STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445210	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntingdon Health & Rehabilitation Center	635 High Street Huntingdon, TN 38344

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, hospital documentation review, observation and interview, the facility failed to protect the resident's right to be free from sexual abuse for 2 of 4 sampled residents (Resident #1 and Resident #2) reviewed. On [DATE] during group activities, the Former Activities Director (FAD) observed Resident #1 display unwanted behaviors towards Resident #4, leaning against him during conversation, putting her arms around him and touching him affectionately. The FAD intervened and reported the inappropriate behaviors to the Staff Development Coordinator (SDC). The SDC notified Medical Doctor (MD) T on [DATE] and obtained orders for medication to be given for hypersexual behaviors. There were no interventions implemented to monitor Resident #1's hypersexual behaviors pending medication administration with evaluation of medication effectiveness. On [DATE], 2 days after the FAD reported Resident #1's inappropriate behaviors, Certified Nursing Assistant (CNA) C observed Resident #1 and Resident #2, both vulnerable, severely cognitively impaired Residents who lack the capacity to consent, engaged in sexual activity. Interviews conducted with Resident #1 and Resident #2's immediate family concluded both Residents maintained their life with character and integrity in such a manner that would have caused humiliation and psychosocial trauma related to the nonconsensual sexual encounter. After a brief stay in a Psych Facility, Resident #1 returned to the facility and has continued displays of affection towards Resident #3, another male whom she mis-identified as her husband. The facility's failure to provide the necessary care and services to prevent sexual abuse resulted in Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) for Resident #1 and Resident #2. The Interim Administrator, Administrator, Director of Nursing and the Regional Clinical Educator were notified of the Immediate Jeopardy on [DATE] at 3:32 PM, in the Administrator's office. The facility was cited at F-600 with a scope and severity of J, which is a substandard quality of care. An acceptable Removal Plan which removed the immediacy of the Jeopardy for F-600 was received on [DATE], and the Removal Plan was validated on-site by the surveyor on [DATE] through [DATE] by medical record review, monitoring log review, observation, review of education records, and staff interviews. The Immediate Jeopardy for F600 began on [DATE] through [DATE], the IJ was removed on [DATE]. (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's noncompliance at F-600 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions. A partial extended survey was done [DATE]- [DATE]. The facility is required to submit a Plan of Correction. The findings included: 1. Review of the facility policy titled, Abuse, Neglect and Exploitation, revised on [DATE], revealed, .It is the policy of this facility to provide protections for the health, welfare, and rights of each resident .prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property .'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse .'Sexual Abuse' is non-consensual sexual contact of any type with a resident .'Mistreatment' means inappropriate treatment or exploitation of a resident .The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs or behaviors which might lead to conflict or neglect . 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included Anxiety Disorder, Dementia with Agitation, and Insomnia. Review of the Progress Notes for Resident #1 dated [DATE], revealed .17:47 [5:47 PM] .Previous facility reports that this resident tends to sundown [a behavioral change that occurs in the late afternoon and evening in people with dementia], wanders, and asks for [Named deceased husband] . Progress Note was entered by Licensed Practical Nurse (LPN) P. Review of the Order Summary Report for Resident #1 revealed, .ALPRAZolam [used to treat anxiety] .Oral Tablet 0.25 MG [milligram] .1 tablet by mouth two times a day for anxiety .Order Date [DATE] .Start Date XXX[DATE] . Review of the Progress Notes for Resident #1 dated [DATE], revealed .21:53 [9:53 PM] .Really wanting to go home to see husband .Pharmacy notified of not receiving all of meds [medication], stated would be arriving on the next run except for the Alprazolam which a script [prescription] is needed . Progress note was entered by LPN W. Review of the Progress Notes for Resident #1 dated [DATE], revealed .12:51 [PM] .Resident also fixating on another resident and standing over him .Not easily redirected .believes her husband .other family members are nearby and keeps asking us to call them to her room to eat lunch . Progress note entered by Registered Nurse (RN) H. Review of the Progress Notes for Resident #1 dated [DATE], revealed .15:23 [3:23 PM] .we have no records for her history and she is a poor historian accept [except] for one page from previous facility that just