STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345143	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Siler City Center	**900 W Dolphin Street , Siler City, North Carolina, 27344**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint survey was conducted on 9/4/25. The survey team returned to the facility on 9/8/25 to validate the Immediate Jeopardy removal plan. Therefore, the exit date was changed to 9/8/25. The following intakes were investigated 2605752 and 869712. Intake 2605752 resulted in Immediate Jeopardy. 2 of the 2 complaint allegations resulted in deficiency. Immediate Jeopardy 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 9/1/25 and was removed on 9/5/25. A partial extended survey was conducted on 9/4/25.	F0000		
F0600 SS = SQC-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 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation, and interviews	F0600	1. Resident #1 was immediately separated from Resident #2 on 9/1/25 by NA#1. On 9/1/25, the Nurse Supervisor interviewed both Residents #1 and #2 in regards to the occurrence. Neither resident was able to recall the incident. A room change was immediately conducted with Resident #2 by facility staff on 9/1/25 and Resident #2 remained on 1:1 supervision. On 9/1/25 the Licensed Nurse conducted skin assessments on Resident #1 and Resident #2. No new findings identified either resident based on the skin assessments conducted. On 9/1/25, the responsible parties for Resident #1 and #2 were notified by the licensed nurse. The Medical Director and Nurse Practitioner were notified of the occurrence by the licensed nurse, and the local Police Department was notified by the Nurse Supervisor. 2. On 9/1/25 skin assessments were completed on all non-alert/oriented residents by licensed nursing staff. There were no negative findings as a result of the skin	09/16/2025

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 reverse for further 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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F0600 SS = SQC-J	Continued from page 1 with the Responsible Parties (RPs), PACE (Program of All-Inclusive Care for the Elderly) Nurse Practitioner, psychiatric Nurse Practitioner and staff, the facility failed to protect a cognitively impaired male resident's right to be free from sexual abuse (Resident #2) perpetrated by a cognitively impaired male resident (Resident #1). On 9/1/25 Nurse Aide (NA) #1 overheard Resident #2 laughing from the hallway and proceeded to the room he shared with Resident #1 as this was an unusual behavior for Resident #2. When NA #1 stepped into the doorway of the room, she observed Resident #2 lying on his back in bed with his penis exposed on the left side of his brief as Resident #1 stood beside the bed grasping Resident #2's penis with his hand as he moved his hand in an up and down motion. The residents did not have the cognitive capacity to consent to sexual relations or express an adverse psychosocial outcome. A reasonable person would have been traumatized by being sexually abused by a resident in their home environment resulting in feelings such as anger, fear, anxiety, and/or humiliation. This deficient practice affected 1 of 3 residents reviewed for abuse (Resident #2). Immediate Jeopardy began on 9/1/25 when Resident #2, who did not have the cognitive capacity to consent, was sexually abused by Resident #1. Immediate Jeopardy was removed on 9/5/25 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with a potential of minimal harm that is not Immediate Jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included: Resident #1 was admitted to the facility on 11/30/21 with diagnoses that included Alzheimer's disease, major depression and dementia with other behavioral disturbance. A quarterly Minimum Data Set (MDS) assessment dated 6/19/25 indicated Resident #1 had severe cognitive impairment and displayed other behavioral symptoms not directed towards others on one to three days during the seven-day look back period. Resident #1 was independent with eating, bed mobility and transfers but required assistance from staff for all other Activities of Daily Living (ADL) and was able to ambulate independently. Resident #1 received an anticonvulsant medication.	F0600	Continued from page 1 assessments. From 9/2/25-9/3/25, the Social Worker Director and the Assistant Social Worker interviewed all alert and oriented residents in regards to resident abuse. There were no negative findings as a result of this audit. From 9/1/25-9/4/25, residents with roommates were interviewed by the Assistant Director of Nursing, Licensed Nurses and Admissions Director to ensure roommate compatibility. There were no concerns at this time as a result of the resident interviews. On 9/4/25, the Director of Nursing and the Regional Nurse Consultant completed a medical record audit of all residents by reviewing the most current comprehensive resident assessment to identify Residents with behaviors. For residents identified as having behaviors, the previous 30 days of the behavior monitoring tool and care plan were reviewed to ensure behaviors were not related to any type of sexual behaviors displayed towards other residents. No issues were identified. The Director of Nursing and Nurse Managers review residents identified as having behaviors in the clinical morning meeting Monday through Friday and the weekend supervisor reviews on Saturday and Sunday to ensure appropriate interventions are in place for the safety of other residents. Interventions include but are not limited to: medication regimen review, one to one supervision, Psychiatric consultation/ visit, Physician notification and assessment, roommate compatibility, etc. 3. Education was provided to all facility staff, to include agency staff, by the Director of Nursing and Nurse Practice Educator on the abuse policy with an emphasis on sexual behaviors: management of symptoms, and ensuring resident safety by reporting, identifying, preventing and managing behavioral symptoms. Any staff identified as not receiving abuse education by 9/4/25 will not be allowed to work before receiving education on the facility's abuse policy. All new hired staff, to include new agency staff, will be educated on the facility's abuse prohibition policy in the new hire orientation program. 4. On 9/15/25 the Administrator will conduct an ADHOC QAPI meeting to present the deficient practice of free from abuse and implement the plan of correction to the QAPI committee in order to include quality improvement monitoring and the frequency of monitoring. review the plan of correction, education and ongoing monitoring to	

