STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065318	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Irondale Post Acute	7150 Poplar St Commerce City, CO 80022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure one (#25) of two residents reviewed for range of motion received services and assistance to prevent a reduction in range of motion out of 35 sample residents. Resident #25 was admitted to the facility on [DATE]. According to the resident's diagnoses on admission, Resident #25 did not admit to the facility with bilateral hand contractures. On 9/9/25 a joint mobility evaluation was completed which indicated Resident #25's right wrist and right fingers had minimum range of motion limitations and left wrist and fingers had moderate range of motion limitations. He had resting bilateral hand splints and was placed on occupational therapy (OT) services for contracture management.The 11/6/25 OT discharge summary revealed the resident was placed on a restorative splint and brace program with bilateral upper extremity orthotics daily as tolerated. The prognosis to maintain the resident's current level of function was good with consistent staff follow through.However, documentation in Resident #25's electronic medical record (EMR) revealed inconsistent application of the resident's bilateral hand splints.The facility's failure to provide consistent services to maintain the resident's mobility contributed to a decline in the mobility of Resident #25's left and right hand (see below).On 1/8/26 a joint mobility was completed which indicated Resident #25's right wrist had minimum range of motion limitations, his right fingers had moderate range of motion limitation and his left fingers had moderate range of motion limitations. The evaluation indicated the change since the last assessment had worsened. The evaluation revealed the resident was working with skilled physical therapy and occupational therapy to return to the prior range of motion for all joints.The 2/3/26 OT discharge summary revealed the long-term goal was for Resident #25 to safely wear a resting hand splint on the left and right hands for up to six hours with minimal signs and symptoms of redness, swelling, discomfort or pain. The resident was tolerating resting hand splints for six hours per day upon discharge from therapy services.However, observations during the survey (from 2/9/26 to 2/12/26) revealed the resident did not have resting hand splints on and he was unable to extend his fingers independently. The facility failed to consistently provide the resident interventions to prevent a reduction in the resident's range of motion of his hands. Specifically, the facility failed to ensure Resident #25's contracture prevention devices were consistently in place.Findings include: I. Facility policy and procedure The Range of Motion and Contracture Prevention policy and procedure, revised November 2023, was provided by the nursing home administrator (NHA) on 2/12/26 at 2:31 p.m. It revealed in pertinent part, To assist residents in restoring and or maintaining joint function through a comprehensive interdisciplinary approach to joint mobility and proper positions.II. Resident #25 A. Resident statusResident #25, age less than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included frontotemporal neurocognitive disorder (a neurological disease causing dementia early on), multiple myeloma (cancer of blood cells), bilateral osteoarthritis of the knee, type 2 diabetes mellitus, generalized idiopathic epilepsy, stage 2 chronic kidney disease, atherosclerotic heart disease (build up of fat, cholesterol along the artery walls), encephalitis (inflammation of the brain), Pick's disease (form of dementia), stiffness of (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 0688 Level of Harm - Actual harm Residents Affected - Few	unspecified joint, other reduced mobility, muscle weakness, and difficulty walking. The 2/1/26 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 his cognitive skills for daily decision making were moderately impaired.The MDS assessment revealed there was no indication of a splint or brace assistance. B. Resident representative interview Resident #25's representative was interviewed on 2/9/26 at 1:11 p.m. The representative said Resident #25 developed contractures in both hands and she said Resident #25's contractures had worsened. She said she tried to make suggestions to the nursing staff, such as having the resident hold a small rubber football in his hand. She said the facility told her Resident #25 complained of pain when they tried to use the football. She said Resident #25 wore a brace and went to therapy to help make the contractures not worsen. C. ObservationsOn 2/9/26 at 11:09 a.m. Resident #25 was in the common area of the secure unit in his wheelchair. Both the resident's right and left hands were contracted and his fingers on both hands were touching the palms of his hands. The resident was not wearing hand splints on either hand. During a continuous observation on 2/10/26, beginning at 10:24 a.m. and ending at 12:50 p.m., Resident #25 was observed in the common area of the secure unit in his wheelchair. Resident #25 did not have a brace or a splint on either hand. D. Record review The mobility care plan, initiated 5/22/25 and revised 9/9/25, revealed Resident #25 had limited physical mobility related to contractures on bilateral hands and wrists. Interventions included to monitor, document and report to the physician as needed signs and symptoms of immobility including contractures forming or worsening, thrombus (blood clot) formation, skin-breakdown and fall related injury. Additional interventions included providing gentle range of motion as tolerated with daily care and providing supportive care and assistance with mobility as needed and documenting assistance as needed.-The care plan failed to indicate where the gentle range of motion should be utilized. The musculoskeletal care plan, initiated and revised on 2/6/26, revealed Resident #25 had an alteration in musculoskeletal status related to bilateral hand and wrist contractures. Interventions included anticipating and meeting the resident's needs, encouraging the use of supportive devices, such as bilateral resting hand splints, giving analgesics as ordered by the physician and monitoring for fatigue and needing to change position. A review of Resident #25's February 2026 CPO revealed the following physician's order: Bilateral resting hand splints as tolerated up to eight hours, ordered 2/9/26 (during the survey). -However, observations during the survey revealed the resident did not have the hand splints applied to his bilateral hands (see observations above). The 9/9/25 joint mobility evaluation revealed it was the initial evaluation. Resident #25's right wrist and right fingers had minimum range of motion limitations and his left wrist and fingers had moderate range of motion limitations. The evaluation revealed Resident #25 had bilateral resting hand splints. Resident #25 had hypersensitivity for limited tolerance for splint application and contracture management. The 11/6/25 occupational therapy discharge summary revealed the goal to use upper extremity support and orthotics to be utilized with good tolerance three times a week in order to decrease pain and further contractures and skin breakdown was met on 11/6/25. The discharge summary revealed at time of discharge, Resident #25 had upper extremity support and orthotics utilized five times a week by a certified nurse aide (CNA) and restorative nursing program. The discharge recommendation and status revealed the discharge recommendation was to continue orthotic management with staff. The restorative program was established and staff was trained for a restorative splint and brace program. The splint and brace program was bilateral upper extremity orthotics daily as tolerated. The prognosis to maintain the resident's current level of function was good with consistent staff follow through. The November 2025 restorative care plan documentation revealed the resident received passive range of motion and splint or brace assistance. The goals were splint placement to bilateral hands and wrist three to five times a week and range of motion with placement of splint. The duration was as tolerated with documentation of hours and time of splint tolerance. The December 2025/January 2026 restorative (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	care plan documentation revealed the resident received passive range of motion, active range of motion and splint or brace assistance. The goals were active range of motion reaching table games, range of motion gentle stretching and splint training and placement as tolerated, three to five times per week up to eight hours as tolerated when out of bed. The resident refused the program on 1/2/26, 1/3/26 and 1/4/26. -There was no documentation of splint placement from 12/4/25 to 12/12/25. -There was no documentation to indicate why the resident refused the restorative program on 1/2/26 through 1/4/26. The 1/8/26 joint mobility evaluation revealed Resident #25's right wrist had minimum range of motion limitations, his right fingers had moderate range of motion limitation and his left fingers had moderate range of motion limitations. The evaluation indicated the change since the last assessment (9/9/25) had worsened. The evaluation revealed the resident was working with skilled physical therapy and occupational therapy to return to the prior range of motion for all joints. -The evaluation revealed the resident's contractures had worsened from 9/9/25 to 1/8/26. The 2/3/36 occupational therapy discharge summary revealed occupational therapy treated Resident #25 from 1/8/26 to 2/3/26. It revealed the short term goal met on 2/3/26 was for the resident to tolerate 15 to 30 minutes of passive range of motion on bilateral upper extremities on all appropriate planes with decreased pain as noted by grimacing and behaviors in preparation for resting hand splints to reduce further contractures and promote skin integrity. On 1/8/26 Resident #25 tolerated passive range of motion with moderate and maximum grimacing secondary to pain. On 1/26/26 Resident #25 tolerated passive range of motion stretching while seated in chair with moderate grimacing and verbal behavior secondary to pain. On 2/3/26, the discharge date , Resident #25 tolerated passive range of motion stretching while seated in a chair with moderate grimacing and verbal behaviors secondary to pain. The long-term goal was Resident #25 would safely wear a resting hand splint on his left and right hand for up to six hours per day with minimal signs and symptoms of redness, swelling, discomfort or pain. The 1/8/26 baseline tolerance of the splints was four hours. The 1/26/26 tolerance of the splints was five hours and on 2/3/26, the discharge, the resident's tolerance of the splints was six hours. III. Staff interviews Certified nurse aide (CNA) #6 was interviewed on 2/11/26 at 4:55 p.m. CNA #6 said restorative aides were responsible for carrying out any resident's restorative nursing plan. CNA #6 said she sometimes put a splint or a brace on for residents but she did not do range of motion. She said she knew if a resident was on a restorative program based on a verbal report. She said she only knew of one resident, Resident #25, who was on a restorative program. CNA #6 said she did not know if the restorative program was documented anywhere and she said she did not document if she placed a brace or splint on a resident. She said she was familiar with Resident #25. CNA #6 said Resident #25 was admitted to the facility with no contractures. CNA #6 said she knew some staff had a hard time putting the splint and brace on Resident #25 because if he did not know the person, he refused care. CNA #6 said she sometimes put the brace on and she said she was told to put the brace on for two hours. Registered nurse (RN) #3 was interviewed on 2/12/26 at 10:49 a.m. RN #3 said she had worked at the facility for a month. She said therapy was responsible for restorative nursing. She said she did not know if CNAs were trained on restorative services. RN #3 said there was a schedule for residents who were on a restorative program. RN #3 said she had not seen a resident on a restorative nursing program since she worked here. RN #2 was interviewed on 2/12/26 at 11:02 a.m. RN #2 said therapy was responsible for restorative nursing. She said therapy and restorative nursing kept a paper list of residents who required splints, braces and range of motion. RN #2 said besides the paper list, if a CNA provided restorative nursing, it would be documented in the resident's chart under CNA tasks. RN #2 said there would be a physician's order for a splint or brace after the resident graduated from therapy. RN #2 said therapy provided an inservice on the resident's needs. RN #2 said she was familiar with Resident #25. She said his restorative plan was for his knee and a splint for his hands. RN #2 said he should wear his brace during the day. RN #2 said he received range of motion during his daily cares, such as when CNAs would get him ready in the morning. The assistant director of nursing (ADON) was interviewed on 2/12/26 at 1:59 p.m. The ADON said she was responsible for (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	the restorative nursing program and she had two restorative aides. She said she knew which residents were on a restorative program because therapy entered their orders on the care plan which triggered the CNA tasks. The ADON said the restorative program was documented in the care plan, the CNA's tasks and the orders. The ADON said if a resident required a splint or brace, it would show up on the CNA tasks and care plan. The ADON said therapy monitored if contractures worsened. The ADON said she was familiar with Resident #25. She said his contracture management plan was for him to wear a brace when out of bed and when tolerated. The ADON said Resident #25 received therapy the entire time up until this week (week of 2/9/26) when he transitioned to restorative nursing.