STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105301	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Hills Health and Rehabilitation Center	1350 Sleepy Hill Rd Lakeland, FL 33810

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interviews, and record review, the facility failed to ensure the comprehensive care plan was implemented related to one to one supervision/enhanced monitoring for one resident (#24) out of ten residents sampled. Findings included: A review of Resident #24's admission record revealed an admission date of 1/14/25 with diagnoses to include cerebral atherosclerosis, Alzheimer's disease, vascular dementia, severe, with anxiety, major depressive disorder, recurrent, moderate, unspecified dementia, unspecified severity, with other behavioral disturbances, restlessness and agitation, and other specified anxiety disorders.A review of the facility's reportable incident log showed the following:- Date of Incident 3/3/26 [Resident #24] /+ [Resident name] Type of Allegation * Sexual .A review of Resident #24's comprehensive care plan revealed the following: - [Resident #24] can be sexually inappropriate at times r/t dx [diagnosis] of Dementia. Date Initiated: 03/10/2026, with interventions to include, Enhanced monitoring by staff as necessary. Revision on: 3/11/2026. A review of Resident #24's progress notes, dated 3/2/26 to 3/11/26, revealed the following:- 3/6/26, Date of Service : 2026-03-06 . As per collected information, patient reported the patient was recently observed in his bed with a female peer, touching her in an inappropriate manner. When question about the incident, the patient denies any incident happening. Patient is confused at baseline. When phrase multiple times, the patient continues to deny any inappropriate touch between him and a peer. No mood swings are observed during the visit. Patient has no depression and anxiety. Patient has fair appetite and improved sleep patterns. No signs of mania, psychosis and agitation are reported. No other psychiatric symptoms observed. Dementia is persisting, but no other behaviors noted.Further review of the progress notes revealed no documentation about 1:1 supervision, enhanced monitoring, or continuous monitoring. On 3/10/26 at 9:31 a.m., an interview was conducted with the Director of Nursing (DON). She said enhanced supervision is documented by the nursing staff in progress notes. The DON stated, Enhanced supervision is not really the same as one to one. She said 1:1 supervision meant one resident to one Certified Nursing Assistant (CNA). She said enhanced supervision is a CNA providing close supervision. She said enhanced supervision and 1:1 supervision is documented in the resident's care plan and did not require a physician order. The DON said when a resident is on enhanced monitoring, it is communicated through verbal reporting from nurse to nurse. On 3/10/26 at 12:04 p.m., an interview was conducted with Staff F, Registered Nurse (RN)/UM. She said 1:1 supervision and enhanced monitoring was the same. She said continuous monitoring or enhanced monitoring (EM) may be used, but they were the same. She said there would be an order in place for the nurses to document and 1:1/EM would be on the care plan which reflected on the Kardex. On 3/11/26 at 9:13 a.m., an interview was conducted with the Assistant Director of Nursing (ADON). She said a physician order was needed for 1:1 supervision. The ADON said the expectation for residents on 1:1 or EM is an implementation of a care plan and documentation in the progress notes.On 3/11/26 at 2:20 p.m., an interview with the Risk Manager (RM) who revealed Resident #24 was placed on 1:1 as soon as the event occurred on 3/3/26. She said his care plan had been updated on 3/10/26 to reflect the incident. The RM stated his care plan showed, Enhanced monitoring by staff as necessary, that was added on 3/11/26. A review of the facility's policy titled Resident Assessment Instrument (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Comprehensive Care Plan Policy, with an effective date of September 2024, revealed the following: Purpose: To ensure that each resident in the facility receives individualized and appropriate care based on a thorough assessment using the Resident Assessment Instrument (RAI), and to comply with state and federal regulations.Policy Statement: The facility will utilize the RAI process to assess residents' needs, develop individualized care plans, and ensure the delivery of quality care. This process will involve interdisciplinary team members and be revised to reflect resident condition changes. Care Plan Review and Revision: - The care plan will be reviewed quarterly and revised as necessary. - The care plan must be updated in response to changes in the resident's condition, new assessments, or input from the resident/family. - Significant changes in the residents' condition will trigger a new MDS assessment, guiding further revisions to the care plan.