STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055833	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton Gardens Post Acute, LLC	537 E. Fulton Street Stockton, CA 95204

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to provide a homelike environment for five of five residents (Resident 4, Resident 5, Resident 6, and Resident 7, and Resident 8) when,Resident 4 displayed episodes of aggression, and repeated yelling throughout the day and night and Resident 4 behavior care plans were not person centered, and staff were not able to address it; and, Multiple residents including Resident 5, Resident 6, Resident 7, and Resident 8 were negatively affected by Resident 4's continuous yelling and had reported to staff their frustration and lack of sleep and/or rest.This deficient practice had the potential to negatively affect the psychosocial (the mental, emotional, social, and spiritual effects of a disease) and physical well-being of the facility's residents. Findings:Review of Resident 4's admission RECORD, indicated, Resident 4 was originally admitted to the facility in the fall of 2023 with a diagnosis including but not limited to cerebrovascular disease (condition that affect blood flow to your brain), vascular dementia (changes in thinking and memory that occur when there isn't enough blood flow to part of the brain, as can happen with a stroke), schizophrenia (A serious mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior.) psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions) not due to a substance or known physiological condition, generalized anxiety disorder (mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), legal blindness (status that government agencies can grant when you have severe vision loss), and difficulty in walking. Review of Resident 4's BRIEF INTERVIEW FOR MENTAL STATUS (BIMS) (a tool that healthcare providers use to assess a person's cognitive function), dated 7/18/25, indicated, Resident 4 had a BIMS score of 5, which indicated severe cognitive impairment (0-7 points, when a person has significant trouble with cognitive tasks, and will likely need extensive help from the others to navigate daily life). Review of Resident 4's Order Summary Report, indicated, .monitor for any combative behavior such as hitting and scratching staff, every shift for combative behavior.Order Date 11/4/23. Review of Resident 4's Behavior Care Plan, dated 11/6/23, indicated, .The resident has a behavior r/t increased agitation/combative w/ [with] screaming and yelling.Goal.The resident will have fewer episodes by review date.Interventions.Anticipate and meet the resident's needs.Assist the resident to develop more appropriate methods of coping and interacting. Encourage the resident to express feelings appropriately.If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident.Minimize potential for the resident's disruptive behaviors (Specify) by offering tasks which divert attention (Specify).Staff will provide one on one care in resident's room as staffing allows to promote calming environment for [name redacted, Resident 4] which decreases his disruptive behavior within the facility. During a phone interview and record review on 9/23/25, at 9:45 a.m., the ADON reviewed Resident 4's Behavior Care Plan and acknowledged the areas of the plan which said Specify were not filled out for specific disruptive behaviors and tasks that should have been offered to Resident 4. The ADON stated the care plan should be person centered. The ADON stated the expectation was that it was filled in with tasks such as offering of food and/or assisting behavior. The ADON stated the care plan was a guide for staff (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	including how to manage behaviors and to prevent them for residents. The ADON stated the ?Intervention' section was not clear on what staff should do. The ADON acknowledged the last revision date was 6/6/24 and stated there should be a review date listed and should have been revised after the most recent altercation with Resident 3 in May of 2025. During a phone interview on 9/10/25, at 12:49 p.m., LN 2 stated Resident 4 would scream and scream if nobody was there with him. LN 2 stated Resident 4 needs someone there with him and it was important to let him know that someone was there as this provides comfort for him. LN 2 stated staff would push Resident 4 in his wheelchair to the dining room to keep him company. During an interview and record review on 9/10/25, at 1:55 p.m., the ADON stated Resident 4 was confused and tended to be aggressive. The ADON stated Resident 4 currently had a roommate. The ADON stated Resident 4 can stand up and he cannot see and on the night of 5/27/25 he might have gotten lost. The ADON stated Resident 4 was transferred to another room after the incident. Through review of Resident 4's clinical record the ADON stated Resident 4 had a BIMS score of 5 which indicated a severe cognition deficit. The ADON stated Resident 4 was receiving psychiatric care, but his family did not want him medicated with psychiatric drugs because they thought it made him overly sleepy and because of this his medications had been reduced. The ADON stated when Resident 4 was on the medications the psychiatrist had recommended, he was more pleasant. During an interview on 9/10/25, at 3:11 p.m., CNA 2 stated Resident 4 was always yelling, and he thought it was part of his mental health condition. CNA 2 stated he kept an eye on Resident 4, and he would not listen to staff. CNA 2 stated Resident 4 often yells out in his native language, and he cannot understand him. CNA 2 stated Resident 4 could walk with assistance. CNA 2 explained if staff use the proper soft voice soft, Resident 4 can be calm, and he likes staff to stay