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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review and staff interview, the facility failed to store, prepare, distribute and serve food in a sanitary manner in the main kitchen.Specifically, the facility failed to:-Maintain the kitchen in a sanitary condition;-Maintain the ice machine in a sanitary condition; and,-Ensure food items were properly covered, labeled, dated and discarded within appropriate use-by timeframes.Findings include:I. Failure to maintain the kitchen in a sanitary conditionA. Professional referenceThe Colorado Retail Food Establishment Regulations, (3/16/24), retrieved on 5/27/26, read in pertinent part, The physical facilities shall be cleaned as often as necessary to keep them clean. (6-501.12) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (4-601.11) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. (4-601.11) The premises shall be free of items that are unnecessary to the operation or maintenance of the establishment. (6-501.114)B. ObservationsThe initial tour of the kitchen was completed on 5/17/26 at 1:05 p.m., and revealed the following: -There was food debris and grease buildup on the floor beneath the steam table and oven area in the kitchen.-There were three unopened butter cups underneath the steam table.-There was dark brown residue, unidentified debris buildup and dirt accumulation underneath the steam table and near the wheels.C. Staff interviewsThe food service supervisor (FSS) was interviewed on 5/19/26 at 1:33 p.m. The FSS said the dietary completed sweeping daily at the end of each meal. The FSS said dietary aides took turns cleaning and staff knew their responsibilities based on the kitchen duty schedule. The FSS said the staff performed spot sweeping and the staff swept and mopped the kitchen after each meal and each night and he reminded them again during the survey. The FSS said failure to keep the kitchen clean could lead to rodents, mold and odors.Dietary aide #2 was interviewed on 5/19/26 at 1:40 p.m. Dietary aide #2 said staff swept the kitchen floors after every meal, including the dish room and the dining room. Dietary aide #2 said the cook was responsible for cleaning the kitchen floors.Dietary aide #3 was interviewed on 5/19/26 at 3:30 p.m. Dietary aide #3 said she followed daily cleaning tasks, swept the floors after each meal and mopped daily.II. Failure to maintain the ice machine in a sanitary conditionA. Professional referenceThe Colorado Retail Food Establishment Regulations, (3/16/24), retrieved on 5/27/26, read in pertinent part, Equipment food-contact surfaces and utensils shall be clean to sight and touch. (4-601.11) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. (4-601.11)B. ObservationsThe initial tour of the kitchen was completed on 5/17/26 at 1:05 p.m., and revealed the following: The ice machine had dirt and debris buildup that was gray in color on the upper interior portion of the ice dispensing opening and on the interior surface near the top of the door. A second observation of the kitchen was conducted on 5/19/26 at 1:20 p.m. Observations identified the same concerns as identified on 5/17/26 during the initial tour. C. Staff interviewsThe dietary manager (DM) was interviewed on 5/19/26 at 1:26 p.m. The DM said the dietary staff cleaned the ice machine weekly and reported any dirt, debris or maintenance concerns to the FSS. The DM said the dietary staff notified maintenance if there were major issues. The DM said dirt and debris could come into contact with the ice, contaminate the ice and cause residents to become sick.The FSS was interviewed on 5/19/26 at 1:33 p.m. The FSS said dietary aides were responsible for cleaning the ice machine every Wednesday. The FSS said he did not think they cleaned the ice machine the previous Wednesday because gray lint buildup was present on the interior surfaces of the ice machine. The FSS said the ice machine was sanitized monthly by either him or maintenance staff. The FSS said if maintenance staff could not sanitize the ice machine, he cleaned it. The FSS said he sanitized the ice machine on 4/28/26.Dietary aide #2 was interviewed on 5/19/26 at 1:40 p.m. Dietary aide#2 said she would notify the FSS if she observed dirt or debris buildup in the ice machine. Dietary aide #2 said she would ask the FSS before cleaning the ice machine and would clean it if the FSS approved. Dietary aide #2 said cleaning kitchen (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	equipment was everyone's responsibility.Dietary aide #3 was interviewed on 5/19/26 at 3:30 p.m. Dietary aide #3 said the ice machine was cleaned weekly and the staff member assigned to duty cleaned it. Dietary aide #3 said she received initial food safety and kitchen sanitation training during orientation and attended monthly in-service training.The maintenance director was interviewed on 5/20/26 at 5:07 p.m. The maintenance director said maintenance staff sanitized the ice machine monthly and dietary staff cleaned it daily. The maintenance director said the filter contained a gauge that alerted staff when replacement was needed. The maintenance director said the ice machine was last sanitized in April 2026 and was due for cleaning again this month. The maintenance director said staff cleaned the entire ice machine during the monthly sanitizing process.III. Failure to properly label, cover and discard expired food itemsA. Professional referenceThe Colorado Retail Food Establishment Regulations, (3/16/24), retrieved on 5/27/26, read in pertinent part, Food shall be protected from contamination by storing the food in a clean, dry location and, where it is not exposed to splash, dust, or other contamination. (3-305.11) Working containers holding food or food ingredients that are removed from their original packages for use in the food establishment shall be identified with the common name of the food. (3-302.12) Refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded. (3-501.17) A food specified in 3-501.17(A) or (B) shall be discarded if it exceeds the temperature and time combination specified, is in a container or package that does not bear a date or day, or is inappropriately marked with a date or day that exceeds the temperature and time combination. (3-501.18)B. ObservationsThe initial tour of the kitchen was completed on 5/17/26 at 1:05 p.m., and revealed the following: -A tray containing 10 individual portions of banana pudding cake was observed in the walk-in refrigerator without a protective covering, wrapping or label.There were multiple food items and drinks observed in the dining room refrigerator beyond their use-by or discard dates. -One opened container of thickened cranberry cocktail was dated 4/30/26;-One container of cranberry juice had a use-by date of 5/15/26;-One container of orange juice had a use-by date of 5/16/26;-Six containers of cantaloupe were dated 5/11/26;-Ten cups of Jello were dated 5/5/26;-Seven cups of butterscotch pudding were dated 5/14/26; and,-One pitcher containing a beverage was observed stored in the refrigerator without a label or date.