STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065291	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Creek Rehabilitation and Healthcare Center	2277 East Dr Monte Vista, CO 81144

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - 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 observations, record review, and interviews the facility failed to ensure two (#25 and #35) of eight out of 24 sample residents were kept free from abuse.Specifically, the facility failed to: -Protect Resident #25 from verbal abuse from Resident #3 on 12/15/25 and 12/21/25, which caused psychosocial distress for Resident #25; and,-Protect Resident #35 from verbal abuse from Resident #3 on 12/23/25 and 12/31/25, which caused Resident #35 to become tearful after both incidents. Resident #3, who was admitted to the facility on [DATE] and readmitted on [DATE], was known to have verbally aggressive behaviors toward others and had been involved in verbal altercations with other residents.On 12/15/25 Resident #3 verbally abused Resident #25 in the dining room by yelling foul language, making threatening comments and moving aggressively toward Resident #25. The facility placed both residents on 15-minute checks and educated staff regarding de-escalation techniques. However, six days later, on 12/21/25, Resident #3 again approached Resident #25 in the dining room, calling him names and threatening to kick his (expletive word).Record review and interviews during the survey revealed Resident #25 became fearful, nervous and emotionally distressed following the repeated verbal abuse incidents from Resident #3.Due to the facility's failure to protect Resident #25 from verbal abuse from Resident #3, Resident #25 sustained psychosocial distress, which included sleep disturbances, fear of Resident #3, avoidance of the dining room and decreased social and activity participation.Additionally, following the second incident with Resident #25, the facility implemented an intervention for staff to escort Resident #3 to and from the dining room. However, on 12/23/25 and again on 12/31/25, Resident #3 was verbally abusive toward Resident #35 in the dining room when he passed by her, causing Resident #35 to become tearful after each incident. Observations during the survey revealed Resident #3 was not consistently escorted to and from the dining room (see observations below). Findings include: I. Facility policy and procedure The Abuse Prevention Program policy and procedure, revised December 2016, was provided by the nursing home administrator (NHA) on 5/18/26 at 12:08 p.m. It read in pertinent part, Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	representatives, friends, visitors, or any other individual. II. Incidents of verbal abuse between Resident #25 and Resident #3 on 12/15/25 and 12/21/25 A. Facility investigation on 12/15/25 The facility's abuse investigation, dated 12/15/25, documented that at approximately 5:40 p.m. on 12/15/25 Resident #25 and Resident #3 were in the dining room eating dinner when a verbal altercation occurred. Resident #3 was walking out of the dining room and Resident #25 looked at Resident #3, which triggered Resident #3 and Resident #3 began yelling foul language at Resident #25. The situation escalated and both residents started yelling at each other. During the altercation, both residents held silverware in a threatening manner. There was no physical contact between the residents during the altercation. The facility staff separated both residents prior to notifying law enforcement. They provided Resident #25 with emotional support. Resident #25 was interviewed and said he would avoid Resident #3. Resident #3 was interviewed and said he did not remember the verbal altercation. The investigation revealed facility staff did not observe changes in Resident #25's behavior following the incident and he remained at baseline. The investigation revealed that five other residents were interviewed and they did not report any ongoing safety concerns. The interventions implemented after the incident for both residents included continued 15-minute checks, adjusting Resident #3's medications and educating staff regarding de-escalation techniques. The investigation documented that the facility substantiated that the allegation of resident-to-resident verbal abuse occurred. B. Facility investigation on 12/21/25 The facility's abuse investigation, dated 12/22/25, revealed that on 12/21/25 at 5:35 p.m. a verbal altercation occurred in the dining room between Resident #25 and #3. Resident #3 walked into the dining room to eat dinner and said to Resident #25 he was a fat (expletive word) and that he was going to kick his (expletive word). Resident #25 yelled back at Resident #3 using foul language. An unknown registered nurse (RN) entered the dining room, separated the residents, ensured the safety of the residents and contacted law enforcement. At that time, both residents denied feeling fearful. The investigation revealed both residents were already on 15-minute checks prior to the altercation. Due to the occurrence, Resident #3 was escorted to and from meals. The following morning, Resident #25 said he