STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Heights Care Center	656 Dillon Way Aurora, CO 80011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 51915 Based on record review and interviews, the facility failed to ensure three (#13, #1 and #6) of five residents out of 13 sample residents were kept free from abuse. Specifically, the facility failed to: -Ensure Resident #13 and Resident #1 were kept free from physical abuse by Resident #2; and, -Ensure Resident #6 was kept free from physical abuse by Resident #7. Findings include: I. Facility policy and procedure The Abuse policy and procedure, dated 2/29/24, was provided by the nursing home administrator (NHA) on 3/27/25 at 2:30 p.m. It revealed in pertinent part, Physical abuse is defined as abuse that results in bodily harm with intent. It includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment and willful neglect of the resident's basic needs. The facility does not condone resident abuse and shall take every precaution possible to prevent resident abuse by anyone, including staff members, other residents, volunteers, and staff of other agencies serving the resident, family members, legal guardians, resident representative, sponsors, friends, or any other individuals. Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraints not required to treat the resident's symptoms. II. Incident of physical abuse by Resident #2 towards Resident #1 and Resident #13 A. Facility investigation of physical abuse by Resident #2 towards Resident #13 on 1/2/25 The 1/2/25 incident report documented Resident #13 was walking next to Resident #2 in the hallway when Resident #2 stopped and hit Resident #13 for no reason. Resident #13 put his hand on her head to stop her. After the incident, Resident #13 stated I was not afraid of her hitting me again; it is not a big deal; she is just a confused, mean old lady. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The incident report documented the incident was witnessed by the admissions coordinator. The witness statement and interviews substantiated the physical abuse by Resident #2 toward Resident #13. The facility called the police and notified the ombudsman, the director of nursing (DON), the attending physician and the state health department. B. Facility investigation of physical abuse by Resident #2 towards Resident #1 on 2/26/25 The 2/26/25 incident report documented Resident #1 was passing in the hallway when Resident #2 was self-propelling her wheelchair in the opposite direction. Resident # 1 stopped and stood to the side so that Resident #2 could pass by him. When Resident #2 passed by Resident #1, she slapped Resident #1 on his left cheek with her open hand. Resident #1 then pushed her to the side, stating, What the hell, lady. Both residents were immediately separated, assessed and placed on frequent checks. Dietary aide (DA) #1 witnessed the incident and reported that Resident #2 wanted Resident #1 to back up, but he cussed her out. DA #1 stated, I moved Resident #1 forward and away. During a post-incident interview, Resident #1 responded, I do not know why she slapped me; she is crazy. Interviews substantiated the physical abuse by Resident #2 toward Resident #1. C. Resident #2 - assailant 1. Resident status Resident #2, age 71, was admitted on [DATE] and readmitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included schizoaffective disorder (depressive type), anxiety disorder and Alzheimer's disease. The 1/21/25 minimum data set (MDS) assessment revealed Resident #2 had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. She required the assistance of one person with transfers, dressing, showering, toileting, and personal hygiene. The MDS assessment documented Resident #2 had physical behavioral symptoms directed toward others which occurred every one to three days during the assessment period. 2. Record review (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The behavioral care plan, initiated on 12/24/19 and revised on 1/21/25, documented Resident #2 had targeted behaviors of paranoia and could have a short temper. The care plan documented when the resident was cycling, she would make false accusations, believing staff were talking about her and making fun of her. Resident #2 had hit people in the past due to being short tempered and having impulsive responses. The interventions included providing one-to-one conversations with staff to discuss her feelings, assisting the resident out of the middle of the hallway, encouraging her to travel on one side of the hallway to mitigate disruptive interactions with others, assigning a one-to-one caregiver for emotional support, speaking to the resident calmly, educating the resident to stay away from people she did not get along with and administering and monitoring medications as ordered. -The facility failed to update Resident #2's care plan after the incident of physical abuse on 2/26/25. The 1/2/25 progress note documented Resident #2 was in the hallway self-propelling in her wheelchair. Resident #13 was waiting for Resident #2 to pass when Resident #2 hit him in the middle of his chest. Resident #2 yelled Get out of my way. Resident #13 said he put his hand on Resident #2's head to stop her and said, stating What the hell old lady. Resident #2 stated she was trying to stop Resident #13 from