STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	025010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ketchikan Med Ctr New Horizons Transitional Care	3100 Tongass Avenue Ketchikan, AK 99901

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Based on interview and record review, the facility failed to treat one resident (#16), out of 26 residents reviewed, with dignity and respect. Specifically, the facility's Administrator took the resident's personal checkbook, against the resident's wishes, and kept this item in her personal desk without communicating an appropriate rationale for the restriction. This failed practice violated the resident's right to be treated with dignity and respect and placed undue stress on the resident which had the potential to affect the resident's overall health and well-being. Findings:During an interview on 9/2/25 at 2:35 PM, Resident #16 stated the Administrator confiscated my checkbook and said if I didn't give it to [him/her] I would be kicked out of the hospital. Resident #16 stated, I was so angry. Resident #16 state the Administrator took the checkbook and wouldn't give it back, she held it over the weekend. Resident #16 could not identify the date this occurred. During an interview on 9/4/25 at 10:04 AM, the Administrator stated Resident #16 was having difficulty with insurance and needed an application for Medicaid completed. The Administrator stated the Power of Attorney (POA) had requested assistance in getting the checkbook because Resident #16 was writing checks and the POA couldn't have the resident writing checks he/she wasn't aware of. When asked to describe her encounter with Resident #16, the Administrator stated she took a nurse with her to Resident #16's room and told the resident he/she had not been on Medicaid since December. The Administrator stated she told Resident #16 she didn't want to initiate a discharge for him/her, but that the facility needed to get a payor source for his/her continued stay. For that reason, the Administrator stated she told Resident #16 she needed to take the checkbook so your POA can apply for Medicaid for you. The Administrator stated Resident #16 initially said no, that he/she did not want anyone to take his/her check book and asked, What are you going to do with it? The Administrator stated after conversing for a while, and only after the Administrator agreed to tell the resident if any checks were written while the checkbook was in her possession, did the resident surrender the checkbook to her. When asked what the Administrator did with the checkbook, the Administrator stated she put it in her personal desk in her office. When asked why she didn't put the checkbook in the facility's resident safe, the Administrator stated she didn't know the process for using the safe. When asked about the timeline of this event, the Administrator stated it was a day or two prior to going on remote status (returning to home out of state but continuing to work), which was the first weekend of August. When asked if she usually took personal belongings from residents, the Administrator stated it was not usual practice. When asked why the POA didn't come with the Administrator to discuss the situation with the resident prior to taking the checkbook, the Administrator stated she could have and probably should have done that. When asked why the Administrator did not give the checkbook to the POA after obtaining it, the Administrator stated she had to leave for a family emergency and switched to remote status before the checkbook could be transferred to the POA. When asked if she informed anyone that Resident #16's checkbook was in her personal desk, the Administrator stated she couldn't remember. During an interview on 9/4/25 at 10:04 AM, the Director of Nursing stated it was not common practice to take personal belongings of residents and put them in staff desks. During an interview on 9/4/25 at 10:04 AM, the Chief Nursing Officer (CNO) stated she knew that the Administrator took Resident #16's checkbook and placed it in her desk, but she was not aware of how long the Administrator had the checkbook. The CNO stated it was not usual practice to keep personal belongings in personal desks. The CNO stated once she had heard Resident #16 was inquiring about his/her checkbook, she went into the Administrator's office and retrieved the checkbook from the Administrator's desk and it was returned to the resident. During an interview on 9/4/25 at 12:18 PM, Staff #45 stated he/she witnessed an interaction between the Administrator and Resident #16, after the Administrator had possession of the checkbook, where Resident #16 said, I want my checkbook! The Administrator dismissed Staff #45 saying, you don't need to be here for this, I got this. Staff #45 left the room. During an interview on 9/4/25 at 12:54 PM, Staff #62 stated he/she witnessed the initial interaction between the Administrator and Resident #16 concerning the checkbook. Staff #62 stated his/her perspective of the conversation was that the Administrator was forcing Resident #16 to give up his/her checkbook and the words used by the Administrator were threatening saying, you don't really have a choice, you need to give me the checkbook. Staff #62 stated Resident #16 was mad. Staff #62 stated the Administrator dismissed him/her from the room prior to the conversation ending, and prior to the Administrator taking possession of the checkbook. Staff #62 was unaware of what transpired after being dismissed. During an interview on 9/4/25 at 12:58 PM, Resident #12's POA stated the Administrator called

