STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255250	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF MORTON	96 OLD HIGHWAY 80 EAST , MORTON, Mississippi, 39117

(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 The State Agency (SA) conducted two (2) Complaint Investigations (CI MS #2688884 and CI MS #2695843), at the facility from 12/22/25 through 12/23/25. CI MS #2688884 was investigated related to accidents and there were no deficiencies cited related to the complaint. CI MS #2695843 was a facility reported incident (FRI) related to sexual abuse. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The facility failed to protect residents' right to be free from sexual abuse by Resident #1 when the facility did not implement immediate protective supervision. The facility's failure to provide supervision and develop a comprehensive care plan related to inappropriate behaviors, resulted in resident-to-resident sexual abuse for Resident #2 and Resident #3. On 12/17/25 at 11:26 AM, Resident #1 (male) inappropriately touched the breast of Resident #2 (female) in the day room. After staff were notified, Resident #1 was taken to his room and left unsupervised. At approximately 11:32 AM, Resident #1 was assisted back to the day room by a staff member who was unaware of the incident. On 12/17/25 at 11:49 AM, Resident #1 inappropriately touched the breast of Resident #3 (female). During the investigation of the FRI, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 12/12/25 and existed at: CFR(s) §483.12(a)(1) Freedom from Abuse, Neglect, and Exploitation (F600) - Scope and Severity "J". The IJ existed at: 42 CFR 483.21(b)(1) Comprehensive Care Plan (F656) – Scope and Severity "J" This situation resulted in Resident #2 and Resident #3 experiencing non-consensual sexual contact and placed other vulnerable female residents at risk for serious injury, serious harm, serious impairment, or death.	F0000		

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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F0000	Continued from page 1 The SA notified the facility's Administrator of the IJs and SQC on 12/23/25 at 9:30 AM and provided the Administrator with the IJ Templates. Based on the facility's implementation of corrective actions on 12/19/25, the SA determined the IJs and SQC to be Past Non-Compliance (PNC) and the IJs were removed on 12/20/25, prior to the SA's entrance on 12/22/25. At the time of the survey, the facility was licensed for 120 beds, with a census of 93 residents.	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 interviews, record review, facility policy review, and facility investigation review, the facility failed to protect the residents' right to be free from sexual abuse by another resident for two (2) of four (4) sampled residents. Resident #2 and Resident #3 On 12/17/25 at 11:26 AM, Resident #1 (male) inappropriately touched the breast of Resident #2 (female) in the day room. After staff were notified, Resident #1 was taken to his room and left unsupervised. At approximately 11:32 AM, Resident #1 was assisted back to the day room by a staff member who was unaware of the incident. On 12/17/25 at 11:49 AM, Resident #1 inappropriately touched the breast of Resident #3 (female). The facility was aware prior to these incidents that Resident #1 had a history of sexually inappropriate behaviors, including sexual	F0600	"Past Noncompliance - no plan of correction required"	

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F0600 SS = SQC-J	Continued from page 2 comments toward staff on 12/12/25, yet failed to implement immediate supervision or restrictions to protect other residents. The facility's failure to implement protective supervision resulted in Resident #2 and Resident #3 experiencing non-consensual sexual contact and placed other vulnerable female residents at risk for serious injury, serious harm, serious impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 12/12/25, when Resident #1 made sexual comments toward facility staff. The State Agency (SA) notified the Administrator of the IJ and SQC on 12/23/25 at 9:30 AM and provided an IJ Template. Based on the facility's implementation of corrective actions on 12/19/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 12/20/25, prior to the SA's entrance on 12/22/25. Findings include: A review of the facility's policy, "Freedom from Abuse, Neglect and Exploitation, dated September 2022, revealed, "…F600 Free from Abuse and Neglect All residents of this facility will be free from abuse…The facility will take steps to ensure that the resident is protected from abuse…When a facility has identified abuse, the facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately…" A review of the facility's policy, "Identifying Sexual Abuse and Capacity to Consent", dated September 2022, revealed, "…Policy Interpretation and Implementation 1. 'Sexual abuse' is non-consensual sexual contact of any type with a resident…a. unwanted intimate touching of any kind especially of breasts or perineal area…Investigating an Allegation or Suspicion of Sexual Abuse 1. For any alleged violation or suspicion or sexual abuse, protective measures and an investigation…will begin immediately. These include: a. immediately implementing safeguards to prevent further potential abuse…" A record review of the "Facility Reported incident Initial Report" dated 12/17/25, revealed an "Allegation Type" of Sexual Abuse. The initial report indicated that on 12/17/25 at 11:26 AM, Resident #1 inappropriately touched Resident #2 on her breast while in the Day Room. The event was witnessed by the facility's Janitor. The janitor separated the residents	F0600		

