STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065166	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Poudre Canyon Rehabilitation and Nursing, LLC	1000 S Lemay Ave Fort Collins, CO 80524

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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** 48112 Based on observations, interviews and record review, the facility failed to take steps to protect residents from abuse for four (#9, #7, #8 and #4) of 20 residents reviewed for abuse out of 22 sample residents. Specifically, the facility failed to: -Protect Resident #9 from repeated instances of sexual abuse by a visitor; -Protect Resident #7 and Resident #8 from physical abuse by each other; and, -Protect Resident #4 from physical abuse by Resident #22 in two separate incidents. I. Facility policy and procedure The Abuse, Neglect and Exploitation policy, revised 4/11/25, was provided by the director of nursing (DON) on 5/6/26 at 12:22 p.m. It read in pertinent part, Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include resident-to-resident altercations. It includes sexual abuse and physical abuse. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. II. Incidents of alleged sexual abuse between Resident #9 and Resident #9's visitor on 2/1/25, 4/12/25 and 4/23/25. A. Facility investigation of the alleged sexual abuse on 2/1/25 (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	The 5/13/25 interdisciplinary (IDT) nurse progress note (written during the survey) revealed a certified nurse aide (CNA) reported Resident #9's boyfriend was observed with his hands inside the resident's shirt, touching the resident's breast (on 2/1/25). The CNA asked the boyfriend to move to a common area. The CNA notified the nurse, who said the facility talked to Resident #9's mother and the mother was okay with the interactions. The facility had interviewed the nurse the CNA reported the incident to on 2/1/25. The nurse did not recall the incident or being notified of the incident. The nurse remembered having a conversation with the mom about the boyfriend and his visits. The nurse said the resident was more vocal when the boyfriend was around. The nurse said Resident #9's mother said she was okay with the resident's boyfriend visiting the resident and she had no concerns about him. She said he had been visiting him for a long time and had never had any issues at other visits. The note documented the risk factors and root cause were that Resident #9 had a history of anoxic brain damage, impeding her ability to communicate and express her thoughts and feelings. The visitor was her boyfriend at the time of the incident that caused the resident's brain injury. The resident's parents were her legal representatives and continued to encourage a relationship between the resident and her boyfriend. The resident's parents provided transportation for the boyfriend to visit and he was typically only able to visit on weekends. Resident #9's parents did not stay for the visits and preferred for the staff to manage the interactions between the resident and her boyfriend. The facility was unable to substantiate or unsubstantiated the allegation of sexual abuse because the resident was unable to communicate her side of the incident. The investigation had been turned over to the local police department and adult protective services (APS) for further investigation. The new interventions included that the boyfriend was not permitted to visit at the time (effective 5/13/25). A care conference was set up with both of Resident #9's parents, the ombudsman, APS, the police department and the social services director (SSD). B. Facility investigation of the alleged sexual abuse on 4/12/25 The witness statement, dated 4/12/25 and written by an unknown CNA (per the NHA), documented Resident #9's boyfriend touched Resident #9 in what appeared to be an inappropriate manner. The resident, who was non-verbal, was screaming. The CNA entered the room and advised the boyfriend they needed to go to the television (TV) room. The witness immediately reported the incident to the nurse, and the nurse took over from there. The 4/12/25 nurse incident note revealed the staff reported the incident between Resident #9 and her boyfriend to the NHA. The nursing staff called the police to report Resident #9's boyfriend, as the staff felt there was inappropriate touching happening in the lounge and the resident was not able to consent to the interactions. The resident was deemed safe, as the boyfriend was no longer in the facility. A skin assessment was completed on Resident #9 with no unusual findings. The family was notified of the incident. The 4/14/25 IDT event note revealed the CNA notified the nurse and the NHA, as she felt Resident #9's visitor was touching her inappropriately. The resident did not have the capacity to consent to the advances. The resident's boyfriend denied the interactions, however, he left shortly after the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The note indicated the risk factor and root cause identified was the resident had a history of anoxic brain damage, impeding her inability to communicate and express her thoughts and feelings. Her visitor was her boyfriend at the time of the incident leading to the brain injury. The resident's parents were her representatives and continued to encourage a relationship between the resident and her boyfriend. The parents provided transportation for him to visit and he was typically only able to visit on weekends. Resident #9's parents did not stay for the visits and preferred for the staff to manage interactions between the resident and the boyfriend, as they wanted to remain a neutral party. The note indicated the prior interventions were anticipating the resident's needs, encouraging out-of-room activities, encouraging relationships with family and friends, allowing space and limiting touch when able. New interventions were the resident's parents would like visits to continue with the boyfriend as the parents believed the interactions were good for the resident. The staff were to ensure visits happened in line of sight and the boyfriend was not permitted to be in the resident's room without staff or the resident's parents present. The 4/14/25 NHA progress note revealed the NHA spoke to Resident #9's parents regarding what happened over the weekend (on 4/12/25). He said he wanted to talk to the resident's boyfriend to get his side of the story. The parents understood the facility's position and wanted to stay out of it to not have any ill-will with the boyfriend. The NHA expressed he understood their position but he was not concerned about their feelings, but the safety of the resident. The 4/23/25 NHA note revealed the NHA had a private discussion with the resident's boyfriend. The NHA said he was a mandated reporter for certain things. The NHA informed the boyfriend of an incident that staff observed on 4/12/25 during his visit with Resident #9 and how the staff thought they witnessed something that made them uncomfortable. The NHA said the police were called. The boyfriend was shocked at the allegation and was completely confused as to what was going on. The NHA expressed to him this was standard protocol, that an investigation was being conducted and no one was being accused or labeled as anything. The resident's boyfriend left the NHA's office, said goodbye to the resident and immediately left. The resident's father picked him up, as he had relied on the resident's family to always bring him to the facility. The 4/24/25 NHA note revealed the NHA received a phone call from the resident's mother wondering how the conversation with the resident's boyfriend went and if the NHA needed anything from her. The NHA reiterated that the police and the State Agency were notified of the 4/12/25 incident. The NHA said the boyfriend needed to stay away until the investigation was completed. The 5/1/25 NHA note revealed the NHA received a phone call from Resident #9's boyfriend that he wanted to visit the resident and asking if that was allowed. The NHA said it would be okay but there were new ground rules for visiting the resident. The visits had to be in the TV room and around people. The NHA said he needed to make sure the boyfriend's hand would stay above Resident #9's waist and only on her hands or shoulders. The NHA said kisses had to be kept to the forehead only. The NHA said since the resident could not verbalize, everything had to stay nice and innocent. The 5/12/25 NHA note revealed the NHA called the boyfriend to let him know the facility was putting all visits from him to Resident #9 on hold until he heard from the NHA again. The boyfriend said he understood. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 5/12/25 SSD note revealed a care conference was scheduled for Resident #9 on 5/15/25 at 1:00 p.m. The resident's parents and the regional ombudsman were invited. The facility's conclusion of the internal investigation was that the incident on 4/12/25 was unsubstantiated (see NHA's interview below). -Review of the 4/12/25 investigation revealed there was no documentation to indicate there was immediate education to staff to keep the resident safe while the investigation was in process. By not having immediate education in place, a second alleged allegation was made on 4/23/25 (see investigation below). -However, the facility failed to conduct a timely and thorough investigation of the incident, to include interviewing Resident #9's boyfriend, in order to prevent another potential sexual abuse incident from occurring. Due to this, an additional allegation of sexual abuse occurred on 4/23/25 (see investigation below). Cross-reference F610 for failure to fully investigate an allegation of sexual abuse. -Additionally, the facility failed to submit a final report of the investigation to the State Agency until 4/24/25, seven days after the final report was due. Cross-reference F609 for failure to report an allegation of sexual abuse. C. Facility investigation of the alleged sexual abuse on 4/23/25 The 5/15/25 IDT nurse progress note (written during the survey) revealed that during the 2/1/25 alleged sexual abuse investigation staff interviews, a CNA reported that she noted Resident #9's boyfriend had his hands between her legs moving up and down (on 4/23/25). The CNA notified nursing that day and the NHA. The boyfriend and the NHA had a conversation on 4/23/25 and the boyfriend left. The resident's representatives, the medical director (MD), the DON, the police department , APS and the ombudsman were notified. The note documented the risk factors and root cause were Resident #9 had a history of anoxic brain damage, impeding her ability to communicate and express her thoughts and feelings. The visitor was her boyfriend at the time of the incident leading to the brain injury. The resident's parents were her representatives and continued to encourage a relationship between the resident and her boyfriend. The resident's parents provided transportation for him to visit and he was typically only able to visit on weekends. Resident #9's parents did not stay for the visits and preferred for the staff to manage the interactions between the resident and her boyfriend. The facility was unable to substantiate or unsubstantiate the allegation, as the resident was unable to communicate her side of the incident. The investigation had been turned over to the police department. The new interventions included that the boyfriend was not permitted to visit at the time (effective 5/13/25). A care conference was set up with both parents, the ombudsman, APS, the police department and the SSD. The police department and APS were investigating. D. Resident #9 - victim (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident status Resident #9, age less than 65, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included anoxic brain damage, hepatitis C, bipolar disorder, and contracture of muscles in multiple sites. The 4/2/25 minimum data set (MDS) assessment revealed a brief interview for mental status (BIMS) was not conducted because the resident was rarely or never understood. According to the staff assessment for mental status, the resident had short and long-term memory problems and her cognitive skills for daily decision making were severely impaired. 2. Record review The communication care plan, revised 12/20/24, revealed Resident #9 had impaired cognition and communication deficits related to anoxic brain injuries. Interventions included staff to ensure visits with the boyfriend happened in community areas and the boyfriend was not permitted to be in a room with the resident without staff or the resident's parents present. -However, the intervention was not initiated until 4/18/25, six days after the alleged incident on 4/12/25. The psychosocial well-being care plan, initiated 4/12/25 and revised 5/7/25, revealed Resident #9 had a potential for alteration to psychosocial well-being related to being a victim of alleged sexual abuse. Interventions included monitoring and documenting the resident's verbal reactions to situations that may indicate her feelings, initiated 4/12/25. Additional interventions , initiated on 5/7/25 (during the survey), included encouraging Resident #9 to participate in meaningful relationships. The resident was in a romantic relationship prior to her accident and her family felt it was beneficial for her to maintain her relationship. If her boyfriend visited, they should meet in a common area or in the presence of the resident's parents. The 5/7/25 interventions additionally included monitoring the resident's mood and behavior, providing opportunities for the resident and family to participate in care and the resident was assessed as not having the capacity to consent to sexual activity. The trauma informed care plan, revised 11/1/24, revealed Resident #9 had a history of trauma that affected her negatively. Interventions included that the resident's boyfriend was not allowed visitation. If he showed up at the facility, staff was to notify the police (initiated 5/7/25 and revised 5/13/25). A sexual activity capacity for consent was completed on 4/14/25. It revealed Resident #9 had a history of anoxic brain injury, she was unable to communicate effectively, and she was unable to determine the level of cognitive status. Due to the resident's inability to communicate effectively and describe her thoughts and feelings, the IDT determined the resident could not make or express her desire to engage in sexual intimacy with others. -However, despite the determination that Resident #9 did not have the capacity to consent to sexual intimacy, the facility failed to put effective interventions in place to protect the resident from another alleged sexual incident with the boyfriend on 4/23/25 (see investigation above). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. 5/15/25 facility care conference A care conference was observed (during the survey) on 5/15/25 from 1:04 p.m. until 2:32 p.m. Resident #9, the resident's father, the resident's mother, the NHA, the DON, the SSD, the ombudsman, a local police detective, an APS representative, regional nurse consultant (RNC) #1, RNC #2, regional vice president of operations (RVPO) and the medical director (MD) were present. The DON said the facility wanted to have the care conference to establish what was in the best interest for Resident #9 in regards to the boyfriend's visits, review the CNAs concerns and to hear from the resident's parents what was best for the resident for her quality of life. The DON said three different CNAs saw Resident #9's boyfriend touch the resident down her pants, in between her legs and down her shirt. The APS representative said she was at the care conference because there was concern about whether or not the resident could consent and understand an intimate type of relationship. The police detective said he had concerns that Resident #9 did not have the capability to have a sexual relationship and did not have the capability to consent. The police detective said he was going to talk to the boyfriend directly and recommended no alone visitations. The DON said the resident was not able to fully communicate if she was okay or not okay in regards to the