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F0600 SS = SQC-J	Continued from page 2 Resident #1's active care plan, last revised on 8/7/25, included focus areas for a behavior of hoarding items, wandering into other residents' rooms, physical and verbal behaviors and refusal of care. Resident #1's care plan did not identify any sexually inappropriate behaviors. Resident #2 was admitted to the facility on 8/19/24 with diagnoses that included dementia and adjustment disorder with mixed anxiety and depressed mood. A review of Resident #2's active care plan, last revised 6/2/25, included focus areas for behaviors of pacing, wandering into other residents' rooms, rummaging, throwing/smearing bodily waste, disrobing in public and physical and verbal behaviors. Resident #2's care plan did not identify any sexually inappropriate behaviors. An annual MDS assessment dated 8/27/25 indicated Resident #2 had severe cognitive impairment and displayed physical and verbal behavioral symptoms as well as other behavioral symptoms not directed towards others, rejection of care and wandering on one to three days during the seven-day look back period. He was independent with eating, bed mobility, and transfers but required assistance from staff for all other ADL and was able to ambulate independently. Resident #2 was coded as being always incontinent of bowel and bladder and received an antidepressant medication. A review of Resident #2's nursing progress notes revealed that on 8/26/25 he was holding the front of his pants, saying "I am burning". The PACE provider was notified and ordered a urinalysis. A review of Resident #2's physician orders included an order dated 8/28/25 for Fosfomycin (an antibiotic) 3 grams by mouth one time only for urinary tract infection (UTI). The incident report completed by the Unit Manager on 9/1/25 at 8:50 AM, revealed that when the NA #1 walked by the room she saw Resident #1 on Resident #2's side of the room by his bed. The NA entered the room and witnessed Resident #2 masturbating and Resident #1 was	F0600	Continued from page 2 ensure compliance with the plan of correction. Effective 9/8/25 The Administrator and / or Director of Nursing will interview five residents with a brief interview of mental status of 12 or greater per week for twelve weeks to inquire if they have felt abused or have witnessed or suspected abuse / neglect. Effective 9/8/25 five residents with roommates will be interviewed 2x a week for 6 weeks then 1x a week for 6 weeks by facility staff to ensure appropriate roommate compatibility and to ensure no concerns related to resident abuse exist between roommates. In the monthly Quality Assurance and Performance Improvement Meeting, the Interdisciplinary Team will review all resident to resident / abuse allegations to ensure appropriate interventions are in place and care plan updated x8 weeks. The Administrator will report the results of the monitoring to the QAPI committee to review audits and make recommendations to assure compliance is maintained ongoing. QAPI Committee will determine the need for further intervention and auditing beyond three months to assure compliance is sustained ongoing.	