could not ignore it anymore because Resident #3 kept coming for him and would not leave him alone. Resident #25 said he would slit Resident #3's throat if he came for him again. Staff educated Resident #25 that the statement was inappropriate and he said he understood. The facility staff provided emotional support to Resident #25. The investigation revealed that Resident #3 was interviewed and said Resident #25 started the altercation and he was not going to let him talk to him that way. The interventions put into place after the incident included continued 15-minute checks, keeping the residents separated, escorting Resident #3 to and from meals and educating staff regarding (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	de-escalation techniques specific to Resident #3. -However, Resident #3 was already on 15-minute checks and educating staff on de-escalation techniques had already been documented as an intervention following the 12/15/25 verbal abuse incident with Resident #25 (see above). Cross-reference F610 for failure to correct an alleged violation. The investigation documented that the facility substantiated that the allegation of resident-to-resident verbal abuse occurred. C. Resident #25 - victim and assailant 1. Resident status Resident #25, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included schizophrenia, depressive episodes and unsteadiness on feet. The 1/1/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He required partial assistance with bathing, dressing and needed supervision assistance with eating and personal hygiene. The MDS assessment revealed the resident did not display physical or verbal behaviors directed towards others during the assessment look-back period. 2. Resident interview Resident #25 was interviewed on 5/20/26 at 9:53 a.m. Resident #25 said he remembered the incidents with Resident #3 in the dining room that occurred in December 2025. Resident #25 said he had been sitting down enjoying his dinner meal when Resident #3 became upset. Resident #25 said residents could not look at Resident #3 because it triggered him. Resident #25 said Resident #3 yelled at him and started moving toward him. Resident #25 said he became scared because Resident #3 was a big guy and was acting erratically. Resident #25 said staff stopped Resident #3 before he reached him. Resident #25 said Resident #3 yelled foul language at him and said (expletive word) you. Resident #25 said he felt nervous and had an eerie feeling when Resident #3 became erratic. Resident #25 said he continued to feel worried, upset and uncomfortable around Resident #3 following the incidents. Resident #25 said the incidents affected his sleep because he thought Resident #3 would come to his room and hurt him. Resident #25 said he continued to think about the incidents, although not as much as before. Resident #25 said he currently felt safe in the facility. Resident #25 said the incidents affected his meals because it was hard for him to go to the dining room due to fear Resident #3 would blow up again. Resident #25 said the incidents also affected his participation in activities because he remained scared of Resident #3 even though Resident #3 did not attend activities. Resident #25 said staff did not talk with him about his concerns or how he felt after the incidents. Resident #25 said he spoke with his counselor, but the facility ignored the incidents and brushed them (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	under the table. Resident #25 said staff did not take residents' concerns about Resident #3 seriously. Resident #25 said Resident #3 bullied other residents and residents were scared of him. Resident #25 said staff should do more to prevent future incidents with Resident #3. 3. Record review The behavior care plan, initiated 6/2/25 and revised 4/27/26, documented Resident #25 had behaviors related to wandering into other residents' rooms, mocking other residents and engaging in verbal altercations with another resident. The care plan revealed the resident believed another resident was out to get him and said if the other resident came at him again, he would stab him with a fork. The care plan revealed the resident brought up race in an inappropriate manner and discussed rape in the dining room, which upset other residents. The care plan revealed these behaviors were related to the resident's delusions and hallucinations. Pertinent interventions included non-pharmacological interventions, such as approaching the resident in a calm manner, redirecting the resident when exhibiting behaviors and re-approaching the resident after de-escalation. Additional interventions included educating the resident regarding appropriate conversations with others, educating the resident it was not appropriate to target others and monitoring behavior episodes to determine the underlying cause, including the location, time of day, persons involved and situations. The 12/16/25 nursing progress note revealed Resident #25 was involved in a verbal altercation with Resident #3. Resident #3 yelled foul language toward Resident #25 which upset Resident #25. Staff redirected and separated both residents. The 