STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115697	A. Building B. Wing	08/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountainview Ctr for Alzheimer	2631 North Druid Hills Road N E Atlanta, GA 30329

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy titled, Abuse, Neglect, and Exploitation, the facility failed to ensure residents were free from sexual abuse for three of six residents reviewed for abuse (Resident (R) 2, R3, and R6). Specifically, R1 displayed inappropriate sexual behaviors towards others on 6/20/2025 when she grabbed a male housekeeper's private area (groin) and buttocks. The resident's inappropriate sexual behavior towards staff members progressed to resident's on the South Pavillion unit sustaining sexual abuse. Even though the facility was aware of R1's inappropriate sexual behavior and her abuse of other residents, the facility failed to implement any interventions to protect the residents who resided on the unit. The facility's failure to ensure residents were free from abuse had caused or was likely to cause serious injury, harm, impairment, or death to a resident. An Immediate Jeopardy was identified on 8/15/2025 and was determined to exist on 6/20/2025. The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy on 8/15/2025 at 9:00 am. The facility was notified that an acceptable plan of removal had been accepted on 8/16/2025 at 4:11 pm. The Surveyor validated the full implementation of the facility's removal plan, and the Administrator was notified on 8/17/2025 at 9:31 am that the Immediacy had been removed.Findings include:Review of the facility's policy titled, Abuse, Neglect, and Exploitation, revised 1/23/2023 revealed the definition of sexual abuse as non-consensual sexual contact of any type with a resident. The policy also revealed Employee Training.C. Training topics will include: .2. Identifying what constitutes abuse.III. Prevention of Abuse, Neglect and Exploitation. The facility will implement policies and procedure to prevent and prohibit all types of abuse.A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, such as the identify when, how, and by whom determinations of capacity to consent to sexual contact will be made and where this documentation will be recorded.The facility will have written procedures to assist staff in identifying the different types of abuse.sexual abuse.Review of R1's undated admission Record, located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder, bipolar type, unspecified dementia, and delusional disorders.Review of R1's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/18/2025 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of two out of 15 which indicated the resident was severely cognitively impaired. The MDS also indicated the resident was assessed to have exhibited other behavioral symptoms directed towards others (e.g., physical symptoms such as.public sexual acts, disrobing in public, and verbal/vocal symptoms. and also assessed that the behaviors significantly impacted others care or living environment during the assessment period.Review of R1's Nursing Progress Note, dated 6/20/2025 and located in the resident's EMR under the Progress Notes tab (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	revealed .At approximately 11:30 am a male housekeeper was observed running away from the resident, with the resident chasing after him. The housekeeper reported that the resident had just grabbed his private area and touched him on his buttocks. The resident had to be redirected several times in order to stop her from chasing after the male housekeeper.Review of R1's Nursing Progress Note, dated 6/24/2025 and located in the resident's EMR under the Progress Notes tab revealed Resident inappropriately fondled narrator. When passing in hall Narrator attempted to say good morning to resident in which she said, Hello to you too and grabbed narrators vagina.Review of R1's Nursing Progress Note, dated 6/25/2025 and located in the resident's EMR under the Progress Notes tab revealed .CNA reported to this nurse that client [resident] walked towards her rolling her hips and thrusting her pelvis toward sher [sic] .then client reached out and started rubbing CNA's right breast.when CNA asked client not ot touch her like that, client responded 'you do not like doing that' .Review of R1's Nursing Progress Note, dated 6/25/2025 and located in the resident's EMR under the Progress Notes tab revealed Resident observed attempting to take male resident into another resident's room stating, 'Want to do it?' Narrator was informed by a visitor that was on site visiting another resident. Both residents separated and easily redirected without issues.Review of R1's Nursing Progress Note, dated 6/28/2025 and located in the resident's EMR under the Progress Notes tab revealed The resident was observed following a particular male resident throughout the shift. She held his hands and attempted to sit in his lap on several occasions. The resident required frequent redirections. Staff continued to intervene, attempted to separate this resident from the male resident, and distract her with games and activities. This resident would get upset when redirected. She continued to follow this male resident.Review of R1's Nursing Progress Note, dated 6/29/2025 and located in