close to him. CNA 2 stated they take Resident 4 out of his room and place him by the nursing station. CNA 2 stated he was not sure if Resident 4 was blind. CNA 2 stated Resident 4's yelling bothers other residents and they will often begin yelling at Resident 4 to shut up. During an observation on 9/10/25, at 3:17 p.m., Resident 4 was observed in the hallway across from the nursing station, he was standing up from his wheelchair, and an alarm was heard. CNA 2 was observed running towards Resident 4 to assist him. During a concurrent observation and interview on 9/10/25, at 3:20 p.m., Resident 5's room door was observed to be closed, and a sign was attached to the door stating to knock prior to entering, the room was observed to be a few doors down the hall from Resident 4's room. Resident 5 was observed laying in her back and was wearing headphones. Resident 5 stated she had lived at the facility for many years and preferred to stay in her room due to her limited mobility. Resident 5 stated Resident 4 (name redacted) could not be controlled, and he was awake at all hours of the night and early morning and would start hollering nonstop. Resident 5 stated the hollering was at all hours, was sporadic, loud, and in different languages and would get everyone else worked up. Resident 5 stated in response the other residents would start yelling too. Resident 5 stated Resident 4 had been physically aggressive with another roommate and was hitting them. Resident 5 explained Resident 4 had hit a staff member and fractured their rib and had bit another staff member. Resident 5 stated she wore noise counseling headphones due to lack of sleep from the noise, and she had been woken up from her sleep due to Resident 4's yelling. Resident 5 stated the yelling, and noise affected her mental health and made her feel crazy and frazzled. During an interview on 9/10/25, at 3:27 p.m., CNA 3 stated Resident 4 screams and shouts and staff will ask him what the matter and he will say nothing. CNA 3 thought he was confused. CNA 3 stated Resident 3 screams very loudly throughout the day and night. CNA 3 explained it was very disturbing and disruptive to the other residents, and they could not get any sleep. CNA 3 stated Resident 4 had been like this the whole time he had been at the facility. CNA 3 stated Resident 4's medications help him, but he will refuse his medication. CNA 3 stated Resident 4 would shout out profanities to other residents and one time he tried to hit a resident. CNA 3 explained the incident that happened in his room and was an altercation with a roommate where Resident 4 hit the roommate. CNA 3 stated Resident 4 went through many roommates due to his shouting. CNA 3 stated Resident 4 shouts at (continued on next page)

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Resident 7 stated he had an altercation with Resident 4 because he told him to shut up because he was about to get socked [to hit or strike very hard] up. Resident 7 stated he was angry because he could not sleep. Resident 7 stated he had karate chopped his table because of his frustration and having to listen to the guy constantly yelling. During a concurrent observation and interview on 9/11/25, 10:58 a.m., Resident 8 was observed in his wheelchair, leaving an adjacent room, and requested to speak to the surveyor. Resident 8 stated his room was two doors down from Resident 4's (name redacted) room and Resident 4 get up at 3:30 a.m. in the morning and he screams and yells at the top of his lungs for 13 hours straight. Resident 8 stated Resident 4 screams at night and during the day and it has been going on since he got here in July of 2025. Resident 8 stated this made him feel exhausted and tired. Resident 8 explained he tried to sleep in the morning but sometimes could not sleep at all. Resident 8 further explained the residents were angry. Resident 8 stated Resident 4 was agitated because he was blind and bored. Resident 8 stated even Resident 4's roommate would tell him to shut up'. Resident 8 stated Resident 4 was very disruptive, and this led to other residents constantly yelling out shut up and take my life. During a concurrent observation and interview on 9/11/25, at 10:38 a.m., Resident 4 was observed in his room, sitting in a wheelchair at the end of his bed. It was observed that Resident 4 had a roommate who was sleeping in his bed. Resident 4 stated he could not see, he needed help, and someone needed to take his hand and help him. Resident 4 stated he needed someone to bring him to school. Resident 4 stated there were no activities for him to do. Resident 4 repeated he needed someone to stand next to him and to hold his hand and it was too difficult for him to find out what to do. Resident 4 stated he had a problem with calling out, and if he needed help, he could talk with his mouth. During an observation on 9/11/25, at 10:45 a.m., in the hallway, outside of Resident 4's room an alarm was heard, staff members were observed running into Resident 4's room. During an interview on 9/11/25, at 10:50 a.m., CNA 8 stated he responded to Resident 4's wheelchair alarm and it went off because Resident 4 stood up and needed redirection. CNA 8 stated Resident 8 was very physically and verbally combative, disruptive, and not easily redirected. CNA 8 stated Resident 4 would curse other residents. CNA 8 stated Resident 4 could get up from his wheelchair and staff tried to redirect and called the family and he missed his family and was mean and angry. CNA 8 stated Resident 4 could not see, was blind. CNA 8 explained he would put music on, and it calmed Resident 4. CNA 8 stated Resident 4 would yell out for pretty much eight hours straight. CNA 8 stated other residents told him they cannot sleep and cannot rest because of the yelling