room [ROOM NUMBER] doors down from R2. During interview with R2's RR they stated that a staff member/nurse (unable to recall name) also informed them that something inappropriate occurred to R2 by R1. This staff member explained to her that they wanted to call law enforcement and report this incident to the appropriate authorities, but they were told (by Administration) to change their documentation in the EMR/Nurses Notes to make the incident appear like R1 did not have a non-consensual encounter with R2. Further interview with R2's RR revealed that they visit R2 daily and visited the resident on 04/19/25 (day before R3 reported incident to RR) but could tell something was off with R2 on that Saturday because of her facial expressions, specifically R2 appeared to have a worried grimace. R2's RR additionally stated that they are disappointed and upset with the facility for not informing her of this incident and does not feel like R2 is safe because R1 is still 2 doors down from her. Although R1 has a sitter with him for now, I feel like after the state agency leaves/in a few weeks when things settle down, he (R1) will be back wandering the facility again and in other resident rooms. During a follow up interview on 04/24/25 at 12:05 PM, CNA1 revealed they were assigned to R1 for 1:1 supervision last week but could not recall which specific date. CNA1 stated the reason they have to provide R1 with 1:1 supervision is because R1 sexually assaulted another resident at the facility and was informed of this by another CNA that works at the facility. CNA1 stated that they haven't personally witnessed R1 touching other resident's inappropriately but have seen him wandering out of female resident rooms and other staff in the past had to redirect him out. Review of R3's Face Sheet revealed that he was admitted to the facility on [DATE], with diagnoses including but not limited to cerebral palsy, muscle weakness, pain, abnormalities of gait and mobility, and major depressive disorder recurrent (mild). Review of R3's Quarterly MDS with an ARD of 03/19/25, revealed that R3 had a BIMS score of 15 out of 15, which indicates that he is cognitively intact. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with R3 on 04/24/25 at 2:10 PM, revealed on 04/17/25 around 7:00 AM I overheard a staff member yelling at R1 from R2's room, What are you doing in [R2's] room with the door closed? R3 stated they heard a staff member yelling out to other staff to help assist her with removing R1 out of R2's room. R3 stated that this was not the first time that R1 wandered into R2's room and he has observed R1 close the door while alone with R2 and could recall this incident happening two times prior. R3 stated that R1 was sent out to the hospital after being found in R2's room that morning but returned to the facility a few hours later and was returned to his room. R3 stated that they did not observe R2 being sent for evaluation. When R1 returned to the facility he was then placed on 1:1 supervision. R3 stated facility staff did not report this incident to R2's RR or call law enforcement but they could not allow this situation to go unreported out of fear for R2's safety because she is vulnerable due to her vegetative state. R3 revealed that they have had conversations with R1 about the incident with R2 while outside smoking with staff and R1 stated, I wanted to touch some pussy. Review of R4's Face Sheet revealed he was admitted to the facility on [DATE], with diagnoses including but not limited to: type 2 diabetes with diabetic neuropathy, acquired absence of left and right leg below knee, abnormalities of gait and mobility, major depressive disorder recurrent severe without psychotic features, and congestive heart failure. Review of R4's Quarterly MDS with an ARD date of 03/13/25, revealed that R4 had a BIMS score of 15 out of 15, which indicates that he is cognitively intact. During an observation and interview with R4 on 04/24/25 at 2:42 PM, revealed that they are currently roommates with R1 and overheard CNA2 yelling at R1 to get out of R2's room. R4 further stated that they witnessed CNA2 bring R1 back into the room and yelling at other staff to call law enforcement because R1 was touching R2 in a non-consensual and sexually inappropriate manner. R4 further revealed, He has been living with me for a few weeks prior to the incident with R2, but R1 has always wandered and taken other resident's food/snacks. R1 would also at times relieve (defecate/urinate) in public areas. There have been times in the past when R1 eats others meal trays that have been left for clean up in the dining area. I always keep my foods/snacks on me and on the back of my wheelchair because I don't want R1 to take my food. During the daytime I stay out of my room because I don't feel comfortable being in the room with R1 and I also don't like now that it has to always have a sitter with him because the incident with R2. R4 he stated that staff have been retaliative towards him because of this incident. R4 revealed that he was outside smoking with R1 after the incident on 04/17/25, and R1 was bragging about, touching [R2's] pussy to [R4], [R3], other residents and staff. One staff member even told R1 that he was being bad but R1 laughed it off. Review of R5's Face Sheet revealed she was admitted to the facility on [DATE], with diagnoses including but not limited to: muscle weakness, need for assistance with personal care, major depressive disorder recurrent, and generalized anxiety disorder. Review of R5's Quarterly MDS with an ARD of 04/17/25, revealed R5 had a BIMS score of 13 out of 15, which indicates that she is cognitively intact. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/24/25 at 3:30 PM, R5 revealed that R1 attempted to enter her room on 04/16/25 around midday. R5 stated that she yelled at R1, If you come in here, I will gouge out your eyes. R1 ran next door into R2's room and was in there for several minutes. R1 was then observed by a staff member in R2's room and ran out of R2's and back into his room and closed his door. R5 stated that this was not the first incident of R1 attempting to enter female resident's room, and they have witnessed R1 enter R2's room at night over the last few weeks. R5 stated that they reported this to a nurse (unsure of name), but nothing was done about the situation/it was brushed off. R5 further stated that she does not feel safe at the facility because R1 is still located on the same hall, R5 also stated that she is frustrated that R1 is still 2 doors away from R1 as well. R5 finally stated that she has informed her family about the incident in the event anything should happen. R5 feels the facility is not protecting R2 by allowing this behavior to continue. During an interview on 04/24/25 at 4:30 PM, R1 revealed I was sent to the hospital on [DATE], because I went in the room next door and touched [R2]. I touched her leg. R1 stated he viewed R2 in bed with one leg hanging out of the covers. R1 begin to demonstrate how he touched R2. R1 beginning to rub his own leg starting at his knee and moving up towards the body. When asked why did you touch R2's leg, R1 replied, Because I'm a man and I have urges. That was the first time I touched another resident and the last time. I realized it was wrong, and someone told me I'm not supposed to do that. I was punished for what I did. The day after the incident I was required to always have a sitter as a punishment. During an interview with CNA2 on 04/25/25 at 9:06 AM, revealed that they did not witness R1 in R2's room on 04/17/25 and that she was providing ADL care to another resident but heard a commotion and someone yelling, What are you doing in here? to R1 while in R2's room. CNA2 stated that when they made it to R2's room, the Unit Manager and a nurse (unable to recall name) assisted the resident back to the room. CNA2 stated that law enforcement was not notified of the incident but R1 was sent to the hospital for an altered mental state. CNA2 stated she was unsure if R2 was assessed or sent out for evaluation for a potential non-consensual sexual encounter. During an interview on 04/25/25 at 9:58 AM, Licensed Practical Nurse (LPN)1 revealed at approximately 6:45 AM on 4/17/25, during med pass she heard a male voice yell out, What are you doing? and upon inspection, she noted her supervisor, standing in R2's doorway while R1 was sitting in his wheelchair outside the room. LPN1 reports that R1 stated, He wanted to see her pussy and that he has needs. LPN1 reports R1 was sent out for a psych evaluation and that no police were called, nor was R2 sent out to be evaluated. LPN1 further stated she reported her concerns to the Administrator and Director of Nursing (DON) and gave them her written statement. LPN1 stated, She felt like they should have done more by calling the police and having [R2] evaluated after an alleged assumption of sexual abuse, but she was told to follow her higher-up's instruction. During an interview on 04/25/25 at 11:51 AM, CNA3 revealed that R1 was placed on 1:1 observation due to wandering into R2's room without her consent. CNA3 revealed that R1 does not have a history of behaviors, and they have never witnessed R1 wandering into other residents' room or exhibiting inappropriate behaviors. CNA3 stated [R1] used to relieve himself in sinks at the facility but does not currently have that behavior. CNA3 stated that they are aware of the facilities abuse policy and that, If you see something then you should report it immediately to the nurse or supervisor then stop talking about the incident. (continued on next page)

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	425129	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Andrews Operator, LLC	3514 Sidney Road Columbia, SC 29210

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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	During an interview on 04/25/25 at 12:54 PM, LPN2 stated on 04/16/25 between approximately 10:00 and 10:30 AM, R5 reported to her, That white man [R1], kept coming in [R2's] room last night and tried to come into my room. LPN2 stated not even 1 hour later, a CNA was screaming that R1 had entered R2's room and pulled her curtains back while she was performing ADL care. R1 was told to leave R2's room. LPN2 then notified the unit manager (UM) about her concerns who replied with OK. LPN2 further states that after she documented in R1's progress notes the UM stated they were placing R1 on 15-minute checks. LPN2 had to redirect R1 from entering female residents' room three more times afterwards. LPN2 stated the potential was there for R1 to abuse residents and expected that the facility would move R1 from the hall and from around female residents and wanted to prevent anything further from happening. During an interview on 04/25/25 at 12:36 PM, the Social Worker (SW) revealed that R1 often sleeps during the day but does not have any significant behaviors. R1 recently began wandering into other resident's rooms which is a new behavior for R1. The SW revealed that R4 reported to them that they witnessed R1 being brought back into the room on 04/17/25, after being observed near R2's room and staff were questioning R1 about what he was doing in front of R2's room. The SW revealed they were not at the facility yet for the day for work when this incident occurred and doesn't know the full details, but they reported what R4 told them to the Administrator and was told the administrative staff was handling this incident. The SW stated that the last abuse training/in-service they received was about two months ago. During an interview with the Unit Manager (UM) on 04/25/25 at 1:40 PM, revealed that they were not at work yet for the day on 04/17/25, but it was reported to them that R1 was observed outside of R2's door and has had an increase of wandering behavior which is new behavior for R1. The UM further stated that because R1 was observed near R2's door he was sent to the hospital due to altered mental status and was placed on 1:1 supervision, when R1 returned from the hospital. The UM stated that a body audit was completed for R2. During an interview on 04/25/25 at 2:29 PM, the Assistant Director of Nursing (ADON) and Administrator, when asked what interventions were implemented after R1 was redirected 3 times from entering female residents' room after being on 15-minute checks, no answer was provided. The Administrator stated he was unaware of R1's documented behavioral concerns on 4/16/25 the day prior to the incident. During a phone interview on 04/25/25 at 2:58 PM, CNA4 revealed that they work the night shift at the facility and is often assigned to R1 and R2. CNA4 stated that most nights R1 wanders the unit and mostly goes to the nurse's station to ask for snacks and to the main dining area. CNA4 states that R1 looks/enters into the female resident's room. CNA4 stated that in the last few weeks (could not recall specific date) they observed R1 wandering into R2's room at night, and they observed at least three separate occasions. On the first two incidents CNA4 stated that they observed R1 in the room but not close to R2 and they observed R2's sheets on her bed were disheveled each time and they had to redirect R1 out of the room and tuck R2's sheet back in place. On the third observation CNA4 stated that she observed R1 in his wheelchair next to R2's bed. CNA4 stated that she did not observe R1 touching R2 but observed that R2's sheets were disheveled again and realized that R1 must have been the reason why the resident's sheets were displaced because he was the only other person in R2's room and she is not able to transfer/move without staff assistance. CNA4 stated that they reported this 3rd incident to LPN1. CNA4 stated that the morning of 04/17/25 at approximately 7:00 AM, CNA2 observed R1 in R2's room and had to redirect him out of her room as well. CNA4 revealed that it has been about one month are longer since the last time they received abuse/neglect training. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Hospital Transfer Form dated 04/25/25 at 3:14 PM, revealed, Key Clinical Information reason for transfer: other: hospital given report. Resident Representative notified on 04/25/25 at 3:22 PM Review of a Hospital Discharge summary dated [DATE] revealed, [R2] has a past medial history of Anoxic brain injury, sacral decubitus ulcer, seizure disorder, functional quadriplegia who presents to the Emergency Department (ED) for evaluation of potential reported sexual assault per patient's mother. Patient is resident at Skilled Nursing Facility, history obtained from the Emergency Medial Services (EMS) and patient's mother. Patient's mother states that she heard from another resident at the facility that another patient (R1) was seen in [R2] room a week ago (04/17/25). According to the mother (R2 Resident Representative) there was no visualization of any sexual activity. EMS sates that the facility did a full physical exam including external genitalia exam and did not see any evidence of infection . During a phone interview on 04/28/25 at 11:19 AM, the Psychiatric Nurse Practitioner (PNP) revealed that they first evaluated R1 on 04/18/25 due to a change in R1's mental status specifically that the resident was exhibiting verbal aggression and sexually inappropriate behaviors towards female residents by wandering into their rooms without their consent. After the initial consult on 04/18/25 a recommendation was made to start Divalproex 250 mg tablet for a diagnosis of dementia with behavioral disturbances. A second evaluation of R1 was conducted by the PNP on 04/25/25 and a recommendation was made to start Seroquel 50 mg tablet for a diagnosis of dementia with behavioral disturbance. During a phone interview on 04/28/25 at 1:10 PM, the Medical Director (MD) revealed that they were not formally informed by the facilities Administration of the potential non-consensual sexual abuse. The MD revealed that they had spoken with other residents and were informed by a potential incident with R1 and R2 during their last visit to the facility on [DATE] but was unaware of the extent of the situation. The MD revealed that the resident has a history of inappropriate behaviors such as urinating in public areas but wandering into other resident rooms is a new behavior for R1. The MD also stated that the only facility staff member that was spoken to regarding the potential incident was the Social Worker and was told that the facility was investigating the matter. The MD stated that he was not notified on the Immediate Jeopardy that is ongoing at this time related to R1 and R2 and the potential non-consensual sexual abuse. On April 28, 2025, the facility provided an acceptable IJ Removal Plan, which included the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/17/25 at approximately 7:00 AM R1 was placed on one-to-one supervision; on 04/17/25 at 8:12 AM R1 was sent to the hospital for evaluation; on 04/17/25 R2 has a skin check performed by a licensed nurse state post the event to check for apparent injuries without findings; on 04/17/25 at approximately 9:15 AM R2 was assessed by the Nurse Practitioner (NP) status post event to check for apparent injuries without findings; on 04/17/25 at 9:45 PM R1 returned from the hospital without orders and was placed on one-to-one staff supervision; on 04/17/25 at approximately 1:30 PM R1 was assessed by the NP post the event without further orders R1 remained on one-to-one staff supervision; on 04/18/25 at 1:30 PM R1 continued on one-to-one staff supervision and was assessed by the NP post event without orders; on 04/18/25 R1 was assessed by the facilities Psychiatric Nurse Practitioner (PNP) post the event with the new medications orders R1 remained on one-to-one staff supervision; on 04/25/25 room change for R1 remains on one-to-one supervision; on 04/25/25 at approximately 3:15 PM R2 was transferred to the hospital for evaluation; on 04/26/25 the Social Services Director (SSD) completed interviews with residents with Brief Interview of Mental Status (BIMS) score of 13 or above were interviewed to ensure no abuse or neglect; on 04/26/25 all current residents had skin checks by licensed nurse and documented in the facility Electronic Medical Report to ensure no suspicious injuries or indication of abuse or neglect. On 04/26/25 current residents with targeted physical behaviors of wandering into other resident room potentially becoming sexually inappropriate towards others were identified by the Interdisciplinary Team (IDT) to include the Administrator, DON, Medical Director (MD), SSD, Therapy Director, Unit Managers, and Regional Clinical Director (RCD). On 04/26/25 current residents with targeted physical behaviors care plans and behavior monitoring tools were reviewed and updated as needed by the IDT to ensure interventions are in place for safety. On 04/26/25 the RCD reviewed the policy with and completed re-education of the facility's policies and procedures for abuse and neglect with the Administrator and DON to ensure understanding with a verbal return demonstration as to the types of abuse and neglect, dealing with disruptive behaviors including dementia care sexually acting out, to include but not limited to what to do if staff witness abuse and neglect, when to report abuse and neglect, to whom to report abuse and neglect and the designated facility abuse coordinator, who is the facility administrator. On 04/26/25 the DON and Unit Managers completed re-education with all current staff, including Dietary, Housekeeping, Laundry, Administration, Maintenance, Social Services, Therapy, Activities, Department Managers, Nursing including Licensed Nurses and Certified Nursing Assistants (CNA) including agency staff on the