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. (continued on next page)

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	.Based on interview and record review, the facility failed to allow resident-invited visitors and/or guests to attend a resident council meeting. This failed practice denied the resident's right to invite visitors to the resident council meeting, which denied all residents (based on a census of 26) the right and opportunity to advocate for themselves and placed them at risk for decreased feelings of self-worth and had the potential to affect their mood and overall wellbeing. Findings:During an interview on 9/2/25 at 1:45 PM, Resident #12 stated that he/she invited his/her family member, who was his/her resident representative, to the resident council meeting that occurred on 7/23/25. Resident #12 further stated that his/her family member invited the Mayor and a City Council member, along with a previous member, to the meeting on his/her behalf. Resident #12 wanted his/her family member and local officials in the meeting to hear of program concerns that had been happening in the facility lately, such as limited activities and low staffing. Resident #12 stated that when the family member and local officials arrived for the meeting, the facility Administrator removed them from the meeting. Resident #12 stated he/she told the Administrator his/her family member was his/her advocate, and the other visitors were there because he/she wanted them there. Resident #12 stated the Administrator still had them vacate the meeting. This upset him/her because he/she wanted their support on resident concerns. During an interview on 9/2/25 at 4:10 PM, Resident #20 stated he/she was happy to see the Mayor and City Council member at the Resident Council meeting on 7/23/25, but the Administrator ordered them to leave. Resident #20 stated he/she was the President of the Resident Council, and he/she told the Administrator he/she couldn't have them leave, but the Administrator said, no way and had them removed anyway. That upset Resident #20 because he/she would have liked them to have stayed for the meeting to hear what the residents had to say. During an interview on 9/3/25 at 10:37 AM, Resident #18 stated he/she was at the 7/23/25 resident council meeting and was happy to see the presence of the Mayor and City Council representative. Resident #18 stated that when the Administrator said they were not allowed to stay, he/she heard other residents tell the Administrator they wanted the visitors to stay. Resident #18 stated he/she would have liked to have had them present in the meeting to hear from the residents. During an interview on 9/3/25 at 12:43 PM, the Resident Representative for Resident #12 stated the resident invited him/her to the 7/23/25 resident council meeting. After hearing the concerns, the residents had planned to address in the meeting, the Resident Representative invited a City Council member, a previous City Council member, and the Mayor to the meeting to hear what the residents had to say. The Resident Representative stated Resident #12 approved of him/her inviting the local officials to the meeting. The Resident Representative stated that when they got to the unit for the meeting, the Administrator met him/her at the activities room door and told him/her that the resident council meeting was for residents only. The Administrator stated they could not attend the meeting. The Resident Representative stated that the City Council member, previous City Council member, and him/her went into the meeting anyway, however the Administrator would not let the meeting start until the resident invited visitors left the room. During an interview on 9/4/25 at 10:04 AM, the Administrator stated that at the time of the meeting, she had a conversation with Resident #12's family member and told him/her that resident council meetings were not a public meeting, was a closed meeting, and that family and visitors couldn't be there. The Administrator stated she thought the resident council meeting was an internal meeting to talk about activities and resident rights and that if any resident wanted a visitor to a meeting, they would have to vote on that at the meeting prior to the visit. When asked if she recalled residents telling her they wanted the visitors to stay for the resident council meeting, the Administrator stated she did not remember hearing that. During an interview on 9/4/25 at 1:14 PM, the Chief Nursing Officer (CNO) stated she was in the 7/23/25 resident council meeting and confirmed the Administrator told the visitors they could not stay for the meeting. The CNO further stated that she witnessed several resident state that they wanted the visitors to stay for the meeting. During an interview on 9/8/25 at 10:45 AM, Visitor #3 stated he/she was invited to the resident council meeting because he/she had heard some of the residents had concerns they wanted to voice, namely about activities. Visitor #3 stated when he/she got there, the Administrator stated she didn't want the meeting to turn political, and Visitor #3 stated the Administrator asked him/her several times to not attend the meeting. Visitor #3 stated he/she left because he/she didn't want to disrupt the resident council meeting or cause a problem. Review of the facility's policy LTC [Long Term Care]: Patient Rights and Responsibilities Policy, dated 1/10/25, revealed: It is the policy of PeaceHealth to define, recognize, protect and promote the rights and responsibilities of the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. .Based