

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Athens		STREET ADDRESS, CITY, STATE, ZIP CODE 1234 Frye Street Po Box 786 Athens, TN 37371	

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)
<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interview, the facility failed to protect the resident's right to be free from sexual abuse for 3 residents (Resident #49, Resident #88, and Resident #15) of 4 residents reviewed for abuse. The facility staff documented Resident #49 exhibited multiple Public Sex Acts from 11/2025 through 3/2026. The facility failed to notify the Medical Director and the Psychiatric Mental Health Nurse Practitioner (PMHNP) of sexually inappropriate behaviors documented and exhibited by Resident #49. On 3/24/2026, surveyors observed Resident #49 who had severe cognitive impairment and lacked capacity to consent, lifting her shirt to expose bare breasts to staff, visitors, and other residents, and putting her arms under the shirt of Resident #88 touching the resident's bare chest and back. On 3/24/2026, Resident #49 was observed touching surveyors and staff members genitalia, breasts, and buttocks and was observed grabbing the buttocks of Resident #15. Resident #49's conservator and Resident #88's immediate family indicated both residents maintained their life with such character and integrity that sexually inappropriate acts would have caused humiliation and psychosocial trauma related to the nonconsensual sexual behaviors. The Director of Nursing (DON) confirmed the sexual activity incidents were reported by staff to her, however, due to Resident #49's poor cognition and inability to consent, failed to recognize the acts as sexual abuse. ^ The facility's failure to identify sexual abuse in resident's with impaired cognition, and failure to provide the necessary care, services, and interventions to prevent sexual abuse, resulted in an 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 #49, Resident #88, and Resident #15 and had the likelihood to affect all 26 residents who resided on the facility's secured memory care unit. ^ The Administrator, Regional [NAME] President, Regional Director of Clinical Services, Clinical Reimbursement Specialist, and Divisional Director of Clinical Services were notified of the Immediate Jeopardy on 3/27/2026 at 12:02 PM, in the Administrator's office. ^ The facility was cited at F-600 with a scope and severity of J, which is substandard quality of care. ^ An extended survey was conducted on 3/27/2026. ^ An acceptable Removal Plan which removed the immediacy of the Jeopardy for F-600 was received on 3/27/2026, and the Removal Plan was validated on-site by the surveyors on 3/27/2026 by medical record review, monitoring log review, observations, review of education records, and staff interviews. ^ The Immediate Jeopardy for F-600 began on 11/11/2025 and continued through 3/27/2026. The IJ was removed on 3/28/2026. ^ Noncompliance at F-600 continues at a scope and severity of D for monitoring the effectiveness of the corrective actions. ^ ^The facility is required to submit a Plan of Correction. The findings include: ^ Review of the facility policy titled, Abuse-Inservice Training, dated 5/6/2025, revealed .The facility will maintain an effective training program for all staff, which includes, at a minimum, training on abuse, neglect and dementia management, that is appropriate and effective, as determined by staff need and the facility assessment.Procedures for reporting incidents of abuse, neglect.Dementia management and resident abuse prevention.Staff - This includes for the purposes of the training guidance, all facility staff.The (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
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>prohibition of all forms of abuse, neglect.must address forms of abuse, neglect. Identifying and preventing behavior constituting abuse.neglect. Identifying physical or psychosocial indicators of abuse.neglect.from situations which include, but are not limited to.Verbal, mental, sexual or physical abuse.Educating staff on factors related to dementia care and abuse prevention, such as understanding that expressions or indications of distress of residents with dementia are often attempts to communicate an unmet need, discomfort or thoughts that they can no longer articulate with words. However, they may be perceived as challenging behaviors to staff and could increase the risk of resident abuse and neglect.Conflict resolution.conflicts between staff and residents, visitor and resident, and resident-to-resident.Resident and/or Resident Representative will be educated on facility policies and procedures for the protection of residents and investigation of alleged abuse.through.the following venues.Family meetings and family nights.Facility newsletter.Resident care conference.Resident/family council.Individual conferencing. ^ Review of the facility policy titled, Abuse-Prevention, dated 5/6/2025, revealed .It is the policy of this facility To prevent and prohibit all types of abuse, neglect .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 [identification] 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, correct and intervene in situations in which abuse neglect .Is more likely to occur to include trained and qualified, registered, license, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms .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.wandering into others rooms/spaces.Analyze features of the physical environment that may make abuse, neglect . ^ Review of the facility policy titled, Abuse - Identification of Types, dated 5/6/2025, revealed .It is the policy of this facility to identify abuse, neglect .This includes .Identifying and understanding the different types of abuse and possible indicators .The resident has the right to be free from abuse, neglect .Abuse.is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse.Sexual abuse.is defined as non-consensual sexual contact of any type with a resident.Willful.is defined as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.Procedure.Facility staff should report any suspected abuse, neglect.noted.to the Executive Director or Director of Nursing.Risk Factors that May Provoke Reactions in Residents, Staff, or Visitors.The risk for abuse may increase when a resident exhibits a behavior(s) that may provoke a reaction.such as.Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing.Wandering into other's room/space.Sexual Abuse is non-consensual sexual contact of any type with a resident.have the capacity to consent. Sexual abuse includes, but is not limited to.Unwanted intimate touching of any kind especially of breasts or perineal area.Generally, sexual contact is nonconsensual if the resident either.Appears to want the contact to occur, but lacks the cognitive ability to consent; or.Does not want the contact to occur. ^ Review of the facility policy titled, Abuse - Protection of Residents, dated 5/7/2025, revealed .The facility will ensure that all residents are protected from physical and psychosocial harm during and after the investigation.The following methods to ensure the protection of residents during an investigation may include.Responding immediately to protect the alleged victim and integrity of the investigation.Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed.Immediate notification of the alleged victim's practitioner and the (continued on next page)</p>		

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The facility will prevent further abuse .And mistreatment from occurring while the investigation is in progress; and take appropriate corrective action, as a result of the investigation findings. Residents have the right to live at ease in a safe environment .Any investigation of alleged resident sexual abuse must start with a determination of whether the sexual activity was consensual on the part of the resident. A resident's apparent consent to engage in sexual activity is not valid if it is obtained from a resident lacking the capacity to consent. regardless of the existence of a pre-existing or current sexual relationship, is considered to be sexual abuse. ^ Review of the facility policy titled, Abuse - Reporting and Response - No Crime Suspected, dated 5/7/2025, revealed .The facility will report alleged violations related to .abuse. The facility will ensure that all staff are aware of reporting requirements .An individual.who report an alleged violation to facility staff does not have to explicitly characterize the situation as abuse.,if facility staff could reasonably conclude that the potential exists related to .abuse.then it would be considered to be reportable and require actions. ^ Review of the facility policy titled, Care of the Cognitively Impaired (Dementia Care), dated 9/2/2025, revealed .The facility will provide dementia treatment and services which may include. Ensuring that the necessary care and services are person-centered and reflect the resident's goals, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. Identify, address, and/or obtain necessary services for the dementia care needs of residents. Develop individualized interventions. providing verbal, behavioral. prompts to assist a resident with dementia. Review and revise care plans that have not be effective. ^ Review of the facility policy titled, Intimacy Between Residents / Sexual Consent, dated 9/26/2025, revealed .The facility will ensure the resident's right to existence, self-determination, and communication. The facility will also treat the resident with dignity and respect that promotes maintenance and enhancement in their quality of life. When a resident has the desire to participate in the sexual activity with others, the facility will ensure the resident has capacity to consent to sexual activity and if not, will prohibit the engagement of sexual activity with others. Intimacy. An expression of the natural desire of human persons for connection; a state of reciprocated physical closeness to, and emotional honesty with another. Physical closeness to another includes physical touch as demonstrated by nongenital, nonsexual touching, hugging, and caressing. Sexual Abuse. Subjecting another person to unwanted sexual contact by use of forcible compulsion. Sexual abuse includes but is not limited to sexual harassment, sexual coercion, and sexual assault. Sexual Contact. Includes sexual intercourse, oral sex, masturbation, and sexual touch. Sexual Activity. Includes sexual contact and other activities intended to cause sexual arousal. Volition. A resident's clear, unequivocal, unforced willing participation in an intimate relationship or sexual activity. Intimate Contact Between Residents. It is important for the associate to be aware of different acts of intimacy between residents. This can be subtle such as hand holding and progress to kissing and even sexual intercourse. Hand holding for example can be a way two individuals comfort each other in the facility but can also be evidence of a desire to engage in a more intimate relationship. The associate needs to be aware that determining the intent of the contact is important in determining the steps the facility needs to take to ensure all parties are consenting to an intimate relationship. If contact between residents is observed by associate, they should immediately determine if this contact is an established relationship or a new one. If the contact between residents is new, the associate should immediately separate the residents from each other to determine if the residents are able to consent (continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>documented on the quarterly MDS assessment, the care plan was not revised with new interventions to prevent recurrence. ^ 1k. Review of the Psychiatric Mental Health Nurse Practitioner (PMHNP) progress note for Resident #49 dated 1/6/2026, revealed .Following up to monitor anxiety and delusions