| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 035099 | A. Building<br>B. Wing | 11/20/2025 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and facility policy and procedure, the facility failed to protect the residents rights to be free from abuse by staff and other resident (#21, #9, #13, #2, #44, #10, #16, #40, #41, #42). The deficient practice could lead to further instances of abuse, thereby promoting an unsafe environment.Findings Include:<br><br>-Regarding Resident #9<br><br>Resident #9 was admitted on [DATE] with diagnosis including paranoid schizophrenia, altered mental status, drug induced subacute dyskinesia, unspecified mental disorder due to known physiological condition, muscle weakness, lack of coordination, abnormalities of gait and mobility, cognitive communication deficit, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety.<br><br>A review of the modification of admission MDS (minimum data set) dated February 2, 2024 revealed a BIMS (brief interview of mental status) score of 0, indicating severe cognitive impairment. No potential indicators of psychosis or behaviors were noted in this MDS.<br><br>A review of the care plan revealed that the resident had a self-care performance deficit due to confusion resulting from dementia and paranoid schizophrenia. Another focus area within the care plan noted that the resident was a high elopement risk, that he was disoriented to place and had impaired safety awareness, with noted interventions to include distraction by offering pleasant diversions, structured activities, food, conversation, television and books.<br><br>A review of the facility reportable incident dated February, 22, 2024 revealed that the CNA (certified nursing assistant, staff #198) stated that she had open-handedly hit the resident in an attempt to redirect him. It was further noted that the CNA was immediately suspended pending an investigation. A statement from CNA, staff #200 revealed that she arrived on the unit in the morning, had asked the staff how the night went and was told by the CNA, staff #198, that resident #9 had hit her and that she had hit him back. It was further noted that staff #200 reported that staff #198 stated that she hit the resident out of a reflex action and that she stated that she had hoped she would not get caught.<br><br>An interview was conducted on September 23, 2025 at 2:40 PM with CNA, staff #196). The CNA stated that abuse can be in the form of mental, physical, financial, emotional and sexual. She further stated that the perpetrator could be anyone, including staff, family, visitors and other residents. Staff #196 stated that the facility does not tolerate any form of abuse and that when abuse does occur, the alleged perpetrator is to be immediately separated from the alleged victim and they are assessed for safety and potential injuries. The CNA stated that once the safety of the residents has been<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | established, abuse has to be reported immediately; however, staff #196 was unsure of the direct timeframe. Staff #196 stated that training regarding abuse, neglect and exploitation transpires at least annually, but generally some related area is addressed monthly.<br><br>An interview was conducted on September 23, 2025 at 2:45 PM with the HR (Human Resource) Director, staff # 115. Staff #115 stated that CNA, staff #198 was an 'agency' CNA. She stated that she did recall staff #198, as she had responded to a subpoena for her. Staff #115 further stated that the agency CNA, staff #198 was noted to be a 'DNR' (do not return). She further stated that the CNA did not return to the facility after the incident.<br><br>A telephone call was placed to CNA, staff #198 on September 23, 2025 at 2:55 PM. A message was left on the voicemail, but no return call had been received.<br><br>A telephonic interview was conducted on September 23, 2025 at 3:04 PM with a representative of the staffing agency, staff # 199. Staff #199 stated that the agency had received a phone call from the facility stating that she was not to return. She further stated that the CNA's account was no longer active in her system and that she had been banned from the agency.<br><br>An interview was conducted on September 24, 2025 at 4:05 PM with administrator, staff #38. Staff #38 stated that the facility video footage from incident is only kept for 3 days at which time it is documented by viewers and then deleted. She stated that video footage is no longer available.<br><br>A telephonic interview was conducted on September 25, 2025 at 9:39 AM with CNA, staff #200. Staff #200 stated that abuse includes mental, physical, verbal, emotional, financial or sexual actions against another. Staff #200 stated that CNA, staff #198 had shared with her that she had hit resident #9 out of a reflex action, while trying to redirect him. She further stated that she was told that there was a reddened area on the resident, but that the facility had attributed it to shearing versus the hit on the back. She stated that she would label this incident as abuse. Staff #200 further stated that the risk could include physical injury as well as the resident's emotional well-being.