bumping into her. An assessment was completed and no injuries were noted. Both residents were placed on frequent safety checks. The 2/26/25 progress note revealed Resident #2 slapped Resident #1 in the face while passing in the hallway to the dining room. Resident #2 refused to talk about the incident and continued yelling at the staff. A head-to-toe assessment was completed for both residents and no physical injuries were noted. Both residents were separated and placed on frequent checks. The facility notified the residents' families and the ombudsman and made an online police report. D. Resident #13 - victim 1. Resident status Resident #13, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the March 2025 CPO, diagnoses included type 1 diabetes mellitus and end-stage renal disease. The 2/12/25 MDS assessment documented Resident #13 was cognitively intact with a BIMS score of 13 out of 15. He was independent with bed mobility, eating, toileting, personal hygiene and dressing. E. Resident #1 - victim 1. Resident status Resident #1, age 70, was admitted on [DATE]. According to the March 2025 CPO, the diagnoses included acute and chronic respiratory failure, unspecified encephalopathy, alcohol use disorder and an acquired absence of right leg above the knee. The 1/16/25 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of 10 out of 15. He required assistance from two people with transfers. He required assistance of one to two people with dressing, toileting and personal hygiene. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. Staff interviews Certified nurse aide (CNA) #3 was interviewed on 3/25/25 at 5:10 p.m. CNA #3 said Resident #2 yelled, screamed, and tried to scratch other residents and staff members often. She said she would give Resident #2 space when she was having a bad day. CNA #3 said every time Resident #2 had a bad day, the facility staff did not walk with the resident down the hallway. She said it was easier to give her space so they did not get hit or scratched. She said she did not try to walk between Resident #2 and any other residents coming down the hallway to ensure another resident was not targeted by Resident #2. She said was concerned if she was too close to Resident #2 during those episodes, she would get hit or scratched. CNA #3 said Resident #2 did not always like it when other residents invaded her personal space and got too close. She said Resident #2 could become physically aggressive if that happened. Registered nurse (RN) #3 was interviewed on 3/25/25 at 5:25 p.m. RN #3 said the facility staff gave Resident #2 space and would backup away from her when she was upset. She said Resident #2 was physically aggressive when she was having a bad day. She said Resident #2 could be physically aggressive with facility staff or toward other residents. She said she was concerned if she got too close to Resident #2 during a bad day, she would be hit. RN #3 said the facility staff did not provide Resident #2 with a one-to-one supervisor when she moved about the facility. She said facility staff did not walk down the hallway to follow the resident and stand between Resident #2 and another resident coming down the hallway if Resident #2 was having a bad day. She said Resident #2 did not like other residents getting too close to her. RN #3 said if Resident #2 was physically aggressive with another resident, she would be placed on 15-minute safety checks for three days. The DON, the NHA, the clinical consultant (CC) and the regional operations manager (ROM) were interviewed together on 3/26/25 at 1:36 p.m. The DON said Resident #2 had a history of physically aggressive behavior towards other residents and staff members. She said she had been institutionalized at a young age and had a difficult time trusting others. She said Resident #2 was very protective of her belongings and personal space. She said Resident #2 did the best when she was regimented in a daily routine. The DON said Resident #2 would get triggered by what she perceived as another resident getting too close to her, especially in areas such as the hallway. She said the resident had a large personal bubble that was not always obvious to others and she was paranoid about people whispering or talking about her behind her back. The NHA said there were a few staff she trusted and she had built a good relationship with them. He said she was part of a program through her insurance that would provide a one-to-one companion once or twice a week for one to two hours. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON said if Resident #2 was having a bad day, the floor staff should notify management and someone she trusted and had a good rapport with would go down and sit with her. She said staff should keep an eye on Resident #2 when she left her room often, because that could be a sign of a bad day. She said the floor staff should walk down the hallway in between Resident #2 and another resident to ensure the other resident did not get too close to Resident #2 in order to prevent an altercation. Cross reference F744: the facility failed to provide effective dementia care to Resident #2 to prevent potential physical altercations toward other residents. The NHA said Resident #2 was willful in the incidents of physical abuse toward Resident #1 and Resident #13. 