STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455628	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Village Nursing and Rehabilitation	1400 Hilltop Rd Kerrville, TX 78028

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51512 Based on observations, interviews, and record reviews, the facility failed to ensure residents' right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate for 4 of 4 residents (Residents #2-5) reviewed for medication self-administration. 1. The facility failed to assess Residents #2-5 for medication self-administration and ensure the medications were being administered per the physician's order. 2. The facility failed to implement care planning for Residents #2-5 for medication self-administration. These failures put residents at risk for incorrect medication administration, which could lead to unintended medication side effects, ineffective therapeutic effects of medications, or illness. In an interview with the DON on 4/17/2025 at 09:13 AM, the DON reported that 4 total residents at the facility have physician orders to self-administer medications. The DON provided the names of the four residents (Residents #2-5). Record review of the residents' electronic medical records revealed the following: Resident #2's face sheet dated 4/15/2025 reflected an [AGE] year-old male with an initial admitted [DATE]. Relevant diagnoses included occipital neuralgia (severe pain in the back of the head and neck) and idiopathic peripheral autonomic neuropathy (chronic nerve pain and/or numbness). Resident #2's quarterly MDS submitted on 4/1/2025 reflected a BIMS score of 13, indicating intact cognition. Active physician orders for the resident included: a. Fluticasone propionate nasal suspension 50mcg/act, 1 spray in both nostrils in the morning for allergies unsupervised self-administration (order dated 12/13/2024) b. Lidocaine HCl external cream 4%, apply to ble topically at bedtime for neuropathy pain unsupervised self-administration (order dated 12/13/2024) c. Systane complete ophthalmic solution, instill 1 drop in both eyes every 4 hours as needed for dry eyes unsupervised self-administration (order dated 12/13/2024) (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Diclofenac sodium external gel 1%, apply to knees, ankles, feet topically every 6 hours for pain- mild; pain [sic] unsupervised self-administration apply 4 grams (order dated 12/7/2024) Resident #2's comprehensive care plan, printed 4/15/2025, did not include any focus areas or interventions related to self-administration of medication. Documentation of care plan meetings hosted on 2/25/2025, 11/26/2024, and 8/27/2024 did not contain documentation of self-administration of medication being discussed by the interdisciplinary team. An assessment in the electronic medical record titled Self Administration of Medication was documented on 4/17/2025. The documented assessment indicated that the resident was approved for self-administration of medications and may keep meds at bedside. No additional assessments addressing self-administration of medication were located within the record. On 4/15/2025 at 1:48 PM, Resident #2 was observed storing 5 medications in a dresser drawer without a lock in his room. The medications contained within the drawer were observed, and it was noted that the resident had possession of 2 medications that did not have physician's orders for self-administration. These medications were Hydrophilic top cream prescription cream and lidocaine ointment 5%. The resident was interviewed during the observation, and he reported having difficulty self-administering the diclofenac sodium external gel 1% to his upper back. It was noted during record review that the physician's order for this medication indicated that the gel be applied to the resident's knees, ankles, and feet; not his back. Resident #3's facesheet dated 4/17/2025 reflected a [AGE] year-old-male with readmitted [DATE]. Relevant diagnoses included repeated falls, other abnormalities of gait and mobility, and unspecified asthma (a breathing disorder that causes constriction of the airway and inhibits breathing). Resident #2's annual MDS submitted 1/30/2025 reflected a BIMS score of 15, indicating intact cognition. Active physician orders for the resident included: a. Trelegy ellipta inhalation aerosol powder breath activated 200-62.5mcg/act, 1 puff inhale orally one time a day for asthma unsupervised self-administration. Rinse mouth after use (order dated 4/16/2025) No assessments addressing self-administration of medication were located within the electronic medical record of Resident #3. The comprehensive care plan, printed 4/17/2025, did not include any focus areas or interventions related to self-administration of medication. Documentation of an interdisciplinary care plan meeting hosted on 2/27/2025 reflected discussion between the team about self-administration of medications and indicated that resident was safe to self-administer. Resident #3 was observed on 4/17/2025 at 1:55 PM, the resident was interviewed and asked if observation could made of any medications that he self-administered. The resident removed a container of over-the-counter lubricant eye drops from the nightstand drawer that did not have a lock. The resident reported no other medications stored in his room, which was inconsistent with the physician's orders. The resident did not have an active prescription from the facility physician for the eye drops, and the Trelegy Ellipta was not observed in the drawer. The resident reported that he last used the eye drops not even every day. The resident stated he did not know what symptoms prompt the use of the eye drops. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #4's facesheet dated 4/17/2025 reflected an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included unspecified asthma and unspecified glaucoma (damage to the nerves of the eye causing vision loss). The annual MDS submitted on 3/25/2025 reported a BIMS score of 15, indicated intact cognition. Active physician orders for the resident included: a. Fluticasone-salmeterol aerosol powder breath active 100-50mcg/dose, 1 inhalation inhale orally every 12 hours for SOB [shortness of breath] unsupervised self-administration. Rinse mouth after use (order dated 8/31/2024) b. Latanoprost solution 0.005%, instill 1 drop in both eyes at bedtime unsupervised self-administration (order dated 8/28/2024) c. Propylene glycol-glycerin ophthalmic solution 1-0.3%, instill 1 drop in both eyes one time a day for dry eyes unsupervised self-administration (order dated 8/28/2024) d. Timoptic ophthalmic solution 0.5%, instill 1 drop in both eyes two times a day for glaucoma unsupervised self-administration (order dated 8/29/2024) Resident #4's electronic medical record contained self-administration medication assessments documented on 1/8/2018 and 5/28/2018. No additional assessments were located within the record. Documentation of interdisciplinary care plan meetings on 2/27/2025, 11/26/2024, and 8/29/2024 did not contain documentation of discussion regarding self-administration of medication. Resident #4's comprehensive care plan, date printed 4/17/2025 did not contain focus areas or interventions related to self-administration of medication. Resident #4 was observed storing the 4 previously listed medications on the top surface of the nightstand on 4/17/2025 at 1:45 PM. Interview with the resident during the observation did not reveal any discrepancies between the ordered medications and resident's description of self-administration. Resident #5's facesheet dated 4/17/2025 reflected a [AGE] year-old female initially admitted to the facility on [DATE]. Relevant diagnoses included other seasonal allergic rhinitis (seasonal allergies causing runny nose), absolute glaucoma, bilateral (vision loss in both eyes from nerve damage), and reduced mobility. Active physician orders for the resident included: a. Artificial tears ophthalmic solution 0.2-0.2-1%, instill 1 drop in both eyes every 4 hours as needed for dry itchy eyes unsupervised self-administration (order dated 8/29/2023) b. Artificial tears ophthalmic solution 0.2-0.2-1%, instill 1 drop in both eyes every 2 times a day for dry itchy eyes unsupervised self-administration (order dated 8/29/2023) c. Biofreeze external gel 4% (menthol topical analgesic), apply to affected areas topically every 6 hours as needed for joint pain unsupervised self-administration (order dated 6/08/2023) d. Biofreeze Professional external gel 5% (menthol topical analgesic), apply to bilateral ankle topically every 4 hours as needed for pain can keep at bedside (order dated 8/30/2024) e. Blink tears ophthalmic gel 0.25%, instill 1 drop in both eyes two times a day for dry eyes unsupervised self-administration (order dated 8/15/2023) (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. Voltaren arthritis pain external gel 1%, apply to bil [bilateral] knees and shoulders topically every 6 hours as needed for pain . unsupervised self-administration 4GMs to joints NTE [not to exceed] 32 GMs in 24 hours (order dated 6/09/2023) Resident #5's comprehensive care plan, date printed 4/17/2025 did not contain focus areas or interventions related to self-administration of medication. Documentation of interdisciplinary care plan meetings hosted on 3/11/2025, 12/12/2024, and 9/5/2024 do not contain documentation of medication self-administration discussion. Resident #5 was observed storing 2 eye drop medications on top of the bedside table next to the bed on 4/16/2025 at 8:37 AM. An interview conducted at this time did not reveal any inconsistencies with the physician's orders. During routine medication administration observation of MA H on 4/16/2025, Resident #5 was observed receiving scheduled medication at 8:37 AM. MA H was not observed verifying with Resident #5 if medications ordered for self-administered had been administered. An interview was conducted with LVN A on 4/16/2025 at 10:07 AM. LVN A explained there is nothing to document on the MAR for self-administered medications, the order will simply populate as a reminder that the medication is due. LVN A stated her responsibility is to ensure the resident has the ordered medication and to reorder as necessary, but she does not verify administration. The DON was interviewed on 4/17/2025 at 9:13 AM. She reported that determination of safety for self-administration of medications by residents is made during quarterly care plan meetings and by assessment from the primary nursing staff, and residents must show that they are able to recite the medication frequency and dosage as well as physically able to ingest the medication, such as an inhaler.The DON said that during routine medication administration, the nursing staff should be verifying at that time that the resident self-administered the ordered medications. The DON was unaware that nursing staff were not verifying the self-administered medications. The DON was also unaware that residents with orders to self-administer medications did not have correct medications stored in their rooms. The DON stated care plans should include planning for self-administration of medications. Record review of policy titled Administering Medications (revised April 2019). Self-administration of medication is addressed in item #27 and reflected residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51512 Based on interview and record review, the facility failed to ensure that residents were free from abuse for 1 (Resident #1) of 7 residents reviewed for abuse, neglect, and exploitation. The facility failed to ensure Resident #1 was free from abuse of unwanted sexual exposure from Resident #6 when he masturbated in front of her. This failure puts residents at risk for abuse and diminished quality of life. Findings included: Record review of Resident #1's facesheet reflected an [AGE] year-old female with admitted [DATE]. Relevant diagnoses included anxiety disorder, depression, and aftercare following joint replacement surgery. Review of Resident #1's quarterly MDS submitted on 4/3/2025 noted that BIMS score was not assessed. The prior quarterly MDS, submitted on 11/21/2024, reflected a BIMS score of 15, indicating intact cognition. Record review of Resident #1's progress notes revealed an entry authored by LVN G on 2/2/2025 at 10:59 PM that stated: Res. Told CNA on Saturday 2-1-25 and Sunday 2-2-25 that her Neighbor has appeared at her door the last two night exposing himself and masturbating at her door [sic]. Further review of Resident #1's progress notes revealed an entry on 2/14/2025 at 