

|   |  |  |  |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>425147 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing   | (X3) DATE SURVEY COMPLETED<br><br>07/17/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Life Care Center of Hilton Head |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>120 Lamotte Drive<br>Hilton Head Island, SC 29926 |  |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p> |

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

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>425147  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing   | (X3) DATE SURVEY COMPLETED<br><br>07/17/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Life Care Center of Hilton Head  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>120 Lamotte Drive<br>Hilton Head Island, SC 29926 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the facility policy, record review, and interviews, the facility failed to ensure Resident (R)26 was free from sexual abuse by R56. Due to both residents' cognitive status and diagnoses, the survey team utilized The Reasonable Person Approach when addressing this noncompliance. On 07/15/2025 at 8:38 PM, the State Agency determined that the facility's non-compliance with one or more federal health, safety, and/or quality regulations had caused or was likely to cause serious harm, psychosocial harm, serious impairment or death. On 07/15/2025 at 8:38 PM, the Administrator was notified that the failure to protect Resident (R)26 from sexual abuse by R56 constituted Immediate Jeopardy (IJ) at F600. On 07/15/2025 at 8:38 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of 07/09/2025. The IJ was related to 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation. On 07/16/2025 at 5:41 PM, the facility provided an acceptable IJ Removal Plan. On 07/17/2025, the survey team validated the facility's corrective actions 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 Recertification Survey and Complaint Survey for non-compliance at F600, constituting substandard quality of care. Findings Include: Review of the facility's policy, with a reviewed date of 05/06/2025, titled, Abuse-Prevention, states, It is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property and exploitation. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, such as the identify when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship. Identify, assess, care plan for appropriate interventions, and monitor residents with needs and behaviors which might lead to conflict or neglect, such as: Sexually aggressive behavior, and residents that require extensive nursing care and/or totally dependent on staff for the provision of care. Review of R56's Face Sheet revealed R56 was admitted to the facility on [DATE] with a readmission date of 02/17/25, with diagnoses including, but not limited to, metabolic encephalopathy, vascular dementia, and adult failure to thrive. Review of R56's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/24/25, revealed he had a Brief Interview for Mental Status (BIMS) of 5 out of 15, indicating he had severe cognitive impairment. Review of R56's Progress Note dated 07/09/25 at 9:13 PM revealed, Observed this resident masturbating in front of a female resident, (room [ROOM NUMBER]-A) in the hallway. Resident was standing beside the female resident, his penis visible and actively masturbation actions movement observed. Instructed the male resident to return to his room. Questioned the female resident, did he, (male resident), touch you? The female resident said, No, he was showing me his penis. Regional Director of Clinical Services was notified at 08:30 PM. Review of R56's Progress Note dated 07/10/25 at 3:06 AM revealed, Resident on 1:1 supervision per care plan intervention related to inappropriate behavior. No acute change in mental status/mood. Cooperative. Review of R26's Face Sheet revealed R26 was admitted to the facility on [DATE], with diagnoses including but not limited to, Huntington's Disease, depression, anxiety, and insomnia. Review of R26's Quarterly MDS with an ARD of 04/16/25, indicated she had a BIMS score of 7 out of 15, indicating she had severe cognitive impairment. During an interview on 07/15/25 at 3:12 PM, Registered Nurse (RN)1 revealed, there was an incident on [NAME] of Tuesday or Wednesday last week where a gentleman, R56, came out of his room and started playing with his genitals and was standing beside another resident, R26. RN1 stated that R56 did not touch R26 and he did not have his genitals in the direction of her. There were no other residents in the hall at the time. The event was intercepted by the nurse on duty, and I was considered a witness. We all had to complete a witness statement and there was an incident report written for the incident. RN1 further stated that R26 was not affected and did not know anything about it or was not in distress, as she has a debilitating disease, Huntington's, and she doesn't remember things sometimes. During an interview on 07/15/25 on 4:34 PM, with the Regional Director of Clinical Services revealed, R56 is confused, and she was notified by the charge nurse on 07/09/25 at 8:30 PM, that he went into R26's room and exposed himself. They both stated that R56 did not touch R26. She stated that they immediately completed a skin assessment and did not identify</p> |  |  |

|   |  |  |  |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>425147 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing   | (X3) DATE SURVEY COMPLETED<br><br>07/17/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Life Care Center of Hilton Head |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>120 Lamotte Drive<br>Hilton Head Island, SC 29926 |  |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                  |
|--|--|
| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p> |