48114 III. Incident of physical abuse by Resident #7 towards Resident #6 on 2/12/25 A. Facility investigation The 2/12/25 facility incident report was provided by the NHA on 3/26/25 at 10:30 a.m. The report revealed Resident #7 came into the dining room and yelled at Resident #6. Resident #6 began yelling back at Resident #7. Resident #7 hit and pushed Resident #6's head causing him to tip over backwards in his wheelchair. The residents were immediately separated, placed on frequent checks and assessed. Resident #6 was assessed by the DON and no injuries were noted. Resident #6 was interviewed by the facility on 2/12/25 and said that crazy (explicit word) just came over and hit me. I was just sitting here and she came and knocked me over. When asked if he was hurt or if he was afraid he stated, No, I' m not hurt and I am not afraid of that crazy (explicit word), she is just mental. Resident #7 was interviewed by the facility on 2/12/25. Resident #7 stated, I just came to the dining room to ask for something and he came up behind me and when I turned around he hit me, so I hit him back defending myself. He has a loud mouth and everyone is tired of hearing it. The cook (CK) was interviewed by the facility on 2/12/25. The CK said Resident #6 went to the kitchen window and asked the staff for salsa. Resident #7 approached the window and began arguing with him. Resident #7 hit Resident #6 and his wheelchair fell and knocked Resident #7 on the ground. The CK said staff stood between the residents and called for assistance. A dietary aide DA was interviewed by the facility on 2/13/25. The DA said Resident #6 went to the kitchen window and asked the staff for salsa. Resident #7 approached the window and began arguing with him. Resident #7 hit Resident #6 and his wheelchair fell and knocked Resident #7 on the ground. The staff stood between residents and called for assistance. The conclusion of the investigation revealed Resident #7 was educated to avoid interactions with those that annoy her. The incident report was substantiated as it was witnessed by staff. B. Resident #7 - assailant (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident status Resident #7, age greater than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included mood disorder and dementia. The 2/5/25 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of 11 out of 15. She was independent with all activities of daily living (ADLs). The assessment indicated Resident #7 did not exhibit any physical or verbal behavioral symptoms directed towards others. 2. Record review The behavior care plan, revised 2/28/25, documented Resident #7 had the potential to be physically aggressive with other residents related to anger and anxiety, dementia processes related to traumatic brain injury (TBI), history of harm to others, poor impulse control and low frustration tolerance related to her TBI. Pertinent interventions included: -Analyzing times of day, places, circumstances, triggers, and what de-escalates behavior; -Providing physical and verbal cues to alleviate anxiety; -Encouraging the resident to seek out of staff members when agitated; -Encouraging the resident to share her frustrations about other residents to staff members; -If agitated, providing the resident with a safe, quiet place to discuss her feelings openly; -Modifying the environment by reducing noise, dimming the lights and keeping the door closed; -Encouraging the resident to eat in another area if she was upset; -Monitoring observed behavior and attempted interventions in behavior log every shift; -Monitoring/documenting/reporting as needed any signs or symptoms of resident posing danger to self and others; and, -Offering the resident assistance with calling her son when she was having periods of frustration. The cognition care plan, revised 9/18/23, documented Resident #7 had impaired cognitive function/dementia or impaired thought processes related to status post head injury and bipolar disorder. Pertinent interventions included asking yes/no questions in order to determine the resident's needs, identifying self at each interaction, facing the resident when speaking and making eye contact and providing the resident with necessary cues. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nursing progress note, dated 2/12/25, documented that at approximately 9:10 a.m. Resident #7 was screaming very loudly towards Resident #6 at the corner of the dining room. Resident #7 was on the floor in a sitting position. Resident #7 said while she was walking, Resident #6 started cursing her out, so she stopped and said do not curse me out. Resident #7 said right after she told Resident #6 to stop cursing, he pushed her to the floor. Resident #7 said they were friends and she would ask Resident #6 for an apology. A head to toe assessment was completed and no injury was noted. The behavior note, dated 2/13/25, documented Resident #7 was involved in a reportable physical resident-to-resident altercation with no injury noted on 2/12/25. Resident #7 initiated the physical aggression and upon interview stated it was Resident #6 who initiated the aggression. Resident #7 said she had no fear of Resident #6 or any other person at the facility. C. Resident #6 - victim 1. Resident status Resident #6, age less than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included spina bifida (a condition that occurs when the spine and spinal cord do not form properly) and Wernicke's encephalopathy (a degenerative brain disorder caused by a lack of vitamin B1). The 2/6/25 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of 12 out of 15. He required partial and moderate assistance with showering and personal hygiene. According to the MDS assessment the resident had verbal behavioral symptoms directed toward others that occurred on one to three days during the assessment review period. 