sexual abuse allegations. The DON, the NHA, the RVPO and Resident #9's mother agreed the resident's boyfriend could visit and it would be a supervised visit by the NHA or the DON. The DON said the facility would write up a plan for the visits and document Resident #9's reactions so the facility knew when the resident wanted the boyfriend around and when she did not want the boyfriend around. F. Staff interviews The physician (PHY) was interviewed on 5/7/25 at 11:03 a.m. The PHY was familiar with Resident #9. She said the resident did not have the ability to consent to sexual intimacy with others. She said she was not part of the sexual activity capacity for consent assessment. She said she did hear about Resident #9's boyfriend allegedly fondling the resident. She said the boyfriend had been her boyfriend for several years before her anoxic brain injury. She said the boyfriend was not happy with the decision the facility made regarding the new rules for when he visited the resident. The NHA was interviewed on 5/7/25 at 2:05 p.m. The NHA said the alleged sexual abuse incident with Resident #9 and her boyfriend occurred on Saturday, 4/12/25. He said he contacted the resident's parents on Monday, 4/14/25, to obtain the boyfriend's contact information. He said prior to the allegation, the facility did not have the boyfriend's contact information. The NHA said the boyfriend visited the resident on the weekends and the resident's parents provided transportation. The NHA said if the boyfriend visited on a Saturday, he would not visit on a Sunday. The NHA said he thought the resident was safe and he did not need to contact the parents for the boyfriend's contact information until the Monday following the allegation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON said, prior to 5/12/25, when Resident #9's boyfriend was allowed to visit, the boyfriend could visit the resident in a supervised area. The DON said the instruction to her staff was to notify the DON if he visited so someone could be assigned to supervise the visit. The DON said there was not a set plan if he were to show up unplanned. The NHA said Resident #9's mother told the NHA when the boyfriend would visit one to two days prior to the visit. The NHA said he knew the boyfriend was going to visit on 4/23/25 in the early morning, around 8:30 a. m. The NHA said he and the DON went into a meeting on 4/23/25 from 9:15 a.m. to 9:45 a.m. The NHA said the boyfriend had not arrived by the end of the 9:45 a.m. meeting. The NHA said the DON went into another meeting and he went across the street for ten minutes. The NHA said around 10:00 a.m. the boyfriend was observed with Resident #9 in the common area with no staff member assigned to monitor the visit. LPN #4 was interviewed on 5/15/25 at 9:10 a.m. LPN #4 said he knew a visitor was not allowed to visit a resident if they were not on a list posted at the nurses' station. He said management told him verbally. LPN #4 said it was also in the resident's medical chart. He said if he saw a visitor who was not allowed to visit a resident, he would ask the visitor to leave. He said if the visitor did not leave, he would tell the NHA or the DON and then call the police. He said Resident #9's boyfriend was not allowed to visit but he said he did not have a picture of the resident's boyfriend. LPN #4 said he was told Resident #9's boyfriend could not visit the resident a couple of weeks ago, but he said he was not sure of the exact date. LPN #4 said prior to the boyfriend not being able to visit the resident, he was told the boyfriend could visit in a public space. He said he never saw staff sit with the resident and her boyfriend when the boyfriend was in the facility. CNA #9 was interviewed on 5/15/25 at 9:10 a.m. CNA #9 said the NHA and the DON communicated what visitors could not visit a resident. She said if the NHA or the DON did not tell her who could not visit, a nurse told her. She said there were pictures of visitors who could not visit the residents. She said if she saw a visitor who could not visit a resident, she would ask the visitor to leave. She said she would tell the NHA or the DON and call the police. CNA #9 said Resident #9's boyfriend could not visit. She said she was told a couple of weeks ago that he could not visit. She said there should be a picture of him at the nurses' station, but there was not one posted yet. She said when he did visit with the resident previously, it was unsupervised and she was never told to monitor his visits. CNA #5 was interviewed a second time on 5/15/25 at 9:15 a.m. CNA #5 said visitor restrictions were in the residents' care plans and she received education from management. She said if a visitor was in the building who was not allowed to be, she would let the NHA or the DON know and call the police. She said Resident #9's boyfriend could not visit. She said she was told at the end of last week or the beginning of this week (between 5/8/25 and 5/12/25). She said there was communication in Resident #9's EMR and a posting one day last week that he was allowed to visit in the common area, but then it was changed to no visitation at all. She said there was no restriction to his visits prior to last week. She said she only saw Resident #9's boyfriend at the facility previously with the resident's parents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #7 was interviewed on 5/15/25 at 9:25 a.m. CNA #7 said she knew if visitors were not allowed to visit by their pictures posted on the wall. She said she just started working at the facility. CNA #7 said if she were to let anyone visit any resident, she would check with the nurse to ensure they could visit. She said the visitor restrictions were in the Kardex (an abbreviated care plan). She said if a visitor tried to visit who was not allowed to visit, she would tell the visitor they were not allowed to visit and tell the nurse. She said Resident #9's boyfriend was not allowed to visit the resident. She said she was told this on 5/6/25. The activity director (AD) was interviewed on 5/15/25 at 9:28 a.m. The AD said the facility usually had a picture of visitors who were not allowed to visit or the facility would provide a description of the person. She said if a visitor tried to visit who was not allowed to visit, she would let the nurse and management know. She said Resident #9 had a boyfriend who could not visit. She said if she saw him, she would direct him out of the building. LPN #1 was interviewed a second time on 5/15/25 at 9:33 a.m. LPN #1 said visitor restrictions were usually documented in the residents' care plans or in a communication note in the residents' EMRs. She said if a visitor tried to visit who was not allowed to visit, she would tell them they could not visit and tell the DON or the NHA. She said Resident #9 had a boyfriend who could not visit. She said there was a communication note from 5/13/25 that said the boyfriend could not visit. She said, prior to 5/13/25, he was allowed to visit the resident only in the common areas. She said he had to be within the view of the nurse's station. She said staff were not required to sit with them, but they would be within eyesight of the resident and the boyfriend. LPN #5 was interviewed a second time on 5/15/25 at 9:37 a.m. LPN #5 said she was told on 5/8/25 that the boyfriend for Resident #9 could not visit. She said there was a communication board in the EMR system she looked at each morning. She said on 5/13/25 the communication board said the resident's boyfriend was not allowed to visit. She said if the boyfriend attempted to visit, she would ask him to leave and call the police. She said she would contact the DON and the NHA. She said there were pictures of visitors who were not allowed to visit. She said prior to last week, there were no restrictions on when Resident #9's boyfriend could visit. She said she was told the residents had the right to have visitors. The DON and the NHA were interviewed together a second time on 5/15/25 at 2:58 p.m., following the care conference. The DON and the NHA said Resident #9's parents and the facility did not know if the resident wanted