-The thickened cranberry, cantaloupe, Jello and butterscotch pudding dates did not indicate if it was a preparation date or use by date.During dinner observation on 5/17/26, the following was observed:At 5:20 p.m. dietary aide #1 filled Resident #30's pitcher with cranberry beverage and returned the pitcher to the refrigerator after filling it.At 5:23 p.m. dietary aide #1 removed Resident #30's pitcher from the refrigerator and placed it on the meal tray cart for delivery to Resident #30.C. Staff interviewsThe FSS was interviewed on 5/19/26 at 1:23 p.m. The FSS said dietary aide #1 prepared the banana pudding the night before. The FSS said dietary aide #1 forgot to wrap and date the dessert because he started working at the facility approximately two weeks ago. The FSS said dietary aide #2 provided training to dietary aide #1. The FSS said he expected staff to label and date food items to prevent contamination.The FSS and the DM were interviewed together on 5/19/26 at 1:33 p.m. The FSS said he used a reference sheet to determine how long food items remained safe and how they should be labeled. The FSS said cantaloupe cups were good for five days and the containers of cantaloupe should have been discarded on 5/16/26. The FSS said he did not know how long Jello remained good once prepared and said he would look it up online. The FSS said pudding was good for two days and the containers of pudding in the refrigerator should have been discarded on 5/16/26. The FSS said the 4/30/26 date on the thickened cranberry cocktail container was the received date. The FSS said the thickened cranberry cocktail was good for seven days and should have been discarded after seven days. The FSS said he discarded the expired food items. The DM said unlabeled food items could not be properly monitored for safety because staff would not know how old the items were. The DM services said unwrapped food items could become contaminated and cause illness.Dietary aide #2 was interviewed on 5/19/26 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	at 1:40 p.m. Dietary aide #2 said she labeled prepared drinks with the date the item was prepared. Dietary aide #2 said, for example, orange juice remained good for three days and she labeled the container with a three-day discard date.Dietary aide #3 was interviewed on 5/19/26 at 3:30 p.m. Dietary aide #3 said she covered and dated food and dessert items immediately after preparation. Dietary aide #3 said the staff member who prepared the item was responsible for labeling and dating it. Dietary aide #3 said if she observed an unlabeled item, she would ask staff when the item was prepared and if she could not determine when it was made, she would discard the item for safety reasons. Dietary aide #3 said she checked dates on food items to identify expired FSS and discarded items after three days. Dietary aide #3 said she would discard Jello if it became watery, even if the item had not expired.

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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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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 investigation documented that the facility substantiated that the allegation of resident-to-resident verbal abuse occurred.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 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). The 12/15/25 interventions proved to be ineffective in preventing the second verbal abuse incident between Resident #3 and Resident #25 on 12/21/25.-Additionally, the facility failed to determine an appropriate corrective action following the 12/15/25 and 12/21/25 verbal abuse incidents with Resident #25 in order to prevent a third occurrence of verbal abuse involving Resident #3 (towards Resident #35 -see below). III. Incidents of verbal abuse between Resident #35 and Resident #3 on 12/23/25 and 12/31/25The investigations of the resident-to-resident altercations between Resident #35 and Resident #3 on 12/23/25 and 12/31/25 were provided by the NHA on 5/18/26 at approximately 2:00 p.m. A. 12/23/25 facility investigationThe facility's investigation report revealed that on 12/23/25 at 12:18 p.m. Resident #3 was escorted with a nurse to the back of the dining room to a single table. Resident #3 sat for a short time by himself with the kitchen staff. Resident #3 called Resident #35 a big (expletive) baby and told Resident #35 All you do is cry. Resident #3 mumbled to himself and staff asked Resident #3 to stop. When Resident #3 did not stop, the charge nurse and the director of nursing (DON) went to the dining room to talk to the resident. Resident #3 was not respectful or redirectable. Resident #3 continued to be disruptive in the dining room, swearing at staff and making comments and refusing to leave the dining room, eat in his room, keep his comments to himself and be kind to others. Staff stayed with Resident #3 until he agreed to leave and go to his room. Resident #35 cried when Resident #3 cursed at her. The facility substantiated the verbal abuse.Cross-reference F600 for failure to keep residents free from abuse.Interventions implemented after the incident included placing both residents on 15-minute checks, moving them to a separate hallway, and offering behavioral health services. Additional interventions included assisting Resident #3 to and from the dining room, additional observation while in the dining room, offering meals in the private dining room, offering extra behavioral health visits during the holidays as his behaviors may be due to depression due to missing his spouse, medications adjusted and recent gradual dose reduction (GDR). -However, 15-minute checks, assisting Resident #3 to and from the dining room and medication adjustments were implemented following the 12/21/25 incident with Resident #25 (see above), before the 12/23/25 incident with Resident #35. -There was no documentation behavioral health services were offered to Resident #3 until 1/28/26, more than 30 days after the incident. -The investigation failed to reveal documentation of education provided to staff regarding the interventions implemented, including additional observations while in the dining room and offering meals in the private dining room. -A review of Resident #3's electronic medical record (EMR) revealed there was no documentation to offer meals to the resident in the private dining room.-The facility failed to determine an appropriate corrective action following the 12/15/25 and 12/21/25 verbal abuse incidents with Resident #25, and the 12/23/25 verbal abuse incident with Resident #35, which resulted in a fourth verbal abuse incident involving Resident #3 (again towards Resident #35) seven days later (see below).B. 12/31/25 facility investigationReview 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 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.-The facility identified and substantiated four incidents of verbal abuse involving Resident #3. However, the facility failed to identify appropriate corrective actions to prevent further incidents of verbal abuse involving Resident #3. IV. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 5/19/26 at 2:17 p.m. LPN #2 said she reported abuse to the NHA. LPN #2 said she should report abuse as soon as the residents were determined to be safe. She said once abuse was reported, an investigation was started by the nurse and then the NHA and the DON completed the investigation. LPN #2 said she started the investigation by writing what happened, notifying the physician, the police and the resident's representative. LPN #2 said she knew what interventions were put into place by verbal communication. LPN #2 said there was a communication section in the facility's electronic records system for nurses to read at the start of their shift. LPN #2 said she was not sure if certified nurse aides (CNA) or other departments had access to the communication section. LPN #2 said she was not educated on resident-specific interventions to prevent resident-to-resident altercations, but there was online training that reviewed different interventions for the staff to try.The interim DON was interviewed on 5/20/26 at 3:15pm. The interim DON said abuse should be reported to the NHA as soon as possible. She said once abuse was reported, the nurse should start an incident file including what was done to keep the residents safe, notifying the physician, the resident's representative, the NHA and the DON. The interim DON said there should be a statement obtained from the assailant, the victim and any witnesses. The interim DON said there should be documentation of the statements obtained. The interim DON said the interventions to keep the resident safe should be documented in the resident's care plan and Kardex (an abbreviated care plan). The interim DON said the interviews should have a date, time and signature of who completed the interviews and the statements. She said the statements should be by the assailant, the victim or the witness if possible and it should have the date and the time when the statements were obtained. The interim DON said when she was a DON, she would complete the staff interviews