STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035093	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Cottonwood	197 South Willard Street Cottonwood, AZ 86326

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of records, and review of facility policy and procedure, the facility failed to ensure one resident (#326) was treated with respect and dignity. The deficient practice could lead to psychosocial harm of a resident. -Findings include: Resident #326 was admitted to the facility on [DATE], with diagnoses that included hypotension, unsteadiness on feet, degeneration of nervous system due to alcohol, and unspecified dementia. A Health Status Note dated November 8, 2021, by a Registered Nurse (RN / Staff #112), revealed Resident #326 had a smoker's patch in place on the right arm. The resident stated rudely, If you people would let me smoke and let me out of here, I would be content!, as the resident raised his hand at the nurse. Staff #112 was startled and told the resident to please settle down and stop acting like a a**. Staff #112 offered to make the resident a sandwich, but, he settled with yogurt, and drank water. The resident was then resting peacefully. An admission minimum data set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. A facility Reportable Event Record / Report dated November 23, 2021, revealed in the evening of November 8, 2021, Staff #112 was in Resident #326's room while the resident was in bed resting, and was startled when the resident raised his arm abruptly and yelled at the staff member. The staff member was caught off guard and surprised and used language that was inappropriate for use around a resident. The resident did not take offense to what was said, and Staff #112 was able to calm the resident by offering food and something to drink. The resident was calmed and peaceful and had all of his needs met. There were no other incidents noted of similar behavior. The language used by the staff member was the result of being startled and was not meant in a personal or attacking way toward the resident. It is still not considered appropriate so the staff member was suspended and educated about customer service and appropriate behavior toward residents. Upon interview, Staff #112 explained that the language used was not meant to be personal to the resident, and was sorry for using it. The resident was also interviewed and stated to not have had any problem with a staff member or feel that he has been spoken to inappropriately or treated poorly. He was pleasant and happy with his care. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on May 20, 2025 at 10:31 AM, with a Certified Medication Assistant (CMA / Staff #66) who stated that if a staff member was overheard to speak to a resident disrespectfully, she would first ensure resident safety, then remove the staff who was doing that to the resident, contact the Director of Nursing (DON), and let the charge nurse know. Staff #66 stated that if a staff member was overheard saying stop acting like an a** to a resident, that would be inappropriate. Additionally, Staff #66 stated in a case where there is suspected verbal abuse, the facility's policy is to first, examine the picture for safety, then report it to the abuse coordinator right away. An interview was conducted on May 20, 2025, at 12:13 PM, with a Licensed Practical Nurse (LPN / Staff #72) who stated if a staff member speaks to a resident disrespectfully, Staff #72 would be expected to intervene, and ask the offending staff member to take a break, and Staff #72 would then take over the situation. Staff #72 stated that in cases of alleged abuse, staff have a 2 hour timeframe to report. Staff #72 stated if a staff member was overheard saying stop acting like an a** to a resident, that would be super inappropriate. An interview was conducted with the Director of Nursing (DON / Staff #56) on May 20, 2025, at 2:50 PM, who stated if she overheard a staff member speak to a resident disrespectfully, she would remove that staff from the patient care area and meet with the staff, then initiate an immediate investigation. The DON stated that if a staff member was overheard saying stop acting like an a** to a resident, that would be considered inappropriate. Review of the facility policy titled Code of Conduct, 2014, revealed standards of professional conduct are expected to be demonstrated by all employees. The following list is provided as examples of behavior that will result in disciplinary action up to and including termination and is not all- inclusive: violation of any zero-tolerance policy, abuse, disrespect of superiors, coworkers, residents or guests, harassment of all forms, fighting or instigation, substandard work, the violation of any Company policy or procedure presently in force, and violation of the Code of Conduct. Review of the facility policy titled Resident Rights, revised December 2016, revealed employees shall treat all residents with kindness, respect, and dignity.

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, facility documentation and policy, the facility failed to ensure that one resident's (#47) consent was given prior to the administration of a psychotropic medication. The deficient practice could result in the resident not being informed of the risk and benefits of proposed care and not being given the opportunity to choose the care option of care he or she prefers. Findings include: Resident # 47 was admitted to the facility on [DATE] with diagnoses of atrial fibrillation, dementia with mood disturbance, anxiety, muscle weakness, and cognitive communication deficit. The admission Minimum Data Set (MDS) dated [DATE], revealed the resident had a brief Interview for Mental Status (BIMS) of 10 indicating the resident had impaired cognition. In addition, the Resident Mood Interview screening, revealed the resident scored a 0, indicating no concerns of depressive symptoms over the past two weeks. The MDS revealed no evidence of high-risk drug classes for anti-anxiety and antidepressants in the data set. The care plan for Antidepressant Medication, related to depression, was initiated on May 7,2025, with interventions that included to administer antidepressant medications as ordered by the physician. An order for one Bupropion HCL Extended release tablet for anxiety was dated May 11, 2025, three days prior to the psychotropic consent was signed. Review of the Informed Consent: Psychotropic Medication revealed consent for Bupropion an antidepressant for depression was declined by the resident's representative May 13, 2025 and witnessed by the facility representative the same day. According to the Medication Administration Record (MAR), 150 mg of Bupropion HCL ER was given once a day to the resident for anxiety on May 11, 2025 - May 13, 2025. An interview was conducted on May 19, 2025 at 9:30 a.m., with the resident's representative. The representative revealed concerns the resident was given an antidepressant without consent. The representative revealed it was the family's wish and decision to hold off on the antidepressant in order to not impede the resident's plan to re-introduce turmeric and curcumin into the medication regimen. The representative expressed discontent upon discovering the resident was given medication without consent. An interview was conducted with Licensed Practical Nurse (LPN/Staff #72) 05/19/25 at 10:36 a.m., revealed consent for psychotropics are done prior to the medication being given. This prevents the resident from receiving medications they may not want. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A panel discussion was conducted on May 20, 2025 at 9:20 a.m. with the clinical resource (Staff # 250 , and the Director of Nursing (DON/Staff #56). Both parties reviewed the psychotropic consent and the Bupropion administration dates during the interview. The parties agreed that consents should be obtained before administration of meds, just in case the resident refuses the medication. Both parties agreed the facility expectation was not met expectation for this resident. The facility expectation is to get the consent signed before administration, as the facility mandates psychotropics consents are obtained prior to given the medication. The facility's Resident's Rights/Dignity policy, effective January 1, 2024, revealed the resident is to be informed and participate in his or her care planning and treatment. The facility's Psychotropic Medication Use policy, effective January 1, 2024, revealed the resident has the right to decline treatment with psychotropic medications.

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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. Based on observations, interviews, facility documentation and policy, the facility failed to ensure a clean, sanitary, and safe environment in the residents' shower rooms, and in shared resident bathroom on the 200-Hall. The deficient practice could result in the spread of infection and the failure to achieve a home-like environment. Findings include: A facility walkthrough was conducted with the Maintenance Supervisor (Staff #302) and the Maintenance Manager (Staff #31) on May 19, 2025 at 08:58 a.m. to observe a resident shared restroom on the 200-Hall. All parties observed feces stuck to the inside of the commode, feces on the handrail, feces on the floor, dust and calcification in the toilet bowl, and a used and stained urinal (occupants of both rooms were females). During a facility walkthrough on May 19, 2025 at 9:15 a.m. with the Maintenance Supervisor (Staff #302), an unlabeled blue chemical in a squirt bottle was observed on the handle near the commode in the 200-Hall shower room. The shower drains had soap scum and multiple strands of hair. The shower room vent was covered in a thick layer of black and grayish substance. An interview was conducted with resident #271 on May 18, 2025 at at 2:44 p.m. The resident voiced discontent about sharing the toilet with three other people. The resident stated They know that four people are using this toilet, I went in there today and feces was on the floor and yesterday, there were feces all over the place! The resident revealed that staff was alerted about the state of the toilet. However, there was no action taken to resolve her concern. An interview was conducted with the Maintenance Supervisor (Staff #302) and the Maintenance Manager (Staff #31) on May 19, 2025, at approximately 9:00 a.m. Both parties revealed the facility had no official housekeeping manager and that the maintenance manager was covering that position. After observing the resident restroom, both parties agreed that the smell and condition of the restroom was unacceptable. They noted that it will be taken care of immediately with housekeeping. In an interview with Staff #302 conducted on May 19, 2025 at 9:15 a.m., staff #302 acknowledged that it is unsafe for cleaning products to be within residents' reach. Staff #302 stated that he was going to send housekeeping to do a deep cleaning of the shower room to include the air vents. Review of the facility's Environmental Services Manager job description indicated that the the individual must have a knowledge of all areas of facility maintenance. The job description indicated that this individual is responsible for the cleanliness and appearance of the physical environment, including offices, common areas, and resident rooms. The facility's Housekeeper job description revealed that the Housekeeper works under the direct supervision of the Environmental Services Manager. This Housekeeper maintains the facility, resident rooms, and all common areas in a cleanly, welcoming, and homelike environment (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated Environmental/Maintenance policy revealed that it is the responsibility of the facility to provide residents, guests, and staff a safe and functional environment. In addition, the facility directed that any hazardous and/or emergency findings are to be reported to the management staff. Review of the Infection Control: Cleaning and Disinfection of Environmental Surfaces policy, with an effective date of January 1, 2024, indicated that housekeeping surfaces will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. Additionally, the policy directed that environmental surfaces will be disinfected on a regular basis and when surfaces are visibly soiled.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record, staff interviews, review of facility documentation, policy and procedures and the State Agency (SA) database the facility failed to implement their policy regarding conducting thorough investigation of abuse/neglect allegation and protecting residents from further abuse for two residents (#26 and #171). The deficient practice could result in abuse/neglect continuing and not being prevented. Findings include: Regarding resident #26 (alleged victim) -Resident #26 was admitted to the facility on [DATE] with diagnoses that included hypotension, chronic kidney disease, and nocturia. Review of the SA database revealed that a self-report was submitted by the facility on January 4, 2023. The report indicated an allegation of neglect. However, it did not detail information on what occurred nor did it indicate who the alleged perpetrator was. The report did not identify that the perpetrator was a staff member and whether the staff member was suspended pending an investigation. However, review of the resident's clinical record did not reveal any progress notes related to the incident. Additionally, there was no indication that the resident was assessed or that notifications to the provider, and other required agencies were made. Review of the 5-day investigation report dated January 20, 2023 indicated that an allegation of neglect was reported regarding a Certified Nursing Assistant (CNA/staff #666) related to resident #26. It was alleged that staff #666 told resident #26 that he should not use the call light for at least an hour since she just got him situated. The report revealed that the facility's investigation did not include interviews of residents and staff members. The report did not include witness statements. Although there was a summary of interview of the alleged victim, alleged perpetrator, and witness, it did not state when the interviews were conducted nor did it identify who the witness was. Further review of the 5-day investigation report also revealed that the facility did not indicate what action was taken after they were notified of the allegation. The investigation concluded that resident neglect did not occur. However, the report noted that the alleged perpetrator was on an improvement plan due to incidents of poor customer service and unprofessional conduct, but never anything that was seen as abuse or neglect. Regarding staff #666 (alleged perpetrator) Review of staff #666's personnel file revealed a job description for a Certified Nursing Assistant (CNA) dated September 30, 2022. Among the tasks and responsibilities identified stated that the CNA will provide direct care and assist residents with activities of daily living including dressing, eating, grooming, communicating, ambulation, toileting, and personal hygiene. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A corrective Action Form signed January 12, 2023 documented that staff #666 had a history of complaints pertaining to patient care. The form documented instances in which staff #666 failed to provide ADL care/services to residents who needed her assistance resulting in her placement on Written Warning for Professional Conduct/Poor Performance. Review of the Corrective Action Form signed January 16, 2023 revealed that on January 13, 2023 a resident's daughter reported staff #666 for failure to assist resident with her meal and instead was observed with her feet propped up on the resident's bed playing a game on her phone. This incident resulted in staff #666 being terminated. A 5-day investigation report dated January 20, 2023 included an undated interview summary conducted with staff #666. The interview summary indicated that per staff #666 she was misheard and was only trying to educate the resident on appropriate call light usage after she had assisted him with his personal care. The report noted that staff #666 was on an improvement plan due to incidents of poor customer service and unprofessional conduct. An interview with a Certified Nursing Assistant (CNA/staff #29) was conducted on May 20, 2025 at 9:51 a.m. Staff #29 stated that neglect can encompass not checking on residents, not providing needed care and services, and not supporting them with their ADL (activities of daily living) needs. The CNA noted that the importance of not neglecting residents is for their safety and comfort. The potential impact of neglect is that residents can feel unsafe, depressed, and discomfort. Staff #29 stated familiarity with resident #26. However, the CNA stated that she could not recall an incident of neglect involving the resident. Regarding resident #171 (alleged victim) -Resident #171 was admitted to the facility on [DATE] with diagnoses that included monoplegia, chronic heart failure, and depression. Review of the SA database revealed that a self-report was submitted by the facility on November 9, 2022. The report indicated an allegation of family to resident verbal abuse. The report did not indicate whether the family member was separated from the resident and not allowed access to the resident pending an investigation. A progress note dated November 9, 2022 revealed that shouting was heard from the resident's room. Staff found resident and husband arguing. The note indicated that the resident was separated from the spouse and that the spouse was asked to leave. The note documented that the resident was visibly upset, had to be comforted, and given time to express feelings. The note also indicated that the physician, administrator, and DON was informed of the incident. Further review of the resident's clinical record revealed a progress note dated November 10, 2022 which documented that the resident stated that she was really depressed in part since her husband blames her for putting herself in the facility. The note indicates suicidal ideation as a result. However, there was no mention regarding the prior day's incident with the husband. Furthermore, there was no indication that resident's interaction with husband will be monitored or that visitation is limited pending investigation. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated 5-day investigation report submitted by the facility on November 15, 2022 revealed that the facility's investigation did not include interview with the alleged perpetrator (family member) or potential witnesses. The report did not contain witness statements. Although there was a summary of interview of the alleged victim and a witness, the summary did not indicate when the interviews were conducted nor did it identify who the witness was. An interview with a Certified Nursing Assistant (CNA/staff #29) was conducted on May 20, 2025 at 9:51 a.m. Staff #29 stated that in instances of abuse, the staff will separate the resident from the alleged perpetrator to ensure safety. This is important in order to maintain the resident's dignity and safety. According to the CNA, the impact of resident abuse is trauma which can lead to behaviors. Staff #29 said that following the policy regarding conducting a thorough investigation of allegations of abuse/neglect and protecting residents from further abuse/neglect is important to ensure that the facility is doing its due diligence to investigate and ensure the safety of residents. The impact of not following the policy regarding conducting a thorough investigation and protecting residents from further abuse is that residents would feel like they could not speak up when something happens, feel like the abuse/neglect will happen again, and assume that the facility does not follow-through on allegations. The CNA stated that she was not familiar with resident #171. During an interview with a Licensed Practical Nurse (LPN/staff #72) conducted on May 20, 2025 at 12:21 p. m., staff #72 stated that following the policy for conducting a thorough investigation and protecting residents from further abuse/neglect is important since you do not want the abuse/neglect to continue or happen to others. The LPN stated that the impact of not following the policy regarding conducting a thorough investigation and protecting residents from further abuse/neglect is that it can create tension, and not have a healthy environment in which residents do not feel safe. Staff #72 stated familiarity with resident #26 but was unfamiliar with the incident. Additionally, the LPN said that she was unfamiliar with resident #171. An interview with the Director of Nursing (DON/staff #56) was conducted on May 20, 2025 at 1:03 p.m. Staff #56 stated that her expectation is that staff defer to the policy and refer to it to ensure they are touching all the points. This is important to ensure that all steps are followed and that they are not missing a bullet point. According to the DON the impact of not following policies is the possibility of missing a step that can affect the outcome. The facility policy titled Abuse revision 0622 indicated that the facility strives to prevent abuse of all their residents. According to the policy, abuse also included the deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. The Reporting and Investigation section of the policy stated that a minimum of three residents will be interviewed to determine if there is a trend. Interviews may also include the alleged perpetrator, witnesses, and staff members as applicable. The policy noted that if the alleged perpetrator is an employee, they will be immediately suspended pending the result of the investigation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interviews, review of records, and review of facility policy and procedure, the facility failed to ensure an allegation of abuse was reported timely to required entities for one resident (#326). The deficient practice could lead to ongoing abuse leading to harm of a resident. -Findings include: Resident #326 was admitted to the facility on [DATE], with diagnoses that included hypotension, unsteadiness on feet, degeneration of nervous system due to alcohol, and unspecified dementia. An admission minimum data set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. A Health Status Note dated November 8, 2021, by a Registered Nurse (RN / Staff #112), revealed Resident #326 had a smoker's patch in place on the right arm. The resident stated rudely, If you people would let me smoke and let me out of here, I would be content!, as the resident raised his hand at the nurse. Staff #112 was startled and told the resident to please settle down and stop acting like a a**. Staff #112 offered to make the resident a sandwich, but, he settled with yogurt, and drank water. The resident was then resting peacefully. Review of State Agency records revealed the facility called the reporting hotline on November 16, 2021, and reported an allegation that a staff member verbally abused Resident #326. A facility Reportable Event Record / Report dated November 23, 2021, revealed in the evening of November 8, 2021, Staff #112 was in Resident #326's room while the resident was in bed resting, and was startled when the resident raised his arm abruptly and yelled at the staff member. The staff member was caught off guard and surprised and used language that was inappropriate for use around a resident. The resident did not take offense to what was said, and Staff #112 was able to calm the resident by offering food and something to drink. The resident was calmed and peaceful and had all of his needs met. There was no other incident noted of similar behavior. The language used by the staff member was the result of being startled and was not meant in a personal or attacking way toward the resident. It is still not considered appropriate so the staff member was suspended and educated about customer service and appropriate behavior toward residents. Upon interview, Staff #112 explained that the language used was not meant to be personal to the resident, and was sorry for using it. The resident was also interviewed and stated to not have had any problem with a staff member or feel that he has been spoken to inappropriately or treated poorly. He was pleasant and happy with his care. An interview was conducted on May 20, 2025 at 10:31 AM, with a Certified Medication Assistant (CMA / Staff #66) who stated that if a staff member was overheard saying stop acting like an a** to a resident, that would be inappropriate. Additionally, Staff #66 stated in a case where there is suspected verbal abuse, the facility's policy is to first, examine the picture for safety, then report it to the abuse coordinator right away. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on May 20, 2025, at 12:13 PM, with a Licensed Practical Nurse (LPN / Staff #72) who stated that in cases of alleged abuse, staff have a 2 hour timeframe to report. Staff #72 stated if a staff member was overheard saying stop acting like an a** to a resident, that would be super inappropriate. An interview was conducted with the Director of Nursing (DON / Staff #56) on May 20, 2025, at 2:50 PM who stated if she overheard a staff member speak to a resident disrespectfully, she would remove that staff from the patient care area and meet with the staff, then initiate an immediate investigation and report it. The DON stated that if a staff member was overheard saying stop acting like an a** to a resident, that would be considered inappropriate. Review of the facility policy titled Abuse Policy, revealed abuse is the infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well- being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, neglect, mental abuse including abuse facilitated or enabled through the use of technology, and misappropriation of property. Potential abusers can be residents, employees, family members, visitors, venders, or any other person who comes into the facility. None of these types or sources of abuse are condoned in Haven Health facilities. Our objective is to provide a safe haven for our residents through preventative measures that protect every resident's right to freedom from abuse. If abuse is witnessed or suspected, or an injury of unknown origin is identified, the resident's safety will immediately be secured. Prompt reporting and investigation will be utilized to identify the validity of findings and reasonable measures will be implemented to deter further incidents of abuse. If abuse is witnessed or suspected, reporting and investigation will take place in this manner: Executive Director (ED) will be notified. ED and witness who is reporting will notify the following entities: Adult Protective Services, Ombudsman, State Survey Agency, Law enforcement when applicable. Suspected abuse will be reported in accordance with timeframes and standards required by CMS.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Cottonwood	197 South Willard Street Cottonwood, AZ 86326

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical records, review of facility documentation, review of the State Agency (SA) database, staff interviews and review of policy and procedure facility failed to ensure two allegations of abuse (resident #171& #326) and an allegation of neglect (resident #26) were fully investigated. The deficient practice could result in allegations of abuse and neglect not being investigated and abuse/neglect occurring in the facility. Findings include: Regarding Resident #26 -Resident #26 was admitted to the facility on [DATE] with diagnoses that included hypotension, chronic kidney disease, and nocturia. A report was received by the State Agency on January 4, 2023 regarding an allegation of neglect. However, the report did not identify the alleged perpetrator. Review of the SA database revealed that the facility failed to submit a thorough investigation of the allegation to the SA. Furthermore, review of the facility's 5-day investigation report dated January 20, 2023 revealed that the investigation did not include interviews of residents and staff members. The report did not include witness statements. Although there was a summary of interview of the alleged victim, alleged perpetrator, and witness, it did not state when the interviews were conducted nor did it identify who the witness was. An interview with a Certified Nursing Assistant (CNA/staff #29) was conducted on May 20, 2025 at 9:51 a.m. Staff #29 stated that neglect can encompass not checking on residents, not providing needed care and services, and not supporting them with their ADL (activities of daily living) needs. The CNA noted that the importance of not neglecting residents is for their safety and comfort. The potential impact of neglect is that residents can feel unsafe, depressed, and discomfort. Regarding resident #171 -Resident #171 was admitted to the facility on [DATE] with diagnoses that included monoplegia, chronic heart failure, and depression. A report was received by the State Agency on November 9, 2022 indicated that resident #171 had a family-to-resident verbal abuse incident. The resident's clinical record revealed a progress note dated November 10, 2022 which documented that the resident stated that she was really depressed in part since her husband blames her for putting herself in the facility. The note indicates suicidal ideation as a result. However, there was no mention regarding the prior day's incident with the husband. Furthermore, there was no indication that resident's interaction with husband will be monitored or that visitation is limited pending investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated 5-day investigation report submitted by the facility on November 15, 2022 revealed that the facility failed to conduct a thorough investigation that included witness interviews, perpetrator interview and staff interviews (potential witnesses). The report did not contain witness statements. Although there was a summary of interview of the alleged victim and a witness, the summary did not indicate when the interviews were conducted nor did it identify who the witness was. Further review of the undated 5-day investigation report revealed that the facility does not believe that abuse has occurred. An interview with a Certified Nursing Assistant (CNA/staff #29) was conducted on May 20, 2025 at 9:51 a.m. Staff #29 said that conducting a thorough investigation of allegations of abuse/neglect is important to ensure that the facility is doing its due diligence to investigate and ensure the safety of residents. The impact of not conducting a thorough investigation is that residents would feel like they could not speak up when something happens, feel like the abuse/neglect will happen again, and assume that the facility does not follow-through on allegations. During an interview with a Licensed Practical Nurse (LPN/staff #72) conducted on May 20, 2025 at 12:21 p. m., staff #72 stated that conducting a thorough investigation is important since you do not want the abuse/neglect to continue or happen to others. The LPN stated that the impact of not conducting a thorough investigation is that it can create tension, and not have a healthy environment in which residents do not feel safe An interview with the Director of Nursing (DON/staff #56) was conducted on May 20, 2025 at 1:03 p.m. Staff #56 stated that her expectation is that staff defer to the policy and refer to it to ensure they are touching all the points. The DON stated that conducting a thorough investigation is important to ensure that allegation is looked into and that safety is made a priority. According to staff #56 the impact of conducting a thorough investigation is that there is a possibility of continued inappropriate actions. The facility policy titled Abuse revision 0622 indicated that the facility strives to prevent abuse of all their residents. According to the policy, abuse also included the deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. The Reporting and Investigation section of the policy stated that a minimum of three residents will be interviewed to determine if there is a trend. Interviews may also include the alleged perpetrator, witnesses, and staff members as applicable. The policy noted that if the alleged perpetrator is an employee, they will be immediately suspended pending the result of the investigation. Based on interviews, review of records, and review of facility policy and procedure, the facility failed to ensure an allegation of abuse was thoroughly investigated for one resident (#326). The deficient practice could lead to ongoing abuse leading to harm of a resident. -Findings include: Resident #326 was admitted to the facility on [DATE], with diagnoses that included hypotension, unsteadiness on feet, degeneration of nervous system due to alcohol, and unspecified dementia. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An admission minimum data set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. A Health Status Note dated November 8, 2021, by a Registered Nurse (RN / Staff #112), revealed Resident #326 had a smoker's patch in place on the right arm. The resident stated rudely, If you people would let me smoke and let me out of here, I would be content!, as the resident raised his hand at the nurse. Staff #112 was startled and told the resident to please settle down and stop acting like a a**. Staff #112 offered to make the resident a sandwich, but, he settled with yogurt, and drank water. The resident was then resting peacefully. Review of State Agency records revealed the facility called the reporting hotline on November 16, 2021, and reported an allegation that a staff member verbally abused Resident #326. A facility Reportable Event Record / Report dated November 23, 2021, revealed in the evening of November 8, 2021, Staff #112 was in Resident #326's room while the resident was in bed resting, and was startled when the resident raised his arm abruptly and yelled at the staff member. The staff member was caught off guard and surprised and used language that was inappropriate for use around a resident. The resident did not take offense to what was said, and Staff #112 was able to calm the resident by offering food and something to drink. The resident was calmed and peaceful and had all of his needs met. There was no other incident noted of similar behavior. The language used by the staff member was the result of being startled and was not meant in a personal or attacking way toward the resident. It is still not considered appropriate so the staff member was suspended and educated about customer service and appropriate behavior toward residents. Upon interview, Staff #112 explained that the language used was not meant to be personal to the resident, and was sorry for using it. The resident was also interviewed and stated to not have had any problem with a staff member or feel that he has been spoken to inappropriately or treated poorly. He was pleasant and happy with his care. The report revealed no witness statements, and no evidence of other resident interviews to establish a trend. An interview was conducted on May 20, 2025 at 10:31 AM, with a Certified Medication Assistant (CMA / Staff #66) who stated that if a staff member was overheard saying stop acting like an a** to a resident, that would be inappropriate. An interview was conducted on May 20, 2025, at 12:13 PM, with a Licensed Practical Nurse (LPN / Staff #72) who stated if a staff member was overheard saying stop acting like an a** to a resident, that would be super inappropriate. An interview was conducted with the Director of Nursing (DON / Staff #56) on May 20, 2025, at 2:50 PM who stated if she overheard a staff member speak to a resident disrespectfully, she would remove that staff from the patient care area and meet with the staff, then initiate an immediate investigation, and report it. The DON stated that if a staff member was overheard saying stop acting like an a** to a resident, that would be considered inappropriate. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Abuse Policy, revealed abuse is the infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well- being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, neglect, mental abuse including abuse facilitated or enabled through the use of technology, and misappropriation of property. Potential abusers can be residents, employees, family members, visitors, venders, or any other person who comes into the facility. None of these types or sources of abuse are condoned in Haven Health facilities. Our objective is to provide a safe haven for our residents through preventative measures that protect every resident's right to freedom from abuse. If abuse is witnessed or suspected, or an injury of unknown origin is identified, the resident's safety will immediately be secured. Prompt reporting and investigation will be utilized to identify the validity of findings and reasonable measures will be implemented to deter further incidents of abuse. If abuse is witnessed or suspected, reporting and investigation will take place in this manner: Executive Director (ED) will be notified. ED will begin investigation immediately and complete within 5 working days using the Abuse Investigation Packet. A minimum of three residents will be interviewed in order to determine if there is a trend. Interviews may also include the Alleged Perpetrator, Witnesses and Staff Members as applicable. Suspected abuse will be reported in accordance with timeframes and standards required by CMS.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, staff interviews, and review of facility process and policy the facility failed to ensure that all transfer/discharge notifications were made for one resident (#176). The deficient practice could lead to notifications of resident transfer/ discharge not being made to all required parties. Findings include: Resident #176 was admitted to the facility with diagnoses that included hyperlipidemia, bipolar disorder, anxiety disorder, and gastro-esophageal reflux disease. Review of the resident's face sheet revealed that the resident #176 had a Public Fiduciary identified as his responsible party, guardian, and emergency contact. The face sheet also listed the contact information for the responsible party which included an office number, fax number, and e-mail address. A Discharge assessment dated [DATE] revealed the reason for the assessment as hospital transfer. The section Parties notified prior to transfer? indicated a check mark that responsible party was notified but did not annotate who was notified and when. A discharge Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident has modified independence regarding cognitive skills for daily decision making. Review of the Order Summary Report did not reveal any order for the resident to be sent to the hospital or indicate that responsible party was notified. An IDT (Interdisciplinary Team) Care Plan Conference note dated August 4, 2022 documented that resident did not attend the conference due to being COVID (Coronavirus) positive. The note indicated that the fiduciary wanted to speak with the resident. The note documented that the facility would set up a video call meeting to enable them to talk later. The note indicated that the resident as having difficulties breathing and was sent to the ER (emergency room) but has since returned. However, review of the resident's Census List indicated that when the resident discharged on August 4, 2022, the resident did not return to the facility until August 21, 2022. Additionally, review of resident #176's progress notes did not reveal any documentation regarding the resident being sent and admitted to the hospital. Furthermore, there was no documentation that the fiduciary was notified that the resident was sent and admitted to the hospital. Review of an ER report dated August 4, 2022 revealed that resident #176 presented to the ER, COVID positive, with oxygen saturation of 83%, productive cough, body aches, and headache. The report indicated that the resident was being admitted due to concern of bacterial process overlying his COVID-pneumonia. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a complaint intake submitted to the State Agency (SA) on August 5, 2022 revealed a complaint from the resident's responsible party/public fiduciary regarding transfer/discharge notification. The complaint alleges that during a care conference convened on August 4, 2022, the responsible party was informed that the resident was in his room following an ER visit for breathing issues. The responsible party asked to have a video conference scheduled later that day so he can discuss the resident's plan of care. However, later on, the responsible party was informed that he could not speak with resident #176 since he was still in the hospital. The responsible party alleges that he was not notified of the resident's transfer to the hospital until the care conference and that the facility did accurately inform him of the resident's status. Review of resident #176's hospital progress notes revealed that he was admitted to the hospital on [DATE]. His disposition was documented as poor prognosis and expected prolonged hospital stay. Further review of the progress notes revealed that the resident was not discharged back to the facility until August 21, 2022. An interview was conducted with a Certified Nursing Assistant (CNA/staff #29) on May 20, 2025 at 9:51 a.m. Staff #29 stated that when a resident is transferred/discharged , the responsible party/public fiduciary is notified by the nurse prior to the transfer. The CNA said that the notification is documented on the assessment as well as on the progress notes. Staff #29 noted that notification of the responsible party/public fiduciary is important so that they can be informed of what is happening with the resident and be there for support, especially if the resident is unable to communicate well. According to the CNA, the impact of not notifying the responsible party/public fiduciary is frustration from lack of communication. Staff #29 said that she was not familiar with resident #176. During an interview with a Licensed Practical Nurse (LPN/staff #72) conducted on May 20, 2025 at 12:21 p. m., staff #72 stated that in the event that a resident need to be transferred to the hospital, the public fiduciary is notified. The LPN said that the notification is documented in a progress note. The note should document that notification was made or that the fiduciary could not be reached. Staff #72 stated that it is inappropriate to not notify the public fiduciary because they need to be notified. The LPN noted that it is important to notify the responsible party/public fiduciary so that they can be aware of the resident's status. The impact of not notifying the responsible party/public fiduciary is that the resident could end up at a place that the responsible party/public fiduciary does not approve of or not prefer. Additionally, the resident will be alone and not have the support of the responsible party/public fiduciary if they are unaware of resident's status. The LPN indicated that she is not familiar with resident #176. An interview with the Director of Nursing (DON/staff #56) was conducted on June 17, 2025 at 1:03 p.m. Staff #56 stated that the POA (power of attorney)/family member/public fiduciary is normally notified about transfers unless the resident or they request not to be notified. The notification is normally documented on the discharge assessment or the progress note. The scenario pertaining to resident #176 was presented to the DON and she indicated that it was inappropriate that the public fiduciary was not notified. Staff #56 said that it is important to notify POA/public fiduciary specifically if they need to be involved in the decision making in order for them to know how to support the resident, and to be able to act as the resident's support when the resident is outside of the facility. The DON indicated that the impact of not notifying the POA/public fiduciary is that it can cause a possible issue with assistance, decision making, and would not be there to assist the resident. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled Admissions/Transfers/Discharges: Transfer or Discharge Documentation indicated that when a resident is transferred or discharged from the facility, information that an appropriate notice was provided to the resident and/or legal representative will be documented in the medical record. Review of the facility policy titled Admissions/Transfers/Discharges: Transfer or Discharge - Emergency indicated that if it becomes necessary to make an emergency transfer or discharge to a hospital or other related institution, the facility will notify the representative or other family member.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility policy, and the Resident Assessment Instrument (RAI) manual, the facility failed to accurately complete a comprehensive Minimum Data Set (MDS) assessment within the required timeframe for one resident (#34). The deficient practice could result in delayed identification of potential risks and care needs. Findings include: Review of resident #34's hospital records prior to his admission to the facility revealed a progress note dated January 10, 2023 which documented that the resident is incompetent to make his own decision. The note indicated that the resident has a public fiduciary. A hospital progress note date January 24, 2023 documented that the resident had a history of cognitive impairment. The note indicated that resident was inpatient status at the hospital and needed long term care that can accommodate his needs. The note stated that the hospital was waiting on public fiduciary for assistance to place resident in a facility. Resident #34 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of mandible, tempomandibular joint disorder, and severe protein-calorie deficit. A speech therapy eval dated February 3, 2023 documented that the resident had a history of cognitive impairment and had a guardian. A progress note dated February 6, 2023 documented that the resident was a poor historian, had cognitive impairment, and had cognitive communication deficit. However, review of the resident's MDS assessments revealed that an admission assessment conducted in February 7, 2023 did not contain a Brief Interview for Mental Status (BIMS) score. The cognitive patterns section was left blank regarding whether the resident could be interviewed to determine a BIMS score. Additionally, the section pertaining to staff assessment for mental status was also left blank. During an interview with a Certified Nursing Assistant (CNA/staff #29) conducted on May 20, 2025 at 9:51 a.m., staff #29 stated that resident #34 has some confusion. The CNA stated recalling the incident in which resident #34 left the facility and was found walking on the road. Staff #29 said that the resident was found up the road, about a mile away. The CNA said that when the resident was asked what he was doing, resident #34 stated that he was walking. Staff #29 said that the way resident #34 presented was misleading and so the staff did not realize that his cognition was not as good as it seemed. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with a Licensed Practical Nurse (LPN/staff #72) was conducted on May 20, 2025 at 12:21 p.m. Staff #72 stated that as part of the assessment, they also review information from where the resident is coming from such as hospital records. Information such as fall risk, elopement risk, and cognition. Accurate assessment is important because for example if a resident is cognitively impaired but ambulatory, they can be an elopement risk and need to be monitored/supervised. Otherwise, there could be a risk of the resident eloping and getting hurt. The LPN indicated familiarity with resident #34. Staff #72 stated that resident #34 is ambulatory and loves to walk around. The LPN said that resident #34 has episodes of confusion. During an interview with the Director of Nursing (DON/staff #56) conducted on May 20, 2025 at 1:03 p.m., staff #56 stated that it is important to assess a resident's cognition and know the cognition level of a resident. The DON indicated that depending on the level of cognition there is a criterion that triggers for an elopement risk. Staff #56 noted that it is important to accurately assess residents to protect them from risks and possible dangerous situation. The DON said that the impact of not accurately assessing residents is the possibility of negative/dangerous situation. Review of the facility's Wander Risk Eval revealed that among the areas that are factored in in determining a wandering risk scores is Orientation and Behavior/Mood. Review of the RAI manual, dated October 2019, revealed that the primary purpose of the MDS assessment tool is to identify resident care problems that are addressed in an individualized care plan. The manual included that the MDS completion date must be no later than 14 days after the Assessment Reference Date (ARD), and there can be no more than 366 days between comprehensive assessments. The facility policy titled Behavioral Assessment, Intervention and Monitoring revise December 2016 indicated that as part of the initial assessment, the nursing staff and attending physician will identify individuals with a history of impaired cognition, altered behavior, or mental illness. Additionally, the policy noted that a part of the comprehensive assessment, the staff will evaluate, based on input from the resident, family, caregivers, review of medical records and general observation the resident's usual patterns of cognition, mood, and behavior. The policy indicated that the interdisciplinary team will evaluate behavioral symptoms to determine the degree of severity, distress, and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm. Furthermore, the policy noted that the care plan will incorporate findings from comprehensive assessment and be consistent with current standards of practice.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, staff interviews, facility documentation, policy and procedure, the facility failed to ensure that one resident's (#34) cognitive communication deficit was appropriately care planned and implemented. The deficient practice could result in a plan of care that does not meet the resident's needs. Findings include: Review of resident #34's hospital records prior to his admission to the facility revealed a progress note dated January 10, 2023 which documented that the resident is incompetent to make his own decision. The note indicated that the resident has a public fiduciary. Resident #34 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of mandible, tempomandibular joint disorder, and severe protein-calorie deficit. A speech therapy eval dated February 3, 2023 documented that the resident had a history of cognitive impairment and had a guardian. A progress note dated February 6, 2023 documented that the resident was a poor historian, had cognitive impairment, and had cognitive communication deficit. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed that resident #34 has difficulty communicating some words or finishing thoughts but is able if prompted or given time. The MDS also noted that the resident misses some part/intent of message but comprehends most conversation. Further review of the admission MDS dated [DATE] did not contain a Brief Interview for Mental Status (BIMS) score. The cognitive patterns section was left blank regarding whether the resident could be interviewed to determine a BIMS score. Additionally, the section pertaining to staff assessment for mental status was also left blank. The assessment also indicated that the resident is ambulatory and does not use any mobility device. A communication care plan initiated on February 12, 2023 revealed that the resident has jaw carcinoma impacting his ability to communicate. Interventions included to anticipate/meet needs, monitor effectiveness of communication strategies, and use communication techniques which enhance interaction. However, further review of the care plan did not indicate that the resident's cognition impairment was addressed. There was no evidence that the facility had interventions in place to mitigate issues/concerns his impaired cognition could cause. Additionally, review of the resident's clinical record did not reveal any indication that the resident's cognition impairment was addressed or interventions put in place to mitigate issues/concerns his impaired cognition could cause. (continued on next page)