on interview and record review, the facility failed to ensure residents were free from abuse. Specifically, the Administrator's conduct towards residents was construed, by residents and staff, as verbally abusive. This failed practice placed all residents (based on a census of 26) at risk for continued exposure to verbal abuse and mental anguish which had the potential to affect their overall health and well-being. Findings:Resident #12 During an interview on 9/2/25 at 1:45 PM, Resident #12 stated she felt verbally abused by negative comments the Administrator had said to him/her, and this made him/her very sad, and he/she was now hopeless, like I'll never get out of here. It was observed that Resident #12 was physically shaking when he/she told this story, wringing his/her hands and his/her voice was cracking with emotion. Resident #20 During an interview on 9/2/25 at 4:10 PM, Resident #20 stated the Administrator, scares me, [he/she] is really bossy and is mean to me. When asked to elaborate on anything the Administrator may have said, Resident #20 couldn't recall a specific conversation, it's how [he/she] talks, its loud and speaks meanly. During an interview on 9/3/25 at 11:45 AM, Staff #76 stated residents have reported to him/her that they didn't feel safe on the unit because the Administrator's interactions were rough with a lack of respect. During an interview on 9/4/25 at 1:14 PM, when asked if she had ever been informed that the Administrator's behavior towards residents was a concern, the Chief Nursing Officer (CNO) stated some things were said and she had started to receive feedback around the time of a staff meeting on 6/25/25. The CNO stated that during this time the information that was shared did not always appear accurate and was different than what the Administrator was sharing with her, so nothing really made her concerned, until almost a month later at the 7/23/25 resident council meeting and she witnessed the Administrator's behavior that day. The CNO stated that when the Administrator addressed the residents in the meeting, the Administrator's voice was raised, and her arm/hand movements were very animated as she talked and the CNO stated she was concerned with the Administrator's presentation. The CNO stated that the way the Administrator addressed the residents made her feel anxious and the conversation had become uncomfortable, and from her perception she felt that the group was not being heard or seen. When asked if the Administrator's oral and gestured language may have been frightening or intimidating to the residents, the CNO stated, Absolutely. The CNO stated she stood up, during this meeting, to nonverbally cue the Administrator that the conversation was veering onto an uncomfortable path, however the Administrator did not stop the behavior. During an interview on 9/4/25 at 4:55 PM, Staff #83 stated that the Administrator's tone of voice was very rude when she talked to residents and the Administrator would often willfully cut them off in conversations. Review of the facility's abuse allegation investigation documentation of the resident interviews, that occurred during the investigation surrounding the concerns identified during the 7/23/25 resident council meeting, revealed an additional resident (#25), had felt verbally abused by the Administrator. Review of the facility's policy LTC [Long Term Care]: Abuse, Neglect, Exploitation and Misappropriation of Residents Property Policy, dated 3/6/25, revealed: Definitions . Verbal Abuse: The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to the resident or their families, or within hearing distance . Examples of verbal abuse include, but are not limited to: threats of harm, saying things to frighten a resident . Each resident has the right to be free from abuse, neglect, exploitation, misappropriation of resident property, corporal punishment . The facility must prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property . Review of the facility's Resident Rights and Responsibilities, undated, revealed: . You have the right to dignity, respect, and compassion. This includes your right to . Freedom from abuse, neglect, exploitation and misappropriation of property .

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	.Based on record review and interview, the facility failed to implement written policies and procedures to investigate an allegation of abuse for 1 Resident (#12), out of 1 allegation of abuse investigation reviewed. Specifically, the facility's HR Department and Risk Management Department failed to: 1) adequately monitor the investigation process to ensure all steps of the investigation procedure were completed appropriately; 2) ensure all investigations processes were adequately documented; and 3) ensure additional investigations from the results of the investigation process were appropriately carried out 2 residents (#'s 20 and 25), out of 5 residents interviewed during the investigation. This failed practice resulted in an inadequate grievance investigation which placed all residents (based on a census of 26) at risk for suboptimal investigations of any resident complaints and grievances. Findings:Incident Reported A facility reported incident (FRI) was submitted to the State Agency for an allegation of verbal abuse, dated 7/23/25, by the Chief Nursing Officer (CNO). Investigation by CNO During an interview on 9/3/25 at 1:34 PM, the CNO stated during the resident council meeting on 7/23/25, in the middle of the meeting, Resident #12 stated he/she felt the Administrator had verbally abused