-However, the resident's discharge summary from therapy was documented on 2/3/26, one week prior (see above). The director of rehabilitation (DOR) was interviewed on 2/12/26 at 2:43 p.m. The DOR said the ADON was responsible for the restorative nursing program. She said a resident started a restorative nursing program after therapy determined the resident met or exceeded expectations and the resident was ready for restorative nursing. She said the occupational therapy discharge summary talked about the restorative nursing plan. The DOR said CNAs were trained on the restorative nursing program and the training was also documented on the therapy discharge summary. The DOR said she was familiar with Resident #25. The DOR said Resident #25's representative had voiced her concerns about Resident #25's hands and wrists over the last couple of months. The DOR said Resident #25 was specific about the staff who cared for him and every session therapy had with him, there was long passive range of motion, including stretching before putting on the brace. The DOR said she completed the joint mobility evaluation on 1/8/26 at the request of nursing staff because nursing was worried about reduced range of motion in Resident #25's fingers. IV. Facility follow up The facility provided a 2/13/26 joint mobility evaluation (completed after the survey exit) that documented Resident #25's current range of motion limitations were none for the left wrist and minimum for his left fingers. -However, the evaluation did not document evaluation of the resident's right wrist or right fingers to determine if the right wrist or right fingers had worsened.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide a comfortable and homelike environment in one of four units. Specifically, the facility failed to: -Ensure all residents' rooms in the secured unit were in good repair; -Ensure the small common area of the secured unit was free from unpainted areas on the walls, free of sheet rock damage and missing floor tiles; and, -Ensure the dining room area of the secured area was free from stains in the ceiling and free of sheet rock damage.Findings include: I. Facility policy and procedure The Safe Homelike Environment policy, revised December 2020, was provided by the nursing home administrator (NHA) on 2/12/26 at 4:24 p.m. It revealed in pertinent part, The facility provides a safe, clean, comfortable and homelike environment.II. Observations On 2/12/26 at 9:00 a.m. an environmental tour of the secure unit was conducted. The small common area at the secure unit entrance doors was observed to have multiple black marks on the ceiling. There were unfinished sheet rock patches and multiple areas that needed stippling (texturing). The ceiling around the metal air vent was dirty and was black. There were unpainted areas on the green wall by room [ROOM NUMBER]. There were multiple brown spots on the ceiling and a loose cover base on a small wall near the crash cart. There was sheet rock damage on the corner of the wall at the crash cart. There were multiple floor tiles with missing top laminate. The dining room area had two red marks or drops (the color of blood) on the ceiling at the entrance to room [ROOM NUMBER]. There were brown water-stained areas and black debris (lint) around the ceiling vent as well as sheet rock damage around the ceiling vent. There were multiple areas on the wall under the nurses' station window shelf into dining area that were unpainted and unpainted sheet rock patches on the hallway wall by room [ROOM NUMBER] and room [ROOM NUMBER]. Resident room [ROOM NUMBER] was observed to have chipped paint on the entrance door frame and loose cover bases at the entrance to the bathroom. The bathroom was missing a towel bar and a black plunger was standing upright (not bagged) in one corner of the room. The plastic toilet seat was torn and rough wood was exposed on the bathroom door near the lower door hinge. Resident room [ROOM NUMBER] was observed to have seven unpainted sheet rock patches on two room walls, sheet rock damage on one wall near the bed by the window, and an unpainted section of wall by the window. There was one missing section of cover base at the bathroom entrance and chipped paint on the entrance door frame. The bathroom had one nonfunctional light over the sink, one wooden leg of a table was used to hold the sink up in the corner of the room, and a black plunger (not bagged) was standing upright in one corner.Resident room [ROOM NUMBER] was observed to have a loose cover base at the entrance to the bathroom.Resident room [ROOM NUMBER] was observed to have chipped paint around the sink, chipped paint on two corners at the sink area, and chipped paint on the bathroom entrance door frame. The bathroom had three torn areas of linoleum flooring, one cracked bathroom tile at the cover base, and black marks on one bathroom door.Resident room [ROOM NUMBER] was observed to have sheet rock damage on two room corners at the sink area and black marks on the wall by the sink area.Resident room [ROOM NUMBER] was observed to have scraped paint on the wall behind bed #1, cracked paint on the ceiling, a missing cover for the glove box at the sink area, a missing towel bar at the sink, and multiple grey areas on the room floor tiles.Resident room [ROOM NUMBER] was observed to have mismatched paint in three small areas above the room window. The bathroom had two small holes above the grab bar, a black plunger (not bagged) standing upright in one corner, and a loose cover base by the toilet base.Resident room [ROOM NUMBER] was observed to have one nonfunctional light over the room sink, one missing towel hanger, four small holes in the wall above the street side window, a torn cover base at the entrance door, chipped paint on the entrance door frame, a missing cover for the heater control device and missing horizontal blinds for the window facing the parking lot.Resident room [ROOM NUMBER] was observed to have (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sheet rock damage on two room corners by the sink, chipped paint around the room sink, two areas of wood damage on the cabinets over the closets, chipped paint on the metal heater cover under the room window and a missing cover base by the bathroom entrance door. The bathroom had a black plunger (not bagged) standing upright in one corner.III. Staff interviews The maintenance director (MTD) and life safety and maintenance resource were interviewed together on 2/12/26 at 12:13 p.m while touring the secured unit. The MTD said he had worked at the facility since June 2025. The MTD said he was responsible for the building's maintenance. He said he had one staff member and was approved for another part-time position. The MTD said he tracked improvements using a spreadsheet. He said he was done patching the walls in the secure unit. The MTD said he prioritized maintenance concerns based on safety tasks first and when there was downtime, he worked on updating the secured unit. The MTD said he knew about the repairs required in the secured unit. The MTD said he was approved to paint the walls in the secured unit and the next step was for the resident council to select the paint color. He said he worked with the NHA to prioritize repairs. The MTD said he knew room [ROOM NUMBER]'s bathroom floor was missing linoleum because the resident who resided in the room pulled up the linoleum constantly and when he repaired the floor, the resident pulled up the floor again. The MTD said the ceiling required a new fire block which arrived on 2/11/26. He said the ceiling would be painted as soon as the resident council approved a color. The MTD estimated the repairs would be done by the end of February 2026. He said in order to update the rooms, including updating the lights, holes,and faucet sinks, he said he tried to have five to six rooms completed by a certain date. The MTD said he did not have a specific end date for when the repairs in the secured unit would be completed.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that two (#51 and #12) of four residents reviewed for abuse out of 35 sample residents were kept free from physical abuse.Specifically, the facility failed to protect Resident #51 and #12 from abuse towards each other.Findings include:I. Facility policy and procedureThe Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy, revised December 2025, was provided by the nursing home administrator (NHA) on 2/12/26 at 2:08 p.m. It read in pertinent part, It is the policy of this facility that reports of abuse, neglect, misappropriation of property, and exploitation are promptly and thoroughly investigated. When an incident or suspected incident of abuse or neglect is reported, the administrator or designee investigates the incident with the assistance of appropriate personnel. A licensed nurse examines the resident upon receiving reports of alleged physical or sexual abuse and records findings in the resident's medical record. The investigation consists of at least the following: a review of the completed complaint report, an interview with the person(s) reporting the incident, interviews with any witnesses to the incident, an interview with the resident if possible, a review of the resident's medical record, and interviews with staff members having contact with the resident during the period/shift of the alleged incident if applicable, and a review of all circumstances surrounding the incident.II. Physical abuse incident between Resident #51 and Resident #12 on 2/4/26A. Facility investigationThe facility investigation was provided by the NHA on 2/10/26 at 2:15 p.m.The investigation documented that at approximately 3:30 pm on 2/4/26, Resident #51 reported to staff that her roommate, Resident #12, had walked over to her and bopped her on the shoulder. An investigation was immediately started. Residents #12 and #51 were assessed and were found to have no pain, injuries, bruising or signs of distress. Resident #12 was interviewed by the social services director (SSD) on 2/4/26 and the resident denied any physical contact with Resident #51. The investigation documented Resident #51 was interviewed by the SSD on 2/4/26, and stated her roommate walked over to her and bopped her on the shoulder. Resident #51 was offered a room move, which she accepted and was immediately moved to a different unit. Resident #51 denied any fear of Resident #12.The investigation revealed that both residents were placed on 15-minute checks and psychosocial monitoring was ordered for both residents.-The investigation revealed the facility interviewed several staff members during the investigation, however, none of the staff members interviewed typically worked on the unit and were not present during the 2/4/26 altercation between the two residents. Cross reference F610 for failure to investigate an alleged violation.B. Resident #51 (victim)1. Resident statusResident #51, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included schizophrenia, anxiety disorder, repeated falls, cognitive communication deficit, muscle weakness, and drug-induced subacute dyskinesia.The 12/8/25 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. She required moderate assistance with toileting, supervision with eating and personal hygiene. The assessment indicated the resident did not exhibit physical or behavioral symptoms towards others.2. Resident interviewResident #51 was interviewed on 2/10/26 at 12:15 p.m. Resident #51 said she remembered the incident of aggression towards her by Resident #12. She said she was sitting in her wheelchair facing her bed, reading her Bible and praying. She said her roommate at that time (Resident #12) approached from behind her and hit her on her right shoulder, causing severe pain in her right shoulder. Resident #51 said she yelled at Resident #12 to leave her alone, but Resident #12 refused to leave and stayed by her side of the room. Resident #51 said she wheeled herself out of the room to report the incident to staff. 3. Record reviewResident #51's dementia care plan, revised 3/1/23, revealed she was at risk for impaired cognitive function or impaired thought processes related to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chronic mental illness, schizophrenia, and neurocognitive disorder with behavioral disturbances. Pertinent interventions included engaging the resident in simple, structured activities that avoided overly demanding tasks, identifying oneself at each interaction, facing the resident when speaking, making eye contact, and monitoring, documenting and reporting to the medical director any changes in cognitive function, specifically changes in decision-making ability, memory, recall and general awareness.Resident #51's psychotropic medication care plan, revised 1/20/26, documented that she received psychotropic medication due to schizophrenia. Pertinent interventions included monitoring for episodes of verbal aggression, mood instability and one-on-one removal from the environment. A 2/4/26 social services progress note documented that the social services director (SSD) contacted Resident #51's representative to inform her of a room change for the resident's safety reasons.On 2/4/26 at 4:56 p.m. a psychosocial follow-up note documented that Resident #51's mood and behavior were assessed. She was located in the common area during the observation. Resident #51 stated she was doing well but would like a different roommate.C. Resident #12 (assailant)1. Resident statusResident #12, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included schizoaffective disorder, bipolar type, muscle weakness, and muscle wasting and atrophy.The 1/2/26 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. She was independent with mobility, personal hygiene, toileting, and eating. The MDS assessment indicated the resident did not exhibit physical behaviors directed towards others and did not reject care.2. Resident interviewResident #12 was interviewed via a translator language line in her native Russian language on 2/10/26 at 1:15 p.m. Resident #12 said she was asleep on the afternoon of 2/4/26 and had a dream in which her roommate prayed against her Christian faith. She said she went over to her roommate's side of the room to ask her to stop praying. Resident #12 said her roommate was sitting in her wheelchair, facing her bed. She said she approached her and touched her on her right shoulder, but Resident #51 turned and hit her on her collarbone. She said she had severe pain in the area of her left collarbone where Resident #51 had hit her. She said her roommate, Resident #51, cursed at her earlier that day while entering the bathroom.3. Record reviewResident #12's behavior care plan, revised 3/7/23, documented the resident had a potential for a mood and/or behavior problem related to diagnoses of schizoaffective disorder, bipolar type. Resident #12 maintained a long history of paranoia, delusions, and hallucinations that were religious and persecutory in nature. She exhibited verbal and physical aggression. Pertinent interventions included anticipating and meeting the resident's needs, approaching the resident in a calm manner, assisting the resident to develop more appropriate methods of coping, interacting, and encouraging the resident to express feelings appropriately.Resident #12's antipsychotic medication care plan, revised 2/9/26, documented that she was on prescribed antipsychotic medication for schizoaffective disorder and to monitor her for verbal and physical aggression and hallucinations.