at night. CNA 8 stated the nursing staff tried to redirect him, but he still screamed all night. CNA 8 stated staff have tried to have Resident 4 join activities and the assisted feeding program, but he was disruptive and caused the other residents to become more confused and disruptive, so they did not have him attend. During an interview on 9/11/25, at 1:31 p.m., LN 1 stated Resident 4 yells constantly and it was all through the day and night and has done so since admission. LN 1 stated residents complained they could not sleep, and administration were aware, and they had tried to adjust medications. LN 1 stated when Resident 4 goes to the activities room he will yell which aggravates the other residents, so he mostly stays in his room or by the nursing station. LN 1 stated Resident 4 was blind and if he has someone close by, he will stop screaming, as he just wants someone to talk to. LN 1 stated Resident 4 had never had a continuous one on one. During a phone interview on 9/11/25, at 12:20 p.m., Responsible Party (RP) stated Resident 4 had a stroke which caused him vision issues and was blind. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was they can rest at night and have a relaxing day and not listen to constant yelling. The ADON stated the expectation was if a resident was yelling staff needs to attend to that resident right away as yelling can be a stressor to others. During a review of a facility policy and procedure (P&P) titled HOMELIKE ENVIRONMENT, revised 1/2025, the document indicated, .The facility strives to provide a personalized, homelike environment which recognizes the individuality and autonomy of the resident, provides an opportunity for self-expression.DEFINITIONS: Homelike Environment: is one that de-emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a homelike environment . facility environment should enhance the quality of life for residents, in accordance with resident preferences. Facility personnel strive for person-centered care that emphasizes individualization, relationships and a psychosocial environment that welcomes each resident and makes her/him comfortable. During a review of a facility P&P titled DEVELOP-IMPLEMENT COMPREHENSIVE CARE PLANS POLICY STATEMENT, revised 1/2025, indicated, .The facility develops a person-centered comprehensive care plan that are culturally competent and trauma-informed, developed and implemented to meet each resident's preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.Resident's Goal: The resident's desired outcomes and preferences for admission, which guide decision making during care planning.Interventions: Actions, treatments, procedures, or activities designed to meet an objective.Person-Centered Care: means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.The interdisciplinary team develops the care plan with corresponding interventions for care that is in accordance with professional standards of practice and accounting for residents' experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident.Care plans shall describe the resident's needs and preferences and how the facility will assist in meeting these needs and preferences.Care plans shall include the discipline providing care or services, measurable objectives, and timeframes in order to evaluate the resident's progress toward his/her goal(s).

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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 observation, interview, and record review, the facility failed to protect one of two sampled residents (Resident 3) right to be free from physical abuse and neglect (failure to provide goods and services necessary to avoid physical harm or mental anguish) when, 1. Resident 3, with a diagnosis of paraplegia (inability to feel or move your legs, making it impossible to stand or walk) was placed in Resident 4's room as his roommate even though Resident 4 had a history of aggressive behavior towards staff and other residents. Subsequently, on 5/27/25, Resident 3 called repeatedly for staff assistance due to Resident 4 coming over to his side of the room and at approximately 2:20 a.m., Resident 4 walked over to Resident 3's side of the room, pulled his room curtain, grabbed Resident 3's call light and tossed it off the bed, grabbed his throat, and began choking him. 2. The facility failed to implement measures that would ensure residents in the facility were safe from Resident 4 by constructing an individualized plan detailing approaches to maintain the safety of Resident 3 and other residents in the facility. These failures resulted in Resident 3 feeling trapped and scared for his life, and had the potential to negatively affect Resident 3's psychosocial (the mental, emotional, social, and spiritual effects of a disease) wellbeing and/or cause him serious injury and/or death.1.Review of Resident 3's admission RECORD, indicated, Resident 3 was admitted to the facility late June/2025 with a diagnosis including but not limited to paraplegia, fusion of the cervical (neck) spine (surgery to connect two or more bones in the neck which prevents them from moving), contracture left hand (causes one or more fingers to bend toward the palm of the hand and can reduce movement and flexibility), and contracture right hand. Review of Resident 3's Care Plan, dated 5/22/25, indicated, .The resident has paraplegia r/t [related to] PERSONAL or HISTORY OF TRANSIENT ISCHEMIC ATTACK (TIA [temporary blockage of blood flow to brain and cause symptoms of stroke), AND CEREBRAL INFARCTION [blood flow to brain is stopped or reduced causing brain cells to die, can cause paralysis, memory loss, trouble talking, and may need help with self-care] , resulting in .SPINAL STENOSIS, CERVICAL REGION.Goal.The resident will maintain optimal