<br><br>An interview was conducted on September 25, 2025 at 10:35 AM with the DON (director of nursing, staff #93). Staff #93 stated that abuse can include anything verbal, physical, emotional, sexual and or financial. She stated a CNA hitting a resident on the back would constitute abuse. The DON stated that her expectation that any incident of abuse would be reported and that the perpetrator, if a staff member, be removed from services. Staff #93 reviewed the 5-day investigation and stated that what was noted in the report would be considered abuse. She stated that the risk to the resident would be safety, physical as well as emotional.<br><br>An interview was conducted on September 25, 2025 at 4:10 PM with the administrator, staff #38. Staff #38 stated that abuse is when a resident is treated inappropriately and that the expectation is immediate intervention, separation, notification and start of investigation. Staff #38 stated that regardless of how light a touch, hitting a resident on the back would be considered abuse. Staff #38 stated that the risk to the resident could include physical injury.<br><br>-Regarding Staff to Resident Abuse (Resident #10, alleged victim)<br><br>An undated 5-day report received from the facility revealed that Resident #10 made allegations on January 5, 2024 that two - night shift CNAs treating her on January 4, 2024 – January 5, 2024 inappropriately touched her. The report included that the 2 CNAs were suspended, and other residents (continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | and staff were interviewed.<br><br>Further review of Resident #10's clinical records revealed no evidence of updated care planned interventions, or review of the effectiveness of care planned interventions regarding this incident, and did not provide sufficient protection to prevent resident to resident abuse.<br><br>-Resident #10 was admitted on [DATE] with diagnoses that included type 2 diabetes mellitus, factitious disorder imposed to self, with combined psychological and physical signs/symptoms, major depressive disorder, need for assistance with personal care, Huntington's disease, and conversion disorder.<br><br>Review of Resident #10's care plan revealed the following:<br><br>Initiated 7/20/2023: May voice allegations of mistreatment or exploitation related to factitious disorder, difficulty controlling anger, depression. Interventions included to implement special care strategies, have 2 caregivers address needs and to observe the situation, have supervisory personnel observe care delivery.<br><br>Initiated on July 20, 2023: behaviors: verbally abusive behavior, yelling – with interventions that included to intervene by speaking calmly and professionally in a soft tone of voice, revised on Aril 2, 2024.<br><br>A nursing note dated September 11, 2023 revealed that resident was compliant with care.<br><br>A nursing note dated December 30, 2023 revealed that resident refused brief check/change after breakfast.<br><br>A skilled charting note dated December 31, 2023 revealed no changes to mood/behavior.<br><br>A quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated intact cognition. The assessment also revealed that verbal and behavioral symptoms toward others were observed.<br><br>A skilled nursing note dated January 1, 2024 revealed no changes to mood or behavior.<br><br>A progress note dated January 2, 2024 revealed that the resident threatened to put nurse and can on face book and complained of quality of care.<br><br>A nursing note dated January 5, 2024, revealed at about 11:30 this writer went into resident's room for medication administration. Resident complained of 2 CNAs that had work overnight. The note reported that the resident said they were rough when they change my brief, held my leg and made indentations. The nurse wrote that she notified the provider and unit manager, a skin assessment was done, with no signs of skin marks or discolorations found on buttocks, peri Area or legs. Called resident's sister and left her a message to call back for notification. Staff continues to provide care on pairs.<br><br>A nursing note dated January 5, 2024 at 12:38, revealed that staff reported that resident was telling her You have to pour my water for me. You are my Slave. Care done in pairs as resident make accusations again staff. This reported to unit manager and Behavioral tech aware. The note indicated<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | that the resident reported that she wanted to place a complaint against staff. The note relayed that a skin check and the resident's legs and sacrum were free of bruising or indentations.<br><br>A facility self-reportable incident form dated January 5, 2024, revealed that Resident #10 reported an allegation of abuse, alleging that staff hurt her while doing cares. The report included that Resident #10 alleged that the two CNAs that took care of her on the night of January 4, 2024 and hurt her while providing care. The investigation also included a statement from a housekeeper that relayed that Resident #10 said to her help me because I have been abused, and the housekeeper replied that you have to tell the nurse, and the resident stated no because no one listens to me. The housekeeper relayed that she walked out of the resident's room.<br><br>Review of the clinical record revealed no evidence that the housekeeper reported the allegation to a supervisor.