STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035172	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Safford	1933 Peppertree Drive Safford, AZ 85546

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51006 Based on clinical record review, staff and family interviews, and facility documents and policy, the facility failed to ensure a resident's privacy was maintained during medication administration for one resident (resident # 23). This deficient practice could result in further violations of resident privacy. Findings include: Resident #23 was initially admitted on [DATE] and readmitted on [DATE] with diagnosis including Non-St Elevation (Nstemi) Myocardial Infarction, Chronic Obstructive Pulmonary Disease, Muscle Weakness, Atherosclerotic Heart Disease, and Gastrointestinal Hemorrhage. A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 12, indicating mild cognitive impairement. An interview was conducted on November 6, 2024 at 8:30 a.m. with a Registered Nurse and Unit Manager, (RN/Staff #26), where Staff #26 explained their expectations with respecting a resident's absolute privacy, that during patient care, doors should be closed, curtains should be drawn, that staff is expected to ask residents for their preferences, ensure resident's know their right to say no. Staff #26 also stated that staff has a learning management system that provides courses on Health Insurance Portability and Accountability Act (HIPAA) and resident rights. Staff #26 stated that the facility's expectations and professional standards apply to all staff when providing patient care. Staff #26 also stated that the expectation during medication administration is to ensure that any resident information is not viewable when staff is away from the medication cart, that the medication cart is locked when unattendance, that they introduce themselves to the resident and ensure the resident confirms their information, and that the resident is not being forced to take medications that they do not want to. However, during the interview with Staff #26 as stated above, an observation was made where Staff #26 provided a visual completion on how a nurse during medication administration is able to lock and unlock a resident's chart on their mobile devices. On November 6, 2024 at 10:12 a.m, a med cart located on the Long-Term Care (LTC) unit was observed unattended, and on the top of the medication cart, a device displayed Resident #23's name, date of birth, photo and the medications. A face bubble packet was also observed next to this device. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 6, 2024 at 10:12 a.m. with a Licensed Practical Nurse (LPN/Staff #88), where Staff #88 stated that the bubble packet does not have any medications in them and that they were left onto of the medication cart to remind her to re-order the medication. Staff #88 also stated that leaving the medication cart unattended with resident information being displayed and out in the open is not the facility's expectation and professional standards. Staff #88 acknowledged that she did leave Resident #23's information out in the open. An interview was conducted on November 6, 2024 at 2:43 p.m. with Director of Nursing (DON/Staff # 48), where Staff #48 stated that the facility's expectation is that staff honor the dignity and privacy of the residents, to ensure that they are closing the doors and closing curtains, and that residents have the right to take their medications in the hall if they wish to. Staff #84 also stated that during medication administration, staff is expected to knock upon entrance, introduce themselves and then close the curtain or close the door. Staff #84 also stated that staff is expected to lock the screen prior to administering any medication or covering any paper documents that may be viewable, as the risk for not ensuring resident confidentially is not within professional standards and that a visitor or an inappropriate party can view resident information. A review of an admission packet, on page 13, there is a section titled, Protected Health Information, revealed that the facility will not releaser any medical information to other parties without a properly signed Medical Release of Information from the resident or the responsible party. A policy titled Resident Rights, Dignity, revealed that the residents have their right to privacy and confidentiality to their medical records.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49399 Based on clinical record reviews, staff and resident interviews, facility documentation and policy and procedures, the facility failed to ensure that one resident (#128) was free from abuse from another resident (#66). This deficient practice could result in further instances of abuse. Findings include: -Resident #128 was admitted at the facility on December 4, 2023 with diagnoses that included dementia, chronic obstructive pulmonary disease, and depression. Review of the quarterly Minimum Data Set (MDS) assessment dated on June 11, 2024 revealed the resident had a BIMS score of 4, which indicated severe cognitive impairment. Review of care plan initially dated on February 26, 2024 and revised on August 1, 2024 revealed that resident #128 use antidepressant medication. The interventions included to monitor/document/report to provider as needed ongoing signs and symptoms of depression which included fear of being alone with others, attention seeking, concern with body functions, anxiety, and constant reassurance. -Resident #66 (alleged perpetrator) was admitted at the facility on March 28, 2024 with diagnoses that included unspecified dementia, type 2 diabetes mellitus, and depression. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 6.0, which indicated severe cognitive impairment. The MDS also included that the resident mood includes feeling down, depressed, or hopeless, rarely feel lonely or isolated, and has verbal behavioral symptoms directed towards others. For every day activities, no impairment on the upper and lower extremities, uses a walker and wheelchair. Review of care plan initially dated on April 10, 2024 and revised on July 8, 2024 revealed that resident #66 has a verbal behavior problem, inappropriate sexual behaviors towards staff and residents, and exhibits personal sexual needs in his room. The interventions included anticipate and meet resident's needs, encourage as much participation/interaction as possible during care activities, identify behavior triggers, and refer to psychiatric provider for consultation as ordered. A a progress note for resident #128 dated on July 7, 2024 revealed resident #128 was yelling Quit touching me! get your hands off of me!, and further revealed the writer quickly turned around and saw resident #66 reaching for resident #128 and he also was looking like he was going to expose himself to her. The note continued that resident #128 thanked the writer several times for stepping in and ordered resident #66 to get away from resident #128. The note concluded that resident #66 is constantly going after our women here and scaring them (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A behavior progress note for resident #66 dated on July 7, 2024 revealed a resident identified as resident #128 yelling quit touching me get your hands off of me. A staff saw resident #66 reaching for resident #128 and resident #66 was looking like he was going to expose himself to resident #128. Furthermore, the progress note revealed that resident #66 is constantly going after our women here and scaring them. Furthermore, the progress note stated spends too much of my time keeping him from sexually harassing them by touching and groping their breasts against their wills. I just saw him going down the hall with his penis hanging out and then realized that he had it hanging out and touching his penis with one hand and trying to grope a Resident with his other hand. A health status note dated July 7, 2024 revealed the administrator was notified of resident #66's behavior. A behavior progress note dated July 8, 2024 revealed resident #66 was immediately removed from resident #128's location and administrative staff were aware of behaviors. A health status note progress note dated July 9, 2024 revealed a room changed for resident #66. A psych follow-up progress note dated on July 10, 2024 revealed provider was aware of resident #66 on change on condition monitoring for having a recent room change and resident #66 continuous to go into female rooms to try to touch them. A behavior progress note dated August 26, 2024 revealed resident #66 has been touching other females' residents on their private areas. The resident has been told multiple times to stop, but he would say I won't stop. The resident has been reported and the CNA's keeping a watch on him. Will continue to monitor. A behavior progress note dated August 28, 2024 revealed resident #66 grabbed another Resident's bottom and tried lifting her shirt. The female Resident swatted this Resident's hand away and said, No!. An interview was conducted on November 7, 2024 at 07:22 a.m. with licensed practical nurse (LPN)/Staff #88. Staff #88 stated that she recalls resident #66 who is very angry, sexually heightened, no impulse control. Resident #66 would grab resident's breasts, and that they moved him to the locked unit about 6 months ago. He scared the female residents. Staff #88 stated that she can recall two female residents that resident #66 targeted specifically in the locked unit. Staff #88 do not wish to share their names. Staff #88 stated that she had witnessed resident #66 touching female residents inappropriately and they have separated the residents and kept resident #66 away from the female resident. Staff #88 stated that she had notified her unit manager, the director of nursing (DON), and their executive director. An interview was conducted on November 7, 2024 at 07:43 a.m. with a certified nursing assistant (CNA/Staff #222). Staff #222 stated that she is familiar with the locked unit for residents with dementia. They observe residents and when residents argue they intervene by calming them down, separate them, and notify the nurse. As far as her training, she took acknowledgment test every month for dementia care and also, she went through abuse training. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 7, 2024 at 08:07 a.m. with a CNA (CNA/Staff #43). Staff #43 stated that his role includes scheduling CNAs and nurses. The CNAs schedule is based on their staff preference and skills and their shifts is 12-hour shift from 6 to 6. They also have a medication tech. An interview was conducted on November 7, 2024 at 08:16 a.m. with a Certified Medical Assistant (CMA/staff #61) Staff #61 identified resident #66 to this surveyor. Staff #61 stated that with resident #66, the resident does not keep still, wheels self in the hallway and in the dining room in the locked unit. Staff #61 stated that they do their best for caring their residents with dementia and when their residents become combative and in the dining room, they try to remove them in the dining room and take them to their room to their calm place. They distract them by for instance offering water. Furthermore, Staff #61 stated that resident #66 wheels himself back and forth, crashing into people and stuff, resident will run his wheelchair into them not intentionally, resident is very inappropriate to other female resident and all healthcare staff. For instance, such as with another resident, resident #66 went up to her and touch her breast and it happened about 1 -2 months ago. Resident#66 still does that. Also, when resident #66 was in the long-term care side, resident #66 went up and touch other resident's breast and verbally said inappropriate things to them and asking sexual favors. The residents over at the long-term side will tell the staff members because they are with it to say something. Staff #61 added that there was one instance that happened in the summer. Staff #61 stated that with Resident #66 when he first came in the facility was going to people's room and wandering. Resident #66 touched other female butt while walking with her walker, it happened like about 1-2 months ago, He also say things to few ladies, like the famous one is you can touch me like anywhere you want, and bribing them by holding a napkin to bribe and to see their breast. Staff #61 stated that she has reported the incident to Staff #55, staff #88 and the director of nursing (DON), they are aware. Staff #61 stated that their schedule sometime include one CNA in the unit and it is hard to constantly watch resident #66 and their nurse is out there in the opposite of their unit, pass the double doors. An interview was conducted on November 7, 2024 at 10:50 a.m. with a Registered Nurse (RN/Staff #55). Staff #55 stated that resident #66 has implosive behavior touching other people and grabbing other people and the last time this behavior happened was in the summer. Staff #55 stated that the process for reporting incident is to let his supervisor and executive director know. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 7, 2024 at 01:58 p.m. with the Director of Nursing (DON/Staff #103). The DON stated that she oversees residents' care and staffing to make sure it staffed properly. They make sure they are providing care and following policies and regulation. Regarding abuse it can be physical, financial, misappropriation of funds and neglect, and include sexual abuse. The process for any suspected abuse is to report to their abuse officer immediately, report to state immediately, if resident to resident make sure resident is safe and then report immediately. The DON stated that regarding resident #66, resident was admitted for skilled for fracture was in skilled unit then went to long-term in April and moved to another unit, resident has dementia then resident was moved in the locked unit in July because of exit seeking, has occasional behavior issue and they try to redirect as much as possible. Resident behavior issues exhibited such as displayed sexual behaviors to staff, mostly to the CNAs by grabbing their butt and breast. The DON recalled an incident who they did self -report where he grabbed a resident's breast. DON stated she does not know any other incident about inappropriate behavior towards other residents. DON stated that music therapy helped resident #66 like playing country music in his room, and more activities. The DON stated that for staff reporting abuse, their training is upon hire and as needed. She added that any abnormal behavior of resident, any change should be reported to the DON. The surveyor informed the DON of resident #66's behavior in his July's progress notes. DON is looking in Point Click Care (PCC) for resident #66 progress notes. DON stated that she is not aware of the July event. DON stated that she definitely needs to look into regarding the July incident with resident #128 and she would get with the administrator to review any documentation on this. DON stated intervention regarding resident #66 included a referral in show low and he was not accepted, resident has been seen by telepsych since May 2024. DON stated that he was started on Paroxetine in August. An interview was conducted on November 8, 2024 at 8:07 a.m. with CMA/Staff #74. Staff #74 stated that in the locked unit, they have 15-16 residents, and for staffing they have one CNA and one CMA and their nurse is in the skilled unit, or they have two CNAs and a nurse in the skilled unit, and today there is one CMA and one CNA. Staff #74 stated that regarding resident care plan, they check each resident's Kardex, it can be found in PCC in point of care (POC). In regards to training and in-services, they have in-services every month and have educational videos. The in-services every month tell them how to distract resident to switch their attention to an activity or how to deal with their behaviors. They use distraction when they are upset to get their mind or attention on something else. Regarding resident #66, Staff #74 stated that resident #66 needs help with activities of daily living (ADLs), activities, and rolls around, sometimes he does not have good behavior, he is not physical but can be nasty with the women with staff and residents, nasty as in he will just say can I see your boobs provocatively, intervention use is he will usually move him or tell him not to say those things, he has not seen any inappropriate touching by resident #66. Staff #74 stated that his role is make sure everyone is safe first then remove the person from situation and grab his radio and call for help. He will call the DON and the administrator to report incident such as physical and emotional abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 8, 2024 at 10:12 a.m. with resident relation/Staff #113. Staff #113 stated that her role is she advocate for resident, help with non-clinical grievances such as with insurance, medical equipment, discharge planning. As a discharge planner she figures out their prior living, if need assistance, if live alone, and then come up with a goal and during their stay to make sure goal is still feasible if not have an alternate plan, referrals for home health and transfer to different facilities if needed. Regarding resident #66, she help locate his family out of state, she has sent referrals out of state in September 2024, and waiting to hear from them, and she made referral to a facility in July. Resident #66 has behaviors and she sent referrals to another facility in May 2024 and was denied. The denial reason was resident did not meet requirement. For the other facility referral , no bed was available. She stated that the behaviors such as sexual behaviors are inappropriate comment mostly to staff and to one resident incident which was reported to the state and that was grabbing resident's chest. She stated that the behavior seems to get better since he was moved to the locked unit which seems to help. Staff #113 recalled an incident that Resident #66 made a comment in September towards a female resident, the comment was show me your panties and he was talked to regarding that comment that was not appropriate, staff #113 saw this incident documented in the progress note by the DON. An interview was conducted on November 8, 2024 at 10:39 a.m. with the Administrator (Admin/Staff #106). Present during the interview are VP clinical Resource/Staff #225 and the DON. The administrator stated that regarding their abuse process, to report to the administrator as their abuse prevention coordinator and if not available to the DON. He stated that there are signs posted up in the building regarding abuse reporting. The administrator stated that they investigate the concern and determine if reportable or not, and a reportable abuse is physical abuse, sexual abuse, and neglect. The administrator stated that regarding sexual abuse, it is improper touching, not consenting to someone else or even uncomfortable situation like sexual advances. The administrator was prompted to review the progress note of resident #66/resident #128 in July 7, 2024. The administrator reading the progress notes, and stated that he agrees it's an abuse, 100 percent to be reported, and it was not reported to state agency and he was not aware of this. A review of facility's policy titled, Resident rights/Dignity: abuse, Neglect, Exploitation and Misappropriation Prevention program, in effect January 1, 2024 revealed residents have the right to be free from abuse, (2) develop and implement policies and protocols to prevent and identify (a.) abuse and mistreatment of residents; (8) identify and investigate all possible incidents of abuse of resident; (9) investigate and report any allegations within timeframes required by federal requirements.