the boyfriend to visit or if the resident wanted physical touch from him. The DON and the NHA were interviewed a third time on 5/15/25 at 4:55 p.m. The NHA said, based on the care conference, he was unable to substantiate the 2/1/25 and 4/23/25 sexual allegations because the boyfriend was important to Resident #9's quality of life. The DON said the facility needed to establish what Resident #9's wants were. The NHA said the facility waited until 5/12/25 to tell the boyfriend not to visit Resident #9 because the ombudsman met with the SSD and the DON on 5/12/25. The NHA said the ombudsman recommended the boyfriend be told to hold off on visiting Resident #9 until after the care conference on 5/15/25. III. Incident of physical abuse of Resident #7 by Resident #8 on 4/8/25 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Facility investigation The investigation of the alleged altercation between Resident #7 and Resident #8 was provided by the NHA on 5/6/25 at approximately 3:30 p.m. The 4/8/25 physical aggression incident note revealed Resident #7 was walking around the facility and entered another resident's room (Resident #8). This caused Resident #8 to become upset and yell at Resident #7. The yelling caused Resident #7 to become upset and both residents began hitting each other. Both residents were separated and assessed for injuries. The 4/9/25 IDT note revealed Resident #7 was admitted on [DATE] with several diagnoses that may increase risk for wandering and in turn physical aggression, including but not limited to, encephalopathy (brain dysfunction), schizoaffective [TRUNCATED]

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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. 19262 Based on record review and interviews, the facility failed to report alleged violations of sexual and physical abuse to the State Survey and Certification Agency in accordance with state law for four of seven alleged abuse violations. Specifically, the facility failed to: -Submit a final report of the facility's investigation of two separate physical abuse allegations involving Resident #5 and Resident #4 to the State Agency within five calendar days of the incidents; -Submit a final report of the facility's investigation of a physical abuse allegation involving Resident #7 and Resident #8 to the State Agency within five calendar days of the incident; and, -Submit a final report of the facility's investigation of a sexual abuse allegation involving Resident #9 and a facility visitor to the State Agency within five calendar days of the incident. Findings include: I. Facility policy and procedure The Compliance with Reporting Allegations of Abuse/Neglect. Exploitation policy, reviewed on 5/7/25 (during the survey), was provided by the chief nurse officer (CNO) on 5/8/25 at 10:55 a.m. The policy revealed the facility would ensure all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property were reported immediately to the administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes. Resident abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which could include staff to resident abuse and certain resident-to-resident altercations. This also included the deprivation by an individual, including a caretaker, of goods or services that were necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, caused physical harm, pain or mental anguish. It included verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Resident sexual abuse was the non-consensual sexual contact of any type with a resident. The facility would report all alleged violations and all substantiated incidents to the State Agency and to all other agencies as required, and take all necessary corrective actions, depending on the results of the investigation. The facility would analyze the occurrences to determine what changes were needed, if any, to policies and procedures to prevent further occurrences. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The administrator or designee would report sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified within five working days of the incident. II. Abuse allegations and State Agency reporting A. Physical abuse allegation on 3/10/25 at 10:15 a.m. involving Resident #5 and Resident #4 The facility submitted an initial report of a physical abuse allegation to the State Agency reporting site on 3/10/25 at 11:41 a.m. The final report of the facility's investigation of the incident was due on 3/15/25 at 11:59 p.m. -However, the facility submitted the final report of the investigation on 4/8/25 at 3:22 p.m., which was 24 days after the final report was due. B. Physical abuse allegation on 3/10/25 at 6:00 p.m. involving Resident #5 and Resident #4 The facility submitted an initial report of a physical abuse allegation to the State Agency reporting site on 3/10/25 at 7:23 p.m. The final report of the facility's investigation of the incident was due on 3/15/25 at 11:59 p.m. -However, the facility submitted the final report of the investigation on 4/8/25 at 3:53 p.m., which was 24 days after the final report was due. C. Physical abuse allegation on 4/8/25 at 1:00 p.m. involving Resident #7 and Resident #8 The facility submitted an initial report of a physical abuse allegation to the State Agency reporting site on 4/8/25 at 2:36 p.m. The final report of the facility's investigation of the incident was due on 4/13/25 at 11:59 p. m. -However, the facility submitted the final report of the investigation on 4/24/25 at 5:38 a.m., which was 11 days after the final report was due. D. Sexual abuse allegation on 4/12/25 at 2:45 p.m involving Resident #9 and a facility visitor The facility submitted an initial report of a sexual abuse allegation to the State Agency on 4/12/25 at 4:24 p. m. The final report of the facility's investigation of the incident was due on 4/17/25 at 11:59 p.m. -However, the facility submitted the final report of the investigation on 4/24/25 at 5:56 a.m., which was seven days after the final report was due. III. Staff interviews (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nursing home administrator (NHA) and the regional vice-president of operations (RVPO) were interviewed together on 5/8/25 at 10:40 a.m. The NHA said he had to notify the appropriate authorities, including the State Agency, immediately or as soon as possible, but no later than 24 hours, after receiving a report of an abuse allegation. He said in the case of serious bodily injury to a resident, the allegation was to be reported no later than two hours after the incident. The NHA said he had to have the final report of the facility's investigation into an abuse allegation submitted to the State Agency within five days of the incident. The NHA agreed with the final submission reporting dates that were documented in the State Agency's reporting system. He said the investigations of the allegations were completed timely but he submitted the final reports late. He said it was his poor timing skills that resulted in the late submissions and he said he was aware of the five-day time constraints. The NHA said he now reported weekly to the RVPO and the regional clinical nurse (RCN) to ensure that any abuse investigations were completed and reported appropriately. 48112