12/21/25 nursing progress note revealed Resident #25 was involved in a verbal altercation with Resident #3 in the dining room. Resident #3 yelled foul language toward Resident #25 and both residents began yelling at each other. Staff intervened and separated both residents. D. Resident #3 - assailant and victim 1. Resident status Resident #3, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the May 2026 CPO, diagnoses included dementia with behavioral disturbance and depressive disorder. The 3/10/26 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 11 out of 15. He required partial assistance with bathing, dressing, and personal hygiene, and required supervision assistance with eating and toileting. The MDS assessment revealed the resident displayed verbal behaviors directed towards others during the assessment look-back period. 2. Record review The dementia and behavioral care plan, initiated 5/17/22 and revised 2/3/26, revealed Resident #3 had verbally aggressive behaviors toward others and used threatening gestures. Pertinent interventions included approaching the resident in a calm manner, redirecting the resident when exhibiting behaviors and re-approaching after de-escalation, monitoring and documenting episodes of inappropriate behaviors, and providing non-pharmacological behavior interventions such as calm approach, positive reassurance, one-on-one interactions and a quiet environment. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-The care plan failed to identify the interventions for 15-minute checks and to have staff escort the resident to and from the dining room for meals. The 12/16/25 nursing progress note revealed Resident #3 was involved in a verbal altercation with Resident #25. Resident #3 yelled foul language toward Resident #25 which upset Resident #25. Staff redirected and separated both residents. The 12/21/25 nursing progress note revealed Resident #3 was involved in a verbal altercation with Resident #25 in the dining room. Resident #3 yelled foul language toward Resident #25 and both residents began yelling at each other. Staff intervened and separated both residents. E. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 5/19/26 at 2:57 p.m. LPN #1 said she would separate residents involved in resident-to-resident verbal altercation, notify the management team, complete a witness statement, and implement interventions to prevent further occurrences. LPN #1 said interventions for residents with known abusive behaviors included redirecting the resident, providing education, notifying the physician for possible medication changes and involving the social services director (SSD) to speak with the resident. LPN #1 said Resident #3 was supposed to be escorted in and out of the dining room and was not supposed to sit near Resident #25 following the incidents December 2025. LPN #1 said Resident #3 had behavioral monitoring in place prior to the incidents in December 2025, which was tracked on the medication administration record (MAR). LPN #1 said staff were expected to provide education, explain situations to the resident, maintain a consistent routine and ensure the residents sat in different areas of the dining room. LPN #1 said after the first incident between Resident #3 and Resident #25 on 12/15/25, the facility implemented 15-minute monitoring checks for Resident #3 for an extended period of time. LPN #1 said staff also remained with Resident #3 during meal times to help prevent additional incidents. The NHA was interviewed on 5/19/26 at 5:40 p.m. The NHA said the facility was responsible for doing the best they could to protect residents from abuse. The NHA said staff received education regarding how to respond to residents with known abusive behaviors. The NHA said that after the first incident between Resident #3 and Resident #25 on 12/15/25, the facility had several conversations with Resident #3 regarding having appropriate conversations with other residents. The NHA said Resident #3 would sometimes talk about being a fighter as part of his personality. The NHA said the facility contacted Resident #3's nephew and asked him to take the resident out for rides as an intervention to help calm the resident. The NHA said the facility offered both residents the option to sit in the private dining area with other residents they got along with so they would not feel isolated from others. The NHA said both residents declined those interventions. The NHA said Resident #25 was doing fine after the incidents and continued to follow with behavioral health services to discuss concerns and behaviors. The NHA said the SSD and the activity director (AD) completed follow-up visits with Resident #25 to ensure his well-being. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	RN #2 was interviewed on 5/20/26 at 10:30 a.m. RN #2 said resident-to-resident verbal abuse should be reported immediately to all appropriate parties, including the physician, the family and the NHA. RN #2 said staff would ensure resident safety by separating the residents involved and initiating 15-minute checks, one-on-one supervision, distraction techniques and using a calm approach. RN #2 said Resident #3 did not respond well when staff talked to the resident like the resident was being blamed. RN #2 said staff should speak to Resident #3 in a calm and softer tone of voice and avoid an accusatory approach. RN #2 said Resident #3 did not do well with male residents. RN #2 said Resident #3 became agitated when people stared at him. RN #2 said interventions for Resident #3, prior to the incidents in December 2025, included encouraging him to verbalize concerns, using a calm approach and reaching out to behavioral health services. RN #2 said the facility reached out to behavioral health services, but Resident #3 refused to speak with behavioral health staff. RN #2 said she remembered speaking with Resident #25 in January 2026 regarding Resident #3's verbal altercations. RN #2 said Resident #25 told her he was not afraid of Resident #3. RN #2 said she could not find documentation of that conversation in the resident's electronic medical record (EMR). The SSD and the NHA were interviewed together on 5/20/26 at 11:15 a.m. The SSD said if she witnessed abuse, she would report it to the NHA and would document interviews with residents. The SSD said she obtained statements from the victim and the assailant. The SSD said she did not interview staff members. The SSD said the care team determined interventions to prevent reoccurrence of incidents. The NHA said she and the director of nursing (DON) interviewed staff members. The SSD said the crisis team was contacted if deemed necessary. The SSD said residents with behaviors were followed closely by social services. The SSD said resident behaviors were monitored through alert charting. The SSD said Resident #3's wife passed away several years ago in December and that triggered him. The SSD said Resident #25 had diagnoses including schizophrenia. The SSD said Resident #25 was not necessarily afraid of Resident #3, but was afraid of what his own actions might be. The SSD said Resident #25 was encouraged not to engage in conversations with Resident #3 and was moved to a different hallway. The NHA said Resident #25 felt targeted and had a history of delusions involving people attacking him while he lived in the community. The SSD said Resident #25 visited his outside counselor once weekly, saw a peer counselor at the facility weekly and talked with a psychiatrist monthly. The SSD said they did not complete a psychosocial assessment with Resident #25 following the verbal abuse incidents. The SSD said post-traumatic stress disorder (PTSD) assessments were completed at admission and during quarterly and annual assessments. The NHA said the facility relied on peer counseling notes and facility observations to implement (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	interventions. The SSD said interventions implemented following the verbal abuse incidents included moving Resident #25 to a different hallway. The SSD said Resident #3 was offered a private dining room. The SSD said Resident #25 was also offered a private dining room. The SSD said they had many conversations with Resident #25 to comfort him and reassured him that he was safe. The SSD said staff reassured Resident #25 that no one could hurt him. The SSD said Resident #25 was observed looking through the window and required reassurance regarding his safety. The NHA said staff encouraged Resident #25 to listen to music and provided him with headphones. The SSD said Resident #25 avoided going to the dining room for meals for approximately three days and ate meals in his room following the 12/21/25 incident. The SSD said there was no documentation indicating whether Resident #25 later returned to eating in the dining room consistently. The SSD said Resident #25 had the choice whether to go to the dining room and the interventions, including 15-minute checks, medication management for Resident #3 and staff interventions were not effective in preventing another verbal altercation between the residents (on 12/21/25). The NHA said Resident #25 had an increase in his Patient Health Questionnaire (PHQ-9 - a tool utilized to determine a resident's level of depression) score following the incidents in December 2025. The NHA said Resident #25 had previously been upset regarding delays related to his surgery and dietary restrictions. The NHA said those concerns may also have contributed to the increase in the resident's PHQ-9 score. LPN #2 was interviewed on 5/20/26 at 1:01 p.m. LPN #2 said that following the incidents between Resident #25 and Resident #3 in December 2025, Resident #25 met with his behavioral health counselor. LPN #2 said Resident #25 told the behavioral health counselor that he was afraid of Resident #3 during that visit. LPN #2 said that after Resident #25 returned from behavioral health appointments, nursing staff reviewed the behavioral health assessment notes. LPN #2 said she remembered asking Resident #25 whether he was afraid of Resident #3 after reviewing the behavioral health note. LPN #2 said Resident #25 told her he was no longer afraid of Resident #3. LPN #2 said Resident #25 had not reported sleep issues to staff or concerns that Resident #3 would try to enter his room. LPN #2 said Resident #25 continued attending meals in the dining room as usual and did not attend meals less frequently following the incidents. The AD was interviewed on 5/20/26 at 2:58 p.m. The AD said she had worked at the facility for two years. The AD said she participated in interdisciplinary team (IDT) meetings that occurred once weekly. The AD said Resident #25 attended group activities and socialized with staff and residents when he felt well. The AD said her notes dated 3/11/26 indicated Resident #25 was not participating in activities as often due to surgery, but still attended activities a few times per week. The AD said Resident #25 enjoyed outings, socializing and music and staff encouraged him to attend more group activities. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The AD said within the last few months, she noticed that Resident #25 had become less active and was not coming out of his room as often. The AD said Resident #25 previously came to speak with her one-on-one consistently, but had not done so recently because he had been hospitalized for surgery and had undergone two knee surgeries. The AD said Resident #25 mentioned that Resident #3 had bothered him in December 2025. The AD said Resident #25 told her he did not want to attend bingo because he was afraid of Resident #3. The AD said she reassured Resident #25 that Resident #3 did not attend bingo. The AD said Resident #25 sometimes attended bingo activities and sometimes declined to attend following the incidents with Resident #3 in December 2025. The AD said she attempted to encourage Resident #25 to attend activities when he reported being tired and sometimes Resident #25 would make excuses not to attend. The AD said she informed the IDT that Resident #25 was not participating in activities and was not as active as he had previously been. The AD said Resident #25 previously attended chapel services regularly, but now only attended approximately half of the time and required encouragement to participate. The AD said Resident #25 attended chapel services approximately three to four times per month. III. Incidents of verbal abuse towards Resident #35 by Resident #3 on 12/23/25 and 12/31/25 A. Facility investigation on 12/23/25 Review of the 12/23/25 facility investigation documented a verbal altercation between Resident #3 and Resident #35. The incident occurred on 12/23/25 in the dining room when Resident #3 passed Resident #35 and called the resident an inappropriate name. An unknown staff member witness said they saw Resident #35 talking to dietary staff and the resident crying when Resident #3 called Resident #35 a big (expletive) baby and said All you do is cry. When interviewed by the facility, Resident #35 began to cry and said Resident #3 was calling her names. She was escorted out of the dining room away from Resident #3. When the facility spoke to Resident #3, he became disruptive, disrespectful and was cursing at staff. He stated he was aware he made nasty comments and stated to staff that he did not feel it was wrong and he did not regret it. He stated he could do whatever he wanted. Staff stayed with Resident #3 until he agreed to leave the dining room. Five residents were interviewed and denied having had issues with Resident #3 being verbally aggressive towards them. Staff interviews were not conducted. Both residents were placed on frequent 15-minute checks. The residents' responsible parties, the police, and the physicians were notified. The facility substantiated the verbal abuse. -However, Resident #3 was already on 15-minute checks following the verbal abuse incident with Resident #25 on 12/21/25 (see above). -Additionally, after the 12/21/25 incident with Resident #25, Resident #3 was supposed to be (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	escorted to and from the dining room as an intervention to prevent further verbal abuse incidents (see above). Cross-reference F610 for failure to correct an alleged violation. B. Facility investigation on 12/31/25 Review of the 12/31/25 facility investigation documented a verbal altercation between Resident #3 and Resident #35. The incident occurred on 12/31/25 in the dining room when Resident #3 began mocking and making fun of Resident #35. The investigation did not reveal what was said between Resident #3 and Resident #35. When interviewed by facility staff Resident #35 again began to cry and said Resident #3 was making fun of her. She was escorted out of the dining room. When staff spoke to Resident #3 he began yelling at the nurse and refused to leave the dining room. Five residents were interviewed and denied having had verbal altercations with Resident #3 or that they were fearful of him. The investigation did not include staff interviews. Both residents were placed on frequent 15-minute checks. The residents' responsible parties, the police, and the physicians were notified. The facility substantiated the verbal abuse. C. Resident #3 (assailant) 1. Resident observation On 5/17/26 at 5:00 p.m. Resident #3 was observed entering the dining room unescorted by a staff member. -However, following the verbal abuse incidents in December 2025, interventions included Resident #3 was to be escorted in and out of the dining room and was to sit in an area that would not trigger negative behaviors (see investigations above). 