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F0600 SS = SQC-J	Continued from page 3 and notified Licensed Practical Nurse (LPN) #1, who took Resident #1 to his room and immediately went to the Director of Nursing (DON) office to notify her of the incident. While LPN #1 was walking to the DON's office, Resident #1 was attempting to come out of his room. Certified Nursing Assistant (CNA) #1, who had no knowledge of the incident and was not his assigned CNA, assisted him out of his room and back to the dayroom. At 11:49 AM, Resident #1 inappropriately touched Resident #3 on her breast. CNA #2 witnessed the incident and immediately separated the residents. The resident was immediately placed on one on one (1:1) observation. Resident #1 A record review of the "Admission Record" revealed the facility admitted Resident #1 on 4/26/2023 with current diagnoses including Cerebral Infarction. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/1/25 revealed Resident #1 had a Brief Interview for Mental Status score of 6, which indicated his cognition was severely impaired. A record review of the "Progress Notes", dated 12/17/25, revealed, "Nurse notified DON and Assistant Director of Nursing (ADON) of incident. While nurse was on the way to tell DON and ADON of incident, student CNA seen resident attempting to exit room, but notice wheelchair was stuck. Student CNA assisted resident out of the room due to no knowledge of the incident. While back in the day room resident inappropriately touch another female resident's breast. CNA immediately separated and took resident with her to notify nurse. ADON educated CNA and nurse that resident is to be on one on one observation. One on One observation was initiated immediately…" A record review of the "Behavior Reporting Form" revealed that on 12/12/25 at approximately 12:00 PM in the facility's hallway, Resident #1 asked employee to see her breasts and documented that "Resident stopped employee in the hallway and asked to see her breasts. Employee educated Resident on inappropriateness of request and instructed to not ask that. Resident showed understanding by nodding." A record review of the "Psych Progress Note", dated 12/15/25 revealed Resident #1 had "Presenting Symptoms" including "Inappropriate Behavior." The "Mental Status Exam" included "…Comprehension: Difficulty with recall, unable to remember current events…Executive Function:	F0600		

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F0600 SS = SQC-J	Continued from page 4 Moderate impairment…impaired decision making…Judgement: Poor Ability to Plan, Poor Social Cognitions, Poor Memory…Thought Process: Confused/Slowed, slowed processing/intermittent confusion." The "Case Conceptualization" documentation included "…He has some increased inappropriate behaviors (sexually impulsive). Discuss this with resident and he states, 'I only do that with people I'm comfortable with.' Discuss inappropriateness of behavior and resident v/u (verbalized understanding)." Resident #2 A record review of the "Admission Record" revealed the facility admitted Resident #2 on 1/31/24 with diagnoses including Classical Phenylketonuria. A record review of the Comprehensive MDS with an ARD of 12/3/25 revealed Resident #2 required a "Staff Assessment for Mental Status" and that her cognitive skills for daily decision making was severely impaired. A record review of the "Progress Notes", dated 12/17/2, revealed, "DON notified nurse that male resident was observed making physical contact with resident's breast…Staff intervened and separated residents…" Resident #3 A record review of the "Admission Record" revealed the facility admitted Resident #3 on 9/15/23 and she had diagnoses including Cerebral Infarction. A record review of the Quarterly MDS with an ARD of 10/3/25 revealed Resident #3 required a "Staff Assessment for Mental Status" that revealed her cognitive skills for daily decision making was severely impaired. A record review of the "Progress Notes", dated 12/17/25, revealed, "Resident was sitting in her wheelchair in the day room when a male resident rolled his wheelchair beside her. The male resident inappropriately touched her right breast. A CNA witnessed the incident and immediately separated the male resident from her…" On 12/22/25 at 12:01 PM, during an interview with Licensed Practical Nurse (LPN) #1, she explained that on Wednesday, 12/17/25, a janitor observed Resident #1 inappropriately touching Resident #2's breast while in the day room and reported the observation to staff at the nurses' station. LPN #1 reported that she removed Resident #1 from the day room and escorted him to his	F0600		