<br><br>Further review of the facility 5-day report revealed a copy of a hand-written note with Staff #154's name on the top. The note revealed that at the end of her shift on January 4, 2024 to the morning of January 5, 2024 she needed to change Resident #10. The note relayed that when the resident woke up she was really grumpy and whining and crying the whole time. The note included that the resident did not like to be changed because she had trouble turning and it seemed to be painful. Staff #154 wrote that the resident was screaming before we even got started. The note continued to relay that the had to turn the resident and every time they turned her it takes some pushing and pulling and the resident was screaming, stop abusing me throughout the whole process. The note continued that the bowel movement was in every crevice of her front and back, and being the size she is takes quite the effort of getting the wipe in the crevices. The note included, we had to clean between the legs but every time I put the wipe to clean her she would squeeze her legs together, we had to use a good amount of strength to hold her legs open enough to get in the areas to clean her properly. The note continued that the resident became furious.<br><br>Review of the clinical record revealed no evidence that nursing was informed of the resident's behaviors on January 5, 2024 during care/treatment.<br><br>A skin assessment conducted on January 5, 2024 revealed no evidence of bruising in the peri or coccyx areas, no redness or swelling.<br><br>Review of the care plan revealed no evidence that interventions were updated or that the care planned interventions were reviewed for effectiveness.<br><br>Review of the clinical record revealed no evidence of an IDT review after the incident.<br><br>A nursing note dated January 5, 2024 at 6:54 PM revealed that the resident showed the nurse a blue paper and stated look, I'm the victim now, the police came and I'm a victim.<br><br>A skilled charting progress note dated January 6, 2024 relayed the resident had notable changes in mood and behavior, care in pairs for the resident due to increased behaviors toward staff.<br><br>A nursing note dated January 8, 2024 at 10:45 PM revealed that a nurse and 2 CANs entered the resident's room, due to call light. The note included that the resident had to be roused from sleep and when she awoke the resident yelled, I don't want to be changed. The note included that brief changes were refused.<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A behavior note dated January 9, 2024 revealed that the resident had been verbally aggressive and threatening toward staff and non-compliant with care. The note included that the resident had skin breakdown because of refusing to be cleaned and changed. The note included that the resident stated that during peri-care CNAs twisted her legs and now have constant pain in my body. The nurse wrote that she asked the resident if she suffered from pain prior to the incident and the resident replied no. The nurse asked the resident again after administering pain medication if she normally had pain, and the resident stated yes, all over my body. 3 staff assist with care at all times.<br><br>A nursing note dated January 9, 2024 revealed that the resident's behavior was erratic throughout the shift, would not let CNAs clean her thoroughly, and was yelling and screaming during the shift.<br><br>A behavior note dated January 10, 2024 at 6:33 AM, revealed that 3 staff in room to assist with care on the shift, resident had large bowel movement (BM). Resident falsely accusing staff of pulling her legs.<br><br>A behavior note dated January 10, 2024 at 9:52 AM revealed that it was reported that the resident had a large BM and was upset that CNAs had to move her and lift her legs to clean her. The note included that the resident continued to yell and scream, and that staff had difficulty re-directing her.<br><br>Review of Staff #154's employee file revealed no evidence of disciplinary actions or interviews regarding the incident that occurred on January 4, 2024 – January 5, 2024.<br><br>However, staff #154's punch detail for January 1, 2024 revealed that she did not work at the facility from January 5, 2024 – January 9, 2024.<br><br>An employee grievance form dated May 25, 2024, signed by CNA (staff #154) revealed that on May 25,2024 she was in Resident #10's room giving a bed bath and cleaning in the resident's vagina area, and after wiping her the resident cried for the CNA to stop, and the CNA showed the resident a wipe with poop on it. The CNA also wrote that she continued to clean Resident #10, who sat up really quick and slapped the CNA. The CNA wrote that her suggestion for resolving the situation was to give Resident #10 a good talking to. However, the employee grievance form did not include evidence that the CNA stopped treatment/care when the resident said stop.