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F0600 SS = SQC-J	Continued from page 3 helping him and touching him inappropriately. The NA called out to stop, which Resident #1 did and returned to his side of the room. Neither one of the residents was able to give a description of what occurred. There were no injuries identified during skin assessments. The two residents were immediately separated and placed on one-to-one monitoring. The physicians, RPs for both residents, Administrator, Director of Nursing (DON) and local law enforcement were notified of the incident. The Initial Allegation Report dated 9/1/25, completed by the Unit Manager, read there was an allegation of resident-to-resident sexual abuse between Resident #1 and Resident #2, who resided in the memory care unit. Staff immediately intervened and separated the residents for safety, and both were placed on one-to-one observation. The local law enforcement was notified. There was no injury or harm to either resident. An undated staff statement from NA #1 read, "…on 9/1/25 as I was coming back onto the hall, I heard Resident #2 laughing not a normal laugh, so I went to look in his room and I saw Resident #1 standing beside Resident #2's bed masturbating Resident #2 and I told him to stop. He stopped and jumped right back into his bed…I also noticed Resident #2 that morning playing with his self before all this occurred". NA #1 was interviewed on 9/4/25 at 2:45 PM. She stated that she was walking in the hallway of the memory care unit on 9/1/25 around 8:45 AM, and overheard Resident #2 laughing, which was unusual behavior for him. The door to Resident #1 and Resident #2's room was open. When she stepped into the doorway, she observed Resident #2 lying on his back in his bed, his arms to his sides with a shirt and fastened brief and his penis exposed to the left side of the brief. She observed Resident #1 standing beside the bed (facing the doorway), fully clothed, with one hand grasping Resident #2's penis and moving his hand in an up and down motion. She stated that Resident #2 was laughing and not attempting to move Resident #1's hand away. There was no verbal interaction between the two. NA #1 stated she immediately yelled "stop", and Resident #1 returned to his bed. NA #1 stated that she placed pants on Resident #2 and escorted him into a chair in the hallway. Nurse #1 approached the room, and she told her what happened. NA #1 stated that she remained in the doorway to keep an eye on both Resident #1 and Resident #2 until management arrived. Both residents were placed	F0600		

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F0600 SS = SQC-J	Continued from page 4 on one-to-one monitoring and Resident #2's room was changed. NA #1 added that around 7:30 AM she had observed Resident #2 with his hand in his brief while in bed but was easily redirected to remove his hand. NA #1 stated that neither resident had displayed inappropriate sexual behavior in the past. An unsigned staff statement dated 9/1/25 read, in part, "while passing medications, I was called to room at approximately [8:50 AM] by NA. When I arrived, the residents were separated. NA reported sexual interactions between the two. I did not witness the above interaction". A phone interview occurred with Nurse #1 on 9/4/25 at 1:08 PM. She explained the morning of 9/1/25 she was in the hallway completing the medication pass when she heard NA #1 saying "stop" very loudly. She stated she locked the medication cart and walked towards the room. Nurse #1 stated that by that time, NA #1 was bringing Resident #2 into the hallway to a chair. She stated that NA #1 told her that when she walked into Resident #1 and Resident #2's room, she observed Resident #1 grasping Resident #2's penis in his hand with a motion involved. NA #1 stated when she yelled out "stop" Resident #1 walked back to his bed. The two residents were separated, and she immediately reported it to the Unit Manager, both residents were placed on one-to-one monitoring and Resident #2's room was changed. Nurse #1 stated that she had written a staff statement regarding the incident on 9/1/25. Nurse #1 stated that neither resident had exhibited inappropriate sexual behaviors in the past. Nurse #1 stated that Resident #2 was currently being treated for a UTI and had been seen pulling at the groin area a few times that morning. The Unit Manager was interviewed on 9/4/25 at 2:30 PM and stated that on the morning of 9/1/25 she was informed by Nurse #1 that Resident #1 and Resident #2 had an incident of inappropriate sexual behavior. She stated Nurse #1 overheard NA #1 say "stop" very loudly. She stopped what she was doing and went to the room. NA #1 explained to the Unit Manager that she had observed Resident #2 lying on the bed and Resident #1 standing beside the bed grasping Resident #2's penis in his hand with an up and down motion. When NA #1 stated "stop" loudly, Resident #1 returned to his bed. The Unit Manager stated that she observed Resident #1 lying in his bed and Resident #2 sitting in a chair in the hallway. The two residents were immediately separated with one-to-one monitoring initiated and Resident #2's	F0600		