that are treated with medication management. Initially during visit resident was observed becoming agitated due to fellow male resident being assisted to sit down to eat, resident was redirected with conversation and ambulating in hall, and this was effective. Thought process is disorganized and participation in conversation is minimal. Coordinated with nursing staff discussing any behavioral concerns. Staff report that resident continues chronic behaviors of wandering, fixating on men residents, and occasional outbursts of agitation. Zyprexa was decreased last month for further GDR attempt, appears to be minimally stable .No further concerns voiced at this time .No changes recommended at this time. ^ 1l. Review of the physician's progress note for Resident #49 dated 1/9/2026, revealed .no significant behaviors . ^ 1m. Review of the nurse's progress note for Resident #49 dated 2/1/2026 at 2:30 PM, and authored by the DON, revealed .wandering in and out of other rooms, seeking male companionship observed kissing male peers in the mouth difficult to redirect . ^ 1n. Review of the nurse's progress note for Resident #49 dated 2/2/2026, revealed the resident had exhibited .Public Sex Acts . ^ 1o. Review of the quarterly MDS assessment dated [DATE], revealed Resident #49 had a BIMS assessment score of 00 which indicated the resident had severe cognitive impairment. Continued review revealed the resident was independent with bed mobility and ambulation. Further review revealed Resident #49 had behaviors for 4 to 6 days during the 7 day look back period of hitting, kicking, pushing, grabbing, and abusing others sexually. Resident #49 exhibited behaviors daily during the 7 day look back period of hitting, pacing, public sexual acts, disrobing in public, and throwing or smearing food or bodily wastes. Review of the care plan for Resident #49 revealed the care plan had not been revised with new interventions for the identified behaviors after the quarterly MDS assessment had been completed. ^ 1p. Review of the physician's progress note for Resident #49 dated 2/13/2026, revealed .doing well. no nursing issues .No significant behaviors .stable . Continued review revealed in 6/2025 the Zyprexa was reduced from 7.5 mg every night to 5 mg every night. On 12/2025, the Zyprexa was further reduced to 2.5 mg every night and is reported as .doing well. ^ 1q. Review of the PMHNP progress note for Resident #49 dated 2/17/2026, revealed .Reason for Follow-up: Medication check: the patient's [Resident #49] condition.monitor effects of medication Zyprexa.was increased from 2.5 MG to 5 MG for behaviors .^Chief Complaint .Anxiety, Delusions, Agitation .wandering in halls of secured unit at time of encounter, appears restless. Following up to monitor.anxiety, delusions, behaviors.treated with medication.Nursing staff note.resident is often difficult to redirect when she is pacing or displaying inappropriate behaviors, with redirection she often becomes resistant and agitated. Resident appears paranoid/suspicious at times during visit.agitated/irritable with redirection. She is very restless. Zyprexa decreased for GDR attempt in December [12/2025], will recommend increasing as it appears her behaviors have been escalating over the last couple of months and more difficult to redirect. No further concerns voiced at this time . ^ 1r. Review of the physician's order for Resident #49 dated 2/20/2026, revealed the Zyprexa was increased to 5 mg at bedtime. ^ 1s. Review of the nurse's progress note for Resident #49 dated 2/22/2026 at 3:16 PM, authored by the DON, revealed Resident #49 was .wandering, exit seeking, setting off exit door alarm, going to male visitors and putting her hands in their shirts . ^ 1t. Review of the nurse's progress notes for Resident #49 dated 2/23/2026, revealed the resident had exhibited .Public Sex Acts . ^ 1u. Review of the nurse's progress notes for Resident #49 dated 3/2/2026 at 1:30 PM, revealed .has been sexually inappropriate by grabbing male and female staff and residents in inappropriate places. Resident was removed from near residents and staff at time of incidents . ^ 1v. Review of the nursing progress notes from 3/1/2026 thru 3/24/2026 for Resident #49 revealed the resident had exhibited public sex acts on the following dates: 3/2/2026 (2 incidents), 3/5/2026, 3/8/2026 (2 incidents), 3/10/2026, 3/11/2026, 3/12/2026, 3/13/2026, 3/17/2026, 3/18/2026, 3/19/2026, and 3/20/2026, 3/22/2026, 3/23/2026, and 3/24/2026 (2 (continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an observation on 3/24/2026 beginning at 6:36 PM, Resident #49 and Resident #88 were seated together on Resident #49's bed holding hands. Resident #49's hands were positioned at the top of Resident #88's right upper thigh, and Resident #88's hands were positioned on top of Resident #49's hand. Resident #49 had her head positioned on top of both pairs of hands on Resident #88's right upper thigh. Certified Nursing Assistant (CNA) I entered the room and removed Resident #49 from the bed. As CNA I and Resident #49 were exiting the room, Resident #15 wandered into the room and Resident #49 grabbed Resident #15's buttocks as the resident walked by. The Administrator and DON entered the resident's room and were told by CNA I and Surveyor #1 of the incident with Resident #49, Resident #88, and Resident #15. ^ 4f. During an interview on 3/24/2026 at 6:37 PM, CNA I stated she had witnessed Resident #49 exhibit Public Sex Acts including grabbing other residents' buttocks, kissing Resident #88 on the cheek, mouth, and neck, and had observed Resident #49 place her hands inside Resident #88's shirt caressing the resident's bare chest and back. CNA I stated she had witnessed Resident #49 and Resident #88 lying in the bed together asleep in Resident #49's room on occasion (the residents were clothed). CNA I stated she had documented the behaviors by checking a box in the electronic records. CNA I stated she had reported the behaviors to the nurse (was unable to provide specific dates and was unable to recall the nurse's name) and to the DON. CNA I stated she had witnessed Resident #49 exhibit behaviors over the past weekend (3/20/2026 and 3/21/2026) and reported the incidents to the DON who was working the secured memory care unit. CNA I stated she had reported the incidents to the DON in person on the days the DON had worked the unit and had called the DON at home to make her aware if she was not working the unit. CNA I was unable to provide specific dates for the reporting. CNA I further stated she had not been advised to increase monitoring or initiate any new interventions for Resident #49 due to the sexually inappropriate behaviors. ^ 4g. During an interview on 3/25/2026 at 3:35 PM, the DON confirmed she was aware of Resident #49's sexually inappropriate behaviors toward other residents, staff, and visitors but did not categorize the acts as sexual abuse due to Resident #49's diagnosis of Dementia and her residing on the secured memory care unit. The DON stated she would have considered the reported acts sexual abuse if she had observed the behaviors in the general population of the facility .if they [residents] knew what they were doing . ^ 4h. During an interview on 3/25/2026 at 7:00 PM, CNA A stated she had worked at the facility for 7 years. CNA A stated she had witnessed Resident #49 and Resident #88 lying in bed together (no sexual intercourse and the residents were dressed), kissing each other on the cheeks and neck. CNA A also stated she had witnessed Resident #49 rub Resident #88's chest and shoulders under and on top of his shirt. CNA A stated she considered rubbing the chest a sexual act and had reported the acts to the DON. CNA A further stated she had witnessed kissing and rubbing on the chest about a month or 2 ago and had reported it to the DON when she worked the secured memory care unit. CNA A further stated Resident #49's sexual inappropriateness had been going on for about 6 months and was .normal for her. CNA A stated she had not been asked to conduct more frequent monitoring or initiate interventions other than redirection for Resident #49. ^ 4i. During an interview on 3/25/2026 at 7:12 PM, CNA B stated she had been working with Dementia and in the secure memory care unit for 3 years and defined public sexual acts as hands under a shirt or hand in pants and kissing. ^CNA B stated she had not been told to monitor any residents for public sexual acts and had not been advised to increase monitoring or initiate any new interventions for Resident #49 regarding the sexually inappropriate behaviors. ^ 4j. During an interview on 3/25/2026 at 7:20 PM, R N E U</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>Based on facility policy review, job description review, facility documentation review, Quality Assurance and Performance Improvement (QAPI) Plan review, and interview, the facility's Administration failed to provide effective leadership and oversight after 1 resident (Resident #49) was not identified by facility staff as having exhibited sexually abusive behaviors or activities. This failure of staff who were trained in Dementia care and Abuse allowed the sexual behaviors to persist which allowed continued non-consensual sexually inappropriate behaviors and abuse. The findings include: Review of the facility policy titled, Abuse Prevention, dated 5/6/2025, revealed .It is the policy of this facility to prevent and prohibit all types of abuse .Identify, correct and intervene in situations in which abuse .is more likely to occur . The identify [identification] 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 .Identify, assess, care plan for appropriate interventions, and monitor residents with needs and behaviors . Review of the facility policy titled, Abuse - Identification of Types, dated 5/6/2025, revealed .It is the policy of this facility to identify abuse, neglect . This includes . Identifying and understanding the different types of abuse and possible indicators . The resident has the right to be free from abuse, neglect .Abuse.is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse.Willful.is defined as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.Procedure.Facility staff should report any suspected abuse, neglect.noted.to the Executive Director or Director of Nursing [DON].Risk Factors that May Provoke Reactions in Residents, Staff, or Visitors.The risk for abuse may increase when a resident exhibits a behavior(s) that may provoke a reaction.such as.Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing.Wandering into other's room/space.Sexual Abuse is non-consensual sexual contact of any type with a resident.have the capacity to consent. Sexual abuse includes, but is not limited to.Unwanted intimate touching of any kind especially of breasts or perineal area.Generally, sexual contact is nonconsensual if the resident either.Appears to want the contact to occur, but lacks the cognitive ability to consent; or.Does not want the contact to occur. Review of the facility's undated policy titled, Abuse-Coordination with the QAPI (Quality Assurance and Performance Improvement) Program and QAA [Quality Assessment and Assurance] Committee, revealed .The facility will communicate and coordinate situations of abuse .with the QAPI program. This will include the corrective actions and tracking by the QAA committee .The QAA Committee will determine .If a thorough investigation is conducted .Whether the resident was protected .Whether an analysis was conducted as to why the situation occurred . Risk factors that contributed to the abuse [e.g., history of aggressive behaviors .Whether there is further need for systemic action such as .Insight on needed revisions to the policies and procedures that prohibit and prevent abuse .Increased training on specific components of identifying and reporting that staff may not be aware of .Measures to verify the implementation of corrective actions .Tracking patterns of similar occurrences . Review of the job description for the Executive Director (ED)/ Administrator, dated 1/8/2021, revealed.The Executive Director provides leadership and direction for overall facility operations to provide quality patient care in accordance with laws, regulations .Provides oversight of key areas including financial operations, human resources, customer service, business development, and clinical operations. Implements policies pertaining to Patient care, Caregiving and Support Staff .Daily leadership Responsibilities .Understands that the ED [Administrator] is ultimately responsible for every department and program within the facility .Makes routine inspections of the facility .Reviews associate [staff] compliance with established policies .Aware of all incidents and accidents and takes proper action including (continued on next page)</p>		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<p>appropriate documentation . Review of Resident #49's Nurses' Progress notes, medical record review, and Minimum Data Set (MDS) assessments review, from 10/2025 through 3/27/2026 revealed the facility staff had documented Public Sexual Acts a multitude of times during the period. In November, a total of 3 time(s) documented; In December, a total of 3 time(s) documented; In January, a total of 1 time(s) documented; In February, a total of 4 time(s) documented; and in March, a total of 17 times documented. The MDS assessments for Resident #49 dated 10/10/2025, 12/29/2025, and 2/3/2026 had documentation the resident had behaviors of grabbing, disrobing, and abusing others sexually without appropriate interventions to deter the behaviors and prevent further abuse. The QAA Committee failed to recognize the pattern and extent of instances where actual/potential abuse occurred and failed to implement interventions in response to each instance or occurrence. The facility failed to prevent resident-to-resident sexual abuse, including unwanted kissing, intimate touching of the breasts, groin, and chest, and exposing breasts/nudity--with non-consensual sexual contact involving Residents #88 and #15 who lacked the cognitive ability to consent, staff, and visitors and had the likelihood to affect all 26 of 26 residents who resided on the facility's secured memory care unit. The resident-to-resident sexual abuse was identified by the State and Federal Survey Agency team during the onsite recertification survey from 3/23/2026 through 3/27/2026. During an interview on 3/25/2026 at 3:55 PM, the DON stated .the staff don't know the residents and don't know how to manage those behaviors and I [DON] am pretty versed on what their normal behaviors are . The DON further stated .Really been looking at documentation of behaviors [in the Alzheimer's Unit] and have a great opportunity to improve .[the documentation by staff of] Public Sex Acts.talking to staff.several of the nurses and CNA's [Certified Nursing Assistants] saw her [Resident #49] put own hands in her own pants, some of them see her holding hands and kissing other residents on the cheek .Its dementia related behavior .Folks are vulnerable . The DON stated she would report sexually inappropriate or abusive behaviors if a resident was in the open population and .it would depend on if the resident had dementia . if the behavior should be reported. During an interview on 3/25/2026 at 7:00 PM, CNA A stated she had witnessed Resident #49 and Resident #88 lying in bed together (no sexual intercourse and the residents were dressed), kissing each other on the cheeks and neck. CNA A also stated she had witnessed Resident #49 rub Resident #88's chest and shoulders under and on top of his shirt. CNA A stated she considered rubbing the chest a sexual act and had reported the acts to the DON and the acts had been going on for about 6 months. CNA A stated after the incidents were reported she had not been asked to conduct more frequent monitoring or initiate interventions other than redirection for Resident #49. During an interview on 3/25/2026 at 7:30 PM, CNA I stated, .to me, public sexual acts are hands up the shirt, down the pants, and kissing. CNA I, further confirmed she had reported multiple occurrences of the Public Sexual Acts to the DON without further interventions and Resident #49 continued with the same behaviors after the incidents were reported. During an interview on 3/27/2026 at 9:48 PM, the Administrator was asked about tracking and trending events in the locked Alzheimer's unit as a part of performance improvement process, he stated identifying behaviors and documentation of the behaviors were currently areas with opportunity for improvement. The Administrator confirmed no performance improvement plans (PIPs) were in place related to sexually inappropriate behaviors, non-consensual sexual activities, or sexual abuse for the secured memory care unit. The facility's administration failed to maintain oversight, establish, and implement effective procedures and interventions to ensure staff were knowledgeable in the identification and prevention of resident-to-resident sexual abuse in the facility. Refer to F-600, F-610, F-865</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility documentation review, and interview, the Quality Assurance Performance Improvement (QAPI) committee continued with the same approach to each resident-to-resident sexual abuse interaction, failed to identify the resident's activity as sexual abuse activity, and resident abuse was continually repeated. The resident-to resident altercations had occurred on multiple occasions between on 11/11/2025 and 3/28/2026 between 3 residents (Resident #49, Resident #15, and Resident #99) which resulted in abuse for Resident #49. The findings include: Review of the facility policy titled, Abuse Prevention, dated 5/6/2025, revealed .It is the policy of this facility to prevent and prohibit all types of abuse .Identify, correct and intervene in situations in which abuse .is more likely to occur .The identify [identification] 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 .Identify, assess, care plan for appropriate interventions, and monitor residents with needs and behaviors . Review of the facility policy titled, Abuse - Identification of Types, dated 5/6/2025, revealed .It is the policy of this facility to identify abuse . This includes . Identifying and understanding the different types of abuse and possible indicators .The resident has the right to be free from abuse, neglect .Abuse.is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse.Willful.is defined as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.Procedure.Facility staff should report any suspected abuse, neglect.noted.to the Executive Director or Director of Nursing [DON].Risk Factors that May Provoke Reactions in Residents, Staff, or Visitors.The risk for abuse may increase when a resident exhibits a behavior(s) that may provoke a reaction.such as.Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing.Wandering into other's room/space.Sexual Abuse is non-consensual sexual contact of any type with a resident.have the capacity to consent. Sexual abuse includes, but is not limited to.Unwanted intimate touching of any kind especially of breasts or perineal area.Generally, sexual contact is nonconsensual if the resident either.Appears to want the contact to occur, but lacks the cognitive ability to consent; or.Does not want the contact to occur. Review of the facility policy titled, Abuse-Coordination with the QAPI (Quality Assurance and Performance Improvement) Program and QAA Committee, dated 5/7/2025, revealed .The facility will communicate and coordinate situations of abuse .with the QAPI program. This will include the corrective actions and tracking by the QAA committee .The QAA Committee will determine .If a thorough investigation is conducted .Whether the resident was protected .Whether an analysis was conducted as to why the situation occurred .Risk factors that contributed to the abuse [.history of aggressive behaviors .Whether there is further need for systemic action such as .Insight on needed revisions to the policies and procedures that prohibit and prevent abuse .Increased training on specific components of identifying and reporting that staff may not be aware of .Measures to verify the implementation of corrective actions .Tracking patterns of similar occurrences . 1. Review of the medical record revealed Resident #49 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Traumatic Brain Injury, and Delusional Disorder. 1a. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #49 was unable to complete the Brief Interview for Mental Status (BIMS) assessment due to poor cognitive impairment. Continued review revealed Resident #49 had severe cognitive impairment and rarely made decisions. Resident #49 had behaviors during the 7 day look back period of . abusing others sexually.disrobing in public.public sexual acts. 1b. Review of the quarterly MDS assessment dated [DATE], revealed Resident #49 had a BIMS assessment score of 00 (continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>which indicated the resident had severe cognitive impairment. Continued review revealed Resident #49 had behaviors multiple days during the 7 day look back period of .abusing others sexually.public sexual acts.disrobing in public. 1c. Review of the quarterly MDS assessment dated [DATE], revealed Resident #49 had a BIMS assessment score of 00 which indicated the resident had severe cognitive impairment and was severely impaired in cognitive skill for daily decision making. Continued review revealed multiple days during the 7 day look back period, Resident #49 was documented as .grabbing, and abusing others sexually.public sexual acts.disrobing in public. 1d. Review of the nurse progress notes for Resident #49 dated from 11/11/2025 through 3/24/2026, revealed the facility staff had documented Public Sexual Acts 3 occurrences in 11/2025; 3 occurrences in 12/2025; 1 occurrence in 1/2026; 4 occurrences in 2/2026; and 17 occurrences in 3/2026. 1e. The QAA Committee failed to recognize the pattern and extent of instances where actual/potential abuse occurred, failed to identify documented occurrences of public sex acts, disrobing, and sexually abusing others, and failed to implement interventions in response to each instance/occurrence. The facility failed to prevent continued and recurring acts of resident-to-resident sexual abuse, including unwanted kissing, intimate touching of the breasts, groin, and chest, and exposing breasts/nudity--with non-consensual sexual contact involving residents who lacked the cognitive ability to consent, and sexually inappropriate behaviors towards staff and visitors. 2. Review of the medical record revealed Resident #88 was admitted to the facility on [DATE] with diagnoses including Vascular Dementia, Severe, with Agitation, Delusional Disorders, and Adjustment Disorder with Mixed Anxiety and Depressed Mood. 2a. Review of a quarterly MDS assessment dated [DATE], revealed Resident #88 scored a 0 on the BIMS assessment which indicated the resident had severe cognitive impairment. 3. Review of the medical record revealed Resident #15 was admitted to the facility on [DATE] with diagnoses including Vascular Dementia, Adjustment Disorder with mixed Anxiety and Depressed Mood, and Delusional Disorder. 