-The care plan failed to address appropriate supervision due to hallucinations and mood when Resident #12 was in her room.The care plan acknowledged that Resident #12's hallucinations were religious and persecutory in nature and that she exhibited verbal and physical aggression. -However, the care plan failed to include specialized strategies to de-escalate these specific psychiatric triggers.III. Staff interviewsCertified nurse aide (CNA) #2 was interviewed on 2/10/26 at 2:31 p.m. CNA #2 said she was familiar with the care of Resident #51 and Resident #12. She said Resident #12 had a documented history of aggression toward staff and other residents. CNA #2 said Resident #12 often refused to take her psychotropic medications, which had resulted in hospitalization in the past. CNA #2 said Resident #51 held strong religious beliefs and did not celebrate several holidays that did not align with her faith. She said Resident #51 often prayed openly in her room and liked to talk to others about her Christian faith.Registered nurse (RN) #1 was interviewed on 2/10/26 at 2:45 p.m. RN #1 said she knew of the incident between Resident #12 and Resident #51 and said both residents attacked each other. She said she was off duty the day of the incident. She said Resident #12 had a tendency to refuse (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication and could be aggressive towards others. She said Resident #12 kept to herself most of the time due to her language barrier. RN #1 said Resident #51 often read her Bible and prayed in her room. She said that, as a result of the altercation, Resident #51 moved to another unit. RN #1 said Resident #51 told her that her roommate (Resident #12) had hit her on her right shoulder.The assistant director of nursing (ADON) was interviewed on 2/12/26 at 10:05 a.m. The ADON said she was present in the building when the altercation between Resident #51 and Resident #12 occurred on 2/4/26. The ADON said Resident #51 came to her office to report the incident of alleged physical abuse to her, and she completed a skin assessment of the resident; however, she did not document her evaluation in the resident's electronic medical record (EMR). The ADON said that a few moments after she spoke with Resident #51, her roommate, Resident #12, arrived at her office, also alleging that her roommate hit her on her left collarbone. She said both residents were separated and 15-minute checks were initiated.The NHA and the social services director (SSD) were interviewed together on 2/12/26 at 11:45 a.m. The NHA said RNs were required to complete an assessment when allegations of abuse were reported. The NHA said both Resident #51 and Resident #12 were assessed, and an investigation was initiated immediately. He said the allegations of abuse were unsubstantiated because there were no witnesses to the allegation.-However, abuse occurred because both residents said the other resident hit them.The SSD said he interviewed both Resident #51 and Resident #12 and followed up to complete psychosocial assessments. The SSD said he interviewed staff from management to ensure there were no widespread allegations of abuse.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to protect one (#27) of three residents from misappropriation of property out of 35 sample residents. Specifically, the facility failed to prevent Resident #27 from having a significant amount of money stolen from his room.Findings include: I. Facility policy and procedureThe Abuse Investigation and Reporting policy and procedure, revised 12/22/25, was provided by the nursing home administrator (NHA) on 2/12/26 at 2:08 p.m. It read in pertinent part, It is the policy of this facility that reports of abuse, neglect, misappropriation of property, and exploitation are promptly and thoroughly investigated.II. Incident of misappropriation of property for Resident #27 A. Facility investigation The 12/24/25 grievance form revealed the resident reported that he had $700.00 missing from his room. The resolution was the former social services director (SSD) would follow up with Resident #27. Resident #27 said the money had been missing since a week ago (12/17/25) and he did not report it. Resident #27 said he thought the money went to the laundry department. The SSD checked with the laundry department and the laundry department said no money was found. Resident #27's sister confirmed that she brought him $1000.00 on 12/17/25. The SSD saw $389.00 in Resident #27's wallet. She offered to put it into the resident's trust account and he declined. The SSD offered a lock box and he declined. A police report was indicated. The date reviewed with Resident #27 was documented as 12/24/25. The 12/24/25 facility investigation report revealed that at approximately 4:00 p.m. on 12/23/25 Resident #27 informed the SSD that he was unable to locate some money his sister gave him. An investigation started immediately. The SSD interviewed the resident and the resident's sister. The resident's sister said she gave him $1000.00 a week prior (12/17/25). The SSD searched the resident's room with the resident's permission and was able to locate $389.00. Resident #27 was unable to remember where he last saw the funds or where he placed it. The interviews with the resident's roommate, the other residents and staff were ongoing. The police were notified and arrived at the facility to interview the resident. Staff at the facility was not aware the resident's sister brought money to the resident at the facility. The resident was offered a lockbox per facility protocol if a resident had money in their possession. The investigation actions taken revealed the SSD interviewed Resident #27 and the resident's sister. The resident's sister said she gave him $1000.00 a week prior. The SSD searched the resident's room with the resident's permission and was able to locate $389.00. Staff on the unit were interviewed regarding alleged misappropriation and laundry was checked for money potentially left in clothing and none was found. Security camera footage prior to the money allegedly going missing was reviewed and revealed no unauthorized person entering the resident's room. Resident #27 was kept safe by contacting the police to interview the resident. -However, the investigation failed to indicate how the resident and his money were kept safe beyond notifying the police to interview the resident.Resident #27 remembered he had the money one week prior to 12/23/25. -The investigation failed to indicate if the allegation was substantiated or unsubstantiated by the facility. -The investigation failed to reveal if the facility asked Resident #27 who he thought took his money or how he thought the money went missing. However, the 12/23/25 police investigation report and an interview with the resident during the survey on 2/9/26 indicated a female nurse took the money from his wallet (see police report and resident interview below).Cross reference F610 for failure to thoroughly investigate an alleged violation. B. Police investigation report The 12/23/25 police investigation report for the investigation into Resident #27's missing money was provided by the police department on 2/10/26 at 3:50 p.m. It revealed that the case status was pending and active. The incident was reported on 12/23/25 and indicated the theft occurred on 12/17/25 between 12:00 p.m and 1:00 p.m. It revealed $700.00 was stolen. The investigation revealed that on 12/23/25, the police officer was dispatched to a theft. The investigation documented Resident #27 said last Wednesday, 12/17/25, a nurse took $700.00 from his wallet. The officer asked how it happened. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #27 said around 12:00 p.m. on 12/17/25, a nurse came into his room and woke him up. The nurse helped him take off his robe for laundry day. The nurse took the robe to the laundry and returned with Resident #27's wallet. Resident #27 said he always kept his wallet in the front pocket of his robe. The nurse put his wallet on his nightstand next to his bed. Resident #27 counted the money inside his wallet and he noticed $500.00 missing. Resident #27 said he needed to go to the bathroom so the nurse assisted him. Resident #27 grabbed his wallet and put it in the front pocket of his pajama bottoms. Resident #27 urinated on his pajama bottoms so the nurse took them off of him and set the pajamas in the room by the sink. When Resident #27 was done using the bathroom, he checked his wallet again. Resident #27 noticed another $200.00 missing. Resident #27 was not sure what to say so he waited to report it. Resident #27 did not know the nurse's name. The officer checked with the nurse on duty and she said the schedule for last week was down so she was not sure who worked. The nurse provided a phone number to the scheduler who was only available during the day. There were no surveillance cameras inside the room. The officer requested the case to be active and assigned back to him for follow-up. III. Resident's representative interviewsThe resident's representative was interviewed on 2/10/26 at 2:03 p.m. The representative said she was aware Resident #27 was missing money. She said another representative called the police to look into it. The resident's representative said Resident #27 told her he was sleeping in bed when a lady woke him up and took his gown that had his wallet in it. She said he told her the lady took the gown to the laundry and took the money out of the wallet. The resident's representative said she gave him $1100.00 and the facility was not doing anything to confirm what happened and what did not happen. She said Resident #27 did not usually have this much money with him. The resident's representative said Resident #27 could be paranoid, but he had the right mind to keep track of his money. A second resident's representative was interviewed on 2/10/26 at 2:47 p.m. The second representative said she called the police department and adult protective services (APS) to look into who stole Resident #27's money. She said no one at the facility cared that Resident #27's money was missing because he was paranoid. She said even though Resident #27 was paranoid, he was very good with his money and was not confrontational about his money. She said she handled Resident #27's money and gave the other representative money because she lived close by to the facility. She said the other representative and Resident #27 got in an argument so the other representative gave Resident #27 all of his money at the same time. She said Resident #27 waited a week to tell her the other representative and he fought and the money went missing afterwards. She said the facility did nothing to resolve the issue. IV. Resident #27A. Resident status Resident #27, age less than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus with hyperglycemia, asthma, delusional disorders, paraplegia, cellulitis of the right lower limb, gout, generalized anxiety disorder, hypertension and depression. The 2/1/26 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. B. Resident interviewResident #27 was interviewed on 2/9/26 at 3:17 p.m. Resident #27 said on 12/17/25 a female nurse took his wallet and took money out of his wallet. Resident #27 said it happened when the nurse assisted him with toileting care. He said the female nurse took his hospital gown off and he had his wallet in the front pocket. Resident #27 said it happened during a morning shift and police were called. Resident #27 said he did not know what the outcome of the investigation was. Resident #27 said he did not know the name of the nurse but knew it was a female, she worked a day shift and was Hispanic. He said he had a lot of money in his wallet because he had to buy a phone. Resident #27 said on 12/17/25 he had $1300.00. and today, 2/9/25, he had $600.00 in his wallet. He said he would use a lock box if he was given one to keep things like his $100.00 bluetooth speaker he had on his table close to the entrance of his room. C. Record review The behavior care plan, initiated 1/9/26 and revised 2/4/26, revealed Resident #27 had the potential for behavior problems due to a history of false accusations towards staff related to hallucinations and delusions. Interventions included administering medications (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered, anticipating and meeting the resident's needs, approaching the resident in a calm manner, assisting the resident to develop more appropriate methods of coping and interacting, educating family members on successful coping and interaction strategies and ensuring if money was brought in for the resident, to deposit it to his bank to keep money safe and accessible to the resident. -The care plan was not initiated until 1/9/26, 15 days after the allegation of the resident's stolen money. The 2/12/26 social services note, documented during the survey, revealed Resident #27 mentioned missing money that occurred back in December 2025 and understood it was reported to the police and investigated. Resident #27 explained he understood but wanted to express himself.