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F 000	INITIAL COMMENTS A complaint investigation was conducted 4/9/25-4/11/25. Event ID #LV1Z11. The following intakes were investigated NC00228999 and NC002279171. 1 of 4 allegations resulted in a deficiency. Intake NC00229171 resulted in immediate jeopardy. Past non-compliance was identified at: CFR 483.12 at tag F600 at a scope and severity (J) The tag F600 constituted Substandard Quality of Care. Immediate jeopardy began on 4/4/25 and was removed on 4/6/25. A partial extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		

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

Electronically Signed | 04/22/2025

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.

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F 600	Continued From page 1 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record reviews, and interviews with staff, Physician Assistant, and responsible party (RP), the facility failed to protect 2 cognitively impaired residents' right to be free from sexual abuse. On 4/4/25 at approximately10:00 PM, a Medication Aide observed a female resident (Resident #1) in a male resident's (Resident #2) room sitting upright on Resident #2's bed. Resident #2 was standing in front of Resident #1 with his pants down and his penis inside of her mouth. When the Medication Aide asked what was going on, Resident #2 backed away from Resident #1 removing his penis from her (Resident #1) mouth. The residents did not have the capacity to consent to sexual relations. Resident #1's RP stated due to Resident #1's advanced dementia she was not aware of her behaviors and had no insight into what happened. A reasonable person expects to be protected from abuse in their home environment and would have experienced trauma with feelings such as fear, humiliation, anger, anxiety, and depressed mood as a result of the intimate sexual relations enacted without the capacity to consent. This deficient practice affected 2 of 3 residents (Resident #1 and Resident #2) reviewed for abuse. The findings included: Resident #1 was admitted to the facility on 1/18/24 with diagnoses that included Alzheimer's disease, communication deficit and dementia. The quarterly Minimum Data Set (MDS)	F 600	Past noncompliance: no plan of correction required.	

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assessment dated 1/7/25 revealed Resident #1 had unclear speech, had difficulty making herself-understood and was severely cognitively impaired. Resident #1 had no behavioral symptoms and she wandered 1 to 3 days during the 7-day MDS look back period. Resident #1 required 1-person assistance from staff for activities of daily living and supervision or touching assistance with ambulation.

Resident #1's revised care plan dated 1/7/25 included a focus area for impaired cognitive function and impaired thought process related to dementia/Alzheimer's disease. Resident #1's care plan did not identify any sexually inappropriate behaviors.

Resident #2 was initially admitted to the facility on 9/3/21 and most recently readmitted on 3/27/25 with diagnoses that included dementia, mood disturbance, anxiety and depression.

Resident #2's revised care plan dated 2/17/25 included a focus area for behaviors of disrobing in common areas, wandering in other resident rooms, and inappropriate behaviors toward others. Resident #2 had potential sexual behaviors exhibited by attempting to invite other residents into his room. Resident #2 had a behavior problem as evidence by wandering and threatening behavior towards other residents. He had the potential to become aggressive when his space was invaded without warning. Resident #2 was historically territorial over his room and personal space. The goal included Resident #2 would not demonstrate inappropriate sexual behaviors. The approaches included notifying physicians of behavior; staff to monitor behaviors, offer redirection and provide structured activities;

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and staff to provide one to one (1:1) monitoring for inappropriate behaviors.

The quarterly MDS assessment dated 3/31/25 revealed Resident #2 was severely cognitively impaired and had no behavioral symptoms or wandering during the 7-day MDS look back period. Resident #2 was independent with dressing, transfers, and ambulation.

A physician order for Resident #2 dated 3/31/25 revealed Depakote (a mood stabilizer that can be used to decrease sexual urges) 125 milligrams one tablet daily and estradiol (synthetic form of estrogen) transdermal patch 0.1 milligrams to be applied on the right shoulder weekly for sexual behavior.