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, interviews and record review, the facility failed to provide incontinence care for one resident (#12) out of three sampled for activities of daily living. Findings includedAn interview conducted on 3/10/26 at 12:13 PM with Resident #12 revealed the resident had many concerns with staff coming timely to provide incontinence and toileting care. The resident stated there had been many instances where the resident had a bowel movement (BM) and no staff would come timely to provide care when it was needed.A review of Resident #12's admission record revealed an admission date of 7/31/25 with diagnoses to include: Type 2 Diabetes Mellitus, anemia, paroxysmal atrial fibrillation, legal blindness, gastrointestinal hemorrhage, and adjustment disorder with anxiety.A review of Resident #12's Bowel and Bladder- Bowel Elimination Task documentation revealed the following:March no care marked on:Shift 11 PM-7 AM: 3/3Shift 3 PM-11 PM: 3/9February no care marked on:Shift 11 PM-7 AM: 2/28Shift 7 AM-3 PM: 2/3, 2/19January no care marked on:Shift 11 PM-7 AM: 1/10, 1/31Shift 3 PM-11 PM: 1/2, 1/5-7, 1/10, 1/12, 1/17, 1/22Shift 7 AM-3 PM: 1/6-9, 1/14, 1/24, 1/31A review of Resident #12's Quarterly Minimum Data Set (MDS) assessment, dated 2/9/26, revealed a Brief Interview Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Resident #12's section GG- Functional abilities revealed the resident uses a wheelchair for mobility and scored a 02-Impairment on both sides for lower extremality range of motion. Resident #12 scored a 01-Dependent- Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity for toileting hygiene. For toilet transfer, Resident #12 scored a 02-Substantial/maximal assistance- Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. Resident #12's section H- Bladder and Bowel revealed Resident #12 is rated as a 3, Always incontinent (no episodes of continent bowel movements) for bowel continence.A review of Resident #12's Order Summary revealed no orders pertaining to incontinence care.A review of Resident #12's progress notes, dated from 1/1/26 to 3/11/26, revealed no documentation of the resident refusing incontinence care.A review of Resident #12's Care Plan revealed Resident #12 has impaired physical mobility and self-care deficit related to deconditioning, decreased endurance, depression, limited ROM (Range of Motion) lower extremity, pain infection, constipation, blindness, multiple diagnoses with multiple medications. The facility has planned interventions including the resident is totally dependent on staff to meet toileting needs toileted in bed with the assistance of staff. Further review revealed Resident #12 has constipation related to the use of opioids causing bowel defunction, decreased mobility and fear of pain. Interventions include encouraging the resident to sit on the toilet to evacuate bowel, and to follow facility bowel protocol for bowel management.An interview conducted on 3/11/26 at 9:33 AM with Staff F, Registered Nurse/Unit Manager (RN/UM) revealed it is the expectation of care staff to document whether a resident voided or not. Staff F, RN/UM stated it is the responsibility of the unit managers to ensure all documentation related to incontinence care is being done, and there is no way to know if a task was completed if it was not charted, if its not documented, its not done.On 3/11/26 at 9:43 AM with Staff R, Licensed Practical Nurse (LPN) revealed aides should be documenting resident toileting care by at least the end of their shift, and there is no way to verify if a task was completed if it was not seen or documented.On 3/11/26 at 2:46 PM and 3:03 PM an interview was conducted with the Director of Nursing (DON) revealed it is expected for aides to document in the system whether a resident voids or not. The DON stated if incontinence and toileting care is not documented, then it did not happen.A review of the facility's Charge Nurse-RN Position Description revealed the following: Minimum Performance Standards include Reports changes in residents' condition or deviation from prescribed treatments promptly to the physician and supervisor. Assists in the maintenance of the medical record as a legal document of the patient/resident. Monitors direct (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care given by Nursing Assistants to ensure compliance with nursing care plan interventions and facility policies.A review of