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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** 49399 Based on clinical record reviews, staff and resident interviews, facility documentation and policy and procedures, the facility failed to follow their abuse policy for one resident. (#128) The deficient practice can result in further incidents of abuse. Findings include: -Resident #128 was admitted at the facility on December 4, 2023 with diagnoses that included dementia, chronic obstructive pulmonary disease, and depression. Review of the quarterly Minimum Data Set (MDS) assessment dated on June 11, 2024 revealed the resident had a BIMS score of 4.0, which indicated severe cognitive impairment. Review of care plan initially dated on February 26, 2024 and revised on August 1, 2024 revealed that resident #128 use antidepressant medication. The interventions included to monitor/document/report to provider as needed ongoing signs and symptoms of depression which included fear of being alone with others, attention seeking, concern with body functions, anxiety, and constant reassurance. -Resident #66 (alleged perpetrator) was admitted at the facility on March 28, 2024 with diagnoses that included unspecified dementia, type 2 diabetes mellitus, and depression. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 6, which indicated severe cognitive impairment. The MDS also included that the resident mood includes feeling down, depressed, or hopeless, rarely feel lonely or isolated, and has verbal behavioral symptoms directed towards others. For every day activities, no impairment on the upper and lower extremities, uses a walker and wheelchair. Review of care plan initially dated on April 10, 2024 and revised on July 8, 2024 revealed that resident #66 has a verbal behavior problem, inappropriate sexual behaviors towards staff and residents, and exhibits personal sexual needs in his room. The interventions included anticipate and meet resident's needs, encourage as much participation/interaction as possible during care activities, identify behavior triggers, and refer to psychiatric provider for consultation as ordered. A behavior progress note dated on July 7, 2024 revealed a resident identified as resident #128 yelling quit touching me get your hands off of me. A staff saw resident #66 reaching for resident #128 and resident #66 was looking like he was going to expose himself to resident #128. Furthermore, the progress note revealed that resident #66 is constantly going after our women here and scaring them. Furthermore, the progress note stated spends too much of my time keeping him from sexually harassing them by touching and groping their breasts against their wills. I just saw him going down the hall with his penis hanging out and then realized that he had it hanging out and touching his penis with one hand and trying to grope a Resident with his other hand. A health status note dated July 7, 2024 revealed the administrator was notified of resident #66's behavior. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A behavior progress note dated July 8, 2024 revealed resident #66 was immediately removed from resident #128's location and administrative staff aware of behaviors. A health status progress note dated July 9, 2024 revealed a room changed for resident #66. A psych follow-up progress note dated on July 10, 2024 revealed provider aware of resident #66 on change on condition monitoring for having a recent room change and resident #66 continuous to go into female rooms to try to touch them. A behavior progress note dated August 26, 2024 revealed resident #66 has been touching other females' residents on their private areas. The resident has been told multiple times to stop, but he would say I won't stop. The resident has been reported and the CNA's keeping a watch on him. Will continue to monitor. A behavior progress note dated August 28, 2024 revealed resident #66 grabbed another Resident's bottom and tried lifting her shirt. The female Resident swatted this Resident's hand away and said, No!. An interview was conducted on November 7, 2024 at 07:22 a.m. with licensed practical nurse (LPN/Staff #88). Staff #88 stated that she recalls resident #66 who is very angry, sexually heightened, no impulse control. Resident #66 would grab resident's breasts, they moved him to the locked unit about 6 months ago. He scared the female residents. Staff #88 stated that she can recall two female residents that resident #66 targeted specifically in the locked unit. Staff #88 do not wish to share their names. Staff #88 stated that she had witnessed resident #66 touched female residents inappropriately and they have separated the residents and kept resident #66 away from the female resident. Staff #88 stated that she had notified her unit manager, the director of nursing, and their executive director. An interview was conducted on November 7, 2024 at 07:43 a.m. with a certified nursing assistant (CNA/Staff #222). Staff #222 stated that she is familiar with the locked unit for residents with dementia. They observe residents and when residents argue they intervene by calming them down, separate them, and notify the nurse. As far as her training, she took acknowledgment test every month for dementia care and also, she went through abuse training. An interview was conducted on November 7, 2024 at 08:07 a.m. with a CNA (CNA/Staff #43). Staff #43 stated that his role includes scheduling CNAs and nurses. The CNAs schedule is based on their staff preference and skills and their shifts is 12-hour shift from 6 to 6. They also have a medication tech. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 7, 2024 at 08:16 a.m. with a certified medical assistant (CMA/staff #61). Staff #61 identified resident #66 to this surveyor. Staff #61 stated that with resident #66, the resident does not keep still, wheels self in the hallway and in the dining room in the locked unit. Staff #61 stated that they do their best for caring their residents with dementia and when their residents become combative and in the dining room, they try to remove them in the dining room and take them to their room to their calm place. They distract them by for instance offering water. Furthermore, Staff #61 stated that resident #66 wheels himself back and forth, crashing into people and stuff, resident will run his wheelchair into them not intentionally, resident is very inappropriate to other female resident and all healthcare staff. For instance, such as with another resident, resident #66 went up to her and touch her breast and it happened about 1 -2 months ago. Resident#66 still does that. Also, when resident #66 was in the long-term care side, resident #66 went up and touch other resident's breast and verbally said inappropriate things to them and asking sexual favors. The residents over at the long-term side will tell the staff members because they are with it to say something. Staff #61 added that there was one instance that happened in the summer. Staff #61 stated that with Resident #66 when he first came in the facility was going to people's room and wandering. Resident #66 touched other female butt while walking with her walker, it happened like about 1-2 months ago, He also say things to few ladies, like the famous one is you can touch me like anywhere you want, and bribing them by holding a napkin to bribe and to see their breast. Staff #61 stated that she has reported the incident to registered nurse (RN)Staff #55, LPN/Staff #88 and the director of nursing (DON), they are aware. Staff #61 stated that their schedule sometime include one CNA in the unit and it is hard to constantly watch resident #66 and their nurse is out there in the opposite of their unit, pass the double doors. An interview was conducted on November 7, 2024 at 10:50 a.m. with a RN/Staff #55. Staff #55 stated that resident #66 has implosive behavior touching other people and grabbing other people and the last time this behavior happened was in the summer. Staff #55 stated that the process for reporting incident is to let his supervisor and executive director know. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Safford	1933 Peppertree Drive Safford, AZ 85546