The incident report completed by Nurse #1 on 4/4/25 at 9:45 PM revealed Resident #1 was found in Resident #2's room performing oral sex on Resident #2. Both residents were separated immediately. Skin assessments were done for both residents and there were no injuries noted. The physician, responsible parties for both residents and Director of Nursing were notified of the incident.

The initial allegation report dated 4/4/25 completed by the Administrator indicated Resident #1 and Resident #2 resided on the memory care unit. Resident #1 was noted in Resident #2's room with Resident #2's penis exposed. Both residents were placed on 1:1 observation. The physician, state agency, local law enforcement and responsible person(s) for both residents were notified. No injury or harm or change of condition noted for either resident and they were each at baseline mental and physical

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status.

The Medication Aide's statement dated 4/4/25 revealed the Medication Aide was looking for another resident to administer medications when he walked into Resident #2's room and saw Resident #1 sitting on the bed. Resident #2 was standing in front of Resident #1 with his pants down and his penis in Resident #1's mouth. He asked what they were doing and Resident #2 backed up and pulled his pants up. Resident #1 was removed from the room and he (the Medication Aide) got the nurse.

A telephone interview was conducted on 4/10/25 at 9:45 AM with the Medication Aide who stated Resident #2's room was at the end of a hall and he did not have a roommate. On 4/4/25 around 10:00 PM he walked to Resident#2's room and the door to the room was open. Resident #1 was observed to have her mouth around the penis of Resident #2. The Medication Aide stated Resident #2 was standing on the floor at the head of the bed with his pants down and Resident #1 was seated on the edge of the bed with her right knee down on the floor. She was actively performing oral sex on Resident #2. The Medication Aide stated when he asked what was going on Resident #2 backed away and pulled up his pants. Both residents were separated immediately. There were no visible signs that Resident #2 forced Resident #1 to perform oral sex. The Medication Aide stated Resident #2's penis was flaccid after he removed his penis from Resident #1's mouth and Resident #1 was removed from the room with the assistance of Nurse Aide #1. He stated he asked Resident #1 what happened, and she was unable to state what happened. Resident #1 left the room with

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Nurse Aide #1 in no apparent distress. The nurse was immediately notified of the incident. He further stated within 15 minutes sitters were sent to each of the residents' rooms for 1:1 monitoring. The Medication Aide stated Resident #2 had been moved to another unit about two years ago before coming back to the memory care unit on 3/7/25 due to a history of inappropriate sexual behaviors and comments. Resident #2 previously made the statement "can an old man get some before he dies".

An interview was conducted on 4/9/25 at 3:29 PM with Nurse Aide #1 who assisted Resident #1 back to her room following the incident on 4/4/25. The Nurse Aide stated when she entered the room, both residents had already been separated and Resident #2 was already dressed. Resident #1 was unable to state what happened when asked and she willingly left the room. Nurse Aide #1 stated Resident #1 did not show any visible distress, voiced no complaints, and expressed no discomfort. Nurse Aide #1 stated she sat with Resident #1 until Nurse #1 did a full assessment. The assigned sitter arrived after completion of the assessment.

A telephone interview was conducted on 4/9/25 at 2:26 PM with Nurse #1 who stated on 4/4/25 the Medication Aide reported that Resident #2 was in his room standing in front of Resident #1 with his pants down. Resident #1 was sitting on the bed. Resident #1 was observed in Resident #2's room actively performing oral sex on Resident #2. She indicated she last saw Resident #2 in the dayroom a little after 9:00 PM and could not recall the location of Resident #1. She further stated she went to Resident #2's room and both residents had already been separated and

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Resident #1 had been taken to her room by Nurse Aide #1. She stated she did a head-to-toe assessment of Resident #2 who had no complaints or injuries. Nurse #1 stated she asked Resident #2 what happened and Resident #2 put his head down. Nurse #1 reported she did Resident #1's head-to-toe assessment and no injuries were noted. Following the assessments, she notified Nurse #2 who immediately came to the unit and provided 1:1 sitters to monitor both residents.