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F0600 SS = SQC-J	Continued from page 5 room changed. She stated that the Administrator and DON were made aware, as well as the providers, RPs and the police department. Skin assessments were completed on Resident #1 and Resident #2 with no negative findings. The Unit Manager stated she attempted to interview both residents regarding the incident, but they were unable to recall what had occurred. The Unit Manager stated that when initially completing the incident report she was under the impression that Resident #2 was masturbating, and Resident #1 was assisting him, since Resident #2 had been seen pulling at his groin several times in the past. Review of a psychiatric progress note dated 9/3/25 read that Resident #1 was seen as an acute visit due to recent sexually inappropriate behavior in the memory care unit at the facility. A NA reported an incident where she found Resident #1 holding his roommate's penis and appearing to perform a sexual act. Upon being instructed to stop, Resident #1 immediately complied and returned to his bed. Since this incident Resident #1 has been assigned a sitter and his roommate has been relocated to a different room. Resident #1's Depakote dosage was increased from twice a day to three times a day on 9/2/25, which may help to slow impulsive behaviors. During the visit, Resident #1 appeared happy with his confusion at baseline. A phone interview occurred with the PACE Nurse Practitioner (NP) on 9/4/25 at 12:21 PM. She indicated she was Resident #2's primary care provider and had been notified of the incident that occurred on 9/1/25. She explained that Resident #2 was being actively treated for a UTI and she had been changing some of his psychotropic medications. The NP further stated that Resident #2 had not displayed any inappropriate sexual behaviors in the past and did not have the cognitive capacity to consent to sexual relations. She completed a face-to-face assessment of Resident #2 on 9/2/25 and had no negative findings to report. A phone interview was completed with Resident #1's psychiatric provider on 9/4/25 at 3:47 PM. He stated he was made aware of the incident on 9/1/25 and was told Resident #2 had his penis out, the NA heard laughter, went to investigate and observed Resident #1 holding Resident #2's penis. When she yelled out "stop", he (Resident #1) went back to his bed. The psychiatric provider stated this was new behavior for Resident #1. He added that Resident #1 was seen via telehealth on 9/2/25 where his Depakote (mood	F0600		

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F0600 SS = SQC-J	Continued from page 6 stabilizer/anticonvulsant) was increased. A face-to-face visit was completed with Resident #1 on 9/3/25 with a recommendation to initiate Sertraline (an antidepressant medication) as it would suppress any libido. The psychiatric provider added that Resident #1 did not have the cognitive capacity to consent to sexual relations. On 9/4/25 at 12:12 PM, Resident #2 was observed walking unassisted out of the dining room on the memory care unit and entering the room across the hall. He was observed turning around at the door and being redirected by staff back into the dining room. On 9/4/25 at 12:13 PM, Resident #1 was observed sitting in a chair in the memory care unit dining room with a staff member beside him. On 9/4/25 at 12:51 PM, a phone interview was held with Resident #1's RP. He indicated he had been made aware of the incident that occurred on 9/1/25 and stated that Resident #1 would never have acted sexually inappropriate prior to his dementia diagnosis. Resident #2's RP was his wife and she was interviewed via the phone on 9/4/25 at 12:58 PM. She indicated she had been made aware of the incident that occurred on 9/1/25. She explained that Resident #2 had recently been diagnosed with a UTI and was undergoing antibiotic treatment. She stated prior to his dementia diagnosis "he would not have let something like that happen" when speaking about the incident from 9/1/25. An interview occurred with the DON on 9/4/25 at 3:09 PM and stated that she was not at the facility when Resident #1 inappropriately touched Resident #2's penis on 9/1/25. She stated the Unit Manager called her to report the incident and she gave her the steps to follow until she arrived at the facility. The DON stated that both residents were immediately separated following the incident and placed on one-to-one monitoring. The providers, RPs and police department were notified. Skin assessments were completed on both residents with no negative findings. The DON added that neither resident had experienced any inappropriate sexual behavior in the past and that they did not have the cognitive capacity to consent. She added that Resident #2 was currently being treated for a UTI as well. The DON stated that she was initially under the	F0600		