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 7, 2024 at 01:58 p.m. with the Director of Nursing, (DON/Staff #103). The DON stated that she oversees residents' care and staffing to make sure it staffed properly. They make sure they are providing care and following policies and regulation. Regarding abuse it can be physical, financial, misappropriation of funds and neglect, and include sexual abuse. The process for any suspected abuse is to report to their abuse officer immediately, report to state immediately, if resident to resident make sure resident is safe and then report immediately. The DON stated that regarding resident #66, resident was admitted for skilled for fracture was in skilled unit then went to long-term in April and moved to another unit, resident has dementia then resident was moved in the locked unit in July because of exit seeking, has occasional behavior issue and they try to redirect as much as possible. Resident behavior issues exhibited such as displayed sexual behaviors to staff, mostly to the CNAs by grabbing their butt and breast. The DON recalled an incident who they did self -report where he grabbed a resident's breast. DON stated she does not know any other incident about inappropriate behavior towards other residents. DON stated that music therapy helped resident #66 like playing country music in his room, and more activities. The DON stated that for staff reporting abuse, their training is upon hire and as needed. She added that any abnormal behavior of resident, any change should be reported to the DON. The surveyor informed the DON of resident #66's behavior in his July's progress notes. DON is looking in Point Click Care (PCC) for resident #66 progress notes. DON stated that she is not aware of the July event. DON stated that she definitely needs to look into regarding the July incident with resident #128 and she would get with the administrator to review any documentation on this. DON stated intervention regarding resident #66 included a referral in show low and he was not accepted, resident has been seen by telepsych since May 2024. DON stated that he was started on Paroxetine in August. An interview was conducted on November 8, 2024 at 8:07 a.m. with a CMA. (CMA/Staff #74). Staff #74 stated that in the locked unit, they have 15-16 residents, and for staffing they have one CNA and one CMA and their nurse is in the skilled unit, or they have two CNAs and a nurse in the skilled unit, and today there is one CMA and one CNA. Staff #74 stated that regarding resident care plan, they check each resident's Kardex, it can be found in PCC in point of care (POC). In regards to training and in-services, they have in-services every month and have educational videos. The in-services every month tell them how to distract resident to switch their attention to an activity or how to deal with their behaviors. They use distraction when they are upset to get their mind or attention on something else. Regarding resident #66, Staff #74 stated that resident #66 needs help with activities of daily living (ADLs), activities, and rolls around, sometimes he does not have good behavior, he is not physical but can be nasty with the women with staff and residents, nasty as in he will just say can I see your boobs provocatively, intervention use is he will usually move him or tell him not to say those things, he has not seen any inappropriate touching by resident #66. Staff #74 stated that his role is make sure everyone is safe first then remove the person from situation and grab his radio and call for help. He will call the DON and the administrator to report incident such as physical and emotional abuse. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 8, 2024 at 10:12 a.m. with a resident representative (rep/Staff #113). Staff #113 stated that her role is she advocate for resident, help with non-clinical grievances such as with insurance, medical equipment, discharge planning. As a discharge planner she figures out their prior living, if need assistance, if live alone, and then come up with a goal and during their stay to make sure goal is still feasible if not have an alternate plan, referrals for home health and transfer to different facilities if needed. Regarding resident #66, she help locate his family out of state, she has sent referrals out of state in September 2024, and waiting to hear from them, and she made referral to a facility in July. Resident #66 has behaviors and she sent referrals to another facility in May 2024 and was denied. The denial reason was resident did not meet requirement. For the other facility referral , no bed was available. She stated that the behaviors such as sexual behaviors are inappropriate comment mostly to staff and to one resident incident which was reported to the state and that was grabbing resident's chest. She stated that the behavior seems to get better since he was moved to the locked unit which seems to help. Staff #113 recalled an incident that Resident #66 made a comment in September towards a female resident, the comment was show me your panties and he was talked to regarding that comment that was not appropriate, staff #113 saw this incident documented in the progress note by the DON. An interview was conducted on November 8, 2024 at 10:39 a.m. with the Administrator (admin/Staff #106). Present during the interview was a clinical Resource (Admin/Staff #225) and the DON. The administrator stated that regarding their abuse process, to report to the administrator as their abuse prevention coordinator and if not available to the DON. He stated that there are signs posted up in the building regarding abuse reporting. The administrator stated that they investigate the concern and determine if reportable or not, and a reportable abuse is physical abuse, sexual abuse, and neglect. The administrator stated that regarding sexual abuse, it is improper touching, not consenting to someone else or even uncomfortable situation like sexual advances. The administrator was prompted to review the progress note of resident #66/resident #128 in July 7, 2024. The administrator reading the progress notes, and stated that he agrees it's an abuse, 100 percent to be reported, and it was not reported to state agency and he was not aware of this. A review of facility's policy titled, Resident rights/Dignity: abuse, Neglect, Exploitation and Misappropriation Prevention program, in effect January 1, 2024 revealed residents have the right to be free from abuse, (2) develop and implement policies and protocols to prevent and identify (a.) abuse and mistreatment of residents; (8) identify and investigate all possible incidents of abuse of resident; (9) investigate and report any allegations within timeframes required by federal requirements.