him/her. After the meeting, the facility team decided to file a State report regarding Resident #12's comment and initiate an investigation. The CNO stated the report was sent to the State Agency on 7/23/25. The CNO further stated that she contacted the HR Director for PeaceHealth on 7/23/25 about the investigation and placed the Administrator on administrative leave pending the conclusion of the investigation. The CNO further stated she completed an interview with Resident #12 on 7/23/25 about the comments in the meeting, however Resident #12 did not comment on what the verbal abuse was. When asked to see the documentation for the interview with Resident #12, the CNO stated no documentation for the interview was completed. The CNO stated she also submitted this incident in the facility's electronic incident reporting system Safe2Share. When asked if the CNO interviewed the Administrator during the investigation, the CNO stated she and the Administrator had talked but this was not documented. When asked if the CNO contacted Resident #12's provider to inform them of the reported allegation of abuse, the CNO stated she did not contact the provider. When asked what other steps occurred during the investigation, the CNO stated she had a Minimum Data Set (MDS - a nationally mandated routine assessment) Nurse interview five other residents to ensure no other residents had any concerns. The CNO stated she drafted questions for the MDS Nurse to use. From these interviews, she determined these residents felt safe. When asked what the investigation's determination was, the CNO stated that because Resident #12 retracted his/her statement and because it was determined it was mainly about the Administrator's approach to communicating with others, she determined the abuse allegation as retracted and concluded the investigation on 7/28/25. The CNO stated the Administrator returned to work on 7/29/25. Review of the facility's documentation of the five other resident interviews that occurred during this investigation, undated, revealed two resident's, Resident #20 and #25, interviews revealed they had felt verbally abused by the Administrator. During an interview on 9/3/25 at 1:34 PM, when asked if these comments were investigated, the CNO stated, no. Facility Policy about Abuse Investigations Review of the facility policy Allegation of Abuse Policy, dated 12/15/24, revealed: . It is the policy of PeaceHealth that any allegation of abuse by a patient against a caregiver will be responded to immediately. An investigation of the facts will be coordinated . Caregiver - Patient Present . Risk Management and Human Resources; - Risk Management and Human Resources, working with the department manager will outline an action plan for investigating the incident using the steps listed here as a guide; - The Risk Manager will review the patient components of the event while human resources will direct their focus on the caregiver . ; - Human Resources (HR) Meet with manager and place caregiver on administrative leave (if appropriate). Meet with and lead caregiver interview. Conduct review of evidence and report findings to HR leadership. Maintain caregiver related documentation in HR records; - Risk Manager. Risk Management [facilitates] the investigation. Obtain lists of involved parties and witnesses. Review CareConnect to learn purpose of admission/encounter, medical history and general information about care that is underway. Lead interviews with patient/legal representative and witnesses. Secure evidence and maintain documentation of the event. Assist with law enforcement reporting. Following discussion with human resources and manager, will close case and identify lessons learned and any process improvement opportunities. Maintain documentation (for the patient) of this event in Safe2Share - Feedback . Risk Management During an interview on 9/5/25 at 9:00 AM, the Clinical Risk Manager and the PeaceHealth Director of Quality, the Clinical Risk Manager stated one of his daily duties was to monitor the

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review and interview, the facility failed to report the results of an investigation of an allegation of abuse to the State Agency within 5 working days as required under CFR 483.12(c)(4). The lack reporting investigation results concerning an allegation of abuse in an appropriate and timely manner inhibited the State Agency from accurately assessing and investigating this allegation, which placed all residents (based on a census of 26) at risk for future exposure to potential abuse. Findings:A facility reported incident (FRI) was submitted to the State Agency for an allegation of verbal abuse, dated 7/23/25, by the Chief Nursing Officer (CNO). During an interview on 9/3/25 at 1:34 PM, the CNO stated she faxed the final report to the State Agency on 8/4/25. When asked to show proof of this fax, the CNO stated she could not provide this proof. A review of the State Agency's fax line and email revealed no final report received from the facility for the 7/23/25 incident. Review of an email received on 9/7/25, from the CNO, revealed: I was talking to . our HR Director Friday [9/5/25] after you guys headed to the airport. She triggered my brain to remember something regarding the final report that I could not prove that I had submitted. I did fax it to the state because on 7/28 I received a phone call from the state asking me to fill out the paperwork electronically for my final report. I am attaching the final report I saved because I wanted to ensure that I had proof of it . Review of the