STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065282	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Longmont	2451 Pratt St Longmont, CO 80501

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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 0604 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents were free from physical restraints for one (#34) of one resident out of 54 sample residents.Resident #34, was admitted on [DATE] with diagnoses that included Alzheimer's disease and dementia with behavioral disturbance. Resident #34 had a history of behavioral symptoms associated with dementia.On 2/9/26 at 4:30 a.m. certified nurse aide (CNA) #13 entered Resident #34's room to assist CNA #2 who was providing incontinence care. Resident #34 was yelling and striking out during care. CNA #2 said CNA #13 placed one hand over Resident #34's mouth and the other hand over the resident's arms while CNA #2 was providing care. CNA #13 said the facility did not pay her enough to get punched. Interviews completed with the resident's representative revealed Resident #34 would have been fearful if she was able to recall the incident. Specifically, the facility failed to ensure Resident #34 was not physically restrained by CNA #13.Findings include:I. Facility policy and procedureThe Abuse Prevention policy and procedure, reviewed 5/6/25, was provided by the nursing home administrator (NHA) on 3/12/26 at 12:18 p.m. It read in pertinent part, It is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation.Identify, correct and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur to include trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms, if any.Identify, assess, care plan for appropriate interventions, and monitor residents with needs and behaviors which might lead to conflict or neglect, such as physically aggressive behavior and verbally aggressive behavior.II. Incident of physical abuse by CNA #13 towards Resident #34 on 2/9/26A. Facility investigationThe 2/10/26 facility investigation revealed an incident occurred on 2/9/26 at 4:30 a.m. when CNA #13 entered Resident #34's room to assist CNA #2, who was providing incontinence care. The investigation revealed Resident #34 was yelling and striking out during care. CNA #2 said CNA #13 placed one hand over Resident #34's mouth and the other hand over the resident's arms and said the facility did not pay her enough to get punched. The facility investigation included a written statement from registered nurse (RN) #10, dated 2/9/26, which documented that between 5:00 a.m. and 5:30 a.m., CNA #2 told RN #10 that CNA #13 was not being nice to the residents and said she would speak with RN #10 about it later.-However, CNA #2 did not inform a nurse (RN #9) of the details regarding the incident involving Resident #34 until the next day (on 2/10/26). The investigation included a written statement from RN #9 who had talked to CNA #2 after the incident. The statement said CNA #13 entered Resident #34's room to assist CNA #2 who was providing care. The statement documented Resident #34 was yelling during care. The statement documented CNA #13 approached the bed and placed her hand over Resident #34's mouth and held it there for approximately two minutes while the resident attempted to move and strike out. The statement documented CNA #13 grabbed Resident #34's hands and forcefully held them against the resident's chest and pushed the resident back onto the bed. The investigation included a statement from CNA (continued on next page)

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

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F 0604 Level of Harm - Actual harm Residents Affected - Few	#13 that said Resident #34 was combative, she held the resident's hands so the resident would not hit her, called the resident a gringa and denied putting her hand over Resident #34's mouth. The investigation revealed a skin and pain assessment was completed for Resident #34 on 2/10/26 and documented no new findings during the skin assessment and no signs or symptoms of pain were observed or reported during the interaction. The investigation revealed Resident #34 was at baseline on 2/11/26 and had no changes in mood or behavior. The investigation documented the facility was unable to substantiate or unsubstantiate abuse. -However, Resident #34 was physically restrained by CNA #13.B. Resident #34 1. Resident statusResident #34, age [AGE], was admitted on [DATE]. According to the March 2026 computerized physician's orders (CPO), diagnoses included Alzheimer's disease and dementia with behavioral disturbance. The 12/23/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of four out of 15. The resident required set-up assistance with eating, partial to moderate assistance with oral hygiene, dressing and substantial to maximal assistance with toileting hygiene and bathing.2. Resident #34's representative interviewResident #34's representative was interviewed on 3/12/26 at 2:46 p.m. The representative said this was the first time Resident #34 experienced an event like this in her life. The representative said the staff informed him a CNA placed her hand over Resident #34's mouth during care for about two minutes. The representative said the floor manager later spoke with Resident #34 and Resident #34 did not remember the incident. The representative said the event would have been frightening for Resident #34 and said he could see her being upset by someone covering her mouth.3. Record reviewThe comprehensive care plan, initiated 4/26/24 and revised 10/2/25, revealed Resident #34 had confusion and anxiety related to dementia. The care plan documented the resident frequently yelled that she was hungry and wanted something to eat. Pertinent interventions included providing snacks throughout the day and offering simple structured activities, such as word searches, crafts and small group activities.-The care plan did not include interventions to guide staff if the resident became physically aggressive during care.The 2/9/26 nursing progress note revealed Resident #34 had ongoing behaviors that included yelling, rejection of care and anxiety. The progress note documented staff attempted redirection and one-to-one interaction when the resident demonstrated these behaviors.The 2/10/26 nursing progress note revealed a skin and pain assessment was completed and documented no new findings and no signs or symptoms of pain were observed. The progress note documented Resident #34 remained at baseline.The 2/13/26 social services progress note documented the social services assistant (SSA) checked in with Resident #34. The note documented Resident #34 presented at baseline with a smile and eye contact and had no signs of stress or discomfort during the interaction. The note documented Resident #34 said her care was going well and nursing reported she slept well through the night and was eating 100% of her meals.III. Staff interviewsCNA #1 was interviewed on 3/10/26 at 2:41 p.m. CNA #1 said Resident #34 had a progressive disease and at times became agitated and could become physical during care. CNA #1 said when Resident #34 became anxious or panicky, staff approached the resident at eye level, reassured her she was not alone and attempted to calm her. CNA #1 said Resident #34's chart listed behaviors and interventions and staff should try to remove the resident from external stimuli when she became overwhelmed. CNA #1 said when a resident became combative during care, staff should step back, give the resident space and reapproach care after the resident de-escalated. CNA #2 was interviewed on 3/10/26 at 3:00 p.m. CNA #2 said she was providing care to Resident #34 (on 2/9/26) when the resident began yelling and became agitated. CNA #2 said CNA #13 entered the room and approached the resident. CNA #2 said CNA #13 placed her hand over Resident #34's mouth. CNA #2 said Resident #34 attempted to remove CNA #13's hand from her mouth. CNA #2 said she told CNA #13 to stop several times but CNA #13 did not stop. CNA #2 said CNA #13 then grabbed Resident #34's hands and pushed them back toward the resident's chest and yelled at the resident using a curse word. CNA #2 said after the incident, Resident #34 was scared and became more combative than before care had started. Licensed practical nurse (LPN) #1 was (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	interviewed on 2/10/26 at 3:25 p.m. LPN #1 said the director of nursing (DON) informed her there was an allegation of abuse involving Resident #34. LPN #1 said CNA #2 told another staff member she observed CNA #13 do something to Resident #34 that she should not have done. LPN #1 said Resident #34 could become combative at times but usually de-escalated when staff calmly explained care. LPN #1 said she completed an assessment of Resident #34 after staff became aware of the allegation on 2/10/26. LPN #1 said Resident #34 said she had no pain and she did not observe injuries during the skin assessment. The DON was interviewed on 3/12/26 at 2:06 p.m. The DON said she had to be notified of all abuse and suspected abuse allegations and staff were expected to report incidents immediately to the NHA and to the DON.The DON said CNA #2 reported the incident one day after it occurred even though she was aware of the facility policy of reporting but she felt fearful of reporting and did not want her coworkers to view her as reporting on them or getting them in trouble. The DON said CNA #2 received education and was instructed that all allegations must be reported immediately and that delays in reporting would result in corrective action. The DON said there was a prior allegation involving CNA #13 and another resident. The DON said CNA #13 was terminated on 2/13/26.The DON said the facility could not substantiate or unsubstantiate the allegation regarding Resident #34 because the resident was not interviewable and the findings were based on CNA #2's account compared to CNA #13's account. The DON said interviews were conducted with residents and staff and no one said they observed staff treat or interact inappropriately with residents.The NHA was interviewed on 3/12/26 at 3:48 p.m. The NHA said the facility was unable to substantiate the allegation because CNA #2 said the incident occurred, CNA #13 said she did not place her hand over the resident's mouth, and the resident could not recall the event. The NHA said the facility assessed the resident for psychosocial harm by reviewing the Patient Health Questionnaire-9 (PHQ-9) (screening tool used to check for depression) to compare the resident's baseline mood and identify any changes and they did not find any changes. The NHA said the medical director completed an assessment, including evaluation for anxiety and provision of active listening and emotional support.The NHA said the unit manager followed up and continued to monitor Resident #34's behaviors, mood, and any changes from baseline. The NHA said staff monitored for nonverbal indicators of distress and observed no changes in appetite or baseline behaviors.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide sufficient nursing staff to ensure the resident received the care and services they required in a timely manner. Specifically, the facility failed to ensure residents received their showers as scheduled and call lights were answered in a timely manner for residents dependent on staff for their care. Findings include:I. Facility policy and procedureThe Staffing policy and procedure, revised 3/9/21, was provided by the nursing home administrator (NHA) on 3/12/26 at 5:42 p.m. It read in pertinent part, The facility maintains adequate staff on each shift to meet residents' needs. The facility utilizes the Facility Assessment as the foundation to determine staffing levels necessary to ensure that residents' needs are met. II. Resident interviewsResident #129 was interviewed on 3/9/26 at 11:00 a.m. He said staffing seemed to be an issue. He said he felt like there were not enough certified nurse aides (CNAs). He said the night shift seemed to be the worst. He said there would be times when there was only one registered nurse (RN) for the entire unit and only one CNA for the entire unit. He said he has waited for over an hour for his call light to be answered. He said he did not always get consistent showers, he said some weeks he will get two, others only one and sometimes no shower at all. Resident #8 was interviewed on 3/9/26 at 11:15 a.m. He said he felt like the staff were not efficient. He said he used a sit-to-stand (mechanical lift) to get up and sometimes it takes a long time to get help. He said there have been times when he did not make it to the bathroom in time because there were no staff to help him. Resident #80 was interviewed on 3/9/26 at 12:55 She said she used the sit-to-stand to use the restroom and to go to bed. She said that there have been times when she did not get to bed until 11:00 p.m. because she was waiting for staff to finish with her roommate. She said she felt like the staff were always new. She said there have been times when she had to wait over an hour for her call light to be answered. She said she felt like there was not enough staff. Resident #93 was interviewed on 3/9/26 at 1:30 p.m. She said she had waited for over an hour to use the restroom multiple times. She said she never had incontinence issues and then ended up wetting herself once because she had to wait for staff to assist her, she said she did not like the feeling of wetting herself. Resident #11 was interviewed on 3/9/26 at 4:00 p.m. She said she was not receiving her showers as scheduled. She said she had not gotten a shower for at least a week. Resident #46 was interviewed on 3/10/26 at 8:45 a.m. She said she did not get her showers on her scheduled days. She said she had to initiate getting a shower and sometimes staff still did not come to get her for her shower. She said she has washed her own hair in the sink because she had not received a shower. Resident #3 and Resident #9 were interviewed together on 3/10/26 at 9:45 a.m. Resident #3 said that there were only two CNAs for the entire 300 hall which made it hard for the staff to get to everyone's needs in a timely fashion. Resident #9 said that he had pushed his call light before because he was having a hard time breathing and had to wait for over an hour. A group interview was conducted on 3/11/26 at 10:00 a.m. with five (#3, #9, #53, #84 and #118) oriented resident per facility and assessment. They said there had been times when they did not get their showers because there was not enough staff. Resident #118 said he did not get a shower because the staff ran out of time. They said for their call lights to be answered timely really depended on the staffing. They said there had been