5:51 PM, authored by LSW B. In these notes, LSW B documented her interview with Resident #1 about the incident and education to staff regarding the need for staff to notify nurse managers and/or social workers when any incidents related to [resident to resident] occurred. LSW B documented a follow-up progress note on 2/18/2025 at 8:57 AM indicating that the resident's psychologist was notified of the incident and would speak to the resident for evaluation. Record review of the facility's incident report for February 2025 did not reflect an entry for Resident #1, however, in subsequent staff interviews, it was revealed that an investigation had been performed by the facility. Record review of Resident #6's facesheet reflected a [AGE] year-old male with admitted [DATE] and discharge date of [DATE]. Relevant diagnoses included unspecified dementia [a progressive disorder that impairs thought processes, such as memory, thinking, reasoning, and decision-making], unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; cognitive communication deficit; and muscle weakness (generalized). Resident #6's quarterly MDS submitted on 1/30/2025, reflected a BIMS score of 5, indicating severely impaired cognition. In Section E, this MDS also indicated that Resident #6 did not have indicators of psychosis (question E0100), did not have behavioral symptoms exhibited towards others (question E0200), or have history of wandering (E0900). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #6's progress notes revealed an entry on 12/12/2024 noting Resident #6 continu[ed] to roam building. An additional progress note entered on 1/23/2025 noted behaviors: wandering, chronic. On 2/11/2025, an entry by LSW B stated resident found in lobby [with] hands in pants rubbing himself. In an interview with Resident #1 on 4/16/2025 at 8:55 AM, Resident #1 stated she was laying in bed and an unknown man entered her room by wheelchair and began masturbating. She reported that she notified 2 to 3 staff members of the incident, and she was told that the resident had been running around the whole building doing that. She was also told that the man was no longer a resident at the facility. She stated the sexual abuse only happened one time and reported feeling safe at the facility. CNA H was interviewed on 4/29/2025 at 11:34 AM. CNA H stated Resident #1 told her on at least 2 separate occasions that she had been sexually abused by Resident #6. CNA H reported Resident #1 seemed upset and scared when she reported the sexual abuse. CNA H stated she did not witness sexual abuse of Resident #1, nor did she see Resident #6 entering or exiting Resident #1's room. CNA H stated she had observed Resident #6 frequently wandering the resident halls in his wheelchair. CNA H stated that she reported the abuse allegations to LVN G on at least 2 separate occasions. CNA H was unsure of the exact dates that these events occurred but felt certain that 2 of the instances were at least a week apart, as she worked weekend shifts exclusively at the time. CNA H recalled that LVN G's response was dismissive in nature and LVN G attributed Resident #1's allegations to the resident being confused. LVN G also responded that she would speak to the resident. CNA H did not consider Resident #1 to be confused or have altered cognition at the time of the incident. CNA H confirmed during the interview she had participated in training about abuse/neglect and reporting abuse/neglect. At the time of the incident, she was unaware that she should report abuse to the Admin/Abuse Coordinator but received an in-service regarding reporting abuse to the Admin when she made her statement about the incident to the facility. An interview was conducted with LVN G on 4/29/2025 at 12:42 PM. LVN G confirmed she had been the nurse caring Resident #1 on or about 2/2/2025 but denied being told allegations of sexual abuse to Resident #1 by any staff member or the resident. LVN G was unsure if the allegations were factual and felt the allegations were a rumor. She did not witness Resident #6 entering or exiting Resident's #1 room. LVN G did not observe any mood or behavioral changes at the time of the incident. LVN G said she had only heard about the sexual abuse allegations through hearsay or possibly in shift report. LVN G said she did not speak to Resident #1 about the sexual abuse allegations while serving as her primary nurse because she had [her] own problems to deal with. She did not report the abuse to the facility because it was her understanding that the allegations were already known by the facility. She denied knowing which staff member had reported the allegations to the facility. LVN G confirmed she had received training about abuse/neglect and reporting abuse/neglect from the facility. She stated reports of abuse/neglect were to be reported to the Admin. In an interview with LSW B on 4/16/2025 at 9:51 AM, LSW B reported that she was notified on 2/14/2025 of the sexual abuse by a third party professional affiliated with the facility; not by facility staff. After being notified, LSW B stated she immediately met with the resident to assess her for any psychosocial distress and trauma related concerns and had no concerning findings. LSW B stated she reported the incident to the facility abuse coordinator/administrator for further investigation, and she also referred the resident to the psychologist for further evaluation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a subsequent interview with LSW B on 4/29/2025 at 9:30 AM, LSW B confirmed Resident #6 had been identified during the facility investigation as the alleged perpetrator of the sexual abuse of Resident #1 based on physical description and behaviors. LSW B stated Resident #6 was known to roam the facility, but she was not aware of any instances of him entering any residents' rooms. LSW B confirmed the 2/11/2025 incident documented in Resident #6's progress notes. She stated Resident #6 was observed in the communal lobby area with his hands in his pants and touching his genital area. Another resident observed the behavior and notified her, and LSW B responded by relocating Resident #6 to his room. She then notified the nurse and the Admin of the incident. LSW B reported Resident #6 was not receiving psychiatric services due to the extent