the resident's EMR under the Progress Notes tab revealed Patient [resident] observed walking in the POD [unit] rubbing on her breast this morning asking CNA to feel on her breast.1. Review of R2's undated admission Record, located in the resident's EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease, and dementia.Review of R2's quarterly MDS with an ARD of 8/13/2025 and located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of five out of 15 which indicated the resident was severely cognitively impaired.Review of R1's Nursing Progress Note, dated 6/29/2025 and located in the resident's EMR under the Progress Notes tab revealed .This morning during morning care the CNA [CNA3] assigned to resident reported the resident had taken her pants off and 'spread eagle' on her bed, with her legs wide apart telling her to, 'come and get it.' The CNA also reported that resident had grabbed her breast and proceeded to shake them at the CNA, while inviting the CNA to feel them. Shortly after leaving her room, the resident then went to one of the dining room [sic], lift up her blouse and then bared her breast to the residents and staff in the dining room. The resident was later observed chasing after a male resident [R2] who was trying to get away from her as he yelled for staff to help him. Staff members were able to redirect her away from the resident. The resident was later observed baring her breast and pushing her breasts in a female resident's face telling her to suck on them.Review of R1's Nursing Progress Note, dated 6/30/2025 and located in the resident's EMR under the Progress Notes tab revealed Resident continues to exhibit sexual behaviors throughout shift to staff and other residents.Review of R1's Nursing Progress Note, dated 7/1/2025 and located in the resident's EMR under the Progress Notes tab revealed Spoke with RP [Resident Representative] in regards to change in Depakote order due to increased sexual behaviors.Review of R1's Nursing Progress Note, dated 7/2/2025 and located in the resident's EMR under the Progress Notes tab revealed Called to room by CNA to observed resident exposing her breast and attempting to touch another resident (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	.Review of R1's Nursing Progress Note, dated 7/2/2025 and located in the resident's EMR under the Progress Notes tab revealed Resident was observed walking in front of another [resident] and starting to pull her blouse up stating she want someone to touch her beast. Staff intervened and redirected her.Review of R1's Nursing Progress Note, dated 7/2/2025 and located in the resident's EMR under the Progress Notes tab revealed Resident continues to be sexually inappropriate throughout the shift wanting to sit on other's [sic] [residents] lap, pulling her blouse up and exposing herself, making sexual gestures and comments. She was consistently redirected throughout the shift.Review of R1's Nursing Progress Note, dated 7/3/2025 and located in the resident's EMR under the Progress Notes tab revealed Resident continues to wander in other residents [sic] rooms and exhibiting hypersexual behaviors.Review of R1's Nursing Progress Note, dated 7/4/2025 and located in the resident's EMR under the Progress Notes tab revealed Resident in stable condition, wandering around exhibiting sexual behavior with others [sic] resident.Review of R1's Nursing Progress Note, dated 7/6/2025 and located in the resident's EMR under the Progress Notes tab revealed Resident noted following staff and other res [resident] rubbing on breast.2. Review of R6's undated admission Record, located in the resident's EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease and dementia.Review of R6's quarterly MDS with an ARD of 8/11/2025 and located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of three out of 15 which indicated the resident was severely cognitively impaired.Review of R1's Nursing Progress Note, dated 7/6/2025 and located in the resident's EMR under the Progress Notes tab revealed The resident was observed @ [at] 9:30 am gyrating on a [AGE] year-old male resident [R6] in program room [ROOM NUMBER]. She was redirected by staff members to which she pulled up her blouse and bared her breasts in public.Review of R1's Nursing Progress Note, dated 7/7/2025 and located in the resident's EMR under the Progress Notes tab revealed MD [medical doctor] increased resident's Seroquel.due to the excessive continuous sexual behaviors.Review of R1's Nursing Progress Note, dated 7/22/2025 and located in the resident's EMR under the Progress Notes tab revealed IDT [interdisciplinary team] psychotropic/mood monitoring meeting.Resident has behaviors of wandering into other residents [sic] room at times also noted making inappropriate sexual comments and disrobing in common areas.Review of R1's Nursing Progress Note, dated 7/26/2025 and located in the resident's EMR under the Progress Notes tab revealed Resident noted this shift aggressively seeking male residents out trying to get them to suck on her breast. Resident was redirected to stay away from male residents and strongly encouraged her to not do any negative behaviors to others.Review of R1's Nursing Progress Note, dated 7/29/2025 and located in the resident's EMR under the Progress Notes tab revealed Nurse-saw resident on top of