STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065311	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Uptown Care Center	745 E 18th Ave Denver, CO 80203

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#6) of six residents reviewed for abuse out of 38 sample residents were free from abuse.Specifically, the facility failed to protect Resident #6 from abuse by Resident #60. Findings include:I. Facility policy and procedureThe Abuse Policy and procedure, dated 5/3/23, was provided by the nursing home administrator (NHA) on 8/4/25 at 9:00 a.m. It read in pertinent part, This facility does not condone resident abuse and shall take every precaution possible to prevent resident abuse by anyone, including staff members, other residents, volunteers, and staff of other agencies serving the resident, family members, legal guardians, resident representative, sponsors, friends or any other individuals. Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraints not required to treat the resident's symptoms. Resident abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment of a resident resulting in physical harm or pain, mental anguish, deprivation of goods or services that are necessary to attain or maintain physical, mental or psychosocial well-being. Physical abuse is defined as abuse that results in bodily harm with intent. It includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment and willful neglect of the resident's basic needs. If abuse happens, separate the assailant from the victim, isolate the assailant to protect others, assess and treat the victim and notify the abuse coordinator.II. Physical abuse of Resident #6 by Resident #60 on 7/20/25A. Facility investigationThe facility investigation was provided by the NHA on 8/6/25 at 1:00 p.m.The investigation documented Resident #6's and Resident #60's roommate was interviewed on 7/22/25. He stated he was in the room on 7/20/25 when the incident occurred and heard what he thought was joking around, and when he looked over, he saw Resident #60 hit Resident #6 in the face. He went to alert the staff.The investigation included a written statement from licensed practical nurse (LPN) #1. LPN #1's statement documented that Resident #6 said that guy hit me and he had a small laceration on the bridge of his nose. Resident #60 was mumbling under his breath, I am going to kick his (explicit word). Resident #60 was separated from Resident #6. LPN #1 cleaned Resident #6's nose wound, notified the director of nursing (DON), the physician and the residents' responsible parties.The investigation documented certified nurse aide (CNA) #3 stated she was at the nursing station when a resident asked her to go to their room. When CNA #3 entered the room she said Resident #60 was seated on Resident #6's bed and the two residents seemed to be arguing. CNA #3 immediately separated the residents and asked the nurse for assistance. CNA #3 did not see a physical altercation between the residents but she did see marks on Resident #6's face.The facility substantiated Resident #60 hit Resident #6 in the face.B. Resident #60 (assailant)1. Resident statusResident #60, age greater than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD- a lung condition making it difficult to breathe), dementia and respiratory failure. The 5/15/25 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a brief interview for mental status (BIMS) score of 12 out of 15. He needed set-up assistance with meals and bathing and was independent with all other activities of daily living (ADL).The assessment did not document the resident had physical or verbal behaviors toward others.2. Record reviewResident #60's behavior care plan, revised 7/28/25, documented he had a behavior problem (agitation, confusion) related to a head injury. Resident #60 had the potential for confusion secondary to a dementia diagnosis. He had a history of making statements related to his past and believed those things to be current. At times, the resident would clean areas repetitively despite redirection or education on infection control practices. Resident #60 had a history of physical altercations with others.Pertinent interventions included intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention, remove from the situation and take to an alternate location as needed (initiated 3/1/23) and complete a clinical and psychiatric workup as indicated; orders and recommendations to be followed as indicated (revised 8/6/25).A review of Resident #60's electronic medical record (EMR) documented the following:The 7/20/25 progress note, documented at 5:40 a.m., revealed the resident continued on observation for a new prescription Zoloft (antidepressant) and continued on every 15-minute safety checks. The resident had recently increased verbal aggression noted towards staff during care.The 7/20/25 progress note, documented at 3:05 p.m., revealed the resident had new skin concerns with a scattered bruise on the back of his right hand.The 7/20/25 progress note, documented at 3:21 p.m., revealed Resident #60 was moved to a different room.The 7/20/25 progress note, documented at 5:27 p.m., (after the altercation) revealed Resident #60 had earlier become agitated about being moved to a new room and threatened his new roommate. The DON requested that Resident #60 be sent to the emergency room. The 7/20/25 progress note, documented at 5:43 p.m., revealed Resident #60 hit his roommate (Resident #6) on his left eye and nose. Resident #6 had a blackened eye and gash on the nasal bridge. Resident #60 was moved to the fourth floor and the decision was made to send him to the