Attempts were made to contact Nurse #2 on 4/10/25 at 1:43 PM and 4/11/25 at 9:00 AM. She was unable to be reached for interview.

Resident #2's RP was contacted on 4/9/25 at 2:37 PM and 4/10/25 at 1:15 PM and was unavailable for interview.

A telephone interview was conducted on 4/10/25 at 1:08 PM with Resident #1's RP who stated he received a call from the Director of Nursing who informed him of the 4/4/25 incident. He stated due to Resident #1's advanced dementia she was not aware of her behavior and had no insight into what happened.

A full body assessment dated 4/4/24 at 10:35 PM completed by the Director of Nursing revealed Resident #1 was assessed due to resident-to-resident sexual abuse. No negative findings were observed.

A full body assessment dated 4/4/25 at 10:38 PM completed by the Director of Nursing revealed Resident #2 was assessed due to resident-to-resident sexual abuse. No negative findings.

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An interview was conducted on 4/9/25 at 3:30 PM, with the Director of Nursing (DON) who stated she received a call on 4/4/25 around 10:00 PM about the incident. She notified the Administrator who came into the facility with her to initiate a full investigation. She reported when they arrived at the facility, both residents had been separated and placed on 1:1 monitoring with sitters. The DON stated Nurse #1 completed skin assessments and contacted the physician assistant who gave instructions to contact the families and inform them of the incident and offer each of them the option to have the resident transferred to the hospital for evaluation to rule out a sexually transmitted disease. The DON further stated she also did a complete head-to-toe assessment of both residents and did not have any negative findings mentally or physically. Following the completion of the physical assessments, she contacted the RPs for both residents and informed them of the incident and offered them a transfer to the hospital for further evaluation and both families declined transfer. Neither family reported any concern with the information provided or the investigation process. The DON stated Resident #1 did not have any known sexual behaviors prior to the incident. The DON asked Resident #1 what happened, and she was unable to state what happened due to her severe cognitive impairment and dementia. Resident #1 did not have the capacity to consent to any sexual activity. Resident #2 was also diagnosed with dementia and had limited insight into what happened or the significance of the inappropriate behavior. The DON reported Resident #2 had a documented history of inappropriate sexual behaviors of touching others without consent and making

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sexual comments. She reported the behaviors were addressed on the care plan with 1:1 supervision, redirection to activities of interest, psychiatric evaluations, transfer to another unit and medication adjustment. The family requested Resident #2 be returned to the memory care unit for safety reasons due to a recent fall. She further stated she was aware all residents must be protected from any form of abuse and the interdisciplinary team would review the current behavior plans for all residents. Resident #2's current medications at the time of the incident included the estradiol transdermal patch and Depakote to address the inappropriate sexual behaviors. The Depakote was increased after the 4/4/25 incident.

An interview was conducted on 4/10/24 at 9:45 AM with the Social Worker who stated Resident #2 had a history of inappropriate sexual advances toward others. The Social Worker reported Resident #2 would attempt to inappropriately touch others or make sexual comments or advances. Resident #2's RP was aware of the inappropriate sexual behaviors and the use of medication to address the behaviors. Resident #2 had been on the memory care unit in the past but had been transferred to another unit for inappropriate sexual advances and comments about a year and half ago. He had 1:1 supervision on the unit. Resident #2 recently returned from the hospital and the family requested the resident return to the memory care unit for safety reasons due to recent falls. The Social Worker stated there had been no previous incident of Resident #1 exhibiting any sexual behaviors toward others.