multiple times when they had to wait for 30 minutes or longer for their call light to be answered. They said this happened on all shifts. The group said they did not think there was enough staff to meet their needs. They said the turnover rate was very high. They said showers were not getting done and any task that can be delayed will be delayed because there was not enough staff. Cross-reference F677: failure to provide activities of daily living for dependent residents. III. ObservationsDuring a continuous observation on 3/11/26, beginning at 12:15 p.m. and ending at 12:45 p.m. the following was observed:At 12:15 p.m. Resident #33, pushed their call light. An unidentified staff member came out of their office and walked past (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #33's room without checking on the resident. The same unidentified staff member walked down the hallway and past Resident #33's room again and did not check on the resident. There were no other staff members present at that time. Another unidentified staff member was walking down the hallway and appeared to be going to answer Resident #33's call light; however, the staff member stopped in the middle of the hallway and turned and went back the way they came and did not check on Resident #33. At 12:30 p.m. resident room [ROOM NUMBER] turned on their call light, which was down the hall from Resident #33. Multiple staff members exited an office and walked down the hallway without answering or checking on either residents. At 12:35 p.m. an unidentified CNA walked down the hallway passing Resident #33's call light and answered room [ROOM NUMBER]'s call light. At 12:40 p.m. another unidentified CNA entered the hallway and and went into Resident #33's room and answered the call light. -Resident #33's call light was not answered for 25 minutes. On 3/12/26 during a continuous observation, beginning at 10:37 a.m. and ending at 11:00 a.m., Resident #79 turned on her call light. CNA #4 entered Resident #79's room at approximately 10:41 a.m. and brought in a commode. CNA #4 told the resident she was waiting on a nurse to help her to get her out of bed and left the room. At 10:50 a.m. CNA #4 entered the room and told Resident #79 she was still waiting on the nurse. At 11:00 a.m. CNA #4 came back and told Resident #79 that she would have to complete her care in bed because she could not get another staff member to help get her up. IV. Facility assessmentThe facility assessment, revised 6/24/24, was provided by the NHA on 3/9/26 at 12:18 p.m. The assessment documented the average daily census as 116 residents and had the bed capacity of 187 residents. The assessment documented the desired staffing per day for the facility was 15 nurses and 28 CNAs.Review of the facility schedule from 1/1/26 to 3/11/26 revealed the facility did not have the correct amount of staff that was identified in the facility assessment on the following dates: On 1/1/26, the schedule indicated 21 CNAs were working at the facility. On 1/2/26, the schedule indicated 22 CNAs were working at the facility.On 1/3/26, the schedule indicated that 25 CNAs were working at the facility. On 1/5/26, the schedule indicated that 12 nurses were working at the facility.On 1/6/26, the schedule indicated that 13 nurses were working at the facility. On 1/7/26, the schedule indicated that 13 nurses were working at the facility. On 1/8/26, the schedule indicated that 12 nurses were working at the facility.On 1/9/26, the schedule indicated that 13 nurses were working at the facility. On 1/11/26, the schedule indicated that 22 CNAs were working at the facility. On 1/13/26, the schedule indicated that 25 CNAs were working at the facility. On 1/14/26, the schedule indicated that 14 nurses were working at the facility. On 1/15/26, the schedule indicated that 26 CNAs were working at the facility. On 1/16/26, the schedule indicated that 12 nurses and 21 CNAs were working at the facility. On 1/17/26, the schedule indicated that 25 CNAs were working at the facility. On 1/18/26, the schedule indicated that 23 CNAs were working at the facility.On 1/19/26, the schedule indicated that 14 nurses and 24 CNAs were working at the facility.On 1/21/26, the schedule indicated that 14 nurses were working at the facility.On 1/22/26, the schedule indicated that 11 nurses were working at the facility.On 1/23/26, the schedule indicated that 14 nurses were working at the facility.On 1/25/26, the schedule indicated that 20 CNAs were working at the facility.On 1/28/26, the schedule indicated that 14 nurses were working at the facility.On 1/30/26, the schedule indicated that 12 nurses were working at the facility.On 1/31/26, the schedule indicated that 14 nurses were working at the facility.On 2/1/26, the schedule indicated that 12 nurses and 27 CNAs were working at the facility.On 2/2/26, the schedule indicated that 13 nurses and 27 CNAs were working at the facility.On 2/3/26, the schedule indicated that 11 nurses were working at the facility.On 2/4/26, the schedule indicated that 13 nurses were working at the facility.On 2/5/26, the schedule indicated that 13 nurses were working at the facility.On 2/7/26, the schedule indicated that 13 nurses and 27 CNAs were working at the facility.On 2/8/26, the schedule indicated that 11 nurses and 26 CNAs were working at the facility.On 2/9/26, the schedule indicated that 14 nurses were working at the facility.On 2/10/26, the schedule indicated that 13 nurses were working at the facility.On 2/11/26, the schedule indicated that 14 nurses were working at the facility.On 2/12/26, (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the schedule indicated that 13 nurses were working at the facility.On 2/13/26, the schedule indicated that 13 nurses were working at the facility.On 2/14/26, the schedule indicated that 11 nurses and 25 CNAs were working at the facility.On 2/15/26, the schedule indicated that 12 nurses and 23 CNAs were working at the facility.On 2/16/26, the schedule indicated that 12 nurses and 27 CNAs were working at the facility.On 2/18/26, the schedule indicated that 14 nurses were working at the facility.On 2/19/26, the schedule indicated that 13 nurses were working at the facility.On 2/20/26, the schedule indicated that 13 nurses were working at the facility.On 2/21/26, the schedule indicated that 14 nurses were working at the facility.On 2/22/26, the schedule indicated that 26 CNAs were working at the facility.On 2/23/26, the schedule indicated that 14 nurses were working at the facility.On 2/24/26, the schedule indicated that 13 nurses were working at the facility.On 2/25/26, the schedule indicated that 11 nurses were working at the facility.On 2/26/26, the schedule indicated that 13 nurses were working at the facility.On 2/28/26, the schedule indicated that 14 nurses were working at the facility.On 3/1/26, the schedule indicated that 27 CNAs were working at the facility.=On 3/2/26, the schedule indicated that 14 nurses were working at the facility.On 3/5/26, the schedule indicated that 14 nurses were working at the facility.On 3/6/26, the schedule indicated that 14 nurses were working at the facility.On 3/7/26, the schedule indicated that 14 nurses were working at the facility.On 3/8/26, the schedule indicated that 13 nurses and 19 CNAs were working at the facility.V. GrievancesReview of the December 2025 to March 2026 grievances revealed the following: A grievance, dated 12/8/25, documented a resident had to take himself to the bathroom due to their call light not being answered between the times of 1:30 a.m. and 4:30 a.m. The resident documented that staff reported that they were under staffed. The CNA was spoken to and the CNA stated she answered his call light timely. The CNA stated they did not make the comment about staffing. The resident was assured that the call light will be answered timely and was apologized to. A grievance, dated 1/6/26, documented one plus hours for response time to call light and conditions were worse since admission. The facility reported they did an inservice with staff about walking to the end of the hall to make sure call lights were not on for extended times and that the resident's shower schedule was being followed as well as his up/down schedule. A grievance, dated 1/7/26, documented the call light wait times were up to 30 minutes, especially during meal times. The facility reported that they reviewed with nurses to be mindful of the all the call lights.A grievance, dated 1/12/26, documented a resident had to wait three hours to get help with the toilet and for pain medication. The facility reported they did a call light audit and the resident said her call light was being answered more timely. A grievance, dated 1/28/26, documented that the call light response times were extremely slow and that showers, especially during the evening shift got cancelled. The resident reported that staff had been telling him that the facility was short-staffed and he could not get a shower. The resident reported that he would prefer his scheduled showers to be in the morning or early afternoon. The facility reported education was given to CNAs about giving showers on time and a call light audit was done. The resident reported that he was satisfied with the results. VI. Staff interviewsCNA #6 was interviewed on 3/10/26 at 4:58 p.m. She said on most days the facility needed more help on all shifts. She said that particular day (3/10/26) there had been a lot of call-offs. She said the facility used agency staff for nurses but not for CNAs. She said they had 47 residents on the 300 hall and there were a lot of residents who required two-person transferred, She said the increased care needs of the residents made meeting the needs of every resident difficult when there is not enough staff. She said that there were currently two CNAs for the east 300 hall and two CNAs for the west 300 hall. She said they could benefit from a shower aide or a third CNA to assist. She said the previous week on Thursday she had 15 showers to give but was only able to get 12 of the 15 completed. The director of nursing (DON) and the NHA were interviewed together on 3/12/26 at 4:31 p.m. The DON said their goal was to have two nurses and four CNAs for each floor during the day shift and evening shift. She said for overnights they staffed one nurse and three CNAs. She said there were times that they were unable to meet their staffing goals. She said they most of the time they were able to get shifts (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, record review and interviews, the facility failed to ensure residents consistently received food prepared by methods that conserved nutritive value and was palatable in taste, texture and temperature.Specifically, the facility failed to ensure the residents' food was palatable in taste, texture and temperature. Findings include:I. Facility policy and procedureThe Food Preparation policy, revised 4/29/25, was provided by the nursing home administrator (NHA) on 3/12/26 at 10:53 a.m. It read in pertinent part, Food is prepared by methods that conserve nutritive value, flavor and appearance. The food that is served to the residents is palatable, attractive and served at the appropriate temperature. Food and drink that is palatable, attractive, and at a safe and appetizing temperature. It also revealed under Definitions, Food palatability refers to the taste and or flavor of the food, and Proper safe and appetizing temperature means both appetizing to the resident and minimizing the risk for scalding and burns. Under Procedure, the policy revealed, Food is seasoned appropriately and acceptable to the residents, Food has an appetizing aroma, and Food and drinks are palatable, attractive and served at a safe and appetizing temperature, while minimizing the risk for scalding and burns.II. Resident group interviewA group interview was conducted on 3/11/26 at 10:00 a.m. with five alert and oriented residents (#3, #9, #53, #84 and #118) who were deemed interviewable per the facility and assessment.The residents said the kitchen frequently ran out of certain food items, such as ice cream and Greek yogurt, usually close to the time of their delivery. The residents said they were offered an alternate option when items were unavailable and that the substitute usually met their needs. The residents said the quality of the food was inconsistent. They said the over-easy eggs were often overcooked, scorched, and hard. The residents said the facility had only one frying pan available for preparing fried eggs in the upstairs dining room. III. Additional resident interviewsResident #63 was interviewed on 3/9/26 at 1:45 p.m. He said breakfast should have been served when he was awake and in a timely manner. He said he had a sign on his door that said do not wake before 7:30 a.m., however the staff still came into his room and left the tray. He said the scrambled eggs served for breakfast were cold and he preferred hot food.Resident #137 was interviewed on 3/9/26 at 2:00 p.m. She said the food was sometimes served cold and she did not like cold food. She said the last time her meal was cold was two days prior.Resident #147 was interviewed on 3/9/26 at 2:57 p.m. She said she often did not receive milk with her cereal. She said the pancakes were often served hard and dry and the hamburgers were served cold.Resident #42 was interviewed on 3/9/26 at 4:31 p.m. She said the food was repetitive and the same foods were served every week. She said she would have liked more variety. She said she reported this concern during a resident council meeting the previous month and staff said they would look into it. She said the food was also served cold. She said food was very important to her and this made her feel ignored. She said staff usually heated the food, however the food became very hard because it was frozen food.Resident #8 was interviewed on 3/10/26 at 6:56 a.m. He said the food did not taste good, was sometimes cold, and he had experienced a few lunches that did not arrive.Resident #79 was interviewed on 3/10/26 at 7:09 a.m. He said the food was often cold, unappetizing, and missing requested items.Resident #46 was interviewed on 3/10/26 at 8:45 a.m. She said the food was inconsistent, was served cold, and was unpredictable. She said three weeks prior she was served green beans that were cold and appeared as if they had just come out of the refrigerator. She said on 3/9/26 her dinner order was not correct. She said she did not want broccoli and gelatin and instead wanted chocolate pudding, however she was still served broccoli and gelatin.Resident #118 was interviewed on 3/10/26 at 9:32 a.m. She said the food was often cold and trays had been forgotten and not delivered to her room.Resident #80 was interviewed on 3/10/26 at 9:58 a.m. She said the food was often cold.Resident #42 was interviewed again on 3/10/26 at 4:10 p.m. She said on 3/10/26 she received one third of a cup of coffee without creamer. She said she asked for oatmeal but did not receive it, then asked for Cheerios cereal and received cereal without milk. She said the staff said (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	there was no milk that day. She said she felt like she was back in school. She said licensed practical nurse (LPN) #1 became aware of the concern and brought her coffee with creamer.Resident #147 was interviewed on 3/11/26 at 5:10 p.m. and said the eggs were cold that day. Resident #147 said the pot pie he was served for diner that day was not in the shape of a pot pie. The resident said the pot pie appeared as broken pieces of chicken and vegetables and did not look like a pot pie.IV. Test trayA test tray for a regular diet was evaluated by four surveyors immediately after the last resident was served their room tray for lunch on 3/11/26 at 12:35 p.m.The test tray consisted of meatloaf with gravy, mashed potatoes, seasoned spinach, cornbread, and fruit crisp.-The spinach lacked flavor;-The mashed potatoes had a pasty consistency and bland taste;-The meatloaf was bland in taste; and,-The cornbread was doughy, bland. V. Record reviewA review of the 2/21/26 concern and comment form documented that a resident voiced concerns related to food service regarding cold food. The follow-up response section documented that they completed a dietary audit for room trays. The findings section documented trays sat for 30 minutes before the last tray was delivered by nursing and the stew's temperature decreased from 175 degrees F to 130 degrees F. The test tray audit form dated 2/23/26 documented the cart left the department at 11:51 a.m., arrived on the floor at 11:52 a.m. and the last tray was served at 12:21 p.m. The response section documented staff were encouraged to have the resident dine in the dining room and to ensure trays were delivered quickly by nursing. -However, residents still had ongoing concerns of cold food (see resident interviews above).VII. Staff interviewsThe cook (CK) was interviewed on 3/11/26 at 3:23 p.m. She said she ensured food was palatable and not overcooked or dry by checking the temperature whenever she cooked items including food on the grill before placing the food on the plate. She said if a resident complained about the taste or quality of the food, she could remake the meal or provide the resident with something different.The CK said the recipes she followed had premade seasonings. She said sometimes residents preferred different flavors, so she individualized the seasoning based on the resident's preference.The dietary supervisor (DS) was interviewed on 3/11/26 at 3:35 p.m. The DS said the facility held a food committee meeting once a month. She said the DS and the dietitian attended the meeting and asked residents if they liked the food or wanted changes to the menu. She said residents provided suggestions during the meeting and they would implement those suggestions.She said the facility addressed resident complaints regarding food quality through the grievance process also. She said grievances were forwarded to her and she followed through with the concern.She said the acceptable hot holding temperature for food was around 140 degrees F and the kitchen staff attempted to keep food at 140 degrees and prevent the temperature from falling below that level. She said if a food item fell below the acceptable hot holding temperature, staff reheated the food to 165 degrees F for 15 seconds. She said staff checked food temperatures during the tray line right before service and again after service. She said the CK was responsible for verifying food temperatures before trays left the kitchen. She said she monitored the tray line process during meal times by assisting the CK, ensured temperatures were taken and helped to expedite meal service.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain proper storage of medications for three out of three medication carts and two of three medication storage rooms.Specifically, the facility failed to:-Label insulin pens with the date they were opened;-Label inhalers with the date they were opened;-Discard medications that had expired;-Keep the cart free of personal items; and,-Ensure medications were labeled with residents' names. Findings include:I. Professional resourceAccording to the manufacturer, Viatris, How to Use a Wixela Inhub (inhaler used to treat asthma and lung disease), 2021, retrieved on [DATE] from https://www.wixelahcp.com/-/media/Project/Common/WixelahcpCom/PDF/[NAME]-2020-0047_V4_US_How-t Take Wixela Inhub out of the foil pouch just before you use it for the first time. Write the pouch opened and use by dates on the label. The use by date is one month from the date you opened the pouch for your first dose.According to the manufacturer Biocon Biologics, 2023, Patient Information-Storing the Insulin Glargine yfgn pen, retrieved on [DATE] from, https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=3ac85ebb-5594-59c8-77fd-df254329d151&ty Only use your pen for up to 28 days after its first use. Throw away the Insulin Glargine yfgn pen you are using after 28 days, even if it still has insulin left in it.II. Facility policy and procedureThe LTC (long term care) Facility's Pharmacy Services and Procedures policy, revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 5:30 p.m. It read in pertinent part, Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. Once any medication or biological package is opened, the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels or cautionary instructions. Facility should ensure that medications and biologicals for expired or discharged or hospitalized residents are stored separately, away from use, until destroyed or returned to the provider.III. Observations and interviewsOn [DATE] at 2:55 p.m. the second floor west medication cart was observed with registered nurse (RN) #1. The following was observed:-An opened bottle of sublingual (under the tongue) Nitroglycerine (medication for chest pain) 0.4 milligram (mg) tablet, without a resident's name on it. Registered nurse (RN) #1 said the bottle should be labeled with the resident's name.-A used Wixela inhaler for Resident #138, which was not labeled with the date it was opened. RN #1 said she thought the inhaler could be used until the medication was empty. -An opened bottle of Docusate sodium 100 mg (a stool softener) with an expiration date of February 2026. RN #1 said the medication should have been discarded at the end of February.The second floor west medication storage room was observed with RN #1 on [DATE] at 3:10 p.m. The following medication was found:An opened bottle of Tuberculin Purified Protein 5 TU per 0.1 milliliter (ml), which was not labeled with the date it was opened. RN #1 did not know how long the medication was good for after opening.On [DATE] at 3:45 p.m. the third floor east medication cart was observed with licensed practical nurse (LPN) #2.A box of 5% lidocaine patches for a resident who was discharged . LPN #2 said the resident had been discharged from the facility. LPN #2 said the medication should have been removed from the cart as soon as the resident had been discharged from the facility.On [DATE] at 5:00 p.m. the first floor east medication cart was observed with LPN #3. The following observations were made.Three opened and undated insulin Glargine pens for Resident # 7, Resident #48 and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #15. LPN #3 said insulin pens must be used within 30 days of opening.A small, half-used bottle of normal saline, labeled opened 3/3.An opened, partially full water bottle, with a staff member's name written on it. LPN #3 said she did not know of any residents with the same name as written on the bottle.An opened bottle of chocolate syrup, partially open, with dried syrup around the lid. The bottle read refrigerate after opening. LPN #3 read the instructions and placed the bottle back in the cart.The first floor medication storage room was observed with LPN #3 around 5:20 p.m. The following was observed:An unopened respiratory syncytial virus (RSV) test with a physician's order to give one time only until [DATE]. LPN #3 said the test was unopened and could go back in the refrigerator despite the expired physician's order.An opened vial of tuberculin purified protein with an expiration date of [DATE]. LPN #3 said the tuberculosis test would be less accurate if staff used an expired vial to perform the test. IV. Staff interviewsThe director of nursing (DON) and the regional clinical resource were interviewed on [DATE] at 6:15 p.m. The DON said nitroglycerin vials were for individual resident use and should be labeled with a resident's name. The DON said insulin pens, Wixela inhalers, and tuberculin vials should all be labelled with the open date and discarded according to the manufacturer's instructions. The regional clinical resource said medications used beyond the manufacturer's recommendations could have reduced efficacy. The DON said the opened water bottle belonged to a staff member. The DON said the discharged resident with medications in the third floor east medication cart had been discharged on [DATE]. The DON said medications should be removed from the medication cart within 24 hours of their discharge.The DON was interviewed again on [DATE] at 9:40 a.m. The DON said the facility has discarded the undated tuberculin vials, inhalers, and insulin pens. The DON said any personal items that belonged to staff were also removed from the cart. The DON said she provided education to all staff about medication storage. The DON said LPN #2 was provided additional education on completing the narcotic log timely upon administration of narcotics.

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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 protect three (#31, #71 and #96) of five residents reviewed for abuse out of 54 sample residents. Specifically, the facility failed to:-Protect Resident #31 from physical abuse by Resident #39; and, -Protect Resident #71 and Resident #96 from sexual abuse by Resident #149. Findings include: I. Facility policy and procedure The Abuse Prevention policy and procedure, reviewed 5/6/25, was provided by the nursing home administrator (NHA) on 3/12/26 at 12:18 p.m. It read in pertinent part, It is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation. Identify, correct and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur to include trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms, if any. Identify, assess, care plan for appropriate interventions, and monitor residents with needs and behaviors which might lead to conflict or neglect, such as physically aggressive behavior and verbally aggressive behavior. II. Failure to protect Resident #31 from physical abuse from Resident #39 on 2/20/26 A. Facility investigation The facility investigation was provided by the NHA on 3/11/26, the investigation revealed the following: On 2/20/26 a certified nurse aide (CNA) reported to the nurse that Resident #39 was found in Resident #31's room. Resident #31 told the CNA that Resident #39 had hit her chest. A second report was made to the same nurse from a different CNA at 11:30 a.m. The CNA reported that Resident #39 was in front of Resident #31's door at approximately 5:55 a.m., and Resident #39 was grabbing Resident #31's leg asking for her help to find his buddy. The CNA reported that she removed Resident #39's hand from Resident #31's leg and removed Resident #39 from the area. The investigation documented that Resident #31 stated Resident #39 crawled into her doorway and when she bent down to help him up, Resident #39 then hit her chest. The investigation documented that Resident #39 was removed from Resident #31's room. Resident #31 stated her chest hurt where she had been hit, but there were no visible signs of injury. Resident #39 was then provided with one-to-one supervision. The investigation documented the interdisciplinary team (IDT) did not feel the incident that occurred (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 2/20/26 was a reportable incident. The investigation documented the IDT did not feel there was an allegation or intent. The facility interviewed Resident #31 she said she was trying to help Resident #39 to get up off of the floor and he did not want her help so he pushed her hand away to decline her assistance and then brushed her chest. The investigation documented that Resident #31 had always loved to help others when able to. -However, abuse occurred as Resident #39 hit Resident #31 in the chest, causing pain. -Cross-reference F609, reporting of alleged violations to the State Agency. B. Resident #31 (victim) 1. Resident status Resident #31, age [AGE], was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included multiple subsegmental thrombotic pulmonary emboli without acute cor pulmonale (multiple small blood clots in the pulmonary arteries), malnutrition, hyperlipidemia and hyperthyroidism. The 2/13/26 minimum data set (MDS) assessment revealed Resident #31 was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. Resident #31 was independent or needed setup or clean-up assistance with her activities of daily living (ADL). The assessment revealed Resident #31 did not have any physical or verbal behaviors directed at others or other behavioral symptoms not directed towards others. 2. Resident interview Resident #31 was interviewed on 3/10/26 at 9:46 a.m. Resident #31 said there was a male resident (Resident #39) that had come into her room and she had tried to help him and he did not want her help and he had hit her chest. She said that when he hit her it had hurt. 3. Record review Resident #31's resistive to care care plan, initiated 2/13/25 and revised 9/30/25, identified Resident #31 had a behavior issue of declining her medications and had a history of being the victim of an altercation. Pertinent interventions included educating the resident and family of the possible outcomes of not complying with treatment or care, praising the resident when behavior was appropriate, providing the resident with opportunities for choice during care, separating immediately from the aggressor and behavior monitoring. Resident #31's potential for verbal aggression care plan, initiated 7/21/25 and revised 11/20/25, identified Resident #31 had the potential to become verbally aggressive due to ineffective coping skills. Pertinent interventions were giving the resident as many choices as possible about cares and activities, when the resident became agitated, intervening before agitation escalated, guiding the resident away from the source of distress, engaging the resident calmly in conversation, if response was aggressive, staff were to walk away calmly and approach later. -The care plan was not updated after the 2/20/26 abuse incident with Resident #39 to indicate that Resident #31 had a tendency to help others even when they might not want the help. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 2/20/26 at 12:10 p.m., revealed a nurse was notified by a CNA that Resident #39 was found inside Resident #31's room at approximately 6:00 a.m. and Resident #31 stated to the CNA that Resident #39 had hit her in the chest when she tried to help him. The progress note documented another CNA reported she had found Resident #39 in front of Resident #31's room at approximately 5:55 a.m. Resident #39 was grabbing Resident #31's leg, asking her to help him find his buddy. The CNA stated she removed Resident #39's hands from Resident #31's leg and moved Resident #39 away from Resident 31's room. The progress note documented skin and pain assessments were done. Resident #31 stated the area where she had been hit was sore and one-to-one supervision was provided for Resident #39. C. Resident #39 (assailant) 1. Resident status Resident #39, age [AGE], was admitted on [DATE]. According to the March 2026 CPO, diagnoses included peripheral vascular disease (reduced blood flow to limbs or organs), dementia and acute kidney failure. The 12/17/25 MDS assessment revealed Resident #39 had short-term and long-term memory deficits and was severely impaired in his daily decision-making, per staff assessment. Resident #39 was dependent on staff for all of his ADLs. The assessment documented Resident #39 had physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others. 2. Record review Resident #39's potential to be verbally aggressive care plan, initiated 6/24/24 and revised 9/24/24, documented Resident #39 had the potential to become verbally aggressive due to his dementia. Pertinent interventions included administering medications as ordered, analyzing key times, places, circumstances, triggers and what de-escalated his behavior and documenting, when the resident became agitated, intervening before agitation escalated, guiding the resident away from the source of distress, engaging the resident calmly in conversation, if response was aggressive, staff were to walk away calmly and approach later. Resident #39's dementia with behaviors care plan, initiated 6/24/24 and revised 2/19/26 documented Resident #39 had the potential to be physically and verbally aggressive with behaviors, such as throwing water on staff, hitting, swearing, kicking at staff, throwing chairs, moving furniture and yelling out. The care plan documented Resident #39 was an aggressor in a resident-to-resident altercation. Pertinent interventions included analyzing key times, places, circumstances, triggers and what de-escalated his behavior and documenting, checking to see if the resident needed to use the restroom every two hours, providing physical and verbal cues to alleviate anxiety, documenting observed behaviors and attempted interventions in the behavior log, increasing observation to line-of-sight monitoring due to physical aggression and providing one-to-one observation for increased safety measures. A progress note, dated 2/20/26 at 2:37 p.m., documented a CNA reported to the nurse that Resident #39 was agitated and was crawling on the floor and was found in Resident #31's doorway. Resident #31 reported that Resident #39 had hit her on the chest when she attempted to help him from the floor. The note further documented that Resident #39 was removed from Resident #31's room and was (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided with one-to-one supervision. The note documented Resident #39 remained agitated and reassurance and redirection was unsuccessful. The note documented that at 11:30 a.m., another CNA reported to the nurse that at approximately 5:55 a.m., Resident #39 had crawled into Resident #31's room and grabbed Resident #31's leg and asked her to help him find his buddy. The CNA removed Resident #39's hands from Resident #31's leg and assisted Resident #39 to another location. D. Staff interviews The resident care assistant was interviewed on 3/11/26 at 9:29 a.m. The resident care assistant said when she was assigned as Resident #39's one-to-one caregiver. She said she tried to keep him entertained. She said the reason he was on a one-to-one was because he had certain behaviors, such as grabbing people. She said she received her information about behaviors in a verbal report or she would ask the nurse or unit manager. The resident care assistant said she had not heard of Resident #39 going into other residents' rooms and she had not heard of the incident between him and Resident #31. Registered nurse (RN) #4 was interviewed on 3/11/26 at 11:45 a.m. RN #4 said Resident #39 could become aggressive and grabby. She said he had struck her before. She said she had heard of the incident between him and Resident #31, but did not know all the details. She said she had not heard of Resident #39 making it into other residents' rooms. She said when a resident was having behaviors, she tried to witness them directly but, if she did not see the behavior in real time the CNAs would report to her or chart it in the CNA charting. She said she would pass off pertinent information to the CNAs or resident care assistants verbally. CNA #9 was interviewed on 3/12/26 at 9:44 a.m. CNA #9 said Resident #31 had reported the incident with Resident #39 to her. She said Resident #39 had grabbed Resident #31's leg in an attempt to pull himself up. She said she did not witness it herself but reported what Resident #31 had told her to the nurse. CNA #10 was interviewed on 3/12/26 at 9:59 a.m. CNA #10 said she was just coming on to her shift and she saw Resident #31 trying to get Resident #39 out of her room. She said Resident #31 reported to her that Resident #39 had punched her chest. She said Resident #31 was holding her chest when she told her about being punched. CNA #10 said she reported the incident to the nurse that was on duty and talked Resident #31 into making the report to the nurse and the unit manager. The social services assistant (SSA) was interviewed on 3/12/26 at 12:13 p.m. The SSA said he was aware of the situation between Resident #31 and Resident #39 on 2/20/26. He said Resident #39 was on the ground and he grabbed Resident #31's ankle as she was walking by and she did not like it. He said he spoke with Resident #31 about it and she had told him that she understood that Resident #39 had memory issues. He said Resident #39 was put on one-to-one supervision after the incident and had remained on the one-to-one monitoring since the incident. He said Resident #39 was not on a one-to-one prior to the 2/20/26 incident and staff would try to keep Resident #39 within their line-of-sight. He said staff would keep him close to the nurses' cart or nurses' station to monitor his behaviors. Licensed practical nurse (LPN) #1, who was the unit manager on the first floor, was interviewed on 3/12/26 at 12:49 p.m. LPN #1 said she was aware of the incident that happened between Resident #31 and Resident #39 on 2/20/26. She said she understood the situation as Resident #39 was on the floor and went into Resident #31's room and he then tapped or grabbed Resident #31's leg. She said (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she had not heard that Resident #31 had been hit in the chest. The director of nursing (DON) and the NHA were interviewed together on 3/12/26 at 3:41 p.m. The NHA said she was aware of the situation between Resident #31 and Resident #39 on 2/20/26. She said Resident #31 reached down to help Resident #39, and he appeared to not want help and then hit her in the chest with his hand. The NHA said the facility was on the fence about reporting it because of the interview with Resident #31. The NHA said Resident #31 had told them that she felt Resident #39 had not meant to hurt her. The NHA said Resident #39 had willfully hit Resident #31 and was then put on one-to-one supervision. III. Incident of sexual abuse of Resident #71 by Resident #149 on 1/3/26 A. Facility investigation The facility's investigation, dated 1/3/26, was provided by the NHA on 3/11/26 at 2:35 p.m. The investigation revealed the following: On 3/5/26 RN #5 witnessed Resident #71 sleeping on a couch in the common area. Resident #149 was sitting on the couch next to Resident #71 and placed his hand down inside Resident #71's pants. The residents were immediately separated. Resident #71 slept through the occurrence. Staff woke up Resident #71 and assisted her back to her room for a skin inspection and incontinence care. The assessment documented a skin assessment was completed and determined there were no changes with Resident #71. The investigation documented Resident #149 was assisted by staff back to his room for assistance with cleaning the feces off his hand. An investigation was initiated and all appropriate notifications were made. A one-to-one observation was initiated with Resident #149. Resident #71 was interviewed by the social services director (SSD). Due to the resident's cognitive impairment, she did not remember the incident. No behavioral changes were noted. Resident #149 was interviewed and due to cognitive impairment, the resident had no recollection and was unable to offer any insight to the situation. The root cause was secondary to dementia progression versus intent. Multiple residents and facility staff members were interviewed. Sample residents and staff member interviews indicated no other concerns during the investigation. The investigation documented the facility unsubstantiated the abuse. -However, abuse occurred due to Resident #149 placing his hand into Resident #71's brief without her consent. B. Resident #71 (victim) 1. Resident status (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #71, age greater than 65, was admitted on [DATE]. According to the March 2026 CPO, diagnoses included dementia with anxiety, chronic kidney disease, diabetes and dysphagia (difficulty swallowing). The 1/29/26 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of two out of 15. She required partial to moderate assistance with all ADLs. 2. Resident representative interview On 3/9/26 at 9:02 a.m. Resident #71's representative was interviewed. The resident's representative said there was an issue with another resident and the facility took care of it. The resident's representative said social services offered Resident #71 psychological services. The representative said the DON and the facility staff were very cooperative. She said Resident #71 did not recall the incident and the facility was good about placing Resident #149 on direct supervision. The representative said the facility notified the police and they decided not to press charges. 3. Record review The 1/3/26 nursing progress note, documented at 2:08 p.m., revealed the nurse was coming back from gathering supplies and noticed Resident #149 was sitting on the couch next to Resident #71 with his hand down the front of her pants. When Resident #149 noticed the nurse, he quickly withdrew his hand from Resident #71's pants. Resident #71 was incontinent of bowel during the incident and had bowel movement streaked from the front of the inside of her brief and outside of her sweater. The nurse had difficulty waking up Resident #71, but the resident did awaken once she was in bed. Resident #149 had bowel movement on his pointer and middle fingers. Staff assisted Resident #149 with cleaning his hands. The 1/4/26 nursing progress note, documented at 6:00 a.m., revealed Resident #71 slept most of the shift. The resident did not report any pain or anything that had happened during the prior incident. There was no interaction between Resident #71 and Resident #149. Staff maintained frequent checks and a safety net to Resident #71's room was up throughout the shift. C. Resident #149 (assailant) 1. Resident status Resident #149, age greater than 65, was admitted on [DATE] and discharged on 2/16/26. According to the March 2026 CPO, diagnoses included peripheral vascular disease, Alzheimer's disease, dementia and chronic obstructive pulmonary disease. The 2/16/26 MDS assessment revealed the resident had short term and long term memory impairment and had severe impairment in making daily decisions. He required supervision or touch assistance with all ADLs. 2. Record review The behavioral care plan, initiated on 12/16/25, revealed Resident #149 had a behavior problem which included grabbing others, public indecency and inappropriate sexual comments to women. The care plan documented the resident was hypersexual towards women. Pertinent interventions included (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IV. Incident of sexual abuse of Resident #96 by Resident #149 on 1/23/26 A. Facility investigation The facility's investigation, dated 1/23/26, was provided by the NHA on 3/11/26 at 2:35 p.m. The investigation revealed the following: Resident #149 was ambulating with a one-to-one caregiver when he reached down towards Resident #96, who was sitting in a wheelchair. Resident #149 touched Resident #96's breast on the outside of her clothing. The one-to-one caregiver intervened as the resident reached down. The investigation documented Resident #149 made contact with Resident #96. The staff member immediately removed Resident #149's hand and escorted him back to his room. He was placed in bed without any further incident and remained on a one-to-one caregiver. The investigation documented immediate education was provided to the one-to-one staff member regarding being in between Resident #149 and any other resident in the building. The investigation documented the police were notified, along with the family of both Resident #96 and Resident #149. The physician was notified and new physician's orders were received for new medications for Resident #149. A skin assessment was completed for Resident #96 and there was no bruising or abnormal findings noted. The investigation documented 10 out of 10 residents that were interviewed for the investigation had no concerns. The medical director (MD) completed a plan of care review on 1/24/26 for Resident #149 and recommended the primary care physician to implement medication management. The DON completed a chart review and updated Resident #149's care plan. On 1/26/26 the IDT and the MD reviewed standards of care and behaviors with medication changes. The investigation documented the facility substantiated the abuse. B. Resident #96 (victim) 1. Resident status Resident #96, age greater than 65, was admitted on [DATE]. According to the March 2026 CPO, diagnoses included encephalopathy (brain dysfunction, disease, or damage), dementia, morbid obesity and acute respiratory failure. The MDS assessment revealed the resident was cognitively impaired with a brief interview for mental status score of four out of 15. She required moderate to maximal assistance with all ADLs. The assessment revealed the resident had a diagnosis of dementia unrelated to Alzheimer's. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident representative interview Resident #96's representative was interviewed on 3/12/26 at 9:13 a.m. The representative said the facility handled the incident regarding sexual abuse well. The representative said the facility raised the issue to the right level, and took it to the top by taking accountability. The representative said the facility was apologetic and put appropriate interventions in place to prevent the incident from happening again. The representative said the facility intervened immediately and had Resident #149 supervised 24/7 as well as maintaining specific distance. The representative said the facility notified him as soon as the incident happened. The representative said the facility notified the appropriate agencies and even found a new placement for Resident #149. The representative said due to Resident #96's cognitive impairment, she did not recall the incident. 3. Record review The dementia care plan, revised on 2/13/26, revealed Resident #96 was at risk for change in mood or behavior due to diagnoses of dementia and encephalopathy. Pertinent interventions included consulting with the resident on preferences regarding her customary routine, administering medications as ordered, offering group activities or active one-to-one listening when Resident #96 appeared to be tearful or confused and redirecting the resident safely as needed. Resident #96 could become confused and tearful thinking she was unsafe (bomb in the building, husband not being able to find her and missing her kids). The resident had difficulty being redirected at times. Additional interventions included providing the resident with redirection and reassurance as needed and notifying the physician of worsening mood. The 1/23/26 nursing progress noted, documented at 10:07 p.m., revealed Resident #96 was sitting at the nurses' station when Resident #149 walked by with his walker and a staff member next to him. Resident #149 reached down and touched Resident #96's breast. Staff witnessing the incident intervened by removing the resident's hand immediately. Resident #149 walked back to his room with the staff member. The nurse asked Resident #96 if she felt safe. Resident #96 said she was shaken up and wanted to talk with her son. The nurse called the resident's son and explained the situation to him. Resident #96's son said he would like a follow up next week with the plan explained to him. The nurse called and reported to the DON and executive director immediately following the incident. The 1/24/26 nursing progress note, documented at 6:30 a.m., revealed at the start of the night shift, Resident #96 was visibly upset from the prior incident with Resident #149. Resident #96 went to bed at approximately midnight, and was able to sleep most of the night. The 1/24/26 social service progress note, documented at 10:30 a.m., revealed the SSA was told by the weekend manager about the incident that occurred with Resident #149. The SSA did a check in with Resident #96 and she reported a female had stopped by to check out her blouse. Resident #96 said she did not have any fears or discomfort due to the incident. Resident #96 said she was happy with her care at the facility. The SSA conducted a BIMS and PHQ-9 assessment with the resident. Resident #96 scored a zero out of 27 on the PHQ-9 assessment, indicating the resident had no signs or symptoms of depression or sadness. Resident #96 scored a four out of 15 on the BIMS assessment, indicating the resident was cognitively impaired. The 1/24/26 nursing progress note, documented at 12:40 p.m., revealed a skin assessment was completed on Resident #96. No bruising or abnormal findings were noted. An interview was conducted related to the incident that happened on 1/23/26. Resident #96 said she was not fearful and had no (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concerns. The 1/24/26 executive director's progress note, documented at 1:55 p.m., revealed a meeting was held with the NHA, social services, the weekend supervisor, and the resident's son at approximately 1:00 p.m. to discuss the situation between Resident #96 and Resident #149. The facility's plan of correction and action steps were reviewed. The facility provided the resident's son with the contact information for the ombudsman and a business card for the NHA. The 1/24/26 nursing progress note, documented at 2:36 p.m., revealed Resident #96 was being monitored for any changes to her mood, eating patterns, sleeping patterns. Interviews with bedside staff were conducted and indicated no changes with the resident. Resident #96 appeared to be in good spirits as she was socializing throughout the unit as per her usual routine. The 1/24/26 social service progress note, documented at 3:32 p.m., revealed due to the resident's BIMS score four out of 15, Resident #96 would not be appropriate for therapy services at this time. C. Resident #149 (assailant) 1. Record review The 1/16/26 nursing progress note, documented at 2:22 p.m., revealed it was reported to the nurse by the one-to-one staff member that Resident #149 made an inappropriate comment to her at the end of her shift. The staff member said the resident asked her to have sex with him. The staff member wrote down the behavior in the one-to-one log. The 1/23/26 nursing progress note, documented at 10:00 p.m., revealed that while Resident #149 was ambulating with a staff member in the hallway, the resident reached down and touched another resident's breast over her clothing. Staff removed the resident's hand immediately and guided him to leave the area. The DON and the physician were notified immediately. The on-call nurse practitioner gave new physician's orders for medication changes. The nurse notified the resident's representative and reported the incident. An immediate intervention of having staff be in between Resident #149 and any other resident was initiated. 4. Staff interviews RN #6 was interviewed on 3/11/26 at 12:07 p.m. RN #6 said Resident #71 did not have any behaviors. RN #6 said the resident normally stayed in her room due to being on hospice care services. RN #6 said before admitting to hospice care services, Resident #71 would come out and sit on the couch in the main area. RN #6 said the DON educated all the staff about Resident #149's hypersexual behaviors. RN #6 said she documented any behavioral changes in a progress note. RN #6 said it was important to document behaviors so the physicians knew how long the behaviors had been going on and they could complete a medication review if necessary. RN #6 said documenting behaviors was also important if a facility needed to refer a resident to another facility. RN #7 was interviewed on 3/12/26 at 9:43 a.m. RN #7 said she was informed through report about the incident involving Resident #71 and Resident #149. RN #7 said Resident #71 was sitting out on the couch and the resident was known for sitting on the couch. RN #7 said Resident #71 fell asleep on the couch and Resident #149 approached her while she was sleeping. RN #7 said Resident #149 put his hand in Resident #71's pants. RN #7 said Resident #149 was ambulatory via his wheelchair. RN #7 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to report alleged violations of physical abuse to the State Survey and Certification Agency in accordance with state law for one (#31) of five residents reviewed for abuse out of 54 sample residents. Specifically, the facility failed to ensure an incident of alleged physical abuse for Resident #31 was reported to the State Survey Agency. Findings include:I. Facility policy and procedureThe Abuse Prevention policy and procedure, reviewed 5/6/25, was provided by the nursing home administrator (NHA) on 3/12/26 at 11:11 a.m. It read in pertinent part, Identify, correct and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur to include trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms, if any. II. Resident #31A. Resident statusResident #31, age [AGE], was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included multiple subsegmental thrombotic pulmonary emboli without acute cor pulmonale (multiple small blood clots in the pulmonary arteries), malnutrition, hyperlipidemia and hyperthyroidism. The 2/13/26 minimum data set (MDS) assessment revealed Resident #31 was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. Resident #31 was independent or needed setup or clean-up assistance with her activities of daily living (ADL). The assessment revealed Resident #31 did not have any physical or verbal behaviors directed at others or other behavioral symptoms not directed towards others. B. Resident interviewResident #31 was interviewed on 3/10/26 at 9:46 a.m. Resident #31 said there was a male resident that had come into her room and she had tried to help him in February 2026. She said he did not want her help and he had hit her chest. She said that when he hit her, it had hurt. C. Record reviewA progress note, dated 2/20/26 at 12:10 p.m., revealed a nurse was notified by a certified nurse aide (CNA) that Resident #39 was found inside Resident #31's room at approximately 6:00 a.m. The note documented Resident #31 stated to the CNA that Resident #39 had hit her in the chest when she tried to help him. The progress note documented another CNA reported she had found Resident #39 in front of Resident #31's room at approximately 5:55 a.m. The note documented the CNA said Resident #39 was grabbing Resident #31's leg, asking her to help him find his buddy. The CNA stated she removed Resident #39's hands from Resident #31's leg and removed Resident #39 from Resident 31's room. The progress note documented a skin and pain assessment were completed. Resident #31 stated the area where she had been hit was sore and one-to-one supervision was provided for Resident #39. The facility's investigation was provided by the NHA on 3/11/26 and revealed the following:On 2/20/26 a CNA reported to the nurse that Resident #39 was found in Resident #31's room and Resident #31 told the CNA that Resident #39 had hit her chest. A second report was made to the same nurse from a different CNA at 11:30 a.m. that Resident #39 was in front of Resident #31's door at approximately 5:55 a.m. The second report documented Resident #39 was grabbing Resident #31's leg asking for her help to find his buddy. The CNA reported that she removed Resident #39's hand from Resident #31's leg and removed Resident #39 from the area. The investigation documented that Resident #31 stated Resident #39 crawled into her doorway and when she bent down to help him up, Resident #39 hit her chest. The investigation documented that Resident #39 was removed from Resident #31's room. Resident #31 stated her chest hurt where she had been hit, but there were no visible signs of injury. Resident #39 was provided with one-to-one supervision. The investigation further documented that the interdisciplinary team (IDT) did not feel the incident that occurred on 2/20/26 was a reportable incident. The investigation documented the IDT did not feel there was an allegation or intent. The facility interviewed Resident #31 and she said she was trying to help Resident #39 get up off the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	floor. Resident #31 said he (Resident #39) did not want her help, so he pushed her hand away to decline her assistance and then brushed her chest. Cross reference F600 for failure to protect residents from abuse. III. Staff interviewsCNA #9 was interviewed on 3/12/26 at 9:44 a.m. CNA #9 said Resident #31 had reported the incident with Resident #39 to her. She said that Resident #39 had grabbed Resident #31's leg in an attempt to pull himself up. She said she did not witness it herself but reported what Resident #31 had told her to the nurse. CNA #10 was interviewed on 3/12/26 at 9:59 a.m. CNA #10 said she was just coming on to her shift and she saw Resident #31 trying to get Resident #39 out of her room. She said Resident #31 reported to her that Resident #39 had punched her chest. She said that Resident #31 was holding her chest when she told her about being punched. CNA #10 said that she reported the incident to the nurse that was on duty and talked Resident #31 into making the report to the nurse and the unit manager. The social services assistant (SSA) was interviewed on 3/12/26 at 12:13 p.m. The SSA said when there were abuse allegations, he interviewed the residents who were involved in the incident and interviewed the other residents to see if they saw or heard anything. He said he was aware of the situation between Resident #31 and Resident #39 on 2/20/26. He said Resident #39 was on the ground and he grabbed Resident #31's ankle as she was walking by and she did not like it. He said he spoke with Resident #31 about it and she had told him that she understood that Resident #39 had memory issues. He said Resident #39 was put on one-to-one supervision after the incident and had remained on the one-to-one monitoring since the incident. Licensed practical nurse (LPN) #1, who was the unit manager of the first floor, was interviewed on 3/12/26 at 12:49 p.m. LPN #1 said her involvement with abuse allegations was to assess the residents, call the police, contact families and report the allegations to the director of nursing (DON). She said she was aware of the incident that happened between Resident #31 and Resident #39 on 2/20/26. She said she understood the situation as Resident #39 was on the floor and went into Resident #31's room and he then tapped or grabbed Resident #31's leg. She said she had not heard that Resident #31 had been hit on the chest. The DON and the NHA were interviewed together on 3/12/26 at 3:41 p.m. The DON said that staff would either notify herself or the NHA about an abuse allegation and then the facility would do an investigation. The NHA said she was aware of the situation between Resident #31 and Resident #39 on 2/20/26. She said Resident #31 reached down to help Resident #39, and he appeared to not want help and then hit her on the chest with his hand. The NHA said the facility was on the fence about reporting it because of the interview with Resident #31. The NHA Resident #31 had told them that she felt Resident #39 had not meant to hurt her. The NHA said that Resident #39 had willfully hit Resident #31 and was then put on one-to-one supervision. The NHA said after reviewing the incident, the facility should have reported it to the State Survey Agency.

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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 record review and interviews the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received necessary services to maintain proper personal hygiene for two (#11 and #46) of six residents reviewed for ADLs out of 54 sample residents.Specifically, the facility failed to ensure Resident #46 and Resident #11 received assistance with showers. Findings include: I. Facility policy and procedure The ADLs policy and procedure, issued 12/11/18 and reviewed 8/23/23, was received from the nursing home administrator (NHA) on 3/12/26 at 5:55 p.m. It read in pertinent part, The resident will receive assistance as needed to complete activities of daily living (ADLs). Any change in the ability to perform ADLs will be documented and reported to the licensed nurse. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. For all other ADLs, this facility will utilize the following Lippincott procedures Tub baths and showers. II. Resident #46 A. Resident status Resident #46, age [AGE], was admitted to the facility on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included displaced trimalleolar fracture of right lower leg (ankle injury), muscle weakness and history of falling. The 2/6/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. She needed set-up assistance with eating, oral hygiene, toileting and partial to moderate assistance with showering/bathing, upper and lower body dressing. B. Resident interview Resident #46 was interviewed on 3/10/26 at 8:45 a.m. She said she had concerns regarding the showering system and said the process for assigning days to residents was broken. She said the facility did not ask about her preference for showers when she was admitted . She said the information the facility provided to her indicated shower days were Sundays and Wednesdays. She said she tried to schedule a shower on Sunday, however staff said the shower schedule was Wednesday and Saturday. She said she was on the list for a shower on Wednesday (3/4/26) and waited until 9:30 p.m. She said no one came to assist her and she did not receive a shower that day. She said when she asked staff they said they were supposed to get her for her shower. She said no one got her and she had to initiate it herself and still no one showed up. She said this made her feel angry. Resident #46 said she had to go to the front desk and ask. She said it still did not happen and she was (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not able to shower. She said she felt disgusted that she had not been able to shower. She said on 3/9/26 she washed her hair in the sink because staff did not come to give her a shower. She said on 3/7/26 she was supposed to receive a shower and did not receive one and she told staff and nothing happened. She said during the past five weeks she had been at the facility, she had only received four showers. C. Record review The ADL care plan, initiated 2/6/26, documented the resident had an ADL self-care performance deficit related to a tibia and fibula fracture. Interventions included providing supervision for bathing and showering and no tub baths until cleared by the surgeon. A review of the bathing documentation report for February 2026, revealed a preference for Wednesday and Saturday evenings showers. The documentation revealed a sponge bath was provided on 2/4/26 and showers on 2/7/26, 2/11/26, 2/18/26, and 2/25/26. -The facility failed to provide Resident #46 with two showers a week according to the shower schedule and preference. A review of the bathing documentation report for March 2026, revealed Resident #46 did not receive a shower on 3/4/26 and 3/7/26 as scheduled. -A review of Resident #46's electronic medical record (EMR) revealed no documentation to indicate why Resident #46 did not receive her showers as scheduled. A review of nursing progress notes, dated 3/4/26, documented the resident returned from an outside physician appointment with instructions she could shower over the incision but could not submerge it underwater. -A review of Resident #46's progress notes failed to reveal any refusals of showers by the resident. D. Staff interviews Certified nurse aide (CNA) #3 was interviewed on 3/11/26 at 10:05 a.m. She said the staff member assigned to provide showers notified the resident on the day of their scheduled shower. CNA #3 said they brought residents to the shower room and residents were not expected to request the shower themselves. She said staff were expected to complete scheduled showers for dependent residents. She said if a shower could not be completed on the day shift, staff asked the evening shift to provide the shower. She said they notified the charge nurse and the nurse documented the information and relayed it to the next shift. She said CNAs could not document in point of care (POC). CNA #3 said Resident #46 had scheduled shower days on Wednesday and Saturday evenings. She said they asked the resident twice before notifying the nurse of a refusal. She said Resident #46 did not refuse showers. Registered nurse (RN) #2 was interviewed on 3/11/26 at 10:24 a.m. RN #2 said the shower schedule was created based on a baseline unit schedule. She said when a resident was admitted , staff placed the resident into the schedule unless the resident had a preference. She said staff accommodated resident preferences when possible. She said the admitting nurse informed residents of their assigned (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shower days. RN #2 said if a resident did not receive a scheduled shower, staff attempted to schedule the shower for the next day. She said staff communicated during shift report regarding missed showers. She said if a resident refused a shower, the CNA would notify the nurse and they would document the refusal. RN #2 said Resident #46 had scheduled shower days on Wednesday and Saturday evenings. She said documentation showed the resident received two showers on 3/3/26, and that she was out of the facility on 3/4/26. She said documentation for February showed the resident received showers once per week and no refusals were documented. The director of nursing (DON) was interviewed on 3/12/26 at 3:17 p.m. The DON said residents who required assistance with bathing received showers based on their preference and the facility offered showers but it was based on what the resident wanted. The DON said if a resident did not receive a scheduled shower, staff were to notify the charge nurse so the nurse could document and inform the next shift. She said missed showers were documented in POC and if the resident refused, the nurse documented the refusal in a progress note. The DON said the facility monitored whether residents received scheduled showers by reviewing the medical record and completing weekly shower audits. The DON said if records showed a resident only received one shower per week and there were no refusals documented, staff would follow up with the resident and staff and offer the shower. The DON said Resident #46 had scheduled shower days on Wednesday and Saturday evenings and from admission, should have received showers two times per week and there were no refusals documented. III. Resident #11 A. Resident status Resident #11, age [AGE], was admitted on [DATE]. According to the March 2026 CPO, diagnoses included left humerus (upper arm) fracture, heart disease, urinary tract infection and diabetes. The 3/9/26 MDS assessment identified Resident #1 had a moderate cognitive impairment with aBIMS score of 12 out of 15. The MDS assessment revealed the resident required set-up assistance for eating and substantial assistance with hygiene, dressing and transferring. B. Resident interview and observation Resident #11 was interviewed on 3/9/26 at 4:00 p.m. Resident #11's hair was disheveled. Resident #11 said she was not getting her showers when they were scheduled. Resident #1 said she had requested to have a shower. She said she did not think the facility had enough staff to assist with showers. She said she had not had a shower in at least a week. C. Record review Resident #11's activities of daily living (ADL) care plan, revised 3/2/26, indicated she had a self-care (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	performance deficit related to left upper extremity fracture and urinary tract infection, and she required substantial assistance for bathing. It revealed the need to check Resident #11's nail length and trim and clean Resident #11's nails on bath (shower) day and as necessary, and to avoid scrubbing and pat dry sensitive skin. Resident #11's shower record from 2/19/26 to 3/11/26 was provided by the NHA on 3/11/26 at 11:52 a.m. The record revealed Resident #11's last documented shower was on 3/1/26, 10 days earlier. The DON provided a document titled Follow Up Question Report on 3/12/26 at 3:40 p.m. The record revealed Resident #11's bathing preference was twice weekly, on Sundays and Thursdays, and the resident would accept showers on other days. The record documented Resident #1 had showered on 3/1/26 and the next documented shower was not until 3/10/26, nine days later. -Per Resident #11's documented shower preference, she did not receive a shower on Thursday (3/5/26) or Sunday (3/8/26). D. Staff interview The DON was interviewed on 3/12/26 at 3:40 p.m. She said Resident #11 should receive two showers per week. The DON said she did not know why there was a nine day gap between Resident #11's showers. The DON said she did not know why there was a discrepancy between the shower record provided by the NHA which did not reveal Resident #11's shower on 3/10/26. The DON said there was no documentation to indicate that Resident #11 had refused any showers.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for one (#46) of four residents reviewed for quality of care out of 54 sample residents.Specifically, the facility failed to ensure physician's orders were obtained and entered for Resident #46's dressing changes following an orthopedic appointment.Findings include:I. Facility policy and procedureThe Physician Orders policy, revised 2/11/26, was received from the nursing home administrator (NHA) on 3/12/26 at 11:11 a.m. It read in pertinent part, The facility is obligated to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines. All physician/practitioner orders, including verbal/telephone orders, are recorded in the medical record for each resident.II. Resident #46A. Resident statusResident #46, age [AGE], was admitted to the facility on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included displaced trimalleolar fracture of right lower leg (ankle injury), muscle weakness and history of falling.The 2/6/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. She needed set-up assistance with eating, oral hygiene, toileting and partial to moderate assistance with showering/bathing, upper and lower body dressing.B. Resident interviewResident #46 was interviewed on 3/10/26 at 8:45 a.m. Resident #46 said she had a right ankle fracture and had a wound on her right ankle following surgery. She said on 3/4/26 after the cast was removed, the orthopedic office ordered the dressing on her ankle to be changed every three days. She said the dressing was not changed until the morning of 3/9/26, after she brought it to the nurse's attention.C. Record reviewReview of the 3/4/26 orthopedic follow-up note revealed Resident #46's sutures were removed. The resident could shower over the incision but was not to submerge the incision under water, and dressing changes were to be completed daily or every other day.The 3/4/26 at 3:30 p.m. progress note revealed Resident #46 returned from an orthopedic appointment where her ankle cast and sutures were removed. The note documented the resident could shower over the incision but not submerge the incision under water, and dressing changes to her ankle were to be completed every other day or daily.Review of Resident #46's March 2026 physician's orders revealed no orders for dressing changes were entered following the 3/4/26 orthopedic appointment.-There was no documentation in the resident's electronic medical record (EMR) to indicate that the resident's ankle dressing had been changed as ordered.-A second review of Resident #46's March 2026 CPO revealed a physician's order for wound care to the resident's right lateral ankle, including cleansing and application of a dry dressing with securement using an ACE wrap every other day, was not initiated until 3/11/26 at 2:25 p.m., during the survey.III. Staff interviewsRegistered nurse (RN) #2 was interviewed on 3/11/26 at 1:41 p.m. RN #2 said when physician's orders were received from an outside provider, the information would be reviewed by the facility's physician. She said if the facility's physician agreed with the outside provider's orders, the facility's physician entered the orders. She said if the facility's physician did not agree with the orders, the physician documented the information in a progress note and verbally notified the nurse. RN #2 said Resident #46 did not report to her or to other staff that the resident's ankle dressing had not been changed. She said the physician's orders for Resident #46's ankle dressing change were received from the orthopedic office on 3/4/26, and the dressing was to be changed daily or every other day. She said there was no documentation in the resident's EMR indicating the dressing was changed after the resident returned from the orthopedic appointment on 3/4/26. RN #3 was interviewed on 3/11/26 at 1:57 p.m. RN #3 said orthopedic provider notes would be reviewed by the nurse and the nurse was expected to write a progress note and enter the physician's orders in the residents' EMRs. She said she was not aware that Resident #46's ankle dressing had not been changed. She said the instructions received from the orthopedic office were for every other day or (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	daily dressing changes. She said the instructions should have been entered into the resident's EMR as a physician's order. She said if dressing change orders were not entered and followed, the resident could be at risk for infection and the infection could lead to sepsis (severe infection response).The director of nursing (DON) was interviewed on 3/12/26 at 3:58 p.m. The DON said when Resident #46 returned from the orthopedic appointment on 3/4/26 with instructions for daily or every other day dressing changes, the nurse was responsible for reviewing the instructions and implementing the physician's orders. She said she did not know why the instructions were missed and said that she completed an audit (during the survey) going back to 3/1/26 to ensure outside appointment instructions were reviewed and entered into the residents' EMRs The DON said the unit managers would complete weekly audits to ensure physician's orders from outside providers were entered into the residents' EMRs and implemented. She said the facility would complete a look-back review and address the concern through the quality assurance and performance improvement (QAPI) process.