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F0600 SS = SQC-J	Continued from page 5 room, provided him with ice cream as a distraction, and remained with him until he appeared calm. She stated that she then left the resident alone in his room and went to notify the Director of Nursing (DON), as Resident #1 was not assigned to her. LPN #1 reported that during this time, another staff member, Certified Nursing Assistant (CNA) #1, returned Resident #1 to the day room, where he was subsequently observed inappropriately touching a second resident, Resident #3. She explained that had Resident #1 not been left alone, the second incident would not have occurred. She stated she immediately returned to the nurses' station but was unsure how long it took before staff initiated one-to-one supervision. LPN #1 explained that residents have the right to be free from inappropriate touching and confirmed that Resident #1 was placed on one-to-one observation following the second incident and was later evaluated by a psychiatric nurse practitioner. On 12/22/25 at 12:25 PM, during an interview with the janitor, he explained that at approximately lunchtime on 12/17/25, he was walking through the day room to clean a room when he observed Resident #1 with his hand inside the shirt of Resident #2, touching her breast. He reported that he immediately intervened by separating the residents and transporting Resident #1 to the nurses' station. He stated that he promptly informed LPN #1 of what he had observed in an effort to protect Resident #2. He further explained that at the time of the incident, no staff were present directly in the day room supervising the residents. On 12/22/25 at 12:37 PM, during an interview with Certified Nurse Aide (CNA) #1, she explained that on 12/17/25, following the initial incident involving Resident #1, she was passing through the hallway near the resident's room and was unaware that any incident had occurred. She stated that at that time, Resident #1 was alone and was not on one-to-one (1:1) observation. She reported that she escorted Resident #1 to the day room because he was in the hallway and she was attempting to clear the hallway to maintain resident safety while lifts and resident care activities were in progress. She stated that had she been informed of the earlier incident, she would not have taken Resident #1 into the day room. She further stated that she believed the facility failed to communicate Resident #1's behaviors to her, and that appropriate communication may have prevented the second incident from occurring. On 12/22/25 at 12:41 PM, during an interview with CNA #2, she explained that on 12/17/25 she walked up the hall and observed Resident #1 seated in the day room with his hands on Resident #3's right breast, actively	F0600		

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F0600 SS = SQC-J	Continued from page 6 grabbing it. She stated that the residents were unsupervised at the time. She reported that she verbally redirected Resident #1 and then escorted him to his room until arrangements could be made for one-to-one (1:1) supervision. CNA #2 stated that at the time of the second incident, she was unaware that an earlier incident involving Resident #2 had occurred earlier. She explained that staff had not communicated the prior incident to her and stated that had communication occurred or had Resident #1 been placed on 1:1 supervision following the initial incident, the second incident could have been prevented. On 12/22/25 at 1:32 PM, during an interview with the Administrator, she explained that she had completed a behavior report for Resident #1 on 12/12/25, five (5) days prior to the incident, and submitted it to psychiatric services. She stated that on that date, Resident #1 stopped her in the hallway and asked her to show him her breasts and then asked if he could see the breasts of another CNA who was nearby. She confirmed that psychiatric services evaluated Resident #1 on 12/15/25 related to these inappropriate verbal behaviors. She reported that the incidents on 12/17/25 were the first occasions in which Resident #1 had physically touched another resident inappropriately. She further explained that Resident #1 had a known history of sexually inappropriate verbal behaviors toward staff, including making sexual comments and attempting to grab staff members' buttocks, as well as a prior incident approximately one (1) year earlier in which the resident pulled down his pants and exposed himself in the day room. She stated that there had been no prior incidents involving physical sexual contact with other residents before the events on 12/17/25. On 12/22/25 at 1:37 PM, during an interview with Registered Nurse (RN) #1, she explained that she was notified by LPN #1 around lunchtime on 12/17/25 that Resident #1 had inappropriately touched Resident #2's breast. She reported that she and the Director of Nursing (DON) immediately attempted to retrieve and review camera footage from the day room and verified that the incident had occurred. She stated that approximately twenty (20) minutes later, Certified Nurse Aide (CNA) #2 came to the office and reported that Resident #1 had inappropriately touched another resident. She explained that following the second incident, Resident #1 was returned to his room and placed on one-to-one observation. RN #1 stated that if Resident #1 had been placed on one-to-one observation after the first incident, the second incident could have been prevented. She further reported that Resident #1's family was understanding of the situation, while	F0600		