hospital for an evaluation (see previous note).The 7/21/25 interdisciplinary team (IDT) note documented the IDT team discussed on 7/20/25 the alleged incident with Resident #6. Resident #60 was found on his roommate's (Resident #6) side of the room, suggesting increased confusion. The IDT again discussed Resident #60 prior to his return from the hospital after receiving a report for his return. Resident #60 was to be placed on increased monitoring as indicated upon return from the hospital related to roommate dynamics and a recent change of condition. The IDT discussed the option of one-to-one monitoring; however, it was determined that this approach may increase agitation. The note documented it was decided not to implement one-to-one monitoring at this time and instead to monitor for any concerns related to roommate dynamics.C. Resident #6 (victim)1. Resident statusResident #6, age less than 65, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included anoxic (lack of oxygen) brain damage, moderate protein calorie malnutrition, COPD, dementia, depressive disorders, schizoaffective disorder (mental illness) and cognitive communication deficit. The 7/10/25 MDS assessment revealed the resident was moderately cognitively impaired with a BIMS score of nine out of 15. He was dependent on assistance with (ADL)The assessment documented the resident had verbal behaviors toward others that occurred daily.2. Record reviewResident #6's behavior care plan, revised 8/25/23, documented he had potential behavior challenges due to a traumatic brain injury and schizoaffective disorder. He had a history of bar fighting prior to admission and a history of verbal and physical altercations with others. He liked to ambulate up and down the hallways and at times would go into other residents' rooms. The care plan documented redirection could be helpful at times.Pertinent interventions included to intervene as necessary when behaviors occurred to protect the rights and safety of others, approach and speak in a calm manner, divert attention. remove from the situation and take to an alternate location as needed (revised 5/16/23); provide education to the resident as needed on keeping his hands to himself and personal boundaries (initiated 5/23/23); a clinical workup to be completed and orders and recommendations to be followed as indicated (7/28/25) and to encourage the resident to participate in visits with mental health providers as (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated (revised 8/6/25).A review of Resident #6's EMR documented the following:The 7/20/25 weekly skin note, documented at 3:06 p.m., revealed Resident #6 had new skin concerns with a bruised left eye approximately 4 centimeter (cm) by 3 cm and ecchymosis (flat, purple bruise) over the nasal bridge approximately 2.5 cm by 2 cm with a 0.4 cm superficial abrasion at the center. Dried blood was noted on and around the nostrils and no active bleeding was observed. Mild swelling was present around the eye and nasal bridge.The 7/20/25 progress note, documented at 4:42 p.m., revealed Resident #6 was laying in bed and said that guy hit me. He had black/purple discoloration to the left periorbital (eyelids to eye brown) region, also a small gash on the upper bridge of his nose. Resident #60 admitted he hit Resident #6 in the face. Resident #60 had several small bruises on his anterior hand. Resident #6 was lying in bed hollering at no one in particular when Resident #60 became irritated and punched Resident #6 in the left eye and nose. The physician was contacted and if the resident had any increased pain, he became drowsy and hard to arouse, and if any bleeding would not stop to call for an order to send the resident for a scan of the left eye and nose. The 7/21/25 progress note, documented at 5:45 a.m,. revealed the resident continued on observation and neurological checks related to a resident-to-resident altercation. Resolving and intact bruising was noted to the left eye, periorbital area, and nasal bridge. No other injury or adverse effects were noted. The 7/23/25 progress note, documented at 10:02 a.m., revealed Resident #6 was monitored for physical aggression he received. His roommate punched him in the left eye. The left eye had periorbital bruising, purple, blue and greenish/yellow and was beginning to resolve. He had a small gash on the bridge of his nose that was dry and left open to the air. The resident's vital signs and neurological checks continued and were within normal limits. The 7/24/25 IDT note, documented at 3:49 p.m., revealed the IDT team discussed Resident #6. He appeared to be at baseline with no changes in behavior observed. A referral was sent for additional psychosocial support. The resident continued to display impulsivity and verbal agitation at times, such as yelling out. While he enjoyed activities of interest, he had difficulty sustaining attention and active participation.III. Staff interviewsLPN #2 was interviewed on 8/7/25 at 1:50 p.m. LPN #2 said she could sometimes hear Resident #6 yelling in his room but more often he yelled when he was sitting up in his chair and in the hallway. LPN #1 said sometimes Resident #6 also swore. LPN #1 said she had not seen any issues between Resident #6 and Resident #60 prior to the incident on 7/20/25.The DON and the NHA were interviewed on 8/6/25 at 2:00 p.m. The NHA said the resident who overheard the incident reported that he said Resident #60 hit Resident #6 in the face and that he was a roommate of Resident #6 and Resident #60. The NHA said initially he did not tell the staff anything but later he did say he saw Resident #60 hit Resident #6. The NHA said the staff were not aware that Resident #6 was yelling prior to the incident. The NHA said Resident #6 would yell for help instead of using his call light.The NHA said Resident #60 said that Resident #6 was yelling although the staff did not hear yelling. The NHA said that Resident #6 told the nurse that guy hit me. The NHA said that when Resident #60 came back from the hospital, she thought with his increased confusion that his memory was poor. The NHA said Resident #6's roommates were not bothered by Resident #6 yelling out. The NHA said after the incident, Resident #60 was placed on frequent checks. The NHA said that Resident #60 had a change in behavior prior to the incident where he displayed increased confusion and was cleaning things repeatedly. The NHA said staff were trying to redirect his behavior and discussed his behavior in morning meetings. The NHA said they did not see agitation from Resident #60 toward other people until the incident on 7/20/25. The DON said Resident #6 said that Resident #60 hit him. The DON said Resident #60 went to the hospital after the incident but Resident #6 did not. The DON said Resident #6 was assessed by the nurse practitioner and registered nurse at the facility. The DON said the assailant had a bruise on his right hand that was not indicated on previous skin documentation. The DON said when CNA #3 walked in after the incident, Resident #60 was sitting on Resident #6's bed and Resident #6 was laying on his bed. The DON said Resident #60 used a cane and did not need assistance to transfer.

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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 revise and implement an effective discharge plan for one (#81) of four residents reviewed for discharge planning out of 38 sample residents. Specifically, the facility failed to: - Ensure that Resident #81's discharge care plan was updated when the resident's discharge plan changed; -Notify the facility's ombudsman in writing of Resident #81's against medical advice (AMA) discharge; and -Notify Resident #81's physician of the resident's AMA discharge.Findings include: I. Resident #81A. Resident statusResident #81, age less than 65, was admitted on [DATE] and discharged back to the community AMA on 5/18/25. According to the August 2025 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), encephalopathy (brain dysfunction) and depression. According to the 4/28/25 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview mental status (BIMS) score of 15 out of 15. He was independent with eating and toileting and required set-up assistance with oral hygiene and showering. He required supervision with personal hygiene.The 4/28/25 MDS assessment revealed the overall goal for discharge was to discharge to the community. The information was provided by the resident. There was not an active discharge plan already occurring for the resident to return to the community. The resident answered yes to wanting to talk to someone about the possibility of leaving the facility and returning to live and receive services in the community. B. Record reviewThe discharge care plan, initiated 4/25/25, revealed Resident #81's discharge goal was to move to another state to live with his daughter. Interventions included establishing a pre-discharge plan with the resident and family, evaluating progress and revising plans as needed, providing the resident with written instructions as required to ensure care continuity post-discharge and making arrangements with the required community resources to support independence post-discharge. The 4/23/25 initial discharge planning review revealed the discharge plan provided by the resident and his family was for the resident to be discharged to the community, and the anticipated length of stay was unknown and preferred to be about a month. The 4/25/25 interdisciplinary team (IDT) care conference note revealed the IDT met with the resident and his son. The notes revealed the son wanted the resident to discharge in the next month to another state with the resident's son and home health services.-However, the care plan identified the resident was to move to another state with his daughter (see above).The 4/30/25 social services note revealed Resident #81 would no longer be discharged to live in another state with his daughter. The son indicated that the daughter denied any desire to be involved in the resident's care. According to the note, the son wanted the resident to remain at the facility for long-term care. -However, the resident's discharge care plan was not updated after 4/30/25 once the discharge plan changed to the resident remaining at the facility for long-term care. The 5/17/25 nurse progress note revealed Resident #81 asked the nurse why he was in the facility. The nurse provided the resident with information regarding his current health condition and his need for care at the facility. The resident expressed understanding of the provided information. The resident was observed with no behavioral issues or concerns during care, was easy to redirect and accepted the care provided. The 5/18/25 nurse progress note revealed at approximately 8:00 p.m., a certified nurse aide (CNA) reported Resident #81 was unable to be located in the building and the elopement protocol was initiated. The director of nursing (DON) and the assistant director of nursing (ADON) were notified. Staff searched the building while other staff searched the surrounding community. Left notification message for son, emergency contact to return call at 8:38 p.m. The nurse for the resident