3a. Review of a significant change MDS assessment dated [DATE], revealed Resident #15 was severely impaired in cognitive skills for daily decision making. The resident-to-resident sexual abuse and sexually inappropriate behaviors were identified by the State Survey Agency and the Federal Center for Medicare and Medicaid Services (CMS) Surveyor Investigator (Surveyor #2) team during the onsite recertification survey through medical record review of Resident #49 and direct observations from 3/23/2026 through 3/27/2026 of the secured memory care unit. Resident #49 displayed repeated sexually inappropriate behavior towards Resident #88, 1 occurrence towards Resident #15 when Resident #15 was touched on the buttocks, and observations of inappropriate touching to facility staff and visitors (surveyors). The preliminary findings were presented to the facility by the team on 3/26/2026. The documented sexually inappropriate acts and public sex acts were confirmed through multiple staff interviews who had witnessed Resident #49 and Resident #88 lying in bed together (clothed), kissing of the cheek, mouth, and neck, and Resident #49 rubbing or caressing the bare chest of Resident #88. Staff interviews further confirmed Resident #49 had inappropriately touched staff members and 1 witnessed occurrence of Resident #49 touching Resident #15's buttocks. During an observation on 3/24/2026, Resident #49 lifted her shirt and exposed her bare breasts to Resident #88, staff, surveyors, and other residents. Resident #49 was observed with both hands and arms underneath Resident #88's shirt and caressing the resident's chest. Additionally, Resident #49 was observed touching Resident #15's buttock without consent. Resident #49, #88, and #15 were cognitively impaired residents and resided on the secured memory care unit. Further observation of Resident #49 during the recertification survey revealed Resident #49 had touched the Staffing Coordinator (SC) between the thighs, groped Surveyor #2's breast, and touched the back and buttocks of Surveyor #1. During an interview on 3/25/2026 at 3:34 PM, the DON stated, she had known Resident #49 for years, including prior to admission to the facility and the resident was considered a .Huggy, Touchy, and Feely person. The DON was questioned about the entries made in the nurse's notes regarding Public Sex Acts exhibited by Resident #49, the DON stated Resident #49 was considered to be with Resident #99 a lot during the day as a companion, the 2 residents held (continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>hands, walked up and down the hall of the secured memory care unit together, and had an occasional peck (kiss) on the cheek which she considered to be related to the resident's diagnosis of Dementia and low cognition. The DON stated she had not considered the acts as sexually inappropriate or sexual abuse and confirmed Resident #49 and #88 lacked the capacity to consent. During an interview on 03/25/2026 at 7:30 PM Certified Nursing Assistant (CNA) I stated, she had documented Public Sex Acts of Resident #49 and she considered the behaviors of Resident #49 to be sexually inappropriate .to me, public sexual acts are hands up the shirt, down the pants, and kissing. CNA I, further confirmed she had reported multiple occurrences of the Public Sexual Acts exhibited by Resident #49 to the DON. During an interview on 3/27/2026 at 9:48 PM, the Administrator stated the facility's secured locked memory care unit had been discussed at times in Interdisciplinary Team (IDT) meetings. The Administrator confirmed the IDT had not formally discussed and he was not aware of any residents' specific sexually inappropriate or abusive behaviors The Administrator stated .there's work to be done back there . Further interview revealed the facility utilized the fish bone method (a visual tool used to assist in the identification of the root cause of a problem) and the facility had not identified sexual abuse on the memory care unit as an area needing to be addressed as he had not been made aware. The QAPI committee failed to maintain oversight, establish, and implement effective action and improvement plans to identify sexual abuse in cognitively impaired residents and to prevent resident-to-resident sexual abuse and sexually inappropriate behaviors towards residents, staff, and visitors on the facility's secured memory care unit. Refer to F-600, F-610, F-835</p>		

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<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, secured unit documentation review, medical record review, and interview, the facility failed to ensure documentation for the participation in the Interdisciplinary Team (IDT) review by the physician for the Secured Unit Placement of 6 residents (Resident #4, #23, #49, #71, #72, and #88) and failed to ensure the resident or resident representative signed the IDT review for the continued placement in the Secure Unit for 2 residents (Resident #72 and #88) of 6 residents reviewed for Secured Unit Placement. The facility's failure had the potential to affect 26 of 26 residents who resided in the facility's Secured Unit. The findings include: Review of the facility policy titled, Secure Unit Placement, dated 9/23/2025, revealed . Each resident has the right to be free from involuntary seclusion. If a resident resides in a secure/locked area that restricts a resident's movement throughout the facility, the facility must ensure that the resident is free from involuntary seclusion. If [a] resident remains appropriate for placement, ongoing evaluations should be conducted as indicated . The residents [resident's] medical record should reflect the following. Documentation of the clinical criteria met for placement in the secure/locked area by the resident's physician along with information provided by members of the interdisciplinary team. Ongoing documentation of the review and revision of the resident's care plan as necessary, including whether he/she continues to meet the criteria for remaining in the secured/locked area, and if interventions continue to meet the needs of the resident. 1. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Delusional Disorders, Unsteadiness on Feet, Protein Calorie Malnutrition, Psychosis, Anxiety Disorder, Depression, Adjustment Disorder, Malignant Neoplasm of Breast, and Vascular Dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #4 scored a 00 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Continued review revealed Resident #4 had a diagnosis of Non-Alzheimer's Dementia. Review of the Secured Unit Continued Placement Evaluation document for Resident #4 dated 9/15/2025, revealed no documentation of the clinical criteria by the physician for the continued placement in the secure unit or physician signature for the participation in the IDT review. Review of the annual MDS assessment dated [DATE], revealed Resident #4 scored a 00 on the BIMS assessment which indicated Resident #4 had severe cognitive impairment. Continued review revealed Resident #4 had a diagnosis of Non-Alzheimer's Dementia. Review of the Secured Unit Continued Placement Evaluation document for Resident #4 dated 1/14/2026, revealed no documentation of the clinical criteria by the physician for the continued placement in the secure unit or physician signature for the participation in the IDT review. 2. Review of the medical record revealed Resident #23 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Vascular Dementia, Unsteadiness on Feet, Generalized Anxiety Disorder, Repeated Falls, Mood Disorder, Delusional Disorders, Major Depressive Disorder, and History of Traumatic Brain Injury. Review of the annual MDS assessment dated [DATE], revealed Resident #23 scored a 6 on the BIMS assessment which indicated the resident had severe cognitive impairment. Continued review revealed Resident #23 had a diagnosis of Non-Alzheimer's Dementia. Review of the Secured Unit Continued Placement Evaluation document for Resident #23 dated 9/15/2025, revealed no documentation of the clinical criteria by the physician for the continued placement in the secure unit or physician signature for the participation in the IDT review. Review of the annual MDS assessment dated [DATE], revealed Resident #23 scored a 9 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Continued review revealed Resident #23 had a diagnosis of Non-Alzheimer's Dementia. Review of the Secured Unit Continued Placement Evaluation document for Resident #23 dated 1/14/2026, revealed no documentation of the clinical criteria by the physician for the continued placement in the secure unit (continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>or physician signature for the participation in the IDT review. 3. Review of the medical record revealed Resident #49 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Dementia with Severe Agitation, Frontal Lobe and Executive Function Deficit, Delusional Disorders, Depression, Anxiety Disorder, and History of Traumatic Brain Injury. Review of the quarterly MDS assessment dated [DATE], revealed Resident #49 scored a 00 on the BIMS assessment which indicated the resident had severe cognitive impairment. Review of the Secured Unit Continued Placement Evaluation document for Resident #49 dated 9/15/2025, revealed no documentation of the clinical criteria by the physician for the continued placement in the secure unit or physician signature for the participation in the IDT review. Review of the Secured Unit Continued Placement Evaluation document for Resident #49 dated 1/14/2026, revealed no documentation of the clinical criteria by the physician for the continued placement in the secure unit or physician signature for the participation in the IDT review. Review of a quarterly MDS assessment dated [DATE], revealed Resident #49 scored a 00 on the BIMS assessment which indicated the resident had severe cognitive impairment. Continued review revealed Resident #49 had a diagnosis of Alzheimer's Disease. 4. Review of the medical record revealed Resident #71 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Fracture of the Left Femur, Vascular Dementia, Anxiety Disorder, Protein Calorie Malnutrition, and Adjustment Disorder with Mixed Disturbance of Emotions and Conduct. Review of the Secured Unit Continued Placement Evaluation document for Resident #71 dated 9/15/2025, revealed no documentation of the clinical criteria by the physician for the continued placement in the secure unit or physician signature for the participation in the IDT review. Review of the Secured Unit Continued Placement Evaluation document for Resident #71 dated 1/14/2026, revealed no documentation of the clinical criteria by the physician for the continued placement in the secure unit or physician signature for the participation in the IDT review. 5. Review of the medical record revealed Resident #72 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Dementia with Early Onset, Dementia with Psychotic Disturbance, Anxiety Disorder, Bipolar Disorder, Schizophrenia, Major Depressive Disorder, and Mood Disorder. Review of a quarterly MDS assessment dated [DATE], revealed Resident #72 scored a 12 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Continued review revealed Resident #72 had a diagnosis of Alzheimer's Disease. Review of the Secured Unit Continued Placement Evaluation document for Resident #72 dated 9/15/2025, revealed no documentation of the clinical criteria by the physician for the continued placement in the secure unit or physician signature for the participation in the IDT review. Continued review revealed no signature the resident representative participated in the IDT review for the continued stay in the Secure Unit. Review of the annual MDS assessment dated [DATE], revealed Resident #72 scored a 14 on the BIMS assessment which indicated the resident was cognitively intact. Continued review revealed Resident #72 had a diagnosis of Alzheimer's Disease. Review of the Secured Unit Continued Placement Evaluation document for Resident #72 dated 1/14/2026, revealed no documentation of the clinical criteria by the physician for the continued placement in the secure unit or physician signature for the participation in the IDT review. Continued review revealed no signature the resident or resident representative participated in the IDT review for the continued stay in the Secure Unit. 6. Review of the medical record revealed Resident #88 was admitted to the facility on [DATE] with diagnoses including Vascular Dementia, Unspecified Symptoms and Signs Involving Cognitive Functions and Awareness, Delusional Disorders, Adjustment Disorder, and Protein Calorie Malnutrition. Review of the annual MDS assessment dated [DATE], revealed Resident #88 had no BIMS score documented. Continued review revealed Resident #88 had moderate cognitive impairment for decision making and had diagnoses including Non-Traumatic Brain Dysfunction and Non-Alzheimer's Dementia. Review of the Secured Unit Continued Placement Evaluation document for Resident #88 dated 9/15/2025, revealed no documentation of the clinical criteria by the physician for the continued placement in the secure unit or physician signature for the participation in the IDT review. Review of the Secured Unit Continued Placement Evaluation document (continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>for Resident #88 dated 1/14/2026, revealed no documentation of the clinical criteria by the physician for the continued placement in the secure unit or physician signature for the participation in the IDT review. Continued review revealed no signature the resident representative participated in the IDT review for the continued stay in the Secure Unit. During an interview on 3/27/2026 at 6:30 PM, the Director of Nursing (DON) confirmed the IDT Secured Unit Evaluations did not contain the required physician documentation or the required signatures which indicated participation in the IDT reviews for Residents #4, #23, #49, #71, #72, and #88. The DON further confirmed the Secured Unit Evaluation documents did not contain an area for the physician signatures.