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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 - Few	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** 49399 Based on clinical record reviews, staff and resident interviews, facility documentation and policy and procedures, the facility failed to ensure an incident of abuse was reported to the state agency. This deficient practice can result in further incidents of abuse not being reported in accordance with professional standards. Findings include: -Resident #128 was admitted at the facility on December 4, 2023 with diagnoses that included dementia, chronic obstructive pulmonary disease, and depression. Review of the quarterly Minimum Data Set (MDS) assessment dated on June 11, 2024 revealed the resident had a BIMS score of 4.0, which indicated severe cognitive impairment. Review of care plan initially dated on February 26, 2024 and revised on August 1, 2024 revealed that resident #128 use antidepressant medication. The interventions included to monitor/document/report to provider as needed ongoing signs and symptoms of depression which included fear of being alone with others, attention seeking, concern with body functions, anxiety, and constant reassurance. -Resident #66 (alleged perpetrator) was admitted at the facility on March 28, 2024 with diagnoses that included unspecified dementia, type 2 diabetes mellitus, and depression. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 6, which indicated severe cognitive impairment. The MDS also included that the resident mood includes feeling down, depressed, or hopeless, rarely feel lonely or isolated, and has verbal behavioral symptoms directed towards others. For every day activities, no impairment on the upper and lower extremities, uses a walker and wheelchair. Review of care plan initially dated on April 10, 2024 and revised on July 8, 2024 revealed that resident #66 has a verbal behavior problem, inappropriate sexual behaviors towards staff and residents, and exhibits personal sexual needs in his room. The interventions included anticipate and meet resident's needs, encourage as much participation/interaction as possible during care activities, identify behavior triggers, and refer to psychiatric provider for consultation as ordered. A behavior progress note dated on July 7, 2024 revealed a resident identified as resident #128 yelling quit touching me get your hands off of me. A staff saw resident #66 reaching for resident #128 and resident #66 was looking like he was going to expose himself to resident #128. Furthermore, the progress note revealed that resident #66 is constantly going after our women here and scaring them. Furthermore, the progress note stated spends too much of my time keeping him from sexually harassing them by touching and groping their breasts against their wills. I just saw him going down the hall with his penis hanging out and then realized that he had it hanging out and touching his penis with one hand and trying to grope a Resident with his other hand. (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 - Few	A health status note dated July 7, 2024 revealed the administrator was notified of resident #66's behavior. A behavior progress note dated July 8, 2024 revealed resident #66 was immediately removed from resident #128's location and administrative staff aware of behaviors. A health status progress note dated July 9, 2024 revealed a room changed for resident #66. A psych follow-up progress note dated on July 10, 2024 revealed provider aware of resident #66 on change on condition monitoring for having a recent room change and resident #66 continuous to go into female rooms to try to touch them. A behavior progress note dated August 26, 2024 revealed resident #66 has been touching other females' residents on their private areas. The resident has been told multiple times to stop, but he would say I won't stop. The resident has been reported and the CNA's keeping a watch on him. Will continue to monitor. A behavior progress note dated August 28, 2024 revealed resident #66 grabbed another Resident's bottom and tried lifting her shirt. The female Resident swatted this Resident's hand away and said, No!. An interview was conducted on November 7, 2024 at 07:22 a.m. with licensed practical nurse (LPN/Staff #88). Staff #88 stated that she recalls resident #66 who is very angry, sexually heightened, no impulse control. Resident #66 would grab resident's breasts, they moved him to the locked unit about 6 months ago. He scared the female residents. Staff #88 stated that she can recall two female residents that resident #66 targeted specifically in the locked unit. Staff #88 do not wish to share their names. Staff #88 stated that she had witnessed resident #66 touched female residents inappropriately and they have separated the residents and kept resident #66 away from the female resident. Staff #88 stated that she had notified her unit manager, the director of nursing, and their executive director. An interview was conducted on November 7, 2024 at 07:43 a.m. with a certified nursing assistant (CNA/Staff #222). Staff #222 stated that she is familiar with the locked unit for residents with dementia. They observe residents and when residents argue they intervene by calming them down, separate them, and notify the nurse. As far as her training, she took acknowledgment test every month for dementia care and also, she went through abuse training. An interview was conducted on November 7, 2024 at 08:07 a.m. with a CNA (CNA/Staff #43). Staff #43 stated that his role includes scheduling CNAs and nurses. The CNAs schedule is based on their staff preference and skills and their shifts is 12-hour shift from 6 to 6. They also have a medication tech. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 7, 2024 at 08:16 a.m. with a certified medical assistant (CMA/staff #61). Staff #61 identified resident #66 to this surveyor. Staff #61 stated that with resident #66, the resident does not keep still, wheels self in the hallway and in the dining room in the locked unit. Staff #61 stated that they do their best for caring their residents with dementia and when their residents become combative and in the dining room, they try to remove them in the dining room and take them to their room to their calm place. They distract them by for instance offering water. Furthermore, Staff #61 stated that resident #66 wheels himself back and forth, crashing into people and stuff, resident will run his wheelchair into them not intentionally, resident is very inappropriate to other female resident and all healthcare staff. For instance, such as with another resident, resident #66 went up to her and touch her breast and it happened about 1 -2 months ago. Resident#66 still does that. Also, when resident #66 was in the long-term care side, resident #66 went up and touch other resident's breast and verbally said inappropriate things to them and asking sexual favors. The residents over at the long-term side will tell the staff members because they are with it to say something. Staff #61 added that there was one instance that happened in the summer. Staff #61 stated that with Resident #66 when he first came in the facility was going to people's room and wandering. Resident #66 touched other female butt while walking with her walker, it happened like about 1-2 months ago, He also say things to few ladies, like the famous one is you can touch me like anywhere you want, and bribing them by holding a napkin to bribe and to see their breast. Staff #61 stated that she has reported the incident to registered nurse (RN)Staff #55, LPN/Staff #88 and the director of nursing (DON), they are aware. Staff #61 stated that their schedule sometime include one CNA in the unit and it is hard to constantly watch resident #66 and their nurse is out there in the opposite of their unit, pass the double doors. An interview was conducted on November 7, 2024 at 10:50 a.m. with a RN/Staff #55. Staff #55 stated that resident #66 has implosive behavior touching other people and grabbing other people and the last time this behavior happened was in the summer. Staff #55 stated that the process for reporting incident is to let his supervisor and executive director know. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 7, 2024 at 01:58 p.m. with the Director of Nursing, (DON/Staff #103). The DON stated that she oversees residents' care and staffing to make sure it staffed properly. They make sure they are providing care and following policies and regulation. Regarding abuse it can be physical, financial, misappropriation of funds and neglect, and include sexual abuse. The process for any suspected abuse is to report to their abuse officer immediately, report to state immediately, if resident to resident make sure resident is safe and then report immediately. The DON stated that regarding resident #66, resident was admitted for skilled for fracture was in skilled unit then went to long-term in April and moved to another unit, resident has dementia then resident was moved in the locked unit in July because of exit seeking, has occasional behavior issue and they try to redirect as much as possible. Resident behavior issues exhibited such as displayed sexual behaviors to staff, mostly to the CNAs by grabbing their butt and breast. The DON recalled an incident who they did self -report where he grabbed a resident's breast. DON stated she does not know any other incident about inappropriate behavior towards other residents. DON stated that music therapy helped resident #66 like playing country music in his room, and more activities. The DON stated that for staff reporting abuse, their training is upon hire and as needed. She added that any abnormal behavior of resident, any change should be reported to the DON. The surveyor informed the DON of resident #66's behavior in his July's progress notes. DON is looking in Point Click Care (PCC) for resident #66 progress notes. DON stated