list a few diagnosis .Dementia with behaviors will use the paroxetine [antidepressant] for the hypersexual behaviors .depression stable with paroxetine 20mg daily . The note was electronically signed by MD T. (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 the Order Summary Report for Resident #1 revealed, .PARoxetine HCL [Hydrochloride] [used to treat depression and anxiety] Tablet 20 MG .one time a day for hypersexual behavior .Order Date XXX[DATE] .Start Date XXX[DATE] . Review of the Progress Notes for Resident #1 dated [DATE], revealed .16:01 [4:01 PM] .Contacted pharmacy again to pull medication [Alprazolam] from backup. Pharmacy says they still do not have a signed script. Provider aware and says they are sending it over . Progress note entered by RN H. Review of the comprehensive care plan for Resident #1 dated [DATE], revealed .Resident has behavior(s) . Interventions .Administer medications as ordered .Approach resident in a calm manner to avoid frustration and behavior escalation, re-approach later .Keep resident safe during episodes of behaviors; attempt to redirect .Observe and document episodes of inappropriate behaviors; notify Physician/NP [Nurse Practitioner]/PA [Physician Assistant] when behaviors persist or won't de-escalate .Offer psychologist/psychiatrist services as needed . Offer/provide activities of interest to keep resident engaged in positive interactions . Review of the Progress Notes for Resident #1 dated [DATE], revealed .19:24 [7:24 PM] ALPRAZolam . Awaiting arrival from pharmacy . Progress Note was entered by LPN R. Review of the Nursing Home Progress Note for Resident #1 dated [DATE], revealed .New admit seen yesterday .[Named MD T] noted hypersexual yesterday and wrote for paxil [paroxetine] .to start med not available yet from pharmacy she denies pain but continues to be interested in wanting sex . The progress note was signed by NP E. Review of the Order Summary Report for Resident #1 revealed, .PARoxetine HCL Oral Tablet 20 MG . Verbal Give 1 tablet by mouth one time only for Hypersexual Behavior .Order Date XXX[DATE] .Start Date XXX[DATE] .End Date XXX[DATE] . Review of the comprehensive care plan for Resident #1 dated [DATE], revealed, .Resident has behavior(s) related to anxiety, dementia, macular degeneration as evidenced by hypersexual behaviors, physically combative with staff when attempted to redirect .wandering, entering other resident rooms .fixated on her husband .Interventions .If resident resists with ADLs [Activities of Daily Living], reassure resident, leave, then return later . Review of the Progress Note for Resident #1 dated [DATE], revealed, .11:00 [AM] .0800 [8:00 AM] dose of Paroxetine was not given due to this Nurse awaiting the pill from pharmacy . Progress note entered by LPN C. Review of the Progress Notes for Resident #1 dated [DATE], revealed, .12:07 [PM] .Resident is showing an increase in sexual behavior at this time . Progress note entered by LPN C. Review of the Progress Notes for Resident #1 dated [DATE], revealed .15:27 [3:27 PM] .Nurse states pharmacy has been notified today that Paxil not available .NP notified and gave hold order until med available .pharmacy has been called today .and yesterday . Progress note was entered by the Regional Clinical Educator (RCE). (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 the Progress Notes for Resident #1 dated [DATE], revealed .18:34 [6:34 PM] .Inappropriate sexual touching, making statements that she wants to leave .difficult to redirect, hypersexual behavior .Stat [immediate] order for Paxil from pharmacy .give paxil immediately on arrival . Progress note was entered by the RCE. Review of the Resident Monitoring Tool revealed staff documented 1 on 1 monitoring for Resident #1 from [DATE] at 10:10 AM through [DATE] at 1:00 PM. Review of the Progress Notes for Resident #1 dated [DATE], revealed .04:33 [AM] .Orders were written for the hold to be removed and for the one time dose of Paroxetine 20 mg po [by mouth] to be given . Progress note entered by LPN G. Review of the Medication Administration Record (MAR) dated [DATE], revealed Resident #1 received an initial dose of Paroxetine 20 mg at 4:33 AM, three days after the order was obtained to treat hypersexual behaviors. Review of the Nursing Home Progress Note for Resident #1 dated [DATE], revealed .f/u [follow/up] .Patient was found c [with] a male resident expressing a desire for sex .she reports today that she no longer desires this but she does have dementia. Recently started paxil 20mg .CHRONIC DX [Diagnosis] .hypersexuality . Continue 1/1 [1 on 1 monitoring] until medication effective . The progress note was signed by NP E. Review of the Progress Notes for Resident #1 dated [DATE] revealed the Resident was transferred to Hospital #1 for medical clearance evaluation for acceptance to Psych Facility #1. Review of the Initial Psych Evaluation for Resident #1 completed at the Psych Facility, dated [DATE], revealed, .female with history of hypertension and dementia presenting for worsening confusion, combativeness, and exit seeking behavior per her paperwork .Social History: unknown, from