and she interviewed whoever was working including nursing, dietary staff and housekeeping. She said she used the incident report to document initial interventions to keep all pertinent information in one place. The interim DON said there should be an interdisciplinary team (IDT) discussion the following day after the alleged abuse to determine what additional interventions should be in place. She said she did that so the residents' care plans were updated at the same time. The interim DON said she started working at the facility on 5/17/26, and she was not very familiar with the incidents involving Resident #3. The interim DON said she reviewed the incident reports for the verbal abuse incidents between Resident #25 and Resident #3 on 12/15/25 and 12/21/25 and the verbal abuse incidents between Resident #35 and Resident #3 on 12/23/25 and 12/31/25. She said the investigation was not thorough because it was not clear on what interviews were completed, what statements were obtained or how staff were educated on the interventions to keep the residents safe and to prevent a recurrence. The NHA was interviewed on 5/19/26 at 5:05 p.m. The NHA said staff reported abuse to the NHA. The NHA said staff should report abuse as soon as the residents were determined to be safe. She said once abuse was reported, an investigation was started by the nurse and then the NHA and the DON completed the investigation. The NHA said the nurse was responsible for documenting what happened, notifying the physician, the police and the resident's representative. The NHA said staff knew what interventions were put into place by verbal communication and. The NHA said nurses had access to a communication section in their electronic records system for nurses to read at the start of their shift. The NHA said CNAs or other departments did not have access to the communication section and a paper communication binder was used for educating CNAs. The NHA said investigating an alleged abuse was divided between the DON and herself. She said sometimes the SSD helped as well. The NHA said the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	questions asked were standard depending on the type of abuse. The NHA said if the type of abuse was verbal, there was a standard set of questions to ask staff and residents. The NHA said staff were interviewed who worked in the unit, were familiar with the resident and included housekeeping and dietary staff. The NHA said the unit nurses determined the initial intervention.The NHA said she did not know if she had access to the electronic records for the communication page to show how nurses were educated. The NHA said she would look to see how CNAs were educated. The NHA was interviewed a second time on 5/20/26 at 9:30 a.m. The NHA said she was unable to locate the electronic records for the communication page to show how the nurses were educated. The NHA said the interventions should be care planned and said the care plans for Resident #25, Resident #35 and Resident #3 could use improvement to reflect the interventions that were put into place after the resident-to-resident altercations in December 2025.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **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 chemical restraints for one (#7) of five residents out of 24 sample residents. Specifically, the facility failed to ensure Resident #7, who was receiving an antipsychotic medication, received appropriate monitoring to ensure signs and symptoms of tardive dyskinesia (involuntary movements that can be caused by taking antipsychotic medications) did not worsen.Findings include: I. Professional reference According to the National Institute of Health (NIH) National Library of Medicine's Impact of A Pharmacist-Driven Tardive Dyskinesia Screening Process (7/16/21), retrieved on 5/26/26 from https://pmc.ncbi.nlm.nih.gov/articles/PMC8287863/#s1, According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), tardive dyskinesia (TD) is defined as involuntary movements generally of the tongue, lower face, jaw, torso, and extremities that are developed from the use of antipsychotics. These movements can either be choreiform (rapid and jerky) or athetoid (slow, snakelike, and writhing). Tardive dyskinesia (TD) is defined as involuntary movements that can develop with prolonged antipsychotic use. Several studies have investigated risk factors that may be associated with tardive dyskinesia, including age, sex, and long-term antipsychotic use. II. Facility policy and procedure The Psychotropic Medication Use policy and procedure, revised February 2025, was provided by the nursing home administrator (NHA) on) on 5/21/26 at 11:32 a.m. It read in pertinent part, Residents are monitored for adverse consequences associated with psychotropic medications, including neurologic effects such as agitation, distress, extrapyramidal symptoms, neuroleptic malignant syndrome, Parkinsonism, tardive dyskinesia and cerebrovascular events. If a psychotropic medication is identified as possibly causing or contributing to adverse consequences, the prescriber will determine whether the medication should be discontinued. If the medication is not discontinued, the rationale for this decision must be documented.III. Resident #7A. Resident status Resident #7, age [AGE], was admitted on [DATE]. According to the May 2026 computerized physician orders, diagnosis included type 1 diabetes mellitus with ketoacidosis, mild cognitive impairment, bipolar disorder and hypertension. The 3/11/26 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 used a cane. He required supervision with eating, oral hygiene, toileting, showering and personal hygiene.The MDS assessment revealed the resident had received antipsychotic medications during the seven-day assessment look-back period. B. Resident interview and observation Resident #7 was interviewed on 5/18/26 at 10:08 a.m. During the interview, Resident #7 was smacking his lips. At the end of the interview, Resident #7 said he had noticed his lips smacking over the last couple of months. He said it was annoying when his lips smacked and the facility did not tell him what they were doing to help him not smack his lips. C. Record review The psychotropic and anticonvulsant care plan, initiated on 5/21/25 and revised on 6/28/25, revealed Resident #7 took psychotropic medications related to his bipolar disorder. Interventions included monitoring for behaviors, administering medications per physician orders, and observing closely for side effects of quetiapine, including extrapyramidal symptoms (EPS), such as tremors, restlessness, and involuntary movement of mouth or tongue and periodically complete the AIMS (abnormal involuntary movement scale) evaluation for EPS. Review of Resident #7's 4/28/26 AIMS assessment revealed a score of 13, indicating the resident's movements were clear, prominent and widespread. The assessment revealed the resident had moderate facial and oral movements around his lips and perioral area, such as smacking, around his jaw, such as biting and mouth opening and around his tongue. His lower legs were moderate movements, such as foot tapping. The assessment revealed the resident was aware of mild distress. -However, according to record review and interviews, Resident #7 had been exhibiting signs of tardive dyskinesia prior to 4/28/26 (see interviews and record review below). (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #7's May 2026 CPO revealed the following physician's orders related to antipsychotic medications: Depakote extended release (ER) 500 milligrams (mg) tablet. Take two tablets by mouth at bedtime for bipolar disorder, ordered 12/6/25. Seroquel 25 mg tablet. Take three tablets by mouth at bedtime, ordered 12/9/25. Haldol 1mg. Take one tablet by mouth every eight hours as needed for agitation related to bipolar mania for 14 days, ordered 5/18/26. Monitor the following agitation behaviors. Takes Haldol as needed every shift for 14 days, ordered 5/18/26. Monitor the following behaviors related to Seroquel: agitation, increase in complaints, elopement, delusions, aggressions, ordered 9/25/25. Observe closely for side effects of Seroquel, including dry mouth, constipation, blurred vision, disorientation, confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea, vomiting, lethargy, drooling, EPS symptoms, every shift, ordered 4/28/25. Review of Resident #7's electronic medical record (EMR) revealed nursing staff observed the resident's lip smacking on 3/11/26, 3/17/26, 3/26/26, 4/15/26, 5/4/26 and 5/18/26. -However, according to staff interviews and record review, Resident #7's physician was not notified that the resident was exhibiting symptoms of tardive dyskinesia. -A review of Resident #7's EMR did not reveal any documentation to indicate the resident had not been seen by a psychiatrist or behavioral health consultant related to his diagnosis or his tardive dyskinesia since 3/18/26.IV. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 5/19/26 at 2:17 p.m. LPN #2 said she was familiar with Resident #7. She said when Resident #7 had a side effect from a psychotropic medication, she documented the side effect on the resident's treatment administration record (TAR) and as a progress note. LPN #2 said she had not seen Resident #7 smack his lips for a while. LPN #2 said she thought he smacked his lips when he took Haldol. LPN #2 said an AIMS assessment was completed quarterly when a resident was on antipsychotic medications. She said the assessment determined if the resident exhibited signs of tardive dyskinesia. LPN #2 said the assessment was done on the computer and if the resident's score indicated signs of tardive dyskinesis, she was not sure what the next step was. LPN #2 said she thought the director of nursing (DON) reviewed all AIMS assessments. LPN #2 said if she noticed tardive dyskinesia, she would document it on the TAR and notify the physician. She said the physician was notified because the physician could look at the resident's medications to see if there were any recommendations to change the resident's medications. The interim DON was interviewed on 5/20/26 at 3:15pm. She said an AIMS assessment was completed at admission, when a resident started a new antipsychotic medication and every six months. The interim DON said an AIMS assessment was completed to monitor for adverse reactions from antipsychotic medications. She said if a resident scored high, the physician was notified to see if a medication should be slowly titrated before starting a new medication. The interim DON said if a nurse noticed a side effect from a psychotropic medication, the nurse should notify the physician so the physician could assess and determine the best recommendation to reduce the adverse effects. She said nurses should document side effects observed and the physician notification as a progress note. The interim DON said she started working at the facility on 5/17/26 and she was not familiar with Resident #7. She said she would look into the resident's medical record. V. Facility follow upOn 5/20/26 at 4:28 p.m. the interim DON completed a new AIMS assessment for Resident #7 which revealed the resident scored a two. The interim DON said despite the resident's AIMS score being lower, the nurses who observed the lip smacking on 3/11/26, 3/17/26, 3/26/26, 4/15/26, 5/4/26 and 5/18/26 should have notified the physician about the symptoms.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide and document sufficient discharge preparation for one (#22) of one resident reviewed for a safe and orderly discharge out of 24 sample residents.Specifically, the facility failed to ensure a written bed hold notice was provided to Resident #22 and/or her representative at the time of the resident's transfer to the hospital.Findings include:I. Facility policy and procedureThe Bed-Holds and Returns policy, revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 11:57 a.m. It read in pertinent part, All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice at the time of transfer (or, if the transfer was an emergency, within 24 hours). The written bed-hold notices provided to the residents/representatives explain in detail: the duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility; the reserve bed payment policy as indicated by the state plan (forMedicaid residents); the facility policy regarding bed-hold periods; the facility per-diem rate required to hold a bed (for non-Medicaid residents), or to hold a bed beyond the state bed-hold period (for Medicaid residents); and the facility return policy. The requirement that residents be permitted to return to the facility following hospitalization or therapeutic leave applies to all residents regardless of payer source. Residents who seek to return to the facility within the bed-hold period defined in the state plan are allowed to return to their previous room, if available. Residents who seek to return to the facility after the state bed-hold period has expired are allowed to return to their previous room if available or immediately to the first available bed in a semi-private room provided that the resident still requires the services provided by the facility and is eligible for Medicare skilled nursing facility or Medicaid nursing facility services.II. Resident #22A. Resident statusResident #22, age greater than 65, was admitted on [DATE], readmitted on [DATE] and transferred to the hospital on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), mild intermittent asthma, acute upper respiratory infection and respiratory syncytial virus (RSV).The [DATE] minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The resident had no impairment of her upper or lower extremities and used a wheelchair for mobility. She required partial to moderate staff assistance with activities of daily living (ADL). B. Record reviewReview of Resident #22's [DATE] CPO revealed a physician's order, dated [DATE], to transfer the resident to the emergency room for evaluation and treatment of low oxygen saturation, cough, and shortness of breath. The [DATE] at 11:00 a.m. nursing progress note revealed Resident #22 was experiencing increased cough, shortness of breath and she was in respiratory distress. She was transported to the hospital for evaluation.Review of Resident #22's electronic medical record (EMR) profile revealed she was her own responsible party. -Review of Resident #22's EMR revealed no documentation to indicate Resident #22 and/or her representative were provided with a written bed hold notice at the time of the resident's transfer to the hospital on [DATE].III. Staff interviewsRegistered nurse (RN) #1 was interviewed on [DATE] at 2:00 p.m. RN #1 said Resident #22 was transferred to the hospital around lunch time on [DATE] for respiratory distress. She said the resident had several instances in the past where she had to be transported to the hospital for respiratory issues and the most recent occurrence was in [DATE]. She said she did not know that a bed hold form had to be completed with the resident prior to her being transported to the hospital. She said she had not been made aware of the form and did not know what was required on the form.The social services director (SSD) was interviewed on [DATE] 8:25 a.m. The SSD said it was her (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsibility to complete a bed hold form when a resident required a transfer to the hospital. She said the resident or their responsible party were to sign the form that indicated they understood the bed hold policy. She said Resident #22 was her own responsible party and she did not complete a bed hold form with the resident when she was transferred to the hospital (on [DATE]). She said at the time of Resident #22's transfer, getting the bed hold form signed did not cross her mind, and she did not notify the facility's frequent visitor of the transfer. She said she had not implemented a good process for completion of the bed hold form for the long-term care residents when they required a hospital transfer. The frequent visitor was interviewed on [DATE] at 8:47 a.m. The frequent visitor said he was not notified that Resident #22 had been transferred to the hospital on [DATE]. He said he received notices when a resident was discharged home, but he was not normally notified of hospital transfers unless there was a reportable incident associated with the transfer.