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F0600 SS = SQC-J	Continued from page 7 Resident #2's son was upset but acknowledged that incidents can occur. On 12/22/25 at 2:19 PM, during an interview with the Director of Nursing (DON), she explained that on the day the incident occurred she was seated in her office with RN #1 when LPN #1 reported that Resident #1 had inappropriately touched Resident #2's breast. She reported that at that time, she and RN #1 began reviewing video camera footage of the day room. She stated that before RN #1 was able to leave the office to ensure Resident #1 was being monitored, CNA #2 entered the office and reported that Resident #1 had inappropriately touched another resident, Resident #3. The DON acknowledged that Resident #1 should have been placed on one-to-one observation immediately following the first incident and that doing so would have prevented further harm to another resident. She stated that the dignity of both affected residents was not maintained and that their resident rights were violated, describing the incidents as traumatic occurrences. She reported that as corrective action, Resident #1 had been placed on direct one-to-one observation and would remain on one-to-one observation indefinitely. She further stated that the affected residents were being rounded on hourly until thirty (30) days following the incident. On 12/22/25 at 3:20 PM, during an interview with Resident #3's son, he stated that she likely felt embarrassed and bothered by what occurred but stated that she would have forgiven Resident #1 and understood that some residents in nursing homes are not in their right state of mind due to Alzheimer's disease or other conditions. On 12/22/25 at 3:28 PM, during an interview with Resident #2's mother and Resident Representative, she stated that she was initially upset that her daughter had been left unattended in a situation where the incident could occur. She reported that she understood that some residents have cognitive impairments or disabilities that may lead to inappropriate behaviors. On 12/23/25 at 10:50 AM, during an interview with the psychiatric Nurse Practitioner, she stated she evaluated Resident #1 on 12/15/25. She explained that she functions as a consultant and makes recommendations for psychiatric medications to the facility's in-house Nurse Practitioner, who is responsible for writing orders. She explained that, at the time of her evaluation, the behavior did not represent an escalation, the resident was easily redirected, denied ongoing impulsive thoughts, and the behaviors were	F0600		

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F0600 SS = SQC-J	Continued from page 8 consistent with dementia-related symptoms. The facility submitted a corrective action plan as follows: 1. Overview of the Issue a. The facility failed to protect residents from abuse and develop and implement effective care plan interventions for Resident #1 related to known sexually inappropriate behaviors (comments). On 12/12/2025, the facility identified escalating sexually inappropriate behaviors (comments) by Resident #1. However, the facility failed to develop a care plan related to supervision and behavioral interventions prior to 12/17/2025, when Resident #1 inappropriately touched Resident #2 and Resident #3. Resident #1 was viewed inappropriately touching Resident #2 in the breast area by, Housekeeper #1. He pulled Resident #1 away from Resident #2 alerting LPN (Licensed Practical Nurse) #1. LPN #1, took Resident #1 to his room to separate them and went to report the incident to DON (Director of Nursing) and ADON (Assistant Director). While the reporting to the DON and ADON was occurring, SNA (Student Nursing Assistant) #1, unaware of the incident, brought Resident #1 back to the day room, where he inappropriately touched Resident #3 in the breast area. LPN #1 failed to implement and communicate 1-1 supervision immediately thus not protecting Resident #3 from abuse. b. The SA handed the facility the IJ template on 12/23/2025 at 9:30 AM. 2. Corrective Action a. On 12/17/2025, a QA (Quality Assurance) meeting was held. Abuse Policy and Care plan policies were reviewed. All disciplines attended. No changes were needed. b. On 12/17/2025, 1-1 observation was started by the DON and ADON when the incident was reported to them. This will be assigned to the scheduled Certified Nursing Assistant (CNA). c. On 12/17/2025, 12/18/2025, and 12/19/2025 In-services were conducted on Abuse and Identifying Sexual Abuse and Capacity to Consent by Staff Development Nurse and the Administrator. All staff received training regarding that if staff witnesses abuse, the one who perpetrates or initiates abusive behavior cannot remain in contact with other residents.	F0600		