-There was no further documentation in Resident #27's electronic medical record (EMR) related to the resident's allegation of the missing money. V. Staff interviewThe NHA was interviewed on 2/12/26 at 11:44 a.m. He said he was the abuse coordinator. The NHA said if a staff member suspected abuse they contacted the director of nursing (DON) and him. He said the investigation was documented in risk management. He said if an allegation was misappropriation of property, it was usually first documented as a grievance form. The NHA said he interviewed the resident, their roommate, other residents, staff and family members. The NHA said he obtained a statement from the resident who was the victim, the residents who witnessed the alleged abuse or misappropriation and from staff who witnessed the alleged abuse or misappropriation. The NHA said the victim's statement was based on the interview conducted by the staff. He said he did not always have the victim write a statement. The NHA said he reported abuse or misappropriation to the stage agency, the police, the resident's representative and the ombudsman. The NHA said he asked the police if they were involving APS or if the facility should notify APS. The NHA said he determined if he substantiated or unsubstantiated an allegation depending on the situation. The NHA said he took the interviews, security footage if applicable and clear evidence to help determine whether or not to substantiate or unsubstantiated an allegation. The NHA said he selected staff to interview based on if they witnessed the allegation or if they worked in the unit where the allegation took place. The NHA said he interviewed all disciplines, not just nursing staff. The NHA said he selected residents to interview based on if they witnessed the allegation. The NHA said he was familiar with the allegation of stolen money from Resident #27. The NHA said in December 2025 he alerted staff that money went missing. The NHA said Resident #27 was not clear on the details and the facility did not know he kept money on him. The NHA said the former SSD found half of the money in his room. The NHA said the facility tried to find the rest of the money by looking in laundry. The NHA said the facility offered Resident #27 a lock box or to keep his money with the facility and Resident #27 declined. The NHA said no one told the facility they had brought money in for the resident. The NHA said the police came on site and interviewed Resident #27. The NHA said the police said they could not do anything with the allegation since he did not say how much or who he thought took it. The NHA said he unsubstantiated the allegation.-However, according to the 12/23/25 police investigation report and the 2/9/26 resident interview, the resident reported that a female nurse took his money (see above). The NHA and the corporate social services resource were interviewed together on 2/12/26 at approximately 1:15 p.m. The corporate social services resource said the information that Resident #27 said in his interview during the survey about a nurse taking his money was new information and the facility would need to open a new investigation. -However, the 12/23/25 police investigation report indicated the resident thought a female nurse took his money (see above). VI. Facility follow up The assistant director of nursing (ADON) provided the following information on 2/12/26 at 5:00 p.m. The information provided revealed Resident #27 was admitted on [DATE] with diagnoses including delusional disorders and generalized anxiety disorder. Resident #27 was noted to have episodes of delusions and confused thoughts. Resident #27 and the family signed a document acknowledging that any items brought in after admission needed to be added to the inventory list. This ensured that the facility was aware of items that were on site. Resident #27 reported to facility staff that he was allegedly missing money on 12/23/25. The money was allegedly identified as missing by the resident on 12/17/25. Once the (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility was notified of the alleged missing money, the facility responded in accordance with established protocol. An investigation was promptly initiated, a search was conducted ($389.00 of an alleged $1000.00 was found), and the incident was reported to the local police department for further investigation. Through the course of the investigation, the resident provided inconsistent information, and the facility was unable to verify that the money had ever been in the resident's possession. The information provided by the ADON indicated the facility was not responsible for items alleged to be in a resident's possession; they must be documented. Therefore, there was insufficient evidence to substantiate the allegation of misappropriation of Resident #27's property as the facility was unable to verify or confirm that these funds were in the resident's possession as alleged.-However, Resident #27 provided a consistent statement with the police officer on 12/23/25 and two resident representatives (see above). -Additionally, according to the facility's own investigation (see above), the facility interviewed one of the resident's representatives who confirmed she had given the resident $1000.00 on 12/17/25 (see investigation above). The resident's belongings inventory list provided by the ADON on 2/12/26 revealed all personal items brought in upon admission and thereafter needed to be properly labeled and added to the inventory list. In order to protect the resident's valuables, all items including money, should be kept in the facility safe or taken home. The facility highly recommended that items that were irreplaceable or of monetary value be left in the care of family or other loved ones, and not stored at the facility. The facility also recommended money be placed in the facility's trust account, if a resident wished to keep it on hand at the facility. Any money placed in the trust account could be requested at the resident's convenience as needed. The signature section on the inventory list documented that by signing below, the resident hereby consented to have all removable appliances clearly identified and marked in a permanent manner with the resident's name. This shall apply, but not necessarily be limited to full dentures, partial dentures, toothbrushes, hearing aids, hearing amplifiers and glasses. -However, the signature section did not confirm if a resident's representative or a resident consented to keep money in the facility's trust account or at home.

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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, interviews and record review, the facility failed to ensure residents were free from chemical restraints for one (#8) of five residents out of 35 sample residents. Specifically, the facility failed to ensure Resident #8's continued use of an antipsychotic medication was appropriately monitored and reviewed by the interdisciplinary team (IDT) for continued medical necessity and gradual dose reduction (GDR).Findings include:I. Facility policy and procedure The Chemical Restraints and Psychotropic Medication Management policy and procedure, revised April 2025, was provided by the nursing home administrator (NHA) on 2/9/26 at 3:59 p.m. It read in pertinent part, Residents who use psychotropic drugs receive gradual dose reductions (GDR), and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Quarterly thereafter, or with any significant change in condition, the residents will be calendared by the social services director for interdisciplinary (IDT) review to assess for continued need and justification of the medication and possible Gradual Dose Reduction.II. Resident #8 A. Resident status Resident #8, age greater than 65, was admitted on [DATE], discharged on 4/21/25, and readmitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses include unspecified dementia, hypertension, atrial fibrillation, muscle weakness, lack of coordination, need for assistance with personal care, unsteadiness on feet and cognitive communication deficit. The 12/8/25 minimum data set (MDS) assessment revealed the resident had short and long-term memory problems and his cognitive skills for daily decision making were severely impaired. He had an impairment on one upper extremity and used a wheelchair. He required supervision with eating and oral hygiene. He required maximal assistance with toileting and showering. He was dependent on personal hygiene. The MDS assessment revealed he had little interest or pleasure in doing things for two to six days, felt down, depressed or hopeless for seven to eleven days, had trouble falling asleep or staying asleep for two to six days during the two week assessment look-back period. The resident did not exhibit verbal or physical behavioral symptoms toward others nor reject care during the assessment look-back period. The assessment revealed the resident was prescribed an antipsychotic medication and a gradual dose reduction was not attempted. B. Observations On 2/9/26 at 11:09 a.m. Resident #8 was observed sleeping in his bed in his room. During a continuous observation on 2/10/26, beginning at 10:24 a.m. and ending at 12:50 p.m., Resident #8 was observed sleeping in his bed in his room. During a continuous observation on 2/11/26, beginning at 10:13 a.m. and ending at 12:24 p.m., Resident #8 was observed sleeping in his bed in his room. -During the observations, staff were observed offering activities to other residents in the common area. Staff did not offer activities to Resident #8. There was no music or television in his room. C. Record reviewThe depression care plan, initiated and revised 8/21/25, revealed Resident #8 was at risk for depression related to dementia, his admission to the facility and a current decline in health. Interventions included administering medications as ordered, monitoring and documenting for side effects and effectiveness, encouraging to express feelings and monitoring, documenting and reporting to the nurse and doctor signs and symptoms of depression. The behavior care plan, initiated 8/29/25 and revised 11/14/25, revealed Resident #8 experienced behaviors of anxiety and agitation related to his current health status. Resident #8 was aggressive and agitated with staff during care such as transfers. Interventions were administering medications as ordered, monitoring and documenting for side effects and effectiveness, anticipating and meeting needs, approaching in a calm manner, assisting to develop more appropriate methods of coping and interacting, encouraging to express feelings appropriately. Behaviors included verbal aggression, declining cares, exit seeking, restlessness, and delusions. Triggers included overstimulation, change in health status and change in environment. Interventions included listening to Spanish rock, offering snacks, offering the weather channel on TV, approaching calmly and slowly, (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sitting outside supervised, visits with family or one-on-one visits from staff. Additional interventions included providing opportunities for positive interactions and attention, documenting behaviors and resident response to interventions, explaining procedures before starting, intervening as necessary, monitoring behavior episodes and attempt to determine underlying cause, praise any indication of progress or improvement of behavior and providing a program of activities that is of interest and accommodates the resident's status. The elopement care plan, initiated 9/19/25 and revised 12/3/25, revealed Resident #8 had wandering and exit-seeking behavior. Resident #8 resided in the secured memory unit. Interventions included distracting the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and books, documenting wandering behavior and attempted diversional interventions, identifying the pattern of wandering, monitoring for exit-seeking behaviors, providing structured activities, and monitoring and documenting observed behaviors and episodes every shift of exit-seeking, unplanned exiting and aimless walking and wandering. The antipsychotic medication care plan, initiated 8/21/25 and revised 11/14/25, revealed Resident #8 took antipsychotic medication related to delusions causing agitation, anxiety and exit-seeking. Interventions included documenting episodes of behavior, monitoring episodes of delusions that caused agitation, anxiety and exit-seeking, calling his significant other on the phone, calm environment, laying down, offering coffee and lemonade, pain management and listening to music or watching television, and quarterly AIMS (abnormal involuntary movement scale) assessments.The 1/15/25 patient health questionnaire (PHQ 9, a diagnostic tool to screen, treat and monitor the severity of depression) revealed the resident had little interest or pleasure in doing things for two to six days; and felt down, depressed or hopeless for 12 to 14 days; fell or stayed asleep for two to six days; felt tired or had little energy for 12 to 14 days; and poor appetite seven to 11 days during the assessment look-back period. Resident #8 scored ten out of 27, indicating moderate depression. The 8/19/25 PHQ 9 evaluation revealed an interview was not completed because the resident was rarely or never understood. -There was no documentation in Resident #8's electronic medical record (EMR) to indicate that social services attempted to reach out to family or staff to determine the resident's current mood and if there was a change in the resident's mood until 11/30/25. The 11/30/25 social services assessment revealed Resident #8 was unable to participate in a cognitive assessment due to his cognitive deficits. His