notified the provider at this time. The 5/19/25 IDT note, documented by the NHA, revealed Resident #81 was located on 5/19/25 at a local hotel that he was familiar with. The resident indicated he preferred to remain at the hotel and not return to the facility. The son was notified and voiced no concerns. The resident was educated on (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	leaving the facility AMA and was offered assistance obtaining medications and contact information for local shelters. Resident #81 voiced understanding of the AMA information, but reiterated his preference to remain at the hotel. The resident declined assistance from the facility and the NHA documented the resident left the facility AMA on 5/18/25. The against medical advice (AMA) form, dated 5/18/25, revealed Resident #81 refused to sign the form but stated understanding of the AMA information provided.-A review of Resident #81's EMR did not reveal documentation to indicate the ombudsman was notified of the resident's AMA discharge in writing (see frequent visitor interview below). -A review of Resident #81's EMR did not reveal documentation to indicate the physician was notified of the resident's AMA discharge. C. Frequent visitor interviewA frequent visitor, with knowledge of the facility, was interviewed on 8/6/25 at 10:30 a.m. The frequent visitor said she had been a frequent visitor since April 2025. She said she was not aware that Resident #81 was discharged from the facility due to leaving AMA. The frequent visitor checked her records during the interview, and she said she did not have any documents in writing or in an electronic (e-mail) format from the facility which informed her that Resident #81 was discharged from the facility due to leaving AMA. The frequent visitor said she did not receive a monthly report of discharges from the facility. II. Staff interviewsSocial services assistant (SSA) #1 was interviewed on 8/7/25 at 11:25 a.m. SSA #1 said the social services director (SSD) position had been open for a couple of months. She said she had worked with the NHA in place of the SSD since the previous SSD left the facility. She said social services was responsible for discharge planning and worked with the resident, the guardian, and the family. She said discharge planning was discussed at admission. She said discharge planning was reviewed at admission with the resident, the guardian and the family to set up goals and expectations to see if there was a viable plan for discharge. She said the discharge plan was then care planned. SSA #1 said discharge planning was reviewed quarterly and as needed. She said if something changed with the discharge plan, the care plan was updated. She said most of the time, residents requested a care conference and discharge planning was discussed at that time. She said the conversation was documented as a progress note or as a care conference summary. She said discharge planning covered if the resident wanted to stay in the facility long term or if they wanted to return to the community. She said the majority of residents stayed in the facility long term. She said if a resident wanted to return to the community, she talked to the decision maker, reviewed the risks and barriers, talked to the physician, set up durable medical equipment (DME) and located a pharmacy. She said the IDT team was responsible for discharge planning. SSA #1 said she would involve the ombudsman if she ran into issues with the resident. She said she would recommend the resident to have a good relationship with the ombudsman. She said she involved the ombudsman if the discharge plan was an unsafe discharge plan. She said the physician was involved in the discharge planning. She said the discharge planning was documented in a progress note, an assessment and in the resident's care plan. She said the physician was notified of the discharge and she was unsure if the ombudsman was notified when a resident was discharged . SSA #1 said if a resident left the facility AMA, the NHA and the director of nursing (DON) were responsible for the notification to the ombudsman and the physician. She said the physician was notified if the resident went AMA and she was unsure if the ombudsman was notified if the resident went AMA. SSA #1 said she was familiar with Resident #81. She said the former SSD had worked with the resident and his family related to his discharge plan and she was not part of his discharge. The NHA was interviewed on 8/7/25 at 2:52 p.m. The NHA said social services was responsible for discharge planning. She said discharge planning was discussed at admission, quarterly and as needed. She said goals were discussed for discharge planning with the resident and representatives at care conferences. She said the primary goal was if the resident wanted to stay at the facility long term or if they wanted to go back to the community. She said the ombudsman could be part of discharge planning. She said the facility had not had a consistent ombudsman for the past couple of months. The NHA said the physician was part of discharge planning. She said discharge planning was documented in the care conference notes, care (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan, the progress notes, the quarterly assessment and the MDS assessment. She said the day the resident was discharged , multiple IDT team members were responsible for different aspects of the discharge. She said the nurse worked to ensure the resident had their medications and social services knew who their home health agency was and transportation She said the physician was notified if it was a planned discharge and if it was AMA. She said it was documented the physician provided an order for planned discharges and if the resident left AMA, it was documented in a file that was not part of the resident's chart. She said the ombudsman was notified, depending on the type of discharge. The NHA was familiar with Resident #81. She said the resident's care plan was not updated when the resident's discharge plan changed to long-term care because there were a lot of different stories from the resident and the son about what the actual discharge plan was. The NHA said she would provide documentation to demonstrate the ombudsman was notified in writing that Resident #81 left AMA. The NHA said she would provide documentation to demonstrate the physician was notified the resident left AMA.