email attachment revealed the report was an Adult Protective Services Intake Report. This report was dated 7/28/25 and labeled initial report. Further review revealed the detailed statement was identical to the initial report and contained no results from the investigation. Review of the facility policy LTC [Long Term Care]: State Reporting and Investigation of Suspected Abuse/Neglect of Resident and the Federal Elder Justice Act Policy, dated 2/18/25, revealed: . Reporting: In accordance with Alaska state law, 42CFR483.13(b)(c), all suspected cases of abuse and/or neglect will be reported as outlined below: Health Facilities Licensing and Certification (HFL&C): The initial reporting of the incident must be faxed or phoned immediately. Fax is the preferred method of contact; please fax (907) [PHONE NUMBER] or call (907) [PHONE NUMBER] for allegations including that involving nursing aide abuse. The results of the investigation must be followed up through a written report within five days of the initial reporting of the incident . Further review of the facility policy revealed the facility was also required to submit the initial report to the Division of Senior Services, which was where the Adult Protective Services Intake Reports would be generated. The policy stated: . it is not required to follow up with the Division of Senior Services with the results of the investigation .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.Based on record review and interview, the facility failed to thoroughly investigate an allegation of abuse for 1 resident (#12), out of 1 allegation of abuse investigation reviewed. Specifically, the facility failed to: 1) Accurately interview Resident #12 to determine the nature and timing of the allegation of abuse; 2) Have evidence of the Administrator's interview conducted during the investigation; 3) Contact the Resident's Provider regarding the allegation of abuse; and 3) Investigate reports of intimidation and verbal abuse received from 2 residents (#'s 20 and 25), out of 5 residents interviewed during the investigation. These failed practices: 1) caused a misinterpretation of what the allegation of abuse was and when it occurred; 2) resulted in the investigation being incomplete; and 3) denied Residents #20 and #25 the right to potentially submit a complaint for an allegation of abuse and placed them at risk for continued emotional upset from the experiences reported. Findings:Incident Reported A facility reported incident (FRI) was submitted to the State Agency for an allegation of verbal abuse, dated 7/23/25, by the Chief Nursing Officer (CNO). Incident Description During an interview on 9/2/25 at 1:45 PM, Resident #12 stated he/she had been asking about going to therapy to help strengthen his/her legs so he/she could walk again. Resident #12 stated the Administrator came to him/her one day while he/she was looking out a window in the activities room and said, You are never going to get out of that chair [meaning wheelchair]. You are a failure, and you are going to die here. Resident #12 stated this comment made him/her very sad and he/she was now hopeless, like I'll never get out of here. It was observed that Resident #12 was physically shaking when he/she told this story, wringing his/her hands and his/her voice was cracking with emotion. When asked when this conversation occurred, Resident #12 stated he/she couldn't remember the exact date, but it was before the 7/23/25 resident council meeting. Investigation by CNO During an interview on 9/3/25 at 1:34 PM, the CNO stated during the resident council meeting on 7/23/25, in the middle of the meeting, Resident #12 stated he/she felt the Administrator had verbally abused him/her. After the meeting, the facility team decided to file a State report regarding Resident #12's comment and initiate an investigation. The CNO stated the report was sent to the State Agency on 7/23/25. The CNO further stated that she contacted the HR Director for PeaceHealth on 7/23/25 about the investigation and placed the Administrator on administrative leave pending the conclusion of the investigation. The CNO further stated she completed an interview with Resident #12 on 7/23/25 about the comments in the meeting, however Resident #12 did not comment on what the verbal abuse was. When asked to see the documentation for the interview with Resident #12, the CNO stated no documentation for the interview was completed. The CNO further stated that Resident #12 stated he/she was just mad and didn't want to file a report, but the CNO felt it was her responsibility to file the report anyhow to make sure an abundance of caution was made. The CNO stated she also submitted this incident in the facility's electronic incident reporting system Safe2Share. When asked if the CNO was aware that when Resident #12 spoke of the verbal abuse in the resident council meeting, the resident was speaking about an incident that had occurred before the resident council meeting, and not about a comment made at the meeting, the CNO stated she was not aware of this and had assumed it was about a comment made in the resident council meeting on 7/23/25. When asked if the CNO interviewed the Administrator during the investigation, the CNO stated she and the Administrator had talked but this was not documented. When asked if the CNO contacted Resident #12's provider to inform them of the reported allegation of abuse, the CNO stated she did not contact the provider. When asked what other steps occurred during the investigation, the CNO stated she had a Minimum Data Set (MDS - a nationally