STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015060	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeway Rehabilitation & Senior Living	4201 Bessemer Super Highway Bessemer, AL 35020

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review and review of a facility policy titled, Notification of Change, the facility failed to ensure Resident Identifier (RI) #312's sponsor/representative was notified when RI #312 had a room change in the facility on 10/18/2024. This deficient practice affected RI #312, one of 27 sampled residents and was cited as a result of the investigation of complaint/report number AL00049381. Findings include: A review of a facility policy titled, Notification of Changes, dated 2024 revealed: . 1. Competent individuals: a. The facility must still contact the resident's physician and notify resident's representative, if known. RI #312 was readmitted to the facility on [DATE]. On 05/01/2025 at 10:03 AM, an interview was conducted with Social Service Designee (SSD)/Care Manager #9. The SSD stated, RI #312 had a room change in the facility on 10/18/2024. The SSD stated, the facility was responsible for notifying the responsible party, and the resident when moving to another room. The SSD stated, she did not notify RI #312's sponsor of the room change. On 05/01/2025 at 11:50 AM, an interview was conducted with RI #312's sponsor. The sponsor was asked when the facility notified her of RI #312's room change. The sponsor stated, the facility did not notify her of the room change. On 05/01/2025 at 4:56 PM, an interview was conducted with the DON (Director of Nursing). The DON stated, Social Services was responsible for notifying family members of a room change. The DON stated, family members and residents should be notified of room changes before the move. The DON stated, according to the policy, someone should have notified RI #312's family of the room change.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review and review of a facility policy titled, Safe and Homelike Environment, the facility failed to ensure residents were provided a safe, clean, comfortable, and homelike environment. During the survey the following concerns were observed in Residents' rooms and common areas: 1) Resident Identifier (RI) #2, RI #7, RI #24, RI #25, RI #31, RI #38 and RI #43 had areas of walls and trim in their rooms in need of painting; 2) RI #1, RI #2, and RI #25 had window blinds in their rooms with broken or missing pieces; 3) RI #15 and RI #25 had windowsills in their rooms in need of repair; 4) RI #26 had a dresser with chipped paint; 5) The Unit Two hallway had broken and stained ceiling tiles; 6) RI #31 and the hallway on Unit Two had as wall with detaching trim; 7) RI #43 had a wall with a hole behind the door and missing pieces of floor tiles. These observations were made on two of two units at the facility; and in the rooms of RI #'s 1, 2, 7, 15, 24, 25, 26, 31, 38, and 43. Findings include: Review of a facility policy titled, Safe and Homelike Environment, with a copyright date of 2024, revealed the following; . Policy: In accordance with residents' rights, the facility will provide a safe, clean, comfortable, and homelike environment, . Definitions: . Environment refers to any environment in the facility that is frequented by the residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby . A homelike environment is one that de-emphasizes the institutional character of the setting, . 9. General Considerations: . e. Report any furniture in disrepair to Maintenance promptly. 1) RI #38 was admitted to the facility on [DATE]. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/29/2025 at 2:44 PM during observations to identify environmental concerns, a board was observed on the wall to the left side of RI #38's bed and plastered areas were observed on the wall behind the head of RI #38's bed. On 05/01/2025 at 8:26 AM the unpainted board was observed on the wall to the left side of RI #38's bed and the plastered areas remained on the wall behind the head of RI #38's bed. On 05/05/2025 at 2:56 PM the Maintenance Director (MTD) observed the areas with the surveyor and he described the area on the left wall of RI #38's bed and areas at the head of the bed as needing to be painted. The MTD said, he had not had a chance to paint the areas yet and they had been that way for at least a month. 2) RI #25 was admitted to the facility on [DATE]. On 04/29/2025 at 3:53 PM the surveyor observed plaster on the wall at the head of RI #25's bed and missing pieces of paint on the wall, and a piece of wood was observed missing from the right windowsill. On 05/05/2025 at 2:59 PM the MTD observed the areas with the surveyor and he described the wall at the head of RI #25's bed as needing to be sanded and painted, the window blind had missing pieces and the piece of wood from the window sill needed to be glued back into place. The MTD said, no one had made him aware of the missing pieces on the blinds or the wood from the windowsill. 3) RI #24 was admitted to the facility on [DATE]. On 04/29/2025 at 4:24 PM, the surveyor observed a plastered area on the right wall and at the head of RI #24's bed. RI #24 said, the walls had been that way for a while. On 05/05/2025 at 3:02 PM, the MTD observed the areas with the surveyor, and he described the walls on the right side and at the head of RI #24's bed as needing to be painted. 4) RI #7 was admitted to the facility on [DATE]. On 04/29/2025 at 5:43 PM, the surveyor observed missing pieces of paint on the wall behind the head of RI #7's bed. On 05/05/2025 at 3:08 PM, the MTD observed the areas with the surveyor, and he described the wall at the head of RI #7's bed as needing to be sanded and painted. 5) RI #2 was admitted to the facility on [DATE]. On 04/29/2025 at 3:04 PM, the surveyor observed missing paint on the wall and missing trim behind the head of RI #2's bed, along with broken blinds at both of the windows in RI #2's room. On 05/05/2025 at 3:09 PM, the MTD observed the areas with the surveyor, and he described the area at the head of RI #2's bed as needing to be patched and painted. The MTD said, the blinds needed to be replaced, and no one had told him about the condition of the blinds. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6) RI #26 was admitted to the facility on [DATE]. On 04/29/2025 at 3:19 PM, the surveyor observed chipped paint on top of the dresser in RI #26's room. On 05/05/2025 at 3:13 PM, the MTD observed the area with the surveyor, and he described the top of RI #26's dresser as having chipped paint which needed to be sanded and painted. 7) On 04/30/2025 at 4:14 PM, the surveyor observed broken ceiling tile over the door leading onto the dining room. On 05/05/2025 at 3:18 PM, the MTD observed the area with the surveyor, and he described the ceiling tile going into the dining room as needing to be replaced. 8) RI #31 was admitted to the facility on [DATE]. RI #15 was admitted to the facility on [DATE]. RI #1 was admitted to the facility on [DATE]. On 04/29/2025 at 2:39 PM, the surveyor observed the baseboard leading into the bathroom shared by RI #31, RI #15 and RI #1 was detaching from the wall and there was a damaged windowsill. On 05/05/2025 at 3:25 PM, the MTD observed with the surveyor areas of concern in the room shared by RI #31, RI #15, and RI #1. The MTD described the wall at the head of RI #31's bed as needing to be painted, the blinds at RI #1's window as needing to be replaced, the window sill of RI #15's window as needing to be replaced, the baseboard leading into the bathroom needed to be glued back, and a black substance on the bathroom floor was worn safety strips that needed to be replaced. 9) On 04/29/2025 at 3:55 PM, the surveyor observed the ceiling tiles in the hallway between rooms Room Locator (RL) #1 and RL #6 to be sagging and torn. On 05/05/2025 at 3:33 PM, the MTD observed the area with the surveyor, and he described the ceiling tiles between RL #1 and RL #6 as being torn and ripped and said the tiles needed to be replaced. 10) RI #43 was admitted to the facility on [DATE] and readmitted on [DATE]. On 04/29/2025 at 2:40 PM, the surveyor observed a hole in the wall in RI #43's room. When asked how long the hole had been in the wall, RI #43 said since he/she had been in the room, which was about three months. Chipped paint was also observed on the wall behind RI #43's bed. On 04/30/2025 at 4:00 PM, the surveyor also observed missing pieces of floor tile in RI #43's room. On 05/05/2025 at 3:34 PM, the MTD observed the areas with the surveyor, and he said the hole on the wall behind the door on the right side of the room needed to be patched; and the area at the head of RI #42's bed needed to be painted. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/05/2025 at 3:37 PM, the surveyor conducted an interview with the MTD. The MTD said staff were supposed to put needed repairs in TELS (a system for entering and managing work orders) when things needed to be repaired in the facility. The surveyor asked the MTD when he was made aware of the needed repairs, that were just observed by himself and the surveyor. The MTD said most of them just now, when the surveyor showed him. The MTD said he would not consider the resident's rooms/environment to be homelike.