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Haven of Cottonwood	197 South Willard Street Cottonwood, AZ 86326

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated March 9, 2023 revealed that the resident was found ambulating on the street with a walker. The note indicated that a staff member escorted resident #34 back to the facility. According to the progress note, the resident stated that he was walking in the parking lot and took a wrong turn. The note documented that a wander guard was placed on the resident. A progress note dated March 10, 2023 documented that resident #34 was found down the street from the facility. According to the progress note a staff member drove to where the resident was located and escorted the resident as he walked to guide him back to the facility. The note documented that the resident stated that he got confused while walking and had to confirm with the staff as he walked which direction to go. An interview with a Licensed Practical Nurse (LPN/staff #72) was conducted on May 20, 2025 at 12:21 p.m. Staff #72 stated that a care plan is important in order to have a plan in place for a resident's known issues, deficits, and impairments. The impact of not having a care plan is that the condition would not be address and appropriate interventions not put in place. An example would be for elopement risk, if it is not properly care planned, the resident can get hurt. The LPN indicated familiarity with resident #34 and noted that he was confused at times. During an interview with the Director of Nursing (DON/staff #56) conducted on May 20, 2025 at 1:03 p.m., staff #56 stated that it is important to assess a resident's cognition and know the cognition level of a resident. The DON indicated that depending on the level of cognition. Staff #56 noted that it is important to accurately assess residents to have interventions in place to protect them from risks and possible dangerous situation. The DON said that the impact of not having interventions in place is the possibility of negative/dangerous situation. The facility policy titled Assessments/Care Planning: Care Plans, Comprehensive Person-Centered indicated that it is the facility's policy to include measurable objectives and timetable to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Furthermore, assessment of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The facility policy titled Behavioral Assessment, Intervention and Monitoring revise December 2016 indicated that as part of the initial assessment, the nursing staff and attending physician will identify individuals with a history of impaired cognition, altered behavior, or mental illness. Additionally, the policy noted that a part of the comprehensive assessment, the staff will evaluate, based on input from the resident, family, caregivers, review of medical records and general observation the resident's usual patterns of cognition, mood, and behavior. The policy indicated that the interdisciplinary team will evaluate behavioral symptoms to determine the degree of severity, distress, and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm. Furthermore, the policy noted that the care plan will incorporate findings from comprehensive assessment and be consistent with current standards of practice.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, review of records, and review of facility policy and procedure, the facility failed to ensure a resident's comprehensive care plan was reviewed and revised to meet the resident's needs for one resident (#324). The deficient practice could lead a resident not receiving care and services to meet their needs, which could lead to harm or injury. -Findings Include: Resident #324 was re-admitted to the facility on [DATE], with diagnoses that included Parkinson's disease, personal history of traumatic brain injury, dementia, unspecified abnormality of gait and mobility, cognitive communication deficit, anxiety disorder, and need for assistance with personal care. An admission minimum data set (MDS) assessment dated [DATE], revealed the resident had a brief interview for mental status (BIMS) assessment that was not completed. Section J revealed the resident had two or more falls with injury since admission, re-entry, or prior assessment. A care plan initiated February 6, 2023, revealed Resident #324 was at risk for falls or had an actual fall. Interventions included to follow the facility fall protocol, follow Falling Leaf Program, be sure the call light is in reach and encourage the resident to use it for assistance, anticipate and meet the resident's needs, therapy evaluations and treatments as ordered or as needed, and encourage the resident to participate in activities that promote exercise, physical activity, strengthening, and improved mobility. An additional care plan intervention was initiated on February 9, 2023, to have a Call Don't Fall as a reminder. Following this update, there was no evidence of any further care plan updates to address the resident's falls from February 9, 2023 until March 4, 2023. An admission Evaluation - Nursing note dated February 6, 2023, revealed Resident #324 admitted from acute hospital via wheelchair for fracture of left humerus. The resident was alert and oriented x 1, and highly confused. An Alert Charting Change of Condition Summary, dated February 6, 2023, revealed the resident was found on the floor. He was attempting to ambulate without assistance. The resident is very confused and very forgetful. No injuries noted at this time. Notifications to appropriate parties were made. A Daily Skilled Evaluation dated February 7, 2023, revealed Resident #324 was found outside of the building and was wandering around on the sidewalk. Resident was redirected to the nursing station for supervision and had a wander guard applied to his right ankle. Resident is alert, but only oriented to himself, he does not say much. He was squirming around in the bed, so he was transferred to his wheelchair to avoid a fall. The resident then made it outside as mentioned above. A Fall Incident Report dated February 8, 2023, revealed the resident was found lying on the floor in his room by a Certified Nursing Assistant (CNA), with no injuries observed at this time, and the resident was placed back in his wheelchair. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A provider Encounter note dated February 9, 2023 revealed the resident has had multiple falls since admission. Ongoing falls will be a challenge, and they are using one-to-one staffing on the overnight hours while he is sundowning and seems to be more agitated. Unfortunately, regardless of treatment plan he remains at high risk for ongoing falls and injuries. We will continue all current interventions. Additionally, a memory care unit may be more appropriate. A Health Status Note dated February 9, 2023, revealed Resident #324 is again 1:1 on night shift for safety as he continues with agitation, restlessness, and unable to stay in his bed. The resident continues ability to self-propel wheelchair in hallways, and wanders into other resident's rooms unless 1:1 observation is provided. Will continue to monitor. A Daily Skilled Evaluation note dated February 9, 2023, revealed the resident fell out of wheelchair at 10:25 AM. The resident is very confused, and no skin issues noted, no injuries or complaints of pain, and range of motion within normal limits. Notifications to appropriate parties were made. A Health Status Note dated February 10, 2023, revealed the resident's call light within reach but the resident is unable to use due to confusion. The resident's bed in low position and frequent room monitoring due to decreased safety awareness, and to address needs as they arise. A Daily Skilled Evaluation note dated February 10, 2023, revealed Resident #324 fell this shift at 1:25 PM. The resident was in his room with his back to his bed pushing his wheelchair and fell backwards onto his bed. Fall was witnessed by this writer, and no injuries noted and neuro checks started. An Alert Charting Change of Condition Summary dated February 11, 2023, revealed CNAs were wheeling the resident back from the nursing station in his wheelchair, and said the resident had a fall with positive head strike, so neuro checks were needing to be re-started. The resident was sitting in his chair looking around, unable to answer questions (which is his baseline). The resident was then assessed. Neuro checks were initiated, skin assessed for any injuries, and the resident was kept at the nursing station for observation and supervision. The physician was notified and elected to send the resident via ambulance to be evaluated at the hospital with concerns of hypotension and increased confusion following head strike. An Alert Note dated February 12, 2023, revealed the resident is very confused. He has been getting out of bed and sliding to the ground. Resident has been wandering to other resident's room as well as between the hallways trying to get outside. Resident would benefit as a one on one candidate. An additional Alert Note dated February 12, 2023, revealed the resident continues to push self and hyperextend his body out of his wheelchair. Resident can self-propel throughout the hallway and is not easily redirected. During previous shift, the resident had a fall and pulled out his foley catheter with balloon still inflated. Resident continuously monitored this shift while out in hallway. Resident attempted to place self on floor numerous times. The resident was helped to bed, lights turned off, heater on, and covered up to help promote sleep, with the bed lowered to the floor, and fall matt placed on floor beside bed. Approximately 30 minutes after being helped to bed, the resident was already observed on the floor in his doorway. The resident had crawled from his bed to the doorway. In addition to crawling out of bed, the resident pulled his foley catheter out with balloon still inflated for the 2nd time today. The resident was helped back into bed, with CNA at bedside. The resident would benefit from psychiatric evaluation and 1:1 supervision. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Health Status Note dated February 13, 2023, revealed that 911 was called to send the resident to the ED for evaluation related to fall and signs and symptoms of possible injury. A Baseline Care Plan note dated February 14, 2023 revealed the resident was found on the floor in the bathroom, he is unable to let his needs be known. The only injuries noticed are a skin tear to the right forearm, and neuro checks have started. A Behavioral Health Services Encounter Summary dated February 27, 2023, revealed the resident presents for new patient psych eval. Th resident was admitted with diagnosis of Parkinson's and multiple recent falls with subsequent fractures, and presents today as lying in bed, confused, alert and oriented to self. He is able to communicate needs, and states doing ok today. Limited history available and most information gathered from chart and staff interview. The resident has a history of behavioral disturbances and treatment, and staff report resident has been doing ok and redirectable at this time. An Alert Charting Change of Condition Summary dated February 28, 2023, revealed the resident was attempting to self-transfer to bed and slipped onto the floor. The resident denies pain at this time. Event paperwork started. An Incident Note dated March 3, 2023, revealed the resident was on the floor beside the bed. He had tried to get out of bed and fell on the floor, and hit the back of his (unspecified body part), but no apparent injury noted at this time. Assisted getting him back in bed. No other injuries observed. Notifications were made, and neuro checks initiated. An Alert Charting Change of Condition Summary dated March 8, 2023, revealed the resident was observed by a CNA sitting on floor mat at bedside, his head resting on his bed, and bed in low position. No new injuries noted, and the resident does not appear to be in pain. An interview was conducted on May 20, 2025, at 11:10 AM, with a Registered Nurse (RN / Staff #3) who stated that to prevent future falls from occurring, the staff would notify the Director of Nursing of concerns about falls, especially if the resident tended to get up and walk on their own. Staff #3 also stated that interventions would be put in place, that could include moving the resident's bed up against the wall, putting the bed in the lowest position, placing fall mats at bedside, and implementing frequent checks every 15 -20 minutes that would be put into the care plan and monitored by staff filling out a form and signing off that frequent checks were completed. Staff #3 stated that sometimes the facility would implement 1:1 supervision for residents. An interview was conducted on May 20, 2025, at 12:13 PM, with a licensed practical nurse (LPN / Staff #72). Staff #72 stated she was not familiar with care planning, and that she is not involved in that process. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on May 20, 2025, at approximately 2:15 PM, with the Director of Nursing (DON / Staff #56) who stated that if a resident has repeated falls, the facility prevents ongoing future falls by assessing the root cause of the fall and updating the care plan with appropriate interventions after each fall. The DON stated that there are many interventions the facility can employ to prevent falls, and that the facility can provide 1:1 supervision, however it is usually done as a last resort as it could cause the resident to be more restless. The clinical record and care plan of Resident #324 were reviewed together and the DON stated the care plan for addressing ongoing falls for Resident #324 was missing updates during the timeframe of February 9, 2023 through March 4, 2023, during which time the resident had repeated ongoing falls, and that this would not meet her expectation for fall prevention for Resident #324. Review of the facility policy titled Assessments/Care Planning: Care Plans, Comprehensive Person-Centered, effective January 1, 2024, revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. The comprehensive, person-centered care plan: includes measurable objectives and timeframes and reflects currently recognized standards of practice for problem areas and conditions. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team reviews and updates the care plan: when there has been a significant change in the resident's condition; when the desired outcome is not met; and when the resident has been readmitted to the facility from a hospital stay.