STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065248	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Care and Rehabilitation	5301 W 1st Ave Lakewood, CO 80226

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to keep residents free from abuse for six (#15, #14, #9, #8, #19 and #20) of 11 residents reviewed for abuse out of 25 sample residents. Specifically, the facility failed to:-Protect Resident #15 from physical abuse by Resident #13 on 11/29/25; -Protect Resident #15 from physical abuse by Resident #16 on 1/6/26; -Protect Resident #15 from physical abuse by Resident #17 on 1/17/26; -Protect Resident #14 from physical abuse by Resident #13 on 11/20/25;-Protect Resident #14 from physical abuse by Resident #8 on 1/2/26;-Protect Resident #9 from physical abuse by Resident #10 on 2/5/26; -Protect Resident #9 from physical abuse by Resident #18 on 2/19/26;-Protect Resident #8 from physical abuse by Resident #9 on 2/15/26; and,-Protect Resident #19 and Resident #20 from verbal and physical abuse towards each other on 2/18/26.Findings include: I. Facility policy and procedure The Abuse policy, reviewed 11/1/17, was provided by the nursing home administrator (NHA) on 2/23/26. The policy read in pertinent part, Residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraints not required to treat the resident's medical symptoms. II. Incident of physical abuse of Resident #15 by Resident #13 on 11/29/25 A. Facility investigation The facility investigation, dated 11/29/25, documented staff heard a commotion coming from Resident #15's room and responded to see what was going on. Staff heard Resident #13 say Get the (expletive) out, this is my room. Resident #13 was at Resident #15's bedside grabbing at Resident #15's feet to try and get him out of the bed and room. The responding nurse documented on 11/29/25 at 6:43 p.m. staff responded to an interaction between two roommates in which Resident #15 was waiting for assistance to get up and out of bed. At that time, Resident #13 approached Resident #15's bedside and displayed an episode of physical aggression in an effort to get Resident #15 out of the room, saying this is my room. The CNA intervened immediately and gently separated both residents to ensure safety, as well as reported to this nurse immediately. A nursing assessment found Resident #15 to be calm and cooperative, with no pain, no discomfort, no injury, and no signs of fear noted. Resident #15 was calm following the event. He displayed no visible signs of fear, distress, or injury, and during the interview he denied recalling the incident. (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 investigation documented Resident #15 was moved to a new room. Resident #13 remained in the room without a new roommate. The investigation documented Resident #13's care plan was updated to reflect increased behavioral monitoring and environmental adjustments. The facility substantiated that abuse occurred. B. Resident #15 (victim) 1. Resident status Resident #15, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included severe dementia with other behavioral disturbance and adult failure to thrive. According to the 11/30/25 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. The assessment indicated the resident had wandering and aggressive behaviors that affected other residents. 2. Record review Resident #15's behavior care plan, initiated 11/30/25, revealed the resident had wandering behaviors. Interventions included anticipating wandering patterns and providing early, staff-led redirection when the resident approached other resident's rooms. 3. Observation During a continuous observation on 2/23/26, beginning at 11:45 a.m. and ending at 12:45 p.m., Resident #15 was observed continuously wandering between the halls and the common area in the secure memory care unit. During a second continuous observation on 2/23/26, beginning at 6:00 p.m. and ending at 7:05 p.m., Resident #15 was observed continuously wandering between the halls and the common area in the secure memory care unit. During a continuous observation on 2/24/26, beginning at 5:31 p.m. and ending at 7:51 p.m. Resident #15 was observed continuously wandering between the halls and the common area in the secure memory care unit. Cross-reference F744 for failure to provide treatment/services for residents with dementia. C. Resident #13 (assailant) 1. Resident status Resident #13, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnoses included Alzheimer's disease and severe dementia with other behavioral disturbance. According to the 12/5/25 MDS assessment, the resident had severe cognitive impairment with a BIMS score of four out of 15. The MDS assessment indicated the resident had wandering and aggressive behaviors that affected other residents. 2. Record review Resident #13's behavior care plan, initiated 12/15/25, revealed the resident had the potential to display physical aggression and had a history of several resident-to-resident altercations. Pertinent interventions included removing other residents from the resident's room, doorway, or personal space, intervening when the resident became agitated and engaging the resident in calm conversation. III. Incident of physical abuse of Resident #15 by Resident #16 on 1/6/26 A. Facility investigation The facility investigation, dated 1/6/26, documented Resident #15 wandered and entered Resident #16's room without invitation. The staff heard yelling and loud noises and went to the Resident #16's room to investigate. Resident #16 physically redirected Resident #15 out of her room. Resident #15 lost his balance, tripped and fell to the floor. The investigation documented the residents were separated and immediate safety measures were put into place. There were no physical or psychosocial injuries noted for either resident. The investigation documented Resident #15's care plan was reviewed and no changes were made. The facility did not substantiate that abuse occurred. B. Resident #16 (assailant) 1. Resident status Resident #16, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included severe dementia with other behavioral disturbance and insomnia. According to the 11/29/25 MDS assessment, the resident had severe cognitive impairment with a BIMS score of nine out of 15. The MDS assessment indicated the resident had wandering and aggressive behaviors that affected other residents. 2. Record review Resident #16's behavior care plan, initiated 3/12/24, revealed the resident could become physically aggressive towards others when they invaded her personal space. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IV. Incident of physical abuse of Resident #15 by Resident #17 on 1/17/26. A. Facility investigation The facility investigation, dated 1/17/26, documented Resident #15 wandered and entered Resident #17's room without invitation. Resident #17 pushed Resident #15 and yelled at him to get out of his room. The investigation documented the residents were separated, and each resident was assessed by nursing staff and no physical or psychosocial injuries were identified. The investigation documented Resident #17's care plan was reviewed, door modifications were added to deter unauthorized room entry, and increased staff monitoring. The facility substantiated that the abuse occurred. B. Resident #17 (assailant) 1. Resident status Resident #17, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included major depressive disorder, traumatic brain injury, cognitive communication deficit and a need for assistance with personal care. According to the 12/18/25 MDS assessment, the resident had severe cognitive impairment with a BIMS score of two out of 15. The MDS assessment indicated the resident had wandering and aggressive behaviors that affected other residents. 