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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 interviews, resident record reviews, review of a facility policy titled Abuse, Neglect and Exploitation, review of Facility Reported Incidents (FRIs) received by the State Agency, and review of the facility's investigative files, the facility failed to protect the residents' rights to be free from sexual and physical abuse perpetrated by residents. Specifically: 1.) The facility failed to ensure Resident Identifier (RI) #49 was free from sexual abuse perpetrated by RI #1, a resident with a history of sexually inappropriate behavior to include vulgar comments and obscene language. On 09/12/2024 RI #1was found unsupervised in the Activity Room with his/her hand on RI #49's breast. The facility had not developed and implemented interventions to ensure RI #1 was supervised in a manner to protect other residents and monitored appropriately for behaviors that could affect residents' safety. On 08/28/2024 RI #1's dosage of Seroquel (an antipsychotic medication ordered to treat RI #1's Schizophrenia) was decreased. The facility did not ensure the staff were providing enhanced supervision or monitoring and documenting RI #1's behaviors to ensure residents' safety following the Gradual Dose Reduction (GDR) of Seroquel. It was determined the facility's noncompliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.12 Freedom from Abuse, Neglect and Exploitation. On 05/06/2025 at 6:45 PM, the Administrator, Director of Nursing (DON), [NAME] President of Clinical Reimbursement, [NAME] President of Clinical Operations, Regional Director of Clinical Operations, and Senior Regional Director of Clinical Operations were provided a copy of the IJ template and notified of the findings of immediate jeopardy and substandard quality of care in the area of Freedom from Abuse, Neglect, and Exploitation at F600- Free from Abuse and Neglect. The IJ began on 09/12/2024 and continued until 05/09/2025 when the survey team verified onsite that corrective actions had been implemented. On 05/09/2025 the immediate jeopardy was removed, F600 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as the result of the investigation of complaint /report number AL00048797. The facility further failed to ensure RI #11 and RI #1 were protected from physical abuse that did not rise to the jeopardy level. 2.) On 10/04/2023, the facility failed to protect RI #1 from physical abuse when RI #262 hit RI #1 in the face. 3.) On 10/15/2024 the facility failed to protect RI #11 from physical abuse when RI #2, a resident with a history of behaviors, hit RI #11 on the arm. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	These deficient practices affected three of eight residents sampled for abuse. These deficient practices were cited as a result of the investigations of facility reported incident/complaint/report numbers AL00048797, AL00049328, and AL00045759. Findings include: Cross-Reference F605 and F740. Review of the facility's policy titled, Abuse, Neglect and Exploitation, with an implemented date of 05/20/2022, and a revised date of 09/12/2024, revealed: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations . It includes verbal abuse, sexual abuse, physical abuse, . Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment . Sexual Abuse is non-consensual sexual contact of any type with a resident . Verbal Abuse means the use of oral, written or gestured communication sounds that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance regardless of their age, ability to comprehend, or disability . Policy Explanation and Compliance Guidelines: . 3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. The components of the facility abuse prohibition plan are discussed herein: . III. Prevention of Abuse, Neglect and Exploitation The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect . that achieves: . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 and assure staff assigned have knowledge of the individual residents' care needs and behavioral symptoms; . D. The identification, ongoing assessment, and care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict . 1) On 09/12/2024 at 5:35 PM the State Agency received a FRI alleging that RI #1 was observed touching RI #49's breast in the activity room. RI #49 was admitted to the facility on [DATE]. RI #49's quarterly MDS assessment with an ARD of 07/07/2024 documented a BIMS score of 10 of 15 which indicated moderate cognitive impairment. RI #1 was admitted to the facility on [DATE] and had diagnoses to include: Paranoid Schizophrenia, Vascular Dementia, Bipolar II Disorder, and Borderline Personality Disorder. A review of RI #1's PASRR Level I Screening & Results dated 10/04/2019 documented . 5. Does the individual's current behavior or recent history within 1 year indicate that they are a danger to self or other . Yes history of sexual inappropriate behaviors . A review of RI #1's comprehensive care plan titled Care Plan Report revealed: Focus Behaviors . AEB [as evidenced by] . cursing, threatening and criticizing others, taunting and provoking others, name calling and demeaning names . sexual remarks and slurs and inappropriate behaviors such as sexually inappropriate and social behaviors of sexual and vulgar remarks, impulsive episodes and cursing out others. Date initiated: 06/02/2022 Revision on 09/06/2022 . Interventions . Counsel concerning invading others personal space and sexual boundaries as needed . Observe for effectiveness of current medication regimen . Observe for episodes of behaviors and response to interventions . The care plan did not provide direction to staff regarding how or when RI #1 needed to be supervised. A review of RI #1's Progress Notes revealed a Nursing Progress Note dated 03/15/2023 that documented: . Resident verbally aggressive and offering sex to staff . RI #1's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 08/03/2024 documented a Brief Interview for Mental Status (BIMS) score of 7 of 15, which indicated the RI #1 had severe cognitive impairment. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Certified Nursing Assistant (CNA) mood and behavior documentation for RI #1 from August 2024 to October 2024 was conducted. The review of the documents revealed the monitoring was not completed each shift per the instructions. No behaviors were documented on 09/12/2024. A review of RI #1's Electronic Medication Record (EMAR) for August and September 2024 revealed a task to monitor for behaviors each shift with start date of 08/18/2022. The review of the documents revealed the monitoring was not completed each shift per the instructions. No behaviors were documented on 09/12/2024. A review of RI #1's Behavior Monitoring notes in 2024 revealed no behaviors were documented except a note on 07/04/2024 which documented refusal of a vaccination and that the resident was combative with the writer of the note. Surveyors attempted and were unable to view video footage during the survey. An interview was conducted with RI #49 on 04/30/2025 at 10:07 AM. RI #49 was asked about the incident involving RI #1 on 09/12/2024. RI #49 indicated he/she knew RI #1 due to their shared residence at the facility, but he/she did not recall the incident. On 05/01/2025 at 10:25 AM, an interview was held with Certified Nursing Assistant (CNA) #15 regarding the incident that occurred on 09/12/2024, involving RI #1 and RI #49. CNA #15 reported that while passing by the Activity Room around 4:00 PM, she observed RI #1 touching RI #49's breast. She said that both residents were seated at a table in the Activity Room and that RI #1's hand was on the RI #49's breast and not under the shirt. CNA #15 said she intervened by separating the residents, remaining in the room, and calling for the nurse who was outside the door. She said no staff members were present in the room during the incident. CNA #15 said the Activity Director finished her shift at 4:00 PM. CNA #15 said the presence of staff in the Activity Room might have prevented the incident. CNA #15 said she this incident was sexual abuse and that RI #49 likely felt violated. On 05/01/2025 at 4:17 PM, an interview was held with LPN #13 regarding the incident involving RI #1 and RI #49 that occurred on 09/12/2024. LPN #13 reported that while she was outside the Activity Room, she heard CNA #15 calling for assistance. Upon entering the room, LPN #13 observed RI #1 with his/her hand on RI #49's breast. LPN #13 stated that she helped to separate the residents and took RI #1 to his/her room. LPN #13 said that the incident was sexual abuse and that RI #49 did not want for RI #1 to touch him/her. An interview was held with CNA #22 on 05/04/2025 at 11:50 AM. CNA #22 said that residents were prohibited from being in the Activity Room without supervision and that a staff member should have been present during the incident. She said unsupervised residents in the Activity Room could engage in arguments or altercations. An interview was conducted with the Activity Director (AD) on 05/03/2025 at 12:17 PM. The AD was questioned regarding the incident that took place on 09/12/2024 involving RI #1 and RI #49. The AD acknowledged that she was aware of the incident but did not witness it firsthand. When asked whether residents were permitted to be in the Activity Room unsupervised, she did not know. The AD said not providing supervision in the Activity Room could lead to resident altercations. She said that the incident involving RI #1 and RI #49 might have been prevented had staff been present, as RI #1 would not have touched RI #49 in front of staff. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with Former Administrator (FA) #10 on 05/05/2025 at 3:55 PM. During the interview, the FA was questioned regarding the incident involving RI #1 and RI #49 that occurred on 09/12/2024. According to the FA, LPN #13 informed her that RI #1 had touched RI #49's breast. The FA said she did not know how long the residents were in the Activity Room unsupervised. She said residents were typically not permitted to be in the Activity Room without supervision, which was usually provided by the AD. The FA said the incident involving RI #1 and RI #49 was sexual abuse and that RI #49 would have likely felt violated. On 05/06/2025 at 2:03 PM, an interview was held with the Director of Nursing (DON) regarding the level of supervision for RI #1. The DON indicated that she was not aware of any specific supervision requirements for RI #1. The DON stated that the RI #1 needed standard supervision, which included monitoring every two hours, as well as during activities, dining, and smoking. When asked about the interventions in RI #1's care plan at the time of the incident could have safeguarded RI #49 and other residents from potential abuse by RI #1. The DON said that the interventions explaining to RI #1 the reasons for not engaging in sexually inappropriate behavior, interacting with RI #1, and redirecting or removing the resident from situations when they became disruptive or agitated. ********** On 05/09/2025, the facility submitted an acceptable removal plan, which documented: F600 Removal Plan 05/09/2025 1. Immediate action(s) taken for the resident(s) found to have been potentially affected include: a. The facility failed to ensure RI #49 was free from sexual abuse perpetrated by RI #1, when RI #1, a resident with a history of sexually inappropriate behavior to include vulgar comments and obscene language, was found alone in the activity room at the facility, with his/her hand on RI #49's breast. b. CNA #15 witnessed RI #1 touch RI #49 on the right breast upon entering the activities room. CNA #15 instructed RI #1 to stop touching RI #49 as she entered the room and approached the residents to separate them. CNA #15 called out for assistance and LPN #13 was present in the hallway outside of the activities room door passing medications and entered the activities room and witnessed RI #1 touch RI #49 on the right breast. Residents were immediately separated. RI #1 was immediately taken to his room and placed on 1:1 observation. c. Resident #49 was assessed by RN #16 on 9/12/24 at approximately 1700. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. 1:1 observation was initiated on 9/12/24 immediately following the occurrence of the incident. Provider was contacted, and resident was assessed on 9/13/24 - Recommendation was to discontinue 1:1 sitter and to provide close monitoring while resident out of bed in common areas. 1:1 observation was maintained for five days as a follow-up provider visit was scheduled for Monday 9/16/2024. NP assessed RI #1 on 9/16/2024 and resident continued to have no further behaviors so 1:1 monitoring was stopped the following day on day 5, 9/17/24. The assigned staff were to complete the documentation flow sheet. Charge nurses verified staff were 1:1 with RI #1 during the above noted dates, and staff submitted the flow sheet to the DON for review when completed. No behaviors were observed during that time. 1:1 observation was in place from 9/12/24 to 9/17/24. RI #1 was unable to transfer out of bed without the assistance of the staff. CNAs assigned to RI #1 were verbally instructed by charge nurses at the start of each shift to notify nurse once resident is assisted out of bed so he can be monitored. This directive was also noted on the CNA's care Kardex. This directive was put into effect following the completion of the 1:1 observation. e. On 05/07/2025, the Regional Director of Clinical Operations conducted an in-service for the Administrator and Director of Nursing covering all types of abuse and the facility's responsibility to ensure resident safety. 2. Identification of Other Residents Having the Potential to Be Affected a. This incident had the potential to affect vulnerable residents, that are unable to consent, residing in the facility. 29 residents with BIMS of 10 or greater were interviewed by Care Manager/designee on 5/07/25 using the Abuse screening interview form, if BIMS less than 10 form allows for staff observation with no abuse findings. b. On 5/07/2025, DON/Designees conducted a comprehensive audit of all PASRR forms of all residents in facility to identify all residents with a history of potentially inappropriate sexual behaviors. 0 additional residents were identified upon completion of the audit. RI #1 is the only resident will this history noted on his PASARR. c. On 5/07/2025, The Clinical Reimbursement Specialist reviewed all residents' care plans for any residents identified with known history of sexually inappropriate behaviors. Two additional residents were identified to have a history of sexually inappropriate behaviors. The 2 additional residents were identified by reviewing all residents' care plans to determine if any other resident was care planned for a history of inappropriate sexual behavior or comments. 3. Actions Taken / Systems to Be Put into Place to Reduce the Risk of Future Occurrences a. On 05/7/2025, the Regional Nurse Consultant/Designees provided one-on-one in-service training to the Administrator and Director of Nursing on the facility's Abuse Policy. b. Three residents are identified with a known history of sexually inappropriate behaviors and have interventions identified in their comprehensive person-centered care plan with individualized interventions in place to prevent the occurrence of abuse. These interventions include that each resident will not be in common areas with other residents unsupervised at any time as none of the three residents identified are physically able to transfer out of bed without the assistance of the staff. Interventions were added by the DON and Clinical support specialist on 05-07-2025. (continued on next page)

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	015060	A. Building B. Wing	05/09/2025

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The two common areas located within the center are the dining room and the activities room. No residents are unsupervised in the dining room as the dining room is locked when meal service is complete. Meal services are supervised by the charge nurse and CNA assigned to the dining room that shift. The activities room is always supervised by a staff member. The identified Residents will be kept in highly visible areas when not in a common area. Nurse, CNAs, housekeepers, dietary staff, administrative staff and therapy staff have been in-serviced and will assist in monitoring these individuals. All staff have been in-serviced that the individuals identified in the communications book cannot be left alone in common areas with other people. The CNA assigned to the identified individuals will notify their charge nurse as directed by their care Kardex when these residents are out of bed as none of these residents are physically capable of transferring out of bed unassisted. If any of the identified residents are in the activities room, the activity director or designee hosting the activity will monitor them. If any of the identified residents are in the dining room the CNAs and nurses assigned to assist in the dining room that shift would be responsible for monitoring these residents in the dining room. All staff have been in-serviced to monitor these residents while in any common areas including the hallways of the facility to maintain every 15-minute observations. All three residents have been placed on every 15-minute observations while out of bed, to be signed off by the observing staff member every 15 minutes. If in activities, the Activities Director will visually observe the resident and sign the observation. If in the dining room, the CNA and/or charge nurse assigned to the dining room will visually observe the resident and sign the observation. If near or at nurses' station, the nurse will visually observe the resident and sign the observations. The charge nurse is responsible for ensuring the observations are made and that the observation monitoring sheet is signed off at the end of the shift. The DON is responsible for collecting the observation sheets and the Administrator is responsible for maintaining these records. Care Plans will be monitored and revised with comprehensive assessments and for any changes by the MDS Coordinator/IDT team during their care plan meetings. c. On 5/9/25, the Dietary Dept. has been in-serviced by the Regional Director of Clinical Operations on the process for ensuring the dining room remains locked between meal services to ensure no resident is unsupervised in the dining room. (continued on next page)

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of a facility policy titled Unnecessary Drugs the facility failed to ensure adequate monitoring for behaviors was completed accurately, properly, and consistently while a Gradual Dose Reduction (GDR) for a psychotropic medication was being attempted. Specifically, RI #1 had a dose reduction of Seroquel on 08/28/2024 and the facility did not have a documented system to include timeframe and instructions to staff on monitoring for behaviors while a GDR attempt was in progress. The Certified Nursing Assistant (CNA) and the nurses' behavior monitoring documentation on the Electronic Medication Record (EMAR) was not completed accurately and in a manner to validate whether RI #1 had behaviors or escalation of behaviors. RI #1 had a history of sexually inappropriate behaviors and on 09/12/2024 RI #1 sexually abused RI #49, 15 days after the dose reduction. It was determined the facility's noncompliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.12 Freedom from abuse, neglect and exploitation. On 05/06/2025 at 6:45 PM, the Administrator, Director of Nursing (DON), [NAME] President of Clinical Reimbursement, [NAME] President of Clinical Operations, Regional Director of Clinical Operations, and Senior Regional Director of Clinical Operations were provided a copy of the IJ template and notified of the findings of immediate jeopardy and substandard quality of care in the area of Freedom from Abuse, Neglect, and Exploitation at F605-Free from Chemical Restraints . The IJ began on 09/12/2024 and continued until 05/09/2025 when the survey team verified onsite that corrective actions had been implemented. On 05/09/2025 the immediate jeopardy was removed, F605 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as the result of the investigation of complaint /report number AL00048797. Findings Include: Cross-Reference F600 and F740. Review of the facility's undated policy titled, Unnecessary Drugs, revealed: Policy: It is the facility's policy that each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical and psychosocial well-being free from unnecessary drugs. (continued on next page)

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Policy Explanation and Compliance Guidelines: . 3. The attending physician will assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with residents and/or representatives, other professionals and the interdisciplinary team . d. Adequate monitoring for efficacy and adverse consequences; . 8. Information gathered during the initial and ongoing evaluations will be incorporated into the resident's comprehensive care plan that reflects the person-centered medication related goals and parameters for monitoring the resident's condition . RI #1 was admitted to the facility on [DATE] and had diagnoses to include: Paranoid schizophrenia, Vascular Dementia, Bipolar II Disorder, and Borderline Personality Disorder. RI #1's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 08/03/2024 documented a Brief Interview for Mental Status (BIMS) score of 7 of 15, which indicated RI #1 had severe cognitive impairment. A review of RI #1's comprehensive care plan titled Care Plan Report revealed: Focus The resident uses antipsychotic and antidepressant medications daily r/t [related to] [his/her] dx [diagnosis] of intermittent explosive disorder, dementia with behavioral disturbances, major depressive disorder and bipolar 2 Date initiated: 05/02/2022 Revision on 05/23/2024 . Interventions . Monitor for change in mood and behaviors . The care plan did not include parameters for monitoring the resident's condition. Continued review of RI #1's Care Plan Report revealed: Focus The resident is resistive to care and has hallucinations r/t schizophrenia, Dementia and history of non-compliance with medication regimen. Date initiated: 01/04/2023 Revision on: 01/03/2023 Interventions . Observe for effectiveness of current medication regimen . A review of RI #1's Physician's Orders revealed RI #1 had an order for: (continued on next page)