<br><br>An interview was conducted on September 24, 2025 at 2:13 PM with a Licensed Practical Nurse (LPN/staff #155) who stated that staff to resident abuse should be reported to the supervisor. The LPN also stated that cares in pairs is provided for resident and staff safety, and that there is a second person that can verify any allegations by the resident. The LPN also stated that when a resident says no or stop during or before care, staff should stop and redirect, or offer a different staff member, and report to nursing. The LPN further stated that if staff is aware that a resident has pain during care/treatment, nursing can medicate the resident prior to the care/treatment. The LPN also stated that when a resident says no, but staff continue on with the care, that could be considered abuse. The LPN stated that she is familiar with Resident #10, and that the resident can be physical and verbal to staff, then be nice. The nurse stated that Resident #10 required all care/treatment in pairs and that the resident may be resistive when CNAs change her briefs by throwing things, but the resident does not refuse care. The resident is bariatric, and is heavy for staff to turn, but she can turn herself. The LPN included that if the resident refused care it is usually because she is really escalated in her behaviors, and that staff should stop all care/treatment at that time. She stated that staff should not start care if the resident is screaming before they start and if a resident calls out stop abusing me during brief changes, the staff should stop and get a nurse. She stated that if the<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | resident refuses to let staff clean between her legs they should stop. The LPN also stated that when a resident is holding her legs closed during peri care and says don't clean me down there staff should stop. The LPN also stated that any of the previous could be considered abuse by staff and that this did not follow the facility abuse policy. The LPN stated that the risk could result in skin issue, psychosocial, increase anxiety. to de-escalate a situation, it can depend on who it is. She said that this could be considered rough treatment.<br><br>An interview was conducted on September 24, 2025 at 2:44 PM with a CNA (staff #99), who stated that when residents refuse care the staff member should stop all care, explain the procedure and what could happen if the care is not provided. She further stated that if the resident still declines the care a nurse should be informed. She further stated that forcing care would be abuse. The CNA stated that the risk of continuing care when a resident refuses could result in additional behaviors, anxiety or skin tears.<br><br>An interview was conducted on September 24, 2025 at 3:10 PM with a CNA (staff #118) who stated that abuse can be physical or verbal. She stated that if abuse is witnessed the staff member should report to a nurse. She also stated that the chart shows which residents require cares in pairs. She further stated that when a resident refuses a brief change, the staff member should leave the resident and get a nurse. She stated that it would be against facility policy anf resident rights to continue care when a resident refuses. The CNA stated that forcing care would be considered abuse, and the risk to the resident could be an injury.<br><br>An interview was conducted on September 24, 2025 at 3:00 PM with a Licensed Practical Nurse (LPN/staff #155), who stated that when a resident refuses care, the staff member should try to re-direct the resident, explain the process, and re-approach or try at a later time. The LPN also stated that a resident should never be forced to have a brief change if the resident has refused.<br><br>An interview was conducted with the Interim Director of Nursing (DON/staff #93) on September 25, 2025 at 9:34 AM, who stated that anytime a resident says stop staff should stop care/treatment immediately, walk away and report to a supervisor for further intervention. The DON also stated that when staff continue to perform care/treatment to a resident after the resident says stop, it could be considered abuse. The DON further stated that when a resident has behaviors that include resistance of care/treatment, staff should still halt any care/treatment if the resident says stop, and get a nurse. The DON also stated that increased behaviors after an abuse incident could result in an increase of behaviors due to psycho/social trauma from the event. The DON reviewed the written statement from Staff #154, and stated that she would consider the described interaction abuse, and this could result in the resident having lack of trust with staff, psychosocial trauma and increased behaviors.<br><br>-Regarding Resident to Resident Abuse: Resident #41 and Resident #42<br><br>A 5 Day facility reported incident (FRI) revealed that on August 21, 2022 Resident #41 was observed pulling Resident #42's hair. The report included that Resident #31 had behavior problems that included hitting, kicking, pinching, wandering, grabbing, scratching. The report included that both residents were immediately separated, both residents were interviewed, and 15- minute checks were completed to ensure residents are ok. The report further relayed that Resident #41's behaviors are managed under the care plan. The report indicated the incident occurred on August 21, 2022, however records in the clinical record reported the event as occurring on August 20, 2022.<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Further review of both Resident #41 and #42's clinical records revealed no evidence of updated care planned interventions, or review of the effectiveness of care planned interventions regarding this incident, and did not provide sufficient protection to prevent resident to resident abuse.