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F0600 SS = SQC-J	Continued from page 9 Take them with you to a supervisor or another employee must remain with them until a decision is made as to what needs to be done. No staff were allowed to work until in-serviced. d. LPN #1 was disciplined and educated on 1-1 supervision when there is an abuse allegation on 12/17/2025. e. CNA #1, was educated on proper undergarment placement for Resident #2 on 12/18/2025. f. Care Plans were updated on 12/17/2025 for all Residents involved and reviewed all residents with behaviors and their care plans. g. On 12/17/2025, body audits were conducted on Resident #2 and Resident #3. h. On 12/17/2025, hourly checks were initiated on Resident #2 and Resident #3. i. On 12/17/2025, Referrals were sent out to multiple Geri-psych units and other facilities for Resident #1. 3. Monitoring a. On 12/17/2025, 1-1 observation of Resident #1 will be assigned to the scheduled Certified Nursing Assistant (CNA). Post Event Hourly Monitoring Form will be used. b. Review Care Plans on Residents with behaviors weekly for 4 weeks, monthly for 3 months, and then quarterly. Social Services Director and Care Plan Nurse will be responsible for reviewing and addressing in QA. The Facility alleges all actions were completed to remove the IJ on 12/19/2025. The Immediate Jeopardy was removed on 12/20/2025, prior to the State Agency's entrance on 12/22/2025. Validation: The SA validated on 12/23/25, through interview and record review, that all corrective actions had been implemented as of 12/19/25, and the IJ was removed on 12/20/25, prior to the SA's entrance on 12/22/25.	F0600		
F0656 SS = J	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F0656	"Past Noncompliance - no plan of correction required"	

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(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
F0656 SS = J	Continued from page 10 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by:	F0656		

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F0656 SS = J	Continued from page 11 Based on interviews, record review, facility policy review, and facility investigation review, the facility failed to develop and implement a comprehensive care plan related to sexually inappropriate behaviors for one (1) of four (4) sampled residents. Resident #1 On 12/17/25 at 11:26 AM, Resident #1 (male) inappropriately touched the breast of Resident #2 (female) in the day room. After staff were notified, Resident #1 was taken to his room and left unsupervised. At approximately 11:32 AM, Resident #1 was assisted back to the day room by a staff member who was unaware of the incident. On 12/17/25 at 11:49 AM, Resident #1 inappropriately touched the breast of Resident #3 (female). The facility was aware prior to these incidents that Resident #1 had a history of sexually inappropriate behaviors, including sexual comments toward staff on 12/12/25, yet failed to implement immediate supervision or restrictions to protect other residents. The facility's failure to develop and implement a comprehensive care plan resulted in Resident #2 and Resident #3 experiencing non-consensual sexual contact and placed other vulnerable female residents at risk for serious injury, serious harm, serious impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) which began on 12/12/25, when Resident #1 made sexual comments toward facility staff. The State Agency (SA) notified the Administrator of the IJ on 12/23/25 at 9:30 AM and provided an IJ Template. Based on the facility's implementation of corrective actions on 12/19/25, the SA determined the IJ to be Past Non-Compliance (PNC) and the IJ was removed on 12/20/25, prior to the SA's entrance on 12/22/25. Findings include: A review of the facility's "Develop/Implement Comprehensive Care Plan" policy, dated September 2022, revealed, "…The facility will develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights and that includes measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs…1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required…"	F0656		