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 48112 Based on record review and interviews, the facility failed to thoroughly investigate allegations of abuse for two of seven abuse allegations. Specifically, the facility failed to: -Thoroughly investigate an allegation of sexual abuse on 4/12/25 for Resident #9 in order to prevent a second incident from occurring on 4/23/25; and, -Thoroughly investigate an allegation of physical abuse between Resident #7 and Resident #8. I. Facility policy and procedure The Abuse, Neglect and Exploitation policy, revised 4/11/25, was provided by the director of nursing (DON) on 5/6/26 at 12:22 p.m. It read in pertinent part, An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include investigating different types of alleged violations; identifying and interviewing all involved persons, including the alleged victim, the alleged perpetrator, witnesses, and others who might know about the allegations; focusing the investigation on determining if abuse has occurred, the extent, and the cause; and providing complete and thorough documentation of the investigation. II. Incident of alleged sexual abuse between Resident #9 and her boyfriend on 4/12/25 A. Facility investigation The investigation of the alleged sexual abuse incident between Resident #9 and her boyfriend was provided by the NHA on 5/6/25 at approximately 3:30 p.m. The witness statement, dated 4/12/25 and written by an unidentified CNA (according to the NHA), documented that Resident #9's boyfriend touched Resident #9 in what appeared to be an inappropriate manner. The resident, who had severely impaired cognition and who was non-verbal, was heard screaming. The CNA entered Resident #9's room and advised the boyfriend that he and Resident #9 needed to go to the television room so staff could monitor the visit. The CNA immediately reported the incident to the nurse on duty, and the nurse took over from there. The 4/12/25 nurse incident note revealed that nursing staff reported the incident to the NHA and called the police regarding Resident #9's boyfriend, reporting an allegation of sexual abuse, because they did not believe Resident #9 was able to consent to sexual contact of that nature. The resident's boyfriend left the facility soon after the incident of inappropriate touching. The resident was deemed safe by the facility, as the boyfriend was no longer in the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #7, CNA #8, CNA #9 were interviewed on 4/14/25. The interview questions were: Do you feel safe here? Do you have specific concerns? Have you ever been hurt, frightened, or made uncomfortable here? Who made you uncomfortable here? If made uncomfortable here, did you report it? -However, the questions for the staff interviews failed to ask staff if they had any knowledge of the incident on 4/12/25 or prior incidents. -The investigation failed to reveal that an interview was completed with the CNA who witnessed the 4/12/25 incident to determine what the CNA specifically saw related to inappropriate touching of Resident #9 by her boyfriend. -The investigation failed to reveal documentation to indicate that an interview was completed with the alleged assailant, Resident #9's boyfriend. -The investigation failed to reveal documentation that the alleged assailant was unable to enter the facility during the investigation process, or what intervention was put in place to keep the resident safe. -The investigation failed to reveal documentation on what education was provided to the staff to keep the alleged victim safe while the investigation was in progress. B. Staff interview The DON was interviewed on 5/8/25 at 11:32 a.m. The DON said she was familiar with Resident #9 and the alleged sexual abuse on 4/12/25. She said Resident #9 was unable to make her own decisions since before she was admitted to the facility. She said the sexual activity capacity for consent was completed by the DON, the SSD, the unit manager, the assistant director of nursing (ADON) and the NHA. She said the medical director and ombudsman were not part of the decision. She said Resident #9's sexual activity capacity for consent was not completed until 4/14/25, after the alleged sexual abuse incident. -Review of the 4/14/25 sexual activity capacity for consent provided by the facility revealed Resident #9 had an inability to communicate effectively and describe her thoughts and feelings. The interdisciplinary team (IDT) determined the resident could not make or express her desire to engage in sexual intimacy with others. -However, despite the determination that Resident #9 did not have the capacity to consent to sexual intimacy, the facility failed to put effective interventions in place to protect the resident from another alleged sexual incident with the boyfriend on 4/23/25. Cross-reference F600 for failure to keep residents free from abuse. The DON said the resident's boyfriend visited on Saturdays when Resident #9's parents brought him to the facility. The DON said prior to the allegation, there were no restrictions on where he could visit with the resident in the facility. The DON said some staff reported to her that Resident #9's boyfriend tickled her, held her hand, and kissed her on her cheek. She said she was not aware of prior allegations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA was interviewed on 5/7/25 at 2:05 p.m. He said the incident between Resident #9 and her boyfriend occurred on Saturday, 4/12/25. He said prior to the allegation, the facility did not have the boyfriend's contact information to inform him that he could not visit until after the incident was fully investigated. He said he contacted the parents on Monday, 4/14/25, two days after the incident occurred to obtain the boyfriend's contact information. The NHA said the boyfriend visited the resident on the weekends and the resident's parents provided transportation. The NHA said if the boyfriend visited on a Saturday, he would not visit on a Sunday. The NHA said he thought the resident was safe and he did not need to contact the parents for the boyfriend's contact information until Monday. The NHA said he was responsible for the questions management used for the resident and staff interviews. The NHA said the interview questions asked of the staff during the investigation for Resident #9 did not make sense for the investigation process. He said the questions were more relevant to ask residents instead of staff members. The NHA was interviewed a second time on 5/8/25 at 1:27 p.m. The NHA said he did not obtain an interview from the CNA who witnessed the incident with Resident #9 and her boyfriend on 4/12/25 to clarify exactly what she saw. The NHA said the witness statement lacked specific information in regards to what the CNA saw related to inappropriate touching of the resident on 4/12/25. The NHA said the investigation did not include an interview from the alleged assailant and an interview or observation from the alleged victim. The NHA said the interview questions for staff were incomplete and did not ask if they witnessed any other potential concerns or incidents with Resident #9 and her boyfriend prior to the 4/12/25 incident. The NHA said since there was a lack of interviews and statements and it was difficult to determine if the allegation was unsubstantiated. The NHA said, looking at the timeline of when the care plan was updated on 4/18/25 to ensure the boyfriend was only in the highly observable areas, to when the NHA contacted the boyfriend on 4/23/25, the investigation process was not completed in a timely manner in order to protect Resident #9 from another allegation of sexual abuse on 4/23/25. III. Incident of physical abuse between Resident #7 and Resident #8 on 4/8/25 A. Facility investigation The investigation of the resident-to-resident altercation between Resident #7 and Resident #8 was provided by the nursing home administrator (NHA) on 5/6/25 at approximately 3:30 p.m. The 4/8/25 incident note revealed that Resident #7 was observed entering Resident #8's room without permission. This caused Resident #8 to become upset and yell at Resident #7. The yelling caused Resident #7 to become upset and both residents began hitting each other. Both residents were separated and assessed for injuries. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility investigation revealed that the investigator, who was the assistant director of nursing (ADON) interviewed certified nurse aide (CNA) #1, registered nurse (RN) #1, dietary aide (DA) #1, licensed practical nurse (LPN) #1, and the social services director (SSD). -However, the staff interviews were not specific to the incident between Resident #7 and Resident #8 and did not indicate if any of the staff members interviewed witnessed or overheard the resident-to-resident altercation. -The investigation failed to reveal that either Resident #7 or Resident #8 were interviewed following the incident to gain understanding of what potentially led to the incident in order to prevent any further incidents from occurring. B. Staff interviews The DON was interviewed on 5/8/25 at 11:32 a.m. The DON said if a facility staff member became aware of resident abuse, they should notify the abuse coordinator, who was the nursing home administrator (NHA), after ensuring the safety of the resident. She said the CNA should document the behavior in the residents' electronic medical records (EMR), on the residents' daily tasks records. She said the nurse was also responsible for initiating an incident report that included completing a skin assessment and pain assessment, notifying the family and notifying the physician. She said the nurse was responsible for developing an immediate intervention to keep the resident safe during the investigation process. The DON said the nurses documented everything they saw and what they did following the incident in the incident report. The DON said the alleged abuse and interventions were communicated to the next shift during the investigation process by a written report called a shift-to-shift report and a verbal report. She said a statement was obtained by the abuse coordinator (the NHA). The DON said she was familiar with the altercation between Resident #7 and Resident #8 on 4/8/25. She said she completed the physical aggression incident report because she heard the yelling between the two residents. She said she was not sure if CNA #1, RN #1, DA #1, LPN #1, or the SSD saw or heard the altercation but she said she was sure other staff members must have heard the yelling based on where Resident #8's room was located in proximity to the nurses' station. The DON said she was not certain which staff witnessed the resident-to-resident abuse because the investigator (the ADON) did not interview all staff on duty. The DON said there was no specific behavior linked to the resident-to-resident abuse that occurred between Resident #7 and #8, per the investigation statements obtained by the NHA. The NHA was interviewed on 5/7/25 at 2:05 p.m. The NHA said when he investigated an abuse allegation, he asked the staff member who saw the resident altercation/abuse to write a statement. He said if he did not directly interview staff, he designated someone in management to conduct the interviews. The NHA said he tried to obtain a statement and interview from the alleged assailant and victim. He said residents and staff interviews were completed by someone in management. He said there should be an intervention put in place to keep the residents safe while the investigation was in process. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA said he attempted multiple times to obtain Resident #7's statement, but he did not document the attempts. He said he obtained a statement from Resident #8 but he did not document his statement. The NHA said when he obtained Resident #8's statement, Resident #8 said he put his hands on Resident #7. The NHA said the immediate actions to keep the resident safe was the stop signs in front of Resident #8's room. The NHA said the sign was placed on 5/5/25. The NHA said he should have substantiated the alleged physical abuse. The NHA was interviewed again on 5/8/25 at 1:27 p.m. He said if staff saw or heard alleged abuse, they should notify him after ensuring the safety of the resident. He said any staff member who saw an alleged abuse incident should write a statement and then they should be interviewed by management.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 Based on record review and interviews, the facility failed to ensure one (#10) of five residents reviewed for medication management were free from significant medication errors out of 22 sample residents. Resident #10 was admitted to the facility on [DATE] with a diagnosis of dementia. On 4/29/25 a nurse administered Resident #10 Lisinopril (used to treat high blood pressure), Metformin (used to treat diabetes), Seroquel (used to treat mental health conditions) and Ramelteon (used to treat insomnia). The resident began to experience severe hypotension (a dangerously low blood pressure) and was sent to the hospital. The resident received intravenous fluids and was monitored. Specifically, the facility failed to ensure Resident #10 did not receive another resident's (Resident #20) medications. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G et.al,, Fundamentals of Nursing, 10th ed., Elsevier, St. Louis, Missouri, pp. 606-607, Take appropriate actions to ensure the patient receives medication as prescribed. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation 7. The right indication. II. Facility policy and procedure The Medication Administration policy, revised 4/11/25, was provided by the nursing home administrator (NHA) on 5/7/25 at 10:38 a.m. It read in pertinent part, Identify resident by photo in the MAR (medication administration record). (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that the six rights of medication administration are followed: right resident, right drug, right dosage, right route, right time and right documentation. The Medication Error policy, revised 2025, was provided by the NHA on 5/7/25 at 10:38 a.m. It read in pertinent part, The facility shall ensure medications will be administered as follows: according to physician's orders, per manufacturer's specifications and in accordance with accepted standards and principles which apply to professionals providing services. Significant medication error means one which causes the resident discomfort or jeopardizes his/her health and safety. The facility must ensure that it is free of medication error rates of five percent or greater as well as significant medication error events. III. Resident #10 A. Resident status Resident #10, age 83, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included dementia, epilepsy (seizure disorder) and dysphagia (difficulty swallowing). The 2/17/25 minimum data set (MDS) assessment indicated the resident had short term and long term memory problems and her cognitive skills for daily decision making were moderately impaired, per staff assessment. Resident #10 was dependent on staff for personal hygiene, toileting and transferring. C. Record review The 4/29/25 incident report was documented at 7:00 p.m. by registered nurse (RN) #3. The incident reported documented RN #3 obtained the wrong medications for Resident #10. RN #3 documented Resident #10 did not have a picture in the electronic medication record (EMR) and her name was not on the door. RN #3 documented she had not worked on the resident's hall previously and was not familiar with the residents. RN #3 documented upon entering Resident #10's room, the resident's representative was at the bedside. RN #3 addressed Resident #10 by another resident's first name (to whom she thought was administering the medications) and the family responded without correction. RN #3 documented the following medications were administered to Resident #10 that were not ordered for her: Lisinopril 20 milligrams (mg), Metformin 500 mg, Seroquel 100 mg and ramelteon 8 mg. The April 2025 CPO revealed Resident #10 had physician's orders for the following daily scheduled medications: mirtazapine (used to treat depression) 45 mg, olanzapine (used to treat mental health conditions)10 mg, tramadol (used to treat pain) 50 mg and divalproex sodium (used to control seizures) 125 mg. -Resident #10 did not have physician's orders for Lisinopril, Metformin, Seroquel or ramelteon. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The 4/29/25 hospital visit, documented at 10:24 p.m., revealed Resident #10 had an accidental drug ingestion of another resident's medications. It documented Resident #10 experienced hypotension (low blood pressure) and tachycardia (high heart rate). The resident was administered 1000 milliliters (ml) intravenous fluids and was observed for six hours at the hospital. Resident #10 was initially discharged from the hospital on 4/30/25 at 1:49 a.m., however, Resident #10's blood pressure decreased again en route to the nursing facility and she was again transported back to the hospital, where she was observed for an additional two hours with no additional interventions needed. A hospice nurse progress note, dated 4/30/25, documented Resident #10 had experienced a medication administration error the night of 4/29/25 and the resident had been transferred to the hospital. The progress note documented Resident #10's blood pressure was 73/33 millimeters of mercury (mmHg) on 4/30/25. The resident was speaking clearly and said she was doing fine. The 4/30/25 physician's progress note, documented at 11:42 a.m., revealed the physician visited Resident #10 on 4/30/25 due to a medication error on 4/29/25. The physician documented a medication error occurred, hospice was notified and Resident #10 was stable at the time of the progress note. The NHA provided the facility's investigation of the medication error on 5/7/25 at 10:38 a.m. The investigation documented that on 4/29/25, RN #3 administered the wrong medications to Resident #10. Resident #10's representative was present at the time of administration. After RN #3 returned to the medication cart, she realized she had given Resident #10 another resident's medications. Resident #10's representative then said that she found it odd that RN #3 had mentioned a blood pressure medication. RN #3 notified the provider, who advised her to obtain the resident's vital signs (blood pressure, heart rate and respiratory rate). The resident had a decrease in blood pressure and her respirations increased. The physician ordered Resident #10 to be administered Midodrine (used to treat low blood pressure) to counteract the blood pressure medication. The resident was then sent to the emergency room , was given fluids and monitored. The resident returned to the facility the following day. The investigation documented RN #3 was interviewed. RN #3 said she had not worked on Resident #10's unit previously and the medications given to Resident #10 were ordered for another resident (Resident #20) whose name was next to Resident #10's on the MAR. RN #3 said Resident#10 had poor hearing and the representative did not correct RN #3 with the correct name when RN #3 said the other resident's name prior to administering the wrong medications to Resident #10. The investigation documented RN #3 was educated on medication administration. Following the incident, the director of nursing (DON) completed a medication administration observation of RN #3. All residents' charts were audited for accuracy, including resident identification and their room identification. It was determined that the root cause of the error was related to Resident #10's picture missing in her chart as well as her name outside of her room. It was identified that a total of 17 residents either did not have a picture in the EMR or a name by their door. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The investigation documented the interventions that were put into place to prevent a recurrence included RN #3 received formal disciplinary action, was educated on medication administration and was observed administering medications. All nursing staff were educated and also observed administering medications. The admissions coordinator was educated regarding the importance of obtaining and updating residents' identification including adding pictures to the EMR and door identification. An admission audit was updated to include the identification information completed. The conclusion of the investigation included there was a deviation from the facility's policy and procedure and multiple facility systems failed, which included Resident #10's name and identification was not properly obtained prior to administering medications. The incident was substantiated as the medication error resulted in Resident #10's hospitalization . IV. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 5/6/25 at 10:40 a.m. LPN #1 said Resident #10 had no previous diagnoses of hypertension or hypotension (high or low blood pressures). LPN #1 said Resident #10 did not have physician's orders for blood pressure medications. LPN #1 said Resident #10's blood pressure readings varied, but usually averaged 110/60 mmHg. LPN #1 said Resident #10's blood pressures had been lower over the past week. The DON was interviewed on 5/6/25 at 11:10 a.m. The DON said Resident #10 was administered Lisinopril 20 mg, Metformin 500 mg, Seroquel 100 mg and ramelteon 8 mg in error on 4/29/25. The DON said Resident #10 did not have physician's orders for any of those medications. The DON said Resident #20 should have received the medications given to Resident #10 and did receive the medications later that day. The hospice RN was interviewed on 5/6/25 at 11:19 a.m. The hospice RN said Resident #10's condition was stable and she was eating well. The hospice RN said she was notified that the facility administered the wrong medications, including Lisinopril, to Resident #10 on 4/29/25. She said Resident #10's blood pressure was usually 85/65 mmHg. The hospice RN said she saw Resident #10 on 4/30/25, and her blood pressure was still low at 73/33 mmHg. The rounding physician was interviewed on 5/7/25 at 10:50 a.m. The rounding physician said RN #3 contacted her after she had administered the wrong medications to Resident #10 in error on 4/29/25. The rounding physician said RN #3 told her, that she called Resident #10 another resident's name, and the resident's name she mentioned could also have been used or interpreted as a term of endearment. The rounding physician said she instructed RN #3 to monitor Resident #10, including her vital signs, which included blood pressure, heart rate and respiratory monitoring. The physician (PHY) said she told RN #3 to inform the hospice agency of the error. The PHY said Resident #10's blood pressure dropped and she was transferred to the hospital. The PHY said the resident was awake and talking the next morning, after she returned from the hospital. The PHY said the DON investigated and then ensured all residents' names were on their doors and their pictures were in their EMRs. The PHY said she thought the likelihood for the medications to cause a significant drop in Resident #10's blood pressure was low and she was surprised Resident #10's blood pressure dropped as significantly as it did. The PHY said the ramelteon may have played a role with the Lisinopril and caused Resident #10's blood pressure to decrease. The PHY said the one time dose administered of Metformin and Seroquel were not of concern for a possibility of contributing to a condition change. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The pharmacist was interviewed on 5/7/25 at 12:00 p.m. The pharmacist said he was told RN #3 was not used to working with the residents on the unit and she administered the wrong medications to Resident #10 on 4/29/25. The pharmacist said he was contacted by nursing staff on 4/29/25 after the medication error. The pharmacist said he told the nurse to monitor Resident #10's blood pressure. The pharmacist said Resident #10 already had lower blood pressures and was on hospice services. The pharmacist said she was concerned Resident #10's blood pressure would drop and she might be more sedated from the Lisinopril and ramelteon. The pharmacist said the starting dose for Lisinopril was usually much lower than 20 mg and the dose could begin as low as 2.5 mg. The pharmacist said for this reason, he knew Resident #10's blood pressure was going to drop, it was just a question of how low it would drop. The pharmacist said Resident #10's blood pressure dropped low enough to require her to be transferred to the hospital. LPN #3 was interviewed on 5/7/25 at 12:10 p.m. LPN #3 said sometimes newer residents did not have their names on the doors. She said this had gotten better recently. The speech therapist (ST) was interviewed on 5/7/25 at 12:20 p.m. The ST said the lack of names on residents' doors worsened in September 2024. The ST said recently she had noticed residents' names were more consistently labeled on the doors. The DON was interviewed a second time on 5/7/25 at 12:34 p.m. The DON said it was possible the name used by RN #3 to identify the resident for medication administration was misinterpreted by Resident #10's family as a term