of his dementia. In an interview on 4/17/2025 at 9:13 AM, the DON reported the facility's expectation of staff notifying leadership of allegations of abuse/neglect/exploitation is immediate notification. The DON was unsure why LVN G did not notify anyone about Resident #1's abuse allegation. She confirmed that an investigation had been initiated and completed by the facility after becoming aware of the allegations. The DON was unsure if the sexual abuse allegations were reported to the SSA. As a result of the investigation, the DON said she performed staff in-services regarding abuse reporting. The DON was interviewed again on 4/29/2025 at 2:00 PM and reported awareness of Resident #6's wandering behaviors and denied knowledge of sexually inappropriate behaviors other than the incident on 2/11/2025 and the allegations made by Resident #1. She said the wandering behaviors were managed by increased supervision. The DON did not feel like other behavioral interventions were necessary after the 2/11/2025 incident as the resident was pending discharge, on 2/15/25, and the increased supervision was sufficient management. An interview was conducted with the Admin/Abuse Coordinator on 4/17/2025 at 10:23 AM. The Admin confirmed that she was aware of this incident, and stated she had not been notified by facility staff of the incident. She reported a third party performing chart reviews discovered the documentation made by LVN G. The third party notified LSW B, who then notified the Admin and the DON. The Admin reported an investigation of the allegations beginning 2/14/2025 with completion date of 2/18/2025. The Admin reported no additional concerns of abuse from any residents. The Admin said that due to the length of time that elapsed between the incident and the facility becoming aware of it; the pending discharge of the alleged perpetrator; and safe surveys conducted on other residents that did not reveal any concerns of safety from other residents, she did not feel that this warranted reporting to the SSA. The Admin stated if she had been notified immediately by staff of the allegations, she would have reported the incident to the SSA if she felt that the resident was in danger, but she didn't feel like she was. She continued to explain that because the resident did not have any adverse reaction to the sexual abuse and it was a one-time occurrence, she did not feel it was necessary. The admin stated negative outcomes did not determine the threshold of reporting incidents at the facility. The facility provided the internal investigation file related to Resident #1 and the allegations of sexual abuse. Record review of the file revealed: a) transcript of an interview with CNA H dated 2/14/2025 4:19 PM b) 5 Resident Safe Surveys all dated 2/14/2025 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c) Record of staff in-service dated 2/18/2025 with DON listed as the instructor. The contents section read any inappropriate behavior between resident to resident must be reported immediately to DON. The in-service included signature pages, signed by 41 staff members. No additional educational materials or handouts were included in the stapled packet. d) Record of staff in-service dated 2/18/2025, titled Abuse and neglect policy with DON listed as the instructor. The signature pages contained 37 staff signatures. A printed copy of the policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program (revised April 2021) was included in the stapled packet. e) Printouts of Resident #1's physician orders, dated 2/18/2025 f) Printouts of Resident #1's progress notes, dated 2/18/2025 In a subsequent interview on 4/29/2025 at 9:15 AM, the Admin stated LVN G's employment was terminated on 2/11/2025 for unrelated performance and behavioral issues. Interview with 10 residents(#2, 16, 17, 18, 19, 20, 21, 22, 23 and 24) on 05/01/2025 between 2:30PM and 3:45PM, for follow up safe survey were asked if any other residents had ever made them feel unsafe or behaved inappropriately towards them, all 10 responded no. A record review of the facility policy titled Accidents and Incidents- Investigating and Reporting revised 2017, indicated in item #1: the nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. The policy did not include information regarding submission of the investigation to the SSA. A record review of the facility policy titled Abuse, Neglect, and Exploitation and Misappropriation Prevention Program revised April 2021, reflected in item #9 investigate and report any allegations within timeframes required by federal guidelines.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51512 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse are reported not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse, to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with state law established procedures for 1 (Resident #1) of 7 residents reviewed for abuse, neglect, and exploitation. The facility failed to report unwanted sexual exposure/sexual abuse to the Administrator and SSA from a resident to Resident #1. This failure puts residents at risk for abuse and diminished quality of life. Findings included: Record review of Resident #1's facesheet reflected an [AGE] year-old female with admitted [DATE]. Relevant diagnoses included anxiety disorder, depression, and aftercare following joint replacement surgery. Review of Resident #1's quarterly MDS submitted on 4/3/2025 noted that BIMS score was not assessed. The prior quarterly MDS, submitted on 11/21/2024, reflected a BIMS score of 15, indicating intact cognition. Record review of Resident #1's progress notes revealed an entry authored by LVN G on 2/2/2025 at 10:59 PM that stated: Res. Told CNA on Saturday 2-1-25 and Sunday 2-2-25 that her Neighbor has appeared at her door the last two night exposing himself and masturbating at her door [sic]. Further review of Resident #1's progress notes revealed an entry on 2/14/2025 at 5:51 PM, authored by LSW B. In these notes, LSW B documented her interview with Resident #1 about the incident and education to staff regarding the need for staff to notify nurse managers and/or social workers when any incidents related to [resident to resident] occurred. LSW B documented a follow-up progress note on 2/18/2025 at 8:57 AM indicating that the