another resident [R2] (in someone else [sic] room. (Female resident [R1] had shirt off). Male had all his clothes on. Did not have sex. Was redirected by Nurse to leave room.Review of R1's Nursing Progress Note, dated 7/31/2025 and located in the resident's EMR under the Progress Notes tab and completed by the Director of Nursing (DON) revealed .spoke with resident's [R1] daughter related to behaviors.suggested a private sitter.3. Review of R3's undated admission Record, located in the resident's EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease and dementia.Review of R3's quarterly MDS with an ARD of 8/13/2025 and located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of zero out of 15 which indicated the resident was severely cognitively impaired.Review of R1's Nursing Progress Note, dated 7/31/2025 and located in the resident's EMR under the Progress Notes tab revealed At 4:45 pm while performing rounds the nursing staff noted resident in room with another male resident with her pants down. Male (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident noted to be fondling resident, both residents were immediate separated and assessed with no acute injuries noted.During an interview on 8/13/2025 at 3:00 pm, the Administrator stated if there was no contact made by R1 to another resident when she was having inappropriate sexual behaviors, then it was not abuse just the resident's behavior.During an interview on 8/13/2025 at 3:50 pm, the Director of Education (DOE) stated she was responsible for providing staff abuse training. When asked about the above documented progress notes, the DOE stated only the incidents on 7/29/2025 and 7/31/2025 met the definition of abuse. The DOE also stated it was not sexual abuse if the other resident was not physically touched by R1.During an interview on 8/13/2025 at 4:25 pm, the Registered Nurse Supervisor (RNS) stated in her opinion, if a cognitively impaired resident pulled her top up in front of residents and staff, that was not abuse, but a behavior. If the other resident would have been touched by R1, then it would have been possible abuse.During an interview on 8/14/2025 at 9:35 am, Certified Nurse Aide (CNA) 1 stated she works on the South Pavillion unit and was familiar with R1. The CNA stated R1 was very sexual and could be redirected; however, she would then just go to a different resident and do inappropriate sexual behaviors to them. CNA1 stated R1 engaged in inappropriate sexual behaviors almost daily and multiple times a day. CNA1 also stated the only thing that could have prevented R1 from bothering other residents would have been to place the resident on one-to-one supervision. The CNA stated sexual abuse was any unwanted sexual behaviors towards another person or resident.During an interview on 8/14/2025 at 10:38 am, Licensed Practical Nurse (LPN) 1 stated a CNA observed R1 and R3 in R1's room. The LPN stated the CNA told her to go look in R1's room. LPN1 stated when she walked into the room, R3 was standing up beside R1's bed with his pants and brief off, and his penis was fully erect. The LPN stated R1 had her shirt pulled behind her head, her breast fully exposed with a blanket covering the rest of the resident's body. The LPN stated when she pulled the blanket off R1, R3 was using his finger to digitally penetrate R1's vagina.During an interview on 8/14/2025 at 11:52 am, the Director of Nursing (DON) stated there were no assessments for residents' capacity to consent for sexual contact completed by the facility. The DON also stated sexual abuse was if a resident received any unwanted sexual behaviors from R1 that involved contact. When asked if a resident had to touch another resident before he considered it as abuse, the DON stated, Yes. The DON stated a resident just exposing her breast to another resident even if the resident also stated something verbally during the exposing of her breast, that was a behavior and not sexual abuse.During an interview on 08/14/25 at 12:18 PM, the Administrator stated R1 was not the normal nursing home resident as her disease manifested the way it did, and she has not filter and that is why she has inappropriate sexual behaviors. The Administrator stated that without physical contact, he would not consider it abuse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy titled, Abuse, Neglect, and Exploitation, the facility failed to complete a thorough investigation which included interviewing and/or assessing other residents who resided on the South Pavillion unit and interviewing staff who worked on the unit for two of two abuse investigations involving residents (Resident (R) 1, R2, and R3). Also, during the facility's investigation, the Administrator who was the Abuse Coordinator failed to thoroughly investigate and identify Certified Nurse Aide (CNA) 2's failure to protect R3 when she discovered R3 in R1's room with his pants off; instead of intervening, the CNA left the resident's room and reported her observations to the nurse. Additionally, the facility failed to protect all residents who resided on the unit when R1's level of supervision (LOS) was not assessed or increased when R1 started engaging in inappropriate sexual behaviors towards other residents which was determined to be sexual abuse. These failures led to the continued