the facility's Charge Nurse-LPN Position Description revealed the following: Responsible and accountable for the effective overall management of a nursing unit and the provision of quality nursing care to all residents. Reports changes in residents' condition or deviation from prescribed treatments promptly to the physician and supervisor. Assists in the maintenance of the medical record as a legal document of the patient/resident. Monitors direct care given by Nursing Assistants to ensure compliance with nursing care plan interventions and facility policies. Supervises and educates Nursing Assistants in safe procedures and enforcing compliance.A review of the facility's Certified Nursing Assistant (CNA) Position Description revealed the following: Essential functions include Provides care as directed by the professional nurse to patients/residents requiring long-term, rehabilitative care or restorative care. Reports observations and other pertinent information related to the care of the patient/resident. Provides services that support the care delivered to the patient/resident. Assistance with restorative programs as-Bowel and Bladder. All entries on charts, notes, flow sheets, etc., are recorded in an informative and descriptive manner. All changes in a patients/residents condition are reported as soon as possible to the Charge/Staff Nurse.A review of the facility's Nursing-Bowel and Bladder/Incontinence Care Policy revealed the following: Purpose-To maximize our resident's/patient's opportunities to remain continent, presume their independence, skin integrity, and dignity. Policy-Residents/patients who have had any episodes of incontinence will be provided assistance for the need of bowel and bladder toileting. Residents will be assisted to the bathroom or checked for incontinence and assisted with or provided incontinence care at least upon rising; before and/or after meals, activities, and therapy; before bedtime; and as needed or as identified per the individual resident plan of care. The C.N.A. will ask the resident to toilet or check for incontinence at the specified times. If the resident requests to be toileted at different times or they were incontinent, toileting and/or incontinence care will be completed as indicated based on the resident plan of care. The CNA will document resident toileting as part of ADL care.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure supervision was provided to residents identified as requiring enhanced monitoring (EM), one to one (1:1) supervision, and/or continuous monitoring (CM) for six residents (#1, #3, #4, #6, #22, and #24) out of six residents sampled. Findings included:1. A review of Resident #1's admission record revealed an admission date of 4/15/25, with diagnoses to include unspecified dementia, unspecified severity, with other behavioral disturbance, major depressive disorder, recurrent, moderate, unspecified psychosis not due to a substance or known physiological condition, and adjustment disorder with anxiety.A review of Resident #1's physician orders revealed the following:- Device: Wander Management Bracelet - Check Function with machine every night shift for elopement risk, with a start date of 9/1/25.A review of the facility's reportable incident log showed the following:- Date of Incident 2/23/26 [Resident #1] + [and] [Resident name] Type of Allegation * Physical .A review of the facility's incident log showed Resident #1 had a behavioral occurrence incident, on 2/23/26.A review of Resident #1's progress notes revealed the following:-2/23/26, Resident stated that she pushed another resident down to the ground whom entered her room and placed hands on her first. No new skin issues noted to resident. Resident placed on 1:1 after incident. All appropriate parties notified of incident with no further behaviors noted.- 2/23/26, Date of Service: 2026-02-24 . Psychiatry Subsequent Note . As per collected information, the patient is reported unstable and requires an evaluation. Staff reports speech was involved in a resident to resident altercation as the aggressor. Its reported the patient pushed an another patient. While meeting with the patient. She does show confusion at times during the visit. She denies any incident occurring between her and a peer. Patient reports she would never replace her hands on anybody else. She expresses she watched her peer go into the bathroom, but says she never goes in the bathroom with her. She waits until she comes out before going in there. Mental Status Exam: . Insight and Judgement: Impaired. Orientation: Oriented x 2 [oriented to person and place] . Summaries: A) Summaries of past notes: 2/24/26: [name of provider]: Pt [patient] has mood d/o [disorder]. Meds [medications]: Donepezil, Namenda, & [and] Trazodone. No meds changed. Removed 1:1 Supervision. Plan of Action: .Based on the patient interview and collected information, it appears that the patient is safer and one on one observation is not the least restrictive option to ensure safety. So, I recommend discontinuing one on one sitter.