mandated routine assessment) Nurse interview five other residents to ensure no other residents had any concerns. The CNO stated she drafted questions for the MDS Nurse to use. From these interviews, she determined these residents felt safe. When asked what the investigation's determination was, the CNO stated that because Resident #12 retracted his/her statement and because it was determined it was mainly about the Administrator's approach to communicating with others, she determined the abuse allegation as retracted and concluded the investigation on 7/28/25. The CNO stated the Administrator returned to work on 7/29/25. Review of the facility's documentation of the resident interviews that occurred during this investigation, undated, revealed two resident's, Resident #20 and #25, interviews revealed they had felt verbally abused by the Administrator. During an interview on 9/3/25 at 1:34 PM, when asked if these comments were investigated, the CNO stated, no. Review of the facility policy Allegation of Abuse Policy, dated 12/15/24, revealed: . It is the policy of PeaceHealth that any allegation of abuse by a patient against a caregiver will be responded to immediately

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. (continued on next page)

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review, interview, and observation, the facility failed to provide an ongoing, resident-centered activity program, aligned with individual care plans, for 17 Residents (#'s 4, 5, 7, 9, 12, 13, 18, 20, 21, 23, 25, 27, 28, 31, 33, 34, and 36), out of 26 residents who enjoyed activities outside of their rooms. Specifically, the facility failed to: 1) Consistently provide activities as documented on the facility's monthly activity calendar for the months of July, August, and September 2025; 2) Provide scheduled outings with the use of the facility's transportation van; and 3) Allow residents with the diagnosis of dementia from participating in scheduled outings. These failed practices placed these residents at risk for loneliness, isolation, boredom and decreased their quality of life, which had the potential to affect their overall physical, mental, and psychosocial well-being .Findings: Resident Activities Preferences Resident #4 Record review on 9/2-6/25 revealed Resident #4 was admitted to the facility with diagnoses that included Type 2 diabetes mellitus (DM-disorder characterized by persistent high blood sugar levels and inability to use insulin properly), senile dementia with behavioral disturbance (age-related memory loss or confusion in older adults) and hypertension (high blood pressure). Review of Resident #4's care plan, start date of 3/13/25, revealed an identified problem [Resident #4's POA] has voiced [Resident #4's] activity preferences as conversing, cooking group, religious events/clergy, books on tape, visits from family/friends, watching TV . [Resident #4] likes [NAME] movies. The goal for this problem was to provide activity choices of interest that will enhance quality of life through next review. This goal was dated 3/13/25 through 10/31/25. Resident #5 Record review on 9/2-6/25 revealed that Resident #5 was admitted to the facility with diagnoses that included gastroesophageal reflux disease (GERD- a chronic condition where stomach acid flows back into the esophagus, causing symptoms like heartburn and acid reflux), late onset Alzheimer disease (characterized as when the disease develops in individuals aged 65 and older) without behavioral disturbance, and anxiety. Review of Resident #5's care plan, start date of 10/16/24, revealed an identified problem [Resident #5's] participation in activities can be sporadic due to [his/her] short attention span r/t [related to] Alzheimer's Dementia. [He/she] enjoys [his/her] baby doll 'Bridget, ', family visits, ambulating on unit, listening to music, sorting items, and watching movies with dancing. The goal for this problem was to provide activity choices of interest that will enhance quality of life through next review. This goal was dated 10/16/24 through 11/30/25. Resident #7 Record review on 9/2-6/25 revealed Resident #7 was admitted to the facility with diagnoses that included hypertension, dementia, and anxiety disorder. Review of Resident #7's care plan, start date of 11/14/24, revealed an identified problem [Resident #7's POA] has voices [his/her] activity preferences as having special events in room, listening to music, watching tv, 1:1 visits with family, family outings, van rides, visits from [NAME] (unit support dog), and going outside for fresh air. The goal for this problem was to provide activity choices of interest that will enhance quality of life through next review. This goal was dated 11/14/24 through 10/31/25. Resident #9 Record review on 9/2-6/25 revealed Resident #9 was admitted to the facility with diagnoses that included hypertension, Type 2 DM, and severe late onset Alzheimer's dementia without behavioral disturbance. Review of Resident #9's care plan, start date of 1/22/25, revealed an identified problem [Resident #9's daughter] has voiced [Resident #9's] activity preferences as group activities such as board games, manicures, cooking, making floral arrangements, arts and crafts, watching television, picture books, listening to religious music and folding/stacking. The goal for this problem was to provide activity choices of interest that will enhance quality of life through next review. This goal was dated 1/22/25 through 9/30/25. Resident #12 Record review on 9/2-6/25 revealed Resident #12 was admitted to the facility with