<br><br>-Resident #41 was admitted on [DATE] with diagnoses that included dementia with behavioral disturbance, major depressive disorder, recurrent.<br><br>An order summer revealed the following medication orders:<br><br>Donepezil HCL, for cognition enhancement<br><br>Sertraline HCL for depression<br><br>A July 2022 Medication Administration Record (MAR) revealed all medications administered as ordered, and behaviors monitored as ordered.<br><br>An annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 1, which indicated severe cognitive impairment. The assessment relayed that no verbal, physical behaviors directed toward others, and no change in behaviors.<br><br>An incident report dated June 26, 2022 revealed that Resident #41 threw milk on another resident while in the dining room.<br><br>An interdisciplinary team (IDT) progress note dated June 27, 2022, regarding the June 26, 2022 incident revealed interventions of frequent checks for 24 hours. There was no evidence of other interventions.<br><br>Review of the resident's care plan revealed no evidence that the behavior interventions were reviewed/updated despite the incident that occurred on June 26, 2025, or of review for effectiveness of the interventions in place.<br><br>A July 24, 2022 behavior progress note revealed that Resident #41 was wandering in and out of others rooms and the behavior was difficult to redirect.<br><br>Review of CNA behavior task revealed behaviors of one of the following: grabbing, pushing, wandering, and threatening behaviors, occurred on 17 shifts in July 2022.<br><br>An August 2, 2022 behavior progress note revealed that Resident #41 was wandering in the hallway, was difficult to redirect.<br><br>A physician progress note dated August 15, 2022 revealed that Resident #41 had been wandering in and out of others rooms and going through the trash can, was difficult to redirect. The note included that after reviewing the patient's psychotropic medication regimen the patient will continue to be monitored.<br><br>Review of the resident's care plan revealed no evidence that the behavior interventions were reviewed/updated despite an increase in behaviors and difficulty to redirect, or of review for effectiveness of the interventions in place.<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An incident note dated August 20, 2022 revealed that a certified nursing assistant (CNA) reported that she observed Resident #41 pull Resident #42's hair, no injuries noted.<br><br>Review of Resident #41's clinical record revealed no evidence of an IDT (interdisciplinary team) meeting regarding the incident that occurred on August 21,2022.<br><br>Further review of the resident's care plan revealed no evidence of updated interventions or review related to the August 20, 2025 incident, or of review for effectiveness of the interventions in place.<br><br>August 2022 CNA behavior symptom observations revealed 17 shifts that behaviors occurred.<br><br>A quarterly MDS assessment dated [DATE] revealed a BIMS score of 01, which indicated severe cognitive impairment. The assessment included no physical or verbal behaviors directed toward others was present at the time of the assessment.<br><br>-Resident #42 was admitted on [DATE] with diagnoses that included major depressive disorder, transsexualism, and anxiety disorder.<br><br>A quarterly MDS dated [DATE] revealed BIMS score of 11, which indicated moderate cognitive impairment.<br><br>A care plan revealed a focus for depression, impaired cognitive function, and potential for wandering/elopement.<br><br>A progress note dated August 20, 2022 revealed that Resident #42's hair was pulled by Resident #41. The resident relayed to the nurse that she felt a pull, and asked her to stop. The note revealed that the patient was assessed for injuries on her back and scalp, none viewed.<br><br>Review of Resident #42's clinical record revealed no evidence of an IDT (interdisciplinary team) meeting regarding the incident that occurred on August 20, 2022.<br><br>Further review of the resident's care plan revealed no evidence of updated interventions or review related to the August 20, 2025 incident, or of review for effectiveness of the interventions in place.<br><br>An interview was conducted with a Licensed Practical Nurse (LPN/staff #98) on September 23, 2025 at 4:00 PM, who stated that pulling the hair of another resident would constitute abuse, and would need to be reported. She reviewed that clinical record for Resident #41 and stated that there was no evidence that the care plan had been updated to reflect the abuse, that Resident #41 had pulled the hair of Resident #42's, or that the interventions had been evaluated for effectiveness. The LPN stated that Resident #41 did wander in other resident rooms and had increased behaviors, and was difficult to re-direct. The LPN stated that there was no evidence in the clinical record clinical record of updates to Resident #41's care plan to reflect the increase in behaviors or that the interventions were evaluated. The LPN reviewed the clinical record for Resident #42 and stated that there was no evidence in the clinical record regarding an update to her care plan regarding the incident, or that the interventions had been evaluated. She stated that this did not meet the facility abuse policy and the risk could result in other residents not being safe, or being abused by other residents.