facility's policy and procedure for abuse and neglect, Dealing with Disruptive Behaviors including Dementia Care Sexually Acting Out, to ensure understanding with a verbal return demonstration as to the types of abuse and neglect to include but not limited to what to do if staff witness abuse and neglect, to whom to report abuse and neglect and the designated facility abuse coordinator. This education for staff will be the responsibility of the DON/ Licensed Nurse Manager for current staff. Staff who were not educated on 04/26/25 either in person or by telephone will be educated prior to the start of their next shift. The DON and Licensed Nurse Managers were notified of this responsibility on 04/26/25. A Quality Assurance Performance Improvement (QAPI) Committee was held on 04/25/25 to formulate and approve a plan of correction for the deficient practice. The Administrator will be responsible for the completion of the corrective action plan. The DON/Designee will review the 24-hour report five times a week for 12 weeks to ensure wandering behaviors are addressed timely and without incident; the DON/Designee will be reviewing five residents skin assessments weekly for 12 weeks to ensure no signs of abuse/neglect; the SSD will interview five cognitively intact residents for 12 weeks to ensure no signs of abuse/neglect. The DON/Designee and the SSD will be responsible for reporting the results of these audits to the facility's monthly QAPI committee will make recommendations and changes as indicated based upon the findings of the audits.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy, the facility failed to ensure Resident (R)1 was being monitored for the use of Psychotropic Medication, for 1 of 3 residents reviewed for chemical restraints. Findings include: Review of the undated facility policy titled Psychotropic Medication Use revealed, Residents will not receive medications that are not clinically indicated to treat a specific condition. A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: anti-psychotics; anti-depressants; anti-anxiety medications; and hypnotics. Residents, families, and or/or the representative are involved in the medication management process. Psychotropic medication management include indications for use; dose (including duplicate therapy); duration; adequate monitoring for efficacy and adverse consequences; and preventing, identifying, and responding to adverse consequences. Residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record. Use of psychotropic (other than antipsychotics) are not increased when efforts to decreased antipsychotic medications are being implemented. Medications not classified as anti-psychotic, anti-depressant, anti-anxiety, and hypnotic medication are not prescribed or administered as a substitution for another psychotropic medication unless there is a documented clinical indication consistent with clinical standard of practice. Consideration of the use of psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes. Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. Residents receiving psychotropic medications are monitored for adverse consequences including anticholinergic effects; cardiovascular effects; metabolic effects; neurologic effects; and or psychosocial effects. Review of R1's Face Sheet revealed he was admitted to the facility on [DATE], with diagnoses including but not limited to: frontal lobe and executive function deficit, impulse disorder, dementia with behaviors, and psychoactive substance dependence in remission. Review of R1's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/05/25, revealed that that he had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, which indicates that he had severe cognitive impairment. Review of R1's April 2025 Physician Orders revealed an order for Depakote Oral Tablet 250 MG related to a diagnosis of dementia with behavioral disturbance with an order date of 04/18/25 and start date of 04/19/25. Review of R1's Medication Administration Record (MAR) for April 2025 revealed R1 received the medication Depakote Oral Tablet 250 MG related to a diagnosis of dementia with behavioral disturbance daily one time each day from 04/19/25 - 04/28/25. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's April 2025 Physician Orders revealed an order for Seroquel Oral Tablet 50 MG related to a diagnosis of impulse disorder and dementia with behavioral disturbance with an order date of 04/27/25 and start date of 04/27/25. Review of R1's MAR for April 2025 revealed R1 received the medication Seroquel Oral Tablet 50 MG related to a diagnosis of impulse disorder and dementia with behavioral disturbance daily one time each day from 04/27/25 - 04/28/25. Review of R1's Physician Orders for April 2025 revealed an order for Antipsychotic Medication Monitoring with a start date of 04/27/25, R1 had no antipsychotic monitoring for his Seroquel from 04/19/25 - 04/26/25. During a phone interview on 04/28/25 at 10:07 AM, the Consultant Pharmacist revealed that R1's antipsychotic monitoring should have behavior monitoring when the resident was started on Depakote on 04/19/25. Review of R1's Care Plan revealed R1 receives antipsychotic medications (Seroquel) related to Impulse Disorder interventions include administer antipsychotic medications as ordered by physician observe for side effects and effectiveness; Abnormal Involuntary Movement Scale (AIMS) every six months and as needed; observed/document/report as needed any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, frequent falls, social isolation, behavioral symptoms not usual to the person, etc. During a phone interview on 04/28/25 at 11:19 AM, the Psychiatric Nurse Practitioner (PNP) revealed that they first evaluated R1 on 04/18/25 due to a change in R1's mental status specifically that the resident was exhibiting verbal aggression and sexually inappropriate behaviors towards female residents by wandering into their rooms without their consent. After the initial consult on 04/18/25 a recommendation was made to start Divalproex 250 mg tablet for a diagnosis of dementia with behavioral disturbances. A second evaluation of R1 was conducted by the PNP on 04/25/25 and a recommendation was made to start Seroquel 50 mg tablet for a diagnosis of dementia with behavioral disturbance. During a phone interview on 04/28/25 at 1:10 PM, the Medical Director revealed that the resident should have had an order for antipsychotic monitoring when the resident was started on Depakote on 04/19/25.