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on documentation, staff and resident interviews, and the facility policy and procedures, the facility failed to assess and monitor the activities for one resident (#24). Findings include: Resident #24 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease, acquired absence of right leg above knee, depression, and anxiety disorder. The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 15 indicating the resident was cognitively intact. The activities care plan dated February 6, 2025 revealed that the resident spends his day in bed either watching TV, playing games on his phone or visit with family. Interventions included: -provide leisure supplies for self-directed pursuits. -introduce to other resident with similar interests, disabilities, and/or limitation. -modify daily schedule, treatment plan as needed to accommodate activity participation. -offer a variety of activity types and locations. -reassess the resident as needed for changes in activity preferences. Review of the task sheets for talking-conversing, pet therapy, one-to-one intervention program, and movie/TV for the last thirty days did not reveal any documentation. Review of the activities tracking for April 2025 revealed that the resident watched movies/TV daily and talked/conversed with others eight days out of the month. Review of the activities tracking for May 2025 revealed that the resident participated in a group activity, Bingo, daily from the first of May through the 20th of May 2025. Review of the Activity Manager job description for the Activity Manager (staff #65) dated October 3, 2023 revealed that the tasks and responsibilities included to actively involve each resident in an ongoing program of activities that appeals to his or her interests and enhances the resident's highest practicable level of physical, mental and psychosocial well-being and to actively monitor the residents' responses and evaluate these responses to the programs in order to determine if the activities meet the assessed needs of the resident. The facility provided documentation stating that the Activities Manager walked the Executive Director through the process of documenting a resident's participation in activities. It was determined that there was an error in the documentation process and the system did not save the documentation. A work order has been completed to fix the error. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on May 19, 2025 at 10:33 a.m. with the Activities Manager (Staff #65), who stated that she has been the Activity Manager since October 2023. She stated that the resident could attend group activities, such as Bingo, if he was willing to get out of bed and he had attended Bingo one time since being admitted . She stated that the system for documenting activity participation just got up and running, so she didn't have any documentation on activities for any of the residents. She did provide documentation of an activities list that showed how many residents attended each activity each day, but had no way of knowing which residents attended. She stated that she did not know that she had to document each residents participation in activities. She stated that the purpose of activities is so the residents keep their dignity, feel more comfortable and at home, to assist with ADLs and to get back to normalcy. Also, it helps with depression. She stated that if a resident is not attending activities, it may indicate that something is wrong, such as depression, and if it continued, there may be a trend, but acknowledged that she wouldn't be able to tell because she had no activity documentation to review. An interview was conducted on May 20, 2025 at 7:54 a.m. with the Administrator (staff #74) and 2. Stock [NAME], the [NAME] President of Operations (staff #83). Staff #72 stated that he supervises the Activity Manager (staff #65) and it is his expectation that she maintains the activity schedule, sets up activities, knows who is attending activities, attends the morning meetings, provides feedback and works with the volunteers. He stated that he has watched staff #65 use the software to document if a resident attended an activity, was sleeping or refused to attend once or twice. He stated that the reason for documentation is because they want to know the residents are up and participating whenever they can and to show when residents are not attending. The data could show a trend when a resident is not attending activities and the facility would want to look into the reason why the resident is not attending. However, there are some resident who don't want to engage as much or don't want to attend activities, such as resident #24. He stated that the Activity Manager should be reviewing the activity data and they meet at least monthly to review the how many people are attending each activity, what is popular, and go over the activity calendar. He stated that he has not reviewed activity documentation for a specific resident. He stated that the purpose of activities are to keep the residents engaged and socializing. It is possible that if someone refuses to attend, there may be some type of emotional/mental concern, such as depression going on and documentation is needed so you can see if there are any changes with the resident. During an interview conducted on May 20, 2025 at 1:48 p.m. with resident #24, he stated that he may want to attend some group activities depending what it is. An Activity Calendar was not observed in the resident's room. He asked what activities are going on. During a second interview conducted on May 20, 2025 at 1:49 p.m. with the Activities Manager (staff #65), she reviewed the activities tracking for April 2025 and May 2025 for resident #24 and stated that she had just completed the activity documentation/data to the best of her memory. The facility policy, Activity Programs - Staffing states that the activity programs are staffed with personnel who have appropriate training and experience to meet the needs and interests of each resident. The Activity Director/Coordinator shall at least monitor and evaluate the resident's responses to activities and revise the approaches as appropriate; and develop, implement, supervise and evaluate the activity program.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation, policy and procedures, the facility failed to ensure adequate supervision to prevent elopement for one resident (#34); and, failed to ensure one resident (#324) was free from preventable accidents of repeated falls. The deficient practice could result in avoidable accidents and/or decline in fuction. Findings include: - Regarding resident #34 Review of resident #34's hospital records prior to his admission to the facility revealed a progress note dated January 10, 2023 which documented that the resident is incompetent to make his own decision. The note indicated that the resident has a public fiduciary. Resident #34 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of mandible, tempomandibular joint disorder, and severe protein-calorie deficit. A speech therapy eval dated February 3, 2023 documented that the resident had a history of cognitive impairment and had a guardian. A progress note dated February 6, 2023 documented that the resident was a poor historian, had cognitive impairment, and had cognitive communication deficit. Another progress note also dated February 6, 2023 documented that it was hard to determine the resident's cognition due to the resident being quiet and not speaking much. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed that resident #34 has difficulty communicating some words or finishing thoughts but is able if prompted or given time. The MDS also noted that the resident misses some part/intent of message but comprehends most conversation. Further review of the admission MDS dated [DATE] did not contain a Brief Interview for Mental Status (BIMS) score. The cognitive patterns section was left blank regarding whether the resident could be interviewed to determine a BIMS score. Additionally, the section pertaining to staff assessment for mental status was also left blank. The assessment also indicated that the resident is ambulatory and does not use any mobility device. Review of resident #34's clinical record did not reveal any evidence that a care plan was initiated to address the resident's cognition impairment. There was no evidence that the facility had interventions in place to mitigate issues/concerns his impaired cognition could cause. A progress note dated March 9, 2023 revealed that the resident was found ambulating on the street with a walker. The note indicated that a staff member escorted resident #34 back to the facility. According to the progress note, the resident stated that he was walking in the parking lot and took a wrong turn. The note documented that a wander guard was placed on the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Incident Report for elopement dated March 9, 2025 revealed that resident #34 was found in the street walking. The report documented that per the resident he was walking in the parking lot and took a wrong turn which resulted in him ending up on the street. The report indicated confused as a predisposing physiological factor for the elopement. The report also documented that an off-duty aide notified the facility about the resident ambulating alone in the street. A progress note dated March 10, 2023 documented that resident #34 was found down the street from the facility. According to the progress note a staff member drove to where the resident was located and escorted the resident to guide him as he walked back to the facility. The note documented that the resident stated that he got confused while walking. The note also indicated that the resident had to confirm with the staff which direction to go as he walked. A physician order dated March 10, 2023 prescribed the use of wander guard at all times. The order also directed to check the bracelet is on properly and functional every shift. A behavioral care plan initiated on March 10, 2023 revealed that the resident has wandering/exit-seeking behavior. Interventions included the wear of wander guard and minimize disruptive behavior by offering tasks to divert attention. Review of resident #34's clinical record revealed that a Wandering Risk Eval was not completed until March 31, 2023. The assessment revealed a risk score of 9 indicating that the resident was a moderate risk for wandering. A request for resident #34's Supervision/Monitoring log was submitted on May 18, 2025. The facility annotated on the request form that there was none available. A request for the investigation file regarding resident #34's elopement was submitted on May 18, 2025. The facility annotated on the request form that there was none available. An interview with a Certified Nursing Assistant (CNA/staff #29) was conducted on May 20, 2025 at 9:51 a.m. Staff #29 stated that staff round on residents every 2-hours or as needed. She indicated that during the initial admission assessment it will document whether a resident has a history of risks such as elopement. The CNA said that staff communicate for frequent checks. If the resident is new, staff is in the room a lot for the first few days if they are having cognitive communication deficit. According to staff #29 it is important to round on residents routinely for safety and to ensure that they are comfortable, not at risk for falls and/or elopement which they try to mitigate. The CNA noted that if residents are not rounded on routinely they can end up with preventable accidents such as falls or elopement. Staff #29 described resident #34 as sometimes confused. The CNA recalled the incident in which resident #34 left the facility and was found walking on the road. Staff #29 said that the resident was found up the road, about a mile away. The CNA said that when the resident was asked what he was doing, resident #34 stated that he was walking. Staff #29 said that the way resident #34 presented was misleading and so the staff did not realize that his cognition was not as good as it seemed. A wander guard was placed on the resident to prevent further incidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with a Licensed Practical Nurse (LPN/staff #72) conducted on May 20, 2025 at 12:21 p. m., staff #72 stated that during assessment they review information from where the resident came from such as hospital records. Information such as fall risk, elopement risk, and cognition are reviewed. Accurate assessment is important because for example if a resident is cognitively impaired but ambulatory, they can be an elopement risk and need to be monitored/supervised. If not, then the resident can go outside, get him, and the facility would not know where or what happened to the resident. There could be a risk of the resident eloping and getting hurt. The LPN indicated familiarity with resident #34. Staff #72 stated that resident #34 is ambulatory and loves to walk around. The LPN said that resident #34 has episodes of confusion. During an interview with the Director of Nursing (DON/staff #56) conducted on May 20, 2025 at 1:03 p.m., staff #56 stated that it is important to assess a resident's cognition and know the cognition level of a resident. The DON indicated that depending on the level of cognition there is a criterion that triggers for an elopement risk. Staff #56 noted that it is important to accurately assess residents to protect them from risks and possible dangerous situation. The DON said that the impact of not accurately assessing residents is the possibility of negative/dangerous situation. Staff #56 stated that although she is familiar with the resident, she is unfamiliar with the incident. Review of the facility policy titled Elopements revised December 2007, revealed that the staff shall investigate and report all cases of missing residents. The policy noted that when the resident returns to the facility, the DON or Charge Nurse has to examine the resident for injuries, notify the physician, resident's legal representation, complete/file Report of Incident/Accident, and document the event in the resident's medical record. The facility policy titled Behavioral Assessment, Intervention and Monitoring revise December 2016 indicated that as part of the initial assessment, the nursing staff and attending physician will identify individuals with a history of impaired cognition, altered behavior, or mental illness. Additionally, the policy noted that a part of the comprehensive assessment, the staff will evaluate, based on input from the resident, family, caregivers, review of medical records and general observation the resident's usual patterns of cognition, mood, and behavior. The policy indicated that the interdisciplinary team will evaluate behavioral symptoms to determine the degree of severity, distress, and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm. Furthermore, the policy noted that the care plan will incorporate findings from comprehensive assessment and be consistent with current standards of practice. Based on observation, interviews, review of records, and review of facility policy and procedure, the facility failed to ensure one resident (#324) was free from preventable accidents of repeated falls. The deficient practice could lead to injury to a resident and/or a decline in function. -Findings Include: Resident #324 was re-admitted to the facility on [DATE], with diagnoses that included Parkinson's disease, personal history of traumatic brain injury, dementia, unspecified abnormality of gait and mobility, cognitive communication deficit, anxiety disorder, and need for assistance with personal care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An admission minimum data set (MDS) assessment dated [DATE], revealed the resident had a brief interview for mental status (BIMS) assessment that was not completed. Section J revealed the resident had two or more falls with injury since admission, re-entry, or prior assessment. A care plan initiated February 6, 2023, revealed Resident #324 was at risk for falls or had an actual fall. Interventions included to follow the facility fall protocol, follow Falling Leaf Program, be sure the call light is in reach and encourage the resident to use it for assistance, anticipate and meet the resident's needs, therapy evaluations and treatments as ordered or as needed, and encourage the resident to participate in activities that promote exercise, physical activity, strengthening, and improved mobility. An additional care plan intervention was initiated on February 9, 2023, to have a Call Don't Fall as a reminder. Following this update, there was no evidence of any further care plan updates to address the resident's falls from February 9, 2023 until March 4, 2023. A Fall Risk Evaluation dated February 7, 2023, revealed the resident scored 17.0 indicating high risk for falls. A physician order dated February 13, 2023 indicated may send patient to ED (emergency department) for eval related to fall. An additional physician order dated March 11, 2023, indicated may send patient to ED for eval and treatment related to fall. Review of the clinical record revealed no evidence of any neuro check logs for Resident #324 for the time frame of his facility admission starting February 6, 2023. An admission Evaluation - Nursing note dated February 6, 2023, revealed Resident #324 admitted from acute hospital via wheelchair for fracture of left humerus. The resident was alert and oriented x 1, and highly confused. An Alert Charting Change of Condition Summary, dated February 6, 2023, revealed the resident was found on the floor. He was attempting to ambulate without assistance. The resident is very confused and very forgetful. No injuries noted at this time. Notifications to appropriate parties were made. A Daily Skilled Evaluation dated February 7, 