2. Record review Resident #17's behavior care plan, revised 1/22/26, revealed Resident #17 had cognitive deficits and a history of inappropriate boundaries with a potential to demonstrate physical behaviors when another resident wandered into his room and touched his belongings. Interventions included applying retractable straps placed in front of his door that both he and his roommate could remove in the hopes of deterring other residents who may attempt to wander into the room. V. Incident of physical abuse of Resident #14 by Resident #13 on 11/30/25 A. Facility investigation The facility investigation, dated 11/30/25, documented Resident #14 suffered physical abuse when Resident #13 hit Resident #14 with his wheelchair, knocking her to the floor, and then hit Resident #14 again while she was on the floor. Resident #13 became highly agitated during this encounter. The investigation documented Resident #14 sustained no physical injuries or psychosocial harm and denied any injuries, pain or fear. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The investigation documented the residents were separated, immediate safety measures were put into place and there were no physical or psychosocial injuries noted. The investigation documented Resident #8's care plan was reviewed and no changes to treatment were made. -The facility unsubstantiated that abuse occurred; however, abuse occurred because Resident #8 pushed Resident #14 in order to make her walk faster. B. Resident #8 (assailant) 1. Resident status Resident #8, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included bipolar schizoaffective disorder, severe dementia with other behavioral disturbance and insomnia. According to the 1/13/26 MDS assessment, the resident had severe cognitive impairment with a BIMS score of four out of 15. The MDS assessment indicated the resident had physical behaviors directed toward others. 2. Record review Resident #8's behavior care plan, initiated 10/9/24, revealed the resident had behavioral problems with the potential to initiate physical aggression. -However, the care plan failed to document any interventions to prevent Resident #8 from becoming physically aggressive toward other residents. VII. Incident of physical abuse of Resident #9 by Resident #10 on 2/5/26 A. Facility investigation The facility investigation, dated 2/5/26, documented Resident #10 took Resident #9's face in her hands and pushed her face away from her. The investigation documented the residents were separated, immediate safety measures were put into place and there were no physical or psychosocial injuries noted. The investigation documented Resident #10's care plan was reviewed and updated, and systemic interventions were implemented to reduce the risk of recurrence. No changes to treatment were made. The two residents were roommates and remained living in the same room with no additional interventions implemented. The investigation indicated the facility did not substantiate the abuse, however, abuse occurred as Resident #10 took Resident #9's face and pushed it away from her. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Resident #9 (victim) 1. Resident status Resident #9, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included dementia and major depressive disorder. According to the 12/23/25 MDS assessment, the resident had severe cognitive impairment with a BIMS score of zero out of 15. 2. Record review Resident #9's behavior care plan, initiated, 7/12/22, revealed the resident had no other documented instances of physical aggression in the past year. C. Resident #10 (assailant) 1. Resident status Resident #10, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included severe dementia with other behavioral disturbances and insomnia. According to the 12/29/25 MDS assessment, the resident had severe cognitive impairment with a BIMS score of zero out of 15. 2. Record review Resident #10's behavior care plan, initiated, 3/6/24, revealed the resident could become physically and verbally aggressive towards others when they invaded her personal space. VIII. Incident of physical abuse of Resident #9 by Resident #18 on 2/19/26 A. Facility investigation The facility investigation, dated 2/19/26, documented several scenarios of the incident and did not give clear descriptions of what occurred in the course of the incident. In the conclusion of the investigation, the document revealed that Resident #18 became upset in the common area when Resident #9 was seated in her preferred location and chair in the common area near her walker and Resident #18 wanted Resident #9 to move. The investigator documented due to cognitive impairment and decreased ability to interpret social situations, Resident #18 became verbally distressed and raised her voice yelling at Resident #9. Resident #18 reached toward Resident #9 during the altercation. In the alteration Resident #9 was moving from the chair and fell to the floor. Resident #9 received a cut to her forehead and required first aid care with steri strips applied to the wound. The investigator unsubstantiated the allegation of resident-to-resident abuse because there was no evidence of intentional harm, malicious intent, or staff neglect. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-However, the facility failed to take into account the regulatory definition of abuse and the importance of considering willful and abusing actions towards another resident. B. Resident #18 (assailant) 1. Resident status Resident #18, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included Alzheimer's disease, dementia and bipolar schizophrenia. According to the 12/22/25 MDS assessment, the resident had severely impaired cognition with a BIMS score of one out of 15. The MDS assessment indicated the resident experienced hallucinations and delusions. The MDS assessment did not indicate the resident had physically aggressive behaviors towards other residents. 2. Record review Resident #18's behavior care plan, initiated, 9/10/25, revealed the resident had impaired coping skills, poor impulse control, and fluctuating mood. She was at risk for emotional dysregulation, verbal outbursts, and occasional physical aggression, particularly when overstimulated, questioned repeatedly, or when personal boundaries were perceived to be violated. Interventions included focusing on redirection and environmental modification, offering and encouraging activities, such as music listening and other structured engagement, such as bingo. When the resident was overstimulated, staff was to offer a quieter setting and approach the resident with clear communication in a calm and respectful manner. IX. Incident of physical abuse of Resident #8 by Resident #9 on 2/15/26 A. Facility investigation The facility investigation, dated 2/15/26, documented Resident #9 wandered into Resident #8's room and grabbed and scratched Resident #8 on the hand. The investigation documented the residents were separated and relocated to different quiet areas with staff supervision to maintain safety. Resident #8 received first aid care medical attention, however did not display pain, or fear. The investigation documented Resident #9's care plan was reviewed and the existing care plan was reinforced with staff education. X. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 2/23/26 at 3:51 p.m. LPN #1 said the younger residents in the secure memory care unit had more mental health issues compared to the older residents who typically had dementia. LPN #1 said the younger residents tended to irritate the older residents that had dementia. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incident began with verbal taunting and then escalated to pushing, finally resulting in him falling over. Resident #20 said he did not recall the incident clearly but remembered there was some pushing. The facility substantiated the incident of physical abuse and determined the root cause of the incident was Resident #19 and #20 living together. The root cause was rectified and Resident #20 was moved to another room. B. Resident #19 (victim and assailant) 1. Resident status Resident #19, age [AGE], was admitted on [DATE]. According to the February 2026 CPO, diagnoses included memory deficits following stroke, history of falling and history of transient ischemic attacks (mini strokes). The 11/27/25 MDS assessment revealed the resident was moderately cognitively impaired with a BIMS score of 11 out of 15. The assessment indicated the resident did not have any aggressive behavior towards others. 2. Resident interview Resident #19 was interviewed on 2/25/26 at 2:43 p.m. Resident #19 said he had a recent altercation with his roommate (Resident #20) over the TV noise in their room. He said it started when he flipped off his roommate because the TV was too loud. He said they both exchanged verbally hostile remarks until he asked Resident #20 if he wanted to fight. He said Resident #20 came over and hit his leg, which resulted in a shoving match between them and eventually leading to him (Resident #19) falling down. Resident #19 said he felt better now that he and Resident #20 resided in different rooms. 3. Record review Resident #19's behavior care plan, initiated 9/9/24, revealed the resident had the potential to display physical aggression and had poor impulse control. Pertinent interventions included attempting to find triggers for behaviors and de-escalating and discussing the resident's aggressive behavior in a private area. C. Resident #20 (victim and assailant) 1. Resident status Resident #20, age [AGE], was admitted on [DATE]. According to the February 2026 CPO, diagnoses included cancer and hip fracture. The 11/27/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. The assessment indicated the resident did not have any aggressive behavior towards others. 2. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident interview Resident #20 was interviewed on 2/24/26 at 2:10 p.m. Resident #20 said he did not know exactly what happened the day of the incident with Resident #19 (2/18/26) and he was unsure how things escalated. He said he was not fearful or nervous of Resident #19 and was not injured during the incident. 3. Record review Resident #20's behavior care plan, initiated 2/18/26, revealed the resident had the potential to display physical aggression. Pertinent interventions included administering medications as ordered, approaching the resident in a calm manner and de-escalating and discussing the resident's aggressive behavior when appropriate. D. Staff interviews LPN #4 was interviewed on 2/26/26 at 3:48 p.m. LPN #4 said abuse could be considered anything from bullying to stealing. She said when resident-to-resident abuse was witnessed, she would separate the residents and figure out what happened. She said there had been no other issues between Resident #19 and Resident #20 after Resident #20 was moved to a different room. CNA #9 was interviewed on 2/26/26 at 3:34 p.m. CNA #9 said anything could be considered abuse, from hitting to sexual abuse. She said Resident #19 was very independent and sometimes did not get along well with others. She said Resident #19 was pretty easy to redirect when he got frustrated. She said there had been no further issues between Resident #19 and Resident #20 since Resident #20 was moved to a different room.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to conduct a thorough investigation into an allegation of physical abuse of a resident by staff for one (#23) of three residents reviewed out of 25 sample residents.Specifically, the facility failed to conduct a thorough investigation in order to assess all facts of Resident #23's allegation of abuse by certified nurse aide (CNA).Findings include:I. Facility policy and procedureThe Abuse: Prevention of and Prohibition Against policy and procedure dated November 2017 was provided by the regional nurse consultant on 2/23/26 at 2:45 p.m. It read in pertinent part: It is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation and mistreatment. The facility will act to protect and prevent abuse and neglect from occurring within the facility by: supervising staff to identify and correct any inappropriate or unprofessional behaviors. The investigation will include an interview with staff members (on all shifts) who may have information regarding the alleged incident; and an interview with staff members (on all shifts) having contact with the accused employee. At the conclusion of the investigation, the facility will take action, as necessary, in light of the information gathered, which may include but is not limited to defining how care provision will be changed and/or improved to protect residents receiving services, if appropriate.II. Allegation of physical abuse of Resident #23 by CNA #3A. Facility investigationThe facility investigation, dated 1/9/26, documented Resident #23 reported CNA #3 provided rough and unnecessary care while assisting her in the shower on the evening of 1/8/26. Resident #23 filed a grievance on 1/9/26 at 10:30 a.m., revealing she felt she was physically abused by CNA #3. Resident #23 said CNA #3 pushed her onto the bath chair and then threw a towel at her and told her to wash herself. The facility's interview with Resident #23, dated 1/9/26 at 7:54 p.m., documented Resident #23 said CNA #3 pushed her onto the bath chair, a towel was thrown at her and then CNA #3 told the resident to wash herself. The interview documented Resident #23 was unable, during the interview, to provide the date that the incident occurred. The investigation revealed the social services director (SSD) interviewed Resident #3 about the incident. The investigation documented Resident #23 initially appeared emotionally distressed and tearful, with a flat affect and guarded posture. However, as the conversation progressed and reassurance and emotional support were provided, the resident's affect improved.The facility's investigation documented the SSD assessed Resident #23's ability to recall the timing of the allegation and concluded the resident was a poor historian, with difficulty recalling long-term details. When asked, the resident said she had no concerns about CNA #3 continuing to work in the facility but Resident #23 did not want CNA #3 taking care of her again. CNA #3 was suspended during the investigation. CNA #3 was interviewed on 1/14/26 by the SSD. CNA #3 denied the allegation made by Resident #23 and said she had not provided care assistance to the resident in a long time. -However, the investigation report did not document the last date that CNA #3 was assigned to the resident's care or assisted another staff member to care for Resident #23.The facility's investigation documented the allegation of abuse was unsubstantiated based on a lack of corroborating evidence, inability to identify a specific timeframe for the incident, and findings consistent with the resident's care being routine and appropriate to the resident's functional limitations.However, the facility's investigation failed to reveal documentation of the following: -The facility's investigation failed to document interviews with other CNAs or nursing staff who worked with Resident #23 to determine if the resident had reported rough care or problems with showering assistance with other staff members during the time of the incident or the initial investigation.