a nursing home and only oriented to self .Plan: dc [discontinue] previously prescribed psychotropics cont [continue] Depakote [used to treat mood disorder] as previously prescribed add rivastigmine [medication used to treat dementia] 3mg .add valium [to treat anxiety] . benzodiazepine [nervous system depressant used to treat anxiety] withdrawal from Xanax [benzodiazepine to treat anxiety] and to aid sleep) . The evaluation was electronic signed by MD CC. Review of the nursing home facility Timed Behavioral Monitor Log dated [DATE], revealed staff documented monitoring for Resident #1 from 7:00 AM through 1:00 PM while the Resident was out of the nursing home facility and at the Psychiatric facility. Review of the Progress Notes for Resident #1 dated [DATE] revealed, .Resident arrived to the unit via [by way of] EMS [Emergency Medical Services] stretcher @ [at] 1310 [1:10 PM] .Resident is on the 15 minute checks, due to recent behaviors (hypersexuality, exit seeking, wandering) . The progress note was entered by LPN P. (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 the Timed Behavioral Monitor Log dated [DATE] through [DATE] revealed, .How to use as behavioral assessment tool .Note what resident is doing at each time increment. Example: wandering, exit seeking, sleeping, eating, or pacing .How to use as safety monitor .Check that resident is safe at each time increment and document 'SAFE' . Staff documented monitoring for Resident #1's Behavior/Status inconsistently with the word OK, check marks, an X, type of monitoring, and/or resident status/location. Review of the comprehensive care plan intervention for Resident #1 dated [DATE], revealed, .Other: 1:1 supervision [DATE] [2025] end on 4/18 [2025] moved to 15 minute checks then dc [discontinue] at [DATE] . The facility was unable to provide documentation of monitoring after [DATE] at 7:00 PM. Review of the Progress Notes for Resident #1 dated [DATE], revealed, .17:09 [5:09 PM] .Resident with wandering and overly affectionate behaviors . Progress note was entered by the Director of Nursing (DON) . Review of the Progress Notes for Resident #1 dated [DATE], revealed .Resident was admitted from psychiatric services .Paxil [paroxetine], Celexa [Resident did not have Celexa ordered during her stay], Seroquel [antipsychotic], and Xanax [Alprazolam] discontinue with the initiation of Rivastigmine, Valium, dosage change of Depakote .placed on 1:1 observation for behaviors to evaluate resident safety .No negative behaviors observed for 72 hours. MD in agreement with 1:1 observations. Will continue to monitor closely . Progress note entered by the Director of Nursing (DON). Review of the comprehensive care plan for Resident #1 with a revision date of [DATE], revealed .Resident was on 1/1 care from Thursday [DATE] to Monday [DATE]. Resident will now be on 15 minute checks for 24 hours, 30 minute checks for the following 24 hours, then DC checks . The facility was unable to provide documentation of monitoring for [DATE] after 7:00 PM through [DATE]. Review of the Psychiatric Progress Note for Resident #1 dated [DATE], revealed .Pt [patient] continues with delusional thought process .will continue to follow and redirect based on clinical course .pt recently returned from [Named Hospital #1- resident actually returned from Psych Facility #1] secondary to neuropsychiatric [mental and behavioral changes] symptoms .Addendum to [DATE] note: A conversation took place with the DON regarding the patients [patient's] removal of one to one monitoring secondary to no new sexual disinhibitions [behaviors considered outside of normal range caused by a reduced ability to control impulses and emotions] .observed since return from [Named Hospital #1- resident actually returned from Psych Facility #1] . Verbal order provided [DATE] Addendum added on this date, [DATE] .[Family Nurse Practitioner-FNP D] . This Addendum related to removal of one to one monitoring was added after the IJ template was given on [DATE]. FNP D documented no new sexual disinhibitions observed since Resident #1 returned to the facility. Monitoring was documented on the log for 6 hours prior to Resident #1's return to the facility and inconsistently documented by staff [DATE] through [DATE]. A Progress note on [DATE] revealed wandering and overly affectionate behaviors not documented for behavior on the monitoring log. Review of the Documentation Survey Report v2 for Resident #1 dated [DATE], revealed staff documented mis-identifying male residents as her husband or significant other. (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 the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated severe cognitive impairment. Resident #1 had no coded behaviors and was coded for Supervision to Partial/Moderate assistance for walking. Mobility Devices was coded for the use of a wheelchair during the 7-day look back period. Review of the Psychiatric Progress Note for Resident #1 dated [DATE], revealed .Pt seen per staff request for intermittent resistance & [and] increased exit-seeking behaviors .will continue to follow .CURRENT MEDICATIONS: DEPAKOTE .RIVASTIGMINE .DIAZEPAM [VALIUM] .MELATONIN [supplement used to encourage sleep] .Hydroxyzine [to reduce anxiety] 25mg Q24 [every 24 hours] prn [as needed] (4/10) [medication added on [DATE]] .Depakote increase 250 mg BID [twice daily] . The psych progress note was signed by Psych NP W. Review of the Psychiatric Progress Note for Resident #1 dated [DATE], revealed, .examined per staff request; pt noted with an increase in delusional thought process and agitation .Pt noted with a preoccupative [preoccupied] thought process and disinhibitory behavior .RECOMMENDATIONS: Start Risperdal [risperidone] .for psychosis [disconnection from reality] elements and reflect [redirect] as clinically indicated . FOLLOW UP: 1-2 months . The psych progress note was completed by Psych FNP D. Review of the Progress Notes for Resident #1 dated [DATE], revealed .00:53 [12:53 AM] .Resident has exhibited ongoing disruptive behavior throughout shift .continues to attempt to wander into other residents' rooms and has been trying .to talk various other residents into helping her rearrange furniture within her room .redirected for a very short time and then immediately resuming previous behaviors . Progress note entered by RN K. Review of the Progress Notes for Resident #1 dated [DATE], revealed .Resident is showing an increase in anxiety and agitation .No new orders at this time . Progress note was entered by LPN C. Review of the Documentation Survey Report v2 for Resident #1 dated [DATE], revealed staff documented sexually inappropriate behavior or touching towards other residents, sexually inappropriate towards staff, exit seeking, unsafe wandering, visual hallucinations, delusional thoughts and mis-identifying male residents as her husband or significant other. Review of the Documentation Survey Report v2 for Resident #1 dated [DATE], revealed staff documented sexually inappropriate behavior or touching towards other residents, sexually inappropriate towards staff, exit seeking, unsafe wandering, visual hallucinations, and delusional thoughts. Review of the Documentation Survey Report v2 for Resident #1 dated [DATE], revealed staff documented sexually inappropriate behavior or touching towards other residents, exit seeking, unsafe wandering, visual hallucinations, delusional thoughts and mis-identifying male residents as her husband or significant other. Review of the Order Summary Report for Resident #1 revealed, .Divalproex Sodium [Depakote] Oral Capsule Delayed Release Sprinkle 125 MG .2 capsule [250 mg] two times a day related to DEMENTIA . WITH AGITATION .Order Date XXX[DATE] Start Date XXX[DATE] .risperidone [antipsychotic medication used to treat psychosis] Oral Tablet 0.25 MG .1 tablet .two times a day for psychosis .Order Date XXX[DATE] .Start Date [DATE] . (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 the Progress Notes for Resident #1 dated [DATE], revealed .Resident noted to have increased agitation with thinking male residents are her husband . Progress note was entered by the SDC. Review of the Documentation Survey Report v2 for Resident #1 dated [DATE], revealed staff documented sexually inappropriate behavior or touching towards other residents, exit seeking, unsafe wandering, visual hallucinations, delusional thoughts and mis-identifying male residents as her husband or significant other. Review of the Documentation Survey Report v2 for Resident #1 dated [DATE], revealed staff documented exit seeking, unsafe wandering, visual hallucinations, delusional thoughts and mis-identifying male residents as her husband or significant other. Review of the Progress Notes for Resident #1 dated [DATE], revealed .Resident continues with delusions of fellow residents being her sons or husband .continues to be difficult to direct . Progress note entered by the Social Service Director (SSD). Review of the Documentation Survey Report v2 for Resident #1 dated [DATE], revealed staff documented exit seeking, unsafe wandering, visual hallucinations, delusional thoughts and mis-identifying male residents as her husband or significant other. Review of the Psychiatric Progress Note for Resident #1 dated [DATE], revealed .seen per staff request for increased irritability, agitation, delusional content, and recent altercation with another resident .becomes tearful on exam lamenting [mourning] time with deceased spouse .recently started on risperidone and appears to tolerate well with no adverse effects reported RECOMMENDATION: Depakote increase to 375mg TID [three times daily] . There was no order to increase Depakote as recommended. The psych progress note was completed by Psych NP W. Review of the Documentation Survey Report v2 for Resident #1 dated [DATE], revealed staff documented sexually inappropriate behavior or touching towards other residents, exit seeking, unsafe wandering, visual hallucinations, delusional thoughts and mis-identifying male residents as her husband or significant other. Observation on the secured unit on [DATE] at 2:00 PM, revealed Resident #1 sat outside of the Dining Room in the hall next to Resident #3 having a conversation. Continued observation revealed Resident #1's room was located at the end of the secured unit hall approximately 45 to 50 feet from the nursing desk. Resident #3's room was two rooms away from Resident #1 on the same side of the hall. (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 [DATE] at 2:25 PM, CNA N stated on [DATE] she noticed the privacy curtain was pulled in Resident #1's room and entered to investigate. CNA N stated, .I walked around the curtain and saw [Named Resident #1] and [Named Resident #2] having sex .