2023, revealed Resident #324 was found outside of the building and was wandering around on the sidewalk. Resident was redirected to the nursing station for supervision and had a wander guard applied to his right ankle. Resident is alert, but only oriented to himself, he does not say much. He was squirming around in the bed, so he was transferred to his wheelchair to avoid a fall. The resident then made it outside as mentioned above. A Fall Incident Report dated February 8, 2023, revealed the resident was found lying on the floor in his room by a Certified Nursing Assistant (CNA), with no injuries observed at this time, and the resident was placed back in his wheelchair. There was no evidence of a progress note in the resident's medical record regarding this fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A provider Encounter note dated February 9, 2023 revealed the resident has had multiple falls since admission. Ongoing falls will be a challenge, and they are using one-to-one staffing on the overnight hours while he is sundowning and seems to be more agitated. Unfortunately, regardless of treatment plan he remains at high risk for ongoing falls and injuries. We will continue all current interventions. Additionally, a memory care unit may be more appropriate. A Health Status Note dated February 9, 2023, revealed Resident #324 is again 1:1 on night shift for safety as he continues with agitation, restlessness, and unable to stay in his bed. The resident continues ability to self-propel wheelchair in hallways, and wanders into other resident's rooms unless 1:1 observation is provided. Will continue to monitor. A Daily Skilled Evaluation note dated February 9, 2023, revealed the resident fell out of wheelchair at 10:25 AM. The resident is very confused, and no skin issues noted, no injuries or complaints of pain, and range of motion within normal limits. Notifications to appropriate parties were made. A Health Status Note dated February 10, 2023, revealed the resident's call light within reach but the resident is unable to use due to confusion. The resident's bed in low position and frequent room monitoring due to decreased safety awareness, and to address needs as they arise. A Daily Skilled Evaluation note dated February 10, 2023, revealed Resident #324 fell this shift at 1:25 PM. The resident was in his room with his back to his bed pushing his wheelchair and fell backwards onto his bed. Fall was witnessed by this writer, and no injuries noted and neuro checks started. An Alert Charting Change of Condition Summary dated February 11, 2023, revealed CNAs were wheeling the resident back from the nursing station in his wheelchair, and said the resident had a fall with positive head strike, so neuro checks were needing to be re-started. The resident was sitting in his chair looking around, unable to answer questions (which is his baseline). The resident was then assessed. Neuro checks were initiated, skin assessed for any injuries, and the resident was kept at the nursing station for observation and supervision. The physician was notified and elected to send the resident via ambulance to be evaluated at the hospital with concerns of hypotension and increased confusion following head strike. An Alert Note dated February 12, 2023, revealed the resident is very confused. He has been getting out of bed and lidding to the ground. Resident has been wandering to other resident's room as well as between the hallways trying to get outside. Resident would benefit as a one on one candidate. An additional Alert Note dated February 12, 2023, revealed the resident continues to push self and hyperextend his body out of his wheelchair. Resident can self-propel throughout the hallway and is not easily redirected. During previous shift, the resident had a fall and pulled out his foley catheter with balloon still inflated. Resident continuously monitored this shift while out in hallway. Resident attempted to place self on floor numerous times. The resident was helped to bed, lights turned off, heater on, and covered up to help promote sleep, with the bed lowered to the floor, and fall matt placed on floor beside bed. Approximately 30 minutes after being helped to bed, the resident was already observed on the floor in his doorway. The resident had crawled from his bed to the doorway. In addition to crawling out of bed, the resident pulled his foley catheter out with balloon still inflated for the 2nd time today. The resident was helped back into bed, with CNA at bedside. The resident would benefit from psychiatric evaluation and 1:1 supervision. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Health Status Note dated February 13, 2023, revealed that 911 was called to send the resident to the ED for evaluation related to fall and signs and symptoms of possible injury. A Baseline Care Plan note dated February 14, 2023 revealed the resident was found on the floor in the bathroom, he is unable to let his needs be known. The only injuries noticed are a skin tear to the right forearm, and neuro checks have started. A Behavioral Health Services Encounter Summary dated February 27, 2023, revealed the resident presents for new patient psych eval. Th resident was admitted with diagnosis of Parkinson's and multiple recent falls with subsequent fractures, and presents today as lying in bed, confused, alert and oriented to self. He is able to communicate needs, and states is doing ok today. Limited history available and most information gathered from chart and staff interview. The resident has a history of behavioral disturbances and treatment, and staff report the resident has been doing ok and redirectable at this time. An Alert Charting Change of Condition Summary dated February 28, 2023, revealed the resident was attempting to self-transfer to bed and slipped onto the floor. The resident denies pain at this time. Event paperwork started. An Incident Note dated March 3, 2023, revealed the resident was on the floor beside the bed. He had tried to get out of bed and fell on the floor, and hit the back of his (unspecified body part), but no apparent injury noted at this time. Assisted getting him back in bed. No other injuries observed. Notifications were made, and neuro checks initiated. An Alert Charting Change of Condition Summary dated March 8, 2023, revealed the resident was observed by a CNA sitting on floor mat at bedside, his head resting on his bed, and bed in low position. No new injuries noted, and the resident does not appear to be in pain. An interview was conducted on May 20, 2025, at 10:31 AM, with a CNA and Certified Medication Assistant (CMA /Staff #66) who stated that if a resident falls, CNAs would first ensure the resident is ok, then would get the nurse to assess and observe the resident. Staff #66 stated that the procedure is to leave the resident where they are at while getting the nurse, because the nurse needs to assess the situation correctly. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on May 20, 2025, at 11:10 AM, with a Registered Nurse (RN / Staff #3) who stated that if a resident falls, the nurse will assess the resident to see if there are any injuries, perform a head to toe assessment, start vitals and neuro checks, notify all applicable parties including the medical provider and family. Staff #3 stated that this would be documented in a progress note and an incident report, and that a fall risk assessment would be completed. Staff #3 stated that to prevent future falls from occurring, the staff would notify the Director of Nursing of concerns about falls, especially if the resident tended to get up and walk on their own. Staff #3 also stated that interventions would be put in place, that could include moving the resident's bed up against the wall, putting the bed in the lowest position, placing fall mats at bedside, and implementing frequent checks every 15 -20 minutes that would be put into the care plan and monitored by staff filling out a form and signing off that frequent checks were completed. Staff #3 stated that sometimes the facility would implement 1:1 supervision for residents, but that the facility is not really equipped for that level of care. Staff #3 stated that he did not believe the facility would hire sitters, that if the resident required a sitter, then the resident would be discharged to a higher level of care. An interview was conducted on May 20, 2025, at 12:13 PM, with a licensed practical nurse (LPN / Staff #72). Staff #72 stated that if a resident falls, the nurse will assess the resident, notify the provider, and other applicable parties, and the incident is documented in a progress note and an incident report, also called a risk management report. Staff #72 stated she was not familiar with care planning, and that she is not involved in that process. Staff #72 stated that if a resident was confused and disoriented and keeps trying to get up without staff assistance, then staff check on the resident frequently an could move the resident's room closer to the nurse's station. Staff #72 stated that the facility does not employ one to one supervision due to staffing issues, and that the facility had a resident who needed one to one supervision and that intervention was not implemented. An interview was conducted on May 20, 2025, at approximately 2:15 PM, with the Director of Nursing (DON / Staff #56) who stated that if a resident falls in the facility, the nurse will complete an assessment of the resident and document it in the medical record, and complete an incident report. Additionally, if a resident has repeated falls, the facility prevents ongoing future falls by assessing the root cause of the fall and updating the care plan with appropriate interventions after each fall. The DON stated that there are many interventions the facility can employ to prevent falls, and that the facility can provide 1:1 supervision, however it is usually done as a last resort as it could cause the resident to be more restless. The clinical record and care plan of Resident #324 were reviewed together and the DON stated the care plan for addressing ongoing falls for Resident #324 was missing updates during the timeframe of February 9, 2023 through March 4, 2023, during which time the resident had repeated ongoing falls, and that this would not meet her expectation for fall prevention for Resident #324. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Resident Safety: Accident and Incidents - Investigating and Reporting, effective January 1, 2024, revealed all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on the facility premises shall be investigated and reported to the administrator. The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. The following data, as applicable, shall be included on the Report of Incident/Accident form: the date and time the accident or incident took place; the nature of the injury/illness (e.g., bruise, fall, nausea, etc.); the circumstances surrounding the accident or incident; where the accident or incident took place; the name(s) of witnesses and their accounts of the accident or incident; the injured person's account of the accident or incident; the time the injured person's attending physician was notified, as well as the time the physician responded and his or her instructions; the date/time the injured person's family was notified and by whom; the condition of the injured person, including his/her vital signs; the disposition of the injured (i.e., transferred to hospital, put to bed, sent home, returned to work, etc.); any corrective action taken; follow-up information; other pertinent data as necessary or required; and the signature and title of the person completing the report. The nurse supervisor/charge nurse and/or the department director or supervisor shall complete a Report of Incident/Accident form and submit the original to the director of nursing services within 24 hours of the incident or accident. The director of nursing services shall ensure that the administrator receives a copy of the Report of Incident/Accident form for each occurrence. Incident/accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Falls/Falls Risk: Falls and Fall Risk, Managing, effective January 1, 2024, revealed that based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. According to the MDS, a fall is defined as: Unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force (e.g., a resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. Resident conditions that may contribute to the risk of falls include: delirium and other cognitive impairment, lower extremity weakness, medication side effects, functional impairments, visual deficits, and incontinence. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once). Examples of initial approaches might include exercise and balance training, a rearrangement of room furniture, improving footwear, changing the lighting, etc. In conjunction with the consultant pharmacist and nursing staff, the attending physician will identify and adjust medications that may be associated with an increased risk of falling, or indicate why those medications could not be tapered or stopped, even for a trial period. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Assessing Falls and Their Causes, revised March 2018, revealed the purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. After a Fall: If a resident has just fallen, or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities. Obtain and record vital signs as soon as it is safe to do so. If there is evidence of injury, provide appropriate first aid and/or obtain medical treatment immediately. If an assessment rules out significant injury, help the resident to a comfortable sitting, lying, or standing position, and then document relevant details. Notify the resident's attending physician and family in an appropriate time frame. Observe for delayed complications of a fall for approximately forty-eight (48) hours after an observed or suspected fall, and will document findings in the medical record. Document any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. Note the presence or absence of significant findings. Complete an incident report for resident falls no later than 24 hours after the fall occurs. The incident report form should be completed by the nursing supervisor on duty at the time and submitted to the Director of Nursing Services. After an observed or probable fall, clarify the details of the fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred. Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident. Refer to resident-specific evidence including medical history, known functional impairments, etc. When a resident falls, the following information should be recorded in the resident's medical record: the condition in which the resident was found (e.g., resident found lying on the floor between bed and chair), assessment data, including vital signs and any obvious injuries, interventions, first aid, or treatment administered, notification of the physician and family, as indicated, completion of a falls risk assessment, appropriate interventions taken to prevent future falls, and the signature and title of the person recording the data.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on documentation, staff interviews, and facility policy and process, the facility failed to ensure pain medications as needed (PRN) was administered within the Pain Parameters for one resident (#54). The deficient practice could result in residents being overmedicated. Findings include: Resident #54 was admitted to the facility on [DATE] with diagnoses that included hepatic encephalopathy and alcoholic cirrhosis of the liver with ascites The order summery included Morphine Sulfate (concentrate) Solution 20 mg/ml give 5 mg by mouth every 3 hours as needed for pain 7-10 ordered April 25, 2025. The medication administration record (MAR) dated May 2025 revealed that Morphine Sulfate (concentrate) Solution 20 mg/ml give 5 mg by mouth every 3 hours as needed for pain 7-10 was administered on May 16, 2025 three times for a pain level of 6, 3, 6. An interview was conducted on May 20, 2025 at 11:33 a.m. with the registered nurse (RN/staff #3), who stated that an order for pain medication as needed (PRN) requires the dosage, frequency, and a pain scale. He also stated that when the pain medication is administered, he documents the level of pain and if the medication was effective on the medication administration record (MAR). He reviewed the MAR dated May 2025 and stated that the Morphine Sulfate (concentrate) Solution 20 mg/ml give 5 mg by mouth every 3 hours as needed for pain 7-10 and stated that the medication was given outside of parameters on May 16, 2025 for pain scale of 6, 3, and 6. He stated that there is a risk of overmedicating, slower breathing, and the resident becoming unconscious when administered outside of the pain scale parameters. An interview was conducted on May 20, 2025 at 11:50 a.m. with the Director of Nursing (DON/staff #), who stated that an order for a pain medication PRN requires the dosage, frequency, and pain scale. It is her expectation that nurses' document the pain level and if the pain medication was effective on the MAR. She stated that if a pain medication is administered outside of the pain parameters, there is a risk of the resident being overmedicated. The DON reviewed the MAR dated May 2025 and stated that the Morphine Sulfate (concentrate) Solution 20 mg/ml give 5 mg by mouth every 3 hours as needed for pain 7-10 was administered outside of parameters on May 16, 2025 for pain scale of 6, 3, and 6. The facility policy titled, Medications: Administering Medications, revealed that medications are administered in accordance with prescriber orders, including any required time frame.