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F0656 SS = J	Continued from page 12 A record review of the "Facility Reported incident Initial Report" dated 12/17/25, revealed an "Allegation Type" of Sexual Abuse. The initial report indicated that on 12/17/25 at 11:26 AM, Resident #1 inappropriately touched Resident #2 on her breast while in the Day Room. The event was witnessed by the facility's Janitor. The janitor separated the residents and notified Licensed Practical Nurse (LPN) #1, who took Resident #1 to his room and immediately went to the Director of Nursing (DON) office to notify her of the incident. While LPN #1 was walking to the DON's office, Resident #1 was attempting to come out of his room. Certified Nursing Assistant (CNA) #1, who had no knowledge of the incident and was not his assigned CNA, assisted him out of his room and back to the dayroom. At 11:49 AM, Resident #1 inappropriately touched Resident #3 on her breast. CNA #2 witnessed the incident and immediately separated the residents. The resident was immediately placed on one on one (1:1) observation. Resident #1 A record review of the "Admission Record" revealed the facility admitted Resident #1 on 4/26/2023 with current diagnoses including Cerebral Infarction. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/1/25 revealed Resident #1 had a Brief Interview for Mental Status score of 6, which indicated his cognition was severely impaired. A record review of the "Care Plan Report" for Resident #1 revealed a focus area titled "Quality of Life," which included the statement, "I see a mental health specialist." Further review revealed there were no individualized or specific care plan interventions, monitoring instructions, or staff guidance addressing Resident #1's documented sexually inappropriate behaviors. A record review of the "Behavior Reporting Form" revealed that on 12/12/25 at approximately 12:00 PM in the facility's hallway, Resident #1 asked employee to see her breasts and documented that "Resident stopped employee in the hallway and asked to see her breasts. Employee educated Resident on inappropriateness of request and instructed to not ask that. Resident showed understanding by nodding." A record review of the "Psych Progress Note", dated 12/15/25 revealed Resident #1 had "Presenting Symptoms" including "Inappropriate Behavior." The "Mental Stus	F0656		

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F0656 SS = J	Continued from page 13 Exam" included "…Comprehension: Difficulty with recall, unable to remember current events…Executive Function: Moderate impairment…impaired decision making…Judgement: Poor Ability to Plan, Poor Social Cognitions, Poor Memory…Thought Process: Confused/Slowed, slowed processing/intermittent confusion." The "Case Conceptualization" documentation included "…He has some increased inappropriate behaviors (sexually impulsive). Discuss this with resident and he states, 'I only do that with people I'm comfortable with.' Discuss inappropriateness of behavior and resident v/u (verbalized understanding)." Resident #2 A record review of the "Admission Record" revealed the facility admitted Resident #2 on 1/31/24 with diagnoses including Classical Phenylketonuria. A record review of the Comprehensive MDS with an ARD of 12/3/25 revealed Resident #2 required a "Staff Assessment for Mental Status" and that her cognitive skills for daily decision making was severely impaired. A record review of the "Progress Notes", dated 12/17/2, revealed, "DON notified nurse that male resident was observed making physical contact with resident's breast…Staff intervened and separated residents…" Resident #3 A record review of the "Admission Record" revealed the facility admitted Resident #3 on 9/15/23 and she had diagnoses including Cerebral Infarction. A record review of the Quarterly MDS with an ARD of 10/3/25 revealed Resident #3 required a "Staff Assessment for Mental Status" that revealed her cognitive skills for daily decision making was severely impaired. A record review of the "Progress Notes", dated 12/17/25, revealed, "Resident was sitting in her wheelchair in the day room when a male resident rolled his wheelchair beside her. The male resident inappropriately touched her right breast. A CNA witnessed the incident and immediately separated the male resident from her…" On 12/22/25 at 1:32 PM, during an interview with the Administrator, she explained Resident #1 had a known history of sexually inappropriate verbal behaviors toward staff, including making sexual comments and attempting to grab staff members' buttocks, as well as	F0656		