PHQ-9 score was a four which indicated the resident had minimal depression. Resident #8 resided in a secured unit due to wandering and exit-seeking. The resident utilized Seroquel (anti-psychotic medication) for dementia with behaviors. The resident enjoyed group activities and visits from his wife. The 12/8/25 PHQ 9 evaluation revealed Resident #8 had little interest or pleasure in doing things for two to six days; felt down, was depressed or hopeless for seven to 11 days; had trouble falling asleep or staying asleep for two to six days; felt tired or had little energy on 12 to 14 days; and had a poor appetite seven to 11 days during the 14-day assessment look-back period. Resident #8 scored four out of 27, indicating minimal depression. -A review of Resident #8'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. The February 2026 CPO revealed the following physician's orders: -Quetiapine fumarate (Seroquel) 50 mg. Take one tablet by mouth twice a day for dementia with behaviors, ordered 9/2/25. Behavior: verbal aggression, declining cares, exit seeking, restlessness and delusions. Triggers: overstimulations, changes in health status, change in environment. Interventions: offer listening to music, offer snacks, offer TV, approach calmly and slowly, sitting outside supervised weather permitting, visits with family or one on ones from staff. Every shift. ordered 2/5/26.Monitor episodes: delusions that cause agitation, anxiety and exit-seeking. Side effects: drowsiness, dry mouth, blurred vision, constipation. Less common side effects: edema, extra pyramidal symptoms, urinary retention, stiff or tight muscles, restlessness. Rare side effect: tardive dyskinesia. Interventions: calling his significant other on the phone, calm environment, lying down, likes coffee and lemonade, pain management, listening to music or watching TV. Every shift. ordered 9/24/25. Monitor for (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exit-seeking behaviors. If exhibiting active exit-seeking behaviors, provide increased monitoring. Every shift, ordered 10/8/25. Wandering and elopement risk. Monitor and document observed behavior and episodes every shift. Exit-seeking, unplanned exiting, aimless walking and wandering. Interventions: Listening to music, watching television, visiting with family, and snacks. Every shift, ordered 11/11/25. -A review of Resident #8's medication administration records (MAR) and treatment administration records (TAR) from 10/7/25 to 2/12/26 revealed the resident did not exhibit any behaviors. -A review of the resident's EMR revealed there was no documentation to indicate the interdisciplinary team (IDT) reviewed the resident's use of Seroquel (a psychotropic medication), on at least a quarterly basis, to determine if the continued use of the medications was justified or if a GDR of the medications was indicated. III. Staff interviews Certified nurse aide (CNA) #6 was interviewed on 2/11/26 at 4:55 p.m. CNA #6 said she was familiar with Resident #8. CNA #6 said Resident #8 would come to the common area for meals, but primarily stayed in his room. CNA #6 said Resident #8 always slept but she noticed he slept more the past month or two. CNA #6 said she thought he was depressed. CNA #6 said she was not sure why he was depressed. Registered nurse (RN) #2 was interviewed on 2/12/26 at 11:02 a.m. RN #2 said all behaviors were monitored and documented on the MAR and TAR. RN #2 said monitoring was documented as a physician's order that included the behavior, the interventions to use and if the interventions were effective. RN #2 said she was familiar with Resident #8. She said the facility monitored Resident #8's episodes of verbal aggression, refusing care, overstimulation, change in health status, wandering, exit-seeking, delusions, anxiety, restlessness, and aimless walking. RN #2 said calling his spouse was helpful when he exhibited those various behaviors. RN #2 said Resident #8 was first admitted to the facility for skilled care and then discharged home with his spouse. RN #2 said Resident #8 returned to the facility for long-term care when his family was unable to care for him. She said Resident #8 was having a difficult time adjusting to living in the facility. The social services director (SSD) was interviewed on 2/12/26 at 9:02 a.m. The SSD said he had worked at the facility for 10 days. The SSD said social services was responsible for completing the PHQ-9 assessment. He said the purpose of the PHQ-9 assessment was to monitor for mood, behavior and for signs and symptoms of depression. The SSD said if the score increased from one evaluation to another, social services would implement services, offer additional support and review if the resident was on any psychotropic medications or antidepressants. The SSD said he would determine if the change in the resident's PHQ-9 assessment score was related to a specific reason, such as a loss or a specific time of year. The SSD said he relied on the nursing staff to report if the resident was self-isolating. The SSD said he would document a narrative of the conversation when the PHQ-9 assessment was completed and depending on the conversation, the concern for self-harm. The SSD said if counseling was offered, a physician's order was obtained by the nursing staff. The SSD said all behaviors should be monitored, especially self harm and aggression behaviors. The SSD said behaviors were documented by social services at admission, quarterly and as needed in the social services assessment. The SSD said he used the referral information, the family and the resident to develop the care plan and Kardex (summary of the resident's care) to identify triggers and develop effective interventions. The SSD said he relied on nursing staff to tell him anything little or big to help provide proper care and to keep the resident safe. The SSD said if a behavior was monitored due to a resident being prescribed a psychotropic medication, there would be a physician's order to monitor the behaviors. The SSD said residents who were on psychotropic medications were reviewed by IDT quarterly and as needed. The SSD said IDT reviewed medications, behaviors, medication refusals, meal intake and activity participation. The SSD said he was not familiar with Resident #8. The assistant director of nursing (ADON) was interviewed on 2/12/26 at 9:28 a.m. The ADON said social services was responsible for completing the PHQ-9 assessment. The ADON said nursing determined what behaviors to monitor based on progress notes and assessments. The ADON said the IDT reviewed progress notes in the morning clinical meeting to review what behavior was observed and what interventions were implemented. The ADON said the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to thoroughly investigate allegations of abuse for three (#51, #12 and #27) of six residents out of 35 sample residents.Specifically, the facility failed to:-Complete a thorough investigation after an allegation of physical abuse between Resident #51 and Resident #12; and,-Thoroughly investigate an allegation of misappropriation of property involving Resident #27.Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy, revised December 2025, was provided by the nursing home administrator (NHA) on 2/12/26 at 2:08 p.m. It read in pertinent part, It is the policy of this facility that reports of abuse, neglect, misappropriation of property, and exploitation are promptly and thoroughly investigated. When an incident or suspected incident of abuse or neglect is reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. A licensed nurse will examine the resident upon receiving reports of alleged physical or sexual abuse and will record findings in the resident's medical record. The investigation will consist of at least the following: a review of the completed complaint report, an interview with the person (s) reporting the incident, interviews with any witnesses to the incident, an interview with the resident if possible, a review of the resident's medical record, and interviews with staff members having contact with the resident during the period/shift of the alleged incident if applicable, and a review of all circumstances surrounding the incident. II. Failed to complete a thorough investigation after an allegation of physical abuse between towards Resident #51 and Resident #12 A. Facility investigation The facility investigation was provided by the NHA on 2/10/26 at 2:15 p.m. The investigation documented that at approximately 3:30 pm on 2/4/26, Resident #51 reported to staff that her roommate, Resident #12, had walked over to her and bopped her on the shoulder. An investigation was immediately started. Residents #12 and #51 were assessed and were found to have no pain, injuries, bruising or signs of distress. Cross reference F600 for failure to keep residents free from abuse and neglect. Resident #12 was interviewed by the social services director (SSD) on 2/4/26 and the resident denied any physical contact with Resident #51. The investigation documented Resident #51 was interviewed by the SSD on 2/4/26, and stated her roommate walked over to her and bopped her on the shoulder. Resident #51 was offered a room move, which she accepted and was immediately moved to a different unit. Resident #51 denied any fear of Resident #12. The investigation revealed that both residents were placed on 15-minute checks and psychosocial (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents by staff, if yes, explain; do you have any concerns of money being taken or stolen from residents by staff or other residents, if yes, explain and who do you report abuse to. -However, the interviews failed to indicate the date the interviews took place and if they had any specific knowledge about Resident #27's missing money. -Additionally, the interviews did not include any nurses, despite Resident #27 indicating in the police report (see below) that a female nurse took his money. B. Police investigation report The 12/23/25 police investigation report for the investigation into Resident #27's missing money was provided by the police department on 2/10/26 at 3:50 p.m. It revealed that the case status was pending and active. The incident was reported on 12/23/25 and indicated the theft occurred on 12/17/25 between 12:00 p.m and 1:00 p.m. It revealed $700.00 was stolen. The investigation revealed that on 12/23/25, the police officer was dispatched to a theft. The investigation documented Resident #27 said last Wednesday, 12/17/25, a nurse took $700.00 from his wallet. The officer asked how it happened. Resident #27 said around 12:00 p.m. on 12/17/25, a nurse came into his room and woke him up. The nurse helped him take off his robe for laundry day. The nurse took the robe to the laundry and returned with Resident #27's wallet. Resident #27 said he always kept his wallet in the front pocket of his robe. The nurse put his wallet on his nightstand next to his bed. Resident #27 counted the money inside his wallet and he noticed $500.00 missing. Resident #27 said he needed to go to the bathroom so the nurse assisted him. Resident #27 grabbed his wallet and put it in the front pocket of his pajama bottoms. Resident #27 urinated on his pajama bottoms so the nurse took them off of him and set the pajamas in the room by the sink. When Resident #27 was done using the bathroom, he checked his wallet again. Resident #27 noticed another $200.00 missing. Resident #27 was not sure what to say so he waited to report it. Resident #27 did not know the nurse's name. The officer checked with the nurse on duty and she said the schedule for last week was down so she was not sure who worked. The nurse provided a phone number to the scheduler who was only available during the day. There were no surveillance cameras inside the room. The officer requested the case to be active and assigned back to him for follow-up. C. Resident's representative interviews The resident's representative was interviewed on 2/10/26 at 2:03 p.m. The representative said she was aware Resident #27 was missing money. She said another representative called the police to look into it. The resident's representative said Resident #27 told her he was sleeping in bed when a lady woke him up and took his gown that had his wallet in it. She said he told her the lady took the gown to the laundry and took the money out of the wallet. The resident's representative said she gave him $1100.00 and the facility was not doing anything to confirm what happened and what did not happen. She said Resident #27 did not usually have this much money with him. The resident's representative said Resident #27 could be paranoid, but he had the right mind to keep track of his money. A second resident's representative was interviewed on 2/10/26 at 2:47 p.m. The second representative said she called the police department and adult protective services (APS) to look into who stole Resident #27's money. She said no one at the facility cared that Resident #27's money was missing because he was paranoid. She said even though Resident #27 was paranoid, he was very good with his money and was not confrontational about his money. She said she handled Resident (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#27's money and gave the other representative money because she lived close by to the facility. She said the other representative and Resident #27 got in an argument so the other representative gave Resident #27 all of his money at the same time. She said Resident #27 waited a week to tell her the other representative and he fought and the money went missing afterwards. She said the facility did nothing to resolve the issue. D. Resident #27 1. Resident status Resident #27, age less than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus with hyperglycemia, asthma, delusional disorders, paraplegia, cellulitis of the right lower limb, gout, generalized anxiety disorder, hypertension and depression. The 2/1/26 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. 