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of facility policy, interview, and record review, the facility failed to implement their abuse policies Abuse Investigation and Reporting and Abuse Prevention Program regarding an allegation of sexual abuse for 2 of 5 residents (Resident (R)1 and R2) reviewed for abuse. Specifically, the facility failed to investigate, report, prevent and or protect allegations of sexual abuse. Findings Include: Review of facility policy titled Abuse Investigation and Reporting last revised July 2017 revealed .5. The administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. Role of the Investigator: 1. The individual conducting the investigation will, as a minimum: g. interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. interview the resident's roommate, family members, and visitors j. review all events leading up to the alleged incident. Review of facility policy titled Abuse Prevention Program last revised December 2016, revealed, As part of the resident abuse prevention, the administration will: 1. Protect our residents from abuse by anyone including .residents . 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. 6. Identify and assess all possible incidents of abuse. 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements. 8. Protect residents during abuse investigations. Review of R1's Nurses Notes dated 04/16/25 at 9:25 AM, revealed, Resident was seen going into a female resident's room [R2] while Certified Nursing Assistant (CNA) was performing Activities of Daily Living (ADL) care. [R1] was directed to leave the room and not return. Female resident next door [R5] also stated that he went into the same resident's room last night and was attempting to come into her room as well. Female resident asked [R1] to leave and not come back. Management was notified of the behavior for possible room change. Review of R1's Nurses Note dated 04/16/25 at 12:57 PM, revealed, Writer educated resident about entering another resident's room without their consent. Resident understood to not enter another resident's room. Plan of care is ongoing. Review of R2's Nurses Notes for April 2025, did not reveal any notes related to this incident. During an interview on 04/24/25 at 12:05 PM, CNA1 revealed they were assigned to R1 for 1:1 supervision last week but could not recall which specific date because R1 sexually assaulted another resident at the facility. CNA1 stated they have previously seen R1 wandering out of female resident rooms in the past. During an interview on 04/25/25 at 9:06 AM, CNA2 stated, on 04/17/25, she heard a commotion and someone yelling, What are you doing in here? to R1 while in R2's room. CNA2 stated when they made it to R2's room, the Unit Manager (UM) and a nurse assisted R1 back to his room. CNA2 further stated law enforcement was not notified of the incident but R1 was sent to the hospital for an altered mental state. CNA2 stated she was unsure if R2 was assessed or sent out for evaluation for a potential non-consensual sexual encounter. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/25/25 at 9:58 AM, Licensed Practical Nurse (LPN)1 stated, at approximately 6:45 AM on 4/17/25, during med pass she heard a male voice yell out What are you doing? and upon inspection, she noted her supervisor, standing in R2's doorway while R1 was sitting in his wheelchair outside the room. LPN1 reports that R1 stated, He wanted to see her pussy and that he has needs. LPN1 reports R1 was sent out for a psych evaluation and that the police were not called, nor was R2 sent out to be evaluated. LPN1 further stated she reported her concerns to the Facility Administrator (FA) and Director of Nursing (DON) and gave them her written statement. LPN1 stated, She felt like they should have done more by calling police and having R2 evaluated after an alleged assumption of sexual abuse, but she was told to follow her higher-up's instruction. During an interview on 04/25/25 at 12:54 PM, LPN2 stated, on 04/16/25 between approximately 10:00 and 10:30 AM, R5 reported to her, That white man [R1], kept coming in R2's room last night and tried to come into my room. LPN2 stated not even 1 hour later, a CNA was screaming that R1 had entered R2's room and pulled her curtains back while she was performing ADL care. R1 was told to leave R2's room. LPN2 then notified the unit manager about her concerns who replied with OK. LPN2 further reports that after she documented in R1's progress notes the UM stated they were placing R1 on 15-minute checks. LPN2 had to redirect R1 from entering female residents' room three more times afterwards. LPN2 stated the potential was there for R1 to abuse residents and expected that the facility would move R1 from the hall and from around female residents and wanted to prevent anything further from happening. During an interview on 04/25/25 at 12:36 PM, the Social Worker (SW) stated they reported what R4 told them to the FA and was told the administrative staff was handling this incident. During an interview on 04/25/25 at 1:40 PM, the UM stated they were not at work yet for the day on 04/17/25, but it was reported to them that R1 was observed outside of R2's door and has had an increase of wandering behavior which is new behavior for R1. UM further stated that because R1 was observed near R2's door he was sent to the hospital due to altered mental status and was placed on 1:1 supervision when R1 returned to the hospital. When asked about how the facility ensured a thorough investigation was completed to ensure that no harm/potential occurred with R2, and the UM stated, a body audit was completed. Further interview with the UM revealed that the facility did not notify R2's Resident Representative of the potential for harm related to this incident, and no other resident's, specifically female residents were interviewed. Lastly, the UM noted they are aware of the facilities abuse/neglect polices and how the investigation process should be handled but the UM was unsure about the facilities polices for potential abuse/allegations of abuse. During an interview on 04/25/25 at 2:29 PM, the ADON and FA, revealed, no residents were interviewed regarding safety concerns, after the alleged incident occurred with R1 and R2. When asked how they ensured that no additional residents were impacted and all residents remained safe, there was no answer given. When asked what interventions were implemented after R1 was redirected 3 times from entering female's room after being on 15-minute checks, no answer was provided. Administrator stated he was unaware of R1's documented behavioral concerns on 04/16/25 the day prior to the incident. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/25/25 at 2:58 PM, CNA4 revealed that R1 looks/enters the female residents' room. CNA4 stated that in the last few weeks (could not recall specific date) they observed three separate occasions of R1 wandering into R2's room at night. On the first two incidents CNA4 stated she observed R1 in the room but not close to R2 and she observed R2's sheets on her bed were disheveled each time and they had to redirect R1 out of the room and tuck R2's sheet back in place. On the third observation CNA4 stated that she observed R1 in his wheelchair next to R2's bed. CNA4 stated that she did not observe R1 touching R2 but observed that R2's sheets were disheveled again and realized that R1 must have been the reason why the residents' sheets were displaced because he was the only other person in R2's room. CNA4 stated that they reported this third incident to LPN1. CNA4 stated that the morning of 04/17/25 at approximately 7:00 AM CNA2 observed R1 in R2's room and had to redirect him out of her room as well.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Andrews Operator, LLC	3514 Sidney Road Columbia, SC 29210

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, and interview, the facility failed to report an allegation of potential non-consensual sexual abuse for Resident (R)2 by R1 to the proper authorities/state agency within the appropriate timeframes. On April 28, 2025 at 4:03 PM, the survey team notified the Administrator and DON that the failure to report an allegation of sexual abuse made by residents and staff constituted IJ at F609. On April 28, 2025 at 4:03 PM, the survey team provided the Administrator and DON with a copy of the CMS IJ Template and informed the facility the IJ existed as of April 16, 2025. The IJ was related to §483.12 - Freedom from Abuse, Neglect, and Exploitation. On April 28, 2025, the facility provided an acceptable IJ Removal Plan. On April 29, 2025 at 10:00 AM, the survey team validated the facility's corrective actions were in place as of April 28, 2025 and removed the IJ. The facility remained out of compliance at F609 at a lower scope and severity of D. An extended survey was conducted in conjunction with the Complaint Survey for non-compliance at F609, constituting substandard quality of care. Findings include: Record Review of the facility policy titled Abuse Investigation and Reporting last revised July 2017 revealed All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and or/ injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Policy interpretation and implementation include: .the administrator will keep the resident and his/her representative informed of the progress of the investigation; the administrator will ensure that any further potential abuse, neglect, exploitation, or mistreatment is prevented; the administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident .All alleged violation involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility administrator, or his/her designee, 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 (Sponsor) of Record; Law Enforcement officials; the resident's attending physician; and the facility Medical Director (MD). An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately but not later than two hours if alleged violation involves abuse or has resulted in serious bodily injury; or 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. The administrator or his/her designee will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five working days of the occurrence of the incident. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of R1's Electronic Medical Record (EMR) Nurses Note revealed a note dated 04/16/25 at 9:25 AM revealed, Resident was seen going into a female resident's room (R2) while Certified Nursing Assistant (CNA) was performing Activities of Daily Living (ADL) care. R1 was directed to leave the room and not return. Female resident next door (R5) also stated that he went into the same resident's room last night and was attempting to come into her room as well. Female resident asked R1 to leave and not come back. Management was notified of the behavior for possible room change. Record review of R1's EMR Nurses Note dated 04/16/25 at 12:57 PM revealed Writer educated resident about entering another resident's room without their consent. Resident understood to not enter another resident's room. Plan of care is ongoing. Record review of R1's Nurses Notes revealed a note dated 04/16/25 at 3:22 PM, revealed 15-minute check was initiated at noon. Resident has been redirected out of female's rooms three times. Record review of R1's EMR Situation Background Assessment Recommendation (SBAR) Summary dated 04/17/25 at 8:12 AM revealed Increased confusion . Resident is being sent to local hospital for evaluation and treatment, Resident Representative notified, primary care physician notified. Record review of R1 EMR Physician Progress Notes dated 04/17/25 at 1:30 PM revealed R1 seen today for management of acute or chronic conditions to avoid decline while in Skilled Nursing Facility (SNF), per staff patient altered mental status now wandering into opposite sexes room two days. Per Nurse Practitioner sent to emergency room (ER). No pain noted, no skin issues reported, staff has no concerns at this time. Assessment/Plan - altered mental status increased for two day and now wandering into opposite sex rooms, sent out for evaluation. Record review of R1 EMR Physician Progress Note dated 04/18/25 at 1:30 PM, revealed R1 being seen today for management of acute or chronic conditions to avoid decline while in SNF. Patient being seen for follow up from ED visit, per staff, no new orders or findings from ED report. No pain noted, no skin issues reported, staff has no concerns at this time. Assessment/Plan - altered mental status increased for two days and now wandering into opposite sexes rooms, sent out for evaluation . Facility made R1 1:1 supervision until resident seen by psychiatric services. Record review of R1 EMR Psychiatry Initial Consult dated 04/18/25, revealed, Assessment and Plan - dementia, BIMS 15 out of 15, moderate symptoms of cognitive impairment, sexual inappropriate behaviors reported, intrusive behavior, symptoms will progress as dementia progress. Start Divalproex ER 250mg tablet extended related 24 hours, take one tablet by mouth once a day. Record review of R2's EMR Nurses Notes for April 2025 revealed no notes related to this incident. Record review of R2's EMR Assessments revealed a Head-to-Toe Skin Check dated 04/17/25 at 7:05 AM, that status was still in progress on 04/24/25 at 1:53 PM. Further review of the Head-to-Toe Skin Check revealed that it was incomplete/blank. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An observation and interview on 04/24/25 at 11:44 AM with R2's Resident Representative (RR) in R2's room revealed that they were informed by another resident at the facility that R2 may have potentially been sexual abused by R1 and that the facility staff were attempting to hide/cover up the incident. R2's RR revealed that a staff member also reported to them off the record that they had concerns with R2 potentially being sexually assaulted by R1 as well. This staff member explained to her that they wanted to call law enforcement and report this incident to the appropriate authorities, but they were told (by Administration) to change their documentation in the EMR/Nurses Notes to make the incident appear like R1 did not have a non-consensual encounter with R2. R2's RR stated that no one from the facility administration has formally on the record notified her of any incident regarding R2 potentially being sexually abused by R1. An interview with R3 on 04/24/25 at 2:10 PM revealed that that they recall R1 being sent out to the hospital after that incident but R2 remained in the facility and law enforcement was not notified and never came to the facility regarding this incident. An interview on 04/25/25 at 9:58 AM, Licensed Practical Nurse (LPN)1 revealed R1 stated, He wanted to see her pussy and that he has needs. LPN1 further stated she reported her concerns to the Administrator and Director of Nursing (DON) and gave them her written statement. LPN1 stated she felt like they should have done more by calling police and having R2 evaluated after an alleged assumption of sexual abuse, but she was told to follow her higher-up's instruction. An interview on 04/25/25 at 12:36 PM, the Social Worker (SW) revealed R4 told the Administrator and was told by the administrative staff that they were handling this incident. An interview with the Unit Manager (UM) on 04/25/25 at 1:40 PM the UM questions were asked about how the facility ensured a thorough investigation was completed to ensure that no harm/potential occurred with R2, and they stated that a body audit was completed. During the interview the surveyor revealed that the body audit dated for 04/17/25, was still marked in progress on the EMR. Further interview with the UM revealed that the facility did not notify R2's Resident Representative of the potential for harm related to this incident, and no other residents', specifically female residents, that are in close contact to R1, were interviewed. Final interview with the UM revealed that they were unaware of other incidents' of R1 being reported in R2 and other female resident's rooms. An interview on 04/25/25 at 2:29 PM, the Assistant Director of Nursing (ADON) and Administrator, revealed no residents were interviewed regarding safety concerns, after the alleged incident occurred with R1 and R2. When asked how they ensured that no additional residents were impacted and all residents remained safe, there was no answer given. When asked what interventions were implemented after R1 was redirected 3 times from entering female's room after being on 15-minute checks, no answer was provided. The Administrator stated he was unaware of R1's documented behavioral concerns on 04/16/25 the day prior to the incident. An observation on 04/25/24 at 4:33 PM, the Administrator and Law Enforcement Officer revealed that the facility is having this alleged incident investigated by law enforcement (8) days after the potential sexual abuse incident. A follow-up interview with the Administrator on 04/25/25 at 4:48 PM, they provided the case number for the law enforcement investigation, Administrator stated that the official report will be ready in a few days. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A phone interview on 04/24/25 at 10:23 AM, the local Ombudsman revealed that they were unaware of any allegations of potential non-consensual sexual abuse and was not notified by the facility. During interview with the Ombudsman state surveyor that complaint was received anonymously and that this was not a facility reported investigation. An in-person follow-up interview on 04/28/25 at 10:30 AM with the local Ombudsman revealed that they still have not been formally notified of the allegation of potential non-consensual sexual incident by R1 with R2 by the facility. Further interview with Ombudsman revealed that they spoke with the facility and explained that their expectation and state regulation require for facilities to report abuse which includes allegation of potential abuse. A follow-up phone interview on 04/28/25 at 12:39 PM with R2's RR revealed that they have still not been formally notified of the potential non-consensual sexual incident regarding R1 and R2. R2's RR stated that the Administrator and Unit Manager spoke with her on 04/25/25 and stated that they were sending R2 to the hospital even though nothing happened but the Administrator and Unit Manager never went into detail about incident/ complete reason for transfer. Record review of a Hospital Transfer Form dated 04/25/25 at 3:14 PM revealed Key Clinical Information reason for transfer: other: hospital given report. Resident Representative notified on 04/25/25 at 3:22 PM Record review of a Hospital Discharge summary dated [DATE] revealed R2 has a past medial history of Anoxic brain injury, sacral decubitus ulcer, seizure disorder, functional quadriplegia who presents to the Emergency Department (ED) for evaluation of potential reported sexual assault per patient's mother. Patient is resident at Skilled Nursing Facility, history obtained from the Emergency Medial Services (EMS) and patient's mother. Patient's mother states that she heard from another resident at the facility that another patient (R1) was seen in R2 room a week ago (*04/17/25). According to the mother (R2 Resident Representative) there was no visualization of any sexual activity. EMS sates that the facility did a full physical exam including external genitalia exam and did not see any evidence of infection . A phone interview on 04/28/25 at 1:10 PM with the Medical Director revealed that they were not formally informed by the facilities Administration of the potential non-consensual sexual abuse. During interview with the MD, they revealed that they had spoken with other residents and were informed by a potential incident with R1 and R2 during their last visit to the facility on [DATE] but was unaware