- 2/23/26, The Change In Condition/s reported on this CIC [change in condition] Evaluation are/were: Behavioral symptoms (e.g. agitation, psychosis) . Neurological Status Evaluation: Nursing observations, evaluation, and recommendations are: Placed on 1:1 monitoring Primary Care Provider Feedback: . A. Recommendations: monitor.- 2/27/26, Resident currently not displaying any behavior. Removed one by one for the time being.A review of the 500-unit Certified Nursing Assistant (CNA) assignment sheets and the schedule provided by the staffing coordinator revealed the following:- On 2/23/26, the 3:00 p.m. to 11:00 p.m. shift had no resident documented or staff assigned for 1:1 supervision. - On 2/24/26, there was no resident documented or staff assigned for 1:1 supervision on all three shifts.- On 2/25/26, the 7:00 a.m. to 3:00 p.m. shift had no resident documented or staff assigned for 1:1 supervision.- On 2/26/26, the 7:00 a.m. to 3:00 p.m. shift had a CNA assigned to 1:1 supervision with no room number or resident name documented. The 11:00 p.m. to 7:00 am shift had no resident documented or staff assigned for 1:1 supervision. 2. A review of Resident #3's admission record revealed an admission date of 2/19/26, with diagnoses to include unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, unspecified psychosis not due to a substance or known physiological condition, and depression, unspecified.A review of Resident #3's physician orders revealed the following:- Continuous Observation for Elopement every shift, with a start date of 2/24/26 and end date of 2/25/26.A review (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of Resident #3's progress notes revealed the following:- 2/19/26, Date of Service: 2026-02-20 . Psychiatry Evaluation Note . Chief Complaint: Psychosis, depression and dementia. Reason for Encounter: . I was consulted for psychiatric evaluation and treatment of depressed mood and disorganized and confused thinking. As per collected information, the patient is new and requires any evaluation. Patient's BIMS [brief interview for mental status] score 7 and PHQ9 [patient health questionnaire measuring severity of depression] score 12 as patient has severe impairment and moderate depression. Patient is at the facility for a rehab services. It's reported last night the patient was restless and observed wandering into other resident's rooms. Prior to coming to the facility the patient was living at home with her spouse. Patient has some depression and sleep issue.- 2/21/26, Called and spoke with [family member] stated that he had someone with her at home all time as she was trying to leave at home also. He stated that he is okay with this and that if we need to permanently moved her to the secure unit he is fine with that and that he understands.- 2/21/26, . MOOD AND BEHAVIOR Mood and behavior patterns: Agitated (repeated vocalizations, screaming, shouting, complaining, moaning, cursing, fidgeting, etc.) .- 2/24/26, Resident is laying in her bed room [room number]. This writer given in report resident has order for continuous observation due to elopement. This writer visualizes resident in her room. Plan of care ongoing.- 2/24/26, Room Change: Resident and [family member] given advanced notification of room change. [Family member] agreed and [Resident #3] will move from [room number] to [room number].- 2/24/26, Resident laying in bed resting talking with [family member] who is at bedside room [room number]. During this writer's shift [family member] was there to visit. Resident continues on increased supervision due to risk for elopement. During this writer's shift no active exit seeking behaviors were noted. Plan of care ongoing.- 2/25/26, Resident continues with wandering and get combative when redirected.A review of the 300-unit CNA assignment sheets and the schedule provided by the staffing coordinator revealed the following:- On 2/24/26, the 7:00 a.m. to 3:00 p.m. and 11:00 p.m. to 7:00 a.m. shifts had no resident documented or staff assigned for 1:1 supervision. The 3:00 p.m. to 11:00 p.m. shift had Staff C, CNA assigned to 1:1 supervision for Resident #1 and Resident #4, who resided in the same room.3. A review of Resident #4's admission record revealed an admission date of 1/28/26 with diagnoses to include metabolic encephalopathy, Alzheimer's disease, unspecified, cognitive communication deficit, and depression, unspecified.A review of Resident #4's physician orders revealed the following:- Psych [psychiatry] consult due to verbal suicidal ideations, with an order date of 2/17/26.- Resident to be on increased supervision with staff one on one, due to verbal suicidal ideations, with an order date of 2/17/26 and end date of 2/18/26.- Continuous Observation for Suicide Ideation every shift, with an order date of 2/18/26 and end date of 3/2/26.A review of the facility's incident log showed Resident #4 had a behavioral occurrence incident, on 2/17/26.A review of Resident #4's progress notes revealed the following:- 2/17/26, The Change In Condition/s reported on this CIC Evaluation are/were: Other change in condition . Nursing observations, evaluation, and recommendations are: Resident stated suicidal ideations to the CNA. CNA reported this to myself. I spoke with resident and resident continued to verbalize suicidal ideations. Resident then went to therapy. This writer notified supervisor and adon [assistant director of nursing] of resident's statements. Primary Care Provider responded with the following feedback: A. Recommendations: [primary physician] notified awaiting further response/direction.- 2/17/26, [Primary physician] ordered resident to be on increased supervision one on one status due to verbal suicidal ideations. (ADON notified). Psych consult. Still awaiting return call from next of kin.- 2/17/26, This writer followed up and repeated a phone call to next of kin [family member] who answered and stated Yes she done that all the time even before she came to y'all. This writer notified next of kin that resident will be on increased supervision one on one with staff per the doctor's orders. Next of kin verbalized thankfulness for care provided. Along with psych consult. Plan of care ongoing.- 2/17/26, The Change In Condition/s reported on this CIC Evaluation are/were: Other change in condition . Nursing observations, evaluation, and recommendations are: Resident stated to me that she was suicidal. I stayed with the resident to make (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sure she did not do anything to harm herself. Resident stated she had a plan and wanted to shoot herself. CNA came and stayed with resident for constant observation. I notified [primary care physician], ADON, and [family member]. I called [psych provider] mental health and notified of resident's statement. I passed this info [information] onto 3-11 [3:00 p.m. to 11:00 p.m.] nurse. Resident is on 1:1 observation with staff. Primary Care Provider responded with the following feedback: A. Recommendations: To put resident on 1:1 constant observation (completed). To notify [psych provider] mental health (completed).- 2/17/26, Resident sitting in the day room talking with aide. Resident is on increased supervision with staff one to one due to previously voiced ideations. This writer gave report to oncoming nurse that [psych provider] will call back with further direction.- 2/18/26, . History and Physical Exam . Apparently patient had suicidal Thoughts. Psychiatry was consulted. Close supervision, on 1:1.- 2/18/26, Resident laying in her bed watching tv [television]. She is refusing to eat. Resident is on increased supervision with staff one on one due to previously voiced suicidal ideations. - 2/19/26, Resident is on close observation with staff one on one due to previously voiced suicidal ideations.- 2/19/26, patient remains on 1:1 observation for safety.- 2/19/26, Care plan meeting held c [with] Resident's [family member] and Interdisciplinary team. Discussed resident's plan of care. [Resident #4] currently has decreased motivation to participate c Rehab Therapy and has decreased appetite. She was referred for psych consult and is also on Enhanced monitoring by staff for safety measures.- 2/19/26, Date of Service: 2026-02-20 . Psychiatry Subsequent Note . Reason for Encounter: . As per collected information, patient is unstable and requires an evaluation. Recently, the patient expressed thoughts of wanting to harm herself. Currently, she remains on one-to-one supervision with staff. Patient one to one staff reports she is doing well today. Based on the patient interview and collected information, it appears that the patient is safer and one on one observation is not the least restrictive option to ensure safety. So, I recommend discontinuing one on one sitter. A) Summaries of the past notes: 2/20/26: [provider name]: Pt [patient] has depression. Pt felt down. Started Trazodone 25 mg [milligrams] PO [by mouth] BID [twice a day] for depression. Removed 1:1 sitter.- 2/20/26, patient remains on 1:1 observation for safety. will continue close monitoring and document any changed or mental status.