2. Resident interview Resident #27 was interviewed on 2/9/26 at 3:17 p.m. Resident #27 said on 12/17/25 a female nurse took his wallet and took money out of his wallet. Resident #27 said it happened when the nurse assisted him with toileting care. He said the female nurse took his hospital gown off and he had his wallet in the front pocket. Resident #27 said it happened during a morning shift and police were called. Resident #27 said he did not know what the outcome of the investigation was. Resident #27 said he did not know the name of the nurse but knew it was a female, she worked a day shift and was Hispanic. He said he had a lot of money in his wallet because he had to buy a phone. Resident #27 said on 12/17/25 he had $1300.00. and today, 2/9/25, he had $600.00 in his wallet. He said he would use a lock box if he was given one to keep things like his $100.00 bluetooth speaker he had on his table close to the entrance of his room. E. Staff interview The NHA was interviewed on 2/12/26 at 11:44 a.m. He said he was the abuse coordinator. The NHA said if a staff member suspected abuse they contacted the director of nursing (DON) and him. He said the investigation was documented in risk management. He said if an allegation was misappropriation of property, it was usually first documented as a grievance form. The NHA said he interviewed the resident, their roommate, other residents, staff and family members. The NHA said he obtained a statement from the resident who was the victim, the residents who witnessed the alleged abuse or misappropriation and from staff who witnessed the alleged abuse or misappropriation. The NHA said the victim's statement was based on the interview conducted by the staff. He said he did not always have the victim write a statement. The NHA said he reported abuse or misappropriation to the stage agency, the police, the resident's representative and the ombudsman. The NHA said he asked the police if they were involving APS or if the facility should notify APS. The NHA said he determined if he substantiated or unsubstantiated an allegation depending on the situation. The NHA said he took the interviews, security footage if applicable and clear evidence to help determine whether or not to substantiate or unsubstantiated an allegation. The NHA said he selected staff to interview based on if they witnessed the allegation or if they worked in the unit where the allegation took place. The NHA said he interviewed all disciplines, not just nursing staff. The NHA said he selected residents to (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview based on if they witnessed the allegation. The NHA said he was familiar with the allegation of stolen money from Resident #27. The NHA said in December 2025 he alerted staff that money went missing. The NHA said Resident #27 was not clear on the details and the facility did not know he kept money on him. The NHA said the former SSD found half of the money in his room. The NHA said the facility tried to find the rest of the money by looking in laundry. The NHA said the facility offered Resident #27 a lock box or to keep his money with the facility and Resident #27 declined. The NHA said no one told the facility they had brought money in for the resident. The NHA said the police came on site and interviewed Resident #27. The NHA said the police said they could not do anything with the allegation since he did not say how much or who he thought took it. The NHA said he unsubstantiated the allegation. -However, according to the 12/23/25 police investigation report and the 2/9/26 resident interview, the resident reported that a female nurse took his money (see above). The NHA and the corporate social services resource were interviewed together on 2/12/26 at approximately 1:15 p.m. The corporate social services resource said the information that Resident #27 said in his interview during the survey about a nurse taking his money was new information and the facility would need to open a new investigation. -However, the 12/23/25 police investigation report indicated the resident thought a female nurse took his money (see above). F. Facility follow up The assistant director of nursing (ADON) provided the following information on 2/12/26 at 5:00 p.m. The information provided revealed Resident #27 was admitted on [DATE] with diagnoses including delusional disorders and generalized anxiety disorder. Resident #27 was noted to have episodes of delusions and confused thoughts. Resident #27 and the family signed a document acknowledging that any items brought in after admission needed to be added to the inventory list. This ensured that the facility was aware of items that were on site. Resident #27 reported to facility staff that he was allegedly missing money on 12/23/25. The money was allegedly identified as missing by the resident on 12/17/25. Once the facility was notified of the alleged missing money, the facility responded in accordance with established protocol. An investigation was promptly initiated, a search was conducted ($389.00 of an alleged $1000.00 was found), and the incident was reported to the local police department for further investigation. Through the course of the investigation, the resident provided inconsistent information, and the facility was unable to verify that the money had ever been in the resident's possession. The information provided by the ADON indicated the facility was not responsible for items alleged to be in a resident's possession; they must be documented. Therefore, there was insufficient evidence to substantiate the allegation of misappropriation of Resident #27's property as the facility was unable to verify or confirm that these funds were in the resident's possession as alleged. -However, Resident #27 provided a consistent statement with the police officer on 12/23/25 and two resident representatives (see above). -Additionally, according to the facility's own investigation (see above), the facility interviewed one of the resident's representatives who confirmed she had given the resident $1000.00 on 12/17/25 (see investigation above).

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to implement activity programs that met the interests and supported the physical, mental, and psychological well-being of one (#12) of 19 residents reviewed for activities out of 35 sample residents. Specifically, the facility failed to offer and provide a personalized activity program for Resident #12.Findings include:I. Facility policy and procedureThe Activity Policy and Procedure Manual, dated December 2024, was provided by the nursing home administrator (NHA) on 2/12/26 at 2:08 p.m. It read in pertinent part, It is the policy of this facility to ensure that residents have the right to choose the types of activities and social events in which they wish to participate.Some activities can be adapted to accommodate the resident's change in functioning due to physical or cognitive limitations: Cognitive impairment (task segmentation, settings that recreate past experiences, smaller groups without interruption, one-to-one); Language barrier (translation tools, audio/video in the resident's language).Daily activities, including those on weekends and holidays, are provided, as well as scheduled religious and social activities. However, residents are free to choose whether or not they wish to attend any activity or other scheduled event(s).II. Resident #12A. Resident statusResident #12, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included schizoaffective disorder, bipolar type, muscle weakness and muscle wasting and atrophy.The 1/2/26 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. She was independent with mobility, personal hygiene, toileting, and eating.The assessment revealed the resident's preferred language was Russian; however did not require an interpreter to communicate with health care staff.The assessment revealed the resident had been interviewed to determine her activity preferences. The resident indicated it was very important for her to keep up with the news, listen to music she liked, participate in her favorite activities, go outside to get fresh air and participate in religious services or practices.B. Resident interviewResident #12 was interviewed via a translator language line in her native Russian language on 2/10/26 at 1:15 p.m. Resident #12 said she did not participate in most activities because she did not see the importance of them if she could not understand them. She said she did not have any one-on-one activities planned. She said she loved music and enjoyed playing the piano. Resident #12 said the facility had a piano that she enjoyed playing and she believed most of the facility's residents enjoyed listening to and watching her play. Resident #12 said she would love to have piano sessions every week. The resident said she would love to have scheduled piano sessions as part of her activity program. She said the activities department handed out a daily chronicle and an activities schedule each morning, however they were both printed in English.Resident #12 said she had enjoyed the activities at the hospital when she was there because they were in her native Russian language.C. ObservationsDuring a continuous observation on 2/10/26, beginning at 1:00 p.m. and ending at 2:30 p.m., the following was observed.At 1:00 p.m. Resident #12 was lying in her bed, covered with a blanket. She said it was cold and wished the facility could turn the heat up to keep her warm. There was no television or music in the resident's room. Her bed was positioned in the corner, close to the wall and she was facing the wall. Her eyes were open, and she was staring at the wall. There was no activity calendar observed in the resident's room.At 2:00 p.m., a country cart activity was going on in the unit's activity room. However, Resident #12 was not invited to attend the activity.At 2:10 p.m. certified nurse aide (CNA) #2 entered the resident's room and checked on her. She did not invite the resident to the country cart activity.During a continuous observation on 2/11/26, beginning at 10:00 a.m. and ending at 11:00 a.m., the following was observed:At 10:05 a.m. Resident #12 was lying in her bed. There was a daily chronicle, printed in English, in the resident's trash can next to her bed. No activity supplies, individualized activities or an activity calendar were observed in her room.At 10:50 a.m. there was a (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fitness activity program going on in the activity room. However, Resident #12 was not invited to attend the activity.D. Record reviewThe communication care plan, initiated 7/20/2020, revealed that Resident #12 was at risk for communication problems due to a language barrier and she spoke mostly Russian. Pertinent interventions included anticipating and meeting her needs, providing American mobile nurses (AMN) language service to provide translation services as necessary to communicate with the resident and providing programs of activities that accommodated the resident's communication abilities.The activities care plan, revised 11/12/24, revealed Resident #12 preferred spending time in her room and resting throughout the day, as well as going for walks around the facility and outside when the weather was nice. Pertinent interventions included staff periodically checking in with the resident to ensure her leisure needs were being met and to offer additional activity supplies as necessary. The staff would provide a monthly activity calendar in the resident's room. -However, there was no activity calendar posted in the resident's room (see observations above).The behavior care plan, revised 3/27/23, documented Resident #12 had potential for a mood and or behavior problem related to diagnoses of schizoaffective, bipolar type. Pertinent interventions included offering for the resident to watch television and listen to preferred music.-However, there was no music device or television in the resident's room (see observations above).-The care plan failed to mention the resident's desire to play the facility's piano as part of her preferred activities.III. Staff interviewsCertified nurse aide with medication authority (CNA-Med) #1 was interviewed on 2/11/26 at 4:54 p.m. CNA-Med #1 said Resident #12 stayed in her room most of the time. CNA-Med #1 said the resident isolated herself because of her limited English proficiency. She said the resident's preferred language was Russian. CNA-Med #1 said she had not observed the resident engaging in one-on-one activities.The activity assistant (AA) was interviewed on 2/12/26 at 8:50 a.m. The AA said she was familiar with Resident #12. She said the resident mostly spoke Russian but also spoke some English. She said the resident refused most of the activities the facility offered. The AA said the resident did not currently have any one-on-one activities.-However, per the resident's interview (see above), she enjoyed playing the facility's piano and was interested in playing it weekly for the other residents.The activity director (AD) was interviewed on 2/12/26 at 10:30 a.m. The AD said Resident #12 refuses most of the activities offered to the residents. The AD said she had not identified the reason the resident refused most of the activities offered. She said all activities were offered in English, and there was no one-on-one activity program scheduled with the resident. The AD said the resident enjoyed playing the facility's piano; however, she had not incorporated that into the resident's activities. The AD said the activities calendar was printed in English and posted in the common area of the facility, not in the residents' rooms.-However, according to Resident #12's activities care plan, a monthly activity calendar was to be posted in the resident's room (see record review above).