<br><br>-Regarding Resident to Resident abuse: Resident #16 and Resident #40:<br>(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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A 5-day report dated July 6, 2022 revealed that an altercation occurred on June 29, 2022 between residents #16 and #40. The report indicated that the residents were in the front lobby by the elevator, the administrator intervened and assisted to de-escalate the situation. During an interview, Resident #40 stated that Resident #16 hit him in the face. The report revealed that Resident #16 stated that he asked Resident #40 to move from the elevator door, and Resident #40 refused, when Resident #16 attempted to push the elevator button, Resident #40 attempted to punch him and there was contact with Resident #16's arm. Resident #16 relayed during the interview that Resident #40 used verbal profanity towards him. The report included that Resident #16's statements were consistent with other witness statements and that Resident #16 did defend himself against Resident #40.<br><br>Further review of both Resident #40 and #16's clinical records revealed no evidence of updated care planned interventions, or review of the effectiveness of care planned interventions regarding this incident, and did not provide sufficient protection to prevent resident to resident abuse.<br><br>-Resident #16 was initially admitted on [DATE] with diagnoses that included Type 2 diabetes with hyperglycemia.<br><br>A quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated intact cognition.<br><br>A progress note dated June 29, 2022 revealed that a staff member reported that two residents were involved in an altercation by the elevator on the first floor, no injuries, residents were separated and monitored and interviewed.<br><br>An IDT progress note dated June 30, 2022 revealed that an altercation occurred between Resident #16 and Resident #40 on June 29, 2022 by the front lobby elevator. The note indicated that during the incident Resident #16 fell and received a skin tear to the right forearm. The note revealed that the residents were separated, the skin tear was cleaned, with no complaints of pain.<br><br>The clinical record revealed no evidence of a skin observation/evaluation regarding the June 29, 2022 altercation with Resident #40.<br><br>Further review of the clinical record revealed no evidence of a fall assessment having been conducted after the June 29, 2022 altercation.<br><br>A provider progress note dated June 29, 2022 revealed the resident has behavior issues, with skin tear on his arm.<br><br>Review of Resident #16's care plan revealed no evidence of a behavioral care plan, or interventions regarding the June 29, 2022 incident, or of evaluation of the resident after the altercation.<br><br>An interview was conducted with the Interim Director of Nursing (DON/staff #93) on September 25, 2025 at 8:13 AM. The DON reviewed the clinical records for resident's #16. She stated that there was no evidence of an IDT note for evaluation, follow up and review of the incident that occurred on June 29, 2022, or review for effectiveness of the care planned interventions in place. She further stated that the resident's care plans were not updated with new interventions regarding the resident to resident altercation. The DON also stated that there was no evidence in Resident #16's record that a skin assessment had been completed following the incident.<br>(continued on next page) |

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|---|---|---|---|
| | 035099 | A. Building<br>B. Wing | 11/20/2025 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Resident #40 was initially admitted to the facility on [DATE] with diagnoses that included altered mental status, type 2 diabetes hypertension, with additional diagnoses that included dementia onset dated November 6, 2021, anxiety disorder, onset March 16, 2022, and schizophrenia onset March 30, 2022.<br><br>A behavior care plan revealed that Resident #40 has potential to be verbally aggressive related to ineffective coping skills.<br><br>An order summary revealed the following:<br><br>Ativan tablet for anxiety as evidenced by restlessness<br><br>Quetiapine Fumarate Tablet for schizophrenia as evidenced by delusions.<br><br>A June 2022 MAR revealed that all medications were administered as ordered, and medication monitoring was completed as ordered.<br><br>An IDT Note dated October 27, 2021 revealed that Resident #40 was verbally aggressive towards another resident, no interventions at this time.<br><br>A behavior note dated February 14, 2022 revealed that Resident #40 started screaming in the hallway, threatening to slap the shit out of you and to kick CNA's ass.<br><br>A physician note dated May 9, 2022 revealed that in the past 30 days the resident has shown some mood swings.<br><br>A behavioral health follow-up progress note dated May 9, 2022, revealed that the resident reports that he gets agitated when people are in his room or say something.<br><br>A practitioner note dated May 12, 2022 revealed that per nursing the patient is exhibiting worsening aggressive behavior towards other residents, plan was to increase Seroquel for schizophrenia as evidenced by delusions and worsening aggressive behavior.