STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065208	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellsprings Care Center	3636 S Pearl St Englewood, CO 80113

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to notify the resident representative when there was a significant change in the resident's condition for two (#7 and #8) of three residents reviewed out of 12 sample residents. Specifically, for Resident #7 and Resident #8, the facility failed to: -Keep the resident's current designated representative's name and contact information updated in the resident's record; and, -Make additional attempts or try alternative methods to contact the representative when the representative was not reachable. Findings include: I. Facility policy and procedure The Change of Condition policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 6/4/25 at 12:24 p.m. It read in pertinent part, The resident, attending physician and legal representative or interested family member are notified when changes in condition or certain events occur. Communication with the IDT (interdisciplinary team) and caregivers is also important to ensure that consistency and continuity are maintained for the resident's benefit. The facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental, or psychosocial status (a deterioration in health, mental, or psychosocial status in either life - threatening conditions or clinical or a decision to transfer or discharge the resident from the facility. II. Resident #7 A. Resident status (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #7, age less than 65, was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), atrial fibrillation (abnormal heartbeat), chronic respiratory failure, depression and type 2 diabetes mellitus with diabetic neuropathy. According to the 4/17/25 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. B. Resident interview Resident #7 was interviewed on 6/3/25 at 10:30 a.m. Resident #7 said the facility failed to notify his representative when he was sent out to the hospital and his representative had been worried when he was not able to contact him at the facility. He said it made him very upset that his representative did not know his whereabouts. Resident #7 said his representative only found out about his hospitalization when he called his representative to see if he was going to come to the hospital. Resident #7 said it was very important to him to have his representative involved in his care. He said he updated his representative`s phone number before the last two hospitalizations, so he was not sure why the facility was unable to notify his representative that he was hospitalized . Resident #7 did not remember who he informed about the change. He said he would inform the NHA to update his representative`s information when needed. C. Record review Resident #7`s clinical resident profile, in the electronic medical record (EMR), was reviewed on 6/3/25 at 12:15 p.m. with Resident #7. The phone number listed for the resident's representative was verified as the correct number by Resident #7. The Situation, Background, Appearance, Review and Notify (SBAR) communication form, dated 4/2/25, revealed that the facility made one attempt to call Resident #7`s representative and the alternative representative on that date (4/2/25). A progress note, dated 4/2/25, revealed licensed practical nurse (LPN) #3 was not able to reach the resident's representatives and no message was left when the representatives were unreachable. -There was no documentation in Resident #7's EMR to indicate the facility attempted to notify the resident's representatives again after the initial attempt to notify them. III. Resident #8 A. Resident status Resident #8, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the June 2025 CPO, diagnoses included chronic systolic heart failure, COPD, bipolar disorder and abnormalities of gait and mobility. According to the 4/28/25 MDS assessment, the resident was cognitively intact with a BIMS score of 15 out of 15. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident interview Resident #8 was interviewed on 6/3/25 at 1:30 p.m. She said the facility failed to notify her representative about her hospitalizations numerous times. She said her representative was only informed about her hospitalization when she came to visit her at the nursing home while she was hospitalized in April 2025. The contact information in the resident's EMR was reviewed with Resident #8 during the interview and she said the person listed on file as her representative was not correct. She said the person listed as her representative in the EMR had passed away last year and her EMR should have been updated to list her current representative contact. She said she did not know why her current representative's information was not on her clinical resident profile. She said the facility did not ask to verify her representative`s information during her stay or at any of her care conferences. She said she was unsure how to make sure the facility had up-to-date contact information for her representative`s phone number. C. Record review -Review of Resident #8`s current clinical profile information, reviewed on 6/3/25 at 1:30 p.m. with Resident #8, did not contain the correct name or contact information for the resident's current representative (see resident interview above). The SBAR communication form dated 4/21/25, revealed that Resident #8's representative was unreachable but there was no documentation of who the nurse attempted to contact. -However, the representative's information listed in Resident #8's EMR was for the resident's previous representative (see above). IV. Staff interview LPN #3 was interviewed