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>425147  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing   | (X3) DATE SURVEY COMPLETED<br><br>07/17/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Life Care Center of Hilton Head  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>120 Lamotte Drive<br>Hilton Head Island, SC 29926 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policy, record review, and interviews, the facility failed to ensure an allegation of abuse was reported in a timely manner. Specifically, the facility was notified of an allegation of sexual abuse on 07/09/25 and did not report the allegation of abuse to the State Agency until 07/16/25. Findings include: Review of the facility's policy, with a reviewed date of 09/05/24, titled, Incident and Reportable Event Management, states, Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Review of R56's Face Sheet revealed R56 was admitted to the facility on [DATE], with a readmission date of 02/17/25, with diagnoses including, but not limited to, metabolic encephalopathy, vascular dementia, and adult failure to thrive. Review of R56's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/24/25 revealed he has a Brief Interview of Mental Status (BIMS) of 5 out of 15, indicating he had severe cognitive impairment. Review of R56's Progress Note dated 07/09/25 at 9:13 PM revealed, Observed this resident masturbating in front of a female resident (room [ROOM NUMBER]-A) in the hallway. Resident was standing beside the female resident, his penis visible and actively masturbation actions movement observed. Instructed the male resident to return to his room. Questioned the female resident, did he, (male resident), touch you? The female resident said, No, he was showing me his penis. Regional Director of Clinical Services was notified at 08:30 PM. Review of R26's Face Sheet revealed R26 was admitted to the facility on [DATE] with diagnoses including but not limited to, Huntington's Disease, depression, anxiety, and insomnia. Review of R26's Quarterly MDS with an ARD of 04/16/25 indicated she had a BIMS score of 7 out of 15, indicating severe cognitive impairment. During an interview on 07/15/25 at 3:12 PM, Registered Nurse (RN)1 revealed that there was an incident on [NAME] on Tuesday or Wednesday last week where a gentleman, R56, came out of his room and started playing with his genitals and was standing beside another resident, R26. RN1 stated that R56 did not touch R26 and he did not have his genitals in the direction of her. There were no other residents in the hall at the time. The event was intercepted by the nurse on duty, and I was considered a witness. RN1 stated that R26 was not affected and did not know anything about it or was not in distress, as she has a debilitating disease, Huntington's, and she doesn't remember things sometimes. During an interview on 07/15/25 at 4:34 PM, the Regional Director of Clinical Services revealed R56 is confused, and she was notified by the charge nurse on 07/09/25 at 8:30 PM that R56 went into R26's room and exposed himself. They both stated that R56 did not touch R26. She stated that they immediately completed a skin assessment and did not identify any new areas. It was a head-to-toe assessment of which we paid close attention to genital areas for any bruising or scratches. They put R56 on 1 to 1 supervision and frequent monitoring but were unsure for how long. The Regional Director of Clinical Services stated that since they did not touch each other, they opted to not report the incident to the state. They had completed a thorough investigation which was completed by 3:00 AM, and the findings were unsubstantiated. She further stated that she is aware that abuse reporting is within two hours or immediately, but since they had completed an investigation, they opted not to report the incident. During an interview on 07/15/25 at 7:16 PM, Licensed Practical Nurse (LPN)1 stated she was familiar with both R56 and R26. She stated she was coming out of another resident's room, and R56 was standing beside R26, actively masturbating. R26 was lying in her Broda chair reclined, and R56 was standing by her face. LPN1 immediately told R56, Go to your room, and asked R26 if R56 had touched her. R26 stated, No, he was showing me his penis. LPN1 stated she then called the Corporate Director of Nursing (DON), and they took care of it. LPN1 further stated it would be classified as sexual abuse because R56 was exposing his private parts. LPN1 stated the incident wasn't consensual, but R26 was aware of what R56 was doing. LPN1 concluded that management is responsible for reporting once they are made aware. During an interview on 07/15/25 at 7:50 PM the Executive Director (ED) revealed she received a call from her Regional Clinical Director, and she came right over to the facility. At that time, they completed questionnaires and an</p> |  |  |