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	. QUEtiapine Fumarate [Seroquel] oral tablet 150 MG . Give 150 mg [milligram] by mouth at bedtime . Start Date . 10/19/2023 . End Date . 08/28/2024 . A review of Consultant Pharmacist Medication Regimen Review dated 08/19/2024 documented: . Quetiapine 150 mg HS started 10/2023. If no present behaviors noted from 150 mg, please consider another dose reduction to find lowest effective dose . AGREE: Please write order . A review of RI #1's Progress Notes reveal an onsite note documented by Certified Registered Nurse Practioner (CRNP) #24 dated 08/28/2024 documented: . Spoke with resident regarding reduction of quetiapine and patient states it was fine . GDR [gradual dose reduction] made and quetiapine reduced to 100 mg . Further review of RI #1's Physician's Orders documented the following: . QUEtiapine Fumarate Oral Tablet 100 MG . Give 1 tablet by mouth at bedtime . Start Date . 08/28/2024 . End Date . 10/23/2024 . A review of Certified Nursing Assistant (CNA) mood documentation for RI #1 from August 2024 to October 2024 was conducted. The document directed staff to document the resident's mood each shift with a corresponding code related to the resident's mood. A review of the documents revealed this was not completed each shift. Seven of 12 shifts from August 28th to August 31 were blank and not completed. 32 of 60 shifts in September 2024 were blank and not completed including 13 of 24 shifts from September 1st to September 12th. A review of CNA behavior documentation revealed an X was documented 19 of 30 shifts in September 2024. The document instructed staff to document numbers 0-12 to correspond to different behaviors including . 10- Sexually Inappropriate . 12- None of the above observed. The instruction's key did not include an X or provide the meaning of an X. A review of nurses' behavior monitoring task on RI #1's EMAR revealed check marks were documented each shift in August 2024 and each shift in September 2024 except one shift on 09/27/2024 which was blank. The instructions for the behavior monitoring documentation on the EMAR was: Anti-Psychotic Monitor for any behaviors (Harassing disruptive loud behaviors, cursing, sexual slurs and remarks) Document: 'Y' if behavior IS noted during the shift 'N' if NO behavior noted during the shift Use chart code 9 and 'Other/See Nurses Notes' putting in specific progress note findings Document TOTAL # [number] of episodes per shift, Non-Pharmacological Interventions Attempted and Outcomes every shift related to PARANOID SCHIZOPHRENIA . Start Date 09/18/2022 . D/C [discontinued] Date 02/04/2025 1407. There was no instruction to document a check mark. The behavior monitoring task had a start date of 08/18/2022. A review of RI #1's Progress Notes and Nursing Notes revealed no Behavior Monitoring notes were documented from 08/28/2024 through 09/11/2024. (continued on next page)

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was completed with the Director of Nursing (DON) on 05/06/2025 at 5:28 PM. During this interview, the DON was asked to examine the Medication Administration Record (MAR) for RI #1 from September 2024 and the CNA documentation for September to October 2024. The DON stated that she could not provide an opinion whether the forms were completed accurately because she was not employed at the facility at the time the forms were filled out. An interview was held with the Social Services Designee (SSD) on 05/06/2025 at 2:57 PM. During the interview, the SSD was asked about the procedure for communicating GDRs to direct care personnel, including nurses, CNAs, and activities staff. The SSD explained that when a GDR was attempted nursing staff or she would verbally alert all staff members to be alert for any increased resident behaviors and were instructed to report back to either the SSD or the nursing staff. The SSD said the importance of monitoring residents following a GDR was to ensure they received the appropriate dosage for effectiveness and to prevent any escalation in behaviors. The SSD said that enhanced monitoring of residents exhibiting behaviors after a GDR could safeguard other residents from potential abuse by enabling staff to recognize problematic behaviors before they escalated into conflicts. An interview was conducted with the Medical Director (MD) on 05/06/2025 at 3:36 PM. During the interview, the MD was questioned regarding the GDR for RI #1 that took place on 08/28/2024. The MD indicated that residents with a history of behavioral issues should be closely monitored following a GDR to prevent the emergence of new behaviors. He noted that while there was no established standard for the duration of monitoring. The MD emphasized that the purpose of monitoring was to ensure that any changes in a resident's condition were not attributable to the medication adjustment. He also mentioned that heightened observation of residents with behavioral issues after a GDR could safeguard other residents by identifying subtle behavioral changes at an early stage. ********** On 05/09/2025, the facility submitted an acceptable removal plan, which documented: F 605 Removal Plan 05/09/2025 1. Immediate action(s) taken for the resident(s) found to have been potentially affected include: a. The facility failed to ensure monitoring for behaviors after a psychotropic/antipsychotic GDR, was completed accurately, properly, and consistently for RI #1 who had a dose reduction of Seroquel on 8/28/2024. b. On 05/07/2025, the Regional Nurse Consultant conducted an in-service with the Director of Nursing addressing the proper procedure for monitoring behaviors after a psychotropic/antipsychotic dose reduction is initiated and the proper procedure for order entry for all monitoring orders. 2. Identification of other residents having the potential to be affected: (continued on next page)

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. This had the potential to affect all residents prescribed a recommended GDR during the last 30 days. On 5/7/25, A comprehensive audit was completed on all residents with a GDR during that period to ensure proper monitoring order procedure followed. Two residents were identified on this audit as having a GDR in the last 30 days. All current behavior monitoring orders for the two residents identified and for RI #1 were audited for accurate order entry. This was completed on 5/07/25 by DON/Designee. 3. Actions taken/systems to be put into place to reduce the risk of future occurrences include: a. On 5/7/25, The Regional Nurse Consultant in-serviced the DON regarding the process to follow with monitoring specific target behaviors with an increase in monitoring during the 30-day period following a GDR. The process included: i. Upon receiving the recommendation of GDR, the DON/designee reviews the recommendations, contacts the physician prior to implementation. If the physician does not approve, they will provide rational and document it in the progress notes or the DON/designee will document it in the progress notes. If the resident has a prior history of a failed GDR, this should be documented in the residents' CP by the MDS Coordinator/Designee and nurse's notes. If approved the charge nurse will initiate the order in the resident's record. ii. The monitoring order will be entered into EMR by the charge nurse entering the prescribed psychotropic/antipsychotic order or GDR. All components including special documentation parameters for accurate and complete documentation/assessment to be recorded as written in the order. iii. All physicians' orders are reviewed each morning in the morning clinical meeting for accuracy of order entry as well as during the weekly clinical risk meetings. iv. The 30 days following the start date of the GDR, the monitoring frequency will be increased to twice per shift. iv. If during that period any increase in targeted behaviors or any new behaviors are observed, the provider will be notified by the charge nurse immediately and address accordingly. v. The GDRs will be reviewed weekly during clinical risk meetings during the first 30 days of initiation of GDR. vi. A GDR audit tool was implemented 5/7/25 by the Regional Nurse Consultant/Designee. B. The DON was in-serviced on process for utilizing GDR Monitoring Tool and proper monitoring order entry on 5/7/25 by the Regional Nurse Consultant. C. On 5/7/25, the DON and Regional Nurse Consultant conducted in-services with all staff on the above process for monitoring residents when GDR attempted. Staff identify these target behaviors through a structured, person-centered approach that emphasizes observation, communication, and individualized care planning. The residents' target behaviors are identified in their care plans and in their behavior monitoring order. 63 of 65 staff trained (two staff members on FMLA). (continued on next page)

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F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	D. On 5/7/25, DON/Designee conducted an in-service with all staff that included the process for monitoring target behaviors. The in-service included how these behaviors are identified and the process for reporting behaviors. The in-service included; New GDRs will be monitored twice per shift by documentation within Behavior Monitoring Orders in the MAR for the first 30 days that a GDR is attempted. GDR attempts will be tracked via GDR Monitoring Tool and reviewed weekly during clinical risk meetings during those first 30 days to monitor for changes in behaviors associated with the attempted GDR. Medication Monitoring Orders Batch Order Set will be utilized for all behavior and medication monitoring orders. The Behavior Monitoring Order will be edited/updated to note the specific targeted behaviors for that resident as listed in their CP. The Monitoring Order will have all components including special requirement documentation parameters attached within the order in the MAR. Orders will be documented accurately according to the directions noted within the order text. (IE: Chart Y/N for yes or no if noted behavior or side effect occurred. Order document number associated with list of targeted behaviors within the order text.) The nurse assigned documents the behavior on the eMAR and then as directed in the monitoring order, the nurse will then make a progress note detailing the behavior. The in-service on targeted behaviors included identifying, reporting and documentation. All LPNs/RNs have been educated and the education is located in the Nursing Communications Binder for nurses to reference. 