on 6/3/25 at 11:40 a.m. LPN #3 said she would call the residents' representative`s number on the clinical resident profile when she needed to update them. She said she would attempt to call two to three times to reach the representative if she was not able to leave a voicemail. She said staff would request a call back without leaving a detailed message and would say whether the call was an emergency or not. She said there was no timeframe to reach the representative, but she said in the case of an emergency, staff would call right away. She said staff documented all calls in the progress notes. She said she would inform the director of nursing (DON) or the resident's physician about an unsuccessful representative notification. -However, there was no documentation to indicate LPN #3 attempted to contact Resident #7's representative more than one time (see record review above). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #3 was interviewed a second time on 6/4/25 at 7:45 a.m. LPN #3 said the nurses were able to update residents' representative contact information in the EMR. She said nurses could also forward the information to the social services department or the medical records department so the information could be corrected for other contact lists. She said she was unsure what to do if staff could not reach the resident's representative in an emergency situation, other than making a progress note. LPN #3 said she thought the DON would read progress notes daily and notice if there was an unsuccessful call to the resident's representative and take care of it. She said nurses were not able to send emails to the residents' representatives. The social services director (SSD) was interviewed on 6/4/25 at 10:30 a.m. The SSD said the facility used the hospital`s referral packet to obtain the residents' representative's contact information most of the time. She said residents were asked to verify information upon admission if they were able to verify the information. She said the facility would ask residents to verify current representative information during their care conferences. She said if the resident or the resident's representative needed to update the representative's contact information, they should notify the social services department, the medical record department or the nurses. The regional nurse consultant (RNC) was interviewed on 6/4/25 at 10:40 a.m. The RNC said there was no official procedure to update the residents' representative information. She said the nurses were able to update this information. She said nurses recorded all notifications to residents' representatives in the EMR progress notes. She said there were two ways the DON would be notified about an unsuccessful representative notification. She said the DON read all notes, including change of condition notes, each morning. She said the DON could also filter notes in the residents' EMRs for high risk notes or change of condition notes. She said it was the nurse`s responsibility to notify representatives about a hospitalization. The RNC said nurses should notify the DON if a representative's notification was unsuccessful. She said the facility expected nurses to reach out to the representatives a couple of times and record all attempts to call the representative in the progress notes. She said the facility should never rely on the hospital`s information. She said the facility should have a better system to keep representatives' information updated during the residents' stay at the facility. She said staff should indicate the representative`s name and number in the progress note. She said staff should attempt to reach the second emergency contact if needed. She said using email could be another way to notify representatives. She said the facility would educate the residents about how to update their representative`s contact information. The NHA was interviewed on 6/4/25 at 12:30 p.m. The NHA said nurses would document all resident representative notification attempts in the residents' progress notes. She said nurses would call the second contact if they could not reach the first representative. She said nurses would reach out to the facility`s management if no contact was able to be made with the representative. She said the facility updated the residents' representative information during quarterly care conference meetings. She said the facility should have updated Resident #3`s representative`s information once he returned from the hospital and all the previous attempts were unsuccessful. -However, there was no documentation to indicate the facility attempted to contact Resident #7's representative more than one time (see record review above). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA said she knew that Resident #8`s previous representative had passed away and said the resident's clinical resident profile should have been updated with the resident's current representative's name and contact information.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews the facility failed to provide a safe, clean, sanitary and comfortable homelike environment throughout the facility in three out of four hallways. Specifically the facility failed to: -Ensure resident rooms were clean and odor free; -Ensure the residents had clean bed linens and privacy curtains; -Ensure the dining room and common areas were clean; and, -Ensure the facility was free from institutional odors. Findings include: I. Facility policy and procedure The Homelike Environment policy, revised February 2021, was provided by the nursing home administrator (NHA) on 6/4/25 at 12:24 p.m. The policy read in pertinent part, Residents are provided with a safe, clean, comfortable and homelike environment. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics included a clean, sanitary and orderly environment, clean bed and bath linens that are in good condition, and pleasant, neutral scents. The facility staff and management minimizes, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. These characteristics included institutional odors. II. Observations Observations of the facility's second floor were conducted on 6/3/25 between 8:47 a.m. to 11:30 a.m. The following was observed: The second floor hallways had a strong smell of urine, cigarettes and body odor. The second floor dining room had food, cigarette butts and a hair tie filled with hair on the floor. The heating unit covers had cigarette butts, dirt and clumps of dust underneath. The window blinds were covered in dust and dirt with pieces broken off. The tables had dried paint splatter and food stains. The second floor dining room was observed again on 6/3/25 at 11:30 a.m., during lunch. The floor had not been cleaned and there were no tablecloths placed on the stained table. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The second floor common area's heating unit was covered with dirt and dust, there were clumps of dust and dirt underneath the heating unit and the vending machines. The common area smelt of urine and cigarettes. Resident room [ROOM NUMBER] had broken blinds on the floor underneath the window, which left the window with no privacy covering to the front of the facility. The resident who resided in that room said the blind had been off for a week. Resident rooms #218 and #221 had broken closet doors. room [ROOM NUMBER]'s closet door was off the track and room [ROOM NUMBER]'s had missing closet hardware. Resident rooms #218, #219 and #221's privacy curtains had yellow and brown stains. Resident rooms #211, #219, #221 and #205 had a strong smell of urine and body odor. Resident room [ROOM NUMBER]'s toilet lid was broken off and placed near the toilet. The overhead light covering had dark yellow stains. Observations made of the facility's first floor were conducted on 6/3/25 at 1:30 p.m. The following was observed: Resident rooms #109 and #111 had brown stained sheets. The blanket on the made bed had brown color stains. Both rooms had a urine odor. Resident room [ROOM NUMBER] had a brown colored, dried sticky substance on the bathroom floor. There was a brown stain around the toilet floor. The window curtains had broken hooks and were partly hanging off the curtain rod. Resident room [ROOM NUMBER] had a urinal that was three quarters full of urine that was left on the bedside table. The urinal did not have a lid and was stained a dark yellow color and the outside of the urinal was soiled. An observation on 6/4/25 at 10:00 a.m. revealed the following: The second floor had food on the floor. The dirt and clumps of dust under the heating unit was still there. The hair tie and cigarette butts remained under the heating unit along the wall. The tables had no coverings and were stained with paint and food. The second floor had a smell of urine and body odor. III. Resident interviews The resident who resided in room [ROOM NUMBER] was interviewed on 6/3/25 11:30 a.m. He said the blinds had been broken off for at least a week. The resident said he told a staff member about the blinds, but did not remember who he told. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident who resided in room [ROOM NUMBER] was interviewed on 6/3/25 at 11:15 a.m. The resident said her room was not cleaned daily. She said she had many personal items but she expected the bathroom to be cleaned everyday. She said if the bathroom was not cleaned, she cleaned it herself. The resident said she had to keep her door closed because the odor from the hallway had been so bad. IV. Staff interviews Housekeeper (HK) #1 was interviewed on 6/3/25 at 9:44 a.m. HK #1 said she cleaned the rooms daily. She said when completing a daily clean of a resident's room, she dusted, swept and mopped the floor, dusted around a resident's personal items, cleaned the bathrooms and took out the trash. She said the maintenance director (MTD) would tell her when a room needed a deep clean. She said if a resident had too many personal items or refused to have the room cleaned she would report it to her supervisor. HK #1 said she did not know how often the privacy curtains were cleaned. The NHA and the MTD interviewed together on 6/3/25 at 1:17 p.m. The MTD said the residents' rooms needed to be cleaned everyday. The MTD said daily cleaning consisted of sweeping and mopping the floors, cleaning high-touch areas (light switches, door knobs), bathrooms and removing trash. The MTD said one room a day got deep cleaned, which included wiping down the walls, beds and mattresses along with the daily cleaning schedule. He said he was working with the residents on decluttering rooms and providing plastic bins to pack up belongings, especially food items. The MTD said the privacy curtains were washed when they were soiled and if a privacy curtain had stains it would be replaced. He said that each room was scheduled to be repaired and painted within the next several weeks. The NHA said if the bed linens or privacy curtains needed to be replaced, she would order new ones. Licensed practical nurse (LPN) #1 was interviewed on 6/4/24 at 10:50 a.m. LPN #1 said the residents'sheets were changed on the resident's shower days, which were twice a week. She said if a resident refused the shower the certified nurse aide (CNA) would still change the sheets. LPN #1 said if a resident refused to have the sheets changed, the nurse kept a log that documented refusals of showers and bedding changes. CNA #1 was interviewed 6/4/25 at 11:00 a.m. CNA #1 said the CNAs were responsible for making the residents' beds everyday. He said the CNAs changed the sheets on shower days, which was twice a week and as needed. CNA #1 said if the bedding looked stained or had holes he would replace the bedding.