-The facility's investigation failed to document interviews with other residents to determine if other (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents had concerns related to the care provided by CNA #3.-The facility's investigation failed to thoroughly assess the condition of the shower area to determine if there were any environmental factors that may have contributed to the resident feeling like she was abused. -The facility's investigation failed to include documentation to indicate attempts were made to observe and assess CNA #3's performance while the CNA was assisting residents with showering and transfer assistance to ensure her understanding of safe transfers in the shower area. B. Resident #231. Resident status Resident #23 age [AGE], was admitted to the facility on [DATE]. According to the February 2026 CPO, diagnoses included a previous knee injury, generalized weakness and a history of falling. The 1/9/26 MDS assessment revealed the resident had moderately impaired cognition with a BIMS score of 10 out of 15. The resident required assistance from one to two staff members for transfers and bathing.2. Resident interview Resident #23 was interviewed on 2/25/26 at 2:40 p.m. Resident #23 said she had a bad experience in the facility when CNA #3 provided her with rough care on more than one occasion, so she filed a complaint. Resident #23 said CNA #3 was assisting her to take a shower but CNA #3 pushed her onto the bath chair, threw the wash cloth on her and told her to wash herself. Resident #23 said CNA #3 was mean to her another time and told her to put herself to bed. Resident #23 was near tears and became upset, speaking loudly with a reddened face, when recalling these events and repeating that she did not want to work with CNA #3 again.Resident #23 said no other staff members were around to observe the incidents with CNA #3 and so she stood up for herself and filed complaints about CNA #3's treatment towards her. Resident #23 said reiterated that never wanted CNA #3 to help her again.3. Record review Resident #23's behavior care plan, initiated 9/11/25, revealed Resident #23 had a potential for a behavior problem related to persistent depression disorder, anxiety and insomnia.Interventions included encouraging the resident to verbalize feelings related to her emotional state, monitoring behavior episodes and attempting to determine underlying cause, considering location, time of day, persons involved, and situations and documenting behavior and potential causes.-The behavior care plan revealed the resident required two staff members with bathing. III. Staff interviewsThe director of nursing (DON) and the NHA were interviewed together on 1/26/26 at 4:45 p.m. The DON said CNA #3 denied the allegations made by Resident #23. The DON said Resident #23 was now being provided with care in pairs (more than one staff member) since the resident made the allegation of abuse against CNA #3, in order to protect the resident and the staff. The DON and the NHA said facility staff were provided training on how to work with residents with limited cognitive and physical functioning. The DON said Resident #23 had a history of depression and stroke and it was difficult to get detailed information from her during the investigation of the allegation. The DON said they did not do any additional investigating of the allegation, other than what was documented in the facility investigation provided during the survey. The DON said only one other resident complained about CNA #3 as a care giver (on 2/12/26). She said the facility changed that resident's caregiver assignment so CNA #3 no longer worked with her and that was the end of the resident's concerns.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADL), received the necessary services to maintain good personal hygiene for one (#4) of five residents out of 25 sample residents. Specifically, the facility failed to ensure Resident #4 received timely incontinence care.Findings include:I. Facility policy and procedureThe Activities of Daily Living (ADL) policy and procedure, revised December 2025, was provided by the regional nurse consultant on 2/24/26 at 12:00 p.m. It read in pertinent part, Residents who are unable to carry out activities of daily living (ADL) will receive necessary services or support from staff.II. Resident #4A. Resident statusResident #4, age [AGE], was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included schizophrenia, an unspecified mood and behavior disorder and epilepsy.The 9/30/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. The resident was dependent on staff assistance for toileting hygiene.B. Observations and staff interviewsDuring a continuous observation on 2/24/26, beginning at 9:20 a.m. and ending at 11:45 a.m., and again, beginning at 11:46 a.m. and ending at 12:18 p.m., the following was observed:At 9:20 a.m. Resident #4 was in his room lying in bed. At 9:50 a.m. an unidentified activities staff member knocked on the resident's door, observed that the resident was sleeping and walked away without fully entering the room.At 10:49 a.m. the hospice social worker entered Resident #4's room to talk with the resident.At 12:07 certified nurse aide (CNA) #7 entered Resident #4's room to check on the resident. CNA #7 proceeded to provide the resident with incontinence care. After checking the resident's brief, CNA #7 changed both the resident's brief and the resident's bed linens which had been soiled. CNA #7 showed Resident #4's brief which was soiled with urine.CNA #7 was interviewed on 2/24/26 at 12:18 p.m. CNA #7 said she did not know exactly when Resident #4 was last changed, but she thought it must have been before her shift started at about 6:00 a.m., when the resident would have been getting showered by hospice staff. She said she had not checked him for incontinence since her shift started at 6:00 a.m. CNA #7 did not say why she had not checked Resident #4 for incontinence since the beginning of her shift. -Resident #4 had not been provided with incontinence care in over six hours. C. Resident's representative interviewResident #4's representative was interviewed on 2/24/26 at 2:37 p.m. The resident's representative said she did not think the facility provided Resident #4 with incontinence care often enough.D. Record reviewThe ADL care plan, revised 11/27/25, revealed Resident #4 had an ADL self-care performance deficit due to his schizophrenia and weakness. Pertinent interventions included substantial supervision, and encouragement due to frequent refusal of care.The nursing progress note, dated 3/29/25 at 5:48 p.m., documented Resident #4 urinated on the floor.The nursing progress note, dated 3/16/25 at 5:33 p.m., documented Resident #4 was found in bed with stool on the floor and urine soaked bed linens and clothing.III. Staff interviewsCNA #7 was interviewed a second time on 2/24/26 at 3:59 p.m. CNA #7 said Resident #4 often refused care and often removed his own briefs when he was wet. CNA#7 said Resident #4 would often just urinate in his bed and she thought he also urinated on the floor. She said he would often lay in urine soaked sheets and she was responsible for changing these urine soaked sheets. She