63 of 65 staff trained (two staff members on FMLA). E. The DON included this process in the in-service provided to all staff on 5/7/2025. The monitoring order will be entered into EMR by the charge nurse entering the prescribed psychotropic/antipsychotic order or GDR. All components including special documentation parameters for accurate and complete documentation/assessment to be recorded as written in the order. All physicians' orders are reviewed each morning in the morning clinical meeting for accuracy of order entry as well as during the weekly clinical risk meetings. The 30 days following the start date of the GDR, the monitoring frequency will be increased to twice per shift. If during that period any increase in targeted behaviors or any new behaviors are observed, the provider will be notified by the charge nurse immediately. This process is also noted in the Nursing Communications binders. 63 of 65 staff trained (two staff members on FMLA). Facility requests for IJ removal plan to be effective on 05/09/25 ********** After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team determined the facility implemented the immediate corrective actions as of 05/09/2025.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, resident record review, and review of the Centers for Medicare & (and) Medicaid Services (CMS) Long-Term Care Resident Assessment Instrument 3.0 Manual, the facility failed to ensure Resident Identifier (RI) #21's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 01/28/2025 was coded to accurately reflect that RI #21 received special treatment of dialysis. This deficient practice had the potential to affect RI #23, one of 27 sampled residents whose MDS assessments were reviewed. Findings include: The review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2024, section O, revealed: . Intent: the intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received during the specified time periods . RI #21 was readmitted to the facility on [DATE] with diagnoses to include: Dependence on Renal Dialysis and Chronic Kidney Disease. RI #21's Physician Orders documented an order dated 01/07/2025 for Renal Dialysis on Tuesday, Thursday, and Saturday. RI #21's quarterly MDS assessment with an ARD of 01/28/2025 was not marked to reflect RI #21 received dialysis. An interview was conducted with the Regional MDS Coordinator (RMDSC) on 05/01/2025 at 3:50 PM. The RMDSC indicated that RI #21 was currently receiving Dialysis. When asked about the quarterly MDS with an ARD of 01/28/2025, the RMDSC said, it had not been recorded that RI #21 received Dialysis. The RMDSC said, the quarterly MDS assessment should have documented RI #21 received Dialysis, which was an oversight, during the completion of the assessment. The RMDSC said, the importance of an accurate MDS assessment was to ensure a true representation of the care being provided.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations, interview, and review of a facility policy titled, Nurse Staffing Posting Information, the facility failed to ensure the total hours staff actually worked were included on the nurse staff forms posted in the facility on 04/29/2025, 04/30/2025, 05/01/2025, 05/02/2025, and 05/03/2025. This deficient practice was observed on five of 11 days of the survey, and had the potential to affect all 61 residents residing in the facility. Findings include: Review of a facility policy titled, Nurse Staffing Posting Information, with a copyright date of 2025, revealed the following: . Policy Explanation and Compliance Guidelines: 1. The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: a. Facility name b. The current date c. Facility's current resident census d. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: i. Registered Nurses [RN] ii. Licensed Practical Nurses [LPN]/Licensed Vocational Nurses iii.Certified Nurse Aides [CNA] . 4. A copy of the schedule will be available to all supervisors to ensure the information posted is up-to-date and current. a. The information shall reflect staff absences on that shift due to call-outs and illness. After the start of each shift, actual hours will be updated to reflect such . On 04/29/2025 at 3:20 PM, the nurse staff posting form for the 7 AM to 7 PM shift was observed on the bulletin board in front of the main dining room. The form listed the number of Registered Nurses (RN), Licensed Practical Nurses (LPN), Medication Assistant Certified (MAC), and Certified Nursing Assistants (CNA) who were to work the shift, but did not include the total hours actually worked. There was not a section on the form to list the hours worked. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	On 04/30/2025 at 8:24 AM, the nurse staff posting form for the 7 AM to 7 PM shift was observed on the bulletin board in front of the main dining room. The form listed the number of RNs, LPNs, MACs, and CNAs who were to work the shift, but did not include the total hours actually worked. There was not a section on the form to list the hours worked. On 05/01/2025 at 9:38 AM, the nurse staff posting form for the 7 AM to 7 PM shift was observed on the bulletin board in front of the main dining room. The form listed the number of RNs, LPNs, MACs, and CNAs who were to work the shift, but did not include the total hours actually worked. There was not a section on the form to list the hours worked. On 05/02/2025 at 8:12 AM, the nurse staff posting form for the 7 AM to 7 PM shift was observed on the bulletin board in front of the main dining room. The form listed the number of RNs, LPNs, MACs, and CNAs who were to work the shift, but did not include the total hours actually worked. There was not a section on the form to list the hours worked. On 05/03/2025 at 10:31 AM, the nurse staff posting form for the 7 AM to 7 PM shift was observed on the bulletin board in front of the main dining room. The form listed the number of RNs, LPNs, MACs, and CNAs who were to work the shift, but did not include the total hours actually worked. There was not a section on the form to list the hours worked. On 05/05/2025 at 11:53 AM, an interview was conducted with the Director of Nursing (DON). The DON said, according to the facility's nurse staff posting policy, the facility name, the current date, the census, and the total actual hours worked for RNs, LPNs, CNAs should be on the form. The DON said, looking at the nurse staff posting forms for 04/29/2025 to 05/03/2025, the total number of hours staff actually worked was missing. When asked why it would be important to have the actual hours staff worked on the staffing form, the DON said, they would need to know how many staff were actually in the building for a certain timeframe.

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, resident record review, and review of a facility policy titled Behavioral Health Care Services, the facility failed to ensure residents with behaviors were managed and addressed to protect other residents from abuse, and to ensure other residents' safety and privacy was protected from residents with combative, aggressive, and sexual behaviors. Specifically, 1.) The facility failed to ensure staff documented the presence of or absence of target behaviors that were identified in Resident Identifier (RI) #1's Care Plan to ensure RI #1's behaviors were managed. RI #1 had diagnoses of Schizophrenia and Bipolar Disorder and a history of sexually inappropriate behavior. On 09/12/2024 RI #1 was found by staff in the Activity Room unsupervised with RI #49 and RI #1 had his/her hand on RI #49's breast. The facility failed to accurately document changes in occurrences of behaviors including the frequency. The facility failed to establish and communicate the level of supervision and monitoring required when a Gradual Dose Reduction (GDR) attempt was made on 08/28/2024. It was determined the facility's noncompliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.40 Behavioral Health Services. On 05/06/2025 at 6:45 PM, the Administrator, Director of Nursing (DON), [NAME] President of Clinical Reimbursement, [NAME] President of Clinical Operations, Regional Director of Clinical Operations, and Senior Regional Director of Clinical Operations were provided a copy of the IJ template and notified of the findings of immediate jeopardy in the area of Behavioral Health at 740-Behavioral Health Services. The IJ began on 09/12/2024 and continued until 05/09/2025 when the survey team verified onsite that corrective actions had been implemented. On 05/09/2025 the immediate jeopardy was removed, F740 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as the result of the investigation of Facility Reported Incident (FRI)/complaint /report number AL00048797. The following deficiency did not rise to the level of IJ. 2) The facility failed to manage RI #2's behavior on 10/15/2024 when RI #2 hit RI #11 in the arm. These deficiencies were cited as a result of the investigation of complaint/report number AL00049328. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	These failures affected RI #1, RI #49, RI #2, and RI #11 four of 27 sampled residents. Findings include: A facility policy titled Behavioral Health Care and Services with an implemented date of 05/20/2022 and a revised date of 05/04/2025 documented: Policy: It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning and well-being . Policy Explanation and Compliance Guideline: 1. Behavioral health encompasses a resident's whole emotional and mental well-being, . 3. The facility will ensure the necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice and safety . 7. The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. The assessment and care plan will include goals that are person-centered and individualized to reflect and maximize the resident's dignity, autonomy, socialization, independence, choice, and safety. Staff will: . b. Obtain history from medical records, the resident, and as appropriate the resident's family and friends regarding mental, psychosocial, and emotional health. f. Assess and develop a person-centered care plan for concerns identified in the resident's assessment. g. Share concerns with the interdisciplinary team (IDT) to determine underlying causes of mood and behavior changes . h. Accurately document the changes, including frequency of occurrence and potential triggers in the resident's record. i. Ensure appropriate follow-up as needed. j. Discuss potential modifications to the care plan. k. Evaluate resident and care plan routinely to ensure the approaches are meeting the needs of the resident. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10. All facility staff, including contracted staff and volunteers, shall receive education to ensure appropriate competencies and skill sets for meeting the behavioral health needs of residents. Behavioral health training as determined by the facility assessment will include, but is not limited to, the competencies and skills necessary to provide the following: a. Person-centered care and services that reflect the resident's goals for care. 11. Facility staff will implement person-centered care approaches designed to meet the individual goals and needs of each resident . 