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure three (#1, #2 and #5) of three residents reviewed for abuse out of 12 sample residents were kept free from abuse. Specifically, the facility failed to: -Ensure Resident #2 and Resident #5 were kept free from physical abuse from each other; and, -Ensure Resident #1 was kept free from physical abuse by Resident #2. Findings include: I. Facility policy and procedure The Abuse policy and procedure, dated 5/3/23, was provided by the nursing home administrator (NHA) on 6/4/22 at 12:24 p.m. It revealed in pertinent part, The facility does not condone resident abuse and shall take every precaution possible to prevent resident abuse by anyone, including staff members, other residents, volunteers, and staff of other agencies serving the resident, family members, legal guardians, resident representative, sponsors, friends, or any other individuals. If a resident experiences a behavior change resulting in aggression toward other residents, the facility will implement interventions for protection of the alleged assailant and other residents. The facility conducts further assessment and arranges for appropriate psychiatric evaluation for further screening. The resident's care plan is revised to include new approaches to reduce or eliminate any further chance of abuse. Recommendations for appropriate intervention, up to and including hospitalization, can then be implemented. Resident abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment of a resident resulting in physical harm or pain, mental anguish, deprivation of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well-being. Also, verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through use of technology. Physical abuse is defined as abuse that results in bodily harm with intent. It includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment and willful neglect of the resident's basic needs. II. Incident of physical abuse between Resident #5 and Resident #2 on 4/20/25 A. Facility investigation (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's abuse investigation, dated 4/20/25, documented that at 11:00 a.m. Resident #2 and Resident #5 were sitting outside on the second floor patio area. Resident #2 asked Resident #5 a question, and before Resident #5 could reply, Resident #2 punched Resident #5 in the face twice with a closed fist. Resident #12 witnessed the incident. Licensed practical nurse (LPN) #2 heard loud voices coming from the patio area. LPN #2 ran from the nurse's station to the patio and observed Resident #2 and Resident #5 arguing and in each other's faces. LPN #2 immediately got in the middle and separated the residents. Registered nurse (RN) #1 assessed Resident #5. Resident #5 said that his tooth was cracked. RN #1 assessed Resident #5 and found no dental injuries. RN #1 offered dental care but Resident #5 declined. LPN #2 completed an injury assessment on Resident #2 and observed an abrasion to Resident #2's forehead, however, the injury did not require more than first aid treatment. The investigation documented that Resident #2 had dementia with impaired cognitive function, resulting in poor impulse control and impaired thought processes. He had a history of behavioral issues, including refusal of medications and occasional verbal and physical aggression directed towards others. He exhibited impaired thought processes and was diagnosed with dementia. Resident #5 was interviewed by the social services director (SSD) on 4/20/25 at 11:30 a.m., following the incident. Resident #5 said that he was complaining about the food and Resident #2 responded by telling him, if you don't like it, there's the street. Resident #5 said he replied that he was capable of making his own decisions and then Resident #2 punched him in the face twice. Resident #5 said he stood up from his wheelchair and struck Resident #2 once in the face. Resident #5 said Resident #2 then made a comment accusing Resident #5 of faking his need for a wheelchair. Resident #2 was interviewed by the SSD on 4/20/25 at 11:40 a.m., following the incident. Resident #2 said that Resident #5 had been speaking negatively about the facility and staff, which upset him. Resident #2 said he told Resident #5 he could leave and then Resident #5 hit him. Resident #2 said he did not strike Resident #5. The investigation documented that Resident #12 provided a verbal witness statement. Resident #12 said he saw Resident #2 hit Resident #5 twice and Resident #5 hit Resident #2 back. Resident #12 said Resident #2 told Resident #5 There is the street and Resident #5 responded that he knew where the street was. The investigation documented the facility substantiated that the allegation of resident-to-resident physical abuse occurred. The interventions put into place after the incident for Resident #2 included 15-minute checks and increased notifications to the resident's family members, the NHA and the director of nursing (DON) if the resident refused medications. B. Resident #5 - victim and assailant 1. Resident status Resident #5, age less than 65, was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included diabetes and a history of psychoactive substance use. The 4/23/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He did not need assistance with the activities of daily living (ADL). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS assessment revealed the resident displayed verbal behavioral symptoms directed toward others. 