STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035196	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandridge Post Acute	255 West Brown Road Mesa, AZ 85201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and review of facility policies, the facility failed to ensure six of six sampled residents (#2, #3, #4, #5, #6 and #8) were free from sexual or physical abuse from one resident #1. The deficient practice could lead to sexual, physical and psychosocial harm to the residents. Findings include: -Regarding residents #1 and #2: -Resident #1 was admitted to the facility December 21, 2021 with dysphagia following cerebral infarction, unspecified dementia, mild, with agitation, schizophrenia, unspecified. A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 completed a Brief Interview for Mental Status (BIMS) score of 08 indicating moderate cognitive impairment. Further review of the MDS revealed no indicators for mood, but will self-isolate. Indicators for physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards others, other behavioral symptoms not directed towards others and wandering. These assessments occurred 1-3 days of the lookback period. Review of the care plan, date-initiated December 22, 2024 revealed a focus for elopement; resident at risk for elopement/exit seeking; wandering related to dementia and other cognitive behaviors. Further review of the care plan revealed focus for behavior problems, agitation related to depression and schizophrenia, likes to follow female residents around to help them with things, per family and the potential to be physically aggressive related to dementia, poor impulse control; citing incident on April 13, 2025 with another resident due to resident not getting out of his desired chair; verbal aggression. Interventions include administer medications as ordered, intervene as necessary to protect the rights and safety of others. Review of the physicians orders dated April 15, 2025 revealed monitoring episodes of restlessness, agitation every shift and record every shift, Depakote Oral Tablet Delayed Release 125 MG (Divalproex Sodium) Give 125 mg by mouth two times a day for Mood/AEB Impulsivity, Mirtazapine Tablet 15 MG Give 1 tablet by mouth in the evening for Depression as exhibited by poor by mouth intake; Quetiapine Fumarate Oral Tablet 50 MG (Quetiapine Fumarate) Give 1 tablet by mouth in the morning for as exhibited by mood. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medication Administration Record for April 15, 2025 revealed a change in the number of times dosage administered for antipsychotic due to elevated behaviors. Review of a Nurse Practitioners Note dated April 14, 2025 at 8:16 p.m. revealed -Patient seen sitting up in activities room eating breakfast without difficulty nurse reports patient with aggressive behavior towards females and other residents. POC discussed with nursing. PMH NP was also alerted to patient behavioral issues at this time. Patient denies any chest pain shortness of breath and has pleasant affect at time of assessment. NAD. Review of the nurse's progress notes dated April 14, 2025 at 3:25 p.m. revealed a note text: During a verbal disagreement between two resident #1 approached and began yelling at the male resident. He then began threatening the male resident and staff had to step between to calm the situation. Resident was escorted back to his room, while also threatening nurses and using vulgar language. A progress note dated April 14, 2025 at 1:31 p.m. revealed a nurse's note text: This writer spoke with CNA who witnessed the alleged res to res. CNA clarified that when she was passing out trays, she heard two residents talking loudly to each other, she turned around to see resident #1 contact resident #8 trying to get him to move chairs. At that time two CNA's stepped in to separate the two residents. A progress note dated April 13, 2025 at 4:46 p.m. revealed a nurse's note text; Nurse summoned to dining room per certified nursing assistant (CNA) reported per CNA resident #1 punched resident #8 because he would not get out of his desired chair. CNA reported hearing a sound when physical contact was made. This nurse attempted to escort resident #1 to his room. Resident #1 is resistive to redirection and had to be redirected X 4 before returning to his bedroom. Resident #8 assessed by other nurse on duty. Representative notified. Manager on duty notified. Nurse Practitioner notified. New order for Hydroxyzine 25mg by mouth every 6 hours as needed for Anxiety X 14days.Representative contacted regarding new order, she declined to initiate Hydroxyzine. Nurse Practitioner notified. A behavior progress note dated April 12, 2025 at 5:37 p.m. states reported per CNA resident #1 required redirection multiple times throughout the day. Resident #1 noted rubbing resident #4 leg. When redirected resident #1 stated, That's my girl. becoming visibly upset when asked to leave the area near resident #4. Frequent visual checks continue to maintain distance of resident #1 and resident #4. Nurse Practitioner notified. A behavior progress note dated April 5, 2025 at 4:31 p.m. revealed resident #1 had an eventful day exhibiting increased sexual tendencies towards female peers. resident #1 noted touching resident #6 legs several times while in the dining room. When redirected resident #1 becomes visibly angered and posturing. Resident #1 stated, I'm gonna do it again. resident #1 had to be redirected from propelling resident #4 female peer per wheelchair from dining room. resident #1 walked away but later returned visibly upset. Attempts to redirect, distract and calm resident #1 were unsuccessful. Resident #5 female peer was found lying in resident #1 room with resident #1 at bedside. When attempting to remove resident #5, resident #1 stated. It's ok, leave her alone, she's with me. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A behavior progress note dated March 28, 2025 at 5:25 p.m. revealed resident #1 has been talking to a female resident and trying to get her to walk with him to his room all afternoon. He was walking the female resident in the direction of his room about 30 minutes ago when this nurse intercepted and started walking the resident back towards the activities room, and he swung a punch at this nurse. Resident is also entering the rooms of female residents continuously, and when staff ask him to leave the room, he does but then goes and enters another female resident's room very shortly thereafter. Will continue to monitor. A behavior progress note dated March 22, 2025 at 2:27 p.m. revealed Reported per CNA resident #1 noted slapping the buttocks of resident #3 The sister of resident #3 was present at the time. Nurse Practitioner notified of incident. New order for Depakote 125mg by mouth twice daily for Mood/AEB. A behavior progress note dated March 21, 2025 at 2:28 p.m. revealed resident #1 increased sexual tendencies towards his female peers. Resident #1 noted leading resident #2. to his bedroom. This nurse attempted to redirect and intervene the situation, this only further angers the resident #1 This nurse leading resident #2 by hand to the common area but resident #1 became visibly upset stating, She's coming with me. Resident #1 grabbed her hand tighter and continued to walk towards his bedroom. This nurse acting as a barrier standing between residents #1 and #2. Resident #1 dropped her hand and walked away to his bedroom. Resident #1 family came to visit shortly after and is aware of the incident. Will notify Primary Care Physician. Resident observation on April 18, 2025 at 8:18 a.m. resident #1 provided with 1:1 intervention for 12 hours by Certified Nursing Assistant (CNA/Staff #18). Stated she was informed April 17, 2025 that she would be providing 1:1 care for resident #1 and to monitor his behaviors due to aggression and sexualized behaviors, she stated this was the first time resident #1 has been provided with 1:1 care. Residents #2 and resident 6 were observed seated in recliners in the dining room. There were two CNA's present. -Regarding Resident #2 -Resident #2 was admitted to the facility February 8, 2025 with diagnosis that included metabolic encephalopathy, cognitive communication deficit and altered mental status, unspecified. A review of the Part A Discharge MDS dated [DATE] revealed Resident #2 completed a Brief Interview for Mental Status (BIMS) score of 02 indicating severe cognitive impairment. Review of the care plan date-initiated February 9 2025 and a revision on April 4, 2025 revealed a focus for psychosocial behaviors; exhibits or is at risk for behavioral symptoms delusions, hallucinations, anxiety, SI without a plan, agitation, disrobing, wandering into others rooms. Interventions included Administer medication as ordered, document and record behavioral episodes and manage environmental factors to optimize comfort. Review of the progress notes revealed a behavior note dated April 4, 2025 at 1:27 p.m. Note Text: Resident was found in another resident's room. Resident was easily directed out of room. Skin check was performed. No abnormal findings. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on April 17, 2025 at 12:46 p.m. with Licensed Practical Nurse (LPN/Staff #93). Stated resident #1 has sexual tendencies mostly touching and kissing, rubbing of female residents' legs and those who are ambulatory. Stated resident #1 is fixated on two of them, resident's #4 and #2. Stated resident #1 has be separated from her before and tried to take resident #2 to his room. Staff #93 stated resident #1 had taken a female resident to his room approximately six weeks ago. The resident was resident #4. Staff #93 stated resident #4 was in his room in her wheelchair and resident #1 was standing up pacing the room. Staff #93 stated resident #1 has kissed resident 2 and #4, he's touched them by rubbing their legs, and he grabbed both of resident #3 buttocks, Staff #93 stated resident #1 paces the unit and staff keep a visual with 15-minute checks on resident #1. Staff #93 stated resident #1 has not been provided with 1:1 intervention and that he is unpredictable with physical aggression and posturing. An interview was conducted on April 17, 2025 at 1:22 p.m. with Certified Nursing Assistant (CAN/Staff #59. She stated she was informed that LPN/Staff #93 resident went to go get resident #1 for dinner when she saw resident #2 laying in the bed, she stated resident #1- he was sitting in a chair in his room. she stated resident #2 paces and wanders and had not seen her for about 30 minutes. Staff #59 stated we have to watch out for resident #1 he touches the females. An interview was conducted on April 17, 2025 at 1:28p.m. with certified nursing assistant (CNA/Staff #51) CAN #51 stated she first became aware of the incident when the nurse (LPN/Staff #93) called out for help to resident #1 room. She stated both (LPN/Staff #29) went to the room to find resident #2 lying on top of resident #1 bed naked with no clothing on. Staff #51 stated resident #1 was seated at the bedside with his shirt off and had put on a coat jacket, further stating his pants were on, but could not recall if his shoes were on. Staff#51 stated staff #29 assisted with getting resident #2 dressed. Staff #51 stated she documented the incident in Point Click Care and assumed LPN# 93 and #29 had reported the incident to the Director of Nursing. Staff #93 stated the doctor; family and the DON are aware of resident #1 sexualized behaviors with the other residents. An interview was conducted on April 17, 2025 at 2:18p.m. with housekeeper (staff #80). Staff #80 stated she has observed resident #1 with two female residents on two different occasions. Staff #80 stated On Saturday April 5, 2025, sometime in the morning while cleaning resident rooms she observed resident #1 had resident #2 laying on his bed covered with a blanket. Staff #80 stated resident #1 had his hands underneath the blanket and was rubbing her body. Staff #80 stated it looked like he was rubbing her up and down from her upper thighs to her chest area and touching her legs. Staff #80 stated she immediately informed the CNA that works on the weekends (did not know her name) and also informed her supervisor, Director of Housekeeping (Staff # 42). Staff #80 stated she was hesitant as to what to do with what she had observed, but stated I knew it was the right thing to do. An interview was conducted on April 17, 2025 at 3:37 p.m. with Operations Manager/ Abuse Coordinator (Staff #62). Staff #62 stated he did not file a report with the state agency because he had not been informed that resident #2 was disrobed and was told that resident #1 was sitting on the other side of the room when found. Staff #62 stated based on the report he received from his staff that there was nothing reportable. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on April 18, 2025 at 10:25 a.m. with Director of Housekeeping (Staff # 42). Staff #42 stated that his expectations are that his staff notify and report what they see immediately. He also stated his staff are instructed to notify him immediately as to what they observed and what happened. Staff #80 stated he will then immediately notify the person in charge of that department and the unit manager for ay type of abuse. Staff #42 stated staff #80 telephoned him on Saturday April 5, 2025 at 9:32 a.m. informing him that she had observed resident #1 touching one of the female residents on the thighs in his room. He stated she also informed hm that the female resident was lying on his bed and was rubbing the female resident. Staff #42 stated that staff #80 informed him that she had told resident #1 to leave and had told one of the CNA's. Staff #42 stated he informed her she did the right thing and that he would handle it from there. Staff #42 stated he immediately called the Unit Manger (Staff #79). Staff #42 stated he told her that he was notified by one of the housekeepers that resident #1 was rubbing one of the residents on the thigh. Staff #42 stated he did not inform her that the female resident was observed lying on the bed in resident #1 room. Staff #42 stated he did not inform the Director of Nursing (DON/Staff #86) or the Abuse Coordinator (Staff #62). An interview was conducted April 18, 2025 at 11:00 a.m. with Register Nurse Unit Manager (RN/UM/Staff #79). Staff # 79 stated she has been in the position as RN/UUM since March 2025 and that her responsibilities are to ensure everything is running ok and to make sure that unit is kept clean- residents are safe, family phone calls, log books updated- meds. Staff #79 stated staff report to her anything out of the norm. this would be anything that could lead to possible concerns, including inappropriate behaviors. Staff #79 stated inappropriate behaviors are reported to the DON, depending what is reported to her and if it is something that can be re-directed and no one is hurt from the behavior, then she feels no need to call the DON- Staff #79 stated she would notify the DON if a resident is hurt or imposing harm to another resident. Staff # 79 stated she notified on a Saturday morning that one of the housekeepers had seen a resident touching another resident. She stated it was on a Saturday-morning. She stated I just called the floor and told them to make sure that he [resident #1] is not around the girls. Further stating I did not feel that it warranted me calling the DON at that time. No one was hurt or in distress at that time. Staff #79 stated she was never informed of the residents sexualized behaviors and had that anything like that would warrant me to call my DON. Staff #79 stated does not take part in report with the nursing staff. -Regarding Resident #3 -Resident #3 was admitted to the facility March 7, 2025 with diagnosis that included vascular dementia, unspecified severity, with other behavioral disturbance, Alzheimer's disease, unspecified depression, unspecified, cerebral infarction, unspecified. A review of the admission MDS revealed a BIMS score of 7, indicating severe cognitive impairment. Further review revealed no indicators for mood or behaviors. There were indicators for wandering that occurred 1-3 days in the lookback period. Review of the care plan date-initiated March 19 2025 revealed a focus for risk for elopement and wandering related to disoriented to place and impaired safety awareness and impaired cognitive function, dementia or impaired thought processes related to dementia, difficulty making decisions and psychotropic drug use. Interventions included distracting the resident from wandering by offering pleasant diversions, intervene as appropriate and administer medications as ordered. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the progress notes revealed no documentation regarding the resident's buttocks being grabbed by resident #1. An interview was conducted April 17, 2025 at approximately 3:00 p.m. Resident #3 interviewed alone and in private in her room- pleasant and able to communicate and make needs knows- resident #3was able to recall being touched inappropriately by another resident. Stated yeah [NAME] has a bad habit of doing inappropriate things- I think he likes the ladies he grabbed my bottom. I didn't like him doing that, I try to keep away from him. I don't think he means any harm, but it's not nice for him to do that. Resident #3 stated I don't feel safe in my room, men come in all the time. I was changing my clothes and had just put on my bra when [NAME] came in. Sometimes I'll find people in my bed or they walk in your room at night. I had pushed the dresser against my door to keep them from coming in but they told me I couldn't. I don't remember if my sister was her with me, I can call and ask her if she was- (resident tried to call sister from cell phone no response. A male resident entered the resident's room during interview. later identified by staff as resident #10. Resident #10 was observed wandering around aimlessly going into different resident's rooms, no intervention observed by staff during observation on the unit. -Resident # 4 Resident was admitted to the facility December 8, 2023 with diagnosis that included unspecified dementia, unspecified severity, with agitation, restlessness and agitation, anxiety disorder, unspecified, impulsiveness, major depressive disorder, recurrent, unspecified. Review of the quarterly MDS dated [DATE] revealed a BIMS score of 12 indicating moderate cognitive impairment. The resident was assessed with a mild mood score of 10 with concerns with self-isolation and depression. There were also indicators for verbal behavioral symptoms directed towards others, e.g., threatening, screaming cursing at others, wandering and rejection of care with presence and frequency of this type occurred 1-3 days. Resident has no impairment of the upper or lower extremities and uses a wheelchair for mobility. Review of the care plan date-initiated December 15, 2023 and revised March 18, 2025 revealed a focus for elopement at risk for elopement, exit seeking, wandering related to dementia or other cognitive behavior and cognitive impairment loss related to Alzheimer's disease or other dementias. Interventions included allow wandering in safe areas within the facility, administering medication as ordered and anticipating the residents needs and met promptly. Review of the progress notes revealed no documentation regarding inappropriate touching or kissing of the resident by resident #4, An interview was conducted on April 17, 2025 at 12:46 p.m. with Licensed Practical Nurse (LPN/Staff #93). Stated resident #1 is fixated on two of them, resident's #4 and #2. Stated resident #1 has been separated from her before and tried to take resident #2 to his room. Staff #93 stated resident #1 had taken a female resident to his room approximately six weeks ago. The resident was resident #4. Staff #93 stated resident #1 has been observed kissing, touching and rubbing on resident #4 legs. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on April 17, 2025 at 1:28p.m. with certified nursing assistant (CNA/Staff #51) CNA #51 stated I know resident #1 touches residents #6 and #4, he will whisper in their ear; I don't know what he is saying. CNA #51 stated resident #1 will touch resident #4 and #6 on their arms and legs, stating it appears sexual when he touches them. -Regarding Resident #5 - Resident was admitted to the facility February 8, 2024 with diagnosis including cardiomyopathy, unspecified, altered mental status, unspecified, dementia in other diseases classified elsewhere, mild, with other behavioral disturbance cognitive communication deficit unspecified dementia, unspecified severity, with other behavioral disturbances. Review of the annual MDS dated [DATE] revealed a BIMS score of 03, indicating severe cognitive impairment. Resident not assessed for mood, unable to respond. Assessment for behaviors revealed other behavioral symptoms not directed toward others, places the resident at significant risk for physical illness or injury, interferes with the resident's care, interferes with the resident's participation in activities or social interactions, and significantly intrude on the privacy or activity of others. Further review of the MDS revealed the resident uses a wheelchair for mobility. Review of the care plan revealed a focus for cognitive impairment related to altered Alzheimer's disease or other dementias and the risk for elopement and wandering related to dementia and other cognitive behaviors, Interventions included administer medications as ordered, allow to wander in safe areas within the facility. Review of the progress notes revealed no documentation of and observation alleged incident involving resident #1 taking resident #5 to his room by the hand and attempting to lay her on his bed. The incident was reported to a certified nursing assistant who was able to intervene and remove resident #5 from resident #1 room. An interview was conducted on April 17, 2025 at 2:18p.m. with housekeeper (staff #80). Staff #80 stated she has observed resident #1 on two different occasions. Staff #80 stated I saw him in his room with her trying to lay her on his bed- I saw him take her by the hand to his room (Staff #80 did not know the residents name but was able to point the resident out- identified as [NAME]) Staff #80 stated I told the CNA who went in the room to get her. -Regarding Resident #6 Resident was admitted to the facility April 11, 2023 with diagnosis including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, cognitive communication deficit, Wernicke's encephalopathy Review of the quarterly MDS dated [DATE] revealed a BIMS score of o5, indicating severe cognitive impairment, no indicators for mood or behaviors. Uses walker and wheelchair for mobility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan revealed a focus for impaired cognitive function and thought processes related to vascular dementia, Wernicke's encephalopathy, and unspecified psychosis. Date Initiated: 04/23/2023 Revision on: 05/04/2023. Interventions included stress key words and present just one thought, question or command at a time. A behavior progress note dated April 5, 2025 at 4:31 p.m. revealed resident #1 had an eventful day exhibiting increased sexual tendencies towards female peers. resident #1 noted touching resident #6 legs several times while in the dining room. When redirected resident #1 becomes visibly angered and posturing. Resident #1 stated, I'm gonna do it again. -Regarding Resident #8 Resident #8 was admitted to the facility August 16, 2024 with diagnosis including unspecified dementia, severe, with psychotic disturbance, altered mental status, unspecified, depression, unspecified, anxiety disorder, unspecified. Review of the significant change of cognitive impairment MDS dated [DATE] revealed a BIMS score pf 03 indicating severe cognitive impairment, no indicators for [NAME] or behaviors, wandering with no impact on others, diagnosis for Anxiety disorder, Depression (other than bipolar), altered mental status, unspecified. Received Antipsychotic, Antidepressant, - gradual dose reduction (GDR) was attempted 11/30/2024- Physician documented GDR as clinically contraindicated 11/30/2024. Review of the care plan date-initiated August 22, 2024 revealed a focus for Psychosocial-Emotional/Trauma: At risk for decreased psychosocial well-being physical, social, or spiritual wellbeing related to alleged incident with peer on April 13, 2025. Date Initiated: April 15, 2025 Revision on: April 15, 2025, Interventions: included contact resident representative/friend for comfort and support. Date Initiated April 15, 2025. Review of eINTERACT Change in Condition Evaluation dated April 13, 2025 at 6:02 p.m. revealed pain in side remains, No signs of bruising/abrasion on skin of left side, pain with movement. Open cyst on upper mid back, cleaned and applied dry dressing. Pain medications administered PRN, dressing change daily on upper back till healed. The change in condition and notifications reported to primary care clinician Review of Treatment Administration Record for April 2025 revealed new orders for treatment for ruptured cyst with a start date of April 14, 2025. Review of the physician order summary dated April 13, 2025 revealed a STAT order for an x-ray ribs left side for trauma during altercation, however the examination results dated April 14, 2025 at 1:39pm and reported date April 14, 2025 at 1:41 p.m. revealed significant findings of unilateral left ribs x-ray. The impression revealed an acute hairline of the left lower rib fracture. Review of the nurses progress noted dated April 13, 2025 at 6:38 p.m. revealed a note text of the following detail; Informed of altercation in dining room, resident states he came out of nowhere and hit me, it was hard enough to push me back in my chair. Skin assessment performed, cyst on upper mid back ruptured and wound care performed, pain in left side ribs under arm no bruising or open skin in that area. Pain reported level 7/10, PRN medication administered. NP [NAME] notified, x-ray ordered and wound care to cyst. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on April 17, 2025 at 12:46 p.m. with Licensed Practical Nurse (LPN/Staff #93). Stated there was an incident involving resident #1 and resident #8, Staff #93 stated it was time to serve dinner came and resident #1 came from his room. Staff #93 stated she was at the med cart. She stated she was told by staff resident #1 told resident #8 to get out of his chair and resident #8 said no and resident #1 struck resident #8 on the upper right back to mid area. Staff #93 stated a weekend intervened and there were lots of lots of commotion. Staff #93 stated resident #1 was standing away from the table and resident #8 was standing at the other side of the table. She stated she had to ask resident #1 to leave the area multiple time- he refused- She stated it took four attempts to get the resident #1 to leave. Staff #93 stated LPN/Staff#9 came and completed a skin check for resident #8. She stated resident #8 complained of pain on the side he had a ruptured cyst, located on the left near his scapula where resident #1 hit him- the ruptured cyst was noted at the time of the assessment. Staff #93 stated an assessment was not done for resident #1 since he had not been hit. An attempt to interview resident #8 was made on April 18, 2025 at 8:35 a.m. due to the resident's severe cognition, he could not recall the incident in detail. Resident was walking the hallways- pleasant mood. An interview was conducted on April 18, 2025 at 1:09 p.m. with Abuse Coordinator (Staff #62) regarding residents #1 and #8. Staff #62 stated he was informed by the DON (Staff #86) of the alleged incident on Sunday, April 13, 2025. Staff #62 stated he was informed there was an altercation between residents #1 and #8 who were fighting over a chair in the dining room and staff intervened and removed resident #1 from the dining room. Staff #62 stated he informed the DON to follow-up with staff on duty and get their statements and made some call to initiate the two-hour required investigation report for the state agency. Staff #62 stated following the investigation injuries reported for resident #8 with an oozing cyst and x-rays taken revealed a hairline fracture of his ribs and that the resident had complained of pain. Staff #62 stated the facility unsubstantiated their investigation based on follow-up with the staff at the time; that it appeared two residents and argued over the chair and staff were able to intervene before anything escalated. Staff #62 stated resident #1 and #8 were pleasant with each other following the incident. An interview was conducted on April 18, 2025 at 1:29 p.m. with Director of Nursing (DON/Staff #86) stated the process for reporting alleged abuse is reporting to the different agencies as soon as they are aware. He stated he provides his staff with as much training as possible and during the facility monthly all-staff meetings. He stated they are told to immediately report to their supervisor or to the abuse coordinator. The DON stated he monitors for potential abuse by rounding the units, keeping up with daily nursing notes and being in front with his teams. The DON stated actions taken to protect the residents and other residents from abuse during the investigation process for resident #1 and #8 were that they were immediately separated and provided with frequent checks. He stated Resident #1 is being monitored 1:1 and will be moving the resident to an all-male unit to protect the females on the unit and the other residents. He stated he was not informed of what had happened with resident #! Nor of the other incidents with the other females on the unit. He stated he is very upset with this information. The DON stated staff #79 is new to her role as unit manager and staff #93 is a new floor nurse, that they report the incidents to me immediately. It is not expected that they make that decision on their own. I will be providing some additional training and education for my new staff. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program states Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes, but is not limited to freedom from corporate punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, facility documentation and policy review, the facility failed to implement their abuse policy, by failing to report an allegation of sexual abuse involving five residents (#2, # 3, #4, #5 and #6) to the State Agency. The deficient practice could result in continued resident to resident sexual abuse Findings include: -Regarding residents #1 and #2: -Resident #1 was admitted to the facility December 21, 2021 with dysphagia following cerebral infarction, unspecified dementia, mild, with agitation, schizophrenia, unspecified. A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 completed a Brief Interview for Mental Status (BIMS) score of 08 indicating moderate cognitive impairment. Further review of the MDS revealed no indicators for mood, but will self-isolate. Indicators for physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards others, other behavioral symptoms not directed towards others and wandering. These assessments occurred 1-3 days of the lookback period. Review of the care plan, date-initiated December 22, 2024 revealed a focus for elopement; resident at risk for elopement/exit seeking; wandering related to dementia and other cognitive behaviors. Further review of the care plan revealed focus for behavior problems, agitation related to depression and schizophrenia, likes to follow female residents around to help them with things, per family and the potential to be physically aggressive related to dementia, poor impulse control; citing incident on April 13, 2025 with another resident due to resident not getting out of his desired chair; verbal aggression. Interventions include administer medications as ordered, intervene as necessary to protect the rights and safety of others. Review of the physicians orders dated April 15, 2025 revealed monitoring episodes of restlessness, agitation every shift and record every shift, Depakote Oral Tablet Delayed Release 125 MG (Divalproex Sodium) Give 125 mg by mouth two times a day for Mood/AEB Impulsivity, Mirtazapine Tablet 15 MG Give 1 tablet by mouth in the evening for Depression as exhibited by poor by mouth intake; Quetiapine Fumarate Oral Tablet 50 MG (Quetiapine Fumarate) Give 1 tablet by mouth in the morning for as exhibited by mood. Review of the Medication Administration Record for April 15, 2025 revealed a change in the number of times dosage administered for antipsychotic due to elevated behaviors. Review of a Nurse Practitioners Note dated April 14, 2025 at 8:16 p.m. revealed -Patient seen sitting up in activities room eating breakfast without difficulty nurse reports patient with aggressive behavior towards females and other residents. POC discussed with nursing. PMH NP was also alerted to patient behavioral issues at this time. Patient denies any chest pain shortness of breath and has pleasant affect at time of assessment. NAD. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the nurse's progress notes dated April 14, 2025 at 3:25 p.m. revealed a note text: During a verbal disagreement between two resident #1 approached and began yelling at the male resident. He then began threatening the male resident and staff had to step between to calm the situation. Resident was escorted back to his room, while also threatening nurses and using vulgar language. A progress note dated April 14, 2025 at 1:31 p.m. revealed a nurse's note text: This writer spoke with CNA who witnessed the alleged res to res. CNA clarified that when she was passing out trays, she heard two residents talking loudly to each other, she turned around to see resident #1 contact resident #8 trying to get him to move chairs. At that time two CNA's stepped in to separate the two residents. A progress note dated April 13, 2025 at 4:46 p.m. revealed a nurse's note text; Nurse summoned to dining room per certified nursing assistant (CNA) reported per CNA resident #1 punched resident #8 because he would not get out of his desired chair. CNA reported hearing a sound when physical contact was made. This nurse attempted to escort resident #1 to his room. Resident #1 is resistive to redirection and had to be redirected X 4 before returning to his bedroom. Resident #8 assessed by other nurse on duty. Representative notified. Manager on duty notified. Nurse Practitioner notified. New order for Hydroxyzine 25mg by mouth every 6 hours as needed for Anxiety X 14days.Representative contacted regarding new order, she declined to initiate Hydroxyzine. Nurse Practitioner notified. A behavior progress note dated April 12, 2025 at 5:37 p.m. states reported per CNA resident #1 required redirection multiple times throughout the day. Resident #1 noted rubbing resident #4 leg. When redirected resident #1 stated, That's my girl. becoming visibly upset when asked to leave the area near resident #4. Frequent visual checks continue to maintain distance of resident #1 and resident #4. Nurse Practitioner notified. A behavior progress note dated April 5, 2025 at 4:31 p.m. revealed resident #1 had an eventful day exhibiting increased sexual tendencies towards female peers. resident #1 noted touching resident #6 legs several times while in the dining room. When redirected resident #1 becomes visibly angered and posturing. Resident #1 stated, I'm gonna do it again. resident #1 had to be redirected from propelling resident #4 female peer per wheelchair from dining room. resident #1 walked away but later returned visibly upset. Attempts to redirect, distract and calm resident #1 were unsuccessful. Resident #5 female peer was found lying in resident #1 room with resident #1 at bedside. When attempting to remove resident #5, resident #1 stated. It's ok, leave her alone, she's with me. A behavior progress note dated March 28, 2025 at 5:25 p.m. revealed resident #1 has been talking to a female resident and trying to get her to walk with him to his room all afternoon. He was walking the female resident in the direction of his room about 30 minutes ago when this nurse intercepted and started walking the resident back towards the activities room, and he swung a punch at this nurse. Resident is also entering the rooms of female residents continuously, and when staff ask him to leave the room, he does but then goes and enters another female resident's room very shortly thereafter. Will continue to monitor. A behavior progress note dated March 22, 2025 at 2:27 p.m. revealed Reported per CNA resident #1 noted slapping the buttocks of resident #3 The sister of resident #3 was present at the time. Nurse Practitioner notified of incident. New order for Depakote 125mg by mouth twice daily for Mood/AEB. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A behavior progress note dated March 21, 2025 at 2:28 p.m. revealed resident #1 increased sexual tendencies towards his female peers. Resident #1 noted leading resident #2. to his bedroom. This nurse attempted to redirect and intervene the situation, this only further angers the resident #1 This nurse leading resident #2 by hand to the common area but resident #1 became visibly upset stating, She's coming with me. Resident #1 grabbed her hand tighter and continued to walk towards his bedroom. This nurse acting as a barrier standing between residents #1 and #2. Resident #1 dropped her hand and walked away to his bedroom. Resident #1 family came to visit shortly after and is aware of the incident. Will notify Primary Care Physician. Resident Observation on April 18, 2025 at 8:18 a.m. resident #1 provided with 1:1 intervention for 12 hours by Certified Nursing Assistant (CNA/Staff #18). Stated she was informed April 17, 2025 that she would be providing 1:1 care for resident #1 and to monitor his behaviors due to aggression and sexualized behaviors, she stated this was the first time resident #1 has been provided with 1:1 care. Residents #2 and resident 6 were observed seated in recliners in the dining room. There were two CNA's present. -Regarding Resident #2 -Resident #2 was admitted to the facility February 8, 2025 with diagnosis that included metabolic encephalopathy, cognitive communication deficit and altered mental status, unspecified. A review of the Part A Discharge MDS dated [DATE] revealed Resident #2 completed a Brief Interview for Mental Status (BIMS) score of 02 indicating severe cognitive impairment. Review of the care plan date-initiated February 9 2025 and a revision on April 4, 2025 revealed a focus for psychosocial behaviors; exhibits or is at risk for behavioral symptoms delusions, hallucinations, anxiety, SI without a plan, agitation, disrobing, wandering into others rooms. Interventions included Administer medication as ordered, document and record behavioral episodes and manage environmental factors to optimize comfort. Review of the progress notes revealed a behavior note dated April 4, 2025 at 1:27 p.m. Note Text: Resident was found in another resident's room. Resident was easily directed out of room. Skin check was performed. No abnormal findings. An interview was conducted on April 17, 2025 at 12:46 p.m. with Licensed Practical Nurse (LPN/Staff #93). Stated resident #1 has sexual tendencies mostly touching and kissing, rubbing of female residents' legs and those who are ambulatory. Stated resident #1 is fixated on two of them, resident's #4 and #2. Stated resident #1 has be separated from her before and tried to take resident #2 to his room. Staff #93 stated resident #1 had taken a female resident to his room approximately six weeks ago. The resident was resident #4. Staff #93 stated resident #4 was in his room in her wheelchair and resident #1 was standing up pacing the room. Staff #93 stated resident #1 has kissed resident 2 and #4, he's touched them by rubbing their legs, and he grabbed both of resident #3 buttocks, Staff #93 stated resident #1 paces the unit and staff keep a visual with 15-minute checks on resident #1. Staff #93 stated resident #1 has not been provided with 1:1 intervention and that he is unpredictable with physical aggression and posturing. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on April 17, 2025 at 1:22 p.m. with Certified Nursing Assistant (CAN/Staff #59. She stated she was informed that LPN/Staff #93 resident went to go get resident #1 for dinner when she saw resident #2 laying in the bed, she stated resident #1- he was sitting in a chair in his room. she stated resident #2 paces and wanders and had not seen her for about 30 minutes. Staff #59 stated we have to watch out for resident #1 he touches the females. An interview was conducted on April 17, 2025 at 1:28p.m. with certified nursing assistant (CNA/Staff #51) CAN #51 stated she first became aware of the incident when the nurse (LPN/Staff #93) called out for help to resident #1 room. She stated both (LPN/Staff #29) went to the room to find resident #2 lying on top of resident #1 bed naked with no clothing on. Staff #51 stated resident #1 was seated at the bedside with his shirt off and had put on a coat jacket, further stating his pants were on, but could not recall if his shoes were on. Staff#51 stated staff #29 assisted with getting resident #2 dressed. Staff #51 stated she documented the incident in Point Click Care and assumed LPN# 93 and #29 had reported the incident to the Director of Nursing. Staff #93 stated the doctor; family and the DON are aware of resident #1 sexualized behaviors with the other residents. An interview was conducted on April 17, 2025 at 2:18p.m. with housekeeper (staff #80). Staff #80 stated she has observed resident #1 with two female residents on two different occasions. Staff #80 stated On Saturday April 5, 2025, sometime in the morning while cleaning resident rooms she observed resident #1 had resident #2 laying on his bed covered with a blanket. Staff #80 stated resident #1 had his hands underneath the blanket and was rubbing her body. Staff #80 stated it looked like he was rubbing her up and down from her upper thighs to her chest area and touching her legs. Staff #80 stated she immediately informed the CNA that works on the weekends (did not know her name) and also informed her supervisor, Director of Housekeeping (Staff # 42). Staff #80 stated she was hesitant as to what to do with what she had observed, but stated I knew it was the right thing to do. An interview was conducted on April 17, 2025 at 3:37 p.m. with Operations Manager/ Abuse Coordinator (Staff #62). Staff #62 stated he did not file a report with the state agency because he had not been informed that resident #2 was disrobed and was told that resident #1 was sitting on the other side of the room when found. Staff #62 stated based on the report he received from his staff that there was nothing reportable. An interview was conducted on April 18, 2025 at 10:25 a.m. with Director of Housekeeping (Staff # 42). Staff #42 stated that his expectations are that his staff notify and report what they see immediately. He also stated his staff are instructed to notify him immediately as to what they observed and what happened. Staff #80 stated he will then immediately notify the person in charge of that department and the unit manager for ay type of abuse. Staff #42 stated staff #80 telephoned him on Saturday April 5, 2025 at 9:32 a.m. informing him that she had observed resident #1 touching one of the female residents on the thighs in his room. He stated she also informed hm that the female resident was lying on his bed and was rubbing the female resident. Staff #42 stated that staff #80 informed him that she had told resident #1 to leave and had told one of the CNA's. Staff #42 stated he informed her she did the right thing and that he would handle it from there. Staff #42 stated he immediately called the Unit Manger (Staff #79). Staff #42 stated he told her that he was notified by one of the housekeepers that resident #1 was rubbing one of the residents on the thigh. Staff #42 stated he did not inform her that the female resident was observed lying on the bed in resident #1 room. Staff #42 stated he did not inform the Director of Nursing (DON/Staff #86) or the Abuse Coordinator (Staff #62). (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted April 18, 2025 at 11:00 a.m. with Register Nurse Unit Manager (RN/UM/Staff #79). Staff # 79 stated she has been in the position as RN/UUM since March 2025 and that her responsibilities are to ensure everything is running ok and to make sure that unit is kept clean- residents are safe, family phone calls, log books updated- meds. Staff #79 stated staff report to her anything out of the norm. this would be anything that could lead to possible concerns, including inappropriate behaviors. Staff #79 stated inappropriate behaviors are reported to the DON, depending what is reported to her and if it is something that can be re-directed and no one is hurt from the behavior, then she feels no need to call the DON- Staff #79 stated she would notify the DON if a resident is hurt or imposing harm to another resident. Staff # 79 stated she notified on a Saturday morning that one of the housekeepers had seen a resident touching another resident. She stated it was on a Saturday-morning. She stated I just called the floor and told them to make sure that he [resident #1] is not around the girls. Further stating I did not feel that it warranted me calling the DON at that time. No one was hurt or in distress at that time. Staff #79 stated she was never informed of the residents sexualized behaviors and had that anything like that would