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#25) of three residents out of 35 sample residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan. Specifically, the facility failed to:-Obtain accurate wound care orders for Resident #25 in a timely manner; and, -Ensure interventions were followed for Resident #25 to prevent an abrasion to the resident's back.Findings include:I. Facility policy and procedure The Wound Care and Treatment Guideline policy and procedure, revised May 2024, was provided by the nursing home administrator (NHA) on 2/12/26 at 4:24 p.m. It read in pertinent part, Treatments will be placed in the electronic medical record (EMR), treatments can be triggered under the EMAR (electronic medication administration record) or TAR (treatment administration record). A licensed nurse will monitor the wounds with treatments and scheduled assessments. Treatments will be placed in the computer upon order from the physician.II. Resident #25A. Resident status Resident #25, age less than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included frontotemporal neurocognitive disorder (a neurological disease causing dementia early on), multiple myeloma (cancer of blood cells), bilateral osteoarthritis of the knee, type 2 diabetes mellitus, generalized idiopathic epilepsy, stage 2 chronic kidney disease, atherosclerotic heart disease (build up of fat, cholesterol along the artery walls), encephalitis (inflammation of the brain), Pick's disease (form of dementia), stiffness of unspecified joint, other reduced mobility, muscle weakness and difficulty walking. The 2/1/26 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 his cognitive skills for daily decision making were moderately impaired.B. Resident's representative interview Resident #25's representative was interviewed on 2/9/26 at 1:11 p.m. The representative said Resident #25 had a wound on his back because he was always bending his back to the right side because he could not hold himself upright. She said she asked the facility to put a pillow on the armrest of the wheelchair to help balance him when he sat in his wheelchair. She said he never had wounds. C. Observations During a continuous observation on 2/10/26, beginning at 10:24 a.m. and ending at 12:50 p.m., Resident #25 was observed in the common area of the secure unit in his wheelchair. He did not have a pillow on his arm rest or behind his back. On 2/11/26 at 8:16 a.m. Resident #25's wound care was observed with the wound care physician (WCP) and the wound care nurse. The resident was in bed, lying on his back. The resident's wound had a hardened crust in a lateral pattern on the right flank. The color appeared to be dark brown with a pink dry center. There was no drainage noted. The surface of the resident's skin appeared to be uneven, dry, and rough. No redness or swelling was noted on the surrounding skin. The resident did not appear to have pain while having his wound assessed. The resident's head was elevated on a pillow, and he did not have any offloading measures on his right flank before the WCP began the wound care. On 2/11/26 at 4:55 p.m. Resident #25 was observed in the common area of the secure unit in his wheelchair. He did not have a pillow on his armrest or behind his back. At 5:20 p.m. (following an interview with certified nurse aide (CNA) #6 - see below), CNA #6 placed a pillow behind Resident #25's back. D. Record reviewThe skin integrity care plan, initiated and revised on 2/2/26, revealed Resident #25 had an actual impairment to skin integrity related to an abrasion to the right side of his back. Interventions included administering treatments as ordered, educating the resident, family and caregivers of causative factors and measures to prevent skin injury, encouraging good nutrition and hydration, observation of resident transferring, sling fit, padding the resident's bed rails and wheelchair arms, providing a pillow to the right side of the resident's high back wheelchair for positioning as he would allow, using caution during transfers and bed mobility to prevent striking the resident's arms, legs and hands against sharp (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or hard surfaces. -However, Resident #25 did not consistently have a pillow to the right side of his wheelchair (see observations above). The 2/10/26 Kardex (an abbreviated care plan utilized to provide consistent resident care by staff) revealed there were no instructions on pillow positioning or wedge use for the resident when he was in his wheelchair. A review of Resident #25's February 2026 CPO revealed the following physician's orders: Skin alteration: wound to right side of back. Monitor for signs and symptoms of infection. Notify the physician of any changes every shift, ordered 1/31/26. -However the WCP's 2/4/26 wound care notes indicated the treatment orders were changed on 2/4/26 (see WCP notes below). Monitor skin: right flank, abrasion. Cleanse site with wound cleanser and normal saline. Pat dry with a clean gauze, apply hydrocolloid (a moisture-retentive wound dressing for superficial wounds)to the affected area, twice a week and as needed for skin alteration prevention. Report to primary care physician if infection or worsening is noted. Offload pressure areas every day shift every Wednesday and Sunday for skin alteration prevention per wound care physician, ordered 2/11/26. Monitor skin: right flank, abrasion. Cleanse site with wound cleanser and normal saline. Pat dry with a clean gauge, apply hydrocolloid to the affected area, twice a week and as needed for skin alteration prevention. Report to primary care physician if infection or worsening is noted. Offload pressure areas as needed, ordered 2/11/26. -However, the above two physician's orders were added on 2/11/26, during the survey after the WCP's interview (see interview below). The 1/29/26 skin evaluation revealed Resident #25 had no new skin issues noted at this time. Turgor (the skin's elasticity and its ability to change shape and return to normal) and temperature were within normal limits. The 1/31/26 skin evaluation revealed Resident #25 had an open area to the right side of his lower back measuring 8 centimeters (cm) in length by 1.5 cm in width. The wound was linear, the wound bed was pink and moist. There was no active bleeding and no signs of infection. There was a periwound (the skin and tissue immediately surrounding a wound) with dark brown discoloration. The 1/31/26 nurse note revealed that at 5:30 a.m. a CNA notified the nurse of Resident #25's open area to the right side of his back. The open area measured 8 centimeters in length by 1.5 cm in width. The wound was linear, the wound bed was pink and moist. There was no active bleeding and no signs of infection. There was a periwound with dark brown discoloration. The wound was cleansed with a wound cleanser and gently patted dry and a dressing was applied. Resident #25 tolerated the treatment well. The physician was notified and staff were unable to reach the resident's representative. The 2/4/26 WCP wound tracker form revealed Resident #25 had a wound on his right flank and the etiology was an abrasion. The dimensions were 0.5 cm in length by 5 cm in width by 0.1 cm in depth. Epithelial tissue (the new, regenerated skin that grows over a wound surface, appearing as a thin, pale pink or pearly white layer) was 100% (percent) and the periwound was discolored. The treatment was hydrocolloid twice a week and as needed. -However the hydrocolloid treatment orders from the wound tracker form were not entered into Resident #25's EMR until 2/11/26 (during the survey- see physician's orders above). The 2/9/26 nurse note revealed Resident #25's representative was updated on the abrasion to the resident's back. A pillow was in place to the right side of the resident's high back wheelchair for positioning.-However, observations on 2/10/26 and 2/11/26 revealed staff were not consistently placing the pillow in the resident's wheelchair (see observations above). The 2/11/26 WCP wound tracker form revealed Resident #25 had a wound on his right flank and the etiology was an abrasion. The dimensions were 0.5 cm in length by 5 cm in width by 0.1 cm in depth. The treatment was hydrocolloid twice a week for prevention. E. 1/3/26 Incident report The 1/31/26 nurse note revealed that at 5:30 a.m. a CNA notified the nurse of Resident #25's open area to the right side of his back. The open area measured 8 centimeters in length by 1.5 cm in width. The wound was linear, the wound bed was pink and moist. There was no active bleeding and no signs of infection. There was a periwound with dark brown discoloration. The wound was cleansed with a wound cleanser and gently patted dry and a dressing was applied. Resident #25 tolerated the treatment well. The physician was notified and staff were unable to reach the resident's representative. The 2/2/26 nurse clinical resource statement (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented an observation of a transfer of Resident #25 related to skin alteration. There were no concerns with the fit of the transfer sling, bed mobility or transfer noted. Per staff, Resident #25 leaned to the right side in his wheelchair at times. Currently, there was a pillow on the right side. There were no sharp edges noted to the wheelchair. The resident denied pain, laughing and talking in word salad at the time of review. The 2/2/26 interdisciplinary (IDT) team note revealed they met to review Resident #25's skin alteration. The risk factors were poor motor control, diabetes mellitus type 2, noted to favor leaning to his sides, and the placement of wheelchair padding. Education provided to staff was notifying the resident's representative of the padding placement on the wheelchair due to the resident's skin alteration. -However, there was no documentation in Resident #25's EMR of the IDT note. III. Staff interviewsWound care nurse #1 and the WCP were interviewed together on 2/11/26 at 1:30 p.m. Wound care nurse #1 said he started seeing Resident #25 today (2/11/26) at 8:15 a.m. The WCP said she started seeing Resident #25 last week (on 2/4/26). The WCP said Resident #25 was at risk for skin breakdown. The WCP said some of the interventions to prevent skin breakdown included a hydrocolloid dressing. The WCP said she ordered the hydrocolloid dressing last week (on 2/4/26) and would continue with the same treatment this week. The WCP said she communicated what interventions the facility should use by completing a wound assessment sheet with the recommendation and measurements and returning the sheet to the director of nursing (DON). The WCP said she would want to see the recommendations entered as physician's orders and interventions passed along to the floor staff. The WD said she had not assessed the resident's wound after initial onset (on 1/31/26) because she was not assigned to Resident #25. The WCP said she was told the wound was caused by moisture. The WCP said ordered interventions must be implemented to assess the effectiveness of the treatment. The WCP said if Resident #25 was in his wheelchair for three hours without a pillow on his right side, the facility was not following the physician ordered interventions. The WCP said the wound treatment order was going to continue to be the same from last week and there were no changes. CNA #6 was interviewed on 2/11/26 at 4:55 p.m. CNA #6 said she knew what interventions to use to help a resident who had skin conditions from her CNA training. She said repositioning was one intervention to prevent skin breakdown, as well as not pulling on residents because a lot of residents' skin was thin and was easy to tear. CNA #6 said interventions were documented as a task in the resident's EMR and in the resident's care plan. CNA #6 said another skin breakdown intervention was to keep residents away from walls. CNA #6 said if she noticed a change in a resident's skin, she would notify the nurse in the unit. CNA #6 said she was familiar with Resident #25. She said he had an abrasion on his back. CNA #6 said she did not know how it happened but based on where the abrasion was located, she thought it happened because of a screw located on his wheelchair. She said no one educated her on what interventions were in place for the resident, but she placed a pillow on his back to help him from leaning on one side of his wheelchair. -After the interview, CNA #6 was observed placing a pillow on the back of Resident #25 while he was in his wheelchair in the common area of the secure unit (see observations above). Registered nurse (RN) #3 was interviewed on 2/12/26 at 10:49 a.m. RN #3 said she had worked at the facility for one month. RN #3 said residents' skin was assessed per physician's orders, once a week. RN #3 said she assessed residents if the CNA reported a change to the resident's skin. RN #3 said she notified the physician anytime there was a change in the resident's skin, such as a skin tear. RN #3 was familiar Resident #25. She said he had a skin condition on his back but it was healed. She said she did not know what caused the skin condition. She said an intervention was in place to keep a pillow on his back. RN #2 was interviewed on 2/12/26 at 11:02 a.m. RN #2 said residents' skin was assessed at admission, the following day, weekly and as needed. She said skin assessments were documented in the assessment tab of the resident's chart. She said the physician and the DON or the assistant director of nursing (ADON) were notified when a skin problem was identified. She said when a new skin condition was identified, a risk assessment was initiated which included a skin assessment and pain assessment, treatment orders were obtained if applicable and the physician, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	family and ADON or DON were notified. RN #2 said skin assessments should be completed every shift if a skin condition was identified to monitor for signs and symptoms of infection. RN #2 said she knew what interventions were in place based on a physician's order. RN #2 was familiar with Resident #25. She said he had a skin condition on his back but it was healed. She said the way Resident #25 sat and the fact that he was restless was what caused his abrasion. She said a pillow placed on his back to prevent him from leaning was one intervention. The ADON and the clinical resource were interviewed together on 2/12/26 at 1:48 pm. The ADON said residents' skin was assessed at admission, the following day, weekly and as needed. She said skin assessments