said she had changed them during the previous interview and thought that was likely why his briefs were not particularly saturated. She said dependent residents needed to be checked on and/or changed every two hours.Registered nurse (RN) #4 was interviewed on 2/25/26 at 10:10 a.m. RN #4 said the expectation for checking and changing residents was once every two hours. She said Resident #4 refused care often and needed to be coaxed or (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bribed with things, such as candy, to agree to care assistance from staff. -However, no direct care staff were observed entering Resident #4's room to offer incontinence care during continuous observations of the resident (see observations above).CNA #5 was interviewed on 2/25/26 at 9:51 a.m. CNA #5 said she checked and changed the residents on her assignment as often as possible and every two hours at a minimum.CNA #8 was interviewed on 2/25/26 at 9:55 a.m. CNA #8 said dependent residents needed to be checked on and changed every two hours. She said Resident #4 needed to be checked on every two hours at minimum. Licensed practical nurse (LPN) #3 was interviewed on 2/25/26 at 10:00 a.m. LPN #3 said dependent residents needed to be checked on for incontinence and changed at least every two hours.The nursing home administrator (NHA) and the director of nursing (DON) were interviewed together on 2/26/26 at 4:46 p.m. The NHA and the DON said the expectation was that staff would check on dependent residents for incontinence and change them, if needed, every two hours.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents who were diagnosed with dementia received the appropriate treatment and services to attain or maintain their highest practical physical, mental, and psychological well-being for nine (#15, #14, #9, #8, #13, #17, #10, #24 and #25) of 11 residents reviewed for dementia care out of 25 sample residents.Specifically, the facility failed to develop and implement effective person-centered dementia management interventions to prevent Residents #15, #14, #9, #8, #13, #17, #10, #24 and #25 from wandering into other residents' rooms and/or engaging in resident-to-resident altercations.Findings include: I. Facility policy and procedure The Care of Dementia policy and procedure, revised April 2022, was provided by the regional nurse consultant on 2/25/26 at 12:00 p.m It read in pertinent part, It is the policy of this facility that all residents will have an individualized plan of care and have the least restrictive approaches to care. Staff are offered training in the care of the dementia population, appropriate approaches to care and managing behaviors. The interdisciplinary staff will initiate a thorough clinical assessment. Monitoring of mood, behavior and/or any psychosocial related issues will be used to identify possible underlying medical problems which may be causing the behavior problems. Social services will also meet with residents and attempt to identify possible psychosocial issues that may be causing behaviors and to develop a baseline social history. The interdisciplinary team (IDT) will review findings of evaluations and develop a plan of care addressing the resident's needs. The physician will be involved in plan of care and make any changes to medical regimen as necessary The facility will offer staff training regarding the dementia disease process, utilizing nationally recognized dementia care guidelines as the basis of the education, including what to expect with progression of the disease, care of this specialized population, approaches to intervening in a crisis situation and managing/monitoring behaviors.II. ObservationsDuring a continuous observation of the secure memory care unit on 2/23/26, beginning at 2:40 p.m. and ending at 3:30 p.m., the following was observed:Resident #25 was observed going into other residents' rooms The activities director (AD) was running a group activity with nine residents in attendance. The AD was applying temporary tattoos, reminiscing and refreshments then moving to a balloon toss activity. While the activity occurred, six residents were observed wandering the halls, pacing back and forth, with no particular purpose but walking and looking down the hall. Resident #14 was observed at the back patio door trying to get outside but the door was locked. The resident was becoming frustrated and continually pushing on the door. After approximately 10 minutes at the door, staff approached the resident and gave her a walker and assisted her to the main common area of the unit. Resident #14 began to wander the unit on her own, heading to the front door of the unit that led to the other community areas. The resident proceeded to try to exit the front door of the unit, for approximately two minutes, before heading back to the common space on the other end of the unit. No staff members had Resident #14 in their line of sight and were not watching her wandering. Resident #24 walked up the hall, stopping several times to look over the hall environment, and then he wandered into several rooms, shutting the door after entering each room. One room belonged to a female resident and the other room belonged to a male resident. No staff members were monitoring or redirecting Resident #24 as he was wandering in and out of other residents' rooms. The female resident's room Resident #24 entered was empty, however the male resident's room he wandered into was occupied by the male resident. Resident #24 remained in each room for a couple of minutes before moving to the next room. He eventually found his own room and went inside.Resident #9 was wandering up and down the halls. She roamed, standing in the middle of the hall for (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	several minutes between walking. She entered another resident's room but then exited when she noted she was being observed. Neither Resident #24 or Resident #9 were being monitored by staff as they entered other residents' rooms.At 3:30 p.m. Resident #15 was observed wandering the hallway without staff assistance or direction. He was going into other residents' rooms. No staff were monitoring his activity or providing redirection to the resident. On 2/23/26 at 3:40 p.m. Resident # 14 was observed touching Resident #13 on his head and holding his hand. Resident #14 was resting her head on Resident #13. No staff monitored or redirected the behavior. -However, Resident #13 had been identified as having a tendency to become aggressive when others got into his personal space (see record review below).During a continuous observation of the secure memory unit on 2/24/26, beginning at 10:20 a.m. and ending at at 11:34 a.m., the following observations were made:Resident #24 was observed pacing the hallways and entering and leaving several other residents' rooms. He was observed wandering around without purpose. Resident #24 wandered into Resident #17's room. Resident #17's room did not have the barrier strap (a wide red cloth strap velcroed to each side of the room's doors) in place that was meant to keep wandering residents out of his room.