status and quality of life within limitations through review date. Review of Resident 3's Care Plan, dated 5/22/25, indicated, .The resident had limited physical mobility r/t [related to] . CONTRACTURE.PARAPLEGIA.SPINAL STENOSIS.PERSONAL HISTORY OF TRANSIENT ISCHEMIC ATTACK (TIA), AND CEREBRAL INFARCTION.Goal.The resident will maintain current level of mobility. Review of Resident 3's Care Plan, dated 5/22/25, indicated, .The resident has altered respiratory status/Difficulty Breathing r/t DX [diagnosis] of Pneumonia [infection in the lungs which can cause difficulty in breathing] .Goal.The resident will have no complication related to SOB [shortness of breath] . Review of Resident 3's SBAR [which stands for Situation, Background, Assessment, and Recommendation (or Request), is a structured communication framework that can help teams share information about the condition of a patient that the team needs to address] Change of Condition, dated 5/29/25, written by Licensed Nurse (LN) 4, indicated, .Situation.alleged physical abuse.This started on.5/27/25.Primary diagnosis.Pneumonia.Assessment Details.CNA found resident (alleged abuser [name redacted, Resident 4]) at the victim's side of bed. Per victim, abuser hit him on the right hip and stomach. While victim tries to push abuser away, he grabbed his face, poke his left eye, and choke. Upon assessment, no post incident injury noted. No bruising or discoloration. Victim denies any pain. Orientation remains within baseline. Review of Resident 3's IDT [Interdisciplinary Team, a group of professionals who collaborate to accomplish a common goal] PROGRESS NOTES - INCIDENT / ACCIDENT, dated, 5/27/76, written by the Director of Nursing (DON), indicated, .On 5/27/25 approximately 0220 [2:20 a.m.], [redacted, Resident 4] standing beside [redacted, Resident 3] bed side. Immediately CNA [Certified Nurse Assistant] removed [redacted, Resident 4] aggressor away from [redacted, Resident 3]. CN [charge nurse] relocated [redacted, Resident 4] into rm [room (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	number redacted] then went back inside [redacted, Resident 3] room for full body assessment, no scratches, or redness around his neck, no discoloration/redness to left eye but observed watery, no skin discoloration o right hip or RLQ [right lower quadrant] abd [abdomen]/stomach. [redacted, Resident 3] stated that [redacted, Resident 4] came to his side of the bed and sat down beside him on the right side and said press it press it, I know he can see because he kept saying press it to my call light then he threw my call light away from me. [redacted, Resident 3] tried to move his hand to tell him to get off from his bed butcan't [sic] move his arms so much, that's when [redacted, Resident 4] hit his right hip and RLQ abd/stomach, while [redacted, Resident 3 tries to push [redacted Resident 4] away, he [Resident 4] grabbed his [Resident 3] face, pressed his left eye and choke him. CN informed res. [Resident 3] he doesn't have any skin impairment like scratch or discoloration around neck, right hip or RLQ of abd/stomach, no discoloration to left eye however CN observed eye to be watery. CNA got wet wash cloth to wipe res [Resident 3] eyes and it was helpful and eased the stinging to left eye. CN notified res. [Resident 3] that [Resident 4] will be transferred to [redacted, room number] .then CN left res. [resident] to rest. Review of Resident 3's Social Services Progress Notes,, dated 5/27/25, indicated, .SS [Social Services] visited resident this morning to ask in regards the roommate incident. Resident mentioned roommate kept going back and forth to resident's side until roommate sat down next to resident. Roommate taped [sic, meaning tapped] resident to make it was on bed, then attempt hitting him in face, threw call light, placed hands around resident's neck, and [NAME] [sic, meaning poked] in resident's left eye. After assessment no injuries were noted besides left watery eye. Psychosocial support was provided. Psych services were offered as well to make sure resident was ok. During a phone interview on 9/10/25, at 2:53 p.m., Resident 3 stated he cannot move his legs due to being a paraplegic and had limited use of his hands due to a previous stroke. Resident 3 stated he was sharing a room with Resident 4. Resident 3 stated Resident 4 screams and hollers all day and night, and he could not get any sleep. Resident 3 recalled the altercation involving Resident 4 on 5/27/25, and stated it happened in the early morning around 3:00 a.m. Resident 3 stated Resident 4 had walked over to his side of the room, stood next to his bed and kept trying to hit him. Resident 3 stated he had used his call light prior to the altercation, to alert staff that Resident 4 was on his side of his room, and he did not want him there and he feared Resident 4. Resident 3 stated on the third incident of Resident 4 walking over to his side of the room that night, Resident 4 pulled his room curtain then grabbed his call light and tossed the call light off the bed. Resident 3 explained Resident 4 grabbed his throat and began choking him. Resident 3 stated he could not get away from Resident 4, felt trapped, was scared for his life and started hollering for help. Resident 3 stated every time Resident 4 came over to his side of the room, he felt scared, and he would use his call light and yelled out for help. Resident 3 stated staff came into his room to assist every time, and each time Resident 4 was over on his side of the room. Resident 3 stated staff told Resident 4 he was not supposed to be there. Resident 3 explained that staff told him they could not move Resident 4 to a different room because it was in the middle of the night. Resident 3 stated after Resident 4 choked him, staff