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F0656 SS = J	Continued from page 14 a prior incident approximately one (1) year earlier in which the resident pulled down his pants and exposed himself in the day room. She stated that she had completed a behavior report regarding sexually inappropriate comments by Resident #1 on 12/12/25, five (5) days prior to the incidents and submitted it to psychiatric services. She stated that on that date, Resident #1 stopped her in the hallway and asked her to show him her breasts and then asked if he could see the breasts of another CNA who was nearby. She confirmed that psychiatric services evaluated Resident #1 on 12/15/25 related to these inappropriate verbal behaviors. On 12/22/25 at 3:30 PM, during an interview with Registered Nurse (RN) #2, the care plan nurse, she explained that resident care plans are updated either by floor nursing staff or by the two designated care plan nurses when new orders are received. She stated that new orders are written in red ink to identify changes and are incorporated into the care plan, which is formally reviewed and updated every three (3) months. She explained that the care plan guides staff in providing appropriate care to residents. On 12/23/25 at 1:32 PM, during a follow-up interview with the Administrator, she confirmed that Resident #1's care plan was not updated until 12/17/25 although inappropriate behaviors were identified on 12/12/25. The facility submitted a corrective action plan as follows: 1. Overview of the Issue a. The facility failed to protect residents from abuse and develop and implement effective care plan interventions for Resident #1 related to known sexually inappropriate behaviors (comments). On 12/12/2025, the facility identified escalating sexually inappropriate behaviors (comments) by Resident #1. However, the facility failed to develop a care plan related to supervision and behavioral interventions prior to 12/17/2025, when Resident #1 inappropriately touched Resident #2 and Resident #3. Resident #1 was viewed inappropriately touching Resident #2 in the breast area by, Housekeeper #1. He pulled Resident #1 away from Resident #2 alerting LPN (Licensed Practical Nurse) #1. LPN #1, took Resident #1 to his room to separate them and went to report the incident to DON (Director of Nursing) and ADON (Assistant Director). While the reporting to the DON and ADON was occurring, SNA (Student Nursing Assistant)	F0656		

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F0656 SS = J	Continued from page 15 #1, unaware of the incident, brought Resident #1 back to the day room, where he inappropriately touched Resident #3 in the breast area. LPN #1 failed to implement and communicate 1-1 supervision immediately thus not protecting Resident #3 from abuse. b. The SA handed the facility the IJ template on 12/23/2025 at 9:30 AM. 2. Corrective Action a. On 12/17/2025, a QA (Quality Assurance) meeting was held. Abuse Policy and Care plan policies were reviewed. All disciplines attended. No changes were needed. b. On 12/17/2025, 1-1 observation was started by the DON and ADON when the incident was reported to them. This will be assigned to the scheduled Certified Nursing Assistant (CNA). c. On 12/17/2025, 12/18/2025, and 12/19/2025 In-services were conducted on Abuse and Identifying Sexual Abuse and Capacity to Consent by Staff Development Nurse and the Administrator. All staff received training regarding that if staff witnesses abuse, the one who perpetrates or initiates abusive behavior cannot remain in contact with other residents. Take them with you to a supervisor or another employee must remain with them until a decision is made as to what needs to be done. No staff were allowed to work until in-serviced. d. LPN #1 was disciplined and educated on 1-1 supervision when there is an abuse allegation on 12/17/2025. e. CNA #1, was educated on proper undergarment placement for Resident #2 on 12/18/2025. f. Care Plans were updated on 12/17/2025 for all Residents involved and reviewed all residents with behaviors and their care plans. g. On 12/17/2025, body audits were conducted on Resident #2 and Resident #3. h. On 12/17/2025, hourly checks were initiated on Resident #2 and Resident #3. i. On 12/17/2025, Referrals were sent out to multiple Geri-psych units and other facilities for Resident #1.	F0656		

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F0656 SS = J	Continued from page 16 3. Monitoring a. On 12/17/2025, 1-1 observation of Resident #1 will be assigned to the scheduled Certified Nursing Assistant (CNA). Post Event Hourly Monitoring Form will be used. b. Review Care Plans on Residents with behaviors weekly for 4 weeks, monthly for 3 months, and then quarterly. Social Services Director and Care Plan Nurse will be responsible for reviewing and addressing in QA. The Facility alleges all actions were completed to remove the IJ on 12/19/2025. The Immediate Jeopardy was removed on 12/20/2025, prior to the State Agency's entrance on 12/22/2025. Validation: The SA validated on 12/23/25, through interview and record review, that all corrective actions had been implemented as of 12/19/25, and the facility was in compliance on 12/20/25, prior to the SA's entrance on 12/22/25.	F0656		