of the extent of the situation. MD revealed that the resident has a history of inappropriate behaviors such as urinating in public areas but wandering into other resident rooms is a new behavior for R1. MD also stated that the only facility staff member that spoke with regarding the potential incident was the Social Worker and was told that the facility was investigating the matter. MD finally stated that he was not notified on the Immediate Jeopardy that is ongoing at this time related to R1 and R2 and the potential non-consensual sexual abuse. On April 28, 2025, the facility provided an acceptable IJ Removal Plan, which included: (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/25/25 the facility completed an initial report with the state agency and the property authorities for allegation of potential sexual abuse for R2 by R1; on 04/26/25 the DON notified the responsible party of R2 of investigation by the facility and proper authorities; on 04/26/25 the Medical Director (MD) was notified of the facility failure to report potential sexual abuse for R2 by R1; on 04/26/25 the Social Services Director (SSD) completed interviews with residents of Brief Interview of Mental Status (BIMS) score 13 or above were interviewed to ensure no potential abuse and neglect needed to be self-reported to the stated agency and proper authorities; on 04/26/25 all current residents had skins check performed by licensed nurse and documented in the facility Electronic Medical Report, to ensure no suspicious injuries or indication of abuse or neglect that needed to be reported to the state agency and proper authorities; on 04/26/25 the Regional Clinical Director (RCD) and Unit Manager reviewed the incident log for the past 30 days for any other potential abuse allegations needing to be self-reported to the state agency and the proper authorities without further instances; on 04/28/25 the Ombudsman was notified by the Administrator of failure to report an allegation of potential sexual abuse for R2 by R1; on 04/26/25 the RCD reviewed the policy with and completed re-education of the facility's policy and procedures for abuse and neglect with the Administrator and DON to ensure understanding with verbal return demonstration as to the types of abuse and neglect, dealing with dealing with disruptive behaviors including dementia care sexually acting out, to include but not limited to what to do if staff witness abuse and neglect, when to report abuse and neglect, to whom to report abuse and neglect and the designated facility abuse coordinator, who is the facility administrator. The RCD will review all reports for 12 weeks to ensure proper notification to the state agency/proper authorities and the facility Medical Director is completed timely. A Quality Assurance Performance Improvement (QAPI) Committee was held on 04/28/25 to formulate and approve a plan of correction for the deficient practice. The Administrator will be responsible for the completion of the corrective action plan. The Administrator/Designee will be responsible for reporting the results of these audits to the QAPI committee meeting for three months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy and procedures, observations and interviews, the facility failed to maintain water temperatures within safe limits. This failure placed residents with access to hand sinks/showers at a potential risk for scalding injuries for three of three halls reviewed. Findings include: Review of the facility policy titled Water Temperatures, Safety of last revised December 2009, states, Tap water in the facility shall be kept within a temperature range to prevent scalding of residents. Policy Interpretation and Implementation, Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 120° [Fahrenheit] F or 48. 88°[Celsius] C, or the maximum allowable temperature per state regulation . If at any time water temperatures feel excessive to the touch (i.e., hot enough to be painful or cause reddening of the skin after removal of the hand from the water), staff will report this finding to the immediate supervisor . Review of an undated facility procedure guide titled F-689 Accidents- Water Temperatures revealed, Common Causes of tap-water burns to the elderly include . Residents may also not check the water temperature . Task Instructions, as the temperature of the water is taken hold your hand under the running water at about the same time assess how the water feels on your skin. 1. For burn prevention, federal guidelines advise that you keep domestic water temperatures below 120 degrees Fahrenheit . Check resident rooms at the end of each wing on a rotating basis or per facility policy. During observation and interview on 04/28/25 at 2:58 PM with the Plant Operations Director (POD), the following room temperatures was observed: room [ROOM NUMBER]: 122.1°F room [ROOM NUMBER]: 132°F room [ROOM NUMBER]: 128.8°F room [ROOM NUMBER]: 124°F room [ROOM NUMBER]: 123°F room [ROOM NUMBER]: 125.6°F room [ROOM NUMBER]: 128°F 100 Hall Shower Room: 131.1°F (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	While checking the room temperatures, the POD placed his hand under the running water and said, this water is way too hot, it shouldn't be this hot, I'll have to turn it down. POD further stated that over the winter period residents made complaints stating the water was too cold, so he turned it up. Lastly, he said, they have not turned the water temperatures down since then, nor after the facility installed boosters around the units. During an interview on 04/28/25 at 3:13 PM, Licensed Practical Nurse (LPN)3, stated, No residents had formally complained about the water temperature. However, she noted that when washing hands, the sinks became really hot. During a follow up interview on 04/29/25 at 10:35 AM, the POD stated that he turned the temperature down at the mixing valve from 137°F to 110°F. POD also noted the facility was replacing the mixing valve as a precaution. During an interview on 04/29/25 at 10:41 AM, the Facility Administrator (FA) stated, Maintenance usually checks the temperatures in rooms and around he facility every couple of days. When asked if he knew the process on how the POD check the temperatures, he stated he was unaware. FA noted the temps are usually set around 120°F and he believes the temperatures were checked after the facility installed booster. When asked if the mixing valve being set at 137°F met the facility's threshold, FA said it was set above their threshold. Lastly, he stated his expectations for temperatures is that it should between 110°F-120°F.