that she is not aware of the July event. DON stated that she definitely needs to look into regarding the July incident with resident #128 and she would get with the administrator to review any documentation on this. DON stated intervention regarding resident #66 included a referral in show low and he was not accepted, resident has been seen by telepsych since May 2024. DON stated that he was started on Paroxetine in August. An interview was conducted on November 8, 2024 at 8:07 a.m. with a CMA. (CMA/Staff #74). Staff #74 stated that in the locked unit, they have 15-16 residents, and for staffing they have one CNA and one CMA and their nurse is in the skilled unit, or they have two CNAs and a nurse in the skilled unit, and today there is one CMA and one CNA. Staff #74 stated that regarding resident care plan, they check each resident's Kardex, it can be found in PCC in point of care (POC). In regards to training and in-services, they have in-services every month and have educational videos. The in-services every month tell them how to distract resident to switch their attention to an activity or how to deal with their behaviors. They use distraction when they are upset to get their mind or attention on something else. Regarding resident #66, Staff #74 stated that resident #66 needs help with activities of daily living (ADLs), activities, and rolls around, sometimes he does not have good behavior, he is not physical but can be nasty with the women with staff and residents, nasty as in he will just say can I see your boobs provocatively, intervention use is he will usually move him or tell him not to say those things, he has not seen any inappropriate touching by resident #66. Staff #74 stated that his role is make sure everyone is safe first then remove the person from situation and grab his radio and call for help. He will call the DON and the administrator to report incident such as physical and emotional abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 8, 2024 at 10:12 a.m. with a resident representative (rep/Staff #113). Staff #113 stated that her role is she advocate for resident, help with non-clinical grievances such as with insurance, medical equipment, discharge planning. As a discharge planner she figures out their prior living, if need assistance, if live alone, and then come up with a goal and during their stay to make sure goal is still feasible if not have an alternate plan, referrals for home health and transfer to different facilities if needed. Regarding resident #66, she help locate his family out of state, she has sent referrals out of state in September 2024, and waiting to hear from them, and she made referral to a facility in July. Resident #66 has behaviors and she sent referrals to another facility in May 2024 and was denied. The denial reason was resident did not meet requirement. For the other facility referral , no bed was available. She stated that the behaviors such as sexual behaviors are inappropriate comment mostly to staff and to one resident incident which was reported to the state and that was grabbing resident's chest. She stated that the behavior seems to get better since he was moved to the locked unit which seems to help. Staff #113 recalled an incident that Resident #66 made a comment in September towards a female resident, the comment was show me your panties and he was talked to regarding that comment that was not appropriate, staff #113 saw this incident documented in the progress note by the DON. An interview was conducted on November 8, 2024 at 10:39 a.m. with the Administrator (admin/Staff #106). Present during the interview was a clinical Resource (Admin/Staff #225) and the DON. The administrator stated that regarding their abuse process, to report to the administrator as their abuse prevention coordinator and if not available to the DON. He stated that there are signs posted up in the building regarding abuse reporting. The administrator stated that they investigate the concern and determine if reportable or not, and a reportable abuse is physical abuse, sexual abuse, and neglect. The administrator stated that regarding sexual abuse, it is improper touching, not consenting to someone else or even uncomfortable situation like sexual advances. The administrator was prompted to review the progress note of resident #66/resident #128 in July 7, 2024. The administrator reading the progress notes, and stated that he agrees it's an abuse, 100 percent to be reported, and it was not reported to state agency and he was not aware of this. A review of facility's policy titled, Resident rights/Dignity: abuse, Neglect, Exploitation and Misappropriation Prevention program, in effect January 1, 2024 revealed residents have the right to be free from abuse, (2) develop and implement policies and protocols to prevent and identify (a.) abuse and mistreatment of residents; (8) identify and investigate all possible incidents of abuse of resident; (9) investigate and report any allegations within timeframes required by federal requirements.

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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 - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49399 Based on clinical record reviews, staff and resident interviews, facility documentation and policy and procedures, the facility failed to investigate an allegation of abuse. This deficient practice could result in further incidents of resident abuse. Findings include: -Resident #128 was admitted at the facility on December 4, 2023 with diagnoses that included dementia, chronic obstructive pulmonary disease, and depression. Review of the quarterly Minimum Data Set (MDS) assessment dated on June 11, 2024 revealed the resident had a BIMS score of 4.0, which indicated severe cognitive impairment. Review of care plan initially dated on February 26, 2024 and revised on August 1, 2024 revealed that resident #128 use antidepressant medication. The interventions included to monitor/document/report to provider as needed ongoing signs and symptoms of depression which included fear of being alone with others, attention seeking, concern with body functions, anxiety, and constant reassurance. -Resident #66 (alleged perpetrator) was admitted at the facility on March 28, 2024 with diagnoses that included unspecified dementia, type 2 diabetes mellitus, and depression. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 6, which indicated severe cognitive impairment. The MDS also included that the resident mood includes feeling down, depressed, or hopeless, rarely feel lonely or isolated, and has verbal behavioral symptoms directed towards others. For every day activities, no impairment on the upper and lower extremities, uses a walker and wheelchair. Review of care plan initially dated on April 10, 2024 and revised on July 8, 2024 revealed that resident #66 has a verbal behavior problem, inappropriate sexual behaviors towards staff and residents, and exhibits personal sexual needs in his room. The interventions included anticipate and meet resident's needs, encourage as much participation/interaction as possible during care activities, identify behavior triggers, and refer to psychiatric provider for consultation as ordered. A behavior progress note dated on July 7, 2024 revealed a resident identified as resident #128 yelling quit touching me get your hands off of me. A staff saw resident #66 reaching for resident #128 and resident #66 was looking like he was going to expose himself to resident #128. Furthermore, the progress note revealed that resident #66 is constantly going after our women here and scaring them. Furthermore, the progress note stated spends too much of my time keeping him from sexually harassing them by touching and groping their breasts against their wills. I just saw him going down the hall with his penis hanging out and then realized that he had it hanging out and touching his penis with one hand and trying to grope a Resident with his other hand. A health status note dated July 7, 2024 revealed the administrator was notified of resident #66's behavior. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A behavior progress note dated July 8, 2024 revealed resident #66 was immediately removed from resident #128's location and administrative staff aware of behaviors. A health status progress note dated July 9, 2024 revealed a room changed for resident #66. A psych follow-up progress note dated on July 10, 2024 revealed provider aware of resident #66 on change on condition monitoring for having a recent room change and resident #66 continuous to go into female rooms to try to touch them. A behavior progress note dated August 26, 2024 revealed resident #66 has been touching other females' residents on their private areas. The resident has been told multiple times to stop, but he would say I won't stop. The resident has been reported and the CNA's keeping a watch on him. Will continue to monitor. A behavior progress note dated August 28, 2024 revealed resident #66 grabbed another Resident's bottom and tried lifting her shirt. The female Resident swatted this Resident's hand away and said, No!. An interview was conducted on November 7, 2024 at 07:22 a.m. with licensed practical nurse (LPN/Staff #88). Staff #88 stated that she recalls resident #66 who is very angry, sexually heightened, no impulse control. Resident #66 would grab resident's breasts, they moved him to the locked unit about 6 months ago. He scared the female residents. Staff #88 stated that she can recall two female residents that resident #66 targeted specifically in the locked unit. Staff #88 do not wish to share their names. Staff #88 stated that she had witnessed resident #66 touched female residents inappropriately and they have separated the residents and kept resident #66 away from the female resident. Staff #88 stated that she had notified her unit manager, the director of nursing, and their executive director. An interview was conducted on November 7, 2024 at 07:43 a.m. with a certified nursing assistant (CNA/Staff #222). Staff #222 stated that she is familiar with the locked unit for residents with dementia. They observe residents and when residents argue they intervene by calming them down, separate them, and notify the nurse. As far as her training, she took acknowledgment test every month for dementia care and also, she went through abuse training. An interview was conducted on November 7, 2024 at 08:07 a.m. with a CNA (CNA/Staff #43). Staff #43 stated that his role includes scheduling CNAs and nurses. The CNAs schedule is based on their staff preference and skills and their shifts is 12-hour shift from 6 to 6. They also have a medication tech. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 7, 2024 at 08:16 a.m. with a certified medical assistant (CMA/staff #61). Staff #61 identified resident #66 to this surveyor. Staff #61 stated that with resident #66, the resident does not keep still, wheels self in the hallway and in the dining room in the locked unit. Staff #61 stated that they do their best for caring their residents with dementia and when their residents become combative and in the dining room, they try to remove them in the dining room and take them to their room to their calm place. They distract them by for instance offering water. Furthermore, Staff #61 stated that resident #66 wheels himself back and forth, crashing into people and stuff, resident will run his wheelchair into them not intentionally, resident is very inappropriate to other female resident and all healthcare staff. For instance, such as with another resident, resident #66 went up to her and touch her breast and it happened about 1 -2 months ago. Resident#66 still does that. Also, when resident #66 was in the long-term care side, resident #66 went up and touch other resident's breast and verbally said inappropriate things to them and asking sexual favors. The residents over at the long-term side will tell the staff members because they are with it to say something. Staff #61 added that there was one instance that happened in the summer. Staff #61 stated that with Resident #66 when he first came in the facility was going to people's room and wandering. Resident #66 touched other female butt while walking with her walker, it happened like about 1-2 months ago, He also say things to few ladies, like the famous one is you can touch me like anywhere you want, and bribing them by holding a napkin to bribe and to see their breast. Staff #61 stated that she has reported the incident to registered nurse (RN)Staff #55, LPN/Staff #88 and the director of nursing (DON), they are aware. Staff #61 stated that their schedule sometime include one CNA in the unit and it is hard to constantly watch resident #66 and their nurse is out there in the opposite of their unit, pass the double doors. An interview was conducted on November 7, 2024 at 10:50 a.m. with a RN/Staff #55. Staff #55 stated that resident #66 has implosive behavior touching other people and grabbing other people and the last time this behavior happened was in the summer. Staff #55 stated that the process for reporting incident is to let his supervisor and executive director know. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 7, 2024 at 01:58 p.m. with the Director of Nursing, (DON/Staff #103). The DON stated that she oversees residents' care and staffing to make sure it staffed properly. They make sure they are providing care and following policies and regulation. Regarding abuse it can be physical, financial, misappropriation of funds and neglect, and include sexual abuse. The process for any suspected abuse is to report to their abuse officer immediately, report to state immediately, if resident to resident make sure resident is safe and then report immediately. The DON stated that regarding resident #66, resident was admitted for skilled for fracture was in skilled unit then went to long-term in April and moved to another unit, resident has dementia then resident was moved in the locked unit in July because of exit seeking, has occasional behavior issue and they try to redirect as much as possible. Resident behavior issues exhibited such as displayed sexual behaviors to staff, mostly to the CNAs by grabbing their butt and breast. The DON recalled an incident who they did self -report where he grabbed a resident's breast. DON stated she does not know any other incident about inappropriate behavior towards other residents. DON stated that music therapy helped resident #66 like playing country music in his room, and more activities. The DON stated that for staff reporting abuse, their training is upon hire and as needed. She added that any abnormal behavior of resident, any change should be reported to the DON. The surveyor informed the DON of resident #66's behavior in his July's progress notes. DON is looking in Point Click Care (PCC) for resident #66 progress notes. DON stated that she is not aware of the July event. DON stated that she definitely needs to look into regarding the July incident with resident #128 and she would get with the administrator to review any documentation on this. DON stated intervention regarding resident #66 included a referral in show low and he was not accepted, resident has been seen by telepsych since May 2024. DON stated that he was started on Paroxetine in August. An interview was conducted on November 8, 2024 at 8:07 a.m. with a CMA. (CMA/Staff #74). Staff #74 stated that in the locked unit, they have 15-16 residents, and for staffing they have one CNA and one CMA and their nurse is in the skilled unit, or they have two CNAs and a nurse in the skilled unit, and today there is one CMA and one CNA. Staff #74 stated that regarding resident care plan, they check each resident's Kardex, it can be found in PCC in point of care (POC). In regards to training and in-services, they have in-services every month and have educational videos. The in-services every month tell them how to distract resident to switch their attention to an activity or how to deal with their behaviors. They use distraction when they are upset to get their mind or attention on something else. Regarding resident #66, Staff #74 stated that resident #66 needs help with activities of daily living (ADLs), activities, and rolls around, sometimes he does not have good behavior, he is not physical but can be nasty with the women with staff and residents, nasty as in he will just say can I see your boobs provocatively, intervention use is he will usually move him or tell him not to say those things, he has not seen any inappropriate touching by resident #66. Staff #74 stated that his role is make sure everyone is safe first then remove the person from situation and grab his radio and call for help. He will call the DON and the administrator to report incident such as physical and emotional abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on November 8, 2024 at 10:12 a.m. with a resident representative (rep/Staff #113). Staff #113 stated that her role is she advocate for resident, help with non-clinical grievances such as with insurance, medical equipment, discharge planning. As a discharge planner she figures out their prior living, if need assistance, if live alone, and then come up with a goal and during their stay to make sure goal is still feasible if not have an alternate plan, referrals for home health and transfer to different facilities if needed. Regarding resident #66, she help locate his family out of state, she has sent referrals out of state in September 2024, and waiting to hear from them, and she made referral to a facility in July. Resident #66 has behaviors and she sent referrals to another facility in May 2024 and was denied. The denial reason was resident did not meet requirement. For the other facility referral , no bed was available. She stated that the behaviors such as sexual behaviors are inappropriate comment mostly to staff and to one resident incident which was reported to the state and that was grabbing resident's chest. She stated that the behavior seems to get better since he was moved to the locked unit which seems to help. Staff #113 recalled an incident that Resident #66 made a comment in September towards a female resident, the comment was show me your panties and he was talked to regarding that comment that was not appropriate, staff #113 saw this incident documented in the progress note by the DON. An interview was conducted on November 8, 2024 at 10:39 a.m. with the Administrator (admin/Staff #106). Present during the interview was a clinical Resource (Admin/Staff #225) and the DON. The administrator stated that regarding their abuse process, to report to the administrator as their abuse prevention coordinator and if not available to the DON. He stated that there are signs posted up in the building regarding abuse reporting. The administrator stated that they investigate the concern and determine if reportable or not, and a reportable abuse is physical abuse, sexual abuse, and neglect. The administrator stated that regarding sexual abuse, it is improper touching, not consenting to someone else or even uncomfortable situation like sexual advances. The administrator was prompted to review the progress note of resident #66/resident #128 in July 7, 2024. The administrator reading the progress notes, and stated that he agrees it's an abuse, 100 percent to be reported, and it was not reported to state agency and he was not aware of this. A review of facility's policy titled, Resident rights/Dignity: abuse, Neglect, Exploitation and Misappropriation Prevention program, in effect January 1, 2024 revealed residents have the right to be free from abuse, (2) develop and implement policies and protocols to prevent and identify (a.) abuse and mistreatment of residents; (8) identify and investigate all possible incidents of abuse of resident; (9) investigate and report any allegations within timeframes required by federal requirements.