-However, no documentation to indicate the ombudsman or the physician were notified of Resident #81's AMA discharge was provided by the survey exit on 8/7/25.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure the resident environment remained as free of accident hazards as possible for one (#69) of four residents reviewed for accident hazards out of 38 sample residents.Specifically, the facility failed to ensure Resident #69 did not sustain a fall during an assisted transfer and implement effective fall interventions. Findings include:I. Facility policy and procedureThe Fall Management policy, 2/29/24, was provided by the quality mentor on 8/7/25 at 6:00 p.m. It read in pertinent part, The purpose of this fall management policy is to modify or eliminate risk factors as applicable and thereby attempt to reduce the likelihood of falls with significant injury. Research has shown that structured fall reduction programs can substantially reduce the rate of falls and related injuries in nursing facilities; however, falls may likely occur. Identifying risk factors, followed by timely and appropriate interventions, is the key to a successful program. Each resident will be reevaluated quarterly, annually and when a significant change occurs. Individualized care plan interventions will be implemented for these residents found to be at high risk for falls. The following interventions may be considered after identification of root cause: Assess the environment and make appropriate changes, such as bed in the lowest position, placement of furniture, lighting, personal items within reach, non-slip footwear, night light, walker, wheelchair within reach if applicable. Complete a thorough analysis of the fall-time of day, location of fall, causative factors. Identify whether the interventions were in place at the time of the fall.II. Resident statusResident #69, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included dementia, major depressive disorder, epilepsy, history of traumatic brain injury (TBI), unsteadiness on her feet, abnormal posture and a history of falling.The 4/21/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. She needed set up assistance for meals and was dependent on assistance with all other activities of daily living (ADL).II. Record reviewResident #69's ADL care plan, revised 8/7/24, documented she had an ADL self-care performance deficit related to post neurological surgery. Resident #69 used a wheelchair for mobility, wore a helmet when she was out of bed, and had decreased activity tolerance and safety awareness with ambulation related to seizures, impulsivity and balance impairment. Pertinent interventions, initiated 5/16/23, included to apply nonslip strips to her chair to prevent sliding out of the chair; Resident #69 had a helmet she was to wear when she was out of bed, and required assistance of one person for toileting.Resident #69's mobility care plan, revised 8/25/23, documented she had limited physical mobility related to a limited range of motion, seizure disorder, and left eye blindness. Pertinent interventions, revised 5/16/23, included Resident #69 used a wheelchair for ambulation and required assistance from one person. Resident #69's fall care plan, revised 8/7/24, documented she was at risk for falls related to poor safety awareness, impulsivity, poor judgement, seizure disorder, left-eye blindness, and a history of falling. She also had impaired mobility. Pertinent interventions included to not leave Resident #69 alone in the bathroom or shower (revised 5/16/23), to educate staff on the use of a gait belt for all transfers and encourage the resident to allow staff to utilize the belt (revised 6/5/25).Resident #69's fall risk evaluation, 4/30/25, categorized her as a high risk for falls and documented the following: the resident was wheelchair bound, the resident had three or more diagnoses that could contribute to falls and was not able to perform a gait evaluation (how a person walks).A review of Resident #69's electronic medical record (EMR) revealed the resident experienced falls on 4/30/25, 6/4/25 and 7/22/25.A 5/1/25 interdisciplinary team (IDT) note documented Resident #69 had an assisted fall on 4/30/25. The root case was weakness. The interventions put into place included orders and recommendations to be followed as indicated and therapy to screen the resident. Staff education was provided on utilizing (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gait belts as needed.The 6/4/25 progress note documented Resident #69 was sitting on the floor and a certified nurse aide (CNA) said the resident stood up from the toilet, went to sit down and misjudged where the wheelchair was and was eased to the floor by the CNA.The 6/5/25 IDT note documented Resident #69 had an intercepted fall and the root cause was poor safety