2. Resident interview Resident #3 was interviewed on 5/19/26 at 4:00 p.m. Resident #3 he did not recall having any negative interactions with Resident #35 on 12/23/25 and 12/31/25. 3. Record review -Review of Resident #3's dementia and behavioral care plan, initiated 5/17/22 and revised 2/3/26, did not include the interventions implemented to prevent further verbal abuse incidents (see investigations above). D. Resident #35 (victim) 1. Resident status (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #35, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the May 2026 CPO, diagnoses included morbid obesity due to excess calories, unspecified intellectual disabilities, depression and seizures. The 4/7/26 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of three out of 15. The MDS assessment indicated the resident did not have behaviors that impacted others. The MDS assessment indicated the resident felt down, depressed, or hopeless, and had little interest or pleasure in doing things for two to six days during the assessment look-back period. 2. Resident interview Resident #35 was interviewed on 5/17/26 at 3:00 p.m. Resident #35 said Resident #3 would call her names that made her cry several times. She said she was not afraid of him but she stayed away from him, especially in the dining room. She said where she now sat in the dining room, her back was toward him so she did not have to look at him. She said he was not a nice man and yelled quite a bit. 3. Record review Review of the communication care plan, initiated 10/3/14 and revised 5/16/24, revealed Resident #35 had limited verbal ability but used smiling, hugging, and holding hands with staff as a form of communication and validation. Interventions included for staff to be aware that this was her form of communication, but due to low cognitive function she would also swing from happiness to sadness as a way of communication and getting her needs met. Review of the vulnerability care plan, initiated 3/13/24 and revised 10/23/25, revealed Resident #35 was at risk of being easily influenced by other residents to the detriment of her own care and wellbeing. Interventions included that the resident needed to be monitored when visiting with residents in their rooms or at daily activities. The resident was vulnerable and should be protected from others who used her to express their own wants or needs. Review of the behavior/trauma care plan, initiated 1/11/16 and revised 4/22/25, revealed Resident #35 had a history of sexual abuse from childhood. She would at times exhibit verbal aggression, self isolation, crying and sadness. Interventions included allowing the resident time to vent and express herself and cry, offering reassurance and attempting to find out what triggered the episode and having the resident removed from the present situation and taken to a private quiet area. Review of the at-risk for abuse care plan, initiated 8/7/25 and revised on 9/30/25, revealed Resident #35 was at risk for abuse related to a diagnosis of intellectual disabilities. The resident could become upset if other residents made derogatory remarks at her. Interventions included assessing the resident regularly and as needed for signs of abuse, investigating any concern or change in functional or mental status as those could be a sign of abuse and observing for and reporting any changes in mental status caused by situational stressors. -The care plan failed to identify the episodes of verbal aggression by Resident #3 towards Resident #35 on 12/23/25 and 12/31/25 (see facility investigations above) and the interventions implemented to prevent further verbal abuse incidents. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #35's EMR, from 12/23/25 to 12/31/25, revealed the following; Review of the December 2025 behavior monitoring documentation revealed Resident #35 had three episodes of crying and sadness on 12/23/25, the date of the first verbal abuse incident with Resident #3. The 12/23/25 nurse progress note revealed Resident #35 was sitting in the dining room when Resident #3 entered the dining room and passed Resident #35's table. Resident #3 told Resident #35You are a big (expletive) baby, all you do is cry. When staff intervened, Resident #3 became disrespectful and unable to be redirected and began cursing at staff and refusing to leave the dining room. Staff stayed with him until he agreed to leave the dining room. Resident #3 said he knew he made the comment because he could do what he wanted. After the incident, Resident #35 was tearful. -Review of Resident #35's EMR failed to reveal documentation of the incident with Resident #3 on 12/31/25. -Further review of Resident #35's EMR revealed no social services involvement or documentation entries related to the two verbal abuse incidents in December 2025 between Resident #3 and Resident #35. E. Staff interviews LPN #1 was interviewed on 5/19/26 at 10:15 a.m. LPN #1 said she witnessed the verbal incidents between Resident #35 and Resident #3 (on 12/23/25 and 12/31/25. She said Resident #3 had mocked Resident #35 and when Resident #35 told Resident #3 to be quiet, he called her a fat (expletive). She said Resident #35 came to nursing staff and complained about Resident #3 because he was calling her names. She said there had not been any recent incidents between the two residents that she knew of and Resident #35 was not afraid of Resident #3 and would try to stand up for herself. LPN #1 said since the incidents in December 2025, Resident #35 had moved to a different table in the dining room to not be in close proximity to Resident #3. She said any form of abuse, whether it was resident-to-resident or staff-to-resident,