warrant me to call my DON. Staff #79 stated does not take part in report with the nursing staff. -Regarding Resident #3 -Resident #3 was admitted to the facility March 7, 2025 with diagnosis that included vascular dementia, unspecified severity, with other behavioral disturbance, Alzheimer's disease, unspecified depression, unspecified, cerebral infarction, unspecified. A review of the admission MDS revealed a BIMS score of 7, indicating severe cognitive impairment. Further review revealed no indicators for mood or behaviors. There were indicators for wandering that occurred 1-3 days in the lookback period. Review of the care plan date-initiated March 19 2025 revealed a focus for risk for elopement and wandering related to disoriented to place and impaired safety awareness and impaired cognitive function, dementia or impaired thought processes related to dementia, difficulty making decisions and psychotropic drug use. Interventions included distracting the resident from wandering by offering pleasant diversions, intervene as appropriate and administer medications as ordered. Review of the progress notes revealed no documentation regarding the resident's buttocks being grabbed by resident #1. An interview was conducted April 17, 2025 at approximately 3:00 p.m. Resident #3 interviewed alone and in private in her room- pleasant and able to communicate and make needs knows- resident #3was able to recall being touched inappropriately by another resident. Stated yeah [NAME] has a bad habit of doing inappropriate things- I think he likes the ladies he grabbed my bottom. I didn't like him doing that, I try to keep away from him. I don't think he means any harm, but it's not nice for him to do that. Resident #3 stated I don't feel safe in my room, men come in all the time. I was changing my clothes and had just put on my bra when [NAME] came in. Sometimes I'll find people in my bed or they walk in your room at night. I had pushed the dresser against my door to keep them from coming in but they told me I couldn't. I don't remember if my sister was her with me, I can call and ask her if she was- (resident tried to call sister from cell phone no response. A male resident entered the resident's room during interview. later identified by staff as resident #10. Resident #10 was observed wandering around aimlessly going into different resident's rooms, no intervention observed by staff during observation on the unit. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident # 4 Resident was admitted to the facility December 8, 2023 with diagnosis that included unspecified dementia, unspecified severity, with agitation, restlessness and agitation, anxiety disorder, unspecified, impulsiveness, major depressive disorder, recurrent, unspecified. Review of the quarterly MDS dated [DATE] revealed a BIMS score of 12 indicating moderate cognitive impairment. The resident was assessed with a mild mood score of 10 with concerns with self-isolation and depression. There were also indicators for verbal behavioral symptoms directed towards others, e.g., threatening, screaming cursing at others, wandering and rejection of care with presence and frequency of this type occurred 1-3 days. Resident has no impairment of the upper or lower extremities and uses a wheelchair for mobility. Review of the care plan date-initiated December 15, 2023 and revised March 18, 2025 revealed a focus for elopement at risk for elopement, exit seeking, wandering related to dementia or other cognitive behavior and cognitive impairment loss related to Alzheimer's disease or other dementias. Interventions included allow wandering in safe areas within the facility, administering medication as ordered and anticipating the residents needs and met promptly. Review of the progress notes revealed no documentation regarding inappropriate touching or kissing of the resident by resident #4, An interview was conducted on April 17, 2025 at 12:46 p.m. with Licensed Practical Nurse (LPN/Staff #93). Stated resident #1 is fixated on two of them, resident's #4 and #2. Stated resident #1 has been separated from her before and tried to take resident #2 to his room. Staff #93 stated resident #1 had taken a female resident to his room approximately six weeks ago. The resident was resident #4. Staff #93 stated resident #1 has been observed kissing, touching and rubbing on resident #4 legs. An interview was conducted on April 17, 2025 at 1:28p.m. with certified nursing assistant (CNA/Staff #51) CNA #51 stated I know resident #1 touches residents #6 and #4, he will whisper in their ear; I don't know what he is saying. CNA #51 stated resident #1 will touch resident #4 and #6 on their arms and legs, stating it appears sexual when he touches them. -Regarding Resident #5 - Resident was admitted to the facility February 8, 2024 with diagnosis including cardiomyopathy, unspecified, altered mental status, unspecified, dementia in other diseases classified elsewhere, mild, with other behavioral disturbance cognitive communication deficit unspecified dementia, unspecified severity, with other behavioral disturbances. Review of the annual MDS dated [DATE] revealed a BIMS score of 03, indicating severe cognitive impairment. Resident not assessed for mood, unable to respond. Assessment for behaviors revealed other behavioral symptoms not directed toward others, places the resident at significant risk for physical illness or injury, interferes with the resident's care, interferes with the resident's participation in activities or social interactions, and significantly intrude on the privacy or activity of others. Further review of the MDS revealed the resident uses a wheelchair for mobility. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan revealed a focus for cognitive impairment related to altered Alzheimer's disease or other dementias and the risk for elopement and wandering related to dementia and other cognitive behaviors, Interventions included administer medications as ordered, allow to wander in safe areas within the facility. Review of the progress notes revealed no documentation of and observation alleged incident involving resident #1 taking resident #5 to his room by the hand and attempting to lay her on his bed. The incident was reported to a certified nursing assistant who was able to intervene and remove resident #5 from resident #1 room. An interview was conducted on April 17, 2025 at 2:18p.m. with housekeeper (staff #80). Staff #80 stated she has observed resident #1 on two different occasions. Staff #80 stated I saw him in his room with her trying to lay her on his bed- I saw him take her by the hand to his room (Staff #80 did not know the residents name but was able to point the resident out- identified as [NAME]) Staff #80 stated I told the CNA who went in the room to get her. -Regarding Resident #6 Resident was admitted to the facility April 11, 2023 with diagnosis including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, cognitive communication deficit, Wernicke's encephalopathy Review of the quarterly MDS dated [DATE] revealed a BIMS score of o5, indicating severe cognitive impairment, no indicators for mood or behaviors. Uses walker and wheelchair for mobility. Review of the care plan revealed a focus for impaired cognitive function and thought processes related to vascular dementia, Wernicke's encephalopathy, and unspecified psychosis. Date Initiated: 04/23/2023 Revision on: 05/04/2023. Interventions included stress key words and present just one thought, question or command at a time. A behavior progress note dated April 5, 2025 at 4:31 p.m. revealed resident #1 had an eventful day exhibiting increased sexual tendencies towards female peers. resident #1 noted touching resident #6 legs several times while in the dining room. When redirected resident #1 becomes visibly angered and posturing. Resident #1 stated, I'm gonna do it again. -Regarding Resident #8 Resident #8 was admitted to the facility August 16, 2024 with diagnosis including unspecified dementia, severe, with psychotic disturbance, altered mental status, unspecified, depression, unspecified, anxiety disorder, unspecified. Review of the significant change of cognitive impairment MDS dated [DATE] revealed a BIMS score pf 03 indicating severe cognitive impairment, no indicators for [NAME] or behaviors, wandering with no impact on others, diagnosis for Anxiety disorder, Depression (other than bipolar), altered mental status, unspecified. Received Antipsychotic, Antidepressant, - gradual dose reduction (GDR) was attempted 11/30/2024- Physician documented GDR as clinically contraindicated 11/30/2024. (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 - Some	Review of the care plan date-initiated August 22, 2024 revealed a focus for Psychosocial-Emotional/Trauma: At risk for decreased psychosocial well-being physical, social, or spiritual wellbeing related to alleged incident with peer on April 13, 2025. Date Initiated: April 15, 2025 Revision on: April 15, 2025, Interventions: included contact resident representative/friend for comfort and support. Date Initiated April 15, 2025. Review of eINTERACT Change in Condition Evaluation dated April 13, 2025 at 6:02 p.m. revealed pain in side remains, No signs of bruising/abrasion on skin of left side, pain with movement. Open cyst on upper mid back, cleaned and applied dry dressing. Pain medications administered PRN, dressing change daily on upper back till healed. The change in condition and notifications reported to primary care clinician Review of Treatment Administration Record for April 2025 revealed new orders for treatment for ruptured cyst with a start date of April 14, 2025. Review of the physician order summary dated April 13, 2025 revealed a STAT order for an x-ray ribs left side for trauma during altercation, however the examination results dated April 14, 2025 at 1:39pm and reported date April 14, 2025 at 1:41 p.m. revealed significant findings of unilateral left ribs x-ray. The impression revealed an acute hairline of the left lower rib fracture. Review of the nurses progress noted dated April 13, 2025 at 6:38 p.m. revealed a note text of the following detail; Informed of altercation in dining room, resident states he came out of nowhere and hit me, it was hard enough to push me back in my chair. Skin assessment performed, cyst on upper mid back ruptured and wound care performed, pain in left side ribs under arm no bruising or open skin in that area. Pain reported level 7/10, PRN medication administered. NP [NAME] notified, x-ray ordered and wound care to cyst. An interview was conducted on April 17, 2025 at 12:46 p.m. with Licensed Practical Nurse (LPN/Staff #93). Stated there was an incident involving resident #1 and resident #8, Staff #93 stated it was time to serve dinner came and resident #1 came from his room. Staff #93 stated she was at the med cart. She stated she was told by staff resident #1 told resident #8 to get out of his chair and resident #8 said no and resident #1 struck resident #8 on the upper right back to mid area. Staff #93 stated a weekend intervened and there were lots of lots of commotion. Staff #93 stated resident #1 was standing away from the table and resident #8 was standing at the other side of the table. She stated she had to ask resident #1 to leave the area multiple time- he refused- She stated it took four attempts to get the resident #1 to leave. Staff #93 stated LPN/Staff#9 came and completed a skin check for resident #8. She stated resident #8 complained of pain on the side he had a ruptured cyst, located on the left near his scapula where resident #1 hit him- the ruptured cyst was noted at the time of the assessment. Staff #93 stated an assessment was not done for resident #1 since he had not been hit. An attempt to interview resident #8 was made on April 18, 2025 at 8:35 a.m. due to the resident's severe cognition, he could not recall the incident in detail. Resident was walking the hallways- pleasant mood. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on April 18, 2025 at 1:09 p.m. with Abuse Coordinator (Staff #62) regarding residents #1 and #8. Staff #62 stated he was informed by the DON (Staff #86) of the alleged incident on Sunday, April 13, 2025. Staff #62 stated he was informed there was an altercation between residents #1 and #8 who were fighting over a chair in the dining room and staff intervened and removed resident #1 from the dining room. Staff #62 stated he informed the DON to follow-up with staff on duty and get their statements and made some call to initiate the two-hour required investigation report for the state agency. Staff #62 stated following the investigation injuries reported for resident #8 with an oozing cyst and x-rays taken revealed a hairline fracture of his ribs and that the resident had complained of pain. Staff #62 stated the facility unsubstantiated their investigation based on follow-up with the staff at the time; that it appeared two residents and argued over the chair and staff were able to intervene before anything escalated. Staff #62 stated resident #1 and #8 were pleasant with each other following the incident. An interview was conducted on April 18, 2025 at 1:29 p.m. with Director of Nursing (DON/Staff #86) stated the process for reporting alleged abuse is reporting to the different agencies as soon as they are aware. He stated he provides his staff with as much training as possible and during the facility monthly all-staff meetings. He stated they are told to immediately report to their supervisor or to the abuse coordinator. The DON stated he monitors for potential abuse by rounding the units, keeping up with daily nursing notes and being in front with his teams. The DON stated actions taken to protect the residents and other residents from abuse during the investigation process for resident #1 and #8 were that they were immediately separated and provided with frequent checks. He stated Resident #1 is being monitored 1:1 and will be moving the resident to an all-male unit to protect the females on the unit and the other residents. He stated he was not informed of what had happened with resident #! Nor of the other incidents with the other females on the unit. He stated he is very upset with this information. The DON stated staff #79 is new to her role as unit manager and staff #93 is a new floor nurse, that they report the incidents to me immediately. It is not expected that they make that decision on their own. I will be providing some additional training and education for my new staff. Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, with a revision date of April 2021 revealed a policy statement All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Reporting allegations to the Administrator and authorities (2) The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. the resident's representative; d. Adult protective services; i.e. law enforcement officials; f. The resident's attending physician; and g. the facility's medical director. (3) Immediately is defined as: a. within two hours of an allegation involving abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, facility documentation and policy review, the facility failed to ensure that an allegation of sexual abuse for five residents (#2, # 3, #4, #5 and #6) was reported to the State Agency. Findings include: -Regarding residents #1 and #2: -Resident #1 was admitted to the facility December 21, 2021 with dysphagia following cerebral infarction, unspecified dementia, mild, with agitation, schizophrenia, unspecified. A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 completed a Brief Interview for Mental Status (BIMS) score of 08 indicating moderate cognitive impairment. Further review of the MDS revealed no indicators for mood, but will self-isolate. Indicators for physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards others, other behavioral symptoms not directed towards others and wandering. These assessments occurred 1-3 days of the lookback period. Review of the care plan, date-initiated December 22, 2024 revealed a focus for elopement; resident at risk for elopement/exit seeking; wandering related to dementia and other cognitive behaviors. Further review of the care plan revealed focus for behavior problems, agitation related to depression and schizophrenia, likes to follow female residents around to help them with things, per family and the potential to be physically aggressive related to dementia, poor impulse control; citing incident on April 13, 2025 with another resident due to resident not getting out of his desired chair; verbal aggression. Interventions include administer medications as ordered, intervene as necessary to protect the rights and safety of others. Review of the physicians orders dated April 15, 2025 revealed monitoring episodes of restlessness, agitation every shift and record every shift, Depakote Oral Tablet Delayed Release 125 MG (Divalproex Sodium) Give 125 mg by mouth two times a day for Mood/AEB Impulsivity, Mirtazapine Tablet 15 MG Give 1 tablet by mouth in the evening for Depression as exhibited by poor by mouth intake; Quetiapine Fumarate Oral Tablet 50 MG (Quetiapine Fumarate) Give 1 tablet by mouth in the morning for as exhibited by mood. Review of the Medication Administration Record for April 15, 2025 revealed a change in the number of times dosage administered for antipsychotic due to elevated behaviors. Review of a Nurse Practitioners Note dated April 14, 2025 at 8:16 p.m. revealed -Patient seen sitting up in activities room eating breakfast without difficulty nurse reports patient with aggressive behavior towards females and other residents. POC discussed with nursing. PMH NP was also alerted to patient behavioral issues at this time. Patient denies any chest pain shortness of breath and has pleasant affect at time of assessment. NAD. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the nurse's progress notes dated April 14, 2025 at 3:25 p.m. revealed a note text: During a verbal disagreement between two resident #1 approached and began yelling at the male resident. He then began threatening the male resident and staff had to step between to calm the situation. Resident was escorted back to his room, while also threatening nurses and using vulgar language. A progress note dated April 14, 2025 at 1:31 p.m. revealed a nurse's note text: This writer spoke with CNA who witnessed the alleged res to res. CNA clarified that when she was passing out trays, she heard two residents talking loudly to each other, she turned around to see resident #1 contact resident #8 trying to get him to move chairs. At that time two CNA's stepped in to separate the two residents. A progress note dated April 13, 2025 at 4:46 p.m. revealed a nurse's note text; Nurse summoned to dining room per certified nursing assistant (CNA) reported per CNA resident #1 punched resident #8 because he would not get out of his desired chair. CNA reported hearing a sound when physical contact was made. This nurse attempted to escort resident #1 to his room. Resident #1 is resistive to redirection and had to be redirected X 4 before returning to his bedroom. Resident #8 assessed by other nurse on duty. Representative notified. Manager on duty notified. Nurse Practitioner notified. New order for Hydroxyzine 25mg by mouth every 6 hours as needed for Anxiety X 14days.Representative contacted regarding new order, she declined to initiate Hydroxyzine. Nurse Practitioner notified. A behavior progress note dated April 12, 2025 at 5:37 p.m. states reported per CNA resident #1 required redirection multiple times throughout the day. Resident #1 noted rubbing resident #4 leg. When redirected resident #1 stated, That's my girl. becoming visibly upset when asked to leave the area near resident #4. Frequent visual checks continue to maintain distance of resident #1 and resident #4. Nurse Practitioner notified. A behavior progress note dated April 5, 2025 at 4:31 p.m. revealed resident #1 had an eventful day exhibiting increased sexual tendencies towards female peers. resident #1 noted touching resident #6 legs several times while in the dining room. When redirected resident #1 becomes visibly angered and posturing. Resident #1 stated, I'm gonna do it again. resident #1 had to be redirected from propelling resident #4 female peer per wheelchair from dining room. resident #1 walked away but later returned visibly upset. Attempts to redirect, distract and calm resident #1 were unsuccessful. Resident #5 female peer was found lying in resident #1 room with resident #1 at bedside. When attempting to remove resident #5, resident #1 stated. It's ok, leave her alone, she's with me. A behavior progress note dated March 28, 2025 at 5:25 p.m. revealed resident #1 has been talking to a female resident and trying to get her to walk with him to his room all afternoon. He was walking the female resident in the direction of his room about 30 minutes ago when this nurse intercepted and started walking the resident back towards the activities room, and he swung a punch at this nurse. Resident is also entering the rooms of female residents continuously, and when staff ask him to leave the room, he does but then goes and enters another female resident's room very shortly thereafter. Will continue to monitor. A behavior progress note dated March 22, 2025 at 2:27 p.m. revealed Reported per CNA resident #1 noted slapping the buttocks of resident #3 The sister of resident #3 was present at the time. Nurse Practitioner notified of incident. New order for Depakote 125mg by mouth twice daily for Mood/AEB. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A behavior progress note dated March 21, 2025 at 2:28 p.m. revealed resident #1 increased sexual tendencies towards his female peers. Resident #1 noted leading resident #2. to his bedroom. This nurse attempted to redirect and intervene the situation, this only further angers the resident #1 This nurse leading resident #2 by hand to the common area but resident #1 became visibly upset stating, She's coming with me. Resident #1 grabbed her hand tighter and continued to walk towards his bedroom. This nurse acting as a barrier standing between residents #1 and #2. Resident #1 dropped her hand and walked away to his bedroom. Resident #1 family came to visit shortly after and is aware of the incident. Will notify Primary Care Physician. Resident Observation on April 18, 2025 at 8:18 a.m. resident #1 provided with 1:1 intervention for 12 hours by Certified Nursing Assistant (CNA/Staff #18). Stated she was informed April 17, 2025 that she would be providing 1:1 care for resident #1 and to monitor his behaviors due to aggression and sexualized behaviors, she stated this was the first time resident #1 has been provided with 1:1 care. Residents #2 and resident 6 were observed seated in recliners in the dining room. There were two CNA's present. -Regarding Resident #2 -Resident #2 was admitted to the facility February 8, 2025 with diagnosis that included metabolic encephalopathy, cognitive communication deficit and altered mental status, unspecified. A review of the Part A Discharge MDS dated [DATE] revealed Resident #2 completed a Brief Interview for Mental Status (BIMS) score of 02 indicating severe cognitive impairment. Review of the care plan date-initiated February 9 2025 and a revision on April 4, 2025 revealed a focus for psychosocial behaviors; exhibits or is at risk for behavioral symptoms delusions, hallucinations, anxiety, SI without a plan, agitation, disrobing, wandering into others rooms. Interventions included Administer medication as ordered, document and record behavioral episodes and manage environmental factors to optimize comfort. Review of the progress notes revealed a behavior note dated April 4, 2025 at 1:27 p.m. Note Text: Resident was found in another resident's room. Resident was easily directed out of room. Skin check was performed. No abnormal findings. An interview was conducted on April 17, 2025 at 12:46 p.m. with Licensed Practical Nurse (LPN/Staff #93). Stated resident #1 has sexual tendencies mostly touching and kissing, rubbing of female residents' legs and those who are ambulatory. Stated resident #1 is fixated on two of them, resident's #4 and #2. Stated resident #1 has be separated from her before and tried to take resident #2 to his room. Staff #93 stated resident #1 had taken a female resident to his room approximately six weeks ago. The resident was resident #4. Staff #93 stated resident #4 was in his room in her wheelchair and resident #1 was standing up pacing the room. Staff #93 stated resident #1 has kissed resident 2 and #4, he's touched them by rubbing their legs, and he grabbed both of resident #3 buttocks, Staff #93 stated resident #1 paces the unit and staff keep a visual with 15-minute checks on resident #1. Staff #93 stated resident #1 has not been provided with 1:1 intervention and that he is unpredictable with physical aggression and posturing. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on April 17, 2025 at 1:22 p.m. with Certified Nursing Assistant (CAN/Staff #59. She stated she was informed that LPN/Staff #93 resident went to go get resident #1 for dinner when she saw resident #2 laying in the bed, she stated resident #1- he was sitting in a chair in his room. she stated resident #2 paces and wanders and had not seen her for about 30 minutes. Staff #59 stated we have to watch out for resident #1 he touches the females. An interview was conducted on April 17, 2025 at 1:28p.m. with certified nursing assistant (CNA/Staff #51) CAN #51 stated she first became aware of the incident when the nurse (LPN/Staff #93) called out for help to resident #1 room. She stated both (LPN/Staff #29) went to the room to find resident #2 lying on top of resident #1 bed naked with no clothing on. Staff #51 stated resident #1 was seated at the bedside with his shirt off and had put on a coat jacket, further stating his pants were on, but could not recall if his shoes were on. Staff#51 stated staff #29 assisted with getting resident #2 dressed. Staff #51 stated she documented the incident in Point Click Care and assumed LPN# 93 and #29 had reported the incident to the Director of Nursing. Staff #93 stated the doctor; family and the DON are aware of resident #1 sexualized behaviors with the other residents. An interview was conducted on April 17, 2025 at 2:18p.m. with housekeeper (staff #80). Staff #80 stated she has observed resident #1 with two female residents on two different occasions. Staff #80 stated On Saturday April 5, 2025, sometime in the morning while cleaning resident rooms she observed resident #1 had resident #2 laying on his bed covered with a blanket. Staff #80 stated resident #1 had his hands underneath the blanket and was rubbing her body. Staff #80 stated it looked like he was rubbing her up and down from her upper thighs to her chest area and touching her legs. Staff #80 stated she immediately informed the CNA that works on the weekends (did not know her name) and also informed her supervisor, Director of Housekeeping (Staff # 42). Staff #80 stated she was hesitant as to what to do with what she had observed, but stated I knew it was the right thing to do. An interview was conducted on April 17, 2025 at 3:37 p.m. with Operations Manager/ Abuse Coordinator (Staff #62). Staff #62 stated he did not file a report with the state agency because he had not been informed that resident #2 was disrobed and was told that resident #1 was sitting on the other side of the room when found. Staff #62 stated based on the report he received from his staff that there was nothing reportable. An interview was conducted on April 18, 2025 at 10:25 a.m. with Director of Housekeeping (Staff # 42). Staff #42 stated that his expectations are that his staff notify and report what they see immediately. He also stated his staff are instructed to notify him immediately as to what they observed and what happened. Staff #80 stated he will then immediately notify the person in charge of that department and the unit manager for ay type of abuse. Staff #42 stated staff #80 telephoned him on Saturday April 5, 2025 at 9:32 a.m. informing him that she had observed resident #1 touching one of the female residents on the thighs in his room. He stated she also informed hm that the female resident was lying on his bed and was rubbing the female resident. Staff #42 stated that staff #80 informed him that she had told resident #1 to leave and had told one of the CNA's. Staff #42 stated he informed her she did the right thing and that he would handle it from there. Staff #42 stated he immediately called the Unit Manger (Staff #79). Staff #42 stated he told her that he was notified by one of the housekeepers that resident #1 was rubbing one of the residents on the thigh. Staff #42 stated he did not inform her that the female resident was observed lying on the bed in resident #1 room. Staff #42 stated he did not inform the Director of Nursing (DON/Staff #86) or the Abuse Coordinator (Staff #62). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted April 18, 2025 at 11:00 a.m. with Register Nurse Unit Manager (RN/UM/Staff #79). Staff # 79 stated she has been in the position as RN/UUM since March 2025 and that her responsibilities are to ensure everything is running ok and to make sure that unit is kept clean- residents are safe, family phone calls, log books updated- meds. Staff #79 stated staff report to her anything out of the norm. this would be anything that could lead to possible concerns, including inappropriate behaviors. Staff #79 stated inappropriate behaviors are reported to the DON, depending what is reported to her and if it is something that can be re-directed and no one is hurt from the behavior, then she feels no need to call the DON- Staff #79 stated she would notify the DON if a resident is hurt or imposing harm to another resident. Staff # 79 stated she notified on a Saturday morning that one of the housekeepers had seen a resident touching another resident. She stated it was on a Saturday-morning. She stated I just called the floor and told them to make sure that he [resident #1] is not around the girls. Further stating I did not feel that it warranted me calling the DON at that time. No one was hurt or in distress at that time. Staff #79 stated she was never informed of the residents sexualized behaviors and had that anything like that would warrant me to call my DON. Staff #79 stated does not take part in report with the nursing staff. -Regarding Resident #3 -Resident #3 was admitted to the facility March 7, 2025 with diagnosis that included vascular dementia, unspecified severity, with other behavioral disturbance, Alzheimer's disease, unspecified depression, unspecified, cerebral infarction, unspecified. A review of the admission MDS revealed a BIMS score of 7, indicating severe cognitive impairment. Further review revealed no indicators for mood or behaviors. There were indicators for wandering that occurred 1-3 days in the lookback period. Review of the care plan date-initiated March 19 2025 revealed a focus for risk for elopement and wandering related to disoriented to place and impaired safety awareness and impaired cognitive function, dementia or impaired thought processes related to dementia, difficulty making decisions and psychotropic drug use. Interventions included distracting the resident from wandering by offering pleasant diversions, intervene as appropriate and administer medications as ordered. Review of the progress notes revealed no documentation regarding the resident's buttocks being grabbed by resident #1. An interview was conducted April 17, 2025 at approximately 3:00 p.m. Resident #3 interviewed alone and in private in her room- pleasant and able to communicate and make needs knows- resident #3was able to recall being touched inappropriately by another resident. Stated yeah [NAME] has a bad habit of doing inappropriate things- I think he likes the ladies he grabbed my bottom. I didn't like him doing that, I try to keep away from him. I don't think he means any harm, but it's not nice for him to do that. Resident #3 stated I don't feel safe in my room, men come in all the time. I was changing my clothes and had just put on my bra when [NAME] came in. Sometimes I'll find people in my bed or they walk in your room at night. I had pushed the dresser against my door to keep them from coming in but they told me I couldn't. I don't remember if my sister was her with me, I can call and ask her if she was- (resident tried to call sister from cell phone no response. A male resident entered the resident's room during interview. later identified by staff as resident #10. Resident #10 was observed wandering around aimlessly going into different resident's rooms, no intervention observed by staff during observation on the unit. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident # 4 Resident was admitted to the facility December 8, 2023 with diagnosis that included unspecified dementia, unspecified severity, with agitation, restlessness and agitation, anxiety disorder, unspecified, impulsiveness, major depressive disorder, recurrent, unspecified. Review of the quarterly MDS dated [DATE] revealed a BIMS score of 12 indicating moderate cognitive impairment. The resident was assessed with a mild mood score of 10 with concerns with self-isolation and depression. There were also indicators for verbal behavioral symptoms directed towards others, e.g., threatening, screaming cursing at others, wandering and rejection of care with presence and frequency of this type occurred 1-3 days. Resident has no impairment of the upper or lower extremities and uses a wheelchair for mobility. Review of the care plan date-initiated December 15, 2023 and revised March 18, 2025 revealed a focus for elopement at risk for elopement, exit seeking, wandering related to dementia or other cognitive behavior and cognitive impairment loss related to Alzheimer's disease or other dementias. Interventions included allow wandering in safe areas within the facility, administering medication as ordered and anticipating the residents needs and met promptly. Review of the progress notes revealed no documentation regarding inappropriate touching or kissing of the resident by resident #4, An interview was conducted on April 17, 2025 at 12:46 p.m. with Licensed Practical Nurse (LPN/Staff #93). Stated resident #1 is fixated on two of them, resident's #4 and #2. Stated resident #1 has been separated from her before and tried to take resident #2 to his room. Staff #93 stated resident #1 had taken a female resident to his room approximately six weeks ago. The resident was resident #4. Staff #93 stated resident #1 has been observed kissing, touching and rubbing on resident #4 legs. An interview was conducted on April 17, 2025 at 1:28p.m. with certified nursing assistant (CNA/Staff #51) CNA #51 stated I know resident #1 touches residents #6 and #4, he will whisper in their ear; I don't know what he is saying. CNA #51 stated resident #1 will touch resident #4 and #6 on their arms and legs, stating it appears sexual when he touches them. -Regarding Resident #5 - Resident was admitted to the facility February 8, 2024 with diagnosis including cardiomyopathy, unspecified, altered mental status, unspecified, dementia in other diseases classified elsewhere, mild, with other behavioral disturbance cognitive communication deficit unspecified dementia, unspecified severity, with other behavioral disturbances. Review of the annual MDS dated [DATE] revealed a BIMS score of 03, indicating severe cognitive impairment. Resident not assessed for mood, unable to respond. Assessment for behaviors revealed other behavioral symptoms not directed toward others, places the resident at significant risk for physical illness or injury, interferes with the resident's care, interferes with the resident's participation in activities or social interactions, and significantly intrude on the privacy or activity of others. Further review of the MDS revealed the resident uses a wheelchair for mobility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan revealed a focus for cognitive impairment related to altered Alzheimer's disease or other dementias and the risk for elopement and wandering related to dementia and other cognitive behaviors, Interventions included administer medications as ordered, allow to wander in safe areas within the facility. Review of the progress notes revealed no documentation of and observation alleged incident involving resident #1 taking resident #5 to his room by the hand and attempting to lay her on his bed. The incident was reported to a certified nursing assistant who was able to intervene and remove resident #5 from resident #1 room. An interview was conducted on April 17, 2025 at 2:18p.m. with housekeeper (staff #80). Staff #80 stated she has observed resident #1 on two different occasions. Staff #80 stated I saw him in his room with her trying to lay her on his bed- I saw him take her by the hand to his room (Staff #80 did not know the residents name but was able to point the resident out- identified as [NAME]) Staff #80 stated I told the CNA who went in the room to get her. -Regarding Resident #6 Resident was admitted to the facility April 11, 2023 with diagnosis including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, cognitive communication deficit, Wernicke's encephalopathy Review of the quarterly MDS dated [DATE] revealed a BIMS score of o5, indicating severe cognitive impairment, no indicators for mood or behaviors. Uses walker and wheelchair for mobility. Review of the care plan revealed a focus for impaired cognitive function and thought processes related to vascular dementia, Wernicke's encephalopathy, and unspecified psychosis. Date Initiated: 04/23/2023 Revision on: 05/04/2023. Interventions included stress key words and present just one thought, question or command at a time. A behavior progress note dated April 5, 2025 at 4:31 p.m. revealed resident #1 had an eventful day exhibiting increased sexual tendencies towards female peers. resident #1 noted touching resident #6 legs several times while in the dining room. When redirected resident #1 becomes visibly angered and posturing. Resident #1 stated, I'm gonna do it again. -Regarding Resident #8 Resident #8 was admitted to the facility August 16, 2024 with diagnosis including unspecified dementia, severe, with psychotic disturbance, altered mental status, unspecified, depression, unspecified, anxiety disorder, unspecified. Review of the significant change of cognitive impairment MDS dated [DATE] revealed a BIMS score pf 03 indicating severe cognitive impairment, no indicators for [NAME] or behaviors, wandering with no impact on others, diagnosis for Anxiety disorder, Depression (other than bipolar), altered mental status, unspecified. Received Antipsychotic, Antidepressant, - gradual dose reduction (GDR) was attempted 11/30/2024- Physician documented GDR as clinically contraindicated 11/30/2024. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan date-initiated August 22, 2024 revealed a focus for Psychosocial-Emotional/Trauma: At risk for decreased psychosocial well-being physical, social, or spiritual wellbeing related to alleged incident with peer on April 13, 2025. Date Initiated: April 15, 2025 Revision on: April 15, 2025, Interventions: included contact resident representative/friend for comfort and support. Date Initiated April 15, 2025. Review of eINTERACT Change in Condition Evaluation dated April 13, 2025 at 6:02 p.m. revealed pain in side remains, No signs of bruising/abrasion on skin of left side, pain with movement. Open cyst on upper mid back, cleaned and applied dry dressing. Pain medications administered PRN, dressing change daily on upper back till healed. The change in condition and notifications reported to primary care clinician Review of Treatment Administration Record for April 2025 revealed new orders for treatment for ruptured cyst with a start date of April 14, 2025. Review of the physician order summary dated April 13, 2025 revealed a STAT order for an x-ray ribs left side for trauma during altercation, however the examination results dated April 14, 2025 at 1:39pm and reported date April 14, 2025 at 1:41 p.m. revealed significant findings of unilateral left ribs x-ray. The impression revealed an acute hairline of the left lower rib fracture. Review of the nurses progress noted dated April 13, 2025 at 6:38 p.m. revealed a note text of the following detail; Informed of altercation in dining room, resident states he came out of nowhere and hit me, it was hard enough to push me back in my chair. Skin assessment performed, cyst on upper mid back ruptured and wound care performed, pain in left side ribs under arm no bruising or open skin in that area. Pain reported level 7/10, PRN medication administered. NP [NAME] notified, x-ray ordered and wound care to cyst. An interview was conducted on April 17, 2025 at 12:46 p.m. with Licensed Practical Nurse (LPN/Staff #93). Stated there was an incident involving resident #1 and resident #8, Staff #93 stated it was time to serve dinner came and resident #1 came from his room. Staff #93 stated she was at the med cart. She stated she was told by staff resident #1 told resident #8 to get out of his chair and resident #8 said no and resident #1 struck resident #8 on the upper right back to mid area. Staff #93 stated a weekend intervened and there were lots of lots of commotion. Staff #93 stated resident #1 was standing away from the table and resident #8 was standing at the other side of the table. She stated she had to ask resident #1 to leave the area multiple time- he refused- She stated it took four attempts to get the resident #1 to leave. Staff #93 stated LPN/Staff#9 came and completed a skin check for resident #8. She stated resident #8 complained of pain on the side he had a ruptured cyst, located on the left near his scapula where resident #1 hit him- the ruptured cyst was noted at the time of the assessment. Staff #93 stated an assessment was not done for resident #1 since he had not been hit. An attempt to interview resident #8 was made on April 18, 2025 at 8:35 a.m. due to the resident's severe cognition, he could not recall the incident in detail. Resident was walking the hallways- pleasant mood. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on April 18, 2025 at 1:09 p.m. with Abuse Coordinator (Staff #62) regarding residents #1 and #8. Staff #62 stated he was informed by the DON (Staff #86) of the alleged incident on Sunday, April 13, 2025. Staff #62 stated he was informed there was an altercation between residents #1 and #8 who were fighting over a chair in the dining room and staff intervened and removed resident #1 from the dining room. Staff #62 stated he informed the DON to follow-up with staff on duty and get their statements and made some call to initiate the two-hour required investigation report for the state agency. Staff #62 stated following the investigation injuries reported for resident #8 with an oozing cyst and x-rays taken revealed a hairline fracture of his ribs and that the resident had complained of pain. Staff #62 stated the facility unsubstantiated their investigation based on follow-up with the staff at the time; that it appeared two residents and argued over the chair and staff were able to intervene before anything escalated. Staff #62 stated resident #1 and #8 were pleasant with each other following the incident. An interview was conducted on April 18, 2025 at 1:29 p.m. with Director of Nursing (DON/Staff #86) stated the process for reporting alleged abuse is reporting to the different agencies as soon as they are aware. He stated he provides his staff with as much training as possible and during the facility monthly all-staff meetings. He stated they are told to immediately report to their supervisor or to the abuse coordinator. The DON stated he monitors for potential abuse by rounding the units, keeping up with daily nursing notes and being in front with his teams. The DON stated actions taken to protect the residents and other residents from abuse during the investigation process for resident #1 and #8 were that they were immediately separated and provided with frequent checks. He stated Resident #1 is being monitored 1:1 and will be moving the resident to an all-male unit to protect the females on the unit and the other residents. He stated he was not informed of what had happened with resident #! Nor of the other incidents with the other females on the unit. He stated he is very upset with this information. The DON stated staff #79 is new to her role as unit manager and staff #93 is a new floor nurse, that they report the incidents to me immediately. It is not expected that they make that decision on their own. I will be providing some additional training and education for my new staff. Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, with a revision date of April 2021 revealed a policy statement All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Reporting allegations to the Administrator and authorities (2) The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. the resident's representative; d. Adult protective services; i.e. law enforcement officials; f. The resident's attending physician; and g. the facility's medical director. (3) Immediately is defined as: a. within two hours of an allegation involving abuse.