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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** 51006 Based on clinical record review, staff interviews, and facility policy, the facility failed to ensure that necessary pain medications were given according to provider instruction for one resident (resident's #18) This deficient practice could result in ineffective medication management resulting in negative outcomes. findings include: -Resident #18 was admitted on [DATE], with diagnoses that included surgical aftercare, surgery on the circulatory system, end stage renal disease, and sepsis. A physician's order dated October 3, 2024, revealed an order for Tramadol 50mg (milligrams) by mouth every 12 hours as needed for a pain scale of 6-10. An admission Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had a BIMS (Brief Interview for Mental Status) score of 15, which indicated the resident had no cognitive impairment. A care plan intervention with the initiated date of October 16, 2024, revealed that Resident #18 is at risk for pain and utilizes opioid medications per physician orders. Review of the Medication Administration Record (MAR) dated November 2024, revealed on November 3, 2024, Resident #18 was administered one tablet of Tramadol 50mg for a pain level of '4' at 3:50 a.m, and for a pain level of '4' at 7:06 p.m. An interview was conducted September 13, 2024 at 10:30 a.m. with a Registered Nurse (RN/Staff #55) to review Resident #18's physician orders and MAR. Staff #55 stated that the order of the Tramadol 50mg was given out of parameters on November 3, at 3:50 a.m. and 7:06 p.m. Staff #55 also stated that administering medications out of order parameters is not in professional standards as Resident #55 could have been offered an alternative medication or non-medicated intervention for the pain level of 4, rather than the Tramadol 50mg. An interview was conducted on November 6, 2024 at 2:43 p.m. with Director of Nursing (DON/Staff #48), where Staff #48 stated that the facility's expectation is medications are to be administered per physician orders, and that providing medication that is not within order parameters is not professional standards and does not properly treat the resident. The policy Administering Medications revealed that the administration of medications must be administered in accordance with the resident's order. 51103 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review, interviews, and review of facility policies and procedures, the facility failed to ensure necessary blood pressure medications were administered according to provider instruction for one resident. (#14) This deficient practice could result in side effects leading to negative resident outcomes. Findings Include: -Resident #14 was admitted to the facility on [DATE], with diagnoses that include hypotension, edema, bipolar disorder, and rheumatoid arthritis. The admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated resident was cognitively intact. A physician order dated August 7, 2024 revealed Midodrine 5mg (milligrams) to be given three times a day for hypotension (low blood pressure) unless the systolic blood pressure is greater than 130. Review of the Medication Administration Record (MAR) for October 2024 through November 2024 revealed multiple dates ([DATE], 5, 19, 25, 26, 28, [DATE], and 7) where Midodrine was administered with a systolic blood pressure greater than 130. An interview was conducted with a Pharmacist (Staff #125) on November 7, 2024 at 1:50 p.m. The pharmacist stated that the physician's orders should be followed unless otherwise ordered. Staff #125 further elaborated that sometimes there may be reasons why medications may be given out of parameters but it would still need to be justified and cleared with the physician. An interview was conducted with a Unit Manager (admin/Staff #26) and the Director of Nursing (DON/Staff #103) November 7, 2024 at 3:00 p.m. They both accessed the clinical record with this surveyor and reviewed the clinical documentation for Resident #14's Midodrine administrations. Both were able to identify episodes when midodrine was given outside of parameters and stated that the medication should have only been given within parameters, unless cleared by the provider. Both also agreed that this medication can cause the blood pressure to continue to rise which can also be problematic if it becomes too high. An interview with Licensed Practical Nurse (LPN/Staff #79) was conducted on November 8, 2024 at 10:57 a.m. The LPN stated that she will always check the blood pressure before giving the medication because it is part of the facility standards to follow physician orders. She further stated if she was to get the same blood pressure result three different times throughout the day she would reassess the resident and do interventions such as changing arms or changing the blood pressure cuff. She also stated the importance of giving midodrine within parameters because otherwise the resident can suffer consequences of hypertension. A policy titled Resident Examination and Assessment advises that the physician should be notified of any abnormal vital signs, and that vital signs for each resident should be obtained in accordance with the standard of care required, and based on the individual resident's condition. A policy titled Medication Administration advises that if the dosage is believed to be inappropriate or excessive, the administering person will contact the prescriber or the facility medical director to discuss the concerns.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51103 Based on observations, clinical record reviews, interviews, and facility documents and policy, the facility failed to ensure one resident (#54), had call light accessibility. The deficient practice could result in residents not having the means to communicate with staff leading to negative outcomes. Findings include: -Resident #54 was admitted to the facility on [DATE], with diagnoses that included left sided paralysis, stroke, Type-2 Diabetes, repeated falls, and depression. The quarterly Minimum Data Set (MDS) dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS also revealed that the resident experienced social isolation on rare occasion and is prescribed an antidepressant for mood support. A falls care plan initiated November 25, 2022 revealed resident #54 was at risk for falls related to deconditioning, with a noted intervention to assure the bed is against the wall, and the call light is within reach to ensure prompt response to all requests for assistance as needed. On November 6, 2024 at 12:10 p.m. the resident was observed in room sitting alone by bedside in a wheelchair. Upon closer inspection of resident, eyes appeared wet with tears, and resident was visibly shaking. The call light plug was securely inserted into the call light face plate. The call light cord extended straight down the wall, and was sandwiched between the mattress and the wall. The hand control for the call light system was not visible. On November 7, 2024 at 11:38 a.m. this surveyor returned to the resident's room and observed the call light system cord similar to the day prior, which extended down and was sandwiched between the wall and mattress. The call light hand control was not visible. This surveyor left the room with the resident who stated they were on the way to socialize in the hallway. This surveyor returned with a Unit Manager (admin/Staff #26) at 11:42 a.m. This surveyor observed staff #26 go to the head of the bed and follow the call light cord. staff #26 was able to use the cord and pull the call light from between the side of the wall and mattress. The Unit Manager then proceeded to affix the call light to the resident bedside to ensure control was reachable upon the resident return to room. An interview conducted on November 5, 2024 at 3:40 p.m. during initial pool screening with Resident #54. Resident #54 stated she does not have a call light, and needs one because she has already fallen out of bed three times already. She stated she wants the staff to keep her door open so when she falls, she can scream for help when in trouble. An interview conducted on November 7, 2024 at 11:38 a.m., with Resident #54 revealed she still never got a call light button. When surveyor pointed to the call light face plate and cord on the wall, the resident stated I can't get way over there to get that!. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview was conducted with a unit manager (admin/staff #26) at approximately 11:42 a.m on November 7, 2024. Staff #26 stated that all residents are supposed to have easy access to their call lights. She further clarified that the position of Resident #54's call light was not easily accessible, especially with the resident's functional limitations. Staff #26 stated they will remind staff the importance of making sure call lights are easily accessible to all residents. An interview was conducted on November 7, 2024 at 3:00 p.m. with the unit manager (admin/staff #26) and the Director of nursing (DON/staff #103). During the interview the unit manager and the DON stated that it was important that call lights were within reach of the residents for routine and urgent matters. The policy titled Falls and Fall Risk, Managing, indicated the use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner.