STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065427	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Park West Llc, The	3727 Parker Blvd Pueblo, CO 81008

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure one (#2) of six residents out of 17 sample residents were provided prompt efforts by the facility to resolve grievances. Specifically, the facility failed to effectively resolve and demonstrate the facility's response to individual grievances for Resident #2.Findings include:I. Facility policy and procedureThe Grievance policy, revised 1/8/24, was provided by the director of nursing (DON) on 10/23/25 at 3:36 p.m. It read in pertinent part, If the complaint is verbal, it is the responsibility of the staff member who received the complaint to properly complete the grievance form on behalf of the complainant. The completed form must be provided to the executive director or designee immediately. The grievance will be given to the appropriate department manager for follow up and resolution. All grievances will be reviewed in the morning meeting with interdisciplinary (IDT) members. The department managers are responsible for the resolution of all complaints within his or her department. The department managers will note the disposition of the grievance in writing to the executive director or designee. It is the responsibility of the department manager in coordination with the executive director, when appropriate, to develop a process and plan for the resolution of the grievance and notify the complainant about the resolution plan. All actions taken on the grievance, including meetings with the patient, telephone calls, action plans, revisions to care plans, etc., must be documented on the grievance form. If the complainant or aggrieved party is dissatisfied with the finding and/or remedies, the executive director will make reasonable attempts to resolve the grievance. The ombudsman will be notified if the grievance is not resolved per the resident/family representative's request.II. Resident #2A. Resident statusResident #2, age [AGE], was admitted on [DATE]. According to the October computerized physician orders (CPO), diagnoses included Alzheimer's disease, fracture of left femur, essential hypertension (high blood pressure), psychotic disturbance, mood disturbance and anxiety.The 9/22/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of nine out of 15. B. Resident #2's representative interviewResident #2's representative was interviewed on 10/22/25 at 4:30 p.m. He said he had filed grievances with the facility regarding Resident #2's physical therapy. The representative said he was concerned the weight bearing status communicated by the orthopedic surgeon was not being followed. The representative said he had not received a response to the grievance he filed. He said the director of rehabilitation (DOR) met with him but he was not satisfied with her explanation. The representative said he emailed the nursing home administrator (NHA), but he had not received a response. He said he had other concerns with the care Resident #2 received. He said he felt the facility did not resolve his concerns for Resident #2's care. C. Record reviewA grievance form for Resident #2 was provided by the director of nursing (DON) on 10/23/25 at 2:28 p.m.The grievance form, completed by the DOR on 10/7/25, documented Resident #2's representative was upset about the new weight-bearing order. The resident's representative felt the therapy department changed Resident #2's weight bearing status and not the orthopedic surgeon. The grievance form documented the therapy team provided education to the resident's representative indicating the resident was not fully weight-bearing and Resident #2 was able to bear weight as tolerated. The grievance form documented the date the grievance was received by social services, the signature line, the substantiated and unsubstantiated line, and the NHA's signature were left blank. It revealed Resident #2's satisfaction was hesitant, concerned, and the comments read that the representative still believed therapy had changed the resident's weight bearing status order. III. Staff interviewsThe NHA was interviewed on 10/23/25 at 6:48 p.m. The NHA said anyone could fill out a grievance form. He said residents and family members can turn in the grievance form to any staff or put it in the box in front of the social services office. He said once a grievance was turned in, the facility had 48 hours to resolve the grievance. He said if a resident was discharged prior to the grievance being resolved, the facility should contact the resident or representative to resolve the grievance. The NHA said based on the format of the grievance form, he was unable to show when any grievance was resolved, including the grievances filed for Resident #2, because there was no section on the form with a date when the grievance was resolved. The NHA said the words cautiously optimistic, doubtful, hesitant and concerned did not reveal if the grievance was resolved to the resident or family's satisfaction. The NHA said before October 2025, nursing documented resident concerns as a progress note. The NHA said resident's concerns documented as a progress note should have been documented on a grievance form to ensure the grievance was resolved.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to develop and implement a baseline care plan that included the instructions needed to provide effective and person-centered care for the resident that met professional standards of quality care for three (#2, #8 and #17) of five residents out of 17 sample residents. Specifically, the facility failed to fully develop, review with the resident and/or his responsible party and implement a person-centered baseline care plan within 48 hours of admission for Resident #2, Resident #8 and Resident #17.Findings include: I. Facility policy and procedure The Baseline Care Plan policy and procedure, revised 3/28/24, was provided by the director of nursing (DON) on 10/23/25 at 6:49 p.m. It read in pertinent part, The baseline care plan must be developed within 48 hours of a patient's admission. The facility must provide the patient and their representative, if applicable, with a summary of the baseline care plan. II. Resident #2 A. Resident status Resident #2, age [AGE], was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease, fracture of left femur, essential hypertension (high blood pressure), psychotic disturbance, mood disturbance and anxiety. The 9/22/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of nine out of 15. The MDS assessment revealed the resident was taking anticoagulant medications, antipsychotic medications, required a mechanically altered diet, and the resident's goal was to be discharged to the community. B. Resident #2's representative interview Resident #2's representative was interviewed on 10/22/25 at 4:30 p.m. Resident #2's representative said he was really frustrated with the facility because they did not communicate when Resident #2 was admitted . He said there was miscommunication on the resident's discharge plans, diet and physical therapy plans. He said it was even more frustrating when the facility said Resident #2 was ready to be discharged because he thought she did not have enough physical therapy. He said he had to tell the facility to cut up the resident's food and she needed assistance. He said he wished the facility had provided more communication when she was first admitted so they could have been on the same page. C. Record review (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's October 2025 CPO revealed the resident had a physician's order for Seroquel (antipsychotic medication) 25 milligrams (mg) one time per day at bedtime for depression, ordered 9/16/25. Review of Resident #2's baseline care plan, dated 9/16/25, revealed the following: -There was no baseline care plan, including a focus, a goal, and an intervention for psychotropic medication. -The baseline care plan identified the resident was to receive a carbohydrate-controlled diabetic diet, however it did not identify that Resident #2 required a mechanical soft diet texture. -The baseline care plan identified Resident #2 received anticoagulant medications, however, the focus, goal, and interventions for anticoagulants were not identified. -The baseline care plan for discharge planning was incomplete and the intervention for the location of where the resident wanted to be discharged to was not identified. -Review of Resident #2's EMR on 10/23/25 did not reveal documentation of a signed Acknowledgement of Care Plan form to acknowledge the resident or the resident's responsible party was provided with a copy of the resident's baseline care plan. The 9/19/25 social services progress note revealed the social services director (SSD) met with Resident #2. The note documented the admission assessments were completed. The SSD explained the discharge plan process and progress updates were conducted on Wednesdays and Thursdays after Tuesday's interdisciplinary team (IDT) discharge meetings. The note documented the resident was aware her discharge date was determined by insurance, therapy progress and her medical status. The resident reported no concerns at the time and the SSD would continue to follow. -However, the SSD did not meet with Resident #2 until three days after her admission to the facility. -Additionally, the progress note did not indicate that the resident's baseline care plan was reviewed with the resident during the meeting with the SSD or that the resident was provided with a copy of her baseline care plan. III. Resident #8 A. Resident status Resident #8 was admitted on [DATE]. According to the October 2025 CPO, diagnoses included acute hematogenous osteomyelitis (an infection of the bone caused by bacteria that travel through the bloodstream) and creation of a bypass arterial graft (a medical procedure to improve blood flow to the heart). The 10/11/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He required moderate assistance with activities of daily living (ADL). (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Resident interview Resident #8 was interviewed on 10/23/25 at 1:00 p.m. Resident #8 said he was planning to return to the community upon discharge. He said he did not understand the reason for why he was still at the facility. The resident said he had surgical staples in his abdomen and once the staples were removed, he would like to return to the community. He said he did not review or receive a copy of his baseline care plan. C. Record review The progress note, dated 10/6/25, revealed Resident #8 was admitted from the hospital after undergoing a coronary artery bypass graft (CABG). The resident had a surgical wound. The resident also had a left toe amputation. -Resident #8's 10/6/25 baseline care plan addressed the left toe amputation, however it did not address the surgical wound from the CABG surgical procedure. -A review of Resident #8's electronic medical record (EMR) on 10/23/25 did not reveal documentation of a signed Acknowledgement of Care Plan form to acknowledge the resident and/or responsible party were provided with a copy of the baseline care plan, which was identified by the director of nursing (DON) as the facility's process (see DON interview below). IV. Resident #17 A. Resident status Resident #17, age [AGE], was admitted on [DATE]. According to the October 2025 CPO, diagnoses included mild neurocognitive disorder due to known physiological condition with behavioral disturbance. The 10/22/25 MDS assessment revealed the resident had severe cognitive impairment and the BIMS assessment was not completed. The staff assessment for mental status revealed the resident had both long and short term memory deficits. He had moderate cognitive impairments. The MDS assessment indicated the resident did not have any behaviors. B. Record review The October 2025 CPO revealed the resident was prescribed Seroquel (antipsychotic medication) oral tablet 25 mg. -The 10/16/25 baseline care plan revealed the use of psychotropic medications, however the baseline care plan did not indicate that the psychotropic medication was an antipsychotic medication and did not include interventions for the use of the antipsychotic medication. -Review of Resident #17's EMR on 10/23/25 did not reveal documentation of a signed Acknowledgement of Care Plan form to acknowledge the resident's responsible party was provided with a copy of the resident's baseline care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V. Staff interviews The SSD was interviewed on 10/23/25 at 9:32 a.m. The SSD said when residents were admitted to the facility, a care conference was held within 72 hours of admission. She said the admitting nurse started the baseline care plan. She said she was not responsible for getting the baseline care plan signed by the resident or the resident's responsible party. The DON was interviewed on 10/23/25 at approximately 6:00 p.m. The DON said the admitting nurse was responsible for reviewing the baseline care plan with the resident and/or the resident's responsible party and getting the baseline care plan signed by the resident or the responsible party. The DON said after the Acknowledgement of Care Plan form (for the receipt of the baseline care plan) was signed by the resident or the responsible party, the form was uploaded into the resident's EMR.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary services to maintain proper personal hygiene and good nutrition for two (#3 and #7) of five residents reviewed for ADLs out of 17 sample residents.Specifically, the facility failed to:-Ensure Resident #3 consistently received assistance with meals and showers; and, -Ensure Resident #7 received assistance with showers. Findings include: I. Resident #3 A. Resident status Resident #3, age greater than 65, was admitted to the facility on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included cellulitis (skin infection caused when germs enter through a crack in the skin) of left lower limb, lymphedema (a condition where fluid called lymph builds up in the body's tissues causing swelling usually in the arms and legs) and benign prostatic hyperplasia (non-cancerous enlargement of the prostate gland) with lower urinary tract symptoms. The 9/30/25 minimum data set (MDS) assessment revealed the resident had severely impaired cognition with a brief interview for mental status (BIMS) score of three out of 15. The assessment revealed the resident was dependent on staff assistance with toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The assessment revealed the resident required supervision or touching assistance while eating. B. Observations During a continuous observation on 10/22/25, beginning at 9:30 a.m. and ending at 1:15 p.m., the following was observed: At 12:07 p.m. an unidentified certified nurse aide (CNA) delivered Resident #3 his lunch. The unidentified CNA provided a few cues before Resident #3 began to feed himself. The unidentified CNA left the room. At 12:30 p.m. Resident #3 finished eating lunch. He ate approximately 25 percent of the meal and drank one cup of coffee. At 12:50 p.m. the same unidentified CNA returned to remove the meal tray. She asked Resident #3 if he was done eating. She did not encourage the resident to eat more, despite Resident #3 having eaten only 25 percent of the meal. During a continuous observation on 10/22/25, beginning at 3:50 p.m. and ending at 6:00 p.m., the following was observed: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 5:05 p.m. an unidentified CNA delivered Resident #3's dinner. She set up the meal tray and provided a few cues to Resident #3. Resident #3 began to feed himself. The unidentified CNA left the room. At 5:19 p.m. Resident #3 finished eating dinner. He ate less than 25 percent of the food. He drank all of the coffee. No staff went into Resident #3's room since his dinner was delivered to encourage him to eat. -During the observation, the staff failed to provide meal assistance by encouraging Resident #3 to eat more food. C. Record review The baseline care plan, created 9/17/25, documented Resident #3 was dependent on staff for bathing. Interventions included providing the resident bathing per his preference, providing assistance as needed with grooming, bathing and personal hygiene and encouraging the resident to do as much as possible for himself as able. The nutrition care plan, initiated 9/22/25 and revised 10/6/25, documented Resident #3 had a potential and/or was at risk for inability to maintain his nutrition due to potential for increased needs for healing. Pertinent interventions included providing and serving diet and supplements as ordered, and the registered dietitian (RD) to evaluate and making nutritional recommendations as needed. The visual/bedside Kardex (staff directive tool), dated 10/23/25, revealed Resident #3 was scheduled for bathing on Monday and Thursday evenings. Review of the October 2025 (10/1/25 to 10/21/25) shower records revealed Resident #3 received bathing on 10/1/25, 10/4/25, 10/6/25, 10/8/25, 10/11/25, and 10/21/25. Resident #3 did not receive bathing for nine days from 10/11/25 to 10/21/25. There was no documentation indicating Resident #3 refused shower at that period of time as the facility did not provide the shower sheets when requested. D. Staff interviews CNA #1 was interviewed on 10/23/25 at 2:10 p.m. CNA #1 said Resident #3 was scheduled to receive showers on Monday and Thursday evenings. CNA #1 said Resident #3 often became combative with the evening shift CNAs, so he would not receive a full shower. He said instead, CNAs offered him a sponge bath as an alternative. CNA #1 said when he started his shift on 10/23/25, Resident #3 needed a shower, so he provided a sponge bath to Resident #3. CNA #1 said when Resident #3 refused both shower and the sponge bath, CNAs notified the nurse and documented the refusal. CNA #1 said he had Resident #3 sign the shower sheet when he refused showers. CNA #1 said Resident #3 did not let staff assist him with toileting or hygiene and often became combative. CNA #1 said he encouraged Resident #3 to eat more if he noticed Resident #3 did not eat much. CNA #1 said when Resident #3 refused to eat, he notified the nurse and documented that the resident refused. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #1 was interviewed on 10/23/25 at 3:25 p.m. LPN #1 said she consulted with the RD when she was notified by the CNAs that a resident ate poorly. LPN #1 said the dietitian could determine what to offer as alternative food options. LPN #1 said she could offer nutritional supplements such as Boost or Ensure to the resident and notify the physician who would then provide the order. LPN #1 said Resident #3 needed cues and guidance while allowing Resident #3 to clean himself. She said she had not worked with Resident #3 much, so she was not aware of his eating habits. She said on 10/23/25 Resident #3 allowed them to bathe him. The RD was interviewed on 10/23/25 at 6:35 p.m. The RD said she had not assessed Resident #3 since her first assessment upon admission. She said Resident #3 would rather benefit from a restorative program if the facility had one. II. Resident #7 A. Resident status Resident #7, age less than 65, was admitted on [DATE]. According to the July 2025 CPO, diagnoses included multiple sclerosis (MS), quadriplegia (paralysis that affects all a person's limbs) and pressure ulcer of right buttock stage 4 (severe wound with tissue loss exposing bone, muscles or tendons). According to the 7/28/25 MDS assessment the resident was cognitively intact with a BIMS score of 15 out of 15. The resident was dependent on staff for all activities of daily living (ADL). B. Resident interview and observation Resident #7 was interviewed on 10/21/25 at 3:30 p.m. During the interview, Resident #7 was lying in bed. His mattress and floor were covered with dry, white flakes. There was a strong unpleasant odor in the room. There was a white board in the room that indicated Resident #7 was to receive baths twice a week in the evening. He said he was dependent on staff for all ADLs. Resident #7 said he had not had a bed bath in a few weeks. He said the staff would tell him they would get to his bath and then get too busy and never come back. He said he did not refuse bed baths. D. Record review The bathing care plan, initiated 7/18/25 and revised 10/22/25, documented the resident agreed to receiving a shower or bed bath. Interventions included Resident #7 preferred a bed bath, frequency was two times a week. The decision care plan, initiated 7/31/25 and revised 10/23/25 (during the survey), documented the resident was non-compliant with cares such as bathing, repositioning of right buttock and refusals to work with therapy. Pertinent interventions included changing the approach and recording approaches which were successful, documenting non-compliance and reporting to the physician. -However, review of the EMR revealed there was no documentation of non-compliant behavior or successful approaches. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 8/9/25 skilled nursing note documented the resident verbalized to the nurse that he had not had a bath since his admission on [DATE]. The October 2025 look back period (9/25/25 to 10/19/25) bathing task record revealed Resident #7 had a bath documented 9/25/25, a bath on 10/2/25 and a refusal documented 10/10/25. -It indicated Resident #7 received two out of eight opportunities. -Review of the daily skilled notes from admission to 10/21/25 did not reveal any refusals of bed baths. E. Staff interviews Wound care nurse (WCN) #1 was interviewed on 10/22/25 at 10:50 a.m. WCN #1 said it was important to bathe residents with skin conditions. She said the odor coming from Resident #7's room has not changed since she started in July 2025. WCN #1 said she did not believe the odor was from the wound and said he may need more hygiene care and bathing. She said the staff may not be cleaning him well enough after a bowel movement. She said she saw feces on the dressing while she changed it on 10/22/25. WCN #1 said she was not aware Resident #7 had refused bed baths. LPN #2 was interviewed on 10/22/25 at 3:30 p.m. LPN #2 said Resident #7 was particular about his care but she was not aware he had refused bed baths. LPN #2 said if a resident refused any care, treatment or medication, the refusal should be documented in the daily skilled note. The director of nursing (DON) was interviewed on 10/22/25 at 4:28 p.m. The DON said the IDT monitors the bathing schedule about every two weeks. She said if a resident refused they are not offered another bath until their next scheduled bath day. The DON said if a resident refused a bath they would fill out a shower form. -However, there were no shower forms for Resident #7 during that time period.

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F 0684 Level of Harm - 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 record review and interviews, the facility failed to provide treatment and care in accordance with professional standards of practice for two (#1 and #5) of six residents out of 17 sample residents.Specifically, the facility failed to:-Provide timely, consistent and effective monitoring and appropriate documentation for Resident #1's left lower leg amputation surgical incision, which resulted in the resident's transfer to the hospital where she was hospitalized for 10 days with a diagnosis of a left below the knee amputation incision infection; and, -Obtain wound care orders for Resident #5's skin tear in a timely manner. Resident #1 was admitted to the facility on [DATE] after a hospital stay for a surgical amputation of her left lower leg. Resident #1 had an initial skin assessment completed at the facility on 8/27/25 which documented the staples to the incision were intact and the wound was well approximated (edges of the skin were closed together). An 8/27/25 wound care evaluation assessment did not address the resident's amputation site incision wound. On 8/29/25 the physician documented Resident #1 was worried the incision was getting infected. The physician documented the resident had an amputation site incision infection and ordered doxycycline (antibiotic) 100 milligrams (mg) twice a day (bid) for seven days and Rocephin (antibiotic given by injection) 1 gram (gm) one time dose and monitor the incision.-However, the Rocephin and doxycycline medications were not entered into the resident's electronic medical record (EMR) until 8/31/25. The Rocephin was administered on 8/31/25 and the doxycycline was started on 9/1/25. The resident was not started on any antibiotics until two days after the physician noted an infection to the amputation site incision on 8/29/25.Despite the physician noting the incision site had an infection and antibiotics being ordered, there was no nursing documentation to indicate staff were consistently monitoring the resident's infected incision for signs of a worsening infection. On 9/5/25 Resident #1 went to an appointment with the vascular surgeon who performed the left lower leg amputation. The resident was advised during that visit to go to the emergency room due to an infected amputation site incision. Resident #1 returned to the facility after the appointment and then was transferred to the hospital via non-emergent ambulance. Due to the facility's failure to closely monitor and document the condition of Resident #1's lower left leg amputation site incision. The resident was hospitalized for 10 days for a diagnosis of left below the knee amputation site infection and underwent washout debridement (procedure to remove infected or damaged tissue from wounds). She had a wound vacuum assisted closure (VAC) (promotes wound healing) of the incision site during her hospitalization. The infectious disease specialist was consulted during her hospital admission and a course of intravenous (IV) ertapenem (antibiotic) was ordered and completed with subsequent improvement to the resident's amputation incision site. Resident #1 did not return to the facility.Additionally, the facility failed to obtain timely wound care orders for Resident #5, who was admitted from home with a skin tear to her left lower leg.Findings include: I. Resident #1 A. Resident status Resident #1, age less than 65, was admitted on [DATE] and discharged to the hospital on 9/5/25. According to the August 2025 computerized physician orders (CPO), diagnoses included encounter for orthopedic aftercare following surgical amputation, osteomyelitis (infection of the bone), chronic obstructive pulmonary disease, depression and type 2 diabetes mellitus. (continued on next page)

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	065427	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Park West Llc, The	3727 Parker Blvd Pueblo, CO 81008

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The 9/5/25 minimum data set (MDS) assessment revealed Resident #1 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #1 was dependent on staff for dressing upper and lower body and substantial to maximal assistance with chair to bed transfers. The MDS assessment revealed the resident did not have any behaviors. The MDS assessment revealed the resident did not refuse care. B. Resident interview Resident #1 was interviewed via phone on 10/22/25 at 2:27 p.m. Resident #1 said when she was admitted to the facility she was no longer on antibiotics for her osteomyelitis because her infection had healed following the amputation of her left lower leg. She said her amputation site incision needed wound care daily, and during the nine day stay at the facility, her wound care was missed being completed twice. She said her hospital discharge orders to the facility said to run water and soap over the incision, but she said that was not done and she only received one shower during her admission at the facility. She said the shower in her room did not accommodate her due to the amputation because of the position of the shower bench. Resident #1 said during the visit with the physician on 8/29/25 she told the physician she thought the amputation incision site was getting infected and he ordered antibiotics. Resident #1 said she voiced the same concern to a nurse a few days later and asked for her incision to be cleaned, but she said she was told the antibiotic would be enough for the infection and the nurse did not clean the incision as she asked. C. Record review The skin care plan, initiated 8/26/25, documented Resident #1 had actual/potential skin breakdown or a surgical wound related to the left below the knee amputation. Pertinent interventions included dressing changes per physician's orders, monitoring the incision everyday and as needed (PRN) and notifying the physician of any signs and symptoms of infections. -The skin care plan did not include any of the specific orders pertinent to the healing of the wound. The amputation care plan, initiated 9/5/25, documented Resident #1 had an amputation of the left lower extremity related to diabetes and infection. Pertinent interventions included checking and documenting on the wound daily for signs and symptoms of infection (excessive drainage, any breakdown of skin and impaired circulation, including edema or pain), encouraging compliance with treatment regimen, monitoring for bleeding, documenting amount of bloody drainage on dressing and in drainage system, and wound care daily as ordered by the physician to include rewrapping the leg stump as ordered and PRN. The 8/27/25 new admission skin progress note documented Resident #1 had a left below the knee amputation (BKA) site with intact staples and the wound was well approximated. -However, the 8/27/25 skin/wound evaluation assessment note documented the resident had a right foot diabetic ulcer wound but did not document any information regarding the resident's left BKA site. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The 8/28/25 order administration note, documented at 2:07 p.m., revealed the abdominal pad (ABD - absorbent pads used for drainage of wounds) covering Resident #1's amputation incision site was saturated with serous sanguineous fluid (pink-tinged bodily fluid typically found in wounds) and the area to the suture line was macerated (a softening and breakdown of the skin caused by prolonged exposure to moisture). The stump shrinker (compression garment worn on the residual limb after an amputation) was put back on the stump but the brace was not applied for a couple of hours to allow the surgical site to dry out. -There was no further documentation on 8/28/25 to indicate the incision site was monitored further following the discovery of the macerated suture line or to indicate the physician or surgeon were notified regarding the condition of Resident #1's incision site. The 8/29/25 skilled progress note documented Resident #1 had a left lower extremity amputation. However, the note did not document any information regarding the condition of the resident's amputation incision site. The resident had no mood or behavioral problems. The 8/29/25 physician's progress note documented Resident #1 was worried the amputation incision site was getting infected and she needed dressing changes daily. The note documented there was an infection to the resident's left stump incision and the plan included administering doxycycline 100 mg twice a day and Rocephin 1 gm and wound care was to follow-up. The resident had no mood or behavior issues. The 8/31/25 progress note, documented at 2:02 p.m., revealed Resident #1 felt her leg was not healing well. She requested an antibiotic and to move up her follow-up appointment. -However, according to the physician's progress note, the physician had ordered two antibiotic medications for an infection of the resident's amputation site infection on 8/29/25, two days prior (see above). The 8/31/25 skilled progress note, documented at 2:05 p.m., revealed there were no concerns with Resident #1's mood or behavior and she had been cooperative. The progress note did not document any information regarding the condition of the resident's amputation incision site. The physician was notified the resident requested a new appointment day and an antibiotic. -However, according to the physician's progress note, the physician had ordered two antibiotic medications for an infection of the resident's amputation site infection on 8/29/25, two days prior (see above). The 8/31/25 progress note, documented at 6:35 p.m., revealed Resident #1 the nurse informed the physician that Resident #1 was concerned her incision site was infected. The physician ordered a one time dose of Rocephin 1 gm and doxycycline 100 mg twice a day for seven days. The note documented the incision site appeared more red and irritated. -However, the progress note did not document if the resident had received a one-time dose of Rocephin on 8/31/25. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The 9/1/25 skilled progress note, documented at 6:57 a.m., did not indicate the resident was receiving antibiotics. The progress note did not document any information regarding the condition of the resident's amputation incision site. There were no mood or behavior problems documented and the resident had been pleasant. -The progress note did not document the resident had received a one-time dose of Rocephin on 8/31/25 or that she was to start a seven-day course of antibiotics. The 9/2/25 skilled progress note, documented at 3:07 p.m., did not indicate the resident was receiving antibiotics. The progress note did not document any information regarding the condition of the resident's amputation incision site. There were no mood or behavior problems documented and the resident had been pleasant. -There was no daily skilled progress note documented for 9/3/25. The 9/4/25 skin/wound progress note documented Resident #1 had a diabetic ulcer to the bottom of her right foot, however, the note failed to document any information regarding the condition of the resident's amputation incision site, despite the fact the resident was receiving antibiotics for an amputation incision site. The 9/4/25 daily skilled progress note, documented at 5:50 p.m., did not indicate Resident #1 was receiving antibiotics. The progress note did not document any information regarding the condition of the resident's amputation incision site. There were no mood or behavior problems documented and the resident had been pleasant. The 9/4/25 progress note, documented at 6:12 p.m., revealed Resident #1 spoke with the assistant director of nursing (ADON) and reported showers were not being offered to her, her wound care had been missed for one and a half days and she was being treated for an incision infection. The ADON documented he communicated to the wound care nurse (WCN) to evaluate the resident's incision wound and add it to weekly rounds. The 9/5/25 transfer to the hospital progress note documented Resident #1 had a change of condition related to an infection to her BKA site. Review of Resident #1's August 2025 and September 2025 (from 8/1/25 to 9/5/25)medication administration records (MAR) revealed the following: -The resident received a one-time dose of Rocephin 1 gm on 8/31/25 at 7:57 p.m.; -The resident received doxycycline 100 mg two times a day on 9/1/25, 9/2/25, 9/3/25, 9/4/25; and, -The resident received doxycycline 100 mg on the morning of 9/5/25 (prior to being transferred to the hospital). -However, the progress notes failed to indicate that the facility was monitoring the resident's amputation site infection for signs/symptoms the infection was worsening, despite the resident being administered the antibiotics (see progress notes above). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's August 2025 and September 2025 (from 8/26/25 to 9/5/25) treatment administration records (TAR) revealed the resident's BKA incision was to be monitored every shift and staff were to report any concerns to the physician or surgeon. Documentation revealed there was a problem (documented as a P) noted with the incision on 8/28/25, but the other dates during the time frame were documented as no concerns (documented as a 0). -However, Resident #1 began receiving antibiotics for an infected amputation site incision on the evening of 8/31/25. -Additionally, Resident #1 was transferred to the hospital for evaluation of her infected amputation site infection on 9/5/25, per the recommendation of the vascular surgeon following the resident's appointment on 9/5/25. D. Staff interviews Nurse practitioner (NP) #1 was interviewed on 10/22/25 at 12:50 p.m. NP #1 said it was important to monitor residents' skin integrity at least daily as changes could happen quickly. NP #1 said when she was in the facility, she would follow up with the wound care nurse (WCN) and discuss wounds for her residents. She said she did not always look at a resident's wound but would review documents, such as the progress notes and laboratory results to determine if there were any complications. She said she trusted the facility to be providing accurate wound care assessments and she would be notified if there were concerns. The director of nursing (DON) was interviewed on 10/22/25 at 4:28 p.m. The DON said if there was a change in a wound or skin condition, such as an infection, the resident's TAR would be marked under skin monitoring and the WCN would be notified via text. The DON and WCN #1 were interviewed together on 10/23/25 at 10:29 a.m. WCN #1 said she did not follow wounds or surgical incisions if there were no issues. She said when Resident #1 was admitted to the facility, there were no concerns regarding her BKA incision She said she was not notified of any changes to the resident's incision site during the resident's stay. Licensed practical nurse (LPN) #1 was interviewed on 10/23/25 at 1:45 p.m. LPN #1 said surgical wounds were monitored for signs of infection, such as excessive drainage, and if the wound was red or warm to the touch. She said if there was a problem, the nurse should write a progress note and notify the physician. She said the WCN should also be notified if there were any changes to a surgical wound. She said the resident's TAR wound monitoring would be documented with a P until the change or infection had cleared. LPN #1 said the skilled nursing progress notes should include if a resident was on an antibiotic and include the wound treatments being utilized. II. Resident #5 A. Resident status Resident #5, age greater than 65, was admitted on [DATE]. According to the October 2025 CPO, diagnoses included dementia. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The 10/22/25 MDS assessment revealed the resident had significant cognitive impairment with a BIMS score of three out of 15. She required extensive assistance with activities of daily living (ADL). B. Observations On 10/21/25 at 5:03 p.m. Resident #5 was observed with an undated loose bandage wrap sparsely covering a large gauze pad on her left lower leg. On 10/22/25 at 11:05 a.m. two hospice nurses came to check on Resident #5. They noticed the bandage to Resident #5's leg had come undone, and proceeded to change it. The hospice nurses said Resident #5 had sustained the skin tear on her leg from a fall at her home prior to being admitted to the facility. On 10/23/25 at 9:30 a.m. WCN #1 was observed changing Resident #5's dressing to her left lower leg skin tear. The wound was a golf-ball size skin tear on the mid-upper lateral side of her calf with a large amount of red and purple discoloration. There was an additional skin tear on the lower section of her calf that was smaller in size, but with the same dark red and purple discoloration. The skin tears were not actively bleeding and were partially scabbed over. C. Record review The 10/20/25 nursing admission note documented that Resident #5 had a single wound on her left ankle. The note specified that the wound was a skin tear on her lower calf, however, the note did not address the larger skin tear on her left upper-mid calf. The note documented that the skin tear dressing was changed. -However, according to registered nurse (RN) #1 (see interview below), she did not change Resident #5's dressing on the day the resident admitted to the facility (10/20/25), but only looked under the dressing that was already on the wound prior to her admission. -The facility failed to obtain physician's orders for a dressing change until 10/22/25 at 11:44 a.m., two days after Resident #5 had been admitted to the facility. D. Hospice RN interview The hospice RN was interviewed on 10/22/25 at 11:05 a.m. The hospice RN said Resident #5 was on hospice services and was at the facility for respite care. The hospice RN said the resident had fallen while at home and sustained a skin tear to her left lower leg. The hospice RN said that the old bandage she removed had adhered to Resident #5's skin and she had to use a wound cleaner to moisten the bandage in order to remove it. E. Staff interviews RN #1 was interviewed on 10/22/25 at 5:40 p.m. RN #1 said she had admitted Resident #5 to the facility on [DATE]. RN #1 said she had peeked under Resident #5's wound dressing on her lower left leg upon her admission, but she said she did not change the dressing because she was waiting for official wound care orders. She said she expected the WCN would have put in wound care orders the following day after the resident's admission. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	WCN #1 was interviewed on 10/23/25 at 10:29 a.m. WCN #1 said she saw Resident #5 on 10/21/25 but forgot to enter the wound care orders from the physician into the resident's electronic medical record (EMR). She said she forgot to document the wound care she completed on Resident #5's leg on 10/21/25. The DON was interviewed on 10/23/25 at 12:56 p.m. The DON said she had provided WCN #1 with education regarding correct and timely documentation of resident care.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide the necessary treatment and services to prevent pressure injuries to prevent or heal pressure injuries for two (#9 and #7) of six residents out of 17 sample residents.Specifically, the facility failed to:- Accurately identify, document, evaluate and monitor a pressure ulcer for Resident #9;- Ensure Resident #9's weekly skin assessments were documented thoroughly and accurately; and,- Ensure appropriate wound prevention interventions, including an air mattress, were implemented timely and consistently monitored for function and settings for Resident #9 and Resident #7.Resident #9, who was at risk for skin breakdown, was admitted to the facility on [DATE] following a hospitalization for a right hip fracture. The admission skin assessment documented she had scattered bruising to her abdomen and a bruise to her right ear. On 9/9/25 the facility documented the resident had moisture-associated skin damage (MASD) to her coccyx and treated the area of skin damage with barrier cream.On 9/15/25 the facility documented the resident had an abrasion to her coccyx related to MASD and put a treatment order of a foam border dressing in place. However, the facility failed to identify the area of skin breakdown as a pressure injury.On 9/18/25 the facility continued to identify the area of skin breakdown to Resident #9's coccyx as an abrasion and added medihoney (a wound treatment that can be used to get rid of slough (whitish non-viable tissue which commonly develops in Stage 3 or Stage 4 pressure wounds - see professional reference below) or necrotic (dead) tissue that can develop in wounds) the treatment order. However, the facility failed to identify the area of skin breakdown as a pressure injury. Resident #9's skin breakdown care plan failed to include an intervention of an air mattress until 9/12/25, after the resident had already developed the skin issue. Additionally, the resident's weekly skin assessments conducted by the nursing staff were inconsistent and incomplete, frequently failing to identify the skin issue to the resident's coccyx.On 9/22/25 Resident #9 discharged to another long-term care facility. The facility identified the resident had an unidentified wound to her coccyx upon discharge.Upon Resident #9's admission to the receiving facility, the staff at the receiving facility documented the resident had an open area to her coccyx with slough present in the wound.-The facility failed to accurately identify a pressure wound to Resident #9's coccyx, which developed during the resident's stay at the facility from 8/30/25 to 9/22/25.Additionally, the facility failed to ensure staff were consistently following and/or documenting appropriate interventions, including ensuring low air loss mattress settings were in place, for Resident #7, who had a Stage 4 pressure injury to his right buttock.Findings include: I. Professional reference According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA (2019), retrieved from https://www.internationalguideline.com/guideline on 2/10/25, Pressure ulcer classification is as follows: Category/Stage 1: Non-blanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk). Category/Stage 2: Partial Thickness Skin Loss Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Category/Stage 3: Full Thickness Skin Loss Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable. Category/Stage 4: Full Thickness Tissue Loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/ or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed. Suspected Deep Tissue Injury: Depth Unknown Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	II. Facility policy and procedure The Pressure Ulcer policy and procedure, dated 3/14/24, was provided by the nursing home administrator (NHA) on 10/23/25 at 3:30 p.m., it read in pertinent part, The [Facility] will provide the necessary requirements to ensure that a patient receives the treatment and care in accordance with professional standards of practice. Upon admission, the nursing staff will complete a full skin evaluation and examine for any ulcerations or alterations in skin. The following is documented; full evaluation of pressure sore including description of the wound, pain evaluation, patients mobility status, current treatments, if applicable. The physician will assist in identifying factors contributing or predisposing patients to skin breakdown, help clarify relevant medical issues and will authorize pertinent orders related to wound treatments. The physician will assist the staff with reviewing current orders when wounds are not healing as anticipated or new wounds develop despite existing interventions. III. Resident #9 A. Resident status Resident #9, age [AGE], was admitted on [DATE] and discharged on 9/22/25 to another long-term care facility. According to the September 2025 computerized physician orders (CPO), diagnoses included fracture of the superior rim of the right pubic (hip bone), subsequent encounter for fracture with routine healing, type 2 diabetes mellitus with diabetic neuropathy (damages the nerves typically in the feet, legs, hands and arms), chronic kidney disease stage 4, cardiomyopathy (chronic disease of the heart muscle), coronary angioplasty implant and graft (a surgical procedure that bypasses a blocked coronary artery by using a healthy blood vessel from another part of the body), essential hypertension (high blood pressure) and acute respiratory failure with hypoxia (lack of oxygen to the body's tissues). According to the 9/22/25 minimum data set (MDS) assessment, the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. The resident required supervision with oral hygiene and personal hygiene and maximal assistance with toileting, showering and dressing. The assessment revealed the resident did not have a pressure ulcer. B. Resident #9's representative interview (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #9's representative was interviewed on 10/21/25 at 4:43 p.m. He said Resident #9 was admitted to the facility after she fell at home and was hospitalized . He said once Resident #9 was at the facility, she acquired a pressure injury on her buttock. He said the facility discovered the pressure injury because she complained of pain on her buttocks so they moved her from one side to the other to relieve her pain and then discovered the pressure injury. He said it took several days for the facility to provide a pressure-relieving mattress. He said Resident #9 received a pressure-relieving mattress two days before she was discharged . He said Resident #9's care at the facility was terrible. He said the nurses were always too busy to help Resident #9 and that was why he moved her to another nursing facility. He said he felt uncomfortable since the first day he visited Resident #9 because he did not think Resident #9 was receiving the correct care and services. C. Record review A review of Resident #9's abrasion to the coccyx care plan, initiated 9/12/25 and revised 9/29/25, revealed the resident had an abrasion to her coccyx. Interventions included determining the cause of the wound and ensuring preventative interventions were in place, documenting a wound evaluation weekly and as needed, notifying the physician of any changes, administering pain medications as ordered before the wound treatments and providing wound treatments as ordered by the physician. Review of Resident #9's skin breakdown care plan, initiated 9/12/25 and revised 9/29/25, revealed she had the potential for skin breakdown related to impaired mobility secondary to weakness, impaired mobility, pain, malnutrition, end stage renal disease (ESRD), pubic fracture recent fall, respiratory problems, muscle spasms, anemia, type 2 diabetes mellitus, incontinence, side effect of medications and debility. Interventions included applying moisturizer to her skin, not massaging over bony prominences and using mild cleansers for peri-care/washing, Braden scale assessment every week per protocol, skin evaluation as ordered and as needed, dressing changes per physician order, encouraging proper nutrition and hydration, monitoring lab values, monitoring, reminding and assisting to turn and reposition frequently as needed and as requested, and toileting as needed. Additional interventions included administering medications per the physician's orders, providing an air mattress and/or air mattress overlay as indicated, providing pressure-reducing devices as needed for the mattress and wheelchair cushion, and a wound nurse was to evaluate and treat the wound as indicated. -The care plan did not identify Resident #9's pressure ulcer to the coccyx (see receiving facility's admission record below). Review of Resident #9's September 2025 CPO revealed the following physician's orders: Moisture-associated skin damage (MASD) to the buttocks. Cleanse the affected area with wound cleanser. Pat dry, apply a thin layer of triad barrier cream every shift. Ordered 9/9/25 and discontinued 9/15/25. Treatment: Abrasion to coccyx related to MASD. Cleanse with wound cleanser, pat dry, apply skin prep to wound bed, and cover with border foam dressing every day shift. Ordered 9/15/25 and discontinued 9/18/25. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Treatment: Abrasion to coccyx related to MASD. Cleanse with wound cleanser, pat dry, apply medihoney to wound bed, cover with border foam dressing every day shift every Monday, Wednesday and Friday. Ordered 9/18/25 and discontinued 9/21/25. Treatment: Abrasion to coccyx related to MASD. Cleanse with wound cleanser pat dry, apply medihoney to wound bed, cover with border foam dressing every day shift related to open area to coccyx. Clean, dry, apply medihoney and mepilex (foam dressing). Ordered 9/21/25 and discontinued 9/22/25. A review of the September 2025 CPO did not reveal a physician's order to monitor the resident's coccyx wound on the days the wound treatment was not provided (see director of nursing (DON) interview below) or a physician's order to check the function and settings of the resident's air mattress. A review of the September 2025 CPO revealed there was a physician's order to provide an air mattress related to Resident #9's right hip fracture. -However, the order did not specify what the air mattress function or setting should have been. A review of Resident #9's electronic medical record (EMR) did not reveal the facility monitored the mattress function or setting. A Braden scale (pressure sore assessment risk) assessment, dated 9/6/25 (completed seven days after the resident's admission to the facility), revealed Resident #9 was at low risk for pressure ulcers. Braden scale (pressure sore assessment risk) assessments, dated 9/13/25 and 9/21/25, did not document any changes from the assessment completed on 9/6/25. -However, the Braden scale assessment did not identify the skin injury that had developed to Resident #9's coccyx. The 8/31/25 skin evaluation revealed Resident #9 had right ear bruising with scab formation and scattered bruising on the abdomen. The 9/6/25, 9/13/25 and 9/21/25 skin evaluations revealed the resident had scattered ecchymosis on the abdomen due to heparin shots. -However the skin evaluations did not document the skin condition of MASD of the resident's buttocks which was identified on 9/4/24 (see below wound nurse progress note). The 9/4/25 wound nurse progress note revealed Resident #9 had bruising to the lower abdomen related to injections and MASD to the bilateral buttocks related to incontinence-associated dermatitis (IAD). There was no indication for wound rounds to be completed. The 9/8/25, 9/10/25, 9/11/25, 9/12/25, 9/15/25 and 9/18/25 daily skilled nurse notes revealed the resident's skin was fragile and dry and the coccyx was reddened. The 9/20/25 daily skilled nurse note revealed there was an open wound to Resident #9's coccyx. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-No additional information was documented, such as physician notification, measurements and staging of the skin issue to the resident's coccyx. The 9/22/25 discharge progress note documented Resident #9 had an identified wound to the coccyx and an ear with a scab and a small bruise. -A review of Resident #9's EMR failed to document the description, including the size, the characteristic, stage and progress of the wound on the coccyx, if there were complications and if there were signs of infection, despite the fact the wound was identified as open on 9/20/25. D. Receiving facility's documentation The receiving nursing facility's 9/22/25 admission skin evaluation revealed Resident #9 had a pressure injury on the coccyx. The 9/22/25 nurse progress note from the receiving facility revealed that a skin assessment was completed. The resident had an open area to the coccyx. The open area was sloughy, off white in color and punchy. The 9/23/25 nurse progress note revealed there was an open wound on Resident #9's coccyx. The area was approximately 2.5 centimeters (cm) in length and 2.5 cm in width and tunneling (burrowing under the skin) at six o'clock by about 2 cm. Slough mostly covered the area except for a hole in the center. The nurse practitioner was notified for wound rounds. The 9/23/25 wound treatment order documented to cleanse Resident #9's wound with wound cleanser and pat dry. Apply calcium alginate with silver and cover with border gauze dressing every day shift and as needed if the dressing was dislodged or soiled for the coccyx wound. The 9/29/25 wound care physician (WCP) note revealed Resident #9 moved from another facility after a fall. She came to the current receiving facility with a pressure injury that was documented by the transferring facility as a red spot. Resident #9 reported pain at all times, worse with movement. The facility nurse stated the wound was covered in slough but had a pinpoint opening that tunneled deeply. The note revealed the dressing was changed on 9/28/25 but the foam was stuck. The slough had rolled back quite a bit, revealing a Stage 4 pressure ulcer probed to the bone. The WCP debrided the wound and Resident #9 had quite a bit of pain. A culture was taken of the wound, Santyl (prescription ointment used to remove dead or damaged tissue from wounds) was ordered, the wound was packed with iodosorb packing, and covered with a foam dressing. The wound dressing was to be changed daily. The 10/6/25 WCP wound assessment report revealed Resident #9 had a Stage 4 pressure injury on the sacrum. The undermining was from 12 o'clock to 12 o'clock with 60 percent (%) granulation (new, pink or red, moist tissue that forms in the healing process of wounds) and 40% slough. There was exposed bone and the attached wound edges had heavy serosanguinous (a combination of serous fluid and blood, usually a light pink to red color) exudate (drainage that seeps out of wounds). E. Staff interviews (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Licensed practical nurse (LPN) #1 was interviewed on 10/22/25 at 3:35 p.m. LPN #1 said residents' skin was assessed upon admission, 24 hours after admission and as needed. LPN #1 said the physician should be notified if treatment orders were required based on those skin assessments. LPN #1 said a risk management should be completed, the physician should be notified and a treatment order obtained when a new skin condition was identified. She said skin assessments should be completed weekly. The director of nursing (DON) was interviewed on 10/22/25 at 4:28 p.m. The DON said air mattresses should be monitored if it was being used as a preventative measure. She said the facility did not do an assessment when a resident first had an air mattress. The DON said the facility did not check the manufacturer's recommendations on what the function and settings should be based on the resident's weight. The DON said if a resident had a physician's order to check the resident's air mattress, it meant to check how firm or soft the mattress was to touch. The DON said the staff did not check the function or setting. The DON was interviewed a second time on 10/23/25 at 5:54 p.m. The DON said a resident's skin was assessed upon admission, every seven days and as needed, along with a Braden scale assessment. She said the certified nurse aides (CNA) notified the nurse if they observed anything abnormal. The DON said the nurse documented their findings on the skin evaluation form. She said if a skin condition was identified, then a treatment order and a monitoring order were obtained from the physician. The DON said when a new skin condition was identified, the floor nurse should complete a risk assessment and include a nurse progress note. The DON said measurements were obtained when the wound nurse was involved with the resident's skin treatment. The DON said when a resident was discharged , the nurse should describe the resident's skin condition and provide the treatment orders to the receiving facility. She said a head-to-toe assessment was not completed upon discharge. The DON said she was familiar with Resident #9. She said there should have been a skin monitoring order in place for the days the skin treatment order was not provided to ensure the treatment area was covered, clean and there were no signs of infection. The DON said there should be an incident report for Resident #9's abrasion to her coccyx. The DON said she knew Resident #9 transferred to another nursing facility. The DON said she was not aware Resident #9 had been discharged with a pressure injury to her coccyx. She said she was informed it was an abrasion. The DON was interviewed a third time on 10/23/25 at 6:15 p.m. The DON said an incident report was not completed for Resident #9's skin breakdown to her coccyx and the wound care nurse was not notified of the open area to Resident #9's coccyx prior to her discharge from the facility on 9/22/25. IV. Resident #7 A. Resident status Resident #7, age less than 65, was admitted on [DATE]. According to the October 2025 CPO, diagnoses included multiple sclerosis (MS), quadriplegia (paralysis that affects all a person's limbs) and pressure ulcer of the right buttock stage 4 (severe wound with tissue loss exposing bone, muscles or tendons). According to the 7/28/25 MDS assessment the resident was cognitively intact with a BIMS score of 15 out of 15. The resident was dependent on staff for all activities of daily living (ADL). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	B. Observations On 10/21/25, at 3:30 p.m., Resident #7 was lying on an air mattress with the head of the bed upright with heel boots in place. His mattress and floor were covered with flakes of skin and there was a strong unpleasant odor in the room. A white board used to pass on information had position changes every two hours written on it and indicated the resident received bathing assistance twice a week in the evening. On 10/22/25 wound care nurse (WCN) #1 and the assistant director of nursing (ADON) completed wound care on Resident #7. The room had a strong foul smell that was observable from the hallway outside of Resident #7's room. Resident #7 had a wound vacuum (vac) covering his wound with a dressing that was intact. A small smear of a brown substance was observed on the corner of the dressing. The dressing was not labeled with the initials of the last staff member to change the dressing or the time and date of the last dressing change. The dressing was removed and revealed a deep, tunneled wound with a moderate amount of brownish-yellowish drainage. The wound bed had a slimly yellowish-brownish film covering it. The walls of the wound were beefy red. The opening of the wound appeared to have a dime-sized black spot on it. WCN #1 said the wound had improved significantly since Resident #7 had been admitted to the facility. A large reddened and peeling area along the inside and back of Resident #7's thigh and buttocks was observed, just below the wound. The ADON glanced at it and said it was probably moisture associated skin damage (MASD). WCN #1 said the area used to be much more macerated but had improved significantly. WCN #1 dressed the wound and labeled the new dressing with her initials, and the time and date of the dressing change. During the wound care observation, the wound was not measured and barrier cream was not applied to the skin around the wound. C. Resident interview Resident #7 was interviewed on 10/21/25 at 3:30 p.m. Resident #7 said he preferred to stay in bed. He said he used to get into a chair but it was uncomfortable for him to sit up. He said he was dependent on staff for all ADLs. Resident #7 said the facility staff repositioned him when he asked for it, but did not come into his room every two hours to offer repositioning. He said he would refuse repositioning at times because he might have just eaten and did not want to lay back further. Resident #7 said he had not had a bed bath in a few weeks. He said facility staff would tell him they were getting ready to give him a bath, but then they would get too busy and never come back. He said he did not refuse bed baths. Resident #7 said he understood the importance of repositioning and bathing. D. Record review (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The skin care plan, initiated 7/18/25, documented Resident #7 had potential for skin breakdown related to impaired mobility due to weakness and debility. The pertinent interventions included an air mattress to his bed per facility guidelines, dressing changes per physician's order, monitoring and assisting the resident to reposition frequently, as needed or requested, and notifying the physician of any signs and symptoms of infections. -However, the October 2025 CPO documented to reposition Resident #7 throughout the shift and the October 2025 treatment administration record (TAR) documented repositioning was done twice a day. The wound care plan, initiated 7/24/25 and revised 7/29/25, documented Resident #7 had a Stage 4 pressure injury to his right buttock due to MS, quadriplegia, need for assistance for personal care, nutritional problems and staff must assist the resident with meals. The pertinent interventions included administering treatments as ordered and monitoring for effectiveness - if the resident refused treatment, conferring with the resident, the interdisciplinary team (IDT) and family to determine why and to try alternative methods to gain compliance and to document alternative methods; and documenting weekly treatments, including measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. The decision care plan, initiated 7/31/25 and revised on 10/23/25 during the survey, documented Resident #7 was non-compliant with care, such as bathing, repositioning of his right buttock and refusals to work with therapy. Pertinent interventions included changing approach and recording approaches which were successful and documenting non-compliance and reporting it to the physician. -Resident #7's care plan, diagnosis list, and July 2025 through October 2025 TARs did not include MASD or interventions to treat MASD. However, WCN #1's assessments, from 8/19/25 and 10/22/25, documented maceration around Resident #7's wound (see observation above for identified MASD). Review of Resident #7's electronic medical record (EMR) and the July 2025 through October 2025 TARs revealed missing treatment documentation from 7/18/25 to 10/23/25. The following was not charted per orders: Wound VAC to right buttock, dressing change every Monday, Wednesday, Friday and PRN was not documented as being completed five times (7/21/25, 9/10/25,10/3/25, 10/10/25 and 10/13/25). Barrier cream to coccyx, periarea every shift and as needed (PRN) was not documented as being completed nine times (8/3/25, 8/11/25, 8/26/25, 9/6/25, 9/9/25, 10/1/25, 10/3/25, 10/4/25 and 10/10/25). Wound Vac check settings and function every shift was not documented as being completed 11 times (7/20/25, 7/21/25, 8/3/25, 8/11/25, 8/26/25, 9/6/25, 9/9/25, 10/1/25, 10/3/25, 10/4/25 and 10/10/25). Reposition side-to-side was not documented as being completed 11 times (8/3/25, 8/11/25, 8/18/25, 8/21/25, 8/26/25, 9/6/25, 9/9/25, 10/1/25, 10/3/25, 10/4/25 and 10/10/25). Low-air-loss mattress check settings was not documented as being completed nine times (8/3/25, 8/11/25, 8/26/25, 9/6/25, 9/9/25, 10/1/25, 10/2/25, 10/3/25 and 10/10/25). (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observations, record review and interviews the facility failed to provide appropriate treatment and services to residents diagnosed with dementia for three (#17, #5 and #3) of five residents out of 17 sample residents. Specifically the facility failed to:-Develop a person-centered care plan to meet Resident #17's dementia care needs;-Ensure Resident #5 was provided activities to meet her preferences; and,-Develop and implement a person-centered care plan to meet Resident #3's dementia care needs.Findings include: I. Facility policy and procedure The Care of the Cognitively Impaired policy, reviewed on 9/22/25, was provided by the director of nursing (DON) on 10/23/25 at approximately 3:00 p.m. Ensuring adequate medical care, diagnosis, and supports based on diagnosis; Ensuring that the necessary care and services are person-centered and reflect the resident's goals, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety; and, Utilizing individualized, non-pharmacological approaches to care (purposeful and meaningful activities). Meaningful activities are those that address the resident's customary routines, interests, preferences, and choices to enhance the resident's well-being. Identify, address, and/or obtain necessary services for the dementia care needs of residents; Develop and implement person-centered care plans that include and support the dementia care needs, identified in the comprehensive assessment; Develop individualized interventions related to the resident's symptomology and rate of progression (providing verbal, behavioral, or environmental prompts to assist a resident with dementia in the completion of specific tasks); Review and revise care plans that have not been effective and/or when the resident has a change in condition; Modify the environment to accommodate resident care needs; and, Achieve expected improvements or maintain the expected stable rate of decline. II. Resident #17 A. Resident status (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #17, age [AGE], was admitted on [DATE]. According to the October 2025 computerized physician orders (CPO), diagnoses included mild neurocognitive disorder due to known physiological conditions with behavioral disturbance. The 10/22/25 minimum data set (MDS) assessment revealed the resident had short term memory problems and had moderately impaired cognition per staff assessment. The MDS indicated the resident did not have any behaviors. B. Observations On 10/21/25 around 10:00 a.m. Resident #17 sat at the nurse's station next to a staff member. The resident and staff member chatted while the staff charted on her computer. She encouraged the resident to stay seated with her and utilize a busy board. -The staff did not provide Resident #17 with his preferred activities that were listed on the care plan (see care plan below). On 10/21/25 at approximately 11:00 a.m. Resident #17 was walking around the nurses' station by himself. He entered another resident's room. The other resident shrieked, the staff immediately went over to Resident #17 and asked him to leave the other resident's room. He left the room. The staff walked and talked with him around the nurses' station. -The staff did not provide Resident #17 with any person-centered interventions to prevent him from wandering into other resident's rooms. C. Record review Resident #17's cognitive deficit care plan, revised on 10/17/25, revealed the following pertinent interventions: allowing the resident ample time to absorb and respond to information, allowing the resident to make as many choices as possible with his care, assisting the resident in performing and/or completing a task or activity that they can not do, avoiding changes in the resident's environment, explaining all procedures and treatments prior to completing them, providing a calm environment and structured routine, reorienting the resident as needed. Residents #17's activity care plan, revised 10/17/25, revealed the resident had problems or concerns that may affect the resident's involvement in activities. Pertinent interventions included encouraging the resident to participate in group and individual activities. The care plan documented the resident enjoyed arts and crafts, games and puzzles, television (TV) and movies, listening to music, being outdoors, visits with family and friends, and physical activity. -However, observations revealed the staff did not offer the resident his preferred activities (see observations above). D. Staff interviews (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The social services director (SSD) was interviewed on 10/23/25 at 9:32 a.m. The SSD said Resident #17's daughter lived out of state. The SSD said the facility had a meeting scheduled for that day (10/23/25) to discuss the resident's placement. The SSD said the resident was placed on a one-to-one care giver to ensure he was safe. She said she was not aware if there had been a care plan developed to address the resident's dementia needs. She said having a one-to-one caregiver sit with him was not the best way to address the resident's dementia needs. She said she was not sure how new staff were provided dementia training. LPN #1 was interviewed on 10/23/25 at 3:20 p.m. She said another resident, Resident #3, had to be moved to a different floor of the building because he and Resident #17 did not get along. She said that on 10/22/25 and 10/23/25 Resident #3 became agitated and yelled at the nurses' station, which triggered Resident #17. She said Resident #17 threw objects, yelled at the resident and staff and made threats. She said on both occasions they were able to redirect the residents away from each other. She said they redirected Resident #17 by having staff talk with him. The activities director (AD) was interviewed on 10/23/25 at approximately 5:30 p.m. The AD said when a resident was admitted to the facility, he conducted an assessment to determine what the resident liked to do. He said he invited the residents to group activities. He said some of the residents preferred individual activities such as puzzles or reading in their rooms. The AD said Resident #17 did not do well in group activities. He said Resident #17 often became agitated and did not stay. He said Resident #17 did not have a special care plan to meet his dementia needs. Registered nurse (RN) #2 was interviewed on 10/23/25 at 5:45 p.m. She said that typical interventions for dementia care were to offer assistance with the restroom, check for incontinence, offer food and fluids, let the resident sit at the nurse's station and to redirect the resident. She said sometimes they will offer books, magazines, word puzzles, the busy board which is a board with a fidget [NAME], locks and other miscellaneous items designed for dementia patients to occupy their time. She said the main focus was to redirect the residents. She said when Resident #17 tried to go into another resident's room, they would try to redirect him by encouraging him to walk and talk with staff, or by offering him soda. Licensed practical nurse (LPN) #3 was interviewed on 10/23/25 at 5:47 p.m. LPN #3 said Resident #17 often walked around the nurses' station and halls. He said Resident #17 had tried to leave the unit before, but had never made it out of the building to his knowledge. He said if the resident did try to leave, a staff member would hopefully see him and bring him back. He said if he made it as far as the lobby, then the receptionist would bring him back. He said Resident #17 was well known by everyone in the building. The DON was interviewed on 10/23/25 at 6:00 p.m. The DON said Resident #17 was placed on a one-to-one caregiver, since he was really agitated and going into other residents' rooms. She said the one-to-one caregiver was helping with the resident's agitation. The DON said the staff gave Resident #17 a Rubik's cube yesterday and he threw it. The DON said they had tried fidget boxes too. The DON said Resident #17 did not staff in the activities. The DON said Resident #17 had a lot of hallucinations. The DON said the staff were provided dementia training at the yearly skills fair. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III. Resident #5 A. Resident status Resident #5, age greater than 65, was admitted on [DATE]. According to the October 2025 CPO, diagnoses included dementia. The 10/22/25 MDS revealed the resident had severe cognitive impairments with a BIMS score of three out of 15. She required extensive assistance with activities of daily living (ADLs). The MDs indicated the resident spoke English. B. Observations On 10/21/25 at approximately 10:40 a.m. Resident #5 was lying in bed on her back trying to get out of bed. She was yelling help. A few minutes later a staff member went into the room to assist her. She was seen later that day, around lunchtime, idly sitting in a wheelchair at the nurses station staring downwards. She was seated away from the counters and appeared to have no activities nearby At 5:03 p.m. Resident #5 was yelling for help while she laid in her bed. The unidentified staff member at the nurses' station said it was Resident #5 yelling again, and did not immediately get up to help. Resident #5 yelled for help for approximately five minutes before the staff member assisted her. During a continuous observation on 10/22/25, beginning at 9:35 a.m. and ending at 1:35 p.m. the following was observed: At 9:35 a.m. Resident #5 was sleeping in her bed. At 10:15 she was sleeping in her recliner with the TV on a Spanish speaking channel. -However, Resident #5 did not speak Spanish. At approximately 11:05 a.m. a registered nurse (RN) from an outside hospice provider checked on the resident. At 11:28 a.m. the hospice RN changed the TV channel to an English channel. -The resident was lying in bed with a Spanish speaking channel playing for over an hour. The facility failed to provide person-centered interventions for Resident #5. C. Record review Resident #5's activity care plan, initiated on 10/21/25, revealed she enjoyed listening to music, social events and activities, spiritual activities, arts and crafts, and being outdoors. Pertinent interventions were to provide her assistance with her activity supplies, to make sure that they are convenient for her to use and to encourage her to participate in her activities of interest. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #5's social isolation care plan, initiated on 10/21/25, revealed the following pertinent interventions assisting Resident #5 to and from activities and encouraging her to participate in activities of interest with others. III. Resident #3 A. Resident status Resident #3, age greater than 65, was admitted to the facility on [DATE]. According to the October 2025 CPO, diagnoses included anxiety disorder, other symptoms and signs involving cognitive functions and awareness and benign prostatic hyperplasia (non-cancerous enlargement of the prostate gland) with lower urinary tract symptoms. The 9/30/25 MDS assessment revealed the resident had severely impaired cognition with a BIMS score of three out of 15. The resident was dependent on staff for most of the activities of daily living (ADL). The assessment revealed the resident had behavior for difficulty focusing attention, being easily distractible or having difficulty keeping track of what was said, and the resident's thinking disorganized or incoherent. B. Observations During a continuous observation on 10/22/25, beginning at 9:30 a.m. and ending at 1:15 p.m., the following was observed: At 9:30 a.m. Resident #3 was lying in bed with his door open. At 10:10 a.m. an unidentified certified nurse aide (CNA) stood at the room entrance, looked into Resident #3's room for less than 30 seconds, and then left. At 11:02 a.m. LPN #1 entered Resident #3's and provided care to the resident. Then LPN #1 assisted Resident #3 to the lobby by the elevators on the third floor and offered him a cup of drink. At 11:18 a.m. an unidentified CNA sat with Resident #3 at the lobby for a few minutes. At 12:07 p.m. an unidentified CNA brought the resident his lunch. -During the observation, Resident #3 was not provided with any person-centered activities to meet his dementia care needs. During a continuous observation on 10/22/25, beginning at 3:50 p.m. and ending at 6:00 p.m., the following was observed: (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 3:50 p.m. Resident #3 was talking with an unidentified staff in the lobby on the first floor. Then they went upstairs on the third floor and Resident #3 stayed a bit in the nurse station talking with staff. At 4:04 p.m. the unidentified CNA assisted Resident #3 to his room. The unidentified CNA assisted Resident #3 in shaving and grooming. Resident #3 later wheeled himself to the hallway and was observed talking to the staff for a while before going back to his room. He stayed in his room sitting in his wheelchair until dinner time. At 5:05 p.m. an unidentified CNA brought the resident dinner. -During the observation, Resident #3 was not provided with any person-centered activities to meet his dementia care needs. At 5:19 p.m. Resident #3 finished eating dinner. On 10/23/25 at 9:10 a.m. Resident #3 was observed sitting by the window with his pants down to the knee. Resident #3 said he had breakfast. At 9:21 a.m. Resident #3 came into the hallway and became combative with staff when they attempted to assist him in pulling up his pants. The staff just walked away at that time. At 10:57 a.m. Resident #3 was moved to the second floor for safety reasons because another resident tried to fight him. -The facility did not provide Resident #3 with any person-centered activities. B. Record review The activities care plan, initiated 9/19/25 and revised 10/7/25, included a care focus for social isolation. Pertinent interventions included one-to-one visits from activities as needed, allowing/encouraging resident to communicate his feelings regarding attended activities, assisting the resident to and from activities of choice and encouraging resident to participate in activities of interest with others. The behavior care plan, initiated 9/19/25 and revised 10/7/25, documented Resident #3 had a potential for mood disturbances. Pertinent interventions included administering medications as per physician's orders, providing distraction/redirection as needed, and providing support and reassurance. The wandering care plan, initiated 9/21/25 and revised 10/7/25, revealed Resident #3 had a history of wandering in a new environment and elopement. Pertinent interventions included reorienting and redirecting resident as needed, providing and involving resident in activities directed at resident's specific interests, monitoring resident's whereabouts regularly as needed to ensure safety and documenting any attempts at elopement and notifying physician and responsible party. -The care plan did not document any person-centered interventions to address Resident #3's dementia care needs. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 10/4/25 nursing note revealed Resident #3 was verbally aggressive to the nurse while passing medications. Resident #3 attempted to strike at the nurse. The nurse asked Resident #3 to refrain from his behavior and redirect him. The weekly activity progress note, dated 10/20/25, revealed Resident #3 had been watching television, exercising as directed by therapy staff/resting to recover, ambulating in his wheelchair and participating in coffee cart and check-in visits. He had declined additional activity supplies and was offered activities this week. Resident #3 had not expressed satisfaction or dissatisfaction with his recreational needs being met. The 10/21/25 physician assistant (PA) note revealed an assessment of dementia with behavioral disturbances/ psychosis for Resident #3. Resident #3 hit a CNA, was verbally aggressive, his behaviors were difficult to control and displayed exit seeking behaviors. The 10/23/25 progress note revealed Resident #3 was moved to the second floor for safety reasons. D. Staff interviews CNA #1 was interviewed on 10/23/25 at 2:10 p.m. CNA #1 said Resident #3 often became combative with the CNAs when they were providing care. CNA #1 said Resident #3 did not let staff assist him with toileting or hygiene. CNA #1 said Resident #3 sometimes wore briefs, but Resident #3 would not allow staff to physically check the briefs during their rounds. CNA #1 said Resident #3 was moved to the second floor for safety reasons on 10/23/25 because another resident tried to fight him. LPN #1 was interviewed on 10/23/25 at 3:25 p.m. LPN #1 said Resident #3 required supervision while allowing Resident #3 to clean himself. She said on 10/23/25 Resident #3 allowed them to clean him as he was very unkempt. LPN #1 said Resident #3 sometimes did not wear briefs during daytime as he was able to use the toilet, but he wore briefs at night. LPN #1 said Resident #3 was yelling at her, which upset another resident. She said that resident attempted to confront Resident #3. LPN #1 said she notified her manager who decided to move Resident #3 to the second floor for safety reasons. The AD was interviewed on 10/23/25 at approximately 5:30 p.m. The AD said Resident #3 spoke Spanish and English. He said he had offered Resident #3 puzzles, but he did not like them. The AD said he had tried to keep Resident #3 busy, but had not found anything that he liked so far. The AD said the facility did not have any Spanish speaking activities. The DON was interviewed on 10/23/25 at 6:00 p.m. The DON said Resident #3 became combative during care and resisted care if he did not recognize the staff member. He said to de-escalate the situation, he would show Resident #3 his badge, explain the care that was going to be provided, and offer Resident #3 a cup of coffee. The DON said the staff needed to approach Resident #3 at his level and he was more willing to listen and allow staff to assist him.