<br><br>Review of the care plan revealed no evidence of inter |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to implement policies and procedures for the documentation and reporting of alleged violations involving abuse for resident (#26). The deficient practice resulted in an allegation of abuse not being reported timely, and the potential for a resident not being protected from further abuse.-Regarding Resident #26Resident #26 was admitted on [DATE] and subsequently discharged on October 26, 2022 with diagnosis including morbid obesity with alveolar hypoventilation, chronic obstructive pulmonary disease, hypertension, type 2 diabetes mellitus with hyperglycemia, cellulitis, anemia, chronic pain syndrome, anxiety disorder, chronic and acute respiratory failure with hypoxia and unspecified schizoaffective disorder.Review of the physician orders revealed an order dated October 13, 2022 for a behavioral health services consultation. Additionally, an order was observed for Quetiapine Fumarate 100mg tablet to be given twice a day for schizoaffective disorder and delusions with an initiation date of September 22, 2022 and a cancellation date of November 1, 2022.A review of the modification of admission MDS (minimum data set) dated October 24, 2022 revealed a BIMS (brief interview of mental status) score of 15, indicating that the resident was cognitively intact. The MDS further noted that the resident was positive for hallucinations, experienced verbal behaviors 4 to 6 days a week as well as other behavioral symptoms not directed toward others which manifested 1 to 3 days a week.A review of the care plan revealed that the resident reported a history of serious trauma including abuse, mistreatment, abusive foster care, involuntary seclusion and domestic violence. Intervention were noted to include trauma informed approaches, and steps to avoid retriggering negative memories. Yet another focus area noted were psychiatric management with interventions of medication management and counseling, monitoring of symptoms as well as support and monitoring of psych-active medications. Additionally, behaviors of yelling at staff and resistance to care were identified.A review of the progress notes revealed a nurse's note dated October 23, 2022, which documented that TPD (Tucson Police Department) had arrived and visited the resident. The police stated that they had received calls from the resident's family that she had been touched inappropriately and that she had been sitting in feces and had not been changed. A review of the facility documentation revealed that the initial submission to the state agency regarding the abuse was not made until the following day on October 24, 2022.An interview was conducted on September 23, 2025 at 2:40 PM with CNA (certified nursing assistant, staff #196). Staff #196 stated that the definition of abuse included mental, physical, financial, emotional and sexual. Staff # 196 stated that the facility does not tolerate any form of abuse. The CNA further stated that if abuse is observed or if made aware of abuse it is to be reported immediately to the supervisor and or administrator. Staff #196 stated that there was a reporting timeframe but did not know the exact requirements, only that it had to be reported right away. Staff #196 stated that once abuse had been identified and it was not reported, interventions to keep it from happening again would not be put in place, then the ?situation' could escalate further and could make it unsafe for residents.An interview was conducted on September 23, 2025 at 2:52 PM with LPN (licensed practical nurse, staff #50). Staff # 50 stated that abuse examples could include physical, verbal, psychosocial, and isolating. The LPN further stated that if abuse dose occur that the facility has to report to the state within 2 hours.An interview was conducted on September 24, 2025 at 8:52 AM with the interim DON (Director of Nursing, staff #93. Staff #93 stated that when there is an abuse allegation that the reporting guidelines stipulate that a report must be made within 2 hours and subsequently investigated. The DON reviewed the progress notes for this resident dated October 23, 2022 and the incident submission documentation dated October 24, 2022. Staff #93 stated that the incident submission had not transpired within the 2-hour timeframe and that this did not meet her expectation. Staff # 93 stated that potential risk would<br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | include resident safety if the report was not made timely.An interview was conducted on September 25, 2025 with the administrator, staff #38. Staff #38 stated that an incident of abuse is to be reported immediately but within 2 hours to the SA (state agency). She further stated that all parties involved would be separated, notifications would transpire and that corrective action would be implemented. Staff #38 stated that a delay in reporting could impact the investigation and safety of the resident.A review of the facility policy titled Abuse and Neglect with an adopted date of May 1, 2024 revealed that notification to the state agencies that an investigation is being initiated is to immediately follow interventions for the resident's safety post suspected incident. The policy further stipulates that allegations of abuse must be reported to appropriate state agencies immediately and not later than 2 hours after receiving the allegation of abuse. |