1) RI #1 was admitted to the facility on [DATE] and had diagnoses to include: Paranoid Schizophrenia, Vascular Dementia, Bipolar II Disorder, and Borderline Personality Disorder. A review of PASARR Level I Screening & Results dated 10/04/2019 documented . 5. Does the individual's current behavior or recent history within 1 year indicate that they are a danger to self or other . Yes history of sexual inappropriate behaviors . A review of RI #1's comprehensive care plan titled Care Plan Report revealed: Focus Behaviors r/t [related to] bipolar do [disorder], personality do, paranoid do and dementia with behaviors of hallucinations and inappropriate social behaviors AEB [as evidenced by] . cursing, threatening and criticizing others, taunting and provoking others, name calling and demeaning names . sexual remarks and slurs and inappropriate behaviors such as sexually inappropriate and social behaviors of sexual and vulgar remarks, impulsive episodes and cursing out others. Date initiated: 06/02/2022 Revision on 09/06/2022 . Interventions . Counsel concerning invading others personal space and sexual boundaries as needed . Observe for effectiveness of current medication regimen . Observe for episodes of behaviors and response to interventions . RI #1's Care Plan Report further revealed: Focus The resident uses antipsychotic and antidepressant medications daily r/t [related to] [his/her] dx [diagnosis] of intermittent explosive disorder, dementia with behavioral disturbances, major depressive disorder and bipolar 2 Date initiated: 05/02/2022 Revision on 05/23/2024 . Interventions . Monitor for change in mood and behaviors . A review of RI #1's Progress Notes revealed a Nursing Progress Note dated 03/15/2023 that documented: . Resident verbally aggressive and offering sex to staff . (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Certified Nursing Assistant (CNA) mood documentation for RI #1 from August 2024 to October 2024 was conducted. The document directed staff to document specific behaviors each day as either cooperative, passive, agitated, or depressed/withdrawn. A review of the documents revealed this was not completed each shift. A review of Certified Nursing Assistant (CNA) behavior documentation revealed an X was documented 19 of 30 shifts in September 2024. The document instructed staff to document numbers 0-12 to correspond to different behaviors including . 10-Sexually Inappropriate . 12- None of the above observed. The instructions key did not include an X or provide the meaning of an X. A review of RI #1's Electronic Medication Record (EMAR) behavior documentation from August 2024 to October 2024 revealed the monitoring was not completed per instructions. A review of RI #1's Behavior Monitoring notes in 2024 revealed no Behaviors Monitoring notes were documented except on 07/04/2024 which documented refusal of a vaccination and that the resident was combative with the writer of the note. An interview was held with the Social Service Designee (SSD) on 05/03/2025 at 11:40 AM. During the interview, the SSD was questioned regarding the behaviors of RI #1. The SSD reported that RI #1 exhibited verbally aggressive behavior, including cursing at staff and residents, refusing care and treatment, and engaging in arguments. She noted that RI #1's care plan addressed that RI #1 had behaviors that include sexually inappropriate behaviors. The SSD said that she had overheard RI #1 complimenting staff by stating they are attractive or nice looking. Furthermore, the SSD indicated that these behaviors are recorded in the nurses' notes and on the EMAR. An interview was conducted with CNA #14 on 05/03/2025 at 12:04 PM. During the interview, CNA #14 was questioned regarding the behaviors of RI #1. CNA #14 reported that she had observed RI #1 become loud and refusing care. She indicated that she had not observed any instances of sexual inappropriate behavior from RI #1 towards either staff or residents. An interview was conducted with CNA #22 on 05/04/2025 at 11:50 AM. During the interview, CNA #22 was questioned regarding the incident involving RI #1 and RI #49 that took place on 09/12/2024. CNA #22 stated that she was on duty that day but did not observe the incident. She said unsupervised residents in the Activity Room could potentially engage in arguments or altercations. When asked about RI #1's behaviors, CNA #22 reported that he/she would use profanity toward staff regarding cigarettes and would make comments about staff members appearances and expressed a desire to marry them. CNA #22 said that those behaviors were reported to the nurse. A follow-up interview took place with CNA #22 on 05/05/2025 at 11:51 AM. During this interview, CNA #22 was questioned regarding RI #1's comments, including phrases like hey honey and will you marry me, and whether these comments had been reported. CNA #22 indicated that she would at times report those behaviors or comments to the nurse or she would redirect RI #1. She noted that these behaviors began approximately two years prior, and she had not witnessed any such behaviors from RI #1 in the last three to six months. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with Former Administrator (FA) #10 on 05/05/2025 at 3:55 PM. During the interview, the FA described RI #1 as someone who would flirt with staff by attempting to make them laugh and singing to them. The FA said that RI #1 had a care plan addressing a history of inappropriate sexual behavior, which should have been monitored by the nursing staff and documented in the MAR. An interview was held with the Administrator on 05/06/2025 at 12:15 PM. During the interview, the Administrator was questioned regarding the procedures for documenting and reporting behaviors. The Administrator said that any resident behavior directed towards staff must be documented and included in the care plan. When asked about strategies to prevent behaviors directed at staff from escalating to residents, the Administrator suggested that proper care planning and a referral to psychiatric services could help mitigate such escalations. ********** On 05/09/2025, the facility submitted an acceptable removal plan, which documented: F 740 Removal Plan 05/09/2025 1.Immediate action(s) taken for the resident(s) found to have been potentially affected include: a. The facility failed to ensure target behaviors were identified, managed, and addressed for RI #1, a resident with Schizophrenia and Bipolar Disorder, to prevent and protect other residents from being abused by RI #1, a resident with a history of sexually inappropriate behavior, when on 09/12/2024 RI #1 was found by staff in the activity room at the facility alone and unsupervised with RI #49 and RI #1 had his/her hand on RI #49's breast. b. CNA #15 witnessed RI #1 touch RI #49 on the right breast upon entering the activities room. CNA #15 instructed RI #1 to stop touching RI #49 as she entered the room and approached the residents to separate them. CNA #15 called out for assistance and LPN #13 was present in the hallway outside of the activities room door passing medications and entered the activities room and witnessed RI #1 touch RI #49 on the right breast. Residents were immediately separated. RI #1 on was immediately taken to his room and placed on 1:1 observation. c. Resident #49 was assessed by RN #16 on 9/12/24 at approximately 1700. d. Provider was contacted and resident was assessed on 9/13/24 - Recommendation was to discontinue 1:1 sitter and to provide close monitoring while resident out of bed in common areas. 1:1 observations were maintained for five days as a follow-up provider visit was scheduled for Monday 9/16/2024. NP assessed RI #1 on 9/16/2024 and resident continued to have no further behaviors so 1:1 monitoring was stopped the following day on day 5, 9/17/24. The assigned staff were to complete the documentation flow sheet. Charge nurses verified staff were 1:1 with RI #1 during the above noted dates, and staff submitted the flow sheet to the DON for review when completed. No behaviors were observed during that time. 1:1 observation were in place from 9/12/24 to 9/17/24. RI #1 is unable to transfer out of bed without the assistance of the staff. CNAs assigned to RI #1 were verbally instructed by charge nurses at the start of each shift to notify nurse once resident is assisted out of bed so he/she can be monitored. This directive was also noted on the CNA's care Kardex. This directive was put into effect following the completion of the 1:1 observation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	e. RI #1 is now included in our list of residents located within the Nursing Communications binders at each desk. Residents on this list are not to be in common areas with other residents unsupervised. All staff have been in-serviced on this directive. This intervention has also been added to the residents' care plan, behavior monitoring order, and Kardex. f. On 05/07/2025, the Regional Director of Clinical Operations conducted an in-service for the Administrator and Director of Nursing covering all types of abuse and the facility's responsibility to ensure resident safety. 2. Identification of other residents having the potential to be affected: a. Any other residents with inappropriate sexual behaviors in the center have the potential to be affected. b. All residents' PASRRs in the center were audited by the DON/designee on 05/07/2025 for history of sexually inappropriate behaviors. On 5/07/2025, The Clinical Reimbursement Specialist reviewed all residents' care plans for any residents identified with known history of sexually inappropriate behaviors. Two additional residents were identified to have a history of sexually inappropriate behaviors. Each of these 3 residents have individualized interventions in their care plans, with specific targeted behaviors to prevent the occurrence of abuse. All three residents noted with history of sexually inappropriate behaviors have intervention to prevent abuse. None of these residents are physically capable of transferring out of bed unassisted. They are to be always monitored while in common areas with other residents. They will not be in common areas unsupervised. All three residents have been placed on every 15-minute observations while out of bed, to be signed off by the observing staff member every 15 minutes. If in activities, the Activities Director will sign the observation. If in the dining room, the CNA and/or charge nurse assigned to the dining room with sign the observation. If near or at nurses' station, the nurse will sign the observations. The charge nurse is responsible for ensuring the observation monitoring sheet is signed off at the end of the shift. The DON is responsible for collecting the observation sheets and the Administrator is responsible for maintaining the records. 63 of 65 staff trained (two staff members on FMLA). c. The Regional Nurse consultant/Designee reviewed resident progress notes from 4/01/2025-current reviewing for sexually inappropriate behaviors none noted. 