were documented in the assessment tab of the resident's chart. The ADON said the physician should be notified of any skin conditions other than the skin being intact. The ADON said when a new skin condition was identified, a risk assessment was started, treatment done and an intervention was identified. She said after a skin condition was identified, skin should be assessed based on the physician's order, but at least monitoring every shift for signs and symptoms for signs and symptoms for infection. The ADON said the treatment order depended on the physician's order. The ADON said the IDT determined the interventions within 24 hours or the next business day. She said the IDT followed a template that included the dimension, location, measurement and what the care plan should be. She said the ADON, therapy and nutrition were part of the IDT. She said the IDT notes were in risk assessment which was separate from the resident's chart. The ADON said sometimes the IDT note was in the resident's chart. The ADON said interventions could be a physician's order, such as skin treatments. an air mattress or a bed bolster. The ADON said the interventions would be found in the residents' care plans. The ADON was familiar with Resident #25. She said he had an abrasion on his back but it was resolved. She said he moved around in his wheelchair so that was why they padded his wheelchair armrest. She said in addition to the padded armrest, other interventions included a pillow. She said the pillow could be anywhere on the back of the resident. She said if the resident was leaning to one side and the pillow was positioned to help him sit straight, that would be an effective intervention. The clinical resource said hydrocolloid was also an intervention because the WCP said Resident #25 had folds on his sides from leaning and the hydrocolloid helped prevent friction. The clinical resource said during the facility's wound audit this week (week of 2/9/26), the WCP shared the clinical resource the process for how the WCP's treatment orders were communicated from the WCP to the floor nurse. The clinical resource said the process should be the wound care nurse was to transcribe the treatment order from the wound tracker form into the resident's chart the day the WCP visited. The clinical resource said wound care nurse #1 told her he was not given the wound tracker form from 2/4/26 and that was why the physician's order for the hydrocolloid treatment had not been entered into the resident's EMR. The clinical resource said the facility should have followed the WCP orders from 2/4/26. IV. Facility follow-up On 2/13/26 at 5:00 p.m. (after the survey exit), the nursing home administrator (NHA) provided the following information. The NHA indicated education was provided to nurses and CNAs on 2/2/26 instructing if the nurse or CNA observed a new skin integrity, they were to notify the nurse immediately. Staff was reminded to provide individualized care following the care plan: turning and repositioning, offering assistance with fluids, offering assistance with a snack, offloading heels by placing them on a pillow or in heel boots as ordered, applying barrier cream and assisting with toileting. Additionally, a wound program review was completed on 2/2/26. It revealed that the facility's wound program was for complex or nonhealing wounds, including but not limited to, pressure injuries, surgical wounds, stasis ulcers and diabetic ulcers. The wound care nurse and the IDT should confirm the following were in place: wound entered on wound rounds log, enhanced barrier precautions ordered and in place if indicated, nutrition at risk meeting list updated, therapy referral as applicable, appropriate treatment in place and comprehensive care plan in place, including factors leading to development and risk for delayed healing and interventions.-However, the WCP's orders from the wound tracker form were not entered into Resident #25's medical record on 2/4/26 (see above).

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure proper treatment and assistive devices to maintain hearing abilities for one (#13) of two residents reviewed for hearing and vision problems out of 35 sample residents.Specifically, the facility failed to ensure Resident #13 was assisted to receive a replacement hearing aid after her hearing aid was broken.Findings include:I. Facility policy and procedureThe Hearing and Vision Services policy, revised January 2022, was provided by the nursing home administrator (NHA) on 2/12/26 at 2:08 p.m. It read in pertinent part, It is the policy of this facility to ensure that all residents have access to hearing and vision services and receive adaptive equipment as indicated. The social worker/social services designee is responsible for assisting residents and their families in locating and utilizing any available resources for the provision of the vision and hearing services the resident needs.II. Resident #13A. Resident statusResident #13, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), unspecified dementia, bipolar disorder, anxiety disorder and cognitive communication deficit.The 11/18/25 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 13 out of 15. The assessment documented the resident had no difficulty hearing and did not require the use of hearing aids.B. Resident observationsOn 2/10/26 at 4:15 p.m. Resident #13 was sitting on her bed. She had a notepad and a pen on her bedside table. She had no hearing aid in either ear.On 2/11/26 at 9:40 a.m. Resident #13 was arranging her room. She had no hearing aid in either ear. She had a notepad and a pen to write.On 2/12/26 at 10:20 a.m. Resident #13 was in her room, sitting on her bed. Certified nurse aide (CNA) #4 entered the resident's room and wrote on the notepad. Resident #13 read the note and responded verbally.C. Resident representative and resident interviewResident #13 was interviewed on 2/10/26 at 4:15 p.m. Resident #13 said her hearing aid was broken and she requested staff to write their questions to her on her notepad. She said her hearing aid had been broken for over a year. Resident #13 said she usually asked staff and visitors to write on her notepad because she could not hear without her hearing aid. She pulled open her bedside drawer and brought out one piece of the broken hearing aid. Resident #13 said she could not find the other piece.The resident representative was interviewed on 2/12/26 at 9:35 a.m. The representative said Resident #13 had been using hearing aids for a very long time. He said that without the hearing aids, it was difficult communicating with the resident, especially on the phone, which sometimes irritated Resident #13. The representative said the resident's current hearing aid had been broken for some time now and the facility had made no effort to repair or replace the hearing aids.D. Record review-There were no documentation in the resident's electronic medical record (EMR) to indicate the facility was attempting to assist Resident #13 with obtaining new hearing aids.III. Staff interviewsCNA #4 was interviewed on 2/11/26 at 2:20 p.m. CNA #4 said Resident #13 had a hearing deficit and often read lips or asked staff to write on her notepads during communication to help her understand. CNA #4 said the resident's hearing aid was broken.Certified nurse aide with medication authority (CNA-Med) #1 was interviewed on 2/11/26 at 3:00 p.m. CNA-Med #1 said Resident #13 had difficulty hearing without her hearing aids. She said Resident #13 would often ask staff to write on her notepad so she could understand. CNA-Med #1 said the resident's hearing aids had been broken for a long time.The social services director (SSD) was interviewed on 2/11/26 at 3:15 p.m. The SSD said he was new to the facility and had not yet met Resident #13. He said residents with hearing impairments should be evaluated for appropriate hearing aids. The SSD said he could not find any recent audiology visit documentation for Resident#13.The SSD was interviewed a second time on 2/12/26 at 11:45 a.m. The SSD said he met with Resident #13 and completed an evaluation. He said he had placed an order (during the survey) to replace the resident's broken hearing aids, which were due to arrive at the facility the next day.-However, the (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order for the replacement hearing aids was not placed until the concern was brought to the facility's attention during the survey. IV. Facility follow-upOn 2/13/26 at 5:55 p.m. (after the survey exit) the SSD provided an audiologist's note for Resident #13 via email. The note was dated 9/12/22. The audiologist's note indicated the resident's hearing aid was to be returned for a replacement, but the staff were unable to locate the old one.-However, there was no documentation in the resident's electronic medical record (EMR) to indicate Resident #13 had been seen by the audiologist since 9/12/22, over a three-year timespan (see record review above).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure medications and biologicals were stored and labeled properly according to professional standards in two of three medication carts and one of three medication refrigerators.Specifically, the facility failed to: -Ensure expired medications were removed from the medication cart and disposed of; and,-Ensure the medication refrigerator was securely locked on one of three units.Findings include:I. Professional referencesThe United States Food and Drug Administration (USFDA) Don't Be Tempted to Use Expired Medicines (revised 10/31/24), was retrieved on 2/13/26 from https://www.fda.gov/drugs/special-features/dont-be-tempted-use-expired-medicines. It read in pertinent part, Expired medical products can be less effective or risky due to a change in chemical composition or a decrease in strength. Certain expired medications are at risk of bacterial growth, and sub-potent antibiotics can fail to treat infections, leading to more serious illnesses and antibiotic resistance. Once the expiration date has passed, there is no guarantee that the medicine will be safe and effective. If your medicine has expired, do not use it.II. Facility policy and procedureThe Storage of Medication policy, revised February 2026, was received from the nursing home administrator on 2/9/26 at 12:25 p.m. It revealed in pertinent part, Medication storage refrigerators must be kept locked when medications are currently being stored under refrigeration. Outdated and contaminated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction and recorded from the pharmacy if a current order exists. III. ObservationsOn 2/9/26 at 9:16 a.m. the medication cart was observed on the secured unit with certified nurse aide with medication aide authority (CNA-Med) #2. The locked narcotic drawer on the medication cart contained the following: -Morphine 20 milligram per milliliter (mg/ml), expired 1/15/26.On 2/9/26 at 9:28 a.m. the medication room on Castle Rock unit was observed with licensed practical nurse (LPN) #1. -The medication refrigerator was unlocked. The medication refrigerator contained a narcotic box that was locked. The locked narcotic drawer on the medication cart contained the following: -Oxycodone HCl Oral solution 5 mg/5 ml.-However, the Oxycodone was discontinued (see interviews below).IV. Staff interviewsCNA-Med #2 was interviewed on 2/9/26 at 9:17 a.m. CNA-Med #2 said the morphine should have been discarded and should not have been administered to the resident. She said it was the responsibility of the nurses and the CNA-Meds to ensure all expired medications were removed from the medication carts.LPN #1 was interviewed on 2/9/26 at 9:33 a.m. LPN #1 said the oxycodone should have been removed from the medication cart because it was discontinued on 11/18/25. She said the medication refrigerator in the medication room should be locked because it contains narcotic and non-narcotic prescribed medications for facility residents. The clinical resource was interviewed on 2/9/26 at 9:39 a.m. She said the staff should not administer expired or discontinued medication to facility residents. She said the nurses should always review the five rights before administering medication to residents. The clinical resource said the nurses should make sure it was the right resident, medication, dose, route, time, and check the expiration date. The consultant pharmacist was interviewed on 2/9/26 at 11:39 a.m. The consultant pharmacist said each nurses' unit in the facility should have a locked door on the medication refrigerator inside the medication room. She said the medication in the medication refrigerator on the Castle Rock unit was secure because the door to enter the medication room was locked. The consultant pharmacist was interviewed again on 2/10/26 at 3:50 p.m. The consultant pharmacist said there was a sheet at the nurses' station that said the morphine was good for one year. She said the nurses were trained to refer to the medication sheet for directions for expired medications. She said the label on the bottle of morphine on the Castle Rock unit indicated it was expired, which was different from the expiration date on the pharmacy label. She (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said the nurses and CNA-med should use the expired date on the bottle and not the expired date on the pharmacy label.Registered nurse (RN) #3 was interviewed on 2/11/26 at 1:41 p.m. RN #3 said she would check the pharmacy label for the expiration date and make sure the medication was not expired. She said she was trained by the facility to always check the pharmacy expiration date before administering medications to residents. The assistant director of nursing (ADON) was interviewed on 2/12/26 at 11:29 a.m. The ADON said she would ensure that all nursing staff who administered medications to residents were educated on the facility policy of medication administration. She said she would initiate this re-education training immediately. She said it was the expectation for staff administering medications, to review the expiration date on the medication bottle and discard medication accordingly.