2. Resident interview Resident #5 was interviewed on 6/3/25 at 1:25 p.m. Resident #5 said Resident #2 punched him twice because Resident #2 became upset when he spoke negatively about the facility. He said he felt it was wrong for Resident #2 to tell him to go on the street. He said he later apologized to Resident #2. Resident #5 said he did not hate Resident #2 and he felt safe at the facility. 3. Record review The behavioral care plan, initiated 4/29/25, documented Resident #5 could become loud or verbally aggressive when refusing care. It indicated the resident had mood and behavior challenges, including yelling or verbal aggression. Pertinent interventions included monitoring, documenting and reporting as needed for increased anger, agitation, or feeling threatened by others and consulting behavioral health as needed. The 4/20/25 nurse progress note revealed that Resident #5 was in a physical altercation with another resident and the altercation resulted in a cracked tooth. C. Resident #2 - assailant and victim 1. Resident status Resident #2, age less than 65, was admitted on [DATE]. According to the June 2025 CPO, diagnoses included delusional disorders, alcohol dependence, restlessness and agitation. The 4/10/25 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. The resident required set-up assistance from one staff member to complete ADLs. The MDS assessment revealed the resident did not display physical behaviors directed towards others during the assessment period. 2. Resident interview Resident #2 was interviewed on 6/3/25 at 2:37 p.m. Resident #2 said he did not punch anyone because if he had, the police would have been notified and he would not still be at the facility. He said another resident called him a racial slur and although the comment upset him, he did not react. He said that if the incident had occurred on the street, it would have ended differently. 3. Record review (continued on next page)

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	065208	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellsprings Care Center	3636 S Pearl St Englewood, CO 80113

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The behavioral care plan, initiated 7/24/24 and revised 5/5/25, documented Resident #2 had a history of verbal and physical aggression toward others, with behaviors related to poor impulse control due to encephalopathy and a subdural hematoma. It indicated Resident #2 had impaired cognitive functioning and impaired thought processes related to dementia. Pertinent interventions included analyzing key times, places, circumstances and triggers that escalated his behavior; assessing his understanding of situations and allowing time for the resident to express himself and his feelings. The care plan documented that Resident #2 could become verbally aggressive when he perceived others as invading his space or when he felt disrespected. Staff were directed to intervene before agitation escalated, guide the resident away from the source of distress, and engage him calmly in conversation. If the resident responded aggressively, staff were instructed to walk away calmly and approach again later. His behavior was noted to de-escalate when he was given time alone. The 4/20/25 nurse progress note revealed that Resident #2 and Resident #5 argued with each other and that Resident #2 hit Resident #5. III. Incident of physical abuse between Resident #1 and Resident #2 on 4/28/25 A. Facility investigation The facility abuse investigation, dated 4/28/25, documented that at 7:30 a.m. Resident #1 made a derogatory racist comment to Resident #2 as Resident #2 was getting up from the table to leave the dining room. Resident #2 grabbed Resident #1's hair while passing by and pulled it. Certified nurse aide (CNA) #2 witnessed the incident and immediately intervened to remove Resident #2's hand from Resident #1's hair. Resident #9 witnessed the incident and provided a written witness statement. RN #1 attempted to assess Resident #1 for injury; however, Resident #1 refused assessment and no treatment was provided. The investigation documented Resident #1 had poor impulse control and the potential to become verbally aggressive, including the use of derogatory names and racial slurs directed towards other residents. Resident #2 was interviewed by the NHA on 4/29/25 regarding the incident that occurred on 4/28/25. Resident #2 initially denied doing anything. He then said, Maybe, but he is fine in reference to pulling Resident #1's hair. He continued by saying that everyone always said he did things he was not doing and added, Whatever, just get me out of this place. The NHA observed that Resident #2 became increasingly agitated and the interview was ended at that time. Resident #1 was interviewed by the NHA on 5/3/25 at 11:30 a.m. regarding the incident. Resident #1 initially refused to discuss the matter and said, it is done and over with. When the NHA brought up the resident's use of racial slurs directed towards Resident #2, Resident #1 admitted making the comment and said he would come up with something else to call Resident #2. Resident #1 was redirected and informed that further disruptive or disrespectful behavior could result in being removed from the dining room. Resident #1 responded dismissively and asked if the NHA was done talking to him. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation documented CNA #2 provided a written witness statement. CNA #2 said he observed Resident #2 holding onto Resident #1's hair so he grabbed Resident #2's hand to prevent him from pulling Resident #1's hair. The interventions put into place after the incident for Resident #2 included 15-minute checks, resident education on respect and appropriate peer interactions, encouraging both residents not to sit near each other and staff was educated on visual monitoring during mealtimes in the dining room. Interventions for Resident #1 included staff intervening before agitation escalated, guiding the resident away from the source of distress, engaging the resident in calm conversation, and, if the resident's response was aggressive, staff were to remain calm, walk away and approach later. The investigation concluded the abuse was substantiated. C. Resident #1 - victim 1. Resident status Resident #1, age [AGE], was admitted on [DATE]. According to the June 2025 CPO, diagnoses included encephalopathy (brain disorder) and acute kidney failure. The 5/13/25 MDS assessment revealed the resident had short-term memory impairment, per the staff assessment for mental status. He was independent with ADLs. The MDS assessment indicated the resident demonstrated rejection of care during the assessment look back period. 2. Record review The behavioral care plan, initiated 10/9/24 and revised 1/17/25, documented Resident #1 had poor impulse control and the potential to become verbally aggressive, including the use of derogatory names and racial slurs towards other residents. Pertinent interventions included intervening before agitation escalated, guiding the resident away from the source of distress, engaging calmly in conversation and walking away and approaching later if the resident responded aggressively. The 4/28/25 nurse progress note revealed that two CNAs witnessed Resident #2 grabbed Resident #1's hair in the dining room. Resident #1 refused to allow staff to assess his skin. D. Resident #2 - assailant The 4/29/25 nursing progress note revealed that Resident #2 informed the nurse that he had pulled another resident's hair. The resident said that Resident #1 called him a racial slur in the dining room and Resident #2 got up and pulled the resident's hair. -However, the care plan was not revised until 5/5/25, seven days after the 4/28/25 incident involving Resident #1. E. Resident #9 interview (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #9 was interviewed on 6/3/25 at 4:02 p.m. Resident #9 said Resident #1 had called Resident #2 a racial slur and Resident #2 became upset and pulled Resident #1's hair. IV. Staff interviews Certified nurse aide (CNA) #2 was interviewed on 6/3/25 at 4:26 p.m. CNA #2 said he had been in the dining room when the incident occurred between Resident #1 and Resident #2 on 4/28/25. CNA #2 said he had been the staff member who held Resident #2's hand to prevent him from pulling Resident #1's hair. He said that since the incident, staff had increased monitoring of the two residents and ensured they did not sit together. He said he redirected residents when he observed potential triggers and, if they attempted to sit at the same table, staff separated them or adjusted their dining times to prevent them from being in the dining room at the same time. CNA #2 said he was not working during the 4/20/25 incident involving Resident #5 and Resident #2 but he had heard about the incident from the management team. He said staff were expected to observe the residents closely and monitor for any signs of agitation to help ensure resident safety. CNA #3 was interviewed on 6/4/25 at 9:45 a.m. CNA #3 said she had worked at the facility for 17 years. She said she had heard about the altercation between Resident #1 and Resident #2 that occurred on 4/28/25 and said that Resident #2 got upset easily. She said that since the incident, a nurse had consistently been present in the dining room when Resident #1 and Resident #2 were there to ensure their safety. She said when she observed any altercations, she intervened and notified the nurse and then the NHA. She said Resident #2 tended to ignore CNAs but responded better when nurses were present. She said that since the incident in the dining room between Resident #1 and Resident #2, a nurse had always been present there to help prevent a recurrence. She said she was not working on 4/20/25, the day of the incident between Resident #2 and Resident #5 but she had heard about the incident from other staff. CNA #1 was interviewed on 6/4/25 at 10:04 a.m. CNA #1 said he had worked at the facility for one year and was familiar with Resident #2. He said Resident #2 became upset when others used racial slurs or violated his personal space. He said that when there was an altercation, he intervened, redirected the residents, and notified the nurse, the DON, and the NHA. He said that following the incident in the dining room when Resident #2 pulled Resident #1's hair, Resident #1 had been eating in his room for 30 days to avoid further altercations. The DON was interviewed on 6/4/25 at 12:30 p.m. The DON said staff completed crisis prevention intervention (CPI) training during onboarding and as needed. She said leadership discussed resident behaviors and related concerns during staff meetings. She said once she became aware of an incident, she separated the residents involved and placed the aggressor on 15-minute checks for 24 hours. She said the facility did not implement checks for the victim if no injury was observed, as frequent checks could agitate some residents. She said if the aggressor continued to escalate, staff implemented one-to-one supervision for the resident. The DON said Resident #2 was difficult to manage due to multiple diagnoses, refusals of medications and elevated blood sugars. She said staff notified her when a resident missed two consecutive doses of medication, especially if increased behavioral symptoms were observed. (continued on next page)

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