resident's psychologist was notified of the incident and would speak to the resident for evaluation. Record review of the facility's incident report for February 2025 did not reflect an entry for Resident #1, however, in subsequent staff interviews, it was revealed that an investigation had been performed by the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #6's facesheet reflected a [AGE] year-old male with admitted [DATE] and discharge date of [DATE]. Relevant diagnoses included unspecified dementia [a progressive disorder that impairs thought processes, such as memory, thinking, reasoning, and decision-making], unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; cognitive communication deficit; and muscle weakness (generalized). Resident #6's quarterly MDS submitted on 1/30/2025, reflected a BIMS score of 5, indicating severely impaired cognition. In Section E, this MDS also indicated that Resident #6 did not have indicators of psychosis (question E0100), did not have behavioral symptoms exhibited towards others (question E0200), or have history of wandering (E0900). Record review of Resident #6's progress notes revealed an entry on 12/12/2024 noting Resident #6 continu[ed] to roam building. An additional progress note entered on 1/23/2025 noted behaviors: wandering, chronic. On 2/11/2025, an entry by LSW B stated resident found in lobby [with] hands in pants rubbing himself. In an interview with Resident #1 on 4/16/2025 at 8:55 AM, Resident #1 stated she was laying in bed and an unknown man entered her room by wheelchair and began masturbating. She reported that she notified 2 to 3 staff members of the incident, and she was told that the resident had been running around the whole building doing that. She was also told that the man was no longer a resident at the facility. She stated the sexual abuse only happened one time and reported feeling safe at the facility. CNA H was interviewed on 4/29/2025 at 11:34 AM. CNA H stated Resident #1 told her on at least 2 separate occasions that she had been sexually abused by Resident #6. CNA H reported Resident #1 seemed upset and scared when she reported the sexual abuse. CNA stated she did not witness sexual abuse of Resident #1, nor did she see Resident #6 entering or exiting Resident #1's room. CNA H stated she had observed Resident #6 frequently wandering the resident halls in his wheelchair. CNA H stated that she reported the abuse allegations to LVN G on at least 2 separate occasions. CNA H was unsure of the exact dates that these events occurred but felt certain that 2 of the instances were at least a week apart, as she worked weekend shifts exclusively at the time. CNA H recalled that LVN G's response was dismissive in nature and LVN G attributed Resident #1's allegations to the resident being confused. LVN G also responded that she would speak to the resident. CNA H did not consider Resident #1 to be confused or have altered cognition at the time of the incident. CNA H confirmed during the interview she had participated in training about abuse/neglect and reporting abuse/neglect. At the time of the incident, she was unaware that she should report abuse to the Admin/Abuse Coordinator but received an in-service regarding reporting abuse to the Admin when she made her statement about the incident to the facility. (continued on next page)

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	455628	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with LVN G on 4/29/2025 at 12:42 PM. LVN G confirmed she had been the nurse caring Resident #1 on or about 2/2/2025 but denied being told by allegations of sexual abuse to Resident #1 by any staff member or the resident. LVN G was unsure if the allegations were factual and felt the allegations were a rumor. She did not witness Resident #6 entering or exiting Resident's #1 room. LVN G did not observe any mood or behavioral changes at the time of the incident. LVN G said she had only heard about the sexual abuse allegations through hearsay or possibly in shift report. LVN G said she did not speak to Resident #1 about the sexual abuse allegations while serving as her primary nurse because she had [her] own problems to deal with. She did not report the abuse to the facility because it was her understanding that the allegations were already known by the facility. She denied knowing which staff member had reported the allegations to the facility. LVN G confirmed she had received training about abuse/neglect and reporting abuse/neglect from the facility. She stated reports of abuse/neglect were to be reported to the Admin. In an interview with LSW B on 4/16/2025 at 9:51 AM, LSW B reported that she was notified on 2/14/2025 of the sexual abuse by a third party professional affiliated with the facility; not by facility staff. After being notified, LSW B stated she immediately met with the resident to assess her for any psychosocial distress and trauma related concerns and had no concerning findings. LSW B stated she reported the incident to the facility abuse coordinator/administrator for further investigation, and she also referred the resident to the psychologist for further evaluation. In a subsequent interview with LSW B on 4/29/2025 at 9:30 AM, LSW B confirmed Resident #6 had been identified during the facility investigation as the alleged perpetrator of the sexual abuse of Resident #1 based on physical description and behaviors. LSW B stated Resident #6 was known to roam the facility, but she was not aware of any instances of him entering any residents' rooms. LSW B confirmed the 2/11/2025 incident documented in Resident #6's progress notes. She stated Resident #6 was observed in the communal lobby area with his hands in his pants and touching his genital area. Another resident observed the behavior and notified her, and LSW B responded by relocating Resident #6 to his room. She then notified the nurse and the Admin of the incident. LSW B reported Resident #6 was not receiving psychiatric services due to the extent of his dementia. In an interview on 4/17/2025 at 9:13 AM, the DON reported the facility's expectation of staff notifying leadership of allegations of abuse/neglect/exploitation is immediate notification. The DON was unsure why LVN G did not notify anyone about Resident #1's abuse allegation. She confirmed that an investigation had been initiated and completed by the facility after becoming aware of the allegations. The DON was unsure if the sexual abuse allegations were reported to the SSA. As a result of the investigation, the DON said she performed staff in-services regarding abuse reporting. The DON was interviewed again on 4/29/2025 at 2:00 PM and reported awareness of Resident #6's wandering behaviors and denied knowledge of sexually inappropriate behaviors other than the incident on 2/11/2025 and the allegations made by Resident #1. She said the wandering behaviors were managed by increased supervision. The DON did not feel like other behavioral interventions were necessary after the 2/11/2025 incident as the resident was pending discharge and the increased supervision was sufficient management. An interview was conducted with the Admin/Abuse Coordinator on 4/17/2025 at 10:23 AM. The Admin confirmed that she was aware of this incident, and stated she had not been notified by facility staff of the incident. She reported an investigation of the allegations beginning 2/14/2025 with completion date of 2/18/2025. The Admin reported no additional concerns of abuse from any residents. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Admin said that due to the length of time that elapsed between the incident and the facility becoming aware of it; the pending discharge of the alleged perpetrator; and safe surveys conducted on other residents that did not reveal any concerns of safety from other residents, she did not feel that this warranted reporting to the SSA. The Admin stated if she had been notified immediately by staff of the allegations, she would have reported the incident to the SSA if she felt that the resident was in danger, but she didn't feel like she was. She continued to explain that because the resident did not have any adverse reaction to the sexual abuse and it was a one-time occurrence, she did not feel it was necessary. The admin stated negative outcomes did not determine the threshold of reporting incidents at the facility. The facility provided the internal investigation file related to Resident #1 and the allegations of sexual abuse. Record review of the file revealed: a) transcript of an interview with CNA H dated 2/14/2025 4:19 PM b) 5 Resident Safe Surveys all dated 2/14/2025 c) Record of staff in-service dated 2/18/2025 with DON listed as the instructor. The contents section read any inappropriate behavior between resident to resident must be reported immediately to DON. The in-service included signature pages, signed by 41 staff members. No additional educational materials or handouts were included in the stapled packet. d) Record of staff in-service dated 2/18/2025, titled Abuse and neglect policy with DON listed as the instructor. The signature pages contained 37 staff signatures. A printed copy of the policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program (revised April 2021) was included in the stapled packet. e) Printouts of Resident #1's physician orders, dated 2/18/2025 f) Printouts of Resident #1's progress notes, dated 2/18/2025 In a subsequent interview on 4/29/2025 at 9:15 AM, the Admin stated LVN G's employment was terminated on 2/11/2025 for unrelated performance and behavioral issues. A record review of the facility policy titled Accidents and Incidents- Investigating and Reporting revised 2017, indicated in item #1: the nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. The policy did not include information regarding submission of the investigation to the SSA. A record review of the facility policy titled Abuse, Neglect, and Exploitation and Misappropriation Prevention Program revised April 2021, reflected in item #9 investigate and report any allegations within timeframes required by federal guidelines.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51512 Based on interviews and record reviews, the facility failed to ensure each resident receives adequate supervision to prevent accidents for 1 of 3 residents (Resident #2) reviewed for quality of care. The facility to provide supervision of Resident #2 while he was showering causing the resident to exit the bathroom independently. These failures could lead to injury or decreased quality of life. Findings included: 1. Record review of Resident #2's face sheet dated 4/15/2025 reflected an [AGE] year-old man with an initial admitted [DATE]. Relevant diagnoses included other asthma (a respiratory disorder that can cause restriction of the lung tissue and difficulty breathing), chronic obstruction pulmonary disease (an ongoing respiratory disease that causes decreased oxygenation and difficulty breathing), other lack of coordination, muscle weakness (generalized), and unsteadiness on feet. Record review of Resident #2's quarterly MDS submitted on 4/1/2025 reflected a BIMS score of 13, indicating intact cognition. Question GG0130 of the MDS noted that Resident #2 required partial/moderate assistance for showering and bathing. Resident #2's comprehensive care plan, date printed 4/15/2025, also noted that the resident required partial assistance by 1 staff when showering. In an interview with Resident #2 on 4/16/2025 at 10:01 AM, the resident reported being left unsupervised in the shower located within his private restroom during a routine shower earlier that morning. The resident stated CNA E assisted him into the shower, then left the area. The resident used the call light to request assistance with exiting the bathroom because he feared that he would fall on the wet tile. The resident reported that the call light was not answered, so he hit the bathroom wall with his hands and yelled for help. The resident stated he felt difficulty breathing during this time due to the heat and humidity as well as fear. The resident then felt he could not wait any longer for assistance, so he ambulated to his wheelchair and exited the restroom without assistance. The resident reported waiting approximately 20 minutes for help prior to ambulating. After dressing himself, the resident stated LVN A entered the room, followed by CNA E. The resident explained to LVN A that he was left alone in the shower, and LVN A reportedly told CNA E that this can't happen and you can't leave him alone in the shower. LVN A was interviewed