-However, Resident #17 had been identified to not like others in his room and often became physically aggressive towards other residents who wandered into his room (see record review below). During a continuous observation of the secure memory care unit on 2/25/26, beginning at 10:25 a.m. and ending at 11:53 a.m., the following was observed: At 11:08 a.m. Resident #24 was observed wandering the hallways and going into several residents' rooms. Resident #24 entered Resident #17's room at approximately 11:40 a.m. No staff members monitored his activity or redirected him. Resident #24 continued to wander until 11:50 a.m. when CNA #4 redirected Resident #24 to the dining room.III. Resident #15 A. Resident statusResident #15, age [AGE], was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included adult failure to thrive, dementia and repeated falls. The 11/30/25 minimum data set (MDS) assessment revealed the resident had severely impaired cognition. The resident was not able to complete the brief interview for mental status (BIMS) assessment. Staff assessment of the resident's cognition revealed the resident had severe cognitive impairment and he never or rarely made decisions of daily life. The MDS assessment revealed that the residents behaviors included wandering and physically aggressive behaviors that could put others at risk for injury. B. Record reviewAccording to the behavior care plan, initiated, 2/23/26, Resident #15 had aggressive behavior. The resident would become combative towards staff during hands-on care and often refused care assistance. Interventions included approaching the resident face-to-face and slowly explaining what care would be provided and why. Staff were to document and observe the behavior and what attempted interventions were used. According to the cognitive decline/dementia care plan, initiated 11/30/25, the resident was at risk for impaired cognitive function, and impaired thought processes due to symptoms of dementia. The resident was at risk for falls; and unintended privacy breaches related to cognitive impairment and wandering behaviors. Interventions included communication and making eye contact, using simple directive sentences, keeping routines consistent and staff anticipating wandering patterns, providing early staff-led redirection when the resident approached other residents' rooms and reinforcing expectations that staff, not other residents, would perform redirection. If the resident entered another resident's room, staff were to intervene immediately, escort the resident back to the common area or hallway, and restore privacy. Review of Resident #15's elopement risk/wandering care plan, initiated 11/28/25, the resident was an elopement risk due to wandering and exit-seeking behavior. Interventions included identifying pattern and purpose of wandering, intervening as appropriate and documenting wandering behaviors and the attempted diversional interventions.-However, staff were not observed to be (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following the care plan interventions to prevent Resident #15 from wandering into other residents' rooms (see observations above). Review of Resident #15's daily activity tracking documentation revealed the resident wandered almost daily, (22 out of 31 days in December 2025 and 28 out of 31 days in January 2026) exploring the environment, observing surroundings and visiting other residents. IV. Resident #14 A. Resident statusResident #14, age [AGE], was admitted on [DATE]. According to the February 2026 CPO, diagnosis included dementia, adult failure to thrive, anxiety disorder and difficulty walking. The 12/23/25 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of four out of 15. The MDS assessment indicated the resident had verbal and physical behavioral symptoms that were directed towards others.The MDS assessment did not indicate the resident wandered. B. Record reviewReview of Resident #14's elopement risk/wandering care plan, initiated, 3/28/25, revealed the resident was at risk for elopement and wandering. Interventions included identifying if the resident's wandering was purposeful or if it was aimless and if the resident was looking for something. Review of Resident #14's daily activity tracking documentation revealed the resident wandered almost daily, (30 out of 31 days in December 2025, 24 out of 31 days in January 2026 and 18 out of 28 days in February 2026).V. Resident #9 A. Resident statusResident #9, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnosis included heart disease, major depressive disorder and dementia. The 12/23/25 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of one out of 15. The MDS assessment indicated the resident did not have any physical or verbal behaviors, but did wander daily. B. Record reviewReview of Resident #9's wandering care plan, initiated 3/14/24, revealed the resident frequently wandered throughout the secured unit looking for her room. The resident had a decreased ability to interpret social interactions, increasing misunderstanding for resident-to-resident contact. Interventions included providing structured activities, toileting assistance, walking inside and outside and utilizing reorientation strategies, including signs, pictures and memory boxes.-However staff were not observed monitoring or redirecting Resident #11 while she was wandering (see observations above). Review of Resident #9's daily activity tracking documentation revealed the resident wandered frequently, (24 out of 31 days in December 2025, 15 out of 31 days in January 2026 and six out of 28 days in February 2026).VI. Resident #8 A. Resident statusResident #8, age [AGE], was admitted on [DATE]. According to the February 2026 CPO, diagnosis included schizoaffective disorder and dementia. The 1/13/26 MDS assessment revealed the resident had severe cognitive impairment with a BIMS) score of zero out of 15. The MDS assessment indicated the resident did not have physical or verbal behaviors and did not wander. B. Record reviewReview of Resident #8's elopement care plan initiated 10/9/24, revealed the resident was at risk for elopement and wandering. The resident preferred to spend the majority of her days in her room either resting or rummaging through her items. The resident had a history of becoming upset if other residents entered her room or stood too long outside of her door. Interventions included identifying if the resident's wandering was purposeful.Review of Resident #8's daily activity tracking documentation revealed the resident wandered into other residents' rooms occasionally.VII. Resident #13 A. Resident statusResident #13, age [AGE], was admitted on [DATE]. According to the February 2026 CPO, diagnoses included dementia, Alzheimer's disease and depression. The 12/5/25 MDS assessment revealed the resident had severely impaired cognition with a BIMS score of four out of 15. The MDS assessment indicated that the resident did not have physical or verbal behaviors but did wander. B. Record reviewReview of Resident #13's elopement care plan revealed the resident was an elopement risk and wandered. The resident had a potential for physical aggression and was territorial. Interventions included diverting the resident's attention and removing the resident to an alternate location (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	if wandering was unsafe. The residents' triggers for behavioral aggression included the resident feeling like others were going into his room uninvited and other residents entering into his personal space.