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents who required respiratory care received care consistent with professional standards of practice for one (#10) of two residents out of 24 sample residents.Specifically, the facility failed to maintain, clean, sanitize and properly store Resident #10's nebulizer machine (breathing treatment device) and mask.Findings include:I. Resident #10A. Resident statusResident #10, age [AGE], was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (chronic lung disease), dependence on supplemental oxygen, and hypertension (high blood pressure).The 3/3/26 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. The MDS assessment documented the resident used continuous oxygen therapy.B. Resident interview and observationsResident #10 was interviewed on 5/17/26 at 3:20 p.m. Resident #10 said he did not know how often staff cleaned his nebulizer mask.Resident #10's nebulizer machine was observed on the television stand in the resident's room. The nebulizer mask had visible brown residue buildup inside it.On 5/18/26 at 2:35 p.m. Resident #10's nebulizer machine remained on the television stand in the resident's room. The nebulizer mask had not been cleaned. The mask had visible brown residue buildup inside it and was greasy. Resident #10 said he did not know whether staff cleaned the nebulizer equipment after use.C. Record reviewA review of Resident #10's May 2026 CPO revealed the following physician's order:-Albuterol Sulfate nebulization solution (2.5 milligrams/3 milliliters) 0.083%, one vial inhale orally via nebulizer, ordered on 5/6/26.-However, there were no physician's orders for cleaning, sanitizing or storing the nebulizer equipment.Resident #10's respiratory care plan, initiated 2/27/26, revealed Resident #10 had an impaired respiratory status. Pertinent interventions included administering medications as ordered, monitoring for signs and symptoms of respiratory distress and reporting to the physician, monitoring lung sounds for wheezing or crackles as needed, providing oxygen as needed when the resident exhibited signs and symptoms of difficulty breathing and treatments as ordered by the physician.-The care plan failed to include interventions related to cleaning, sanitizing or storing the resident's nebulizer equipment.II. Staff interviewsCertified nurse aide (CNA) #3 was interviewed on 5/19/26 at 9:43 a.m. CNA #3 said nurses were responsible for sanitizing nebulizer equipment. CNA #3 said nebulizer equipment was usually taken apart and cleaned between treatments. CNA #3 said brown residue buildup inside a nebulizer mask was not sanitary. CNA #3 said if a resident's respiratory equipment was dirty, she would notify the nurse and obtain new equipment.Licensed practical nurse (LPN) #1 was interviewed on 5/19/26 at 9:54 a.m. LPN #1 said nurses were responsible for rinsing nebulizer equipment. LPN #1 said nebulizer equipment should be rinsed, taken apart and allowed to air dry after breathing treatments. LPN #1 said the night shift changed the nebulizer tubing and masks and provided a new one. LPN #1 said visible residue buildup inside nebulizer masks created a risk that the resident could inhale contaminants. LPN #1 said Resident #10's nebulizer treatment was ordered every six hours as needed and the resident's last breathing treatment was administered on 5/5/26, during the night shift. LPN #1 said staff should discard nebulizer equipment with visible buildup or contamination and obtain new equipment.The nursing home administrator (NHA) was interviewed on 5/19/26 at 10:55 a.m. The NHA said oxygen tubing changes were documented, however nebulizer equipment cleaning was not documented. The NHA said nursing staff received infection control training through SNF (skilled nursing facility) Clinic as needed. The NHA said respiratory equipment with visible buildup should be replaced because it was important for infection control. The NHA said nurses were responsible for ensuring nebulizer equipment remained clean and sanitary after each use. The NHA said Resident #10's nebulizer mask should have been discarded and replaced with a new mask.

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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 (#37) of one resident reviewed for pain out of 24 sample residents. Specifically, the facility failed to:-Ensure a thorough pain assessment was completed that identified Resident #37's history of pain and its treatment, history of addiction, characteristics of pain and the impact of pain on the resident's quality of life; -Identify Resident #37's goals for pain management and the resident's acceptable level of pain; -Ensure Resident #37's location of pain was consistently identified when administering pain medication to the resident; and, -Ensure Resident #37's pain medication was administered as ordered and needed, based on the resident's observed status.Findings include: I. Facility policy and procedure The Pain Assessment and Management policy and procedure, revised April 2025, was provided by the nursing home administrator (NHA) on 5/21/26 at 11:32 a.m. It read in pertinent part, Pain assessments should include the resident's pain history and prior treatments, including pharmacological and non-pharmacological interventions. The assessment should identify whether the pain is acute, subacute, or chronic and evaluate pain characteristics such as location, intensity, description, pattern, frequency, timing, and duration. The assessment should also address the impact of pain on function, mobility, mood, sleep, and quality of life; factors that worsen or relieve pain; associated symptoms; history of opioid use disorder; current medical conditions and medications; and the resident's pain management goals and satisfaction with pain control. When establishing a pain medication regimen, considerations include starting with lower doses and increasing as needed, administering medications routinely rather than only as needed, combining long-acting medications with as needed medications for breakthrough pain, using non-narcotic and narcotic analgesics together when appropriate, and implementing measures to reduce or prevent adverse medication effects, such as bowel regimens for opioid-related constipation.II. Resident #37A. Resident status Resident #37, age [AGE], was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included Parkinson's disease, Lewy body neurocognitive disorder with dementia and behavioral disturbances (progressive brain disease caused by abnormal protein clumps that damage nerve cells), anxiety, depression, type 2 diabetes, hypertension, lumbar radiculopathy and sciatica (irritation or compression of nerve root in the lower spine and radiating leg pain caused by sciatic nerve), tremors, encephalopathy (damage to the brain) and history of lumbar compression fracture (vertebrae in lower spin collapses often due to osteoporosis or trauma). The 4/23/26 minimum data set (MDS) assessment revealed a brief interview for mental status (BIMS) assessment was not conducted because the resident was rarely or never understood. According to the staff assessment for mental status, the resident had short and long-term memory problems and her cognitive skills for daily decision making were severely impaired. The assessment revealed Resident #37 had a pain medication regimen and did not receive as needed pain medications. The assessment revealed non-medication interventions were provided to the resident. The assessment section indicating the pain frequency, the effect on daily activities, the numeric scale and pain intensity was not completed. B. Observations During a continuous observation on 5/17/26, beginning at 4:30 p.m. and ending at 5:52 p.m., the following observations were made in the facility's dining room: Resident #37 was observed at a dining room table close to the door to the outside. An unknown staff member was assisting the resident with eating her meal. Prior to the meal, the resident was observed biting her clothing protector. No