abuse of the vulnerable residents who resided on the South Pavillion unit. (Cross reference F600 Free from Abuse and Neglect and F657 Care Plan Timing and Revision)The facility's failure to implement their abuse policy and procedures to complete thorough abuse investigations and the failure of implementing interventions to protect all residents of the unit from sustaining abuse from R1 was likely to cause serious injury, harm, impairment, or death to a resident. An Immediate Jeopardy was identified on 8/15/2025 and was determined to exist on 6/20/2025. R1 attempted to take an unidentified male resident to a room to engage in sexual activity. The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy on 8/15/2025 at 9:00 am. The facility was notified that a plan of removal had been accepted on 8/16/2025 at 4:11 pm. The Surveyor validated the implementation of the facility's removal plan, and the Administrator was notified on 8/17/2025 at 9:31 am that the Immediacy had been removed. Findings include:Review of the facility's policy titled, Abuse, Neglect, and Exploitation, revised 1/23/2023 revealed .Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: .b. Establish policies and procedures to investigate any such allegations.The components of the facility abuse prohibition plan are discussed herein: .B. Prospective residents will be screened to determine whether the facility has the capability and capacity to provide the necessary care and services for each resident admitted to the facility. 1. An assessment of the individuals mood/behavioral status, medical acuity, and special needs will be reviewed prior to admission. 2. The facility will make individual determinations in consideration of current staffing patterns, staff qualifications, competency and knowledge, clinical resources, physical environment, and equipment.III. Prevention of Abuse, Neglect and Exploitation. The facility will implement policies and procedures to prevent and prohibit all types of abuse.A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse, such as the identify when, how, and by whom determinations of capacity to consent to sexual contact will be made and where this documentation will be recorded.B. Identifying, correcting and intervening in situations in which abuse.is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents.V. Investigation of Alleged Abuse, Neglect, and Exploitation. A. An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse.occur.4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations.6. Providing complete and thorough documentation of the investigation.VI. Protection of Resident. The facility will make efforts to ensure all residents (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation.C. Increased supervision of the alleged victim and residents.Review of R1's undated admission Record, located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder, bipolar type, unspecified dementia, and delusional disorders.Review of R1's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/18/2025 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of two out of 15 which indicated the resident was severely cognitively impaired. The MDS also indicated the resident was assessed to have exhibited other behavioral symptoms directed towards others (e.g., physical symptoms such as.public sexual acts, disrobing in public, and verbal/vocal symptoms. and also assessed that the behaviors significantly impacted others care or living environment during the assessment period.Review of R2's undated admission Record, located in the resident's EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease, and dementia.Review of R2's quarterly MDS with an ARD of 8/13/2025 and located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of five out of 15 which indicated the resident was severely cognitively impaired.Review of R1's Nursing Progress Note, dated 7/29/2025 and located in the resident's EMR under the Progress Notes tab revealed Nurse-saw resident on top of another resident [R2] (in someone else [sic] room. (Female resident [R1] had shirt off). Male had all his clothes on. Did not have sex. Was redirected by Nurse to leave room.Review of R3's undated admission Record, located in the resident's EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease and dementia.Review of R3's quarterly MDS with an ARD of 8/13/2025 and located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of zero out of 15 which indicated the resident was severely cognitively impaired.Review of R1's Nursing Progress Note, dated 7/31/2025 and located in the resident's EMR under the Progress Notes tab revealed At 4:45 pm while performing rounds the nursing staff noted resident in room with another male resident with her pants down. Male resident noted to be fondling resident, both residents were immediate separated and assessed with no acute injuries noted.During an interview on 8/14/2025 at 10:38 am, Licensed Practical Nurse (LPN) 1 stated on 7/31/2025 at approximately 4:45 pm, CNA2 approached her at the medication cart and told her to go look in R1's room. LPN1 stated when she entered R1's room, R3 was standing beside R1's bed with his pants and brief completely off. LPN1 also stated R3's penis was fully erect and his had was under the blanket covering R1's lower extremity. Continued