diagnoses that included depression, hypertension, and cerebrovascular accident (CVA- also known as a stroke, is when blood flow to a part of the brain is stopped either by a blockage or rupture of a blood vessel). Review of Resident #12's care plan, start date of 12/27/24, revealed an identified problem [Resident #12] had voiced [his/her] activity preferences as coloring, books on tape, writing, painting, cooking, [playing] cards, resident council, pet therapy, watching tv, games, out on patio, sports, conversing, hair, current events and music. The goal for this problem was to provide activity choices of interest that will enhance quality of life through next review. This goal was dated 12/27/24 through 9/30/25. During an interview on 9/2/25 at 1:45 PM, Resident #12 stated the facility used to have a monthly outing to Walmart for residents. Resident #12 stated they would use the facility van to take the residents, but this hasn't happened in a while. Resident #12 stated, Residents just want to get out and look around. It's nice to leave the facility

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	. Based on record review and interview, the facility failed to ensure float nursing staff (NS) and travel NS, had the job specific competencies and skill sets necessary to care for long-term care (LTC) residents' needs. Specifically, the facility failed to ensure: 1) float/travel NS had current LTC training for ADL (activities of daily living) Coding and Definitions;2) float/travel NS had current LTC training for Behavioral Health (BH);3) float/travel NS had current LTC training for QAPI (quality assurance performance improvement);4) float/travel NS had current LTC training for Dementia for LTC; and5) float/travel NS had current LTC training for Trauma Informed Care. This failed practice had the potential to place all residents (based on a census of 26) at risk of not receiving the necessary specific treatment and care needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being .Findings: Record review on 9/2-5/25 of the float NS training records revealed: 1) 17 NS (NS #'s 1, 2, 3, 4, 5, 6, 8, 9,10, 11, 12, 13, 14, 16, 17, 19, 20), out of 20 NS personnel files reviewed, did not have current training for ADL Coding and Definitions; 2) 17 NS (NS #'s 1, 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 14, 16, 17, 19, 20), out of 20 NS personnel files reviewed, did not have current training for BH; 3) 17 NS (NS #'s 1, 2, 3, 4, 5, 6, 8, 9, 10, 11,12,13, 14, 16, 17, 19, 20), out of 20 NS personnel files reviewed, did not have current training for QAPI; 4) 11 NS (NS #'s 3, 4, 5, 6, 8, 9, 12, 14, 17, 19, 20), out of 20 NS personnel files reviewed, did not have current training for Dementia for LTC; and 5) 17 NS (NS #'s 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 16, 17, 19, 20), out of 20 NS personnel files reviewed, did not have current training for Trauma Informed Care. During an interview with the Clinical Nurse Educator on 9/4/25 at 11:00 AM, she stated that she was only aware of abuse and neglect training being required for staff who floated to the LTC. She also stated that she did not know about dementia specific modules being required and therefore the float staff did not complete the same training as the core staff. When asked if she thought a staff member floating to the LTC without this specific job training could impact resident care, she stated: I think they are still giving good care, but it's possible the lack of LTC specific training could have an impact. Review of the document Facility Assessment - staff training and competencies, dated 5/2024, revealed: .The Nurse Educator keeps records of all training and skill fair documents. The Nurse Educator and Facility Administration education department ensure all areas are included. These training programs are also reviewed by PeaceHealth System education department. Evaluation of the facility's training program and effectiveness in ensuring training needs are met for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. During an interview on 9/4/25 at 1:00 PM, NS #20 stated that he/she had not received any LTC specific education prior to working in the LTC unit. He/she stated: .I only had general orientation. He/she further stated that no education was provided for dementia care, trauma-informed care, and cultural competency. During an interview on 9/4/25 at 12:23 PM, House Supervisor #1 stated that to float nursing staff to the LTC unit, staff must have completed an online module that provided education on abuse and neglect. When asked if the module educated on dementia care or trauma-informed care, House Supervisor #1 stated that abuse and neglect was the only education being tracked. Review of the facility provided policy Trauma Informed Care Policy, dated 9/3/2025, revealed: .Health Care organizations often train their clinical staff in trauma-specific treatment approaches. Facility Environment: train all staff to be sensitive to individuals (residents or staff) who are responding to a situation due to past trauma and understand how to support them. Review of the facility training module LTC ADL Coding and Definitions, updated in 2023 revealed that the module focuses on educating caregivers about accurately coding ADL's such as bathing, dressing, eating, and toileting, which are critical for assessing a resident's functional status and support needs in LTC. It outlines objectives to define self-performance and support required for ADLs, code them correctly on the MDS (Minimum Data Set - federally mandated assessment tool used in long-term