staff members tried to redirect the resident from biting her clothing protector. During a continuous observation on 5/18/26, beginning at 2:22 p.m. and ending at 4:25 p.m., the following observations were made: From 2:22 p.m. to 4:10 p.m. Resident #37 was observed lying on her back in her bed. Resident #37 was observed leaning to the left side of the bed (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and her back was not touching the bed. At 3:21 p.m. certified nurse aide (CNA) #2 told licensed practical nurse (LPN) #2 that Resident #37 kept trying to crawl out of her bed and was trying to hold on to the left side of her mattress. From 4:10 p.m. to 4:25 p.m. Resident #37 was observed in her high back wheelchair in her room and the hallway in front of her room. At 4:12 p.m. Resident #37 was observed with her left leg shaking more than her right leg. At 4:23 p.m. Resident #37 was observed with her right hand trying to hold the toes on her right foot. On 5/19/26 at approximately 1:52 p.m. Resident #37 was observed in her high back wheelchair in the hallway in front of her room. Resident #37 was observed biting her shirt and lifting her shirt up. CNA #2 told Resident #37 to stop biting her shirt and assisted the resident to lower her shirt. At 1:53 p.m. Resident #37 stopped biting her shirt and started to bite her lips. CNA #2 went to LPN #2 and said Resident #37 was in pain. LPN #2 came over and assessed the resident for pain. CNA #2 said she thought Resident #37 bit her clothes because she was in pain. As CNA #2 talked about Resident #37's pain, Resident #37 leaned forward to touch and hold the toes on her left foot. CNA #2 said Resident #37's legs did not always shake but today, 5/19/26, the resident's legs were more shaky than usual. C. Record Review Resident #37's pain care plan, initiated 7/28/25 and revised 7/29/25, revealed the resident had the potential for acute and chronic pain. She was able to verbalize she was in pain. If she had pain, she became restless and was at risk for falls. She had a stable fracture to her thoracic (T) 3 and T4 vertebrae (middle back), chronic fracture to her T8 vertebra and a stable fracture to her lumbar (L)1 vertebra (lower back) and a sternal fracture (thoracic and lumbar spine fractures on the mid-back and lower back region, breastbone). Interventions included administering medications per physician orders and monitoring for effectiveness, determining what the resident's optimal pain level was for day-to-day function, ensuring the resident's fentanyl patch (pain patch) was in a location, monitoring for any changes in usual activities, monitoring for changes in behavior that may be indicators of pain, monitoring for changes in mood that may be indicators of pain, monitoring for changes in sleep patterns, monitoring for verbal and non-verbal signs and symptoms relating to pain, offering non-pharmacological interventions to relieve pain and providing rest periods to prompt relief, sleep and relaxation. -The care plan did not identify the resident's goal for pain management and acceptable level of pain. Resident #37's behavior care plan, initiated 4/20/23 and revised 8/12/25, revealed the resident had a behavior of constantly chewing on the neck of her shirt and blanket. Staff tried to redirect her, but she continued. Interventions included assessing and anticipating the resident's needs, assessing the resident's understanding of the situation, encouraging as much participation and interaction by the resident during care activities and offering non-pharmacological behavior interventions prior to behavior medication administration. The 1/8/26 pain assessment revealed Resident #37 did not have evidence of pain and the FACES pain rating scale (a self-reported assessment tool that uses a series of six facial expressions to measure pain intensity) was used. Pharmacological interventions included administering acetaminophen, Sombra and fentanyl patches for pain management. -However, the prior non-pharmacological interventions section of the assessment was not completed, the pharmacological interventions section failed to indicate the use of tramadol, the resident's acceptable pain level was not completed and the pain location section failed to indicate the resident's leg pain. The 4/8/26 pain assessment revealed Resident #37 expressed complaints of back and leg pain at times. The resident was unable to communicate the intensity of her pain. The pharmacological interventions section indicated the resident used gabapentin and Tylenol. The pain location section, including the pain duration and frequency of pain revealed the resident had pain in her upper to mid-vertebrae. Relieving factors included position changes and medication. -However, the prior non-pharmacological interventions section was not completed, the pharmacological interventions section failed to indicate the use of a fentanyl patch, tramadol, Sombra gel and acetaminophen suppositories, the pain location section failed to indicate the resident's leg pain and the resident's acceptable pain level section was not completed. Review of Resident #37's May 2026 CPO revealed the following physician's orders: Fentanyl transdermal patch (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	72-hour 12 microgram (mcg)/hour. Apply one patch transdermally in the morning every three days for pain, ordered 10/3/25. Gabapentin 300 milligrams (mg) capsule. Take one capsule by mouth in the afternoon for painful legs, ordered 11/15/24. Acetaminophen 500 mg tablet. Take two tablets three times a day by mouth for back pain, ordered 7/1/24 and discontinued 2/24/26. Acetaminophen 500 mg tablet. Take two tablets by mouth every eight hours as needed for pain control, ordered 2/24/26.Acetaminophen 650 mg suppository. Insert one suppository rectally every six hours as needed for pain. Do not exceed three grams of acetaminophen in 24 hours, ordered 7/28/25. Sombra natural pain relieving external gel 3%. Apply to legs, feet and back topically every four hours as needed for pain, ordered 11/15/24. Tramadol 50 mg tablet. Take one tablet by mouth every six hours as needed for pain, ordered 1/27/26. Check fentanyl patch placement every shift, ordered 8/26/25. Document pain every shift two times a day for pain, ordered 2/6/23. Observe closely for side effects of opioid medication use, ordered 10/3/25. Offer non-pharmacological pain interventions prior to pain medication administration. Non-pharmacological interventions include repositioning, pillows for support, cold compress and massage. Complete two times a day, ordered 3/19/24. -Review of Resident #37's EMR did not reveal documentation indicating if the non-pharmacological interventions were effective or what interventions were attempted for the resident's pain relief. Review of Resident #37's medication administration records (MAR) from February 2026 to May 2026 revealed the following as needed pain medications were administered: Tramadol 50 mg was administered on 2/1/26, 2/2/26, 2/3/26, 2/8/26, twice on 2/13/26, 2/20/26, 2/24/26, 2/26/26, 2/27/26, 3/4/26, twice on 3/15/26, 3/24/26, 4/13/26, 5/4/26, 5/11/26 and 5/12/26. Acetaminophen 500 mg was administered on 4/17/26, 5/4/26 and 5/10/26 -However, there was no documentation indicating where the resident's pain was located when the tramadol 50 mg or the acetaminophen 500 mg was administered to the resident.III. Staff interviews CNA #2 was interviewed on 5/19/26 at 1:52 p.m. CNA #2 said she was familiar with Resident #37. She said she thought Resident #37 bit her clothes because she was in pain. She said it was hard for Resident #37 to communicate when she was in pain. CNA #2 said she was not sure why Resident #37 bent forward to touch and hold her feet when she was in her wheelchair. CNA #2 said she must be uncomfortable but she was not sure why. CNA #2 said she told the nurse when she noticed the resident was uncomfortable. LPN #2 was interviewed on 5/20/26 at 5:52 p.m. LPN #2 said a pain assessment included if the resident had pain, using the Pain Assessment in Advanced Dementia (PAINAD)scale (an observational tool used by healthcare providers and caregivers to assess