interview revealed R1 was lying in her bed with the head of bed elevated approximately 90 degrees, her shirt was pull up over her head with her breast exposed, and her lower extremity was covered with a blanket. LPN1 stated when she pulled the blanket back from R1's lower extremities, she looked down and R3 was digitally penetrating R1's vagina. LPN1 stated R3 may have wandered into R1's room and she saw the opportunity; however, she was not sure how or when R3 entered R1's room. LPN1 further stated R1 had been engaging in inappropriate sexual behaviors since her admission and progressed from the sexual inappropriate behaviors being isolated to just R1 herself, to male and female staff persons, and then to male and female residents. LPN1 stated R1's care plan was never updated with interventions for sexual behaviors nor has she been provided any education about R1's sexual behaviors. When asked what could have been implemented to protect the residents of the South Pavillion unit from abuse, the LPN stated the only way would have been placing R1 on a one-to-one level of supervision at all (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	time.During an interview on 8/14/2025 at 12:18 pm, when asked if he interviewed other residents on the unit or if nursing completed any type of skin or body assessments on the other residents of the unit for the reported abuse incidents on 7/29/2025 and 7/31/2025, the Administrator stated he only interviewed R1, R2, and R3. The Administrator stated he did not interview any of the other residents on the unit because the other residents would not be able to articulate anything useful. The Administrator also stated there were no assessments of any kind completed on the other residents of the unit by nursing or social services after the incidents because it did not affect any other residents. Continued interview revealed that the Administrator did not have staff write out any statements and just verbally spoke to the nurses who documented the two incidents; however, he did not document the interview or have the nurses write out any statements. When asked did his investigation determine that R1 was penetrated digitally, the Administrator stated he only determined R3 was touching R1 in the pubic area. When asked during his investigation, if he was able to determine how LPN1 discovered R1 and R3's sexual encounter, the Administrator stated he believed the LPN was making rounds and walked in on it. When asked if he was aware a CNA observed the sexual encounter between R1 and R3 first, did not intervene, and left the residents alone to go report the incident to the nurse, the Administrator stated he was not aware of that. The Administrator stated it was his expectation CNA2 would have intervened and separated the residents before reporting to the nurse.

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy titled, Comprehensive Care Plans, the facility failed to revise the resident's care plan with nonpharmacological interventions for inappropriate sexual behavior for one of nine sampled residents (Resident (R) 1). This failure led to multiple residents on the South Pavillion unit being victims of sexual abuse by R1. Cross Reference: F600 Free from Abuse and Neglect.The facility's failure to ensure R1's care plan was revised with interventions protecting residents from sexual abuse had caused or was likely to cause serious injury, harm, impairment, or death to a resident. An Immediate Jeopardy was identified on 8/15/2025 and was determined to exist on 6/20/2025. R1's care plan focus was revised to identify the problem of the resident engaging in inappropriate sexual behavior; however, there were no revisions to the interventions for R1's inappropriate sexual behavior. The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy on 8/15/2025 at 9:00 am. The facility was notified that an acceptable plan of removal had been accepted on 8/16/2025 at 4:11 pm. The Surveyor validated implementation of the facility's removal plan, and the Administrator was notified on 8/17/2025 at 9:31 am that the Immediacy had been removed.Findings include:Review of the facility's policy titled, Comprehensive Care Plans, dated 9/1/2023 revealed Policy: It is the policy of [Facility's Name] to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care.3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 6. The comprehensive care plan will include measurable objectives and time frames to meet the resident's needs as identified in the resident's comprehensive assessment.Alternative interventions will be documented as needed.The policy did not entail a process related to revision of care plans outside of the comprehensive and quarterly MDS assessment.Review of R1's undated admission Record, located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder, bipolar type, unspecified dementia, and delusional disorders.Review of R1's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/18/2025 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of two out of 15 which indicated the resident was severely cognitively impaired. The MDS also indicated the resident was assessed to have exhibited other behavioral symptoms directed towards others (e.g., physical symptoms such as.public sexual acts, disrobing in public, and verbal/vocal symptoms. and also assessed