came in and moved Resident 4 outside of the room and placed him in the hallway. Resident 3 stated there was a scratch on his neck after the altercation and police came and took a statement form him and spoke to Resident 4 as well. 2. Review of Resident 4's admission RECORD, indicated, Resident 4 was originally admitted to the facility in the fall of 2023 with a diagnosis including but not limited to cerebrovascular disease (condition that affect blood flow to your brain), vascular dementia (changes in thinking and memory that occur when there isn't enough blood flow to part of the brain, as can happen with a stroke), schizophrenia (A serious mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior.) psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions) not due to a substance or known physiological condition, generalized anxiety disorder (mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), legal blindness (status that (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	government agencies can grant when you have severe vision loss), and difficulty in walking. Review of Resident 4's BRIEF INTERVIEW FOR MENTAL STATUS (BIMS) (a tool that healthcare providers use to assess a person's cognitive function), dated 7/18/25, indicated, Resident 4 had a BIMS score of 5, which indicated severe cognitive impairment (0-7 points, when a person has significant trouble with cognitive tasks, and will likely need extensive help from the others to navigate daily life). Review of Resident 4's Order Summary Report, indicated, .monitor for any combative behavior such as hitting and scratching staff, every shift for combative behavior.Order Date 11/4/23. Review of Resident 4's Behavior Care Plan, dated 11/6/23, indicated, .The resident has a behavior r/t increased agitation/combative w/ [with] screaming and yelling.Goal.The resident will have fewer episodes by review date.Interventions.Anticipate and meet the resident's needs.Assist the resident to develop more appropriate methods of coping and interacting. Encourage the resident to express feelings appropriately.If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident.Minimize potential for the resident's disruptive behaviors (Specify) by offering tasks which divert attention (Specify).Staff will provide one on one care in resident's room as staffing allows to promote calming environment for [name redacted, Resident 4] which decreases his disruptive behavior within the facility. During a phone interview and record review on 9/23/25, at 9:45 a.m., the ADON reviewed Resident 4's Behavior Care Plan and acknowledged the areas of the plan which said Specify were not filled out for specific disruptive behaviors and tasks that should have been offered to Resident 4. The ADON stated the care plan should be person centered. The ADON stated the expectation was that it was filled in with tasks such as offering of food and/or assisting behavior. The ADON stated the care plan was a guide for staff including how to manage behaviors and to prevent them for residents. The ADON stated the ?Intervention' section was not clear on what staff should do. The ADON acknowledged the last revision date was 6/6/24 and stated there should be a review date listed and should have been revised after the most recent altercation with Resident 3 in May of 2025. The ADON stated her expectation for staff was they were to ask Resident 4 what he needed and stated his behavioral care plan should have been more specific so staff know how to care for Resident 4 and what interventions should be implemented to manage his behaviors. Review of Resident's 4's Behavior Management Care Plan, dated 1/30/24, indicated, .The resident uses psychotropic medications Depakote [mood altering medication] r/t [related to] Behavior management.Goal.The resident will have fewer episodes by review date.Interventions.The resident is on a behavior management program with (Specify: alternatives to prn [as needed] medication use).Monito/record occurrence of for target behavior symptoms (Specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. Etc.) and document per facility protocol. Review of Resident 4's SBAR: Change of Condition, dated 5/27/25, written by LN 3, indicated, .Situation.physical aggression (initiated).This started on.5/27/25.Primary diagnosis.CEREBRAL VASCULAR DISEASE.Assessment Details.Resident unable to provide details of the resident. alert and verbally responsive to care. Review of Resident 4's IDT PROGRESS NOTES - INCIDENT / ACCIDENT, dated, 5/27/76, written by the DON, indicated, .On 5/27/25 approximately 0200 [2:20 a.m.], [redacted, Resident 4] had an alleged aggression (recieved0 from [redacted, Resident 4]. CN went to res [redacted, Resident 4] to ask about the incident, however res [sic, Resident 4] unable to provide description of the incident r/t cognitive impairment AEB [as evidence by] BIMS of 07 with confusion upon admission. Will continue plan of care.IDT rec [recommendation].separated both res [sic, residents] and transferred to another rm [room].by himself. During a concurrent interview and record review on 9/9/25, at 2:50 p.m., the Social Services Director (SSD) stated resident to resident altercations required the facility to complete a three day follow up which includes monitoring the resident for psychiatric changes. The SSD stated for residents who engaged in repeated resident to resident altercations the primary intervention would be a psychiatry consultation. During a phone interview on 9/10/25, at 12:49 p.m., LN 2 stated Resident 4 would scream and scream if nobody was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement appropriate safety measures to ensure a safe environment free of accidents or hazards and prevent elopement (form of unsupervised wandering that