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and interview, the facility failed to provide reasonable accommodations of needs for 1 resident (Resident #22) and failed to ensure call lights were in reach for 2 residents (Resident #40, and #43) of 30 residents observed. The findings include: Review of the medical record revealed Resident #22 was admitted to the facility on [DATE] with diagnoses including Traumatic Ischemia of Muscle (a serious condition where blood flow to a muscle is severely reduced or blocked due to trauma), Cerebral Infarction Affecting Left Side, and Neuralgia (severe shooting pain along a nerve pathway), and Neuritis (inflammation of the optic nerve behind the eye) . Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #22 scored a 7 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Continued review revealed Resident #22 had a functional impairment to the bilateral upper and lower extremities, was dependent on staff for activities of daily living (ADL's) and used a wheelchair for mobility. Review of the comprehensive care plan for Resident #22 dated 3/11/2026, revealed, .ADL self-care performance deficits r/t [related to] impaired mobility .will maintain mobility .does not ambulate .uses wheelchair .wheel 50 feet with two turns dependent .provide supportive care as needed .potential for decline in psychosocial well being r/t decline in mobility .assist with mobility . During an observation and interview on 3/23/2026 at 2:45 PM, revealed Resident #22 was resting in bed, bilateral heel protectors secured in place. Further observation revealed a wheelchair at the resident's bedside without bilateral footrests in place. Resident #22 stated he would like to use his wheelchair for mobility but there were no footrests to rest his feet. The resident stated the footrest on his wheelchair had disappeared (was unable to recall the date or for how long the footrests had been missing) and he could not use his wheelchair to propel himself without the footrests. Resident #22 stated he had made multiple requests to staff (was unable to recall staff names) for the return of the footrests without success. During observations on 3/24/2026 at 9:00 AM, on 3/25/2026 at 7:15 AM and 8:00 AM, Resident #22 was lying in the bed with eyes closed, bilateral heel protectors secured in place. The wheelchair was at the resident's bedside without bilateral footrests in place. During an observation and interview on 3/26/2026 at 9:34 AM, Licensed Practical Wound Care Nurse (WCN) confirmed Resident #22 was able to propel himself in a wheelchair, used the wheelchair for mobility, and confirmed the wheelchair was missing the footrests. During an interview on 3/26/2026 at 2:00 PM, the Physical Therapy Director of Rehabilitation (DOR) stated, .The footrests keep going missing. The staff takes them and uses them for someone else . The DOR stated she spoke with Resident #22 on 3/26/2026 regarding the missing footrests. The DOR confirmed Resident #22's footrests were frequently missing, and the resident did not have them readily available for use. Review of the medical record revealed Resident #40 was admitted to the facility on [DATE] with diagnoses including Myocardial Infarction, Respiratory Failure, and Need for Assistance with Personal Care. Review of a quarterly MDS assessment dated [DATE], revealed Resident #40 scored a 00 on the BIMS assessment which indicated the resident had severe cognitive impairment. Resident requires substantial/maximal assistance with ADL's. Review of a comprehensive care plan dated 1/27/2026, revealed Resident #40 had an .ADL self-care deficit r/t impaired mobility .impaired cognition .Bed Mobility .prefers call light and bed control draped across her for security .During an observation on 3/23/2026 at 4:11 PM, revealed Resident #40 was lying in bed with the head of the bed elevated and a quarter size rail was in the up position. Further observation revealed the resident's call light was wrapped around the bed rail, hanging behind the resident's bed, and was out of the resident's reach.During an observation on 3/24/2026 at 8:38 AM, revealed Resident #40 was lying in bed, the resident's call light was lying on the floor, and was out of the resident's reach. Review of the medical record revealed Resident #43 was admitted to the facility on [DATE] with diagnoses including Dementia, Adjustment Disorder, and Osteoporosis. Review of a (continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>significant change MDS assessment dated [DATE], revealed Resident #43 scored a 3 on the BIMS assessment which indicated the resident had severe cognitive impairment. Review of a comprehensive care plan dated 3/2/2026, revealed Resident #43 had an Impaired Mobility .maintain call light within reach when she is unattended in her room .During observations on 3/23/2026 at 3:57 PM; on 3/24/2026 at 8:27 AM; and on 3/25/2026 at 7:53 AM, revealed Resident #43 was lying in bed, the resident's call light was wrapped around the bed rail behind the resident's bed, and was out of the resident's reach. During observations in Resident #40 and #43's rooms and interview on 3/25/2026 at 2:40 PM, Certified Nurse Assistant (CNA) K observed Resident #40 and Resident #43 in their rooms and confirmed the call lights were out of the residents' reach. During an interview on 3/24/2026 at 3:47 PM, Assistant Director of Nursing (ADON) stated staff was to ensure the call lights were in reach before exiting the room.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interview, the facility failed to conduct a thorough investigation after 28 documented incidents of Public Sex Acts by 1 resident (Resident #49), failed to ensure investigations were conducted after the occurrence of sexual abuse by Resident #49 to 1 resident (Residents #88), and failed to investigate 1 incident of bruising of an unknown origin for 1 resident (Resident #49), of 4 residents reviewed for abuse. The findings include: Review of the facility policy titled, Abuse-Inservice Training, dated 5/6/2025, revealed .The facility will maintain an effective training program for all staff, which includes, at a minimum, training on abuse.and dementia management.that is appropriate and effective, as determined by staff need and the facility assessment.The prohibition of all forms of abuse, neglect.must address forms of abuse, neglect.and dementia management. Identifying and preventing behavior constituting abuse (including injuries from an unknown source), neglect. Identifying physical or psychosocial indicators of abuse (including injuries from an unknown source), neglect.from situations which include, but are not limited to. Verbal, mental, sexual or physical abuse. Review of the facility policy titled, Abuse - Identification of Types, dated 5/6/2025, revealed .It is the policy of this facility to identify abuse. This includes . Identifying and understanding the different types of abuse and possible indicators .The resident has the right to be free from abuse .It includes verbal abuse, sexual abuse, physical abuse, and mental abuse. Injuries of unknown source - An injury should be classified of an injury of an unknown source when all of the following criteria are met. The source of the injury was not observed by any person; and. The source of the injury could not be explained by the resident. The injury is suspicious because of the extent of the injury or the location of the injury (.the injury is located in an area not generally vulnerable to trauma). The risk for abuse may increase when a resident exhibits a behavior(s) that may provoke a reaction. such as. Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing. Wandering into other's room/space. Sexual Abuse is non-consensual sexual contact of any type with a resident. Sexual abuse includes, but is not limited to. Unwanted intimate touching of any kind especially of breasts or perineal area. Generally, sexual contact is nonconsensual if the resident either. Appears to want the contact to occur, but lacks the cognitive ability to consent; or. Does not want the contact to occur. In addition to reports from residents and others that sexual abuse occurred, possible physical indicators of sexual abuse that would require investigation by the facility and survey team include. Bruises around the breasts. Review of the facility policy titled, Abuse - Protection of Residents, dated 5/7/2025, revealed .The facility will ensure that all residents are protected from physical and psychosocial harm during and after the investigation. The following methods to ensure the protection of residents during an investigation may include. Responding immediately to protect the alleged victim and integrity of the investigation. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed. Immediate notification of the alleged victim's practitioner and the family or responsible party. Monitor the alleged victim and other residents at risk. Review of the facility policy titled, Abuse-Conducting an Investigation, dated 5/7/2025, revealed .It is the policy of this facility that all allegations of abuse . Injuries of an unknown source . Are promptly and thoroughly investigated. The facility will prevent further abuse .And mistreatment from occurring while the investigation is in progress; and take appropriate corrective action, as a result of the investigation findings. Residents have the right to live at ease in a safe environment .Following identification of alleged abuse, the resident(s) received prompt medical attention as necessary and the resident(s) are protected during the course of the investigation to prevent recurrence. Staff will respond immediately to protect the alleged victims)/others and integrity of the investigation. When an incident Or suspected incident of resident abuse and/or neglect, [NAME] of unknown source . Is reported, the administrator/designee will investigate the occurrence. Protection will be provided to the alleged victim and other residents . (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility must thoroughly collect evidence to allow the Administrator to determine what actions are necessary (if any) for the protection of residents .the investigation would include . Conducting observations of the alleged victim, including identification of any injuries.interactions and relationships between staff and the alleged victim and/or other residents, and interactions/relationships between resident to other residents.Conducting interviews with, as appropriate, the alleged victim and representative, alleged perpetrator, witnesses, practitioner, interviews with personnel from outside agencies such as other investigatory agencies.Conducting record review for pertinent information related to the alleged violation.such as progress notes.If it is determined that alleged abuse and/or neglect, injury of unknown source.has occurred, the administrator [Administrator], director of nursing [Director of Nursing (DON)], or his/her designee will promptly notify officials in accordance with state and federal regulations.The written summary of the investigation should include.A review of the Incident Report.An interview with the person(s) reporting the incident.Interviews with any witnesses to the incident.An interview with the resident, if appropriate.A review of the resident's medical record.Interviews with staff members on all shifts having contact with the resident at the time of the incident.Interviews with.family, and/or visitors who may have information regarding the incident.If the accused abuser is another resident, the residents must be separate while investigating the incident. Interventions must be implemented to assure the safety of all residents.Any investigation of alleged resident sexual abuse must start with a determination of whether the sexual activity was consensual on the part of the resident. A resident's apparent consent to engage in sexual activity is not valid if it is obtained from a resident lacking the capacity to consent, or consent is obtained through intimidation, coercion or extorted sexual activity with a resident, regardless of the existence of a pre-existing or current sexual relationship, is considered to be sexual abuse. 1. Review of the medical record revealed Resident #49 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Traumatic Brain Injury, and Delusional Disorder. 1a. Review of the comprehensive care plan dated 8/22/2024, revealed Resident #49 had a mood problem related to a Dementia diagnosis. The resident wandered, exhibited behaviors, had a male companion on the secured memory care unit. 1b. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #49 was unable to complete the Brief Interview for Mental Status (BIMS) assessment due to poor cognitive impairment. Resident #49 had behaviors during the 7 day look back period of abusing others sexually, disrobing in public and public sexual acts. (Review of the medical record revealed no documentation an investigation had been completed for the documented occurrence(s) of abusing others sexually or public sex acts). 1c. Review of the nurse's progress notes for Resident #49 dated 11/11/2025, 11/13/2025, 11/19/2025, 12/9/2025, 12/15/2025 and 12/29/2025, revealed the resident had exhibited .Public Sex Acts . (Review of the medical record revealed no documentation an investigation had been completed for the 6 documented occurrence(s) of public sex acts). 1d. Review of the quarterly MDS assessment dated [DATE], revealed Resident #49 had a BIMS assessment score of 00 which indicated the resident had severe cognitive impairment. Continued review revealed Resident #49 had behaviors of abusing others sexually, public sexual acts, and disrobing in public. (Review of the medical record revealed no documentation an investigation had been completed for the documented occurrence(s) of abusing others sexually or public sex acts). 1e. Review of the nurse's progress note for Resident #49 dated 2/1/2026 at 2:30 PM, authored by the DON, revealed .wandering in and out of other rooms, seeking male companionship observed kissing male peers in the mouth difficult to redirect . 1f. Review of the nurse's progress note for Resident #49 dated 2/2/2026, revealed exhibited .Public Sex Acts . (Review of the medical record revealed no documentation an investigation had been completed for the documented occurrence of a public sex act). 1g. Review of the quarterly MDS assessment dated [DATE], revealed Resident #49 had a BIMS assessment score of 00 which indicated the resident had severe cognitive impairment. Continued review revealed Resident #49 had behaviors of abusing others sexually, public sex acts, and disrobing in public. (Review of the medical record revealed no (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>documentation an investigation had been completed for the documented occurrence(s) of abusing others sexually or public sex acts). 1h. Review of the Psychiatric Mental Health Nurse Practitioner (PMHNP) progress note for Resident #49 dated 1/6/2026, revealed .Following up to monitor.Staff report that.[Resident #49].continues chronic behaviors of wandering, fixating on men residents. 1i. Review of the nurse's progress note for Resident #49 dated 2/22/2026 at 3:16 PM, authored by the DON, revealed the resident was .wandering.going to male visitors and putting her hands in their shirts . 1k. Review of the nurse's progress note for Resident #49 dated 2/23/2026, revealed Resident #49 had exhibited .Public Sex Acts . (Review of the medical record revealed no documentation an investigation had been completed for the documented occurrence of a public sex act). 1l. Review of the nurse's progress note for Resident #49 dated 3/2/2026 at 1:30 PM, revealed .has been sexually inappropriate by grabbing male and female staff and residents in inappropriate places. Resident was removed from near residents and staff at time of incidents . (Review of the medical record revealed no documentation an investigation had been completed for the documented occurrence(s) of sexual inappropriate behaviors or sexual abuse). 1m. Review of the nurse's progress notes for Resident #49 dated 3/2/2026 through 3/24/2026 revealed the resident had exhibited Public Sex Acts on the following dates: 3/2/2026 (2 occurrences), 3/5/2026, 3/8/2026 (2 occurrences), 3/10/2026, 3/11/2026, 3/12/2026, 3/13/2026, 3/17/2026, 3/18/2026, 3/19/2026, 3/20/2026, 3/22/2026, 3/23/2026, and 3/24/2026 (2 occurrences). Continued review revealed no documentation an investigation had been completed by the facility regarding the 17 documented occurrences of Public Sex Acts. 1n. Review of the nurse progress note for Resident #49 dated 3/21/2026 at 3:02 PM, authored by the DON, revealed Resident #49 was .in bed with another resident curled up at their feet combative when removed setting off exit alarm to courtyard . 1o. During an observation on 3/24/2026 at 5:49 PM, revealed Resident #49 stood in the hallway by the nurse's station doorway near Surveyor #2. Resident #49 placed both hands on either side of Surveyor #2's neck and proceeded to rub hands down both sides of the surveyor's spine until she reached the buttocks, touching the buttocks. Surveyor #2 jumped forward to remove herself from the resident's reach and exited the memory care unit. 2. Review of the medical record revealed Resident #88 was admitted to the facility on [DATE] with diagnoses including Vascular Dementia, Severe, with Agitation, Delusional Disorders, and Adjustment Disorder with Mixed Anxiety and Depressed Mood. 2a. Review of a quarterly MDS assessment dated [DATE], revealed Resident #88 scored a 0 on the BIMS assessment which indicated the resident had severe cognitive impairment. Further review revealed Resident #88 was independent with bed mobility, walking 150 feet, and had exhibited behaviors daily. 2b. Review of the comprehensive care plan dated 3/24/2026, revealed Resident #88 had .Potential for decline in mood/behaviors/psychosocial well being r/t [related to] severe dementia with agitation . 2c. During an observation and interview on 3/23/2026 at 3:34 PM, in the hallway of the secured unit by the nurse's station door, revealed Resident #49 and Resident #88 holding hands walking down the hall. Registered Nurse (RN) E stated in addition to Resident #49 and Resident #88 holding hands .it gets pretty heated sometimes . RN E did not provide details to describe heated. 2d. During an observation on 3/24/2026 at 5:10 PM, Resident #49 exited her room with Resident #88. Resident #49 lifted her shirt using both hands and exposed bare breasts to staff, surveyors, and other residents. Continued observation revealed Resident #49 then touched Surveyor #2's breast, grabbed Resident #88's hand and stated to Resident #88 .look .touch it too [referring to Surveyor #2's breast] . Surveyor #2 put clipboard to her chest to prevent Resident #49 from further touching the breast and moved away. Further observation revealed Resident #49 then rubbed her hand down the back left side of Surveyor #1 from the shoulder to the buttocks, touching the buttocks. 2e. During an interview on 3/24/2026 at 6:37 PM, CNA I stated she had witnessed Resident #49 exhibit Public Sex Acts including grabbing other resident's buttocks, kissing Resident #88 on the cheek, mouth, and neck, and place her hands in Resident #88 shirt caressing the resident's chest and back. CNA I stated she had witnessed on occasion Resident #49 and Resident #88 in the bed together asleep in Resident #49's room. CNA I (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>stated she had documented the behaviors by checking a box in the electronic records and had reported (was unable to provide specific dates) the behaviors to the nurse (was unable to recall the nurse's name) and to the DON. CNA I stated she witnessed Resident #49 exhibit behaviors over the past weekend 3/20/2026 and 3/21/2026 and reported the incidents to the DON who was working the secured memory care unit. CNA I stated she had reported the incidents to the DON in person on the days the DON worked the unit and had called the DON at home to notify of the incidents if she was not working. CNA I was unable to provide specific dates of the reporting. CNA I stated she had not been interviewed by facility staff about the sexual incidents and was not aware of a facility investigation regarding the sexual acts. 2f. During an observation on 3/24/2026 at 5:56 PM, Resident #49 placed both hands and arms on the inside of Resident #88's shirt and began to rub the resident's chest. The Staffing Coordinator (SC) separated the residents and Resident #49 turned back to the SC and rubbed her hand on the front private area between the SC's thighs. The SC removed Resident #49's hand from between her thighs and Resident #49 then opened her mouth and leaned forward toward the SC's face. 2g. During an interview on 3/25/2026 at 7:00 PM, CNA A revealed she had worked at the facility for 7 years. CNA A stated she had witnessed Resident #49 and Resident #88 lying in the bed together (no sexual intercourse and the residents were dressed), kissing each other on the cheeks and neck. CNA A also stated she had witnessed Resident #49 rub Resident #88 chest and shoulders under and on top of his shirt, considering rubbing the chest a sexual act, and had reported the acts to the DON. CNA A further stated she had witnessed the kissing and rubbing on the chest about a month or two ago and had reported it to the DON when the DON worked the secured memory care unit. CNA A stated Resident #49's sexual inappropriateness had been going on for about 6 months, and was .normal for her . CNA A stated she had not been interviewed by any facility staff regarding Resident #49's sexually inappropriate or sexually abusive incidents and was not aware of a facility investigation regarding the incidents. 