An interview was conducted on 4/10/25 at 10:00AM with the Physician Assistant who stated

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he received a call on 4/4/25 about inappropriate sexual activity between Resident #1 and Resident #2. He stated he gave the nurse instructions to offer the residents family the option for hospital transfer for evaluation for sexually transmitted diseases. He was informed both residents had been separated and placed on 1:1 monitoring. He further stated he had a discussion with the Director of Nursing who informed him both resident's family declined the hospital evaluation, therefore he ordered a psychiatric evaluation. Review of the skin assessments done by nursing and the Director of Nursing revealed there was no evidence of any sexual penetration other than the visible observation made by the medication aide. The Physician Assistant indicated Resident #1 and Resident #2 did not have the capacity to consent due to their diagnosis of dementia. Resident #1 did not exhibit any inappropriate sexual behavior prior to the 4/4/25 incident. Resident #2 had been on estradiol transdermal patch weekly and Depakote 125 milligram daily to address inappropriate sexual behaviors for more than a year along with intermittent 1:1 supervision on different units.

An interview was conducted on 4/10/25 at 5:30 PM with the Administrator who stated when he received the call on 4/4/25 about the incident between Resident #1 and Resident #2, he came to the facility along with the Director of Nursing to investigate the incident. He reported the nursing team handled the residents' care and assessments and he completed the documents and reporting process to the local authorities and state agencies in accordance to facility policies and procedures and federal regulations. The Administrator acknowledged that all residents must be protected from any form of abuse. He

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stated the interdisciplinary team would evaluate the current behavior plans for all residents.

The Administrator was notified of the Immediate Jeopardy on 4/10/25 at 4:36 PM.

The facility provided the following Corrective Action Plan:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
The facility identified an incident where residents' rights to be free from sexual abuse were not adequately protected. On 04/04/2025 at 10:00 PM, a Medication Aide observed an incident between Resident #1, a female resident with severe cognitive impairment related to dementia/Alzheimer's Disease (last seen between 8:45 PM and 9:00 PM by a CNA), and Resident #2, a male resident with severe cognitive impairment (last seen by a nurse at 9:03 PM). Resident #2 had a care plan for behaviors including wandering and disrobing due to personal preference to sleep without clothing and brief. The incident occurred in Resident #2's room where the Medication Aide observed Resident #1 sitting upright on the bed with Resident #2 standing in front of her. Resident #2's penis was in Resident #1's mouth; the penis was observed to be flaccid. When the Medication Aide asked what was going on, Resident #2 backed away, removing his penis from Resident #1's mouth. Neither resident possessed the cognitive capacity to consent to sexual activity.

Upon discovering the incident on 04/04/2025 at 10:00 PM, the Medication Aide immediately separated the residents and notified the Charge

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Nurse. The Charge Nurse promptly conducted initial physical assessments of both residents, with no immediate concerns identified. No evidence of ejaculation was noted in Resident #1's mouth. Both residents were immediately placed on 1:1 supervision by nursing staff following the incident to ensure their safety and prevent recurrence. As of 04/11/2025, both Resident #1 and Resident #2 are still residents at the facility and currently remain on 1:1 supervision.

On 04/04/2025 at 11:00 PM, Residents #1 and #2 were assessed by the Director of Nursing (DON), including complete skin assessments, with no injuries noted. The DON notified the primary care physician for both residents at 10:30 PM on 04/04/2025. The physician did not provide any new orders at that time. At 11:30 PM on 04/04/2025, the DON completed further assessments for Residents #1 and #2, including behavior assessments and updated sexual behavior assessments, covering areas such as trauma, psychosocial status, behavior monitoring, sexual history/activity, and change in condition evaluation. Also at 11:30 PM on 04/04/2025, the Director of Nursing notified the responsible parties for Residents #1 and #2 of the incident, with detailed documentation of these conversations obtained and filed.