[Resident #1]'s clothes were pulled down to her ankles and [Resident #2]'s clothes were around his ankles .he was behind her, erect as he could get and going at it .I told them to stop and [Resident #2] seemed caught off guard but [Resident #1] was mad because I interrupted them, she said I should give her and her husband some privacy .[Resident #2] pulled up his pants and left the room .I cleaned [Resident #1] up and walked her down the hall and into the main dining room [and] got the scheduler to stay with both residents .then went and told [Named RCE S] . CNA N stated both Residents were monitored and Resident #1 was moved off the unit to another hall. When asked if Resident #1 had been on monitoring prior to the day of the incident ([DATE]), CNA N replied, No, she had only been here for a couple of days before it happened .Her son told us if she was in her right mind she would be mortified about the sexual behaviors she is having . During an interview on [DATE] at 2:35 PM, CNA B stated Resident #2 had been on 15-minute checks and 1 on 1 monitoring multiple times for exit seeking behaviors. CNA B stated, .[Resident #1] thinks [Resident #3] is her husband and walks with him in the hall often .[Resident #1] sits really close to him when we go in for activities or watching tv .we try to separate them as much as possible, she will whine to him and get him all worked up .agitated . When asked what care plan interventions were implemented to prevent Resident #1's sexually inappropriate behaviors, CNA B stated, .we try to keep her busy and redirect her if she is getting touchy with the male residents . During an interview on [DATE] at 3:26 PM, LPN P stated Resident #1 was not on increased monitoring at this time and had not been on monitoring prior to having the sexual behavior on [DATE]. LPN P stated she was unaware of Resident #1 having inappropriate behaviors on [DATE]. LPN P stated, .[Resident #1] thinks the male residents, especially [Named Resident #3] are her husband and gets really agitated if we try to separate her from him . Review of the Progress Notes for Resident #1 dated [DATE], revealed, .Resident presented with increased confusion. Resident continues to believe others are her family members. Difficult to redirect . Progress note was entered by LPN P. Review of the Documentation Survey Report v2 for Resident #1 dated [DATE], revealed staff documented sexually inappropriate behavior or touching towards other residents, exit seeking, unsafe wandering, visual hallucinations, delusional thoughts and mis-identifying male residents as her husband or significant other. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 10:46 AM, the Former Regional Director of Operations (FRDO) stated she had conducted the facility investigation for the incident between Resident #1 and Resident #2. The FRDO stated during the investigation a staff member had acknowledged Resident #1 was sitting by another male resident leaning in talking to him but nothing sexually inappropriate had happened. The FRDO stated CNA (N) went to Resident #1's room looking for her and found the two residents, with their pants down, one standing behind the other .[Resident #1] was leaning forward on her walker and [Resident #2] was standing behind her .the CNA (N) announced herself, then Resident #2 turned and pulled his pants up and Resident #1 asked why they couldn't have some privacy . When asked if the facility had substantiated the allegation of sexual abuse, the FRDO replied, .We were not able to prove sexual contact occurred .we were not able to substantiate that sexual intercourse had occurred . When asked if sexual intercourse had to occur for nonconsensual sexual contact to be considered, the FRDO replied, .Without being able to prove penetration or know intercourse had happened .we didn't feel like it was something we needed to intervene on .we checked to see if they were able to consent and since he was not able to consent, we made the decision to keep them separated .we didn't feel like it was appropriate contact because he could not consent for sure .our feeling was both patients appeared to be willing participants, even though they were willing, we did deem him incompetent so we did want to prevent contact going forward . When asked to define sexual abuse, the FRDO replied, Nonconsensual sexual contact. The FRDO was asked to review the State Operations Manual guideline for nonconsensual sexual contact and agreed both residents lacked the capacity to consent, and the facility did not substantiate sexual abuse. During a telephone interview on [DATE] at 11:12 AM, the SDC stated Resident #1 had no history of inappropriate behaviors prior to [DATE]. The SDC confirmed on [DATE] the FAD notified her about Resident #1 getting close to a male resident in activities and Family Member (FM) I having concerns due to Resident #1's history of going into male residents' room in the last facility [Facility #2]. When asked what she meant by Resident #1 getting close to a male resident, the SDC stated, .