that the behaviors significantly impacted others care or living environment during the assessment period.Review of R1's Care Plan, initiated on 6/13/2025 and located in the resident's EMR under the Care Plan tab revealed a Focus of Resident exhibits behavioral episodes as evidenced by wandering. The Care Plan interventions for the Focus included Administer behavior medications as ordered, Allow opportunity to make choices and participate in care if able, Allow resident to calm and reapproach as needed, Approach from the front in a calm, unhurried manner, Assess for signs/symptoms of infection, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115697	A. Building B. Wing	08/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountainview Ctr for Alzheimer	2631 North Druid Hills Road N E Atlanta, GA 30329

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	constipation, or pain that may be causing delirium or increased behavioral episodes, Assist to quiet area with less distractions if behaviors observed and difficult to redirect, Elicit family input for best approach(es) to resident, Ensure safety of resident and others, Make sure resident can see you before you touch or move them, monitor for side effects of medications, provide diversional activities as indicated, Provide small group activities to decrease distraction, and Talk in calm voice when behavior is disruptive. Review of R1's Nursing Progress Note, dated 6/20/2025 and located in the resident's EMR under the Progress Notes tab revealed .At approximately 11:30 am a male housekeeper was observed running away from the resident, with the resident chasing after him. The housekeeper reported that the resident had just grabbed his private area and touched him on his buttocks. The resident had to be redirected several times in order to stop her from chasing after the male housekeeper.Review of R1's Care Plan, revised 6/20/2025 and located in the resident's EMR under the Care Plan tab revealed the resident's focus area was revised to [R1's Name] exhibits behavioral episodes as evidenced by wandering, inappropriate sexual behavior directed toward male staff. Review of the Interventions for the Focus area revealed there were no revisions to the interventions after the revised Focus of the resident exhibiting inappropriate sexual behavior directed toward male staff.Review of R1's Nursing Progress Note, dated 6/24/2025 and located in the resident's EMR under Progress Notes tab revealed Resident inappropriately fondled narrator. When passing in hall Narrator attempted to say good morning to resident in which she said, Hello to you too and grabbed narrators vagina.Review of R1's Care Plan, revised 6/24/2025 and located in the resident's EMR under the Care Plan tab revealed the resident's focus area was revised to [R1's Name] exhibits behavioral episodes as evidenced by wandering, inappropriate sexual behavior directed toward male and female staff members. Review of the Interventions for the Focus area revealed there were no revisions to the interventions after the revised Focus of the resident exhibiting inappropriate sexual behavior directed toward male and female staff members.Review of R1's Nursing Progress Note, dated 6/25/2025 and located in the resident's EMR under the Progress Notes tab revealed Resident observed attempting to take male resident into another resident's room stating, 'Want to do it?' Narrator was informed by a visitor that was on site visiting another resident. Both residents separated and easily redirected without issues.Review of R1's Care Plan, revised 6/26/2025 and located in the resident's EMR under the Care Plan tab revealed the resident's focus area was revised to [R1's Name] exhibits behavioral episodes as evidenced by wandering, inappropriate sexual behavior directed toward staff members and other residents. Review of the Interventions for the Focus area revealed there were no revisions to the interventions after the revised Focus of the resident exhibiting inappropriate sexual behavior directed toward staff members and other residents.During an interview on 8/13/2025 at 2:00 pm, the Minimum Data Set Coordinator (MDSC) stated she developed and initiated R1's care plan on 6/13/2025. The MDSC stated when the care plan was initiated the resident was care planned for wandering behaviors. The MDSC stated she revised R1's care plan on 6/20/2025 when the resident engaged in inappropriate sexual behavior toward a male staff member. Continued interview revealed the MDSC revised R'1s care plan again on 6/24/2025 when the resident engaged in inappropriate sexual behavior towards a female staff member and then revised it again on 6/26/2025 when the resident engaged in inappropriate sexual behavior towards a resident. When asked if there were any revisions to the resident's interventions for the inappropriate sexual behaviors, the MDSC stated, there were no intervention revisions to address R1's inappropriate sexual behavior towards staff and residents.During an interview on 8/13/2025 at 3:00 pm, with the Administrator revealed when asked about what his expectations were related to the resident's care plan interventions not being revised, the Administrator stated with R1, it was hard to predict when (continued on next page)

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