pain in patients with advanced dementia or severe cognitive impairments who cannot verbally communicate), what the resident's acceptable level of pain was, where the pain was located, what non-pharmacological and pharmacological interventions were used and if the interventions were effective. LPN #2 said when pain medications were used as needed, the nurse found out where the resident had pain, tried non-pharmacological interventions first and if that was not effective, to offer an as needed pain medication to the resident. LPN #2 said she followed up with the resident to see if the pain medication was effective. LPN #2 said the location of pain should be documented on the MAR and she entered a progress note with a thorough explanation of the pain. LPN #2 said when a resident had multiple as needed pain medications and the resident was unable to communicate, she used the PAINAD and used her judgment on what medication to use based on the resident's level of pain. LPN #2 said she was familiar with Resident #37. She said she thought the resident's pain management goal was to have a pain level of zero and be comfortable. LPN #2 said Resident #37 had pain in her lower legs in the afternoon and had pain in her back. She said she knew Resident #37 had pain because she would vocalize pain, and demonstrate facial grimacing, biting, and grabbing or reaching out for things. LPN #2 said she used the stronger as needed pain medications, such as tramadol when Resident #37's pain level was high based on the PAINAD scale. The interim director of nursing (DON) was interviewed on 5/20/26 at 3:15pm. The interim DON said a pain assessment covered the resident's pain history, the pain impact on the resident's life, the resident's pain management goal, the acceptable level of pain and the location of pain. The interim DON said the (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment helped determine what interventions to use to help manage the resident's pain. She said the assessment helped to determine if the pain medications were controlled in order to ensure a better quality of life for the resident. The interim DON said when administering as needed pain medications, a nurse should assess the resident to see if there was facial grimacing, guarding and what the nurse was actually seeing from the resident. The interim DON said the location of pain should be documented in a progress note and on the MAR. She said the nurse should attempt a non-pharmacological pain intervention and if the non-pharmacological intervention was ineffective, the pain medication could be attempted. The interim DON said it was hard for nurses to determine which pain medication to administer when residents had multiple pain medications ordered as needed. The interim DON said the physician should direct which pain medication should be administered. The interim DON said she started working in the facility on 5/17/26 and she was not familiar with Resident #37. She said she would review the residents' pain medication regimen and pain assessment.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents diagnosed with a mental disorder or psychosocial adjustment difficulty received appropriate treatment and services to attain the highest practicable mental and psychosocial well being for one (#3) of seven residents out of 24 sample residents. Specifically, the facility failed to identify Resident #3's history of depression to monitor and provide ongoing assessment to determine whether the care approaches met the emotional and psychosocial needs of the resident.Findings include: I. Resident #3 A. Resident status Resident #3, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included dementia with behavioral disturbance and depressive disorder.The 3/10/26 minimum data set (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.The MDS assessment revealed the resident had depression based on the patient health questionnaire-9 (PHQ-9), a standardized, 9-question self-report tool used by healthcare providers to screen, diagnose, and measure the severity of depression.) Resident #3 reported he felt little interest or pleasure in doing things every day (12 to 14 days), felt down, depressed and hopeless every days, had trouble fall asleep or sleeping too much on seven to 11 days, felt tired or having little energy on two to six days, had a poor appetite or overeating on 12 to 14 days and felt bad about himself on two to six days during the assessment look-back period. The assessment revealed the resident took an antipsychotic medication and an antidepressant medication. The assessment revealed a gradual dose reduction was not attempted and was not documented as clinically contraindicated. B. Resident observations and interview On 5/17/26 at 3:00 p.m. Resident #3 was in his room. The room was dark with no lights on and the blinds closed. Certified nurse aide (CNA) #2 went into his room and spoke Spanish to the resident. On 5/17/26 at 5:01 p.m. Resident #3 was in the dining room. Resident #3 sat by himself in the corner of the dining room and did not engage with other residents.On 5/18/26 at 9:55 a.m. Resident #3 was lying in his bed and had his television turned on. The room was dark with no lights on and the blinds closed. Resident #3 said he stayed in his room most of the day and he did not like to participate in any facility activities. He said he liked to stay in his room because the other residents did not have the same interests as him. On 5/18/26 at 2:35 p.m. Resident #3 was in his room. The room was dark with no lights on and the blinds closed. CNA #2 went into his room and asked him if he wanted to attend the resident council meeting. Resident #3 said no. C. Record reviewThe dementia and behavioral care plan, initiated 5/17/22 and revised 2/3/26, revealed Resident #3 had verbally aggressive behaviors towards 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.The psychotropic medication care plan, initiated 3/7/22 and revised 6/16/25, revealed Resident #3 was medicated daily with a psychotropic medication due to depression and self isolation. Interventions included monitoring for behaviors for Seroquel treatment, including calling out, offering non-pharmacological interventions for noted behaviors, such as calm approach, positive reassurance, one-on-one and quiet environment, encouraging resident to verbalize his feelings, establishing a consistent daily routine, and monitoring for side effects of antipsychotics and antidepressants. Monitoring for target behavior and documenting; monitoring for isolation throughout (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shift for Lexapro, providing psychiatry consult as needed, providing distraction and diversional activities and responding to concerns and feelingsThe depression care plan, initiated 5/17/22 and revised 10/6/25, revealed Resident #3 was at risk for alteration in psychosocial well-being related to depression and at times would self-isolate in his room. Interventions included allowing the resident to express his feelings, encouraging alternative communication opportunities with visitors, encouraging and providing activities of interest, monitoring for changes in psychosocial changes, notifying the physician of changes in mental status, offering behavioral services and talking with a therapist, PHQ-9 assessment quarterly and as needed. The 5/25/25 psychiatry behavioral health note revealed the facility was to encourage Resident #3 to attend activities by using a slightly more proactive approach, such as going into his room and saying It is time to go to dinner or It is time to attend whatever activity is about to occur rather than asking if he would like to go to dinner or to an activity. The facility was to respect the resident if he declined or refused.