of endearment. The DON said RN #3 notified her of the medication administration error on the night of the incident (4/29/25). The DON said RN #3 should have followed the six rights of medication administration and ensured she identified the resident prior to medication administration. The DON said RN #3 monitored Resident #10 after the error and Resident #10 was transferred to the hospital when her blood pressure did not respond to the physician's ordered medication to counteract the Lisinopril medication. The DON said Resident #10 was monitored after her return from the hospital and no further interventions were required beyond encouragement of increased fluid intake. The DON said during the investigation, she discovered that RN #3 was not familiar with the residents on the unit and there was not a picture of Resident #10 in the EMR, which would assist with identification. The DON said after the incident on 4/29/25, all nurses were provided one-to-one medication administration education which included review of the medication administration policy which focused on the six rights of medication administration, including the identification process for each resident. The DON said the audit tool for resident admissions was updated to include adding photo identification in the EMR and ensuring the correct names on resident doors for both admission and after any resident room changes. The DON said the admission coordinator was provided additional education to ensure his prompt attention during residents' admission to ensuring pictures and door identification were added. The DON said she was conducting weekly audits of the photo identification in the residents' EMRs and the names on resident doors. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The DON said RN #3 had made another medication administration error on 4/9/25. The medication which RN #3 administered, Lyrica (used to treat pain and seizures), was administered in a larger dose than what was ordered. The DON said RN #3 pulled the wrong medication card which contained the wrong dose. The DON said the medication error was reported to the physician and no additional monitoring was required for that resident. The DON said after the error on 4/9/25, RN #3 was provided reminders of the six medication rights to include right identification. She said no additional education was provided at that time. The DON said after the error on 4/29/25, RN #3 received disciplinary action and was provided additional one-to-one medication administration and error prevention education. She said RN #3 was observed performing medication administration. The DON said all nursing staff were observed performing medication administration and the facility would continue four to eight random medication administration observations per month. The DON said all medication administration errors were reviewed at the quality assurance performance improvement (QAPI) meetings each month. She said the root causes of the 4/29/25 medication error included the nurse not following the six rights of medication administration, the resident pictures not being entered into the EMR and the resident's name not being placed on the door. The DON said all residents were audited and 17 residents were found to have either no picture in their EMR or no name on their door. The DON said all residents had both photos in the EMR and names on the door at the time of interview. RN #3 was interviewed on 5/7/25 at 2:40 p.m. RN #3 said she was unfamiliar with the residents and administered the wrong medications to Resident #10 on 4/29/25. RN #3 said she went into the wrong resident's room. RN #3 said she did not confirm the room number or ask the resident or representative the resident's name, though the resident was not familiar to her. RN #3 said she called Resident #10 by the first name of the resident who was to receive the medication (Resident #20). RN #3 said the resident and the representative did not correct RN #3 when she said the wrong name. RN #3 said she recognized the error immediately after leaving Resident #10's room. RN #3 said she contacted the resident and representative, the physician, the DON and hospice. She said she monitored Resident #10 for a change of condition, including her blood pressure readings. RN #3 said Resident #10 did not want to go to the hospital, however her representative encouraged the resident to go to the hospital as her blood pressure decreased to 58/34 mmHg. RN #3 said Resident #10 was transferred to the hospital for evaluation. RN #3 said she should have ensured it was the correct resident prior to administering the medications. RN #3 said she looked at the wrong room number on her report sheet. RN #3 said it would have been helpful if Resident #10's picture was in the EMR and her name was on the door. RN #3 said after the incident, she received an inservice about the six rights of medication administration and she was observed during administration of medications. RN #3 said she had recently had issues with her concentration and had not felt as cognitively sharp, and it was helpful for her to not be assigned to different units for her shifts. RN #3 said she was now assigned to the same units for each shift where she knew residents better. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The DON was interviewed a third time on 5/8/25 at 1:35 p.m. The DON said she recently discovered RN #3's concern regarding her concentration and cognition and the DON had developed a performance improvement plan (PIP) to ensure RN #3 was not more likely than any other nursing staff to make another medication error. The DON said the plan included RN #3 would report to the DON any cognitive symptoms that might affect performance and the DON would address the concern by finding a replacement for RN #3 on the particular shift. The DON said she was confident the disciplinary action and education provided had impacted RN #3 and caused her to be much more cautious and attentive to the requirements of medication administration. The DON said RN #3 would also be audited during medication administrations to include three to five resident observations weekly. The DON said RN #3 would remain assigned to the 400 and 500 units, where she was most comfortable and knew the residents she was assigned. The medical director (MD) was interviewed on 5/8/25 at 2:50 p.m. The MD said he was aware that Resident #10 received another resident's medication on 4/29/25. The MD said he was not surprised Resident #10's blood pressure dropped, as her blood pressure typically ran lower and her status as a hospice resident may have made her more sensitive to the medications. The MD said all nursing staff received education regarding medication administration as the most important. V. Facility follow-up A PIP was provided by the NHA on 5/8/25 at 3:04 p.m. The plan was initiated on 4/30/25 and revised on 5/7/25 and 5/8/25 (during the survey). The action items included the following: RN #3 will receive additional training related to prevention of medication errors, including the six rights of medication administration, facility medication administration policy and procedure and medication error policy (completed 4/30/25). RN #3 will be observed administering medications to ensure competency (completed 5/1/25). RN #3 will receive consistent staffing assignments to assist with developing a rapport with the residents and decrease opportunity for error (5/8/25 and ongoing). RN #3 reported that she may have symptoms that impact her work performance. In the event she is experiencing symptoms, she will report them immediately to the DON or another nurse manager (5/7/25 and ongoing). RN #3 will receive weekly med pass observations unless not scheduled, as she is an as needed (PRN) employee. Medication pass observations will include at least 25 opportunities across multiple residents including a variety of routes (beginning 5/13/25 and ongoing, for a minimum of three months). RN #3 will have weekly check-ins with her supervisor to provide an opportunity for coaching and feedback for a minimum of three months (beginning 5/13/25 and ongoing for three months).