- 2/20/26, Resident seen by [psych provider] recommendation is remove continuous observation and start Trazodone 25mg PO BID for depression.- 2/21/26, Resident continues to be monitored for suicidal ideations.- 2/21/26, Resident continues on 1:1 monitoring for suicidal ideations, no suicidal ideations voiced during this shift.- 2/21/26, Resident continues to be monitored for suicidal ideations.- 2/23/26, . Visit Type: Psychotherapy . History of Present Illness: . Patient is currently on one-to-one supervision due to reportedly expressing thoughts of wanting to die.- 2/23/26, Patient is alert and orientedx2 [to person and place], 1:1 observation on continues by protocol.- 2/24/26, .Resident has active order for continuous observation. Resident is currently on enhanced monitoring continuous monitoring due to history of suicidal ideations.- 2/25/26, Enhanced monitoring with 1:1 continues by protocol.- 2/27/26, . Psychiatry Subsequent Note . Currently, she remains on one to one supervision with staff. A) Summaries of the past notes: 2/27/26: [provider name]: Pt at baseline. Removed 1:1 sitter.- 2/28/26, Continuous Observation for Suicide Ideation every shift. Per Report patient is no longer on 1:1 suicidal observation.- 3/1/26, Continuous Observation for Suicide Ideation every shift. Per Report patient is no longer on 1:1 suicidal observation.- 3/2/26, Continuous Observation for Safety .A review of the 300-unit CNA assignment sheets and the schedule provided by the staffing coordinator revealed the following:- On 2/23/26, the 11:00 p.m. to 7:00 a.m. shift had Staff D, CNA assigned to 1:1 supervision for Resident #4, as well as rooms 312-324 in her assignment.- On 2/24/26, the 3:00 p.m. to 11:00 p.m. shift had Staff C, CNA assigned to 1:1 supervision for Resident #1 and Resident #4, who resided in the same room.- On 2/28/26 and 3/1/26, there was no resident documented or staff assigned for 1:1 supervision on all three shifts. 4. A review of Resident #6's admission record revealed an admission date of 12/1/25 with diagnoses to include other specified anxiety disorders, major depressive disorder, recurrent, moderate, and weakness.A (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident #6's physician orders revealed the following:- 1:1 Observation every shift, with a start and end date of 2/13/26.- 1:1 Observation for suicidal behaviors every shift, with a start and end date of 2/13/26.- 1:1 Observation for Suicidal Ideation every shift, with a start date of 2/13/26 and an end date of 2/25/26.- Continuous observation for Suicidal Ideation every shift, with an order date of 2/13/26 and an end date of 2/25/26.A review of the facility's incident log showed Resident #6 had a behavioral occurrence incident, on 2/13/26.A review of Resident #6's progress notes revealed the following:- 2/13/26, Date of Service: 02/13/2026 . Psychiatry Subsequent Note . As per collected information, as part of the patient is unstable requires any evaluation. Patient recently lost a good friend and expressed as he has increased symptoms of depression. Patient reports he has no family members left. At this time, patient is visibly upset throughout the visit. Patient shows symptoms of increasing anxiety and agitation. Patient reports he just wants to go be with his family. When it asked to elaborate the patient reports all of his family is dead, so if he has to harm himself to go be with them, he will. When asked if he had a plan, patient reports he would walk out in front of traffic or go get drugs to overdose such as fentanyl. Mental Status Examination . Abnormal thought processes: Has thoughts of self harm . Orientation: Alert, Oriented X 3 (oriented to person, place, time) . A) Summaries of the past notes: . 2/13/26: [provider name] . Initiated 1:1 sitter: . Based on the collected information and patient interview, the patient is not safe. For safety purposes, initiating the one on-one sitter for close observation is the only least restrictive treatment option available. Therefore, I ordered one on one sitter. Our team will follow up closely and will recommend removal of a one-on-one sitter when the patient is safe.- 2/13/26, Writer was told from psychiatrist and from resident that he did not want to live . Writer was told he had a plan to either harm himself or walk out. New meds ordered ,and resident aware.- 2/14/26, .resident cont. [continue] to be 1/1 [one to one supervision] and received his shower as well today.- 2/15/26, . Sitter at bedside, 24 hr. [hour] sitter. Plan ongoing.- 2/15/26 09:43, Resident tolerated medication and conts [continues] on 1/1 with no speaking of hurting himself this shift.