2. Resident interview Resident #6 was interviewed on 3/26/25 at 11:56 a.m. Resident #6 said he could not recall the incident with Resident #7 on 2/12/25. Resident #6 said if someone pushed him he would not be happy and he would want to get that person out of the facility. He said if a resident was really aggressive and pushed him, he would be afraid. He said he would not be happy at all. Resident #6 said he did not have any problems with staff or residents. He said he did not feel threatened by anyone and felt safe at the facility. 3. Record review The behavior care plan, revised 3/9/24, documented due to his diagnosis of Wernicke's encephalopathy, Resident #6 had frequent outbursts of cursing, sometimes the outbursts had a direct cause, other times they did not. Pertinent interventions included: -Anticipating and meeting the residents' needs; -Assisting the resident to develop more appropriate methods of coping and interacting by having him remove himself from the situation when he became frustrated and working on calming himself down; -Encouraging the resident to express his feelings appropriately; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Providing an opportunity for positive interaction and attention; and, -Discussing the resident's behavior, explaining why his behavior was inappropriate and/or unacceptable and how there were better ways to discuss his frustrations. The cognition care plan, revised 7/19/23, documented Resident #6 had impaired cognitive function related to TBI. Pertinent interventions included communicating with the resident/family/caregivers regarding the resident's capabilities and needs, using the resident's preferred name, identifying self at each interaction and facing the resident when speaking and making eye contact. The progress note, dated 2/12/25, documented Resident #6 was angry and speaking very loudly towards another resident at the corner of the dining room. Upon arrival the nurse observed Resident #6 on the floor in a sitting position beside his wheelchair. Resident #6 did not say anything about how he ended up on the floor. A head to toe assessment was completed and the resident was alert and oriented times two to three with periods of confusion and forgetfulness. The note documented the resident did not have a mental status change. Resident #6 denied hitting his head and there was no bump or skin issue observed. The resident's vital signs were within normal limits. Resident #6 was assisted off the floor and was sitting in his wheelchair. Neurological follow up was initiated. The physician and the DON were notified. The progress note, dated 2/12/25, documented at 9:10 a.m. Resident #6 was angry and screaming very loudly towards another resident at the corner of the dining room. Resident #6 was on the floor in a sitting position besides his wheelchair. Resident #6 was wheeled back to his room. Resident #6 apologized to Resident #7. 4. Staff interviews CNA #2 was interviewed on 3/26/25 at 9:51 a.m. CNA #2 said Resident #7 was friendly with staff and residents. She said Resident #7 would notify staff if a resident was hollering and would intervene and tell the resident to stop hollering. CNA #2 said she had not seen Resident #7 become aggressive with staff or residents. CNA #2 said she was working the day of the physical altercation on 2/12/25. She said she was not in the dining room when the incident happened. She said she heard about the incident. She said that Resident #7 and Resident #6 had never had any history of verbal or physical aggression towards each other. CNA #2 said the DON and the supervisor told her to keep an eye on both residents and if she saw something to report it right away to the nurse. CNA #2 said Resident #6 used his call light frequently and if no one answered he would come out of his room and shout. CNA #2 said he would yell for help, saying he needed a nurse, needed coffee or needed his bed made. CNA #2 said Resident #6 cursed a lot. CNA #2 said when Resident #6 did not get attention right away he would get upset. CNA #2 said when staff saw Resident #6 out of his room they would go over and talk to him. She said when she passed the resident's room that she checked in on him all the time. RN #2 was interviewed on 3/26/25 at 10:17 a.m. RN #2 said Resident #7 had never had any aggressive behaviors. RN #2 said that Resident #7 would get upset, but not to the point of hitting anyone. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114 Based on record review and interviews, the facility failed to ensure residents received adequate supervision to prevent accidents for one (#4) of three residents reviewed for accidents out of 12 sample residents. Specifically, the facility failed to: -Ensure Resident #4 was provided with the supervision necessary to prevent elopement; and, -Ensure Resident #4's elopement on 3/2/25 was investigated thoroughly. Findings include: I. Facility policy and procedure The Elopement and Wandering policy and procedure, dated 2/29/24, was provided by the nursing home administrator (NHA) on 3/26/25 at 3:36 p.m. It read in pertinent part, It is a goal of the facility to provide a safe environment using the least restrictive measures available in care for residents who are exhibiting elopement behavior. 