-However, observations of Resident #13 in the secure memory care unit's common spaces and staff interactions revealed the unit staff did not provide Resident #13 with supervision or redirection when other residents were heading towards his room or when other residents were in close proximity to him and in his personal space (see observations above.Review of Resident #13's daily activity tracking documentation revealed the resident wandered frequently (22 out of 31 days in December 2025 20 out of 31 days in January 2026 and six out of nine days in February 2026).VIII. Resident #17 A. Resident statusResident #17, age [AGE], was admitted on [DATE]. According to the February 2026 CPO, diagnoses included major depressive disorder, insomnia, personal history of traumatic brain injury and cognitive communication deficit. The 12/5/25 MDS assessment revealed the resident was severely impaired with a BIMS score of four out of 15. The MDS assessment indicated that the resident did not have physical or verbal behaviors, and did not wander. B. Record reviewReview of Resident #17's elopement risk wandering care plan, initiated 10/8/25, revealed the resident was an elopement risk and wandering risk with a potential to demonstrate physical behaviors when others wandered into his room and touched his belongings. Interventions included identifying patterns of wandering and intervening as appropriate to provide structured activities. Retractable straps would be placed in front of his door that both he and his roommate could remove in hopes of deterring other residents who may attempt to wander into his room.-However, the retractable straps intervention was not observed to be in place consistently (see observations above). Review of Resident #17's daily activity tracking documentation revealed the resident wandered frequently (28 out of 31 days in December 2025 21 out of 31 days in January 2026 and nine out of 28 days in February 2026).IX. Resident # 10 A. Resident statusResident #10, age [AGE], was admitted on [DATE]. According to the February 2026 CPO, diagnosis included anxiety disorder, dementia and muscle weakness. The 12/29/25 MDS assessment revealed the resident was severely impaired with a BIMS score of zero out of 15. The MDS assessment indicated the resident did not have physical or verbal behaviors and did not wander. B. Record reviewReview of Resident #10's behavior care plan initiated 3/6/24, revealed the resident could become physically aggressive towards others. Interventions included providing food, distraction, offering country music to listen to or to write in a book. The resident persevered with other residents going into her room. Review of Resident #10's elopement care plan initiated 3/11/24, revealed the resident was at risk for elopement and could be disoriented to place. Interventions included staff were to redirect the resident as needed.Review of Resident #10's daily activity tracking documentation revealed the resident wandered frequently (27 out of 31 days in December 2025 14 out of 31 days in January 2026 and six out of six days in February 2026).X. Resident #24 A. Resident statusResident #24, age less than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnosis included Alzheimer's disease and degenerative disease of the nervous system. The 12/22/25 MDS assessment revealed the resident was moderately impaired, per the staff assessment for mental status. The MDS assessment indicated the resident did not have physical or verbal behaviors, but did wander daily, which significantly intruded on the privacy of others. B. Record reviewReview of Resident #24's wandering care plan revealed the resident wandered frequently. Interventions included identifying if the wandering was purposeful, aimless, or escapist and providing redirection interventions as appropriate. XI. Resident #25 A. Resident statusResident #25 age [AGE], was admitted on [DATE]. According to the February 2026 CPO, diagnosis include dementia, type 2 diabetes and depression. The 1/13/26 MDS assessment revealed the resident was severely impaired with a BIMS score of zero out of 15. The MDS assessment indicated the resident did (continued on next page)

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	065248	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Care and Rehabilitation	5301 W 1st Ave Lakewood, CO 80226

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not have physical behaviors and did not wander, but did have verbal behaviors and behaviors that could include hitting or scratching self B. Record reviewReview of Resident #25's wandering care plan, initiated 7/16/25, revealed the resident wandered frequently. Interventions included using redirection and diversional interventions, and identifying a pattern of wandering.XII. Staff interviewsCertified nurse aide (CNA) #5 was interviewed on 2/25/26 at 11:50 a.m. CNA #5 said she was not aware of Resident #10 displaying aggressive behaviors towards Resident #9 on 2/5/26. She said this was the first time that she had heard there may be problems with their interactions with each other. CNA #5 said Resident #9 was friends with Resident #10 and that was why Resident # 9 and Resident #10 were roommates. Cross-reference F600 for failure to keep residents free from abuse.CNA #5 said there were a few residents that wandered, including Resident #24, Resident #15, Resident #9 and a few others. CNA #5 said she did de-escalate residents when they got involved in resident-to-resident altercations. She said staff were trying to do restraints without actually restraining residents, but she was unable to explain what she meant by that. CNA #5 said when a resident complained about other residents wandering into their rooms, the staff would put up a red barrier strap across the door to prevent the other residents from entering.-However, the retractable straps intervention was not observed to be consistently in place on Resident #17's door (see observations above).Licensed practical nurse (LPN) #1 was interviewed on 2/25/26 at 11:30 a.m. LPN #1 said he had worked at the facility on the secured memory care unit for several years. He said the biggest problem in the dementia unit was the younger residents bothering the older residents. He said that all of the residents wandered and this was especially true for Resident #24. LPN #1 said the staff did not prevent the residents from wandering unless they saw a resident go into another resident's room that was not theirs and then staff would redirect the resident out of the other residents' rooms as a preventative manner.-However, staff were not observed to be consistently redirecting residents out of other residents' rooms (see observations above).LPN #1 said that activities were good for the residents and the programs were improving as well.CNA #4 was interviewed on 2/25/26 at 1:30 p.m. CNA #4 said a lot of residents, if not all residents, had wandering behaviors and wandered into other residents' rooms. Cross -reference F600 for failure to keep residents free from abuse.CNA #4 said that he had made the recommendation of having a red stripe barrier placed on all the residents' rooms to prevent wandering. He said the activities programming in the secure memory care unit was getting better. He said when a resident did not participate in activities, he would try and get them reengaged with that activity.LPN #2 was interviewed at 10:35 a.m on 2/26/26. LPN #2 said Resident #24 wandered the most out of all the residents. He said unfortunately they could not stop residents from going into other residents' rooms. He said they could try to redirect the residents from wandering into other residents' rooms but it was difficult LPN #2 said the energy in the secure memory care unit changed quickly and it was difficult to manage sometimes. He said activities programming was important to keep the residents occupied and engaged. He said he would like to see more one-to-one activities with residents but he said he knew that this was difficult, based on staffing and the need for the staff to attend to the residents' care needs. LPN #2 said training on