leads to the resident leaving the facility) for two of two residents (Resident 1 and Resident 2) when, 1. Resident 1 had a documented history of substance use disorder (SUD, a disease that affects a person's brain and behavior and leads to an inability to control the use of a legal or illegal drug or medicine and can refer to the use of illegal substances, such as marijuana, methamphetamine and the misuse of legal substances such as alcohol or prescription medications) and was homeless, and there was not a plan in place to address Resident 1's risk of exit seeking or eloping behavior, nor was Resident 1 advised of the risk of leaving the facility early, and subsequently Resident 1 eloped from the facility in the early morning hours of 7/8/25, with his PICC (peripherally inserted central catheter, is a long, thin tube that's inserted through a vein in the arm and the tube is passed through to the larger veins near the heart and is used to give medications or liquid nutrition) line intact. As a result of the Resident 1s elopement, he did not finish his intravenous (IV) antibiotic (medication used to treat serious infections and administered directly into the person's bloodstream through a vein) treatment, scheduled to end on 7/30/25; and, 2. Resident 2 had a documented history of SUD and the facility did not have careplan in place to provided access to or offered drug counseling or other access to SUD support groups and to monitor Resident 2's visitors who may be under the influence of illicit drug (illicit drug includes not only illegal drugs but also prescription medications that are obtained or used unlawfully), and subsequently on 8/29/25, Resident 2 was visited by her boyfriend who was under the influence of drugs and assaulted Resident 2 in her room. These failures had the potential to result in Resident 1 and Resident 2 sustaining life-threatening injury and/or psychosocial (the mental, emotional, social, and spiritual effects of a disease) harm. 1.Review of Resident 1's admission RECORD, indicated, Resident 1 was admitted to the facility late June/2025 with a diagnosis including but not limited to osteomyelitis (bone infections), Type 2 diabetes mellitus (body cannot regulate blood sugar) with foot ulcer (open sore that often develops in people with diabetes), absence of right toes (surgical removal of toes), acquired absence of right toe(s), acquired absence of left toe(s), other stimulant abuse (stimulants have high addiction potential, example is methamphetamine, can cause anxiety, rapid heart rate, or fatal overdose), and abnormalities of gait (walking) and mobility.Review of Resident 1's ED [Emergency Department] Physician Notes, dated 6/18/25, indicated, .FROM [name redacted, shelter] FOR LOWER EXTREMITY PAIN. PT [patient] STATES HE HAS FOOT ULCER. PMH [past medical history] .AMPUTATION [surgical removal] OF ALL 10 TOES AND DM [diabetes mellitus] .Diagnosis this visit. Problem List/Past Medical History.Diabetic foot infection.Methamphetamine abuse (lab made stimulant with high addiction potential) .Review of Resident 1's Hospital History and Physical, dated 6/18/25, indicated, .[name redacted, Resident 1] is a 50yo [year old] homeless male.pt [patient] says his right stump has started to hurt more for past one day.Problem List/Past Medical History.Ongoing. Diabetic foot infection.Methamphetamine abuse.noncompliance with medication regimen.severe sepsis [life-threatening medical emergency}.suicide risk.Review of Resident 1's Hospital Discharge summary, dated [DATE], indicated, . Patient was seen and evaluated on the day of discharge. PICC line was placed on 6/24/25.He will continue to IV vancomycin [strong antibiotic used to treat bacterial infections] [1 g [gram, unit of measure] twice daily till 7/30/25.PICC line can be removed after this last dose. He will follow up with podiatry [medical specialty dedicated to conditions affecting the foot and lower leg] .Review of Resident 1'a Psychosocial Assessment/Social History/Discharge Planning, dated 6/27/25 and signed by the Social Service Director (SSD), indicated, .History of alcohol/substance use.No.Currently smokes .No.Living arrangement prior to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hospitalization.shelter [temporary living situation for someone experiencing homelessness, providing a bed in a shared space] . Review of Resident 1's Wandering/Elopement Risk Evaluation,, dated 6/25/25, indicated, .RESIDENT EVALUATION FACTORS: Does the resident have the ability to walk or self-propel off the premises without assistance .No. Review of Resident 1' Smoking Risk Assessment, dated 6/25/25, indicated, .Does the resident currently smoke .Yes.Review of Resident 1' History and Physical Option, dated 6/26/25, written by the Medical Doctor (MD) 1, indicated, .he [Resident 1] will be on iv vancomycin till 7/30/35.via picc line.Review of Resident 1's Health Status Note, dated 6/29/25, indicated, .on monitoring for IV ABT [antibiotics]/osteomyelitis.also on monitoring for hyperglycemia [high blood sugar] with noncompliant with food.resident continue to request for food.education resident on the importance oof a balance diet for a diabetic resident.resident verbalized okay but continue to request for food. Review of Resident 1's Assessment Summary, written by LN 4, dated 7/8/25, indicated, SBAR [which stands for Situation, Background, Assessment, and Recommendation (or Request), is a structured communication framework that can help teams share information about the condition of a patient that the team needs to address] Communication for Changes in Condition.The change in condition, symptoms, or signs I am calling about is/are: elopement.Started on 7/08/25.Staffs observed that resident could not be located within the facility. Resident [Resident 1] was last seen by his primary nurse around 0310 [3:10 a.m.] on a black shirt in his wheelchair coming out from the patio. Also, one of the CNAs saw resident around 0320 [3:20 a.m.] asking if resident needs anything. Resident is AO4 [alert and orientated times four, meaning alter to person, place, time, and event], no signs of distress or eloping noted, PICC line present, Facility wide search conducted, code green initiated [meaning resident elopement], looked at the nearby park but resident still cannot be found. Police department notified.During an interview on 9/8/25 at 4:00 p.m., the Administrator (ADM) stated Resident 1 left in the middle of the night and as far as she knew he had not contacted his family, and she was not sure of his whereabouts. The ADM stated Resident 1 was admitted to the facility for IV antibiotics and was here from June 24th through July 8th. The ADM stated he was normally a night owl, and his mother said he was homeless prior to coming to the facility. During a concurrent interview and record review on 9/9/25, at 2:50 p.m., the SSD stated Resident 1 had a history of being homeless and prior to his hospital and facility admission he was living in a homeless shelter. The SSD explained the plan was for him to return to the shelter on discharge. The SSD stated Resident 1 decided to leave the facility unannounced in the middle of the night on 7/8/25. The SSD stated she spoke to Resident 1's mom and she said she was not concerned with his whereabouts. The SSD stated Resident 1 was being treated for osteomyelitis with IV antibiotics administered via a PICC line and had not finished his antibiotic course when he left the facility. The SSD confirmed Resident 1 left the facility with his PICC line intact. The SSD stated she had performed a risk assessment for Resident 1 on admission due to his current homelessness and was not aware Resident 1 had been using methamphetamines prior to him being admitted into the facility. The SSD stated if a resident voiced, they were drug seeking then staff would create a care plan to address the behavior. Through record review of Resident 1's Psychosocial Assessment/Social History/Discharge Planning, the SSD confirmed it was marked no for history of drug use. The SSD stated if a resident was using illicit drugs before their hospital admission, then the facility would want to address the drug use. The SSD explained they would want to offer the resident counseling and a psychiatry referral. The SSD stated Resident 1 was homeless and the shelter he was previously staying at would not take him back if he was actively using drugs or alcohol because sobriety was a condition of the housing agreement. The SSD stated he was living at the shelter a couple of months prior to being admitted to the hospital so she thought he was not using drugs. The SSD stated nursing staff would be looking at Resident 1's hospital discharge papers and not social services, so she was not aware of the hospital's documentation. Through record review of Resident 1's ED Physician Notes, the SSD confirmed the last date of methamphetamine use was 5/18/25. The SSD stated Resident 1 should have had a care plan addressing his methamphetamine drug use. The SSD stated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	seeking and elopement risk should have been identified and care planned as he could have experienced drug withdrawals or suffered a relapse of drug use while in the facility. The ADON explained the drug seeking and potential elopement risk was important to care plan and address clinically so nursing staff were aware so the residents could be monitored, and staff can ensure measures were in place to keep the residents safe. The ADON confirmed Resident 1 left the faciity on 7/8/25, with his PICC line and did not finish his antibiotic treatment course which was scheduled to end on 7/30/25. The ADON stated for residents with a history of homelessness and recent drug use, nursing staff would have wanted to address the risks of leaving before their treatment ends. The ADON stated the risk for Resident 1 would have been at increased risk for infection from not completing his antibiotic treatment. The ADON stated that normally social service deals with homelessness and drug use, but she could see how this could affect the clinical nursing side of ensuring the care of the residents. 2.Review of Resident 2's admission RECORD, indicated, Resident 2 was admitted to the facility late July//2025 with a diagnosis including but not limited to ulcer with perforation (hole or break in the stomach and is a medical emergency), perforation of intestine (a hole or break in the wall of the gastrointestinal (GI) tract, which causes intestinal contents to leak into the abdomen), other psychoactive substance abuse (drug addiction), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and can affect how a person feels, thinks and behaves and can lead to a variety of emotional and physical problems), and unsteadiness on feet.Review of Resident 2's Hospital Adult admission History, dated 8/21/25, indicated, .admitted From.Homeless.Transportation Issues.Yes.Alcohol.Current.Beer, Wine, Liquor.Substance Abuse.Current.Marijuana.Review of Resident 2's Order Summary Report, indicated, .Appointment with [Medical Doctor, name redacted] on 9/8/25 @ 3:30 pm.pt [patient] will arrange [name redacted, ride-hailing service] transport.Review of Resident 2's Health Status Note, dated 9/9/25, indicated, .Resident makes her appointment on 9/10/25.Resident arrange her transportation via [name redacted, ride-hailing service] .Review of Resident 2's Care Plan, dated 9/2/25, indicated, .Resident has discharge plans pending to a less restrictive environment. History of being homeless at risk for leaving AMA [against medical advice] .Goal. Resident will be discharged to less restrictive environment per MD's [medical doctor] order when deemed appropriate.Interventions.Invite resident/support person to care plans meetings as planned/and requested.Review of Resident 2's History and Physical Option, dated 8/30/25, written by the MD 2, indicated, .This is a medically complex patient.Patient has a history of hypertension, meth [methamphetamine] use.Review of Resident 2's Psychosocial Assessment/Social History/Discharge Planning, dated 9/2/25 and signed by the SSD, indicated, .Gender Female.History of alcohol/substance use.Yes.Have you ever experienced any physical/psychological trauma.NO.MOOD & BEHAVIORAL/MEDICATION RECEIVED.Resident Mood/Areas of Concern Review.Episodes of depression due to previous relationships and health concerns. Referral to psyc [sic, meaning psychiatrist, a medical doctor specializing in treating mental health conditions] was submitted.Psychiatric/ Psychological consult. [not marked] .Living arrangement prior to hospitalization.living alone.Location prior to hospitalization.Homeless. Review of the report indicated Resident 2 did not have a history of alcohol, substance use, and/or history of trauma, and contradicted to Resident 2's clinical medical record.Review of Resident 1's SBAR: Change of Condition, dated 8/30/25, written by LN 2, indicated, .Situation.Alleged Abuse from Boyfriend.This Started on.8/29/25.Other relevant information.Residents boyfriend noted with alleged drug abuse.Assessment/ Appearance.Appearance Details:. at 1905 [7:05 p.m.], resident reported that her boyfriend, [name redacted] visited her @ [at] 1900 [7:00 p.m.] and talked to her about money. The visitor was allegedly under the influence of drugs and got triggered when the resident's bedside phone started ringing, causing [name redacted, boyfriend] to get agitated. He began questioning the resident Who's calling you on the phone and grabbing her face by cheeks and pushing her onto the bed when the resident tried to move away. [name redacted, boyfriend] was reported to have threatened to slap her but didn't follow through. Resident also (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 2's boyfriend had been rough with her. LN 2 recalled Resident 2 stated her boyfriend was agitated, got physical and held her by her cheeks and pushed her onto the bed. LN 2 stated Resident 2 had discoloration on both sides of the cheeks. LN 2 stated he followed protocol including calling the police department and filing the abuse report. LN 2 stated Resident 2 told him she thought her boyfriend was under the influence of harder drugs like fentanyl and did not want to be around him or his friends requested he not be allowed in the facility. LN 2 stated for new admissions the night shift creates resident care plans. LN 2 stated Resident 2's former illicit drug use should have been care planned. LN 2 explained the care plans would help to inform staff of the needs of residents and staff should be aware that visitors could potentially bring illicit drugs or alcohol in the building for residents with addiction issues. LN 2 stated there was potential risk to the resident or others for exposure to illicit drugs or potential overdose. LN 2 stated the interventions were necessary due to the high risk of relapse and addiction was a very serious thing. LN 2 explained residents with addiction issues could exhibit exit seeking behavior such as wandering or leaving the facility.During a concurrent observation and interview on 9/11/25, at 1:32 p.m., Resident 2 stated yesterday she took a lift ride to her primary care doctor appointment and facility did not help her arrange the appointment or transportation. Resident 2 stated she had to wait two hours after her appointment to get a ride back and needed help getting her blood work done the doctor ordered. Resident 2 explained she could not get a ride there and needed help getting transportation to her medical appointments. Resident 2 stated she had shared with the nurses how difficult it has been to get her medical appointments arranged and trying to get her own transportation but no one from the facility has offered to help her. Resident 2 stated she tried to go to the Social Service office but has not been able to speak with anyone. Resident 2 stated she has anxiety about where she was going to live when she leaves because she doesn't want to go back to living on the streets. Resident 2 stated she would like to have drug counseling while at the facility. Resident 2 stated she loved the feeling of being sober and because of being sober her daughter had come around to visit her at the facility. Resident 2 explained it had been three years since she had spoken with her children. Resident 2 stated she was scared she was going to relapse. Resident 2 stated staff had not offered help with addiction, behavior, or housing support. Resident 2 stated she had been diagnosed with anxiety and was taking medications to help with it. Resident 2 stated she had PTSD and felt sad and would start to cry randomly.During an interview on 9/11/25, at 2:53 p.m., with the SSD and the ADON, the SSD stated the facility can provide transportation for residents with outside medical or other appointments and the assistant administrator helps with this. The ADON stated nursing staff could help schedule medical appointments. The SSD stated she could help with locating substance abuse programs and scheduling appointments for residents. The SSD stated for residents with a history of substance abuse within the last six months, staff would want to address this with the residents and develop interventions to be used in a care plan. The SSD explained residents who were agreeable to participate in a drug or alcohol abuse pro