'Elopers' are defined as residents who make an overt or purposeful attempt to leave the facility and do not have the ability to identify safety risks. II. Resident #4 A. Resident status Resident #4, age less than 65, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included dementia and schizophrenia. The 3/12/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. He was independent with most activities of daily living (ADL) but required supervision/touching assistance with showering. According to the assessment, Resident #4 had a wander/elopement alarm. B. Record review The elopement care plan, revised 3/17/25, documented Resident #4 was an elopement risk. He was unsafe to be in the community independently related to an unsteady gait and history of falling when ambulating to the gas station. The resident had a wander guard in place and his picture and information was in the facility's wander/elopement binder. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4 liked to sit on the couch in the common area at times. Resident #4 would attempt at times to remove his wander guard and would ask staff to remove it. Interventions included ensuring the resident's current identification form was in the elopement binder, reassuring the resident that he had enough cigarettes and that he did not have to buy any at that time had been a successful intervention in the past with redirecting exit seeking behaviors, the resident liked to drink Mountain Dew and eat Lay's potato chips, offering these snacks may also assist in redirecting him, identifying patterns of wandering, intervening as appropriate, distracting the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and books, providing structured activities, such as toileting, walking inside and outside, reorientation strategies including signs, pictures, calling his sister, a wander guard for safety and checking placement of the device, which was located on the resident's right wrist every shift. The 9/13/24 physical restraint/safety device informed consent form for a wander guard due to safety reasons to prevent Resident #4 from going out of the facility unassisted documented Resident #4 gave verbal consent to have a wander guard placed. The wander/elopement risk evaluation, dated 3/10/25, documented Resident #4 routinely wandered or paced and had previous attempts to elope at the facility. Review of Resident #4's electronic medical record (EMR) revealed the following progress notes: The nursing progress note, dated 3/2/25 at 7:22 a.m., documented Resident #4 left the facility at about 5:30 a.m. through the back door of the smoking area. The nurse and a certified nurse aide (CNA) went outside to look for the resident around the block but did not find him. The nurse called the on-call nurse who then notified the NHA and the director of nursing (DON) about the situation. The NHA told the nurse to call 911 and report that Resident #4 was missing. The on-call nurse practitioner was notified, and a message was left for the resident's emergency contact. A couple of police officers came to the facility at about 7:15 a.m. and asked the nurse questions about the resident. The police said they were going to look at the cameras and try to find the resident. The nursing progress note, dated 3/2/25 at 1:33 p.m, documented Resident #4 was reported to have left the facility at 5:30 a.m., according to the night nurse. The nurse spoke to the local police department about Resident #4's contacts, where he could be going and was able to provide a photo of the resident. Resident #4 returned to the facility about 11:30 a.m. Resident #4's vital signs were taken upon his return to the facility and he was assessed to have no new skin wounds or contusions. The police officers followed up around 2:15 p.m. and spoke to the resident. Resident #4 said he wanted to open a bank account and get a bank card. He said he left the facility to go to the bank but the bank was closed. The nurse informed Resident #4 that staff could help facilitate him opening a bank account. The facility's investigation report for Resident #4's 3/2/25 elopement incident was requested from the NHA on 3/26/25 at 11:40 a.m. -On 3/26/25 at 1:40 p.m. the NHA said the facility did not have an investigation report for the 3/2/25 elopement incident and the elopement was not reported to the State Agency. III. Staff interviews (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #1 was interviewed on 3/25/25 at 4:39 p.m. CNA #1 said Resident #4 was a smoker and went outside to smoke during smoking times. CNA #1 said Resident #4 was a supervised smoker. She said staff had to be outside with Resident #4 and watch him while he smoked. She said Resident #4 only liked to go outside to smoke but would not sit outside and hang out. CNA #1 said Resident #4 had a wander guard on for his safety and because he liked to elope. CNA #1 said she did not know if Resident #4 had eloped from the facility. CNA #1 said the facility had a smoking schedule and had to remind Resident #4 of the times. She said Resident #4 was able to go outside when he wanted. She said the wander guard alarmed when he exited the door to go outside. She said the resident did not stay outside and would come back inside right after he was done smoking. Registered nurse (RN) #1 was interviewed on 3/25/25 at 4:17 p.m. RN #1 said Resident #4 was fairly independent. RN #1 said Resident #4 got up pretty early and would be up by 5:00 a.m. RN #1 said Resident #4 stayed in his room and only came out to smoke. RN #1 said Resident #4 was a supervised smoker. RN #1 said the facility had smoking times and when it was time to go out to smoke, a CNAwent outside with the residents. She said the CNA was outside the whole time the residents were outside smoking. She said Resident #4 did not like to hang out outside and usually came back inside when he was done smoking. She said Resident #4's biggest behaviors were around him being able to smoke. She said Resident #4 had done better with knowing the smoking times. She said Resident #4 was developing a routine. RN #1 said Resident #4 had a wander guard on for his safety and elopement reasons. RN #1 said Resident #4 had had a couple of attempts of leaving the facility. RN #1 said there were alarms on the outside gates and if Resident #4 tried to leave, the alarm would go off. RN #1 said Resident #4 had not tried to elope while he was outside smoking. RN #1 said Resident #4 had eloped during other times of the day. RN #1 said Resident #4 was fixated on going to the bank and getting more cigarettes. She said Resident #4 was confused about the time of day. The NHA, the DON, the social services director (SSD), and the clinical consultant (CC) were interviewed together on 3/26/25 at 1:40 p.m. The NHA said Resident #4 had eloped and went to the bank on 3/2/25. The NHA said Resident #4 was focused on going to the bank and getting cigarettes. He said Resident #4's cigarettes were provided to him by the facility. He said Resident #4 had exited through the back door and then through the wood fence. The NHA said Resident #4 had a wander guard. The NHA said he did not know how long the resident had had the wander guard. The NHA said Resident #4 had a wander guard because staff did not know Resident #4's baseline. He said Resident #4 was a high elopement risk. The DON said Resident #4 did not have cigarettes. The DON said Resident #4's family was not willing to provide the cigarettes for him. The DON said the facility bought packs of the cigarettes for Resident #4 but it got expensive. She said they bought tobacco and started rolling his cigarettes. The DON said during the weekends, Resident #4 was afraid that he was going to run out of cigarettes. She said that was one of the resident's biggest fears. The DON said activities thought about putting Resident #4 on a work program to keep him busy. The DON said she spoke to activities but they did not offer Resident #4 a work program. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said on 3/2/25 Resident #4 eloped from the back gate. The DON said staff noticed the alarm was going off. The DON said she did not know if staff just turned off the alarm and did not know Resident #4 had left. She said she could not speak to what occurred that day. The DON said when the alarms sound, staff are supposed to look for whichever resident set the alarm off. She said that morning (3/2/25), it was dark outside. She said Resident #4 was fast and staff were not able to see where he had gone. The DON said staff called the NHA and let him know what was going on. The DON said staff searched the block and could not find the resident, so they called 911. The DON said Resident #4 came back to the facility on his own. The DON said she could not speak on behalf of the staff who were working that morning as to whether they responded to the alarm quickly or not. She said she could not speak to what a reasonable amount of time staff should have before they turn the alarm off. She said she did not know what staff were doing at the time the alarm went off. She said the response time for the alarms should be less than five minutes. The NHA said the back gate had a different alarm on it. The NHA said staff should know the difference between the door alarm and the gate alarm. The NHA said there was a key by the nurses station and staff had to go to the fence alarm to turn it off with the key.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51915 Based on observations, record review and interviews, the facility failed to ensure one (#2) of five residents out of 13 sample residents who were diagnosed with dementia, received the appropriate treatment and services to attain or maintain the highest practicable physical, mental and psychosocial well-being. Specifically, the facility staff failed to implement person-centered interventions to prevent Resident #2 from displaying physically aggressive behaviors toward other residents related to her diagnosis of dementia. Findings include: I. Facility policy and procedure The Dementia-Clinical Protocol policy and procedure, dated 2/29/24, was provided by the nursing home administrator (NHA) on 3/27/25 at 2:30 p.m. It revealed in pertinent part, The staff will review the current physical, functional, and psychosocial status of individuals with dementia, and will summarize the individual's condition, related complications, and functional abilities and impairments. The IDT (interdisciplinary team) will identify a resident-centered care plan to maximize remaining function and quality of life. Nursing assistants will receive initial training in the care of residents with dementia and related behaviors. The facility will strive to optimize familiarity through consistent staff-resident assignments. Direct care staff will support the resident in initiating and completing activities and tasks of daily living. Bathing dressing, mealtimes, and therapeutic and recreational activities will be supervised and supported throughout the day as needed. The IDT will identify and document the resident's condition and level of support needed during care planning and review changing needs as they arise. Resident needs will be communicated to direct care staff through care plan conferences, during change of shift communications and through written documentation (nurses' notes and documentation tools). Progressive or persistent worsening of symptoms and increased need of staff support will be reported to the IDT. II. Resident #2 A. Resident status Resident #2, age 71, was admitted on [DATE] and readmitted on [DATE]. According to the March 2025 computerized physician orders (CPO), the diagnoses included schizoaffective disorder (depressive type-mental disorder), anxiety disorder and Alzheimer's disease. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/21/25 minimum data set (MDS) assessment revealed Resident #2 had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. She required the assistance of one person with transfers, dressing, showering, toileting and personal hygiene. The MDS assessment documented Resident #2 had physical behavioral symptoms directed toward others which occurred every one to three days during the assessment period. A. Observations During continuous observation on 3/25/25, beginning 9:25 a.m. and ending at 5:00 p.m. the following was observed: At 9:25 a.m. Resident #2 was in her room. At 1:15 p.m. Resident #2 exited her room and began self-propelling herself down the hallway. Staff members were at the nursing station did not follow Resident #2 while she was wheeling herself down the hallway on her way to the facility's candy store and then returned to her room. She passed close to two residents and interacted with one staff member. At 3:10 p.m. Resident #2 exited her bedroom, self propelled herself down the hallway toward the dining room and stayed there until it was dinner time. She passed by residents in the hallway. Staff did not step in between Resident #2 and other residents as they were passing. During continuous observation on 3/26/25, beginning 8:45 a.m. and ended at 12:00 p.m., the following was observed: At 8:45 a.m. Resident #2 was in the physical therapy gym. At 9:00 a.m. Resident #2 self propelled herself out of the physical therapy gym and went to her bedroom. She passed close to other residents and staff members while wheeling herself down the hallway to her room. Staff members did not step in between Resident #2 and any other resident she passed by in the hallway. At 10:20 a.m. Resident #2 self propelled herself from her room to the management offices and then to the dining room without supervision. She passed close by other residents and staff members while she wheeled through the hallway. Staff members did not step in between Resident #2 and any other resident she passed by in the hallway. B. Record review (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The behavioral care plan, initiated on 12/24/19 and revised on 1/21/25, documented Resident #2 had targeted behaviors of paranoia and could have a short temper. The care plan documented when cycling, she would make false accusations, believing staff were talking about her and making fun of her. Resident #2 hit people in the past due to being short tempered and impulsive responses. The interventions included one-to-one conversations with staff to discuss her feelings, assisting the resident out of the middle of the hallway, encouraging her to travel on one side of the hallway to mitigate disruptive interactions with others, assigning a one to one caregiver for emotional support, speaking to the resident calmly, educating the resident to stay away from people she does not get along with and administering and monitoring medications as ordered. -However, observations revealed Resident #2 was not encouraged to travel on one side of the hallway as indicated on her care plan (see observations above). The 11/6/24 nursing progress note documented Resident #2 continued to have irritability towards other residents at times in the hallways and would become verbally aggressive when provoked. The 11/24/24 nursing progress note documented Resident #2 grabbed another resident's hair after contact between wheelchairs in the hallway. The 1/2/25 progress note documented Resident #2 was in the hallway self-propelling her wheelchair. Resident #13 was waiting for Resident #2 to pass when Resident #2 hit him in the middle of his chest. An assessment was completed and with no injury noted. Both residents were placed on frequent safety checks. The 1/2/25 incident report documented when Resident #2 was next to Resident #13 in the hallway, she stopped and hit him for no reason. Resident #2 said, stating get out my way. Resident #13 said he put his hand on Resident #2's head to stop her and said, stating What the hell old lady. Resident #2 said she was trying to stop Resident #13 from bumping into her. The 2/3/25 nursing progress note documented Resident #2 tried to hit and scratch the nurse when he asked how he could help Resident #2. The 2/26/25 incident report documented Resident #1 was passing in the hallway when Resident #2 was self-propelling her wheelchair in the opposite direction. Resident # 1 stopped and stood to the side so that Resident #2 could pass him. When Resident #2 passed by Resident #1 him, she slapped him on his left cheek with her open hand. The incident was witnessed by a dietary aide. Cross reference F600: the facility failed to prevent physical abuse by Resident #2 toward other residents. III. Staff interviews (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nurse aide (CNA) #3 was interviewed on 3/25/25 at 5:10 p.m. CNA #3 said Resident #2 yelled, screamed, and tried to scratch other residents and staff members often. She said she would give Resident #2 space when she was having a bad day. CNA #3 said every time Resident #2 had a bad day, the facility staff did not walk with the resident down the hallway. She said it was easier to give her space so they did not get hit or scratched. She said she did not try to walk between Resident #2 and any other residents coming down the hallway to ensure another resident was not targeted by Resident #2. She said was concerned if she was too close to Resident #2 during those episodes, she would get hit or scratched. CNA #3 said Resident #2 did not always like it when other residents invaded her personal space and got too close. She said Resident #2 could become physically aggressive if that happened. CNA #4 was interviewed on 3/26/25 at 10:00 a.m. CNA #4 stated that Resident #2 gets frustrated when she could not move. CNA #4 said that changed her mood and the behaviors began. CNA #4 said when incidents happened, the staff usually addressed the cause of the issue and gave her some space. CNA #4 said in order to protect other residents during these incidents, the staff separated them and took Resident #2 to her bedroom. Registered nurse (RN) #3 was interviewed on 3/25/25 at 5:25 p.m. RN #3 said the facility staff gave Resident #2 space and would backup away from her when she was upset. She said Resident #2 was physically aggressive when she was having a bad day. She said Resident #2 could be physically aggressive with facility staff or toward other residents. She said she was concerned if she got too close to Resident #2 during a bad day she would be hit. RN #3 said the facility staff did not provide Resident #2 with one-to-one supervisor when she moved about the facility. She said facility staff did not walk down the hallway to follow the resident and stand between Resident #2 and another resident coming down the hallway if Resident #2 was having a bad day. She said Resident #2 did not like other residents getting too close to her. RN #3 said if Resident #2 was physically aggressive with another resident, she would be placed on 15-minute safety checks for three days. The director of nursing (DON), the NHA, the clinical consultant (CC) and the regional operations manager (ROM) were interviewed together on 3/26/25 at 1:36 p.m. The DON said Resident #2 had a history of physically aggressive behavior toward other residents and staff members. The DON said she had been institutionalized at a young age and had a difficult time trusting others. She said Resident #2 was very protective of her belongings and personal space. The DON said Resident #2 does the best when she is regimented in a daily routine. The DON said Resident #2 was triggered by what she perceived as another resident getting too close to her, especially in areas such as the hallway. She said the resident had a large personal bubble that was not always obvious to others and was paranoid about people whispering or talking about her behind her back. The NHA said there were a few staff she trusted and had built a good relationship. He said she was part of a program through her insurance that will provide a one-to-one companion once or twice a week for one to two hours. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said if Resident #2 was having a bad day, the floor staff should notify management and someone she trusted and had a good rapport with would go down and sit with her. She said staff should keep an eye on Resident #2 when she left her room often, because that could be a sign of a bad day. She said the floor staff should walk down the hallway in between Resident #2 and another resident to ensure the other resident does not get too close to Resident #2 to prevent an altercation. The NHA said the facility staff should be aware of Resident #2's triggers and the interventions identified on the care plan. The DON said staff should be walking in between Resident #2 while she wheeled herself down the hallway to ensure she does not have a physically aggressive incident with another resident. The NHA confirmed the interventions identified on the comprehensive care plan could not be evaluated to be effective or ineffective without implementation by all staff.