[Resident #1] was just leaning into the resident too close when they were talking, not touching him or anything .I did notify the doctor [MD T] because the family had concerns .[MD T] started [Resident #1] on Paxil 20 mg . When asked if the medication was given for hypersexual behavior, the SDC responded, .I am not sure, I really don't remember . When asked if she had ordered monitoring for the resident pending evaluation of the medication's effect on Resident #1's hypersexual behaviors, the SDC replied, I think it was just a verbal nothing written down. (Multiple interviews revealed staff were not aware of orders to monitor Resident #1 prior to [DATE].) The SDC concluded residents with a BIMS score equal to or higher than 8 had the capacity to consent to sexual contact. The SDC was asked if she provided in-services related to abuse to the staff, she replied, Yes. During a telephone interview on [DATE] at 1:20 PM, FM L stated Resident #1 had no history of inappropriate sexual behaviors prior to coming to the facility. FM L stated, .Mom [Resident #1] had wandered in and out of rooms at [Named Facility #2] .[Resident #1] was a very devoted wife, a Christian woman .she would have just died of humiliation and embarrassment to know she was so casually seducing strangers . FM L stated the facility had not contacted her to discuss Resident #1's plan of care related to the sexual encounter, only the agitation and wandering behavior. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445210	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntingdon Health & Rehabilitation Center	635 High Street Huntingdon, TN 38344

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 2:27 PM, the FAD stated on [DATE] Resident #1 had inappropriate behaviors during activities. The FAD stated, .She [Resident #1] was just all over [Named Resident #4] she had her arm around him, just had to be touching him .I could see he was getting agitated and I got in between them .[Resident #1] got up and stood behind him and began touching his shoulders . [Resident #1] got agitated because I separated them . The FAD stated after activities she spoke to FM I, who had concerns due to Resident #1's wandering behavior at the prior facility. The FAD suggested there might be medication to help with the behaviors and FM I asked her to talk to the nurse about the medication. The FAD confirmed she had reported the behaviors and the medication request to the SDC on [DATE]. Observation on the secured unit on [DATE] at 3:00 PM, revealed Resident #1 and Resident #3 standing at the end (C Hall entrance) of the hall talking. No staff were observed in the hall during the observation. A CNA came and escorted the residents to the dining room at 3:11 PM. Resident #1 and Resident #3 were unsupervised at the end of the hall, outside of resident rooms for 11 minutes. Observation on [DATE] at 4:05 PM revealed Resident #1 sat at a table next to Resident #3. During conversation, Resident #1 placed her hand on Resident #3's thigh and began to rub back and forth. CNA F was present in the dining room interacting with another resident and unaware of the contact between Resident #1 and #3. This surveyor alerted CNA F to the behavior and Resident #1 was redirected at that time. During an interview on [DATE] at 4:10 PM, CNA F stated there was monitoring after the [DATE] sexual encounter between Resident #1 and Resident #2. CNA F stated there had not been any monitoring in place before [DATE] and monitoring had not been on-going for Resident #1 since the incident. CNA F stated Resident #1 was fixated on Resident #3 and often was seen touching him on the leg or arm requiring staff intervention. CNA F confirmed Resident #1 refers to Resident #3 as her husband and at times, her son. When asked if staff were able to always monitor Resident #1 and #3, CNA F replied, .We do try, it isn't possible for us to monitor all the time. We try to watch Resident #1 because she tries to talk Resident #3 into helping her arrange furniture in her room and he follows her wherever she goes .back here in memory care all the residents require constant attention . Review of the Documentation Survey Report v2 for Resident #1 dated [DATE], revealed staff documented sexually inappropriate behavior or touching towards other residents, exit seeking, unsafe wandering, visual hallucinations, delusional thoughts and mis-identifying male residents as her husband or significant other. During a telephone interview on [DATE] at 8:25 AM, FM I confirmed she had spoke with the FAD on [DATE] about concerns with Resident #1's behavior and the possibility of medication to help with her increased sexual desire. FM I stated the FAD had spoken to the Nurse Superv[TRUNCATED]