The DON notified the psychiatric services provider on 04/05/2025 at 1:44 AM. A medication review was conducted for both residents by the Psychiatric Provider on 04/05/2025 at 1:44 AM, resulting in new orders for Resident #2 that were implemented immediately upon receipt. For Resident #2, the psychiatric provider increased the dosage of his prescribed mood stabilizer

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(Divalproex Sodium) to address the inappropriate sexual behaviors. Resident #1 did not require medication changes as her assessment did not indicate a need for pharmacological intervention. The Director of Nursing updated care plans for both residents on 04/04/2025 at 11:45 PM to reflect current status, behavioral interventions, and increased monitoring requirements. For Resident #1, care plan updates included: 1) documentation of the incident, 2) implementation of 1:1 supervision, 3) specific approaches for redirection during periods of increased confusion, 4) activity participation guidelines to promote appropriate social interaction, and the addition of a trauma-informed care approach. For Resident #2, care plan updates included: 1) documentation of the incident, 2) implementation of 1:1 supervision, 3) behavior monitoring with specific triggers and warning signs identified, 4) incorporation of the psychiatric provider's medication recommendations including monitoring parameters for the increased mood stabilizer dosage, 5) specific interventions for staff to redirect inappropriate sexual behaviors, 6) activity programming to channel energy appropriately. Both care plans include detailed guidance for all shifts and disciplines on prevention strategies, early intervention techniques, and response protocols.

The Administrator notified the local police department at 11:30 PM on 04/04/2025 of the incident/potential abuse, and a formal police report was taken. Adult Protective Services was also notified on 04/04/2025 at 11:35 PM.

A long-term plan for Residents #1 and #2 has been developed. Initially, both residents will remain on 1:1 supervision for 10 days. Both

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Resident #1 and Resident #2 are still residents at the facility and currently remain on 1:1 supervision (as of 04/11/2025). Following this period, the interdisciplinary team will conduct a comprehensive reassessment to determine appropriate ongoing monitoring levels based on individual needs. This may include continued 1:1 supervision, 15-minute checks, or 30-minute checks as determined necessary. Resident #2 will receive ongoing behavioral health services with weekly assessments for the first month. Room placement and activity participation will be carefully monitored to ensure appropriate separation while maintaining quality of life for both residents.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.
All residents are at risk for this deficient practice, particularly those with cognitive impairments. On 04/05/2025, the Director of Nursing individually interviewed all residents with a Brief Interview for Mental Status (BIMS) score of 10 or greater to determine if they had experienced any inappropriate/unwanted sexual contact and if they felt safe in the facility. These interviews were conducted using a standardized interview protocol. Results of these interviews revealed no additional concerns or reports of inappropriate or unwanted sexual contact, and all interviewed residents reported feeling safe in the facility.

On 04/05/2025, licensed nurses, specifically the Unit Managers on each unit, assessed all residents on the secured memory care unit for behaviors using the Behavior Assessment tool (Point of Care User-Defined Assessment). All residents on the secured memory care unit have

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severe cognitive impairment. This assessment revealed no resident who had additional concerns for sexual behaviors or resident abuse. Documentation was completed in each resident's electronic health record.

On 04/05/2025, the Director of Nursing completed comprehensive skin assessments on all residents with a BIMS score of 9 or less to determine if there were any signs or symptoms of abuse, with no additional concerns noted. These assessments included full-body skin checks with documentation of findings in each resident's record.

On 04/05/2025, licensed nursing staff, including Unit Managers and Charge Nurses, updated sexual history/behavior assessment User-Defined Assessment for all residents to ensure complete and current documentation of potential risk factors or concerns. This comprehensive assessment identified residents' normal sexual behaviors, history of inappropriate sexual behaviors, and risk factors that may contribute to sexual behaviors.

On 04/05/2025, the Director of Nursing created a comprehensive list of all residents with behaviors, including those with histories of being sexually inappropriate or care planned for being sexually inappropriate, to ensure appropriate monitoring. This identification process included review of admission assessments, behavior tracking records, care plans, progress notes, and consultation with direct care staff who regularly interact with residents. No additional residents were found to have these behaviors.