on 4/16/2025 at 10:07 AM, and she confirmed that she responded to Resident #2's call light. She also confirmed that he reported to her that he had been left unsupervised in the shower and had independently exited the restroom. LVN A stated residents should never be left alone while bathing, and she reported providing re-education to CNA E after Resident #2 notified her of the incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA E was interviewed on 4/16/2025 at 10:34 AM. CNA E was asked if she ever leaves residents unsupervised while they are showering. CNA E responded yes, they don't like us being in there, like [Resident #2]. CNA E elaborated her answer by explaining that after she helps residents into the shower, she will leave the resident's room to assist a different resident or to obtain supplies. She reported that she ensures their safety by try[ing] not to go far and checking on the residents. CNA E was then asked if it was the facility policy to leave residents unattended or unsupervised while they were showering, and she responded no. CNA E responded that residents could slip on soap if they try to stand up when asked what potential harm could result from residents showering without supervision. The DON was interviewed on 4/17/2025 at 09:13 AM. She reported that residents should not be left unsupervised in the shower by staff. The DON was aware of the incident with CNA E leaving Resident #2 and reported re-education of CNA E regarding resident safety during showers. Documentation of this re-education was provided to survey team on 4/17/2025 at 12:05 PM, in the form of an in-service signed by CNA E titled showers and listed contents all residents must be supervised during showers/ abuse and neglect.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51512 Based on observation, interviews, and record reviews, the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice and the comprehensive care plan for 1 of 3 residents (Resident #2) reviewed for quality of care. The facility failed to ensure Resident #2 had signed physician's orders and care planning for nightly use of continuous positive airway pressure (CPAP) therapy. This failure could place residents at risk for inadequate oxygenation and respiratory complications. Findings included: Record review of Resident #2's face sheet dated 4/15/2025 reflected an [AGE] year-old man with an initial admitted [DATE]. Relevant diagnoses included other asthma (a respiratory disorder that can cause restriction of the lung tissue and difficulty breathing), chronic obstruction pulmonary disease (an ongoing respiratory disease that causes decreased oxygenation and difficulty breathing), and obstructive sleep apnea (a blockage of the airway when sleeping that causes decreased oxygenation). Record review of Resident #2's quarterly MDS submitted on 4/1/2025 reflected a BIMS score of 13, indicating intact cognition. Resident #2 was observed and interviewed on 4/15/2025 at 1:48 PM. The resident was observed to have an oxygen concentrator present in his room. A CPAP therapy device was noted on the nightstand next to the bed. The resident confirmed that he utilized the oxygen concentrator to delivery oxygen by means of nasal cannula when he needed it, and he confirmed that he uses the CPAP therapy every night. The resident stated that he applied both devices (the nasal cannula and the CPAP mask) to his face independently. A record review of Resident #2's current, active orders as of 4/15/2025 revealed one order for oxygen use, dated 11/27/2024. The order read may use portable O2 when out on appt 2-4L to maintain O2 sats >90% as needed for s/sx of hypoxia [sic]. No active orders for oxygen use while at facility or CPAP therapy were located within the medical record. A review of Resident #2's documented vital signs was performed to confirm that resident utilized PRN oxygen. Records indicated that in the 30 days prior to survey, oxygen was in use via nasal cannula on 3/31/2025 at 01:06 AM. The quarterly MDS submitted on 4/1/2025 indicated no in Section O for the question regarding the resident's use of oxygen therapy and the question regarding the resident's use of non-invasive mechanical ventilation (which includes CPAP therapy). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2's comprehensive care plan, printed 4/15/2025, was reviewed and contained a focus area related to supplemental oxygen use, with a listed intervention of PRN oxygen at a rate of 2-4 liters/minute to maintain oxygen saturation rate >90% (date initiated 7/12/2024). Further review of the care plan did not reveal any mention of CPAP therapy or maintenance of the therapy device. An interview was conducted on 4/17/2025 at 08:36 AM with LVN A. LVN A reported that Resident #2 typically used 2 liters/minute of oxygen to nasal cannula when he was at physical therapy or when he's standing for a long period of time. She elaborated that this usage occurs almost daily, and she confirmed that it is her understanding that he used CPAP every night, although she did not work night shift and had not observed him using it directly. LVN A reported that the amount of oxygen Resident #2 used was included in an order, and when notified that the surveyor could not locate an order for PRN oxygen use in the facility or for CPAP therapy, LVN A reviewed the medical record and confirmed that these orders were not present but that they should be. LVN A reported that not having these orders in place could cause inadequate oxygenation of a resident if they did not receive the amount of oxygen they needed. In an interview on 4/17/2025 at 09:13, the DON confirmed that Resident #2 should have signed physician's orders in place and care planning for CPAP therapy. The DON also stated if a resident was self-applying oxygenation devices, the nursing staff should be ensuring that it has been done correctly by assessing the application and checking vital signs, if needed. Record review of facility policy Oxygen Administration (revised October 2010) revealed under subheading preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51512 Based on observations, interviews, and record reviews, the facility failed to store all drugs in locked compartments for 4 of 4 residents (Resident #2, Resident #3, Resident #4, and Resident #5) reviewed