awareness and impulsivity. Interventions put into place included to re-educate staff to utilize gait belts with residents that used assistive devices.The 7/22/25 progress note documented at 6:00 p.m. revealed the nurse was notified of a fall by the second floor nurse. Resident #69 was sitting in a wheelchair next to the nursing station (post fall). The resident was assessed and had a 0.7 by 0.5 centimeter (cm) laceration on the back of her head and a new forming bruise on the top of her right knee. The resident reported nine out of ten pain and the resident had regular neurological checks initiated.The 7/22/25 progress note documented at 6:10 p.m. revealed that a CNA reported that Resident #69 fell in the bathroom after being changed. The resident was lying down on the floor after her fall. After having her vital signs taken, the resident was assisted to a sitting position. During assessment the resident was alert and oriented with a 0.7 by 0.5 cm laceration on the back of her head, but not bleeding, and potential bruise on the top of the right knee noted. The resident stated I was dizzy when I tried to sit and slid down from the wheelchair to the floor.The 7/25/25 IDT note documented the resident had a witnessed fall on 7/22/25 at 5:40 p.m. The root cause was poor safety awareness and poor impulse control. Interventions put into place included staff education on fall preventions, a therapy screen and resident education on fall safety. The resident verbalized understanding.-However, Resident #69 had sustained two previous falls on 4/30/25 and 6/4/25. Post fall interventions for each fall prior to the resident's 7/22/25 fall included a therapy screening of the resident and staff education was provided on utilizing gait belts as needed.III. Staff interviewsCNA #4 was interviewed on 8/7/25 at 1:35 p.m. CNA #4 said Resident #69 was unable to transfer independently. CNA #4 said she used a gait belt to transfer Resident #69, and prior to transferring would ask the resident if she was able to stand up. CNA #4 said if she needed a second CNA to transfer Resident #69 she would ask and they would both transfer the resident to and from her chair as needed. CNA #4 said Resident #69 could turn her feet and take a step but the resident would not try to transfer herself independently. CNA #4 said Resident #69 did not try to shift herself in her chair or adjust in her chair. CNA #4 said Resident #69 was compliant wearing her helmet.The director of nursing (DON) was interviewed on 8/7/25 at 3:00 p.m. The DON said Resident #69 fell in the bathroom connected to the shower room on 7/22/25. The DON said a CNA had taken the resident to the bathroom and the resident fell during the transfer from the toilet to the wheelchair. The DON said the CNA assisted the resident during the transfer. The DON said the CNA thought the resident was in her chair, but she was not all the way in her wheelchair and then the resident slid down to the floor on her bottom. The DON said the resident's only injury was to her head. The DON said the resident hit her head, but the CNA who transferred the resident did not see what the resident hit her head on. The DON said the resident wore her helmet while out of bed and she was wearing her helmet during the fall. The DON said the resident was assessed by a registered nurse (RN) and an licensed practical nurse (LPN) on staff. The DON said they provided education with the certified nurse aide post fall.The administrator in training was interviewed on 8/7/25 at 3:00 p.m. The administrator in training said staff should have used the gait belt during Resident #69's transfer. The administrator in training said the facility changed the cushion on Resident #69's chair the day after the fall on 7/22/25 so Resident #69 was able to move herself back in her chair better.IV. Facility follow upThe NHA provided documentation of education on 8/11/25 at 2:00 p.m. The education was provided individually to facility staff from 7/25/25 to 8/1/25. The education documented in pertinent part, If a resident falls while staff is present and no interventions was attempted, it becomes a serious concern for resident safety and facility liability. Use gait belts when appropriate and position yourself in a way that allows you to intervene immediately if a resident begins to lose balance. In cases where a fall is truly unavoidable, assisting the resident safely to the floor is the best option to prevent more severe injury. This is acceptable only if all other efforts to prevent the fall were (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attempted and failed and the staff demonstrated that appropriate inventions were made.The facility staff signed and dated the education provided.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents were free from significant medication errors for two (#59 and #69) of six residents reviewed for medication errors out of 38 sample residents. Specifically, the facility failed to:-Ensure Resident #59 was administered her blood pressure medication per the physician orders; and, -Ensure Resident #69 was administered her rescue seizure medication per the physician order. Findings include: I. Facility policy and procedure The Medication administration policy, dated 8/4/25, was provided by the nursing home administrator (NHA) on 8/7/25 at 11:55 a.m. It read in pertinent part, Resident medications are administered in an accurate, safe, timely, and sanitary manner. Medications are administered in accordance with written orders of the attending physician or physician extender. If a dose is inconsistent with the resident's age and condition or