3. Address what measures will be put into place

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or systemic changes made to ensure that the deficient practice will not recur.
On 04/05/2025, the Administrator, Director of Nursing, and Quality Assurance (QA) Nurse educated all facility staff on the abuse prohibition and reporting policy, with emphasis on the requirement to document and report any behaviors affecting other residents at the time of occurrence. This education was conducted in person during all shifts through mandatory in-service meetings. The education covered: 1) identification of all forms of abuse including sexual abuse, 2) immediate intervention protocols to ensure resident safety, 3) proper reporting procedures including timeframes and notification chain, 4) documentation requirements, 5) resident rights, and 6) staff responsibilities for prevention and reporting. Following the education session, each staff member's understanding was verified through discussion and response to scenario-based questions. Staff acknowledged their understanding of the material and responsibilities by signing an attestation form, which is maintained in their personnel file. All education is documented in individual personnel files with employee signatures acknowledging understanding. Staff who were not present will not be permitted to work until they receive this education. The Director of Nursing maintains a tracking log to ensure 100% staff completion.

On 04/05/2025, the facility established a comprehensive behavioral monitoring program for residents identified with behaviors such as physical/verbal aggression, wandering, disruptive vocalizations, inappropriate sexual advances, etc., to be placed on 15-minute checks, 30-minute checks by designated nursing staff, or 1:1 supervision for 72 hours or until determination

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can be made for continuation of monitoring.

On 04/05/2025, all staff members (including agency personnel) received comprehensive education about the behavioral monitoring program. This education was provided by the Director of Nursing and Unit Managers. Any staff member not educated by 04/05/2025 will be educated prior to their next scheduled shift. The Administrator is responsible for ensuring this education is completed and documented in personnel files. Education includes dementia-specific training components.

On 04/05/2025, the facility implemented clear staff responsibilities when a behavior is identified, with emphasis on prevention and immediate intervention when abuse is observed or reported. These responsibilities are detailed as follows:

Nurses are responsible for immediately assessing residents involved in reported behavioral incidents for both physical and psychological impacts. They must document comprehensive assessment findings in progress notes including physical and mental status. Nurses implement interventions according to facility protocols and individualized care plans, which include specific approaches for each resident based on their unique needs and triggers. They notify the Unit Manager, Director of Nursing, and Administrator of significant behavioral incidents immediately upon discovery. Nurses contact the appropriate provider for consultation regarding new or modified orders when residents exhibit behavioral changes. They follow the provider's orders and document implementation and resident response. Following incidents, nurses monitor residents closely for

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changes in condition, complete incident reports for all behavioral events per facility policy, conduct thorough shift-to-shift handoff regarding residents with behavioral concerns, ensure appropriate supervision levels are maintained based on resident needs, and report changes in resident condition to primary physician and psychiatric services. Nurses report directly to their Unit Managers for guidance and support when managing resident behaviors.

Nurse Aides immediately report any observed behaviors to the charge nurse/unit manager verbally and document observed behaviors in the Point of Care system at time of occurrence. They implement immediate interventions as directed by care plan (redirection, one-to-one supervision, etc.), monitor residents for escalation or changes in behavior and report changes promptly, and follow specific behavioral care plan approaches for each individual resident. Nurse Aides also follow directives from nurses and/or management regarding interventions for behaviors and use techniques learned in dementia-specific training to de-escalate situations before they progress.

Unit Managers assess residents when behavior is reported, conducting comprehensive evaluations that include physical, cognitive, and psychosocial components. They document assessment findings in progress notes, notify the Director of Nursing/Administrator of behavior incidents, contact primary physician and responsible party as appropriate, update care plans to reflect new or increased behaviors, communicate behavior and interventions to all staff during shift report, conduct follow-up assessments to monitor effectiveness of interventions, ensure all documentation is complete and accurate, and

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coordinate interdisciplinary team response to behavior incidents.