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on staff interviews and review of facility documentation and policy, the facility failed to use the services of a registered nurse (RN) for at least eight consecutive hours a day, seven days a week. The census was 67 and the sample was 20. The deficient practice could result in residents not receiving advanced care activities to meet their needs. Findings include: The Facility assessment dated of May 25, 2021, revealed an average daily census range of 38 - 42, with full capacity being 80 residents. Staffing planning included one FT (full time) DON (director of nursing), wound nurse, admission nurse, unit manager, and, an MDS (minimum data set) nurse. Per the assessment there should be at least one RN per 24-hour period; individual nursing staff assignments was based on patient care needs and individual staff needs/training; and that, nursing shifts are twelve hours with a goal of consistent assignments. The following dates were reviewed of the punch detail for registered nurses: -November 23 - 27, 2023; -February 16 - 19, 2024; -May 24 - 27, 2024; -August 30 - 31, 2024 -September 2. 2024; -November 2 - December 2, 2024; -May 16 - 18, 2025 The punch detail revealed no evidence of RN coverage on the following dates: - May 25, 2024 - August 30, 2024, August 31, 2024 and - May 16, 2025, May 17, 2025 An interview was conducted with the Staffing Coordinator (staff #29) on May 19, 2025 at 12:45 p.m. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Staffing Coordinator admitted that one RN is needed to work in the facility at least one 8-hour shift daily. She additionally stated that if a registered nurse (RN) was not available to provide the RN coverage that the DON would cover on occasion in the role of an RN floor nurse. The staffing coordinator also stated that the LPN, unit manager and herself will cover shifts if they could not find coverage. She is aware of the need to have RN coverage for 8 hours every day, the facilities expectations are not met if they do not meet the RN coverage need. She verbalized the risk to the residents could be a situation could occur that is out a an LPN ' s scope of practice, that could lead to resident harm. An interview was conducted with the Director of Nursing (DON) (staff # 56) on May 20, 2025 at 3:15 p.m. with the Clinical Resource (staff #250) and the Executive Director (staff # 74) in attendance. The DON stated that it did not meet the the facility expectations to not have an RN coverage for 8 hours every day and the risk could result in staff not being able to adequately cover that position. The Clinical Resource (Staff #250) stated that they have less staff compared to our competitors, this is due to low RN hours on the weekends, but they have higher LPN hours compared to other facilities and that this will be addressed in upcoming quality performance discussions. According to Centers for Medicare & Medicaid Services, The requirements for long-term care facilities require that a skilled nursing facility provide 24-hour licensed nursing services, an RN for 8 consecutive hours a day, 7 days a week (more than 40 hours a week), and that there be an RN designated as Director of Nursing on a full time basis.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews, facility documentation and policy, the facility failed to ensure safeguards and systems were in place to ensure accurate reconciliation and accounting for all controlled substances. The deficient practice could result in inventory loss, and potential diversion. Findings include: An observation of the Medication Cart # 1 narcotic logbook was conducted on May 19, 2025 at approximately 8:09 a.m. with the Director of Nursing (DON/Staff # 56). The Shift to Shift Narcotic Sheet & Card Verification revealed the following for May 1 to May 19, 2025: - Count inconsistencies from May 1, 2025 through May 3, 2025. - 6 missed staff signature entries - Duplicate signature entries on May 18, 2025. - The date of May 2020 is written on the log sheet with the entries for May 17 - May 19. An interview was conducted with the DON on May 19, 2025 at approximately 8:09 a.m. The DON revealed the expectation is to have two licensed nurses to sign the log once narcotic count has been completed accurately. In an interview conducted on May 19, 2025 at 10:10 a.m. the Clinical Resource (Staff #250) reviewed the narcotic count logs, and revealed the missing signatures did not meet facility expectation. The resource staff revealed two nurses are instrumental in ensuring proper count of narcotics, to avoid the possibility of missed medications. In an interview conducted with RN (Staff # 3) on May 19, 2025 at approximately 1:39 p.m. revealed that nurses do narcotic counts at the beginning and end of each shift. The off going shift refers to the narcotic book and the oncoming nurse will count the cards and medications. As long as there are no discrepancies, both nurses will then sign to validate the counts were correct. The facility's Medication Therapy policy revealed the facility shall review medication-related issues as part of its quality assurance and performance improvement committee and activities. The facility's Administration Medications Policy effective date January 1, 2024, revealed the DON supervises and directs all personnel who administer medications and/or have related functions.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, facility documentation and policy, the facility failed to ensure that one resident (#94) did not receive medications against their wishes. This deficient practice can result in not respecting the rights of the resident. Findings include: Resident # 94 was admitted to the facility on [DATE] with diagnoses of atrial fibrillation, dementia with mood disturbance, anxiety, muscle weakness, and cognitive communication deficit. The admission Minimum Data Set (MDS) dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. An order for one Bupropion HCL Extended release tablet for anxiety was dated May 11, 2025. According to the Medication Administration Record (MAR), 150 mg of Bupropion HCL ER was given to the resident for anxiety on May 11, 2025 - May 13, 2025. A progress note dated May 13, 2025, revealed the antidepressant was considered a good option and was started. The note further explains that the medication was to be discontinued because the family wanted to take the non-pharmacological route. The informed consent for psychotropic medication use was declined by the resident's representative on May 13, 2025, after the resident received three doses of the medication. The clinical record fails to reflect the resident giving consent prior to starting the antidepressant. An interview was conducted on May 19, 2025 at 9:30 a.m., with the resident's representative. The representative stated displeasure that the facility administered the anti-depressant without proper consent, and against the family's request. An interview was conducted on May 19, 2025 at 1:39 p.m. with Registered Nurse (RN/Staff # 410). The RN stated that if a resident was to receive a medication without their consent, that will be a violation of their rights. A panel discussion conducted with the Clinical Resource (Staff # 250) and the Director of Nursing (DON/Staff #56) on May 20, 2025 at 9:20 a.m. Both parties reviewed the resident's clinical record and stated that the resident received the medication without consent, and that this failed to meet the facility expectations. The Clinical Resource stated that the facility was to obtain consent, before administering a psychotropic. The facility's Psychotropic Medication Use policy, effective January 1, 2024, revealed the resident has the right to decline treatment with psychotropic medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, facility documentation and policy, the facility failed to ensure that two of four sampled medication carts had medications stored according to professional standards. The deficient practice can result in cross-contamination of medications and medication errors. Findings include, During medication cart storage observation with the Director of Nursing (DON/Staff # 56), the following was observed on March 19, 2025 at 8:09 a.m. : Medication Cart # 1: -An unrefrigerated vial of Lorazepam 2 mg/ml , with the affixed label stating keep refrigerated, was located in the narcotic storage area of the cart. -A pink like solution was crusted on the outside of a Geri-Tussin bottle. -Product crusting was present on an opened and unlabeled sixteen-ounce bottle of Milk of Magnesia. - A bottle of Wild Cherry Pro-Stat with the open date of April 5, 2025 had a crusted solution extending down the sides of the bottle. - Geri-Lanta bottle was opened but not dated. -Pepto Bismol Ultra was opened and not dated. Medication Cart # 2 -A medicine cup, contained two tablets, labeled as Zofran 4 mg was found in the medication cart drawer. An interview was conducted with the DON on March 19, 2025 at approximately 8:20 a.m. The DON revealed that it was against facility policy to store medications in the medication cart that was not in the original container. She further stated that the medication should have been disposed of if the resident was not available to receive the medication. The DON also stated that the facility expectation would be to refrigerate narcotics if indicated and should have been properly stored, in order to preserve the drugs potency. She stated that opened bottles of medication should be dated, and all bottles and containers should be clean and sanitary to prevent contamination. During a resident council meeting conducted on May 19, 2025 at 2:30 p.m., the attendees revealed that they would expect and are very confident that the staff are preparing their medications in a clean and safe environment. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Registered Nurse (RN/Staff # 3) revealed that during medication pass, it is important that the medication cart stays clean and orderly to reduce the chance of spreading disease or cross contaminating. During a panel discussion held on May 20, 2025 at 2:30 p.m. with the Clinical Resource Director (Staff # 250) and the DON, both parties stated that the facility expectation was not met during the medication cart audit the day prior. Staff # 250 stated the facility expectations are to keep the medication carts and room in clean and sanitary conditions, and to store medications according to facility policy. The facility's Medication Labeling and Storage policy effective date January 1, 2024, revealed medications are to be stored in the containers they are received. In addition, the staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Also, medications requiring refrigeration are stored in a refrigerator at a secured location.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and a review of facility documentation and policies, it was found that the facility failed to incorporate food safety, storage and hygiene. Findings Include: -Regarding food storage and expired food items: A kitchen observation was conducted with the morning cook (staff #20) on April 18, 2025 at 9:53 AM and revealed the following: - food items found in the refrigerator were beyond their use by date and food items were not sealed properly. -Within the large, three-door refrigerator,cooked bacon was discovered wrapped in tinfoil and lacked any date labeling. - A full one-pound plastic container of strawberries contained two strawberries exhibiting approximately one-inch diameter white colored substance. - A one-gallon plastic bag of lettuce was observed to be brown and wilted, and the bag was undated. - A second plastic bag of spring lettuce was unsealed and bore an illegible date. - A 32 ounce bag of green onions was unsealed and bore a May 2, 2025. - A carton containing multiple heads of green lettuce was observed, with a significant number of leaves appearing wilted and brown. -A staff member discarded a tinfoil of bacon in the trash, then retrieved the tinfoil of bacon. Without washing hands or wearing gloves, they stirred a pan of broccoli with their bare right hand using a large spoon. This spoon was then placed on a plate, with the handle touching a butcher knife. -A staff member did not perform hand hygiene. -Regarding the Mixer, ice machine & Gas Range: An observation of the ice machine in the kitchen was conducted with the morning [NAME] during kitchen observation and the interior frame of the ice machine was observed with dirt and dust buildup, and the exterior of the machine appeared dirty, dust was observed on the vent of the ice machine, covering the filter. An observation of a large mixer was conducted with Dietary Aide (staff #30) on April 18, 2025 at 10:27 AM, and the large mixer located to the right of the ice machine was visibly dirty with food splatter in multiple areas. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of the gas range in the kitchen was conducted with the morning cook (staff # 20) on April 18, 2025 at 10:58 AM, the range was observed with a buildup of grease and dust sitting under and on both sides of the gas range. Cleaning logs provided for March 2 to April 27, 2025, show that the refrigerators and ice machine were last cleaned on March 30, 2025. -Regarding vents and lights: An observation of the ceilings, vents and lights in the kitchen was conducted with Dietary Aide (staff # 30) on April 18, 2025 at 10:45 AM, and the ceilings, vents, and lights were found to be covered in dust and dirt. Additionally, the ceilings and tube lights in the freezer room (located between the storage room and kitchen) had numerous cob webs. An interview was conducted with the morning [NAME] (staff #20) on April 18,2025 at 9:53 AM, who stated that sealing and dating food prevents residents from receiving spoiled items. The cook further acknowledged that serving moldy foods poses a risk of resident illness and that failing to perform hand hygiene creates a risk of cross-contamination. The cook also stated that each shift cook is responsible for checking for and discarding spoiled food during their shift. Furthermore, the cook stated that each shift cook is responsible for checking for and discarding spoiled food, but noted there's no supervisory schedule or sign-off sheet to verify these checks. An interview conducted with a Dietary Aide (staff # 30) on April 18, 2025 at 10:27 AM, who stated that unopened food items risk freezer burn and acknowledged the freezer's lack of cleanliness, committing to a weekly cleaning schedule. The Dietary Aide further stated that there was an unsealed open plastic bag of frozen sausage in the freezer and a significant accumulation of dust in the freezer handles' crevices. Another interview was conducted with the morning [NAME] (staff # 20) on April 18,2025 at 11:00 AM , who ran a finger along the inside lining of the ice machine, revealing a dark and wet substance that transferred to their finger. The Staff member confirmed the presence of dust on the plastic vent covering the ice machine's filter, but asserted that it does not impact the filter's function. The cook stated that maintenance last cleaned the ice machine the previous Thursday. The cook further stated that grease buildup on the stove increases the risk of fire, and that the night cook is responsible for cleaning it. An interview conducted with the Maintenance Manager (staff # 10) on April 18,2025 at 11:20 AM, who stated that the maintenance team was responsible for calling a vendor to clean ceiling vents. However, staff #10 then clarified that maintenance cleans the kitchen's ceiling vents every two months, with the last cleaning occurring a month prior. The staff member also confirmed that the maintenance team is responsible for cleaning lights when covers need removal, and that kitchen staff would submit orders for these cleanings. The Maintenance Manager also stated that kitchen staff are responsible for cleaning the stove, fridges, and freezers, and that the kitchen manager ensures the kitchen ceilings are clean. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview conducted on April 20 ,2025 at 08:18 AM with the Director of Nursing (DON/Staff #40) who stated that the ice machine maintenance protocols included that kitchen staff clean the interior and exterior, while housekeeping and maintenance handle general external cleanliness and dust prevention. The DON also stated that kitchen staff also clean the kitchen vents, but maintenance changes the filters. The DON further stated that kitchen staff are responsible for visual cleanliness and that they have a contract company that conducts quarterly kitchen cleanliness inspections, with reports sent to the Executive Director. The DON stated that if the ice in the ice machine is determined to be contaminated it should be discarded and the machine cleaned and that internal contamination requires a third-party vendor to clean. The DON stated that all opened food must be dated, properly sealed, and discarded when necessary, adhering to storage policies. The DON further stated all kitchen staff must follow the general policy, washing hands before and after tasks, and cleaning surfaces. the DON stated that to prevent cross-contamination, staff should wash hands between handling contaminants and changing gloves. The DON emphasized that moldy produce must be immediately discarded, and wilted or discolored produce should not be served, as this falls short of her expectations. She also stated that improperly sealed food could result infoodborne illnesses, and serving freezer-burned food is unacceptable due to its potential to cause resident illness. The DON stated that the kitchen staff are responsible for cleaning all their equipment, including the ice machine, large mixers, gas range, and refrigerators including handles. An interview was conducted on April 20 ,2025 at 08:18 AM with the Dietary Manager (Staff # 50) who stated that the large mixer is rarely used, and is cleaned bi-weekly. She also stated that all kitchen staff are responsible for cleaning, with visual oversight and that dietary aides clean the stove weekly. Tje Dietary Manger stated that kitchen aides clean the stove vents weekly, while maintenance cleans other vents during filter changes, though this isn't documented. She also stated that refrigerators are checked daily and thoroughly cleaned weekly by dietary aides. The Dietary Manager further stated that kitchen staff clean the ice machine's exterior and internal dust daily and they clean behind the ice machine as needed and maintenance also cleans the ice machine. The Dietary Manager stated that when ice in the ice machine would become contaminated, the ice would be discarded and replaced with bagged ice. She also stated that mainenance is responsible for cleaning the kitchen ceilings and lights. The Dietary Manager stated that staff are requiree to immediately date and label opened food packages and practice thorough hand hygiene at a sink, using hot water and soap for at least 20 seconds. She further stated to prevent cross-contamination, they emphasize using more utensils and expressed strong disapproval for staff touching garbage then food without handwashing, deeming it an unacceptable risk and would lead to retraining. She also stated that refrigerators are checked daily for spoiled/expired food, and moldy produce must be immediately discarded. An interview was conducted on April 20 ,2025 at 11:22 AM with the Executive Director (ED/Staff #60) who emphasized that food storage must be orderly, fresh, and rotated, requiring cooks to conduct daily refrigerator inspections and immediately date all opened food items. The ED stated that expired or improperly sealed food poses a significant risk of bacterial growth and foodborne illness, necessitating that it is immediately discarded to protect residents. The ED added that improperly sealed meat risks freezer burn and spoilage, and wilted produce must be discarded. He also stated that kitchen staff are responsible for cleaning all equipment, including freezers (and handles), ice makers, ceilings, vents, and tube lights, noting that dust on handles can cause cross-contamination. The ED also stated that staff failing to perform hand hygiene creates an unacceptable cross-contamination risk, and that serving ice from a dusty ice maker risks foodborne illness, a practice he would personally avoid. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A faciltiy policy titled, Food storage and Date Marking, revealed that all the food items must be stored and dated properly. A facility policy titled, Cleaning Instructions:Ice Machine and Equipment, revealed that the ice machine should be cleaned and sanitized on a regular basis to maintain a clean, sanitary condition. The steps include removing the ice, washing the interior thoroughly using a detergent solution. Rinse and drain the interior with clean hot tap water and pay close attention to the crevices. A facility policy titled, Cleaning Instructions: Refrigerators, revealed that the refrigerators will be cleaned thoroughly inside and outside with a detergent and followed by a sanitizer at least once every month , or as needed. Spills and leaks will be cleaned as they occur. A facility policy titled, Cleaning Instructions:Stoves, revealed that the cooktops will be cleaned after every use. A facility policy titled, General HACCP Guidance for Food Safety, revealed that staff should wash hands prior to working with food, after using the restroom or soiling hands in any way. The facility was not able to provide a policy for cleaning the kitchen ceiling / lights.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, review of records, and review of facility policy and procedure, the facility failed to ensure the medical record was complete and accurate for one resident (#324) The deficient practice could lead to care team members not being aware of a resident's status, and could lead to missed or delayed treatment. -Findings Include: Resident #324 was re-admitted to the facility on [DATE], with diagnoses that included Parkinson's disease, personal history of traumatic brain injury, dementia, unspecified abnormality of gait and mobility, cognitive communication deficit, anxiety disorder, and need for assistance with personal care. An admission minimum data set (MDS) assessment dated [DATE], revealed the resident had a brief interview for mental status (BIMS) assessment that was not completed. Section J revealed the resident had two or more falls with injury since admission, re-entry, or prior assessment. Review of the clinical record revealed no evidence of any neuro check logs for Resident #324 for the time frame of his facility admission starting February 6, 2023. An Alert Charting Change of Condition Summary, dated February 6, 2023, revealed the resident was found on the floor. He was attempting to ambulate without assistance. The resident is very confused and very forgetful. No injuries noted at this time. Notifications to appropriate parties were made. A Fall Incident Report dated February 8, 2023, revealed the resident was found lying on the floor in his room by a Certified Nursing Assistant (CNA), with no injuries observed at this time, and the resident was placed back in his wheelchair. There was no evidence of a progress note in the resident's medical record regarding this fall. A Daily Skilled Evaluation note dated February 10, 2023, revealed Resident #324 fell this shift at 1:25 PM. The resident was in his room with his back to his bed pushing his wheelchair and fell backwards onto his bed. Fall was witnessed by this writer, and no injuries noted and neuro checks started. There was no evidence in the medical record that notifications to the medical provider and resident's family were made. An Alert Note dated February 12, 2023, revealed the resident is very confused. He has been getting out of bed and sliding to the ground. Resident has been wandering to other resident's room as well as between the hallways trying to get outside. Resident would benefit as a one on one candidate. There was no evidence in the medical record that notifications to the medical provider and resident's family were made. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An additional Alert Note dated February 12, 2023, revealed the resident continues to push self and hyperextend his body out of his wheelchair. Resident can self-propel throughout the hallway and is not easily redirected. During previous shift, the resident had a fall and pulled out his foley catheter with balloon still inflated. Resident continuously monitored this shift while out in hallway. Resident attempted to place self on floor numerous times. The resident was helped to bed, lights turned off, heater on, and covered up to help promote sleep, with the bed lowered to the floor, and fall matt placed on floor beside bed. Approximately 30 minutes after being helped to bed, the resident was already observed on the floor in his doorway. The resident had crawled from his bed to the doorway. In addition to crawling out of bed, the resident pulled his foley catheter out with balloon still inflated for the 2nd time today. The resident was helped back into bed, with CNA at bedside. The resident would benefit from psychiatric evaluation and 1:1 supervision. There was no evidence that notifications to the medical provider and resident's family were made. A Baseline Care Plan note dated February 14, 2023 revealed the resident was found on the floor in the bathroom, he is unable to let his needs be known. The only injuries noticed are a skin tear to the right forearm, and neuro checks have started. There was no evidence that notifications to the medical provider and resident's family were made. An Alert Charting Change of Condition Summary dated February 28, 2023, revealed the resident was attempting to self-transfer to bed and slipped onto the floor. The resident denies pain at this time. Event paperwork started. There was no evidence that notifications to the medical provider and resident's family were made. An Alert Charting Change of Condition Summary dated March 8, 2023, revealed the resident was observed by a CNA sitting on floor mat at bedside, his head resting on his bed, and bed in low position. No new injuries noted, and the resident does not appear to be in pain. There was no evidence in the medical record that notifications to the medical provider and resident's family were made. An interview was conducted on May 20, 2025, at 11:10 AM, with a Registered Nurse (RN / Staff #3) who stated that if a resident falls, the nurse will assess the resident to see if there are any injuries, perform a head to toe assessment, start vitals and neuro checks, notify all applicable parties including the medical provider and family. Staff #3 stated that this would be documented in a progress note and an incident report, and that a fall risk assessment would be completed. An interview was conducted on May 20, 2025, at 12:13 PM, with a licensed practical nurse (LPN / Staff #72). Staff #72 stated that if a resident falls, the nurse will assess the resident, notify the provider, and other applicable parties, and the incident is documented in a progress note and an incident report, also called a risk management report. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on May 20, 2025, at approximately 2:15 PM, with the Director of Nursing (DON / Staff #56) who stated that if a resident falls in the facility, the nurse will complete an assessment of the resident and document it in the medical record, and complete an incident report. Additionally, if a resident has repeated falls, the facility prevents ongoing future falls by assessing the root cause of the fall and updating the care plan with appropriate interventions after each fall. The clinical record and incident reports of Resident #324 were reviewed together and the DON stated that the fall on February 8, 2023, had an incident report but did not have any indication in the medical record, and that a number of the resident's falls were missing documentation that the provider and family were notified. Additionally, the DON confirmed that there was no evidence of neuro check logs for the falls during the resident's admission. Review of the facility policy titled Documentation: Charting and Documentation, effective January 2024, revealed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record may be electronic, manual or a combination. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Documentation of procedures and treatments will include care-specific details, including: the date and time the procedure/treatment was provided; the name and title of the individual(s) who provided the care; the assessment data and/or any unusual findings obtained during the procedure/treatment; how the resident tolerated the procedure/treatment; whether the resident refused the procedure/treatment; notification of family, physician or other staff, if indicated; and the signature and title of the individual documenting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035093	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Cottonwood	197 South Willard Street Cottonwood, AZ 86326

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. The facility failed to ensure that staff followed appropriate infection control practices. The deficient practice could result in a spread of preventable illness to residents and staff. Findings included: On May 19, 2025 at 11:03AM, a Certified Nursing Assistant (CNA/Staff #64) was observed completing a resident's vitals near a nursing station. It was observed that Staff #64 did not sanitize or wash his hands before and after obtaining the resident's vital signs. Upon exiting the room the CNA was observed to write the vital signs of the resident on a clipboard and set the clipboard on the nursing station. Staff #64 was then observed entering another resident;s room without first sanitizing his hands. An interview was conducted on May 19, 2025 at 11:19AM with Staff #64, who stated that the facility's expectations regarding hand hygiene was to perform handwashing before and after providing care or coming in direct contact with a resident. Staff #64 also stated that hand hygiene and infection control practices are expected when obtaining the vitals of a resident. Staff #64 stated he did not complete proper hand hygiene while obtaining the vitals of the resident, and stated that he did not complete proper hand hygiene before and after obtaining vitals, and did not sanitize his hands when he entered another resident's room immediately after obtaining the vital signs. Staff #64 stated that the facility's expectation is to perform hand hygiene before and after obtaining vital signs, as well as disinfecting the devices that had been utilized to obtain the vital signs, due to the risk of spreading germs, illnesses, and diseases. An interview was conducted with another CNA (Staff #20) on May 19, 2025 at 2:50 PM, who stated that hand hygiene is to be completed before and after patient care, and to ensure handwashing is to be completed every few times after hand sanitizing. Staff #20 also stated that the facility's expectation is to ensure appropriate infection control practices are followed due to the risk of spreading infections from resident to resident and to the staff. Staff #20 had also stated that when obtaining labs, the facility's expectation is to ensure appropriate infection control practices are followed. Staff #20 then demonstrated what devices are to be disinfected and where the disinfectant can be found, as infection control practices included hand hygiene and disinfecting the devices utilized to obtain a resident's vital signs. An interview was conducted with the DON/IP (Director of Nursing/Infection Preventionist/Staff #56) and a Clinical Resource (Staff #250) on May 19, 2025 at 3:50PM. Staff #56 stated that hand hygiene is expected to be completed before and after patient care, whether that may be bringing in a tray of food or providing a patient with medications. The DON/IP also stated that obtaining vitals is considered patient care and that hand hygiene is expected to be completed before and after obtaining the vitals. The DON/IP stated that when obtaining vitals, disinfecting the devices and equipment with appropriate disinfectant is just as important as hand hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A policy titled, 'Infection Control, Handwashing/Hand Hygiene' stated that the facility considers hand hygiene the primary means to prevent the spread of infection. It also stated that hand washing should be done after hands are visibly soiled, and after contact with a resident with an infectious diarrhea. The policy also stated that the use of an alcohol-based hand rub can be used before and after coming on duty, coming in contact with residents, handling medications, any non-surgical invasive procedures, handling invasive devices, before donning sterile gloves, handling clean or soiled dressings, moving from a contaminated body site to a clean site during resident care, after contact with a resident's intact skin, bloody or bloodily fluids, dressings and contaminated equipment and objects in the immediate vicinity of the resident, after removing gloves, before and after entering isolation precaution settings, eating or handling food, assisting a resident with heir meals and after the personal use of the toilet or conducting personal hygiene.