2h. During an observation on 3/24/2026 at 6:36 PM, revealed Resident #49 and Resident #88 were seated together on Resident #49's bed holding hands. Resident #49's hands were positioned at the top of Resident #88's right upper thigh, and Resident #88's hands were positioned on top of Resident #49's hand. Resident #49 had her head positioned on top of both pair of hands to the upper things. Certified Nursing Assistant (CNA) I entered the resident's room and removed Resident #49 from the bed. The Administrator and DON entered the resident's room and were told by CNA I and Surveyor #1 of the incident with Resident #49 and Resident #88. During an interview on 3/25/2026 at 3:35 PM, the DON confirmed she was aware of Resident #49's sexually inappropriate behaviors toward other residents, staff, and visitors but did not categorize these acts as sexual abuse due to Resident #49's diagnosis of Dementia and residing on the secured memory care unit. The DON stated she would have considered the reported acts sexual abuse if she had observed the behaviors in the general population of the facility .if they knew what they were doing . During an interview on 3/25/2026 at 7:12 PM, CNA B revealed she had been working in dementia care and the facility secured memory care unit for 3 years and defined public sexual acts as hands under a shirt or hand in pants and kissing. CNA B stated she had not been told to monitor any residents for public sexual acts. CNA B stated she had not been interviewed by facility staff and was not aware of a facility investigation regarding sexual abuse or sexually inappropriate behaviors exhibited by Resident #49. During an interview on 3/26/2026 at 11:38 AM, RN L stated she observed on 3/2/2026, Resident #49 [NAME] behind and grab a female staff members breast. RN L stated the touching of the breast and buttocks of residents by the other residents on the secured memory care unit were not considered sexual abuse because .they [cognitively impaired residents] don't know what they are doing and it's not intentional. RN L further stated if the resident was aware of what they were doing then she would report it. RN L stated she had not been interviewed and was not aware of any facility investigations conducted regarding the inappropriate sexual touching or sexual behaviors on the secured memory care unit. During an interview on 3/26/2026 at 2:49 PM, the physician stated he was not aware of Resident #49's 17 documented Public Sex Acts in March of 2026 and would have (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>expected to be notified. The Physician stated he was not aware of any investigation conducted by the facility regarding sexual abuse or sexually inappropriate behaviors of Resident #49. 4. Review of a facility document for Resident #49 titled, Weekly Skin Integrity Data Collection dated 1/1/2026, revealed .light blue bruise with yellowed edges noted to the left upper chest area . (Review of the medical record revealed no documentation or investigation of the cause of the discoloration). 4a. Review of a facility document for Resident #49 titled NRSG: Skin Integrity update dated 1/14/2026, revealed .6 cm [centimeter] scratch to left breast .Bruises .above scratch and middle of scratch .above findings new . (Review of the medical record revealed no documentation or investigation of the cause of the bruise or scratch). 4b. Review of a facility document for Resident #49 titled, Weekly Skin Integrity Data Collection dated 1/15/2026, revealed .8 cm x 0.4 cm red linear scratch to the left breast area .green bruise with yellowed edges noted to the left upper chest area-6 cm x 3 cm and 2 cm x 3cm yellow bruise to the left breast area . (Review of the medical record revealed no documentation or investigation of the cause of the bruise or scratch). 4c. Review of a facility document for Resident #49 titled, Weekly Skin Integrity Data Collection dated 1/22/2026, revealed .8cm x 0.4 cm red linear scratch to the left breast area-resolved .green bruise with yellowed edges noted to the left upper chest area-6 cm x 3 cm and 2 cm x 3 cm yellow bruise to the left breast area-both still present . (Review of the medical record revealed no documentation or investigation of the cause of the bruise or scratch). 4d. Review of a facility document for Resident #49 titled, Weekly Skin Integrity Data Collection dated 1/29/2026, revealed .green bruise with yellowed edges noted to the left upper chest area-6 cm x 3 cm and 2 cm x 3 cm yellow bruise to the left breast area-both still present . (Review of the medical record revealed no documentation or investigation of the cause of the bruise). 4e. Review of a facility document for Resident #49 titled, Weekly Skin Integrity Data Collection dated 2/5/2026, revealed .green bruise with yellowed edges noted to the left upper chest area-6 cm x 3 cm and 2 cm x 3 cm yellow bruise to the left breast area-both still present but light . (Review of the medical record revealed no documentation or investigation of the cause of the bruise). 4f. Review of a facility document for Resident #49 titled, Weekly Skin Integrity Data Collection dated 2/12/2026, revealed .green bruise with yellowed edges noted to the left upper chest area-6 cm x 3 cm and 2 cm x 3 cm yellow bruise to the left breast area-both resolved as of now . During an interview on 3/25/2026 at 3:35 PM, the DON stated when the bruises were discovered on Resident #49's breast by the staff and reported to her, she had remembered the resident had previously been observed pushing on the exit door to the courtyard so she thought that .might be where. the bruising had originated and did not consider the bruise as an injury of unknown origin. The DON confirmed the facility had not completed an official investigation related to the bruising and scratch of Resident #49's breast and chest.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, observation, and interview, the facility failed to ensure proper grooming was provided for 2 residents (Resident #11 and #78) of 5 residents reviewed for Activities of Daily Living (ADLs) of 30 residents observed. The findings include: Review of the facility policy titled, Activities of Daily Living, dated 9/4/2025, revealed resident [residents] will receive assistance as needed .grooming .resident who is unable .receives the necessary services to maintain good grooming . Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including Multiple Rib Fractures, Malnutrition, and Heart Failure. Review of a comprehensive care plan dated 2/25/2026, revealed Resident #11 had an .ADL self-care performance deficit r/t [related to] impaired mobility .personal hygiene: partial/moderate assistance . Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #11 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Further review revealed Resident #11 required substantial/maximal assistance with hygiene. During an observation and interview on 3/23/2026 at 10:57 AM, in Resident #11's room revealed the resident lying in bed. Resident #11 was observed with long facial hair on her chin. Resident #11 stated she did not like the whiskers and preferred them not to be there. Resident #11 further stated she was unable to shave herself and did not know if the staff would shave her and had not been offered. Review of the medical record revealed Resident #78 was admitted to the facility on [DATE] with diagnoses including Dementia, Depression, and Diabetes. Review of the comprehensive care plan dated 1/2/2026 revealed Resident #78 had an . ADL self-care performance deficit r/t impaired cognition . Review of the quarterly MDS assessment dated [DATE], revealed Resident #78 scored a 5 on the BIMS assessment which indicated the resident had severe cognitive impairment. Further review revealed Resident #78 was dependent with hygiene. During an observation on 3/23/2026 at 2:45 PM, Resident #78 was observed sitting in her wheelchair with several facial hairs on her chin. During an interview on 3/24/2026 at 2:29 PM, Certified Nurse Assistant (CNA) K stated the residents were to be offered shaving on shower days. CNA further stated she did not recall ever asking Resident #11 or #78 if they preferred to be shaved and had not offered to shave the residents. During an interview on 3/24/2026 at 3:47 PM, Assistant Director of Nursing (ADON) confirmed residents were to be shaved on the residents' shower days. The ADON further stated the female residents were to be offered to be shaved when staff observed facial hair.</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, medical record review, observation, and interview, the facility failed to provide foot and nail care to 1 resident (Resident #22) of 1 resident reviewed for foot care of 30 residents observed. The findings include: Review of the facility policy titled, Foot Care, dated 5/19/2025, revealed, .regular toenail trimming promoted cleanliness, prevents infection, stimulates peripheral circulation .it is particularly important for bedridden patients . Review of the facility policy titled, Foot Care, dated 9/4/2025, revealed .This facility will ensure that foot care provided is consistent with professional standards of practice .includes treatment to prevent complications . Review of the medical record revealed Resident #22 was admitted to the facility on [DATE] with diagnoses including Traumatic Ischemia of Muscle (serious condition where blood flow to a muscle is severely reduced or blocked due to trauma), Cerebral Infarction Affecting Left Side, and Neuralgia (severe shooting pain along a nerve pathway), and Neuritis (inflammation of the optic nerve). Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #22 scored a 7 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Continued review revealed the resident had functional impairment to bilateral upper and lower extremities, and dependent on staff for activities of daily living (ADL's). Review of a comprehensive care plan for Resident #22 dated 3/11/2026, revealed .assist to keep nails trim and clean .SS [Social Services] to refer to podiatry for services as needed . During observations on 3/23/2026 at 2:45 PM; on 3/24/2026 at 7:15 AM; and on 3/25/2026 at 8:00 AM, revealed Resident #22 was resting in bed, bilateral heel protectors secured in place. Continued observation revealed the resident had long, jagged, untrimmed toenails which curved over the tips of the second, third, and fourth toe of each foot. During an interview on 3/26/2026 at 9:30 AM, the Social Service Director (SSD) stated the treatment nurse sent her a request when a resident needed to be added to the podiatry visit list. The SSD was unaware Resident #22 needed podiatry services and was not currently scheduled for the service. During an observation and interview on 3/26/2026 at 9:34 AM, the Licensed Practical Wound Care Nurse (LPN/WCN) observed Resident #22's feet and long jagged toenails. The LPN stated she conducted the skin assessment evaluations and stated, .I should have caught it [the long, jagged and untrimmed toenails] before this [the 3/26/2026 observation] . The LPN stated nails were to be trimmed when needed when baths were done and confirmed she had not provided nail care to Resident #22 after the weekly skin assessments and had not notified the SSD of the need for podiatry services for Resident #22.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation and interview, the facility failed to maintain and store a nebulizer circuit in a clean and sanitary condition for 1 resident (Resident #7) of 2 residents reviewed for nebulizer use. The findings include: Review of the facility policy titled, Small Volume Nebulizer Therapy, dated 9/18/2025, revealed .The facility will provide Small Nebulizer Treatments in accordance with professional standards of practice .Nebulizer circuit should be stored in a patient-care-set-up bag labeled with the patients name and dated .entire setup should be changed weekly .rinse the nebulizer with distilled water .disinfect the nebulizer .Complications associated with .nebulizer therapy may include .infection from contaminated equipment . Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including Neuromuscular Dysfunction of Bladder and Chronic Obstructive Pulmonary Disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #7 scored a 10 on Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment and had Chronic Lung Disease. Review of the comprehensive care plan for Resident #7 dated 1/19/2026, revealed .resident has Emphysema/COPD [Chronic Obstructive Pulmonary Disease] r/t [related to] exposure to industrial pollutants .Change nebulizer as ordered . Review of the Physician recapitulation orders for Resident #7 with a print date of 3/24/2026, revealed an order dated 8/15/2025 for .Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML [milligram per milliliter] (Ipratropium-Albuterol) 3 ml [milliliters] inhale orally every 6 hours as needed for SOB [shortness of breath] . Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 3 ml inhale orally via nebulizer two times a day for cough/congestion . change nebulizer circuit every night shift every Tuesday . During an observation on 3/23/2026 at 3:04 PM, in Resident #7's room revealed a nebulizer circuit with a light brown dried substance in between the corrugated plastic rings. Further observation revealed the neck of a plastic emesis bag laying partially across the corrugated plastic rings of the circuit with the mouthpiece resting on the top of the nightstand. During an interview on 3/26/2026 at 8:06 AM, Registered Nurse (RN) D stated the nebulizer circuits were changed weekly and stated she usually placed the nebulizer circuit in the handle [of the compact compressor]. The RN D stated .I don't suppose it should be left like that [stored incorrectly and soiled] .it leaves it [nebulizer circuit] exposed to germs and bacteria . During an interview on 3/26/2026 at 8:15 AM, the RN Unit Manager (UM) confirmed Resident #7's nebulizer circuit was soiled, had not been cleaned, covered, or stored appropriately.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on facility policy review, observation, and interview, the facility failed to ensure expired over the counter (OTC) medications were disposed of and not available for resident use in 1 of 3 medication rooms and the Central Supply room. The findings include: Review of the facility policy titled, Storage and Expiration Dating of Medications and Biologicals, dated 6/30/2025, revealed .Once any medication or biological package is opened, [the] facility should follow manufacturer/supplier guidelines with respect to expiration dates for open medications .the facility staff should record the date opened on the primary medication container when the medication has a shortened expiration date once opened .medications with a manufacturer's expiration date expressed in month and year will expire on the last day of the month . During an observation and interview on 3/24/2026 at 7:32 AM, on the zone 2 medication cart revealed 1 container of Prilosec over the counter (OTC) (a medication to treat acid reflux) 20 milligrams (MG) with an expiration date of 1/26/2026, and 1 bottle of Cetirizine (an OTC medication used to treat allergies) 10 MG tablets opened, undated, and available for use. The Licensed Practical Nurse Unit Manager (LPN UM) confirmed the Prilosec OTC was expired and the Cetirizine medication was opened, undated, and both medications were available for resident use. During an observation and interview on 3/25/2026 at 1:00 PM, in the Central Supply room, with the Staffing Coordinator (SC), revealed 1 bottle of slow release Iron tablets with an opened date of 4/8/2024 and an expiration date of 12/2025, 1 bottle of Aspirin 325 MG 100 tablets with an expiration date of 10/2025, 1 bottle of Cholest Off Plus (dietary supplement medication) 104 tablets soft gels with an expiration date of 2/2026, a 2 boxes of Acid reducer (25) 20 MG tablets with an expiration date of 11/2025. The SC stated she inventoried the medication cabinet once a month and removed all expired medications. The SC confirmed the Iron tablets, Aspirin, Cholest Off Plus, and Acid Reducer tablets were expired, available for resident use, and had not been removed from inventory or discarded. During an interview on 3/25/2026 at 1:28 PM, the Assistant Director of Nursing (ADON) stated, .Expired medications are checked by night shift . The ADON confirmed the expired medications in the Central Supply and Zone 2 medication cart had not been discarded and were available for resident use.</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, observation, and interview, the facility failed to discard expired food items and maintain the cleanliness of personal refrigerators for 2 residents (Resident #32 and #35) of 5 resident's personal refrigerators observed. The findings include: Review of the facility policy titled, Resident Refrigerators, dated 4/30/2025, revealed .A temperature monitoring log will be maintained, and a designated staff member will document refrigerator temperatures on a daily basis .facility staff will check individual food items weekly for expiration dates and discard outdated food promptly from the residents' personal refrigerators . Review of the medical record revealed Resident #32 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Parkinsons Disease, Insomnia, Diabetes, and Heart Failure. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #32 scored a 00 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. During an observation on 3/23/2026 at 3:50 PM, in Resident #32's room, revealed a personal refrigerator with dried brown particles scattered in the refrigerator. Continued observation revealed a bottle of salad dressing with an expiration date of 5/7/2025, a bottle of brown mustard with an expiration date of 2/26/2026, and a container of yogurt with an expiration date of 2/10/2026. Further observations revealed no thermometer or temperature log readings documented. Review of the medical record revealed Resident #35 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disorder, Cognitive Impairment, Anxiety, Depression, Adjustment Disorder, and Dependence on Wheelchair. Review of a quarterly MDS assessment dated [DATE], revealed Resident #35 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. During an interview and observation on 3/23/2026 at 10:15 AM, in Resident #35's room, revealed a personal refrigerator with 1 container of ice cream with an expiration date of 12/19/2025, 1 small carton of milk with an expiration date of 3/7/2026, and a bottle of ketchup with an expiration date of 5/25/2023. Resident #35 stated she did not know who was responsible for cleaning out her refrigerator and was not aware of the expired food items. Further observation revealed no thermometer or temperature log readings documented. During an interview on 3/27/2026 at 8:00 PM, the Director of Nursing (DON) stated there was no system in place for monitoring resident refrigerators for expired items or temperatures. The DON further stated that the expired item should not have been available for resident use.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interview, the facility staff failed to perform appropriate hand hygiene during meal service for 3 residents (Residents #40, #59, and #85) on 1 of 3 units observed for meal tray distribution and failed to ensure infection control prevention measures were followed related to an indwelling urinary catheter for 1 resident (Resident #7) of 4 residents reviewed with indwelling urinary catheters. The findings include: Review of the facility's policy titled, Hand Hygiene for Residents, Families, and Visitors, revised 7/8/2025, revealed The facility should assist either physically or through reminders to residents to preform hand hygiene .before meals . Review of the facility policy titled, Indwelling Urinary Catheter (Foley) Management, dated 9/4/2025 revealed The facility will ensure that residents .with a urinary catheter .will have the following areas addressed .ongoing care and catheter .protocols that adhere to professional standards of practice and infection prevention and control procedures .Review of the medical record revealed Resident #40 was admitted to the facility on [DATE] with diagnoses including Myocardial Infarction, Respiratory Failure, and Need for Assistance with Personal Care. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #40 scored a 00 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Continued review revealed the resident required substantial/maximal assistance with Activities of Daily Living (ADLs). Review of a comprehensive care plan dated 1/27/2026, revealed Resident #40 had an .ADL self-care deficit r/t [related to] impaired mobility .impaired cognition .Eating .set up or clean up assistance . During an observation on 3/23/2026 at 11:33 AM, Certified Nurse Assistant (CNA) J delivered the lunch meal tray to Resident #40. CNA set up the tray for Resident #40 and failed to offer hand hygiene to the resident. Review of the medical record revealed Resident #59 was admitted to the facility on [DATE] with diagnoses including Dementia, Heart Failure, and Depression. Review of the quarterly MDS assessment 3/13/2026 revealed Resident #59 scored a 00 on the BIMS assessment which indicated the resident had severe cognitive impairment. During an observation on 3/23/2026 at 11:37 AM, CNA J delivered the lunch meal tray to Resident #59. CNA J set up the tray for Resident #59 and failed to offer the resident hand hygiene. Review of the comprehensive care plan for Resident #59 dated 3/24/2026, revealed .ADL .Self Care Performance Deficit r/t Dementia .set up or clean-up assistance . Review of the medical record revealed Resident #85 was admitted to the facility on [DATE] with diagnoses including Parkinson, Dementia, and Dysphagia. Review of the quarterly MDS assessment dated [DATE], revealed Resident #85 scored an 11 on the BIMS assessment which indicated the resident had moderate cognitive impairment and was dependent upon staff for eating and personal hygiene. Review of the comprehensive care plan for Resident #85 dated 1/19/2026, revealed .ADL Self Care Performance Deficit r/t Parkinson, Dementia .Eating .Dependent . During an observation on 3/23/2026 at 11:48 AM, CNA J delivered the lunch meal tray to Resident #85. CNA J set up tray for Resident #85 and failed to offer hand hygiene to the resident. During an interview on 10/23/2026 at 2:42 PM, CNA J confirmed she had not offered hand hygiene with or prior to meal service to Residents #40, #59, and #85. During an interview on 3/24/2026 at 3:47 PM, the Infection Preventionist (IP) confirmed hand hygiene was to be offered to residents prior to meal service. Review of the medical record revealed Resident # 7 was admitted to the facility on [DATE] with diagnoses including Neuromuscular Dysfunction of Bladder and Chronic Obstructive Pulmonary Disease. Review of the quarterly MDS assessment dated [DATE] revealed Resident #7 scored a 10 on BIMS assessment which indicated the resident had moderate cognitive impairment. Continued review revealed Resident #7 had a Neurogenic Bladder, and an indwelling urinary catheter. Review of a comprehensive care plan dated 1/19/2026 revealed .potential for complications r/t use of [indwelling urinary catheter] .will be free of complications .provide assistance . Review of the Physician recapitulation orders for Resident #7 dated 3/23/2026, revealed, .Indwelling [urinary] (continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Life Care Center of Athens		STREET ADDRESS, CITY, STATE, ZIP CODE 1234 Frye Street Po Box 786 Athens, TN 37371	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>catheter . During an observation and interview on 3/23/2026 at 3:00 PM, in Resident #7's room, revealed Resident #7 sitting in his wheelchair with a urinary drainage bag clipped to the arm rest partially covered with the evacuation tip (tubing tip for emptying urine from drainage bag) unsecured, exposed, hanging down near and touching the wheel of Residents #7's wheelchair. During an interview on 3/26/2026 at 8:17 AM, the Licensed Practical Nurse (LPN) Unit Manager (UM) confirmed Resident #7's urinary catheter evacuation tip was not secured appropriately, exposed to the elements, and had the potential for contamination.</p>		