- 2/16/26, Resident noted to be upset with one on one this this shift per CNA. Resident was advised that he will need to remain on 1:1 until he has been cleared. Resident was noted to be upset and then laughing.- 2/16/26, Resident seen by psych via [by] Tele [telehealth] visit, Psych recommend to D/C [discontinue] continuous observation and have resident seen by psychotherapist.- 2/19/26, .Resident continues on close observation.- 2/21/26, Resident continues on 1:1 monitoring for suicidal ideations.- 2/22/26, Resident continues 1:1 per orders.- 2/25/26, IDT [interdisciplinary] team review resident being on continuous observation. Resident evaluated by [psych provider], new order received to D/C continuous observation.A review of the 300-unit CNA assignment sheets and the schedule provided by the staffing coordinator revealed the following:- On 2/17/26, the 3:00 p.m. to 11:00 p.m. and 11:00 to 7:00 p.m. shifts had no resident documented or staff assigned for 1:1 supervision.- On 2/18/26, the 11:00 p.m. to 7:00 a.m. shifts had no staff assigned to Resident #6 for 1:1- On 2/24/26, there was no staff assigned for 1:1 supervision for Resident #6 on all three shifts.- On 2/25/26, there was no staff assigned for 1:1 supervision for Resident #6 on all three shifts.5. On 3/9/26 at 6:30 a.m., an interview was conducted with Staff A, Licensed Practical Nurse (LPN). She said Resident #22 was on one-to-one supervision at this time. An observation of Resident #22's room showed he was alone with no staff present.A review of Resident #22's admission record showed an admission date of 9/18/25 with diagnoses to include cerebral atherosclerosis, vascular dementia, severe, with agitation, unspecified mood (affective) disorder, restlessness and agitation, major depressive disorder, recurrent, moderate, other specified anxiety disorders, brief psychotic disorder, and other specified persistent mood disorders.A review of Resident #22's physician orders revealed no active or discontinued orders related to enhanced monitoring or one-to-one supervision.A review of the facility's reportable incident log showed the following:- Date of Incident 2/3/26 [Resident #22]/[Resident name] Type of Allegation * Physical .A review of Resident #22's progress notes revealed the following:- 2/2/26, Writer located at the nurse's station when I observed resident being escorted out of [room number] by CNA. Resident in [room (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	number] came out of room with bruise present to forehead, stating resident hit her. 3-11 [3:00 p.m. to 11:00 p.m.] supervisor notified on unit at 10:33PM. Resident's [family member] notified of incident at 10:41 PM, [primary care provider] notified at 10:44 PM and hospice notified at 10:45PM.- 2/2/26, The Change In Condition/s reported on this CIC Evaluation are/were: Behavioral symptoms (e.g. agitation, psychosis) . Behavioral Status Evaluation: Physical aggression . Nursing observations, evaluation, and recommendations are: Resident has a hx [history] of going into other resident's rooms.- 2/3/26, Chief Complaint: Psychosis, mood disorder, depression, anxiety, dementia, insomnia. Today, I saw the patient as it was reported to me that patient is unstable requiring psychiatric assessment. As per collected information, it reported the patient was involved in a resident to resident altercation as the aggressor. Patient has history of dementia. Patient does not remember the incident occurring. Staff report the patient does have increased anxiety and agitation at times. Patient has a history of wandering around the unit and goes in and out of his peers rooms. Patient remains on one to one supervision at this time.- 2/3/26, Resident seen by psych new order received to increase Seroquel from 50 mg to 75 mg at bedtime. Resident continue enhance monitoring r/t [related to] behaviors. Agitation observed.- 2/3/26, Res [resident] remains alert with confusion. Wandering/exit seeking behaviors present. Remains on enhanced monitoring for previous aggressive behaviors.- 2/7/26, . Wandering/exit seeking behaviors present. Res [resident] remains 1:1 r/t behavior.- 2/9/26, . Remains on enhanced monitoring for aggressive behaviors, none noted during shift.- 2/11/26, Per psych. services can discontinue 1:1 due to medication changes resident has improved with no further behaviors noted.- 2/11/26, IDT met and spoke with PCP [primary care provider] in regard to discontinuation of 1:1 which he was in agreement with.- 2/16/26, . Wandering/exit seeking behaviors witnessed.- 2/18/26, . Wandering/exit seeking behaviors present.- 2/27/26, The resident is seen opening and closing all doors. The resident enters women's rooms on several occasions and becomes aggressive with CNA [Staff I, CNA] when she tries to remove him from the situation. The resident is taken to his room but refuses to stay in his bed.