3. Actions taken/systems to be put into place to reduce the risk of future occurrences include: a. On 5/07/25 the Regional Nurse Consultant provided in-service for the Administrator and Director of Nursing training on the facility's Behavioral Health Services Policy and facility's Abuse Policy to include management of sexually inappropriate behaviors and behaviors that that increase residents risk of abuse such as masturbation, unwanted touching of sexual organs by another resident, cursing, shadowing, calling out, and disrobing. b. Facility-wide staff training was initiated on 05/07/2025, by the Director of Nursing/ designee. No staff are permitted to work until this training is completed. The training covered: (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	i. The abuse policy. This policy emphasizes that all residents have the right to be free from sexual abuse, outlines how to identify abuse, and mandates immediate residents when abuse is suspected or observed, by physically moving the resident and the aggressor away from each other. When abuse is suspected or observed report to abuse coordinator once residents have been provided safety. An incident report is completed, and reports are reviewed by the DON and Administrator. ii. Prevention of Abuse, Neglect and Exploitation. a. The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: 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. This may include identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship; B. Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property 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, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms; C. Assuring an assessment of the resources needed to provide care and services to all residents is included in the facility assessment; D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect; E. Ensuring the health and safety of each resident with regard to visitors such as family members or resident representatives, friends, or other individuals subject to the resident's right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions. (See Resident Right to Access and Visitation Policy); F. Providing residents, representatives, and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution; and providing feedback regarding the concerns that have been expressed; G. Addressing features of the physical environment that may make abuse, neglect, exploitation, and misappropriation of resident property more likely to occur; and iii. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	iv. When any staff observe behaviors, staff should report behaviors to charge nurse for documentation in the medical record. Behaviors are reported during shift-to-shift reports by charge nurses. IDT team reviews documentation in clinical meetings weekly during clinical risk meeting and daily during morning clinical meeting for interventions/follow up. During morning clinical meeting, all of this information is read aloud by the DON to the IDT team members present during each meeting and assigns follow-up to the designated team member responsible for the item needing follow-up. As part of the weekly risk meeting, behaviors, psychotropic medications, and monitoring orders are reviewed and documented by the IDT team members during the meeting as needed. Staff identify these target behaviors through a structured, person-centered approach that emphasizes observation, communication, and individualized care planning. The residents' target behaviors are identified in their care plans and in their behavior monitoring order. v. On 5/7/25, DON/Designee conducted an in-service with all staff that included the process for monitoring target behaviors. The in-service included how these behaviors are identified and the process for reporting behaviors. a. Residents identified with a potential for exhibiting inappropriate sexual behaviors reviewed during weekly risk meetings, by the interdisciplinary team. Residents identified with a potential for/history of exhibiting inappropriate sexual behaviors, individualized, person-centered care plans will be developed by the MDS coordinator/Designee, implemented by all staff providing care to the residents. Each nurse assigned to the identified residents each day will observe to ensure care planned interventions that are listed on the care Kardex for the CNA are in place and effective. The charge nurses will communicate with the IDT team as needed if care planned interventions are ineffective, and the MDS Coordinator/Designee will revise CP as necessary. All three residents have been placed on every 15-minute observations while out of bed, to be signed off by the observing staff member every 15 minutes. If in activities, the Activities Director will visually observe the resident and sign the observation. If in the dining room, the CNA and/or charge nurse assigned to the dining room will visually observe the resident and sign the observation. If near or at nurses' station, the nurse will visually observe the resident and sign the observations. The charge nurse is responsible for ensuring the observations are made and that the observation monitoring sheet is signed off at the end of the shift. The DON is responsible for collecting the observation sheets and the Administrator is responsible for maintaining the records. b. 63 of 65 staff trained (two staff members on FMLA). c. DON/designee will monitor the schedule for staff who have not completed the training. DON/designee will provide training prior to the start of the shift. Staff not physically present were in-serviced via phone. No staff are permitted to work until this training is completed. 63 of 65 staff trained (two staff members on FMLA). vi. An audit was completed on 5/7/25 by the Clinical Reimbursement Specialist. Care plans of the three residents identified to have a history of sexually inappropriate behaviors including RI #1 were reviewed to ensure they were appropriate, person centered and that they considered pertinent history of the residents. All three residents had revisions made to their care plans to include the added directive that those residents will not be in common areas unsupervised with other residents. The revisions were made by the Director of Nursing and by the Clinical Operations Support nurse on 5/7/25 and 5/8/25. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	j. The regional nurse consultant in-serviced the DON 5/7/25 regarding the process to follow with monitoring specific target behaviors with an increase in monitoring during the 30-day period following a GDR. Monitoring orders will list target behaviors specific to each resident identified with sexually inappropriate behaviors. Monitoring orders with be reviewed for accuracy on initiation of order and daily in morning clinical meeting weekly in clinical risk meeting. Facility requests IJ removal plan to be effective on 05-09-2025. ********** After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team determined the facility implemented the immediate corrective actions as of 05/09/2025. ********** 2) RI #2 was admitted to the facility on [DATE] and had diagnoses to include: Psychotic Disturbance, Mood Disturbance, Anxiety Disorder, and Major Depressive Disorder. RI #2's quarterly MDS assessment with an ARD of 09/13/2024 documented a BIMS score of 8 of 15, which indicated that RI #2 had moderate cognitive impairment. A review of RI #2's comprehensive care plan revealed RI #2 may exhibit outbursts toward staff and may become combative, striking out by hitting and/or kicking. This care plan was initiated on 06/28/2022 and revised on 07/29/2024. The care plan did not provide direction to staff regarding the level of supervision required to protect residents and ensure safety. A review of a Progress Note for RI #2, dated 07/19/2024, indicated the following behaviors: During an onsite psychological visit, RI #2 was observed to ball up his/her fist and attempted to strike another resident while passing through the door. A verbal intervention was conducted, during which RI #2 was informed that such actions would not be allowed, and the potential consequences of retaliation and injury were explained. RI #2 reacted with anger and directed profanity towards the writer. The inappropriate nature of his/her behavior and language was addressed, along with the associated risk of injury stemming from such conduct. A review of the Progress Note for RI #2, dated 07/24/2024, indicated that the appointment was a follow-up to the visit to the 07/19/2024 visit. During this session, RI #2 denied feelings of anger and was advised against hitting others and using derogatory language towards others. RI #2 did not want to talk with the provider, leading to the termination of the interview. Staff were directed to observe and intervene in any behavioral disturbances as necessary. An interview with Social Services Designee (SSD) was conducted on 05/03/2025, at 4:17 PM. The SSD was questioned regarding the behaviors of RI #2. She indicated that RI #2 had exhibited verbal aggression towards both staff and other residents and had made attempts to physically strike staff. When asked about strategies for managing RI #2's behaviors, the SSD said that if the aggression was directed at a staff member, they should leave when safe and return later. If the aggression was directed at other residents, staff should intervene and remove RI #2 from the situation. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview with FA #10 took place on 05/05/2025 at 4:20 PM. The FA reported that RI #2 had instances of verbal outbursts, including the use of racial slurs, and a refusal to accept care. She said that staff should not compel a resident to receive care but should pause and attempt again later. In cases of verbal altercations between residents, staff should intervene, remove the resident, and de-escalate the situation. When asked about the management of RI #2's behavior on 10/15/2024, she confirmed that staff was present in the room and did intervene. When questioned about the possibility of preventing the incident, she suggested that if the situation had been identified earlier, RI #2 could have been removed and the incident could have been prevented. On 10/16/2024 at 10:39 AM the State Agency received a FRI alleging that RI #2 struck RI #11 on the arm.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, medical record review, review of a facility policy titled, Diagnostic Testing Services, and a review of a Facility Incident Report (FRI) received by the State Agency, the facility failed to ensure RI #412's laboratory services were provided timely when an order was received on 07/19/2024 to obtain a Urinalysis (UA) and Culture and Sensitivity (C&S) for RI #412. This deficient practice affected RI #412, one of 27 sampled residents. Findings include: RI #412 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include Benign Prostatic Hyperpasia and History of Cystitis. RI #412's July 2024 Physician Orders were reviewed and revealed an order dated 07/19/2024 for a laboratory test of urinalysis and culture and sensitivity. RI #412's medical record contained laboratory results for a Urinalysis that was collected 07/29/2024 and included a final report documenting there was probable urogenital contamination and no further work up would follow. On 05/02/2025 at 11:08 AM Registered Nurse (RN) #9 was asked about a Nursing Progress Note entry she had documented and signed on 07/19/2024 for collection of a clean catch urine specimen for RI #412. RN #9 said, RI #412 was more confused that day, she obtained an order from the doctor to get a urine specimen, and it was collected with no issues. When asked how long it would take for a urine culture report to come back, RN #9 said, a day or two. RN #9 said they completed another UA on 07/29/2024 ten days later. On 05/05/2025 03:59 PM Clinical Laboatory Services (CLS) was contacted and CLS Employee, CLS #21 was asked about RI #412's physician order dated 07/19/2024 for a Urine specimen. CLS #21 said, she saw the order in the system, but they never received the specimen, and the collection was pending.