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F0600 SS = SQC-J	Continued from page 7 impression that Resident #1 had laid his hand on top of a clothed Resident #2's penis. She explained she had not asked the NA specific questions about whether Resident #2's penis was exposed, or if Resident #1 was using any motion with his hand. She added the investigation was ongoing, and she wasn't sure if this would be substantiated as both residents were cognitively impaired. The interim Administrator was interviewed on 9/4/25 at 3:30 PM and stated that he was informed that Resident #2 had been observed grasping Resident #1's penis on the morning of 9/1/25 by the Unit Manager. He presumed that Resident #2 was engaged in a masturbating act in his room and Resident #1 was observed assisting him, as this was what he had been told by the Unit Manager. The interim Administrator stated the DON was currently completing the investigation and added that providers, RPs, police department as well as Department of Social Services were notified on 9/1/25 of the incident. The Administrator was notified of the Immediate Jeopardy on 9/4/25 at 4:00 PM. The facility provided the following credible allegation of Immediate Jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: On 9/1/25 at approximately 8:50am, NA #1 entered the room for Residents #1 (Brief Interview for Mental Status score of 3 indicating the resident had severe cognitive impairment) and Resident #2 (Brief Interview for Mental Status score of 0 indicating the resident had severe cognitive impairment) due to hearing Resident #2 laughing loudly inside of his room. NA #1 witnessed Resident #2 lying in the A bed (the bed located closest to the door) on his back, both hands by his side while Resident #1 was standing beside Resident #2's bed with his hand on Resident #2's penis making an up and down motion while Resident #2 was lying in bed. Resident #2 was wearing a tee shirt and a brief while lying in bed. NA #1 stated that resident #2's brief was fastened; however, his penis was outside of the brief on the left side. NA #1 yelled "stop" when she observed the incident and Resident #1 returned to his bed. Nurse #1 heard NA #1 yell "stop" and went to assist her in	F0600		

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F0600 SS = SQC-J	Continued from page 8 the resident's room and immediately separated both Residents #1 and #2 to ensure safety. Both residents were immediately placed on 1:1 supervision by facility staff. Staff that witnessed the event were interviewed by the Nurse Supervisor on 9/1/25 and statements were obtained related to the incident. On 9/1/25, the Nurse Supervisor interviewed both Residents #1 and #2 in regard to the occurrence. Neither resident was able to recall the incident. A room change was immediately conducted with Resident #2 by facility staff on 9/1/25 and Resident #2 remained on 1:1 supervision. On 9/1/25, the Responsible Parties for Resident's #1 and #2 were notified by the licensed nurse. The Medical Director and Nurse Practitioner were notified of the occurrence by the licensed nurse, and the local Police Department was notified by the Nurse Supervisor. On 9/1/25 the Licensed Nurse conducted skin assessments on Resident #1 and Resident #2. No new findings identified on either resident based on the skin assessments conducted. An initial report was sent to the North Carolina Department of Health and Human Services by the Nurse Unit Manager on 9/1/25 at 10:31am for the allegation of resident abuse. Adult Protective Services was notified of the allegation of resident abuse on 9/1/25 by the Nurse Unit Manager on 9/1/25 at 11:04am. Psychiatric services was notified by the Assistant Director of Nursing on 9/2/25 at 8:30am for Resident #1 due to the allegation. A telehealth visit was conducted on 9/2/25 and a follow up in person visit was conducted on 9/3/25. Follow up notes from the psychiatric visit on 9/2/25 recommended continued 1:1 supervision for Resident #1 as well as medication changes were recommended for the following: Increased Depakote (a mood stabilizer) 250 milligrams (mg) by mouth, three times a day (TID) and Hydroxyzine (an antihistamine that can be utilized to treat anxiety) 25mg by mouth, two times a day (BID), as needed for 14 days. On 9/2/25, the Nurse Practitioner for the Program of All Inclusive Care for the elderly (PACE, a program that provides comprehensive medical and social services) conducted an onsite assessment for Resident #2. Resident #2's Zoloft (antidepressant) was increased from 50MG to 75MG to decrease resident libido (sexual	F0600		