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, review of facility records, and review of policies and procedures, the facility failed to have evidence that an alleged violation involving sexual abuse regarding five residents (#2, # 3, #4, #5 and #6) was thoroughly investigated. The deficient practice could result in additional alleged violations involving abuse not being investigated Findings include: -Regarding residents #1 and #2: -Resident #1 was admitted to the facility December 21, 2021 with dysphagia following cerebral infarction, unspecified dementia, mild, with agitation, schizophrenia, unspecified. A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 completed a Brief Interview for Mental Status (BIMS) score of 08 indicating moderate cognitive impairment. Further review of the MDS revealed no indicators for mood, but will self-isolate. Indicators for physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards others, other behavioral symptoms not directed towards others and wandering. These assessments occurred 1-3 days of the lookback period. Review of the care plan, date-initiated December 22, 2024 revealed a focus for elopement; resident at risk for elopement/exit seeking; wandering related to dementia and other cognitive behaviors. Further review of the care plan revealed focus for behavior problems, agitation related to depression and schizophrenia, likes to follow female residents around to help them with things, per family and the potential to be physically aggressive related to dementia, poor impulse control; citing incident on April 13, 2025 with another resident due to resident not getting out of his desired chair; verbal aggression. Interventions include administer medications as ordered, intervene as necessary to protect the rights and safety of others. Review of the physicians orders dated April 15, 2025 revealed monitoring episodes of restlessness, agitation every shift and record every shift, Depakote Oral Tablet Delayed Release 125 MG (Divalproex Sodium) Give 125 mg by mouth two times a day for Mood/AEB Impulsivity, Mirtazapine Tablet 15 MG Give 1 tablet by mouth in the evening for Depression as exhibited by poor by mouth intake; Quetiapine Fumarate Oral Tablet 50 MG (Quetiapine Fumarate) Give 1 tablet by mouth in the morning for as exhibited by mood. Review of the Medication Administration Record for April 15, 2025 revealed a change in the number of times dosage administered for antipsychotic due to elevated behaviors. Review of a Nurse Practitioners Note dated April 14, 2025 at 8:16 p.m. revealed -Patient seen sitting up in activities room eating breakfast without difficulty nurse reports patient with aggressive behavior towards females and other residents. POC discussed with nursing. PMH NP was also alerted to patient behavioral issues at this time. Patient denies any chest pain shortness of breath and has pleasant affect at time of assessment. NAD. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the nurse's progress notes dated April 14, 2025 at 3:25 p.m. revealed a note text: During a verbal disagreement between two resident #1 approached and began yelling at the male resident. He then began threatening the male resident and staff had to step between to calm the situation. Resident was escorted back to his room, while also threatening nurses and using vulgar language. A progress note dated April 14, 2025 at 1:31 p.m. revealed a nurse's note text: This writer spoke with CNA who witnessed the alleged res to res. CNA clarified that when she was passing out trays, she heard two residents talking loudly to each other, she turned around to see resident #1 contact resident #8 trying to get him to move chairs. At that time two CNA's stepped in to separate the two residents. A progress note dated April 13, 2025 at 4:46 p.m. revealed a nurse's note text; Nurse summoned to dining room per certified nursing assistant (CNA) reported per CNA resident #1 punched resident #8 because he would not get out of his desired chair. CNA reported hearing a sound when physical contact was made. This nurse attempted to escort resident #1 to his room. Resident #1 is resistive to redirection and had to be redirected X 4 before returning to his bedroom. Resident #8 assessed by other nurse on duty. Representative notified. Manager on duty notified. Nurse Practitioner notified. New order for Hydroxyzine 25mg by mouth every 6 hours as needed for Anxiety X 14days.Representative contacted regarding new order, she declined to initiate Hydroxyzine. Nurse Practitioner notified. A behavior progress note dated April 12, 2025 at 5:37 p.m. states reported per CNA resident #1 required redirection multiple times throughout the day. Resident #1 noted rubbing resident #4 leg. When redirected resident #1 stated, That's my girl. becoming visibly upset when asked to leave the area near resident #4. Frequent visual checks continue to maintain distance of resident #1 and resident #4. Nurse Practitioner notified. A behavior progress note dated April 5, 2025 at 4:31 p.m. revealed resident #1 had an eventful day exhibiting increased sexual tendencies towards female peers. resident #1 noted touching resident #6 legs several times while in the dining room. When redirected resident #1 becomes visibly angered and posturing. Resident #1 stated, I'm gonna do it again. resident #1 had to be redirected from propelling resident #4 female peer per wheelchair from dining room. resident #1 walked away but later returned visibly upset. Attempts to redirect, distract and calm resident #1 were unsuccessful. Resident #5 female peer was found lying in resident #1 room with resident #1 at bedside. When attempting to remove resident #5, resident #1 stated. It's ok, leave her alone, she's with me. A behavior progress note dated March 28, 2025 at 5:25 p.m. revealed resident #1 has been talking to a female resident and trying to get her to walk with him to his room all afternoon. He was walking the female resident in the direction of his room about 30 minutes ago when this nurse intercepted and started walking the resident back towards the activities room, and he swung a punch at this nurse. Resident is also entering the rooms of female residents continuously, and when staff ask him to leave the room, he does but then goes and enters another female resident's room very shortly thereafter. Will continue to monitor. A behavior progress note dated March 22, 2025 at 2:27 p.m. revealed Reported per CNA resident #1 noted slapping the buttocks of resident #3 The sister of resident #3 was present at the time. Nurse Practitioner notified of incident. New order for Depakote 125mg by mouth twice daily for Mood/AEB. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A behavior progress note dated March 21, 2025 at 2:28 p.m. revealed resident #1 increased sexual tendencies towards his female peers. Resident #1 noted leading resident #2. to his bedroom. This nurse attempted to redirect and intervene the situation, this only further angers the resident #1 This nurse leading resident #2 by hand to the common area but resident #1 became visibly upset stating, She's coming with me. Resident #1 grabbed her hand tighter and continued to walk towards his bedroom. This nurse acting as a barrier standing between residents #1 and #2. Resident #1 dropped her hand and walked away to his bedroom. Resident #1 family came to visit shortly after and is aware of the incident. Will notify Primary Care Physician. Resident Observation on April 18, 2025 at 8:18 a.m. resident #1 provided with 1:1 intervention for 12 hours by Certified Nursing Assistant (CNA/Staff #18). Stated she was informed April 17, 2025 that she would be providing 1:1 care for resident #1 and to monitor his behaviors due to aggression and sexualized behaviors, she stated this was the first time resident #1 has been provided with 1:1 care. Residents #2 and resident 6 were observed seated in recliners in the dining room. There were two CNA's present. -Regarding Resident #2 -Resident #2 was admitted to the facility February 8, 2025 with diagnosis that included metabolic encephalopathy, cognitive communication deficit and altered mental status, unspecified. A review of the Part A Discharge MDS dated [DATE] revealed Resident #2 completed a Brief Interview for Mental Status (BIMS) score of 02 indicating severe cognitive impairment. Review of the care plan date-initiated February 9 2025 and a revision on April 4, 2025 revealed a focus for psychosocial behaviors; exhibits or is at risk for behavioral symptoms delusions, hallucinations, anxiety, SI without a plan, agitation, disrobing, wandering into others rooms. Interventions included Administer medication as ordered, document and record behavioral episodes and manage environmental factors to optimize comfort. Review of the progress notes revealed a behavior note dated April 4, 2025 at 1:27 p.m. Note Text: Resident was found in another resident's room. Resident was easily directed out of room. Skin check was performed. No abnormal findings. An interview was conducted on April 17, 2025 at 12:46 p.m. with Licensed Practical Nurse (LPN/Staff #93). Stated resident #1 has sexual tendencies mostly touching and kissing, rubbing of female residents' legs and those who are ambulatory. Stated resident #1 is fixated on two of them, resident's #4 and #2. Stated resident #1 has be separated from her before and tried to take resident #2 to his room. Staff #93 stated resident #1 had taken a female resident to his room approximately six weeks ago. The resident was resident #4. Staff #93 stated resident #4 was in his room in her wheelchair and resident #1 was standing up pacing the room. Staff #93 stated resident #1 has kissed resident 2 and #4, he's touched them by rubbing their legs, and he grabbed both of resident #3 buttocks, Staff #93 stated resident #1 paces the unit and staff keep a visual with 15-minute checks on resident #1. Staff #93 stated resident #1 has not been provided with 1:1 intervention and that he is unpredictable with physical aggression and posturing. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on April 17, 2025 at 1:22 p.m. with Certified Nursing Assistant (CAN/Staff #59. She stated she was informed that LPN/Staff #93 resident went to go get resident #1 for dinner when she saw resident #2 laying in the bed, she stated resident #1- he was sitting in a chair in his room. she stated resident #2 paces and wanders and had not seen her for about 30 minutes. Staff #59 stated we have to watch out for resident #1 he touches the females. An interview was conducted on April 17, 2025 at 1:28p.m. with certified nursing assistant (CNA/Staff #51) CAN #51 stated she first became aware of the incident when the nurse (LPN/Staff #93) called out for help to resident #1 room. She stated both (LPN/Staff #29) went to the room to find resident #2 lying on top of resident #1 bed naked with no clothing on. Staff #51 stated resident #1 was seated at the bedside with his shirt off and had put on a coat jacket, further stating his pants were on, but could not recall if his shoes were on. Staff#51 stated staff #29 assisted with getting resident #2 dressed. Staff #51 stated she documented the incident in Point Click Care and assumed LPN# 93 and #29 had reported the incident to the Director of Nursing. Staff #93 stated the doctor; family and the DON are aware of resident #1 sexualized behaviors with the other residents. An interview was conducted on April 17, 2025 at 2:18p.m. with housekeeper (staff #80). Staff #80 stated she has observed resident #1 with two female residents on two different occasions. Staff #80 stated On Saturday April 5, 2025, sometime in the morning while cleaning resident rooms she observed resident #1 had resident #2 laying on his bed covered with a blanket. Staff #80 stated resident #1 had his hands underneath the blanket and was rubbing her body. Staff #80 stated it looked like he was rubbing her up and down from her upper thighs to her chest area and touching her legs. Staff #80 stated she immediately informed the CNA that works on the weekends (did not know her name) and also informed her supervisor, Director of Housekeeping (Staff # 42). Staff #80 stated she was hesitant as to what to do with what she had observed, but stated I knew it was the right thing to do. An interview was conducted on April 17, 2025 at 3:37 p.m. with Operations Manager/ Abuse Coordinator (Staff #62). Staff #62 stated he did not file a report with the state agency because he had not been informed that resident #2 was disrobed and was told that resident #1 was sitting on the other side of the room when found. Staff #62 stated based on the report he received from his staff that there was nothing reportable. An interview was conducted on April 18, 2025 at 10:25 a.m. with Director of Housekeeping (Staff # 42). Staff #42 stated that his expectations are that his staff notify and report what they see immediately. He also stated his staff are instructed to notify him immediately as to what they observed and what happened. Staff #80 stated he will then immediately notify the person in charge of that department and the unit manager for ay type of abuse. Staff #42 stated staff #80 telephoned him on Saturday April 5, 2025 at 9:32 a.m. informing him that she had observed resident #1 touching one of the female residents on the thighs in his room. He stated she also informed hm that the female resident was lying on his bed and was rubbing the female resident. Staff #42 stated that staff #80 informed him that she had told resident #1 to leave and had told one of the CNA's. Staff #42 stated he informed her she did the right thing and that he would handle it from there. Staff #42 stated he immediately called the Unit Manger (Staff #79). Staff #42 stated he told her that he was notified by one of the housekeepers that resident #1 was rubbing one of the residents on the thigh. Staff #42 stated he did not inform her that the female resident was observed lying on the bed in resident #1 room. Staff #42 stated he did not inform the Director of Nursing (DON/Staff #86) or the Abuse Coordinator (Staff #62). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted April 18, 2025 at 11:00 a.m. with Register Nurse Unit Manager (RN/UM/Staff #79). Staff # 79 stated she has been in the position as RN/UUM since March 2025 and that her responsibilities are to ensure everything is running ok and to make sure that unit is kept clean- residents are safe, family phone calls, log books updated- meds. Staff #79 stated staff report to her anything out of the norm. this would be anything that could lead to possible concerns, including inappropriate behaviors. Staff #79 stated inappropriate behaviors are reported to the DON, depending what is reported to her and if it is something that can be re-directed and no one is hurt from the behavior, then she feels no need to call the DON- Staff #79 stated she would notify the DON if a resident is hurt or imposing harm to another resident. Staff # 79 stated she notified on a Saturday morning that one of the housekeepers had seen a resident touching another resident. She stated it was on a Saturday-morning. She stated I just called the floor and told them to make sure that he [resident #1] is not around the girls. Further stating I did not feel that it warranted me calling the DON at that time. No one was hurt or in distress at that time. Staff #79 stated she was never informed of the residents sexualized behaviors and had that anything like that would warrant me to call my DON. Staff #79 stated does not take part in report with the nursing staff. -Regarding Resident #3 -Resident #3 was admitted to the facility March 7, 2025 with diagnosis that included vascular dementia, unspecified severity, with other behavioral disturbance, Alzheimer's disease, unspecified depression, unspecified, cerebral infarction, unspecified. A review of the admission MDS revealed a BIMS score of 7, indicating severe cognitive impairment. Further review revealed no indicators for mood or behaviors. There were indicators for wandering that occurred 1-3 days in the lookback period. Review of the care plan date-initiated March 19 2025 revealed a focus for risk for elopement and wandering related to disoriented to place and impaired safety awareness and impaired cognitive function, dementia or impaired thought processes related to dementia, difficulty making decisions and psychotropic drug use. Interventions included distracting the resident from wandering by offering pleasant diversions, intervene as appropriate and administer medications as ordered. Review of the progress notes revealed no documentation regarding the resident's buttocks being grabbed by resident #1. An interview was conducted April 17, 2025 at approximately 3:00 p.m. Resident #3 interviewed alone and in private in her room- pleasant and able to communicate and make needs knows- resident #3was able to recall being touched inappropriately by another resident. Stated yeah [NAME] has a bad habit of doing inappropriate things- I think he likes the ladies he grabbed my bottom. I didn't like him doing that, I try to keep away from him. I don't think he means any harm, but it's not nice for him to do that. Resident #3 stated I don't feel safe in my room, men come in all the time. I was changing my clothes and had just put on my bra when [NAME] came in. Sometimes I'll find people in my bed or they walk in your room at night. I had pushed the dresser against my door to keep them from coming in but they told me I couldn't. I don't remember if my sister was her with me, I can call and ask her if she was- (resident tried to call sister from cell phone no response. A male resident entered the resident's room during interview. later identified by staff as resident #10. Resident #10 was observed wandering around aimlessly going into different resident's rooms, no intervention observed by staff during observation on the unit. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident # 4 Resident was admitted to the facility December 8, 2023 with diagnosis that included unspecified dementia, unspecified severity, with agitation, restlessness and agitation, anxiety disorder, unspecified, impulsiveness, major depressive disorder, recurrent, unspecified. Review of the quarterly MDS dated [DATE] revealed a BIMS score of 12 indicating moderate cognitive impairment. The resident was assessed with a mild mood score of 10 with concerns with self-isolation and depression. There were also indicators for verbal behavioral symptoms directed towards others, e.g., threatening, screaming cursing at others, wandering and rejection of care with presence and frequency of this type occurred 1-3 days. Resident has no impairment of the upper or lower extremities and uses a wheelchair for mobility. Review of the care plan date-initiated December 15, 2023 and revised March 18, 2025 revealed a focus for elopement at risk for elopement, exit seeking, wandering related to dementia or other cognitive behavior and cognitive impairment loss related to Alzheimer's disease or other dementias. Interventions included allow wandering in safe areas within the facility, administering medication as ordered and anticipating the residents needs and met promptly. Review of the progress notes revealed no documentation regarding inappropriate touching or kissing of the resident by resident #4, An interview was conducted on April 17, 2025 at 12:46 p.m. with Licensed Practical Nurse (LPN/Staff #93). Stated resident #1 is fixated on two of them, resident's #4 and #2. Stated resident #1 has been separated from her before and tried to take resident #2 to his room. Staff #93 stated resident #1 had taken a female resident to his room approximately six weeks ago. The resident was resident #4. Staff #93 stated resident #1 has been observed kissing, touching and rubbing on resident #4 legs. An interview was conducted on April 17, 2025 at 1:28p.m. with certified nursing assistant (CNA/Staff #51) CNA #51 stated I know resident #1 touches residents #6 and #4, he will whisper in their ear; I don't know what he is saying. CNA #51 stated resident #1 will touch resident #4 and #6 on their arms and legs, stating it appears sexual when he touches them. -Regarding Resident #5 - Resident was admitted to the facility February 8, 2024 with diagnosis including cardiomyopathy, unspecified, altered mental status, unspecified, dementia in other diseases classified elsewhere, mild, with other behavioral disturbance cognitive communication deficit unspecified dementia, unspecified severity, with other behavioral disturbances. Review of the annual MDS dated [DATE] revealed a BIMS score of 03, indicating severe cognitive impairment. Resident not assessed for mood, unable to respond. Assessment for behaviors revealed other behavioral symptoms not directed toward others, places the resident at significant risk for physical illness or injury, interferes with the resident's care, interferes with the resident's participation in activities or social interactions, and significantly intrude on the privacy or activity of others. Further review of the MDS revealed the resident uses a wheelchair for mobility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035196	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandridge Post Acute	255 West Brown Road Mesa, AZ 85201

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan revealed a focus for cognitive impairment related to altered Alzheimer's disease or other dementias and the risk for elopement and wandering related to dementia and other cognitive behaviors, Interventions included administer medications as ordered, allow to wander in safe areas within the facility. Review of the progress notes revealed no documentation of and observation alleged incident involving resident #1 taking resident #5 to his room by the hand and attempting to lay her on his bed. The incident was reported to a certified nursing assistant who was able to intervene and remove resident #5 from resident #1 room. An interview was conducted on April 17, 2025 at 2:18p.m. with housekeeper (staff #80). Staff #80 stated she has observed resident #1 on two different occasions. Staff #80 stated I saw him in his room with her trying to lay her on his bed- I saw him take her by the hand to his room (Staff #80 did not know the residents name but was able to point the resident out- identified as [NAME]) Staff #80 stated I told the CNA who went in the room to get her. -Regarding Resident #6 Resident was admitted to the facility April 11, 2023 with diagnosis including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, cognitive communication deficit, Wernicke's encephalopathy Review of the quarterly MDS dated [DATE] revealed a BIMS score of o5, indicating severe cognitive impairment, no indicators for mood or behaviors. Uses walker and wheelchair for mobility. Review of the care plan revealed a focus for impaired cognitive function and thought processes related to vascular dementia, Wernicke's encephalopathy, and unspecified psychosis. Date Initiated: 04/23/2023 Revision on: 05/04/2023. Interventions included stress key words and present just one thought, question or command at a time. A behavior progress note dated April 5, 2025 at 4:31 p.m. revealed resident #1 had an eventful day exhibiting increased sexual tendencies towards female peers. resident #1 noted touching resident #6 legs several times while in the dining room. When redirected resident #1 becomes visibly angered and posturing. Resident #1 stated, I'm gonna do it again. -Regarding Resident #8 Resident #8 was admitted to the facility August 16, 2024 with diagnosis including unspecified dementia, severe, with psychotic disturbance, altered mental status, unspecified, depression, unspecified, anxiety disorder, unspecified. Review of the significant change of cognitive impairment MDS dated [DATE] revealed a BIMS score pf 03 indicating severe cognitive impairment, no indicators for [NAME] or behaviors, wandering with no impact on others, diagnosis for Anxiety disorder, Depression (other than bipolar), altered mental status, unspecified. Received Antipsychotic, Antidepressant, - gradual dose reduction (GDR) was attempted 11/30/2024- Physician documented GDR as clinically contraindicated 11/30/2024. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan date-initiated August 22, 2024 revealed a focus for Psychosocial-Emotional/Trauma: At risk for decreased psychosocial well-being physical, social, or spiritual wellbeing related to alleged incident with peer on April 13, 2025. Date Initiated: April 15, 2025 Revision on: April 15, 2025, Interventions: included contact resident representative/friend for comfort and support. Date Initiated April 15, 2025. Review of eINTERACT Change in Condition Evaluation dated April 13, 2025 at 6:02 p.m. revealed pain in side remains, No signs of bruising/abrasion on skin of left side, pain with movement. Open cyst on upper mid back, cleaned and applied dry dressing. Pain medications administered PRN, dressing change daily on upper back till healed. The change in condition and notifications reported to primary care clinician Review of Treatment Administration Record for April 2025 revealed new orders for treatment for ruptured cyst with a start date of April 14, 2025. Review of the physician order summary dated April 13, 2025 revealed a STAT order for an x-ray ribs left side for trauma during altercation, however the examination results dated April 14, 2025 at 1:39pm and reported date April 14, 2025 at 1:41 p.m. revealed significant findings of unilateral left ribs x-ray. The impression revealed an acute hairline of the left lower rib fracture. Review of the nurses progress noted dated April 13, 2025 at 6:38 p.m. revealed a note text of the following detail; Informed of altercation in dining room, resident states he came out of nowhere and hit me, it was hard enough to push me back in my chair. Skin assessment performed, cyst on upper mid back ruptured and wound care performed, pain in left side ribs under arm no bruising or open skin in that area. Pain reported level 7/10, PRN medication administered. NP [NAME] notified, x-ray ordered and wound care to cyst. An interview was conducted on April 17, 2025 at 12:46 p.m. with Licensed Practical Nurse (LPN/Staff #93). Stated there was an incident involving resident #1 and resident #8, Staff #93 stated it was time to serve dinner came and resident #1 came from his room. Staff #93 stated she was at the med cart. She stated she was told by staff resident #1 told resident #8 to get out of his chair and resident #8 said no and resident #1 struck resident #8 on the upper right back to mid area. Staff #93 stated a weekend intervened and there were lots of lots of commotion. Staff #93 stated resident #1 was standing away from the table and resident #8 was standing at the other side of the table. She stated she had to ask resident #1 to leave the area multiple time- he refused- She stated it took four attempts to get the resident #1 to leave. Staff #93 stated LPN/Staff#9 came and completed a skin check for resident #8. She stated resident #8 complained of pain on the side he had a ruptured cyst, located on the left near his scapula where resident #1 hit him- the ruptured cyst was noted at the time of the assessment. Staff #93 stated an assessment was not done for resident #1 since he had not been hit. An attempt to interview resident #8 was made on April 18, 2025 at 8:35 a.m. due to the resident's severe cognition, he could not recall the incident in detail. Resident was walking the hallways- pleasant mood. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on April 18, 2025 at 1:09 p.m. with Abuse Coordinator (Staff #62) regarding residents #1 and #8. Staff #62 stated he was informed by the DON (Staff #86) of the alleged incident on Sunday, April 13, 2025. Staff #62 stated he was informed there was an altercation between residents #1 and #8 who were fighting over a chair in the dining room and staff intervened and removed resident #1 from the dining room. Staff #62 stated he informed the DON to follow-up with staff on duty and get their statements and made some call to initiate the two-hour required investigation report for the state agency. Staff #62 stated following the investigation injuries reported for resident #8 with an oozing cyst and x-rays taken revealed a hairline fracture of his ribs and that the resident had complained of pain. Staff #62 stated the facility unsubstantiated their investigation based on follow-up with the staff at the time; that it appeared two residents and argued over the chair and staff were able to intervene before anything escalated. Staff #62 stated resident #1 and #8 were pleasant with each other following the incident. An interview was conducted on April 18, 2025 at 1:29 p.m. with Director of Nursing (DON/Staff #86) stated the process for reporting alleged abuse is reporting to the different agencies as soon as they are aware. He stated he provides his staff with as much training as possible and during the facility monthly all-staff meetings. He stated they are told to immediately report to their supervisor or to the abuse coordinator. The DON stated he monitors for potential abuse by rounding the units, keeping up with daily nursing notes and being in front with his teams. The DON stated actions taken to protect the residents and other residents from abuse during the investigation process for resident #1 and #8 were that they were immediately separated and provided with frequent checks. He stated Resident #1 is being monitored 1:1 and will be moving the resident to an all-male unit to protect the females on the unit and the other residents. He stated he was not informed of what had happened with resident #! Nor of the other incidents with the other females on the unit. He stated he is very upset with this information. The DON stated staff #79 is new to her role as unit manager and staff #93 is a new floor nurse, that they report the incidents to me immediately. It is not expected that they make that decision on their own. I will be providing some additional training and education for my new staff. Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, with a revision date of April 2021 revealed a policy statement All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Reporting allegations to the Administrator and authorities (2) The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. the resident's representative; d. Adult protective services; i.e. law enforcement officials; f. The resident's attending physician; and g. the facility's medical director. (3) Immediately is defined as: a. within two hours of an allegation involving abuse