resident care plans and interventions was provided and when provided for the residents, the care planned interventions made the day-to-day activities in the unit run more smoothly.CNA #10 was interviewed on 2/26/26 at 1:20 p.m. CNA #10 said when resident-to-resident altercations occurred, he would separate the residents and redirect the residents away from each other. CNA #10 said it was most beneficial to prevent residents from going into another resident's room initially. He said he did this by telling the resident not to go into another person's room. He said he did not know where the residents' care plans were, but knew that they were somewhere in the (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	office. The nursing home administrator (NHA) was interviewed on 2/26/26 at 4:46 p.m. The NHA said the facility was working hard to prevent resident-to-resident altercations and abusive behaviors between residents. She said the facility's leadership team had implemented training for staff to learn redirection techniques for residents. She said leadership was working on contracting with a specialist in dementia-managed care to assist staff with providing improved care and services for residents diagnosed with dementia.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review and interviews, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented, in order to facilitate improvement in the lives of nursing home residents through continuous attention to quality of care, quality of life and resident safety.Specifically, the quality assurance and performance improvement (QAPI) committee failed to identify and address concerns related to abuse, neglect and dementia care.Findings include:I. Facility policy and procedureThe QAPI Facility Program policy was provided by the nursing home administrator (NHA) 2/25/26 at 12:05 p.m. It read in pertinent part, The facility will establish and implement a Quality Assessment and Assurance Committee and develop a written Quality Assurance and Performance Improvement Plan, which will be reviewed and updated annually, and implement Performance Improvement Projects (PIP) through a data driven and proactive approach. II. Cross reference citationsA. Cross reference F600: The facility failed to ensure residents were free from abuse. The facility failed to protect residents from abuse on several occasions when residents were able to wander from room to room in the secure memory unit, resulting in resident-to-resident physical abuse. B. Cross-reference F744: The facility failed to ensure residents who displayed or were diagnosed with dementia received the appropriate treatment to attain or maintain their highest level of care. III. Staff interviewsThe director of nursing (DON) and the NHA were interviewed together on 2/25/26 at 10:25 a.m The DON and the NHA said the facility did not have a QAPI PIP plan in place for the secure memory care unit at this time, but did talk about plans for the unit such as the ability cares programming. The NHA and the DON were interviewed together again on 2/26/26 at 4:46 p.m. The NHA and the DON said the facility was working hard to prevent residents' abusive behaviors and to train the staff on crisis prevention intervention (CPI) and dementia care procedures. The DON said that staff needed education related to abuse and dementia and they had not had that.The DON said the facility was working on several PIPs at that time, including falls and dementia training but could not provide specific details about the specific PIPS.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on record review and interviews, the facility failed to provide training to their staff that at a minimum educates staff on activities that constitute abuse, neglect, exploitation and misappropriation of resident property as set forth, procedures for reporting incidents of abuse, neglect, exploitation or misappropriation of resident property and resident abuse prevention.Specifically, the facility failed to ensure contracted and agency staff met training requirements, including timely reporting of suspected abuse. Findings include:I. Facility policy and procedureThe Abuse policy, revised April 2025, was provided by the regional nurse consultant on 2/23/26 at 12:00 p.m. The policy read in pertinent part, The facility will provide oversight and monitoring to ensure its staff, who are agents of the facility, deliver care and services in a way that promotes and respects the rights of the residents to be from abuse, neglect, misappropriation of resident property, exploitation, or use of technology that would infringe on the resident's right to personal privacy. This policy applies to all facility staff including, but not limited to, employees, consultants, contractors, volunteers, students, and other caregivers who provide care and services to residents on behalf of the facility. II. Record review and staff interview An allegation of neglect incident report, dated 11/25/25, documented the allegation was initiated by a hospice certified nurse aide (CNA) who believed a resident being provided care by himself and his contracted hospice provider was being neglected by the facility when the resident was left wet for an extended period of time. The incident report and facility investigation revealed the contracted hospice CNA failed to report suspected neglect in a timely manner. The incident report documented that although the hospice CNA witnessed suspected neglect on 11/9/25, the allegation was not reported to the facility until 11/19/25, ten days later. A request was made to the regional nurse consultant on 2/24/26 at 12:00 p.m. for documentation of training provided to contracted and agency staff working with the facility's residents, in relation to the facility's policies and procedures and expectations for reporting abuse. The regional nurse consultant provided training records of abuse identification, prevention and reporting for facility staff, however, she was unable to provide any facility-specific abuse training that had been provided to contracted or agency staff. The regional nurse said the contracted and agency staff members were trained on abuse by their agency, prior to coming to work at the facility.III. Staff interviewsCNA #6 was interviewed on 2/24/26 at 4:25 p.m. CNA #6 said she was an agency employee. She said the facility had not provided any supplementary training regarding facility policies and facility expectations related to abuse and neglect prior to her starting her shifts at the facility. The regional nurse consultant was interviewed on 2/25/26 at 4:23 p.m The regional nurse consultant said she thought the agency's and other contracted staff were educated on abuse by their agency and the facility did not need to provide additional training to the contracted and agency staff related to abuse and abuse reporting. The regional nurse consultant agreed it would be beneficial for the facility to provide a read and sign binder for agency and contracted staff so they were aware of relevant facility policies and expectations for reporting abuse. The nursing home administrator (NHA) and the director of nursing (DON) were interviewed on 2/4/26 at 4:46 p.m. The DON said she thought the facility needed to work better with their hospice agency so the hospice agency had certain points of contact to keep in touch with facility leadership when concerns occurred. The DON said the facility had not provided training to agency staff in relation to reporting abuse, but they were planning to develop educational binders that could be used for agency staff training.