Social Workers conduct psychosocial assessment following behavior incidents, facilitate communication with families regarding behaviors and interventions, coordinate referrals to mental health services when indicated, assist with development of behavior management strategies, provide staff education on behavior management techniques specific to individual residents, participate in care plan meetings to address behavioral concerns, document all interventions and resident response in the medical record, follow up with residents to assess ongoing psychosocial needs, and provide resources and support to residents and families.

On 04/05/2025, the Director of Nursing implemented daily reviews of progress notes, electronic Medication Administration Record, and Plan of Care for behavior documentation. These reviews occur 7 days a week; the DON or designee reviews the previous day's documentation during the morning clinical meeting held Monday-Friday at 9:30 AM, and the weekend Charge Nurse performs these reviews on Saturdays, Sundays, and holidays. This process identifies any new or increased behaviors and ensures appropriate follow-up. The appropriate follow-up includes immediate notification to providers, family, updating care plans, and implementing appropriate interventions.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

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Beginning 04/05/2025, the Administrator and Director of Nursing will interview at least 5 staff members per week for 4 weeks to identify any new or increased resident behaviors (including sexual behaviors) using an incident-specific monitoring tool and ensure appropriate reporting. This will be followed by interviewing 3 staff members per week for an additional 8 weeks (total monitoring period of 12 weeks). If the Administrator or Director of Nursing is unavailable, this responsibility will be delegated to the Social Worker to ensure continuity.

Beginning 04/05/2025, the Director of Nursing will conduct daily reviews of all behavior documentation, including progress notes, electronic Medication Administration Record, and Point of Care during morning clinical meetings, seven days a week including weekends and holidays. On days when the Director of Nursing is not available, the Assistant Director of Nursing or designated Unit Manager will conduct these reviews to ensure continuous monitoring.

Beginning 04/05/2025, the Administrator determined all findings shall be formally reported to the Quality Assurance Performance Improvement committee with detailed documentation. Audits will continue at the discretion of the Quality Assurance Performance Improvement committee based on findings, with potential for increased frequency or extended duration if any concerns are identified.

The monitoring process will include verification that all staff have received the required education, documentation review, and continued assessment of all residents with specific attention to those residents identified as being at higher

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risk.

All corrective actions were implemented by 04/05/2025.

The facility's alleged date of compliance is 04/06/2025.

Allegation of immediate jeopardy removal and compliance date: 4/6/25.

The corrective action plan was validated onsite on 4/9/25 and 4/10/25. It was verified through staff interviews that Residents #1 and #2 were immediately separated and assessed for injury. There were no negative findings for either resident. Resident #1 and Resident #2 were placed on 1:1 supervision and documentation of supervision was verified. Observations of the 1:1 for both residents were conducted on 4/9/25 and 4/10/25. Review of skin assessments and body audit forms verified they were completed on all residents on the memory care unit as well as residents on the other 4 units on 4/5/25. In addition to skin assessments, resident interviews were conducted for individuals with a BIMS score of 10 or greater to determine if they had experienced any type of inappropriate/unwanted sexual contact. All residents were assessed with the use of the behavior assessment tool, sexual activity assessment, and post-traumatic stress disorder assessment. Care plans for Resident #1 and Resident #2 and other residents with identified behavioral concerns were reviewed and revised if needed. Staff interviews verified employees were educated with post-education knowledge checks completed as indicated in the corrective action plan that included sexual abuse, dementia, reporting/ documentation of abuse, 1:1

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F 600	Continued From page 21 supervision, increased unit rounds for wandering residents and review of the updated care plans for residents with behaviors. The facility implemented monitoring systems that included interviews with 5 staff per week for 4 weeks to identify new or increased resident behaviors and to ensure the reporting process was effective. In addition, management was reviewing medical records dailyfor any newly identified behaviors. The Quality Assurance Performance Improvement committee will monitor the audit process for accuracy and effectiveness of the implemented program. The facility's immediate jeopardy removal date and compliance date of 4/6/25 were validated.	F 600		