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on record review and interviews, the facility failed to take appropriate corrective actions, as a result of abuse investigations, for four of nine abuse allegations. Specifically, the facility failed to take appropriate corrective action following the investigations of four verbal abuse incidents by Resident #3 towards Resident #25 on 12/15/25 and 12/21/25, and Resident #35 on 12/23/25 and 12/31/25, to ensure that verbal abuse did not recur.Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigating policy and procedure, revised 9/22, was provided by the nursing home administrator (NHA) on 5/21/26 at 11:32 a.m. It read in pertinent part, All allegations are thoroughly investigated. The administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation. The individual conducting the investigation reviews the documentation as evidence, reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident, observes the alleged victim, interviews the person reporting the incident, interviews any witnesses, interview the resident, interview staff members, interview the staff member who had contact with the resident, reviews all events leading up to the alleged incident and documents the investigation completely and thoroughly. II. Incidents of verbal abuse between Resident #25 and Resident #3 on 12/15/25 and 12/21/25 The investigations of the resident-to-resident altercations between Resident #25 and Resident #3 on 12/15/25 and 12/21/25 were provided by the NHA on 5/18/26 at approximately 2:00 p.m. A. 12/15/25 facility investigation The facility's abuse investigation, dated 12/15/25, documented that at approximately 5:40 p.m. Resident #25 and #3 were in the dining room eating dinner when a verbal altercation occurred. Resident #3 was walking out of the dining room and Resident #25 looked at Resident #3, which triggered Resident #3 and Resident #3 began yelling foul language at Resident #25. The situation escalated and both residents started yelling at each other. During the altercation, both residents held silverware in a threatening manner. There was no physical contact between the residents during the altercation. The facility staff separated both residents prior to notifying law enforcement. They provided Resident #25 with emotional support. Resident #25 was interviewed and said he would avoid Resident #3. Resident #3 was interviewed and said he did not remember the verbal altercation. The investigation revealed facility staff did not observe changes in Resident #25's behavior following the incident and he remained at baseline. The investigation revealed that five other residents were interviewed and they did not report any ongoing safety concerns.The investigation documented that the facility substantiated that the allegation of resident-to-resident verbal abuse occurred.The interventions implemented after the incident for both residents included continued 15-minute checks, adjusting Resident #3's medications and educating staff regarding de-escalation techniques.-However, the investigation failed to reveal documentation of the education provided to staff regarding de-escalation techniques as a corrective action in order to prevent a recurrence of verbal abuse.Cross-reference F600 for failure to keep residents free from abuse.B. 12/21/25 facility investigationThe facility's abuse investigation, dated 12/22/25, revealed that on 12/21/25 at 5:35 p.m. a verbal altercation occurred in the dining room between Resident #25 and #3. Resident #3 walked into the dining room to eat dinner and said to Resident #25 he was a fat (expletive word) and that he was going to kick his (expletive word). Resident #25 yelled back at Resident #3 using foul language. An unknown registered nurse (RN) entered the dining room, separated the residents, ensured the safety of the residents and contacted law enforcement. At that time, both residents denied feeling fearful.The investigation revealed both residents were already on 15-minute checks prior to the altercation. Due to the occurrence, Resident #3 was escorted to and from meals.The following morning, Resident #25 said he could not ignore it anymore because Resident #3 kept coming for him and would not leave him alone. Resident #25 said he would slit Resident #3's throat if he came for him again. Staff educated Resident #25 that the statement was inappropriate and he said he (continued on next page)

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