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#33) of five residents reviewed for accidents out of 54 sample residents received adequate supervision to prevent accidents. Specifically, the facility failed to:-Ensure Resident #33's care plan was accurate and up to date with the resident's correct transfer status; and, -Ensure therapy timely assessed the resident after she sustained bruising related to a transfer. Findings include:I. Professional referenceAccording to the ARJO product guide, retrieved on 3/23/26 from https://www.arjo.com/en-us/products/patient-handling/floor-lifters/#product-list-tab-1, Sara Steady enables a single caregiver to assist patients or residents perform sit to stand transfers throughout the day. The pivoting seat can be moved out to enable the patient to stand, and provides an angled seated support during the transfer. According to the [NAME] Sit-to-Stand Lift product guide, retrieved on 3/23/26 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.hillrom.com/content/dam/hillrom-aem/emea The [NAME] sit-to-stand lift is especially designed for people who have difficulty in standing up on their own from a seated position. There are two different sling bar options for [NAME] sit-to-stand lift, as well as many different sit-to-stand vests. The patient's overall mobility determines the choice of cling bar and sit-to-stand vest.II. Resident #33A. Resident statusResident #33, age greater than 65, was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), the diagnoses included Parkinson's disease, chronic respiratory failure, myocardial infarction (heart attack), and atrial fibrillation (heart arrhythmia). The minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 13 out of 15. She required substantial/maximal assistance with all ADLs. The resident was dependent on staff for transfers.The MDS assessment revealed the resident was taking an anticoagulantB. Resident interviewsResident #33 was interviewed on 3/9/26 at 10:45 a.m. Resident #33 said she had a large bruise on her back from staff not using the sit to stand properly. The resident said she was on Eliquis for blood thinner and was aware that she bruised easily. Resident #33 said staff came in to assist her with a transfer using a lift. The resident said she was instructed to reach out with her hands and grab on to two bars in front of her. Resident #33 said a certified nurse aide (CNA) placed a belt around her back and did not put it on correctly. Resident #33 said as the resident began standing with the lift it started hurting her. Resident #33 yelled out for the CNA to stop because it was hurting. The resident said the CNA did not stop and continued lifting the resident from her wheelchair. C. Record reviewThe ADL care plan, revised on 1/13/26, revealed Resident #33 had an ADL self-care performance deficit related to her Parkinson's disease, chronic respiratory failure with hypoxia, myocardial infarction, hypertensive urgency, muscle weakness, and unsteadiness on feet. Pertinent interventions included the resident required maximum assistance of two people using the Sara Steady The Kardex (staff directive tool), dated 3/10/26, revealed Resident #33 was a two person maximum assist with a hoyer lift. -However, during an interview with CNA #6. CNA #6 said Resident #33 required a Sara Steady lift on Kardex (see interview below).The 3/1/26 social services note documented at 6:30 p.m. revealed the social services department met with Resident #33 to follow up on the nursing report regarding the bruise to her rib area. The resident said it happened with the lift and the lift continued to be uncomfortable. Social services met with the CNAs who reported struggling with space and layout of the resident's room. Resident #33 said the staff treated her well and no person has intentionally caused her discomfort or mistreated her in any way. The note documented the social service director (SSD) would review transfer concerns with the therapy team. -However, review of the resident's electronic medical record (EMR) did not reveal documentation that the therapy team was notified to review the transfer concerns of the resident. The 3/2/26 nursing progress note documented at 9:46 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	p.m. revealed Resident #33's Xray was cleared with no acute rib fracture. The 3/3/26 nursing progress note documented at 8:19 p.m. revealed Resident #33 had bruising across her back with bruising on her left side all the way to her breast. The nurse changed the resident from using a Sara Steady to the Hoyer lift for transfers. The nurse advised the CNAs to pad under the resident's shirt with pillows to cushion during the Hoyer transfer. Resident #33 was on Eliquis and bruised easily. D. Staff interviewsCNA #7 was interviewed on 3/10/26 at 2:35 p.m. CNA #7 said Resident #33 had bruising all across her back. CNA #7 said the bruise was black. CNA #7 said did not know how Resident #33 acquired the bruise. CNA #7 said it may have been from using a lift improperly. CNA #7 said she was only supposed to use a Hoyer lift with Resident #33, which required the assistance of two CNAs.CNA #6 was interviewed on 3/10/26 at 2:51 p.m. CNA #6 said she was made aware of Resident #33's bruising on her side, but had not visually seen the bruise herself. CNA #6 said initially she was informed Resident #33 used the Sara Steady lifts for transfers, but now the resident was a hoyer. CNA #6 said the incident occurred about two weeks ago. She said she was unsure of the root cause but thought it could have been due to pressure from a sling. CNA #6 said she did not know how the incident was documented in the electronic charting system but heard by word of mouth about the residents' bruising and to use the hoyer moving forward. CNA #6 said the resident's Kardex should also reflect the resident's transfer needs. CNA #6 said the Sara Steady lift was approved by therapy and only required the use of one CNA unless otherwise ordered by the rehabilitation department. CNA #6 said Resident #33 was not appropriate for the sit to stand because if a resident has a curved spine the sling for the sit stand was not appropriate. CNA #6 said the resident required a Sara Steady lift because it worked with her curved spine. CNA #6 said therapy had informed her about the curvature of the spine.CNA #6 said to her knowledge Resident #33 currently required a Hoyer lift. She said a couple months prior when she looked at the Kardex it said Resident #33 required a Sara Steady lift for transfers. CNA #6 said she the resident's Kardex currently said she required a Hoyer lift with the assistance of two people. CNA #6 said she observed two CNA's the other day attempting to go into Resident #33's room with a sit to stand and CNA #6 had to notify the RN on duty and the RN went and put a stop to the CNA's using the sit to stand on Resident #33. Registered nurse (RN) #5 was interviewed on 3/10/26 at 3:48 p.m. RN #5 said she was not working the specific day the incident occurred, however, days later RN #5 was on shift and was in Resident #33's room. RN #5 said the resident told RN #5 she was hurting on her side and in pain. RN #5 said she observed bruising to Resident #33's left side and immediately notified the physician, family, and arranged for an Xray. RN #5 said the bruising was caused during a transfer with a sling from the sit to stand. RN #5 said she could not recall what day the resident notified RN #5 but she believed it was over a weekend. RN #5 said the therapy team assessed the resident for the appropriate use of a lift. RN #5 said she reported any changes in the resident's mobility or transfer status to therapy so they could further evaluate the resident. RN #6 was interviewed on 3/11/26 at 12:02 p.m. RN #6 said she was unaware of any bruising to the resident's side. RN #6 said she reviewed Resident #33's chart and said a chest Xray was completed on 3/2/26 related to bruising. RN #6 said a risk management assessment and incident report were done on 3/1/26. RN #6 said Resident #33 did voice discomfort to arms, and the resident was evaluated for the sling for a proper fit. RN #6 said physical therapy was responsible for assessing a resident to determine the proper use of a sling and lift. The director of rehabilitation was interviewed on 3/11/26 at 10:07 a.m. The director of rehabilitation said Resident #33 had not been on the therapy caseload since 2/4/26 (prior to the bruising). The director of rehabilitation said facility staff had concerns with the Resident's transfer status. The director of rehabilitation was reviewing notes and said Resident #33 did not care for a gait belt because it hurts her ribs. The director of rehabilitation said a gait belt was always appropriate when transferring a resident. The director of rehabilitation said when staff are using the Sara Steady they should be putting a gait belt on the resident. The director of rehabilitation said any RN could always upgrade a resident, however if a Resident was a hoyer and the facility wanted to downgrade a resident to a sit to stand that resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would need to be assessed by therapy. The director of rehabilitation said if a resident isn't feeling well or needs more assistance then it was always best practice and safer for the resident to use a maximum assistance which could be the hoyer lift. The director of rehabilitation reviewed more notes and said Resident #33's bruising came from a sling and the progress note was dated 3/1/26. The director of rehabilitation said the RN's have degrees for a reason and are more than capable of assessing a resident to determine if the resident needs more assistance with a transfer. The director of rehabilitation said she suspected the Hoyer lift was accurate for Resident #33. The director of rehabilitation said therapy was not always involved with a resident. The director of rehabilitation said therapy tried to be involved as much as possible but it was not always necessary. The director of rehabilitation said Resident #33 was not making progress in therapy and she was dropped from the therapy caseload on 2/5/26.Physical therapist (PT) #1 was interviewed on 3/12/26 at 11:50 a.m. PT #1 said if a resident was deemed inappropriate for a sit stand lift if they were non weight bearing either to their upper or lower extremities. PT #1 said determining an appropriate lift is also individual based and dependent on the resident and their specific needs. PT #1 said a sit to stand lift would be inappropriate for a resident with a curved spine depending on if the belt was causing pain across the spine. PT #1 said the sit to stand would be inappropriate for anyone if it caused pain. The DON and the NHA were interviewed together on 3/12/26 at 3:00 p.m. The DON said as of 1/13/26 the resident required a sit to stand lift. The DON said therapy recommended Resident #33 used a sit to stand lift. The NHA said an audit was performed on therapies recommendation. The NHA said she thought the nurses on the floor are interchanging the words sit to stand and Sara Steady which was causing confusion. The NHA said the ideal process would be upon admission of a resident therapy was to assess them. The NHA said the therapy department was not always available and the facility was not going to wait until therapy had time. The NHA said an RN could make the initial assessment, however they also wanted the therapy departments input. The NHA said the RN's were always going to do what was quick and easier for the resident when it comes to transfers. The NHA said the RN might determine that a resident was a sit to stand but they wanted therapy to come in after and do a more thorough assessment to ensure the RN's determination was appropriate. The NHA said the facility would error on the side of caution for a level of higher assistance always to ensure the residents safety. The NHA said if a resident was a Hoyer lift then therapy would need to assess that resident to determine if the resident would be appropriate to step down to a sit stand because the RN's are not able to make that determination.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Longmont	2451 Pratt St Longmont, CO 80501

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide an effective pain management regimen in a manner consistent with professional standards of practice, resident-centered care plans, and resident preferences for one (#147) of two residents out of 54 sample residents. Specifically, the facility failed to ensure Resident #147's pain medication was administered as ordered and needed per the resident's condition. Findings include:I. Facility policy and procedureThe Pain Management policy was provided by the nursing home administrator (NHA) on 3/12/26 at 1:49 p.m. It read in pertinent part, The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.II. Resident #147A. Resident statusResident #147, age [AGE], was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included explantation of knee joint prosthesis (surgical removal of the medical knee device), infection and inflammatory reaction due to internal left knee prosthesis, seizure disorder and neuropathy.Resident #147's minimum data set (MDS) assessment had not yet been completed as of 3/9/26. An MDS note on 3/6/26 at 2:40 p.m. documented Resident #147 had severe left knee pain.B. Resident observation and interviewResident #147 was interviewed on 3/9/26 at 3:05 p.m. Resident #147 was lying in bed with her left leg elevated on a pillow. A wound dressing was on Resident #147's left knee. Resident #147 said she had three knee surgeries prior to admission. Resident #147 said the most recent surgery had been the most extensive due to an infection and the resident said she experienced a lot of pain after this surgery. Resident #147 said when she arrived at the facility on 3/4/26, her pain was not significant because she had just received narcotic pain medication prior to leaving the hospital. Resident #147 said on 3/4/26 at 10:00 p.m. her left knee pain had increased to a level that was an 8 out of 10 on a pain scale and she requested narcotic pain medication. Resident #147 said the nurse gave her Tylenol for pain and then later told her that the narcotic medication was not available for administration. Resident #147 said by 3/5/26 at 5:00 a.m., she rated her pain a 10 out of 10 on the pain scale. Resident #147 said she did not receive the first dose of narcotic pain medication until mid-day on 3/5/26. Resident #147 said she managed to wait for the medication, however, she did not want other residents to have the same experience she had.C. Record reviewResident #147's pain care plan, initiated 3/5/26, revealed the resident expressed pain. The care plan interventions included evaluation of pain interventions and administration of pain medication as ordered. The pain care plan contained instructions to specify the pain type and what the pain was related to within the care plan. Resident #147's March 2026 CPO revealed the following physician's ordersNumeric Scale Pain Assessment every four hours for three days, ordered on 3/4/26 at 1:30 p.m.Hydromorphone Hydrochloride (HCL) oral tablet two milligrams (mg), one tablet by mouth every four hours as needed for pain, ordered on 3/4/26 at 1:30 p.m.-However, the first dose of Hydromorphone two mg was not administered until 3/5/26 at 11:30 a.m., 19.5 hours after Resident #147 began rating her pain at a seven level. -There were no physician orders for Tylenol or Tylenol administration documented until 3/10/26 (see Resident #147's interview above).-Resident #147's pain level intensity was documented as a seven on 3/4/26 at 4:00 p.m. and a seven on 3/4/26 at 8:00 p.m. on a numeric scale from zero to 10.-Resident #147's pain level was eight on 3/4/26 at 10:00 p.m, and ten on 3/5/26 at 5:00 a.m. (see interview above) and the resident's pain was not documented as ten until 3/5/26 at 11:30 a.m.A physician's progress note on 3/6/26 at 8:43 p.m. documented Resident #147 said the Hydromorphone helped her pain, however it took a while to get the medication after admission. D. Staff interviewsThe director of nursing (DON) was interviewed on 3/12/26 at 4:20 p.m. The DON said due to Resident #147's surgical pain, she should have pain medication available for administration upon the resident's admission. The DON said the facility had an automated medication dispensing system to retrieve medications if the (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication was not yet available from the pharmacy at admission. The DON said if the nurse did not find the medication ordered in the automated medication dispensing machine, she should have contacted the physician on-call so the physician could order an alternative pain medication. The DON said she had not seen documentation from the nurse regarding any Tylenol administration. The DON said the facility would provide reeducation to nursing staff regarding pain medication assessment and administration.The DON was interviewed again on 3/12/26 at 5:30 p.m. The DON said she reviewed the inventory for the automated medication dispensing machine, and the Hydromorphone HCL two mg dose was available for administration on 3/4/26 and the nurses should have administered the medication when requested by Resident #147.