a medication order is inconsistent with the resident's current diagnosis or condition, contact the physician for clarification prior to the administration of the medication. Document the interaction with the physician in the nursing progress notes and elsewhere in the medical record, as appropriate. Procedure: verify the medication label against the medication administration record (MAR) for accuracy of drug frequency, duration, strength, and route. Be sure to check the bottle's label against the physician's order. Double-check the amount of medication to be administered. Medication is to be given in compliance with physician orders and or manufacturer's recommendations. II. Resident #59 A. Resident status Resident #59, age less than 65, was admitted on [DATE]. According to the August 2025 computerized physician orders (CPO), diagnoses included schizoaffective disorder (psychosis and mood disorder), Type 2 diabetes mellitus (insulin disorder), mild chronic kidney disease, stage two and hypertension (elevated blood pressure). The 7/9/25 minimum data set assessment (MDS) revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She was independent with hygiene, bed mobility, transfers, and ambulation. She required set up assistance with eating. B. Observations and interviews During a continuous observation on 8/6/25 beginning at 8:31 a.m. and ending at 9:40 a.m. the following was observed: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/6/25 at 8:31 a.m., licensed practical nurse (LPN) #1 was checking the second floor medication cart for Resident #59's Metoprolol succinate (blood pressure medication) extended release (25 milligram (mg) tablets. LPN #1 was unable to find the medication in the medication cart or the overstock medications located in the second floor medication storage room. LPN #1 said she would need to get the medication from the facility's Nexsys (automated medication dispensing) machine. At 9:14 a.m., LPN #1 was in the third floor medication storage room retrieving Resident #59's Metoprolol from the Nexsys machine. LPN #1 typed the first three letters of Resident #59's last name, scrolled to the resident's name and verified her date of birth before selecting her profile. LPN #1 searched for the medication by typing in the first three letters of the Metoprolol. LPN #1 scrolled to Metoprolol and selected Metoprolol tartrate (immediate release) 25 mg tablets. LPN #1 selected Metoprolol tartrate 25 mg tablets and dispensed two individually packaged tablets. LPN #1 selected the Metoprolol tartrate (immediate release), instead of the resident's ordered Metoprolol succinate ER 25 mg tablet (see order below). LPN #1 said she pulled an extra tablet from the machine so the nurse on the next shift would have the medication to administer. At 9:24 a.m. LPN #1 was at the second floor medication cart. LPN #1 dispensed one of the Metoprolol tartrate 25 mg tablets and the tablet fell onto the floor. LPN #1 discarded the pill in a medication destruction container located inside the medication cart. LPN #1 dispensed the second tablet of Metoprolol tartrate 25 mg and poured it into a medication cup. -LPN #1 did not verify the physician's order and medication prior to administering the medication to Resident #59. At 9:31 a.m. LPN #1 placed the medication cup, containing one Metoprolol tartrate 25 mg tablet on the table in front of Resident #59. Resident #59 took the medication presented to her. After returning to the medication cart, LPN #1 confirmed the resident's order was for Metoprolol succinate ER 25 mg, not Metoprolol tartrate 25 mg. LPN #1 stated a medication error had occurred. LPN #1 said she was unsure what the process was for medication errors. LPN #1 sent a text message to the unit manager (UM) and reported the error. C. Record review A review of Resident #59's August 2025 CPO revealed the following physician's order: Metoprolol succinate ER oral 25 mg tablet. Take one tablet by mouth in the morning for hypertension. Hold for systolic blood pressure less than 100 millimeters of mercury (mmHg) and a heart rate less than 60 beats per minute (bpm), ordered 1/13/25. The cardiovascular status care plan, initiated 12/29/21, documented Resident #59 had altered cardiovascular status due to diagnoses of hypertension and hyperlipidemia (elevated cholesterol). Interventions included assessing the resident for chest pain, monitoring the resident's vital signs daily, monitoring/documenting/reporting any signs and symptoms of coronary artery disease (narrowing of the vessels supplying blood to the heart). A nurse note, dated 8/6/25 at 10:30 a.m., documented Resident #59's nurse practitioner (NP) was notified of the incident and frequent neurologic assessments were initiated per policy. It documented an order was obtained to complete frequent checks with neurologic assessment. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A medication regimen review note, dated 8/6/25, documented the pharmacist recommendation was to administer one dose of Metoprolol tartrate 25 mg the evening on 8/6/25. It documented to resume Metoprolol succinate ER 25 mg once daily on 8/7/25. D. Additional staff interviews The UM was interviewed on 8/6/25 at 9:56 a.m. The UM said the medication error process included notifying the resident's provider, having a registered nurse (RN) perform an assessment and initiating 15-minute checks with neurologic assessments. The UM said the treatment plan would be adjusted depending on the provider's recommendations. The director of nursing (DON) was interviewed on 8/6/25 at 10:20 a.m. The DON said the nurses were responsible for verifying the rights of medication administration for all residents. The DON said the potential consequences of not verifying the correct medication was being administered included experiencing side effects, serious harm, change in condition or death. III. Resident #69 A. Resident status Resident #69, age less than 65, was admitted on [DATE]. According to the August 2025 CPO, diagnoses included dementia, major depressive disorder, epilepsy (seizure disorder), history of traumatic brain injury (TBI), unsteadiness on her feet, abnormal posture and a history of falling. The 4/21/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. She needed set up assistance for meals and was dependent on assistance with all other activities of daily living (ADL). The assessment documented the resident had a seizure disorder or epilepsy. B. Record review Resident #69's seizure care plan, revised 8/25/23, documented she had a seizure disorder and Resident #69 saw an outside neurology provider. Resident #69, although she had increased medication doses, continued to have seizures and falls. Pertinent interventions included to ask the resident about the presence or absence of auras prior to a seizure (revised 3/26/18); and give seizure medication as ordered by a doctor and monitor and document the side effects (revised 5/16/23). A review of Resident #69's August 2025 CPO revealed the resident had a physician's order for the following medication: Midazolam HCl (hydrochloride -sedative) Injection Solution 5 mg/5 milliliter (ml). Inject 5 ml intramuscularly (directly into the muscle) every 30 minutes as needed for an acute seizure. Give 5 ml intramuscularly every 30 min for up to three doses for an acute seizure as needed, ordered 1/3/25. Review of resident #69's electronic medication administration record (MAR) revealed the following: A 6/26/25 administration note documented at 4:30 a.m. a Midazolam HCl Injection Solution 5 mg/5 ml was administered; the resident had a seizure. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 6/26/25 administration note documented at 7:59 a.m. the administration of Midazolam HCl Injection Solution 5 mg/5 ml was effective. A 6/26/25 nursing note documented at 8:20 revealed that at approximately 4:15 a.m. Resident #69 had a seizure for approximately two minutes. A midazolam hcl injection solution 5 mg/5 ml was administered. The nurse who administered the medication documented an actual administration of 2 ml midazolam hcl and reported the administration to the provider who gave follow up orders to monitor and check the resident's oxygen. The resident denied pain or discomfort and vital signs were at baseline. The resident said she was fine and felt no pain. A RN was notified and the RN assessed the resident. Vital signs and neurological checks were implemented for every 15 minutes with seizure protocol. The supervisor and assistant director of nursing (ADON) were notified. A 6/27/25 nursing note documented at 8:00 a.m. revealed that the incident initially documented as an overdose medication error had been reassessed and identified as an underdose medication error. The nurse reported administering 2 ml of medication; however, upon review, the full vial contained only 1 ml in total. Inspection of the used vial revealed 0.6 ml of medication remained, indicating that approximately 0.4 ml was actually drawn and administered. The remainder of the 2 ml syringe was filled with air, leading to the mistaken belief that 2 ml had been given. The resident was assessed and was stable with no adverse effects noted. No further treatment or monitoring was required at that time in regards to the medication error per the provider's assessment. The resident continued on monitoring related to post seizure policy. The 6/27/25 interdisciplinary Team (IDT) note documented at 8:37 a.m. revealed that on 6/26/25 a medication error occurred in which the nurse did not give a large enough dose. The root cause was the nurse did not check the label and pull the medication correctly. The intervention put into place was education was provided to the nurse. C. Staff interviews The DON, the assistant director of nursing (ADON) and quality mentor were interviewed together on 8/6/25 at 2:00 p.m. The DON said Resident #69's post seizure mediation was supposed to decrease seizure activity. The DON said the resident could be administered one dose initially after a seizure. The DON said if the first dose was effective an additional dose of the medication did not have to be administered. The DON said after administration, the nurse would monitor to see if the seizure symptoms were reducing and talk to the resident to see if the medication was effective. The DON said if the resident's vital signs or symptoms were getting worse after the first dose of the post seizure medication the facility would call and notify the provider. The quality mentor said if the first dose of the post seizure medication was not effective to decrease seizure activity the facility would call emergency services. The ADON said after the nurse administered the medication she called the RN, the RN looked at the vial and asked her how many vials she used. The nurse responded that she used 2 ml and the RN realized it was a 1 ml vial, the RN saw there was some medication left in the vial. The ADON said that was when she realized it was an underdose and they could not administer any additional medication to the resident because the seizure had already stopped. The ADON said the facility then reported back to the provider it was an underdose. (continued on next page)

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