-However a review of Resident #3's EMR did not reflect the recommended intervention. The 12/9/25 social services director (SSD) note revealed an assessment was completed for Resident #3 on 12/9/25. Resident #3's advance directives were do not resuscitate with comfort focused treatment and no artificial nutrition. Resident #3 had an acute hospitalization for chronic obstructive pulmonary disease, depression, dementia, psychotic disturbance, mood disturbance, anxiety and other specified depressive episodes. Resident #3 was on Lexapro (an antidepressant medication) 20 milligrams (mg) daily in the morning for depressive episodes and Seroquel (an antipsychotic medication) 25 mg twice a day for verbal aggression. The facility would continue to monitor the resident for changes in mood and behaviors. Resident #3 could make his needs known and did leave his room more frequently and was eating in the dining room. He sat in the lobby and talked with others occasionally. The resident's family was involved with his care and attended care conferences by phone. The SSD continued to monitor the resident's mood status. The SSD would encourage positive behaviors, continue the current plan of care and provide social emotional support as tolerated. Review of Resident #3's PHQ-9 assessments revealed the following:The 9/18/25 PHQ-9 assessment revealed Resident #3 scored a nine out of 27, indicating the resident had mild depression.The 12/10/25 PHQ-9 assessment revealed Resident #3 scored a 14 out of 27, indicating the resident had moderate depression, which had increased since his previous PHQ-9 assessment.The 3/10/26 PHQ 9 assessment revealed the resident scored a 13 out of 27, indicating the resident continued to have moderate depression. -A review of Resident #3's EMR did not reveal any documentation that addressed the resident's PHQ-9 score and what follow up, interventions or services were offered to the resident. Review of Resident #3's May 2026 CPO revealed the following physician's orders: Escitalopram 20 mg (Lexapro, an antidepressant medication). Take one tablet in the morning, ordered 12/24/25. Seroquel 25 mg (an antipsychotic medication). Take one tablet three times a day for verbal aggression, ordered 1/14/26. Behavior monitoring for verbal outbursts throughout shift twice a day for behavior monitoring, ordered 6/14/22. Monitor for behaviors for Seroquel, including negative statements every shift, ordered 6/4/25.Monitor for adverse side effects of antipsychotic medications, ordered 5/10/24. Monitor for side effects of Lexapro, ordered 10/9/25.Monitor for isolation throughout shift for Lexapro every shift for behavior monitoring, ordered 8/29/24. Offer non-pharmacological interventions for noted behaviors. Interventions included calm approach, positive reassurance, one-on-one and quiet environment. Complete twice a day. Document Y for yes interventions attempted prior to medication administration and N for no interventions not attempted prior to medication administration, ordered 7/1/24. Escort in and out of the dining room for meals attending three times a day for behavior, ordered 12/22/25.-However, this intervention was not being implemented consistently by staff, which resulted in four verbal abuse incidents with other residents.Cross-reference F600 for failure to keep residents free from abuse. -A review of Resident #3's medication administration records (MAR) and treatment administration records (TAR), from 12/1/25 to 5/20/26, revealed the resident exhibited behaviors and interventions that were not consistently offered and documented if interventions were effective. II. Staff interviews CNA #2 was (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviewed on 5/19/26 at 1:52 p.m. CNA #2 said interventions for residents who had behaviors were documented on shift report. CNA #2 said if she saw a resident had a behavior that required an intervention, she told the nurse and the nurse charted the behavior. She said some residents had an option for her to chart if she saw a behavior and when she could chart the behavior, she documented what behavior she saw, what intervention was used and if the intervention was effective. CNA #2 said she was familiar with Resident #3. She said one effective intervention to de-escalate Resident #3 was to speak Spanish to him. CNA #2 said Resident #3 spoke Spanish and he was in a good mood when they spoke Spanish together. CNA #2 said she tried to make jokes in Spanish to keep his mood positive. CNA #2 said the facility could identify better interventions for Resident #3's behavior. She said he was in a lot of resident-to-resident altercations and he was blamed for most of the altercations. CNA #2 said if the facility staff approached him differently, instead of blaming him for the altercations, but seeking to understand what happened from his standpoint, Resident #3 would be in a different spot. Licensed practical nurse (LPN) #2 was interviewed on 5/19/26 at 2:17 p.m. LPN #2 said interventions for residents who had behaviors were documented in a couple of different ways. She said if nursing needed to monitor post resident-to-resident altercation, there was alert charting where the nurse was responsible for documenting what they saw during their shift. LPN #2 said the alert charting was free form and the nurse could chart whatever they saw. LPN #2 said when a resident was first admitted , she tried to learn the resident's behaviors and what escalated the resident and what de-escalated the resident. LPN #2 said she knew what interventions worked to de-escalate a resident by trying one approach and if it upset the resident, then she did not try that approach again. LPN #2 said if she saw a behavior, she documented it as a progress note and wrote what intervention was used and if the intervention was effective. LPN #2 said she was familiar with Resident #3. LPN #2 said interventions to de-escalate Resident #3 included encouraging him to stay away from residents he did not like, calling his family to come in and talk to him to calm him down and removing him from the situation. LPN #2 said she learned first hand to not approach Resident #3 in a way that suggested he was to blame for resident-to-resident altercations. She said Resident #3 escalated when she and other staff members approached him in a way that suggested he was to blame. The nursing home administrator (NHA) was interviewed on 5/19/26 at 5:05 p.m. The NHA said staff knew what interventions were put in place by verbal communication. The NHA said nurses had access to a communication section in their electronic records system for nurses to read at the start of their shift. The NHA said CNAs or other departments did not have access to the communication section and a paper communication binder was used for educating CNAs. The NHA was interviewed a second time on 5/20/26 at 9:30 a.m. The NHA said she was unable to locate the electronic records for the communication page to show how the nurses were educated on interventions for Resident #3's behaviors. The NHA said the interventions should be care planned and said the care plans for Resident #3 could use improvement to reflect the interventions put into place after the resident-to-resident altercations. The SSD and the NHA were interviewed together on 5/20/26 at 12:07 p.m. The SSD said she and the corporate social services director were responsible for completing PHQ-9 assessments with residents. The SSD said the PHQ-9 assessment measured the resident's level of depression. She said the PHQ-9 assessment was completed at admission, quarterly and as needed. The NHA said anyone who triggered for depression was reviewed by the interdisciplinary team (IDT) in a monthly meeting. The NHA and the SSD said the SSD documented what occurred while the PHQ 9 was completed with the resident as a progress note. The NHA said the IDT reviewed the PHQ 9 to see if there were interventions, review medications and add activities as needed. The SSD said if a resident's PHQ 9 score increased from one quarter to another, she documented the conversation as a progress note and she offered behavioral health services to the resident. The NHA said the facility looked to see why the resident's PHQ-9 assessment score increased. The NHA said maybe the resident's score increased because of a recent death, an anniversary of a death or the resident was sad because of the season. The SSD said she was responsible for coordinating behavioral health (continued on next page)

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