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for three (#2, #15, and #16) of five certified nurse aides (CNA).Specifically, the facility had not completed annual performance reviews for CNA #2, #15, and #16 in order to determine potential training needs. Findings include:I. Facility policy and procedureThe Performance Evaluation policy and procedure, reviewed 12/4/25, was provided by the nursing home administrator (NHA) on 3/12/26 at 6:02 p.m. It read in pertinent part, Ongoing performance feedback is strongly encouraged between associates and their supervisors throughout their employment. New associates should receive a formal 90-day evaluation, as should associates newly transferred or promoted to a new role. Annual performance reviews are given to all associates. II. Record reviewAnnual performance reviews were requested on 3/12/26 at approximately 11:33 a.m. Review of the employee files revealed CNA #2's last employee evaluation was done on 7/14/23, CNA #15's last employee evaluation was done on 6/5/24, and CNA #16's last employee evaluation was done on 7/14/23.III. Staff interviewsThe director of nursing (DON) and the NHA were interviewed together on 3/12/26 at 4:31 p.m. The DON said the staffing development coordinator (SDC) tracked all the information for employee evaluations. The NHA said they do their all-staff training during their annual skills fair. The NHA said the SDC was unable to be interviewed due to being in the hospital.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure the medication error rate was less than five percent (%).Specifically, the facility had a medication error rate of 10.34%, which was three errors out of 29 opportunities for error. Findings include:I. Professional referenceAccording to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), Elsevier, St. Louis Missouri, pp. 606-607. Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environmentˆ.ˆ ˆˆProfessional Standards such as nursing scope ˆand standards of practice apply to the activity of medication administrationˆ. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. ˆMany medication errors ˆcan be linked ˆin some way to an inconsistency ˆin adhering to these seven rightsˆ: 1. The right medication2. The right dose3. The right patient4. The right route5. The right time6. The right documentation7. The right indication.II. Facility policy and procedureThe Administration of Medications policy, revised 9/9/25, was provided by the nursing home administrator (NHA) on 3/12/26 at 5:29 p.m. It read in pertinent part, The facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms.III. Observations and record reviewOn 3/10/26 at 2:38 p.m. registered nurse (RN) #1 was observed during Resident #22's medication administration. The physician's order read:Give five milligrams (mg) of Oxycodone (an opioid pain medication) oral tablet every three hours for pain, ordered 3/7/26.RN #1 placed one tablet of Oxycodone in an administration cup and placed the medication cup on the bedside table in front of Resident #22. RN #1 then went out in the hall and performed hand hygiene. RN #1 then walked back into Resident #22's room and asked the resident if she had taken the medication. Resident #22 said she took the medication.-RN #1 did not watch Resident #22 take the medication and the resident did not have an order or assessment completed that allowed them to take their medication unsupervised.On 3/10/26 at 5:15 p.m. licensed practical nurse (LPN) #3 was preparing Resident #34's medications for administration.The physician's order read:Give 37.5 mg of Seroquel (an antipsychotic medication) two times a day for dementia with behaviors, ordered 1/24/26.LPN #3 pulled a medication card for propranolol (a blood pressure medication) out of the medication cart, pointed to the medication name, and incorrectly stated Seroquel. LPN #3 then placed the propranolol into the medication cup. She marked the Seroquel as given in the medication administration record (MAR). She then took the medication cup, which contained the propranolol, to administer the medication to Resident #34. Upon prompting, LPN #3 did not administer the medication after she was informed it was the incorrect medication.-Cross-reference F760: failure to ensure residents were free from a significant medication error.On 3/10/26 at approximately 5:17 p.m. LPN #3 was preparing Resident #34's medications. The physician's order read: Give 37.5 mg of Seroquel two times a day for dementia with behaviors, ordered 1/24/26.LPN #3 correctly identified the seroquel medication card and placed a 25 mg tablet into the medication cup. LPN #3 then administered the medication to Resident #34.-LPN #3 administered 25 mg of Seroquel. The correct dose for administration was 37.5 mg (1.5 tablets).IV. Staff interviewsLPN #3 was interviewed on 3/10/26 at 5:15 p.m. LPN #3 said she was not sure why she had attempted to administer propranolol instead of Seroquel. LPN #3 said it was two and a half hours before Resident #34 was due to receive propranolol. LPN #3 said she had charted the Seroquel had been given on the MAR, which indicated Resident #34 would have received the propranolol dose given in error in addition to her scheduled dose to be administered in the evening. LPN #3 said Resident #34 could have had adverse effects from receiving two doses of propranolol.LPN #1 verified the correct dose of Seroquel for Resident #34. LPN #1 said the correct dose of Seroquel was 37.5 mg, which was one and a half tablets. The director of nursing (DON) was interviewed on 3/10/26 at 6:15 p.m. The DON said Resident #34 could have suffered an adverse (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reaction to receiving propranolol instead of the prescribed medication. The DON said it could have resulted in Resident #34 receiving a second dose of the medication when it was scheduled to be given, which could have resulted in hypotension (low blood pressure).The DON was interviewed again on 3/12/26 at 1:55 p.m. The DON said the facility had given the remainder of the Seroquel dose to Resident #34 on 3/10/26. The DON said LPN #3 had been terminated in response to her medication errors. The DON said RN #1 should have observed Resident #22 taking their medications rather than leaving the room. The DON said she would provide education to RN #1 on medication administration.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#34) of 10 residents reviewed for medication administration was kept free from significant medication errors out of 54 sample residents.Specifically, the facility failed to ensure the correct medication was administered to Resident #34 based on the physician's orders. Findings include:I. Professional referenceAccording to the manufacturer, Amneal Pharmaceuticals NY LLC, 2025, Propranolol Hydrochloride (HCL) tablet Drug Label Information, retrieved 3/17/26 from https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=14d0c95d-418f-40a8-bad3-e20c82424960&audienc Adverse reactions - The following adverse events were observed and have been reported in patients using propranolol: Bradycardia (low heart rate); congestive heart failure (when the heart is unable to pump blood efficiently); hypotension (low blood pressure); paresthesia of hands (numbness and tingling); arterial insufficiency (a lack of, or slow blood flow). Overdosage - Hypotension and bradycardia have been reported following propranolol overdose and should be treated appropriately.According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), Elsevier, St. Louis Missouri, pp. 606-607. Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environmentˆ.ˆ ˆˆProfessional Standards such as nursing scope ˆand standards of practice apply to the activity of medication administrationˆ. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. ˆMany medication errors ˆcan be linked ˆin some way to an inconsistency ˆin adhering to these seven rightsˆ: 1. The right medication2. The right dose3. The right patient4. The right route5. The right time6. The right documentation7. The right indication.II. Facility policy and procedureThe Administration of Medications policy, revised 9/9/25, was provided by the nursing home administrator (NHA) on 3/12/26 at 5:29 p.m. It read in pertinent part, Medication Error - This means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; Significant medication error - This means one which causes the resident discomfort or jeopardizes his or her health and safety. Right Drug. Every drug administered must have an order from the provider. Compare the order with the medication administration record (eMAR) for accuracy. Compare the label on the drug to the information on the eMAR. three times: i. Before removing the container from the drawer ii. As the drug is removed from the container and iii. At the bedside before administering it to the resident\.III. Resident #34A. Resident statusResident #34, age [AGE], was admitted on [DATE]. According to the 3/11/26 computerized physician's orders (CPO), diagnoses included Alzheimer's disease, dementia, major depressive disorder, and anxiety disorder.The 12/23/25 minimum data set (MDS) assessment revealed the resident had a severe cognitive impairment with a brief interview for mental status (BIMS) score of four out of 15.B. Record reviewReview of Resident #34's March 2026 CPO revealed the following physician orders:Seroquel (an antipsychotic medication) 25 milligrams (mg) tablet, give 37.5 mg two times a day for dementia with behaviors, ordered 1/24/26.Propranolol HCL 20 mg, give one tablet by mouth twice a day. Hold (do not give) for heart rate less than 55 beats per minute, ordered 11/6/25.C. ObservationsOn 3/10/26 at 5:15 p.m. licensed practical nurse (LPN) #3 was preparing medications for administration to Resident #34. LPN #3 obtained a medication out of the medication cart, which read propranolol 20 mg. LPN #3 pointed to the medication name and stated, Seroquel. LPN #3 then placed the propranolol tablet into the medication cup. She marked the Seroquel as given on the medication administration record (MAR). LPN #3 took the medication cup to which contained the propranolol, to administer to Resident #34. - LPN #3 was prompted that there was a medication error, so the propranolol was not administered to the resident.-Cross-reference F759: failure to ensure residents were free from medication errors greater than five percent.D. Staff interviewsLPN #3 was interviewed on 3/10/26 at (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5:15 p.m. LPN #3 said she was not sure why she had attempted to administer propranolol instead of Seroquel. LPN #3 said Resident #34 was not due for propranolol until later that evening. LPN #3 said she had documented the Seroquel had been administered on the MAR, which meant Resident #34 would have received propranolol twice within a few hours. LPN #3 said Resident #34 could have had adverse effects from receiving two doses of propranolol, such as a low heart rate.The director of nursing (DON) was interviewed on 3/10/26 at 6:15 p.m. The DON said Resident #34 could have suffered an adverse reaction from receiving propranolol instead of the prescribed medication. The DON said Resident #34could have experienced hypotension from receiving a second dose of the medication in the evening when it was scheduled to be given.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the hospice services provided met professional standards and principles that applied to individuals providing services in the facility for one (#62) of two residents reviewed for hospice services out of 54 sample residents.Specifically, the facility failed to implement a hospice care plan for Resident #62 when she was admitted to hospice. Findings include: I. Facility policy and procedureThe Hospice Coordination of Care policy and procedure, revised 9/3/25, was provided by the nursing home administrator (NHA) on 3/12/26 at 11:11 a.m. it read in pertinent part, The facility provides hospice care under a written agreement and must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the resident; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.II. Resident #62A. Resident statusResident #62, age [AGE], was admitted on [DATE]. According to the March 2026 computerized physician orders (CPO), diagnoses included senile degeneration of the brain (age-related loss of nerve cells causing cognitive decline), Alzheimer's disease, and dementia with psychotic disturbance. The 2/12/26 minimum data set (MDS) assessment revealed Resident #62 had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. The assessment revealed Resident #62 needed supervision or touching assistance with most of her activities of daily living. The assessment indicated Resicent #62 was receiving hospice care.B. Record reviewReview of the March 2026 CPO revealed Resident #62 was admitted to hospice on 2/3/26 with a diagnosis of senile degeneration of the brain. Review of Resident #62's comprehensive care plan, reviewed 2/24/26 did not reveal a hospice care plan with a delineation of cares. C. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 3/10/26 at 3:01 p.m. She said that there was not a hospice communication book. She said everything is uploaded into the electronic medical record (EMR). She said the EMR was their lifeline. The social services assistant (SSA) was interviewed on 3/12/26 at 12:13 p.m. He said he stayed in constant communication with the hospice social workers. He said they email and call back and forth and he will ensure everyone is aware of the care conferences.The SSA said he said he was not responsible for creating the hospice care plan. He said he thought that the unit manager or nursing was responsible for creating the hospice care plan. LPN #1 was interviewed a second time on 3/12/26 at 12:49 p.m. She said she did not initiate the hospice care plans. She said the MDS nurse initiated them. She said generally, the hospice care plans were generic and very general. The director of nursing (DON) was interviewed on 3/12/26 at 3:31 p.m. She said the MDS nurse primarily updated the care plans. She said hospice care plans should be initiated at the time of admission to hospice. She said the hospice care plan should include the delineation of care. She said the delineation of care was important because the facility and the hospice care company needed to be on the same page when caring for the resident. She said Resident #62 did not have a hospice care plan. She said she should have had a hospice care plan with a delineation of care implemented when she was admitted to hospice.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations, record review and interviews, the facility failed to ensure residents, family members and legal representatives had full access to review the results of the facility's most recent survey findings that included the survey results, certifications, complaint investigations and plans of correction in effect for the past three years. Specifically, the facility failed to ensure three years of survey and investigation findings were available for the public, and where individuals wishing to examine survey results did not have to ask to see them. Findings include: I. ObservationsOn 3/11/26 at 3:15 p.m. the facility's survey results binder was found in the front lobby of the facility. The binder was found to have the findings from the surveys on 9/28/22, 11/12/20, and 9/26/19 . The survey results binder failed to include the facility's most recent recertification survey from 1/23/24 and the last three years of complaint findings. II. Staff interviewsThe nursing home administrator (NHA) was interviewed on 3/11/26 at 3:37 p.m. She said the most recent survey and the last three years of complaint findings should be in the binder. She said she had thought that they were in the binder.