for self-administration of medications. The facility failed to ensure that residents (Residents #2-5) with physician orders to self-administer medications had methods of securing medications that prevented other residents from having access. This failure could lead to unintended access and ingestion of medication causing illness. Findings included: In an interview with the DON on 4/17/2025 at 09:13 AM, the DON reported that 4 total residents at the facility have physician orders to self-administer medications. The DON provided the names of the four residents (Residents #2-5). Record review of the residents' electronic medical records revealed the following: Resident #2's face sheet dated 4/15/2025 reflected an [AGE] year-old male with an initial admitted [DATE]. Relevant diagnoses included occipital neuralgia (severe pain in the back of the head and neck) and idiopathic peripheral autonomic neuropathy (chronic nerve pain and/or numbness). Resident #2's quarterly MDS submitted on 4/1/2025 reflected a BIMS score of 13, indicating intact cognition. Active physician orders for the resident included: a. Fluticasone propionate nasal suspension 50mcg/act, 1 spray in both nostrils in the morning for allergies unsupervised self-administration (order dated 12/13/2024) b. Lidocaine HCl external cream 4%, apply to ble topically at bedtime for neuropathy pain unsupervised self-administration (order dated 12/13/2024) c. Systane complete ophthalmic solution, instill 1 drop in both eyes every 4 hours as needed for dry eyes unsupervised self-administration (order dated 12/13/2024) d. Diclofenac sodium external gel 1%, apply to knees, ankles, feet topically every 6 hours for pain- mild; pain [sic] unsupervised self-administration apply 4 grams (order dated 12/7/2024) Resident #3's facesheet dated 4/17/2025 reflected a [AGE] year-old-male with readmitted [DATE]. Relevant diagnoses included repeated falls, other abnormalities of gait and mobility, and unspecified asthma (a breathing disorder that causes constriction of the airway and inhibits breathing). Resident #3's annual MDS submitted 1/30/2025 reflected a BIMS score of 15, indicating intact cognition. Active physician orders for the resident included: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Trelegy ellipta inhalation aerosol powder breath activated 200-62.5mcg/act, 1 puff inhale orally one time a day for asthma unsupervised self-administration. Rinse mouth after use (order dated 4/16/2025) Resident #4's facesheet dated 4/17/2025 reflected an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included unspecified asthma and unspecified glaucoma (damage to the nerves of the eye causing vision loss). The annual MDS submitted on 3/25/2025 reported a BIMS score of 15, indicating intact cognition. Active physician orders for the resident included: a. Fluticasone-salmeterol aerosol powder breath active 100-50mcg/dose, 1 inhalation inhale orally every 12 hours for SOB unsupervised self-administration. Rinse mouth after use (order dated 8/31/2024) b. Latanoprost solution 0.005%, instill 1 drop in both eyes at bedtime unsupervised self-administration (order dated 8/28/2024) c. Propylene glycol-glycerin ophthalmic solution 1-0.3%, instill 1 drop in both eyes one time a day for dry eyes unsupervised self-administration (order dated 8/28/2024) d. Timoptic ophthalmic solution 0.5%, instill 1 drop in both eyes two times a day for glaucoma unsupervised self-administration (order dated 8/29/2024) Resident #5's facesheet dated 4/17/2025 reflected a [AGE] year-old female initially admitted to the facility on [DATE]. Relevant diagnoses included other seasonal allergic rhinitis (seasonal allergies causing runny nose), absolute glaucoma, bilateral (vision loss in both eyes from nerve damage), and reduced mobility. Active physician orders for the resident included: a. Artificial tears ophthalmic solution 0.2-0.2-1%, instill 1 drop in both eyes every 4 hours as needed for dry itchy eyes unsupervised self-administration (order dated 8/29/2023) b. Artificial tears ophthalmic solution 0.2-0.2-1%, instill 1 drop in both eyes every 2 times a day for dry itchy eyes unsupervised self-administration (order dated 8/29/2023) c. Biofreeze external gel 4% (menthol topical analgesic), apply to affected areas topically every 6 hours as needed for joint pain unsupervised self-administration (order dated 6/08/2023) d. Biofreeze Professional external gel 5% (menthol topical analgesic), apply to bilateral ankle topically every 4 hours as needed for pain can keep at bedside (order dated 8/30/2024) e. Blink tears ophthalmic gel 0.25%, instill 1 drop in both eyes two times a day for dry eyes unsupervised self-administration (order dated 8/15/2023) f. Voltaren arthritis pain external gel 1%, apply to bil knees and shoulders topically every 6 hours as needed for pain . unsupervised self-administration 4GMs to joints NTE 32 GMs in 24 hours (order dated 6/09/2023) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/15/2025 at 1:48 PM, Resident #2 was observed storing 5 medications in a dresser drawer without a lock in his room. Resident #3 was observed on 4/17/2025 at 1:55 PM storing 1 medication in the drawer without a lock of the nightstand next to his bed. Resident #4 was observed storing 4 medications on the top surface of the nightstand on 4/17/2025 at 1:45 PM, and Resident #5 was observed storing 2 medications on top of the bedside table next to the bed on 4/16/2025 at 8:37 AM. All four residents were interviewed at the time of the observations and all reported that the storage method observed was the usual means of storage. In an interview with the DON on 4/17/2025 at 09:13 AM, the DON said medications were safely stored in the rooms of residents who self-administer medications because staff keeps the medications high where they can't reach them. The DON said that residents were told not to keep the medications in their bedside nightstands or anywhere that is in sight. The DON was informed of the survey team's observations of storage of the self-administered meds, and the DON stated she had intentions to implement lockboxes or locking drawers for safety. Record review of a policy related to self-administration of medications reflected the policy does not address storage of medications in a resident's room.