care). Review of the facility training module Care of the Resident with Mental Disorders, updated in 5/2023 revealed that the module aims to enhance caregivers' ability to support residents with behavioral health issues, focusing on identifying signs, symptoms, and triggers of these conditions, as well as specific strategies for improved communication with residents who have experienced trauma. It emphasizes the importance of trauma-informed care to mitigate triggers and ensure culturally competent care, aligning with regulatory standards that mandate facilities should eliminate or reduce abuse and provide care in accordance with residents' preferences and professional standards. Review of the facility training module QAPI Training for Caregivers, updated in 2023, revealed that the module aims to equip caregivers with the knowledge to contribute to QAPI by discussing

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. .Based on record review and interview, the facility failed to ensure their facility assessment was reviewed and updated annually. This failed practice had the potential to place all residents (based on a census of 26) at risk of not having the necessary care and resources from an accurate assessment. Findings:Review of the facility's Proactive LTC Consulting Facility Assessment revealed this assessment was last updated on 5/21/24. The Chief Nursing Officer (CNO) acknowledged this finding and stated the facility assessment needed to be updated

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review and interview, the facility failed to ensure four float Certified Nurse Assistants (CNAs) out of four float CNAs chosen for review, received the required 12 hours of annual in-service training, specifically including education on dementia care and abuse/neglect prevention. This failed practice placed all residents (based on a census of 26) at risk for substandard care due to staff not being provided with the education necessary to ensure continuing competence in the care of long-term care (LTC) residents .Findings: Record review on 9/2-5/25 of CNA training records revealed:CNA #52 - 12 Hour Annual CNA Training with Dementia/Abuse/Neglect, expired on [DATE];CNA #53 - 12 Hour Annual CNA Training with Dementia/Abuse/Neglect, not completed;CNA #54 - 12 Hour Annual CNA Training with Dementia/Abuse/Neglect, not completed;CNA #55 - 12 Hour Annual CNA Training with Dementia/Abuse/Neglect, expired on [DATE]. Review of the facility provided schedule document Charge Back - Non Home Employee Detail, dated [DATE]-[DATE], revealed the following CNAs worked without the required 12 hours of annual in-service training on the following dates:CNA #52 worked in the LTC on [DATE] and [DATE];CNA #53 worked in the LTC on [DATE];CNA #54 worked in the LTC on [DATE];CNA #55 worked in the LTC on [DATE]. During an interview with the Director of Nursing (DON) on [DATE] at 9:30 AM, she stated that she was unaware that float staff needed LTC specific training to care for LTC residents, other than the abuse and neglect module. During an interview on [DATE] at 11:00 AM, CNA #55 stated that he/she had worked as a float in the LTC and had not received any education on dementia care or abuse/neglect within the past year. During an interview on [DATE] at 12:23 PM with the House Supervisor #1, he/she stated that to float a CNA to the LTC unit, they must have completed an online module that provided education on abuse and neglect. When asked if the module educated on dementia care, the House Supervisor stated that abuse and neglect was the only education being tracked. During an interview on [DATE] at 11:30 AM with the Clinical Nurse Educator, she stated that float CNAs working in LTC do not attend the annual educational retreats provided to the LTC CNAs to meet the 12-hour requirement. She further stated, There's a program for float CNAs, an article that they do for their Continuing Education Units (CEUs) to renew their license, but it does not provide education for dementia care or abuse and neglect in the LTC residents. Review of the document Facility Assessment - staff training and competencies, dated 5/2024, revealed: .The Nurse Educator keeps records of all training and skill fair documents. The Nurse Educator and Facility Administration education department ensures all areas are included. These training programs are also reviewed by PeaceHealth System education department. Evaluation of the facility's training program and effectiveness in ensuring training needs are met for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. Review of the facility adopted training module Dementia-related Conditions - Resident Care - PeaceHealth's Long Term Care Education, updated 5/2023, revealed that caregivers like CNAs are encouraged to adopt a person-centered approach, recognizing stress triggers (physical, psychosocial, environmental) and using a four-step behavioral model (Prevent, Gather, A.C.T. [Ask, Collect, Treat], Redirect) to manage behaviors effectively. The module further trains caregivers with job specific behavioral models that include specific strategies such as preventing escalation with calm interactions, gathering information on resident preferences, and triggers. Review of the facility adopted training module Abuse, Neglect, and Exploitation in the Elder Care Setting, updated in 6/2022, revealed the module aimed to educate caregivers on recognizing and reporting abuse, neglect, and exploitation in elder care settings, covering types such as physical, verbal, mental, and financial abuse, as well as neglect and exploitation