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and review of the Dietary Manager's (DM) employee file, the facility failed to have a qualified Dietary Manager. This had the potential to affect 60 of 60 residents receiving meals from the kitchen. Findings include: An undated job offer letter for the position of Dietary Director (Dietary Manager) from the Administrator included: 1.) The date the offer was accepted by the Dietary Manager: 01/21/2025. 2.) The hire date for the Dietary Manager: 02/14/2025. 3.) The start date for the Dietary Manager: 03/11/2025. A job description for Dietary Manager, dated 12/08/2018 and signed by the Dietary Manager on 03/11/2025, included the following: . JOB SUMMARY: The primary purpose of the Dietary Manager position is to oversee in planning, organizing, developing and directing the overall operations of the Dietary Department. JOB REQUIREMENTS: . Education * Must be a graduate of an accredited course in dietetic training approved by the American Dietetic Association or a graduate of another course in food service supervision * Must be a Certified Dietary Manager; or * Must be certified Food Service Manager in this state; or * Must have a similar national certification for food services management and safety from a national certifying body; or * Must have an associate's [sic] degree or higher degree in food service management or hospitality, if the course study includes food service or restraint [sic] (restaurant) management, from an accredited institution of higher learning; . During the initial kitchen tour on 04/29/2025 which began at 1:55 PM, the Dietary Manager said, she had been working at the facility for about two months. During the tour the Dietary Manager said, 60 residents were served meals from the kitchen with one additional resident being NPO (nothing by mouth) and receiving a tube feeding. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/30/2025 at 5:00 PM, the Dietary Manager was interviewed, with the Registered Dietitian (RD) in attendance, to review the Dietary Manager's experience and training as follows. The Dietary Manager had previously worked three years as the dietary manager of another nursing facility in Alabama. The Dietary Manager had completed some coursework in Food Safety and Management as provided by the University of North Dakota Nutritional and Foodservice Training Program, from 2022 through March 2025. An extension was approved by the University of North Dakota for completion of the coursework. The Dietary Manager was working on completing Module #17 of the seventeen-part module training program. Once Module #17 was complete, the Dietary Manager would be eligible to apply for certified dietary manager status with ANFP (Association of Nutrition & Foodservice Professionals). The RD is a full-time employee of the facility's parent company and visits the facility weekly and as needed to provide support. During a kitchen observation on 05/01/2025 at 10:04 AM, the Dietary Manager said she had stayed late last night to complete Module #17 and now just needed to submit it. The Dietary Manager said once the the course was finalized, she could apply to take the ANFP exam to become a Certified Dietary Manager (CDM). During an interview on 05/01/2025 at 3:59 PM, the RD said the Dietary Manager was hired with the understanding she would complete the dietary manager course and then pass the CDM test. The RD further said the Dietary Manager was three modules away from completing the dietary manager course at the time of her hire. The RD said Long Term Care (LTC) experience was desired and the dietary Manager had 25 years of LTC foodservice experience and dietary manager experience.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure Resident Identifier (RI) #29's bed was in a safe operating condition at all times. During the dinner meal on 04/29/2025, RI #29's head of bed (HOB) was observed to be in a flat position. Certified Nursing Assistant (CNA) #23 reported the bed had been broken since 04/28/2025. This affected RI #29, one of 27 sampled residents. Findings include: RI #29 was admitted to the facility on [DATE] with diagnoses to include Dementia, Anxiety, Intellectual Disabilities, and Gastrostomy Status. On 04/29/2025 at 6:10 PM, RI #29 was observed on a low bed with the HOB in a flat position while Certified Nursing Assistant (CNA) #23 tried to wake RI #29 up for the dinner meal. CNA #23 said, the HOB was flat due to the bed being broken and maintenance needed to fix the bed. On 04/30/2025 at 7:57 AM, RI #29 was observed in bed and the HOB remained in the flat position. On 05/02/2025 at 8:49 AM, the surveyor conducted an interview with CNA #23. When asked when she noticed the remote on RI #29's bed was not working, CNA #23 said, Monday, 04/28/2025. CNA #23 said, she was not sure when she notified the Maintenance Director (MTD) of RI #29's bed being broken. On 05/05/2025 at 3:38 PM, the surveyor conducted an interview with the MTD. The MTD said the first time he was told something was wrong with RI #29's bed was on Tuesday, 04/29/2025. The surveyor shared with the MTD that the surveyor had been informed RI #29's bed was not functioning on Monday. The MTD said if the bed was not functioning on Monday, he or the Director of Nursing (DON) should have been informed. The MTD said the residents needed a functioning bed at all time so they could get out of the bed without trouble. On 05/04/2025 at 10:26 AM, a follow-up interview was conducted with CNA #23. CNA #23 said it would be important to have a resident's bed operating properly at all times because staff wanted to be able to let the HOB up and down when providing care and the head to be in an upright position when staff were feeding the resident so they would not choke. On 05/05/2025 at 11:53 AM, an interview was conducted with the DON. The DON said she had not been informed RI #29's bed was not functioning properly. The DON said the MTD should have been informed of this as soon as possible. The DON said it would be important to ensure a resident's bed was operating properly for the residents safety. The DON said if staff had a resident who was to be fed, the HOB needed to be elevated so the resident did not aspirate or choke. The DON said staff also needed to be able to let the bed up or down for the resident's safety and to care for the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015060	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeway Rehabilitation & Senior Living	4201 Bessemer Super Highway Bessemer, AL 35020

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 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. Based on observations and interview, the facility failed to ensure: 1) hand rails in the hallways were not missing plastic end cap pieces, 2) a small handrail was not missing from the wall on the left side of the hall, and there was not a missing handrail on the right side of the hallway on Unit One; and 3) a small hand rail was not missing from the wall next to the nurses station on Unit Two. This deficient practice was identified during observations of the environment and had the potential to affect residents who ambulated in the facility. Findings include: On 04/29/2025 at 4:00 PM, the surveyor observed the hand rail in front of the nurses' station on Unit One was missing the end cap. On 04/29/2025 at 4:16 PM, the surveyor observed the hand rail near the Respiratory Supply Closet was missing the end cap. On 04/29/2025 at 4:17 PM, the surveyor observed a the hand rail near Social Service (SS) office was missing the end cap. On 05/05/2025 at 3:05 PM during observations of areas of concern with the environment in the facility with the Maintenance Director (MTD) he said, end cap pieces were missing from the hand rail by door #4 (the respiratory supply closet), the hand rail outside the SS door, and the hand rail across from the nurses' station on Unit One. On 04/29/2025 at 3:57 PM during observations of the hallways, the surveyor observed a hand rail with a missing end cap piece outside of Room Locator (RL) #1 and the hand rail near RL #2 was broken. On 05/05/2025 at 3:24 PM during observations of the facility with the MTD, he said, the hand rail outside of RL #2 needed to be replaced because there was a crack in the hand rail and the hand rail outside of RL #3 needed the end cap replaced. On 04/29/2025 at 3:28 PM, the surveyor observed a small hand rail was missing from the wall between doors/offices marked with a 9 and 10 on the left side of the hallway and a hand rail was missing between doors/offices marked 11 and 12 on the right side of the hallway on Unit One. On 05/03/2025 at 10:25 AM, the surveyor observed that a small hand rail was missing from the wall next to the nurses station on Unit Two. On 05/04/2025 at 11:16 AM, the surveyor observed with the MTD areas of the facility with missing hand rails. The MTD said, the length of the missing hand rail between offices 9 and 10, on Unit One, would be about 10 inches. When asked how long had it been that there was no hand rail on the wall, the MTD said at least three weeks to a month. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015060	A. Building B. Wing	05/09/2025

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/04/2025 at 11:19 AM, the surveyor asked the MTD what he would say was the length of the missing hand rail between RL #4 and RL #5 on the right side of the hall way on Unit One. The MTD said about two or three feet. The MTD said he was also aware of the missing hand rail by the nurses station on Unit Two. When asked why it would be important to have hand rails permanently affixed to the walls in the hallways, the MTD said for the residents that need assistance with walking, this would prevent them from falling. The MTD said the hand rail would be something for the residents to hold onto. On 05/05/2025 at 11:53 AM, an interview was conducted with the Director of Nursing (DON). When asked why it would be important to ensure there were hand rails permanently affixed to the walls in the hallways, the DON said for safety. The DON said most of the residents walk on the side of the hall using the hand rails, especially if the resident did not have a steady gait.