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F0600 SS = SQC-J	Continued from page 9 desires). On 8/27/25, a urine sample was collected on Resident #2 due to a burning sensation while urinating. Culture result dated 9/2/25, antibiotics started. On 9/1/25, a chart review was completed of Resident #1 and Resident #2 by the Director of Nursing. Neither resident has a history of sexual behaviors. The chart review included reviewing the care plan with no indication of sexual behavior. There was no behavior or indication prior to the event that would have indicated this occurrence. On 9/1/25 skin assessments were completed on all non-alert/oriented residents by licensed nursing staff. There were no negative findings as a result of the skin assessments. From 9/2/25 to 9/3/25, the Social Worker Director and the Assistant Social Worker interviewed all alert and oriented residents in regard to resident abuse. There were no negative findings as a result of this audit. From 9/1/25 to 9/4/25, residents with roommates were interviewed by the Assistant Director of Nursing, Licensed Nurses and Admissions Director to ensure roommate compatibility. There were no concerns at this time as a result of the resident interviews. On 9/4/25, the Director of Nursing and the Regional Nurse Consultant completed a medical record audit of all residents by reviewing the most current comprehensive resident assessment to identify residents with behaviors. For residents identified as having behaviors, the previous 30 days of the behavior monitoring tool and care plan were reviewed to ensure behaviors were not related to any type of sexual behaviors displayed towards other residents. No issues were identified. The Director of Nursing and Nurse Managers review residents identified as having behaviors in the clinical morning meeting Monday through Friday and the weekend supervisor reviews on Saturday and Sunday to ensure appropriate interventions are in place for the safety of other residents. Interventions included but are not limited to: medication regimen review, one to one supervision, Psychiatric consultation/ visit, Physician notification	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345143	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Siler City Center	**900 W Dolphin Street , Siler City, North Carolina, 27344**

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F0600 SS = SQC-J	Continued from page 10 and assessment, roommate compatibility, etc. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: From 9/1/25 to 9/4/25 education was provided to all facility staff, to include agency staff, by the Director of Nursing and Nurse Practice Educator on the abuse policy with an emphasis on sexual behaviors: management of symptoms, and ensuring resident safety by reporting, identifying, preventing and managing behavioral symptoms. Any staff identified as not receiving abuse education by 9/4/25 will not be allowed to work before receiving education on the facility's abuse policy. All newly hired staff, to include new agency staff, will be educated on the facility's abuse prohibition policy in the new hire orientation program. The Director of Nursing and Nurse Practice Educator are tracking the abuse education to ensure no staff works after 9/4/25 prior to receiving education. Alleged date of Immediate Jeopardy removal: 9/5/25 The credible allegation was verified on 9/8/25 as evidenced by interviews completed with staff from different departments and who worked different shifts and verified, they had received education about the types of abuse (physical, sexual, emotional, neglect and financial), how to report abuse, who to report to, and the prevention of abuse. Interviews with staff verified the training was provided following the incident on 9/1/25 prior to staff being allowed to work with residents. A review was completed of educational information provided to staff during the in-service and a review of in-service staff sign-in logs. The in-service logs were reviewed; staff names were randomly selected and verified to have received training. Interviews were completed with alert and oriented residents and verified they knew they had the right to be free from abuse and to report incidents to staff immediately. Review of residents' skin checks was completed and showed no negative findings. Documentation showed the DON and Regional Nurse Consultant reviewed the comprehensive resident assessment, care plans, and any behavior logs for the previous 30 days to identify any type of sexual behavior directed towards other residents. No issues were identified.	F0600		

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F0600 SS = SQC-J	Continued from page 11 The facility's alleged immediate jeopardy removal date of 9/5/25 was validated.	F0600		