- 2/28/26 and 3/1/26, . Wandering behaviors present, keeps going in and out of other resident's rooms without permission, very difficult to redirect this behaviors.- 3/2/26, . Resident ambulates independently throughout unit, frequently entering other resident's rooms.- 3/6/26, . Date of Service : 2026-03-06 . As per collected information, its reported the patient is unstable and require an evaluation. It's Reported the patient was involved in a physical altercation with a peer. The patient is confused at baseline. Patient has a behavior of going into the wrong room on the unit. It was in the wrong room that he was involved in an altercation. Patient is not able to express why he went into the wrong room. Patient does not remember anything occurring between him and his peer. Currently the patient is on one-to-one supervision with staff.A review of the 500-unit CNA assignment sheets and the schedule provided by the staffing coordinator revealed the following- On 3/6/26, the 3:00 p.m. to 11:00 p.m. and 11:00 p.m. to 7:00 a.m. shifts had no staff assigned for 1:1 supervision for Resident #22.- On 3/7/26, the 3:00 p.m. to 11:00 p.m. shift had a staff member assigned to enhanced monitoring (EM) for Resident #22 and Resident #24 who resided in different rooms. On the 11:00 p.m. to 7:00 a.m. shift, there was no staff member assigned to Resident #22.- On 3/8/26, the 7:00 a.m. to 3:00 p.m. shift had a staff member assigned to Resident #22 and Resident #24. The assignment sheet for the 7:00 a.m. to 3:00 p.m. shift did not indicate if the assigned staff was to provide 1:1 supervision, EM, or continuous monitoring. The 3:00 p.m. to 11:00 p.m. shift had a staff member assigned to EM for Resident #22 and Resident #24. A review of the 11:00 p.m. to 7:00 a.m. shift CNA assignment sheet had no staff assigned for 1:1 supervision for Resident #22. A review of the staffing sheet provided by the staffing coordinator showed on the 11:00 to 7:00 a.m. shift, Staff I, CNA was assigned EM for Resident #22 and Resident #24.6. A review of Resident #24's admission record revealed an admission date of 1/14/25 with diagnoses to include cerebral atherosclerosis, Alzheimer's disease, vascular dementia, severe, with anxiety, major depressive disorder, recurrent, moderate, unspecified dementia, unspecified severity, with other behavioral disturbances, restlessness and agitation, and other specified anxiety disorders.A review of Resident (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#24's physician orders revealed there were no orders for 1:1 supervision, EM, or continuous monitoring.A review of the facility's reportable incident log showed the following:- Date of Incident 3/3/26 [Resident #24] /+ [Resident name] Type of Allegation * Sexual .A review of Resident #24's care plan revealed the following: - [Resident #24] can be sexually inappropriate at times r/t dx [diagnosis] of Dementia. Date Initiated: 03/10/2026, with interventions to include, Enhanced monitoring by staff as necessary. Revision on: 3/11/2026.A review of Resident #24's progress notes, dated 3/2/26 to 3/11/26, revealed the following:- 3/6/26, Date of Service : 2026-03-06 . As per collected information, patient reported the patient was recently observed in his bed with a female peer, touching her in an inappropriate manner. When question about the incident, the patient denies any incident happening. Patient is confused at baseline. When phrase multiple times, the patient continues to deny any inappropriate touch between him and a peer. No mood swings are observed during the visit. Patient has no depression and anxiety. Patient has fair appetite and improved sleep patterns. No signs of mania, psychosis and agitation are reported. No other psychiatric symptoms observed. Dementia is persisting, but no other behaviors noted.Further review of the progress notes revealed no documentation about 1:1 supervision, enhanced monitoring, or continuous monitoring.A review of the 500-unit CNA assignment sheets and the schedule provided by the staffing coordinator revealed the following:- On 3/7/26, the 7:00 a.m. to 3:00 p.m. shift showed no staff member was assigned to Resident #24 for 1:1 supervision or EM. The 3:00 p.m. to 11:00 p.m. shift had a staff member assigned to enhanced monitoring (EM) for Resident #22 and Resident #24 who resided in different rooms.- On 3/8/26, the 7:00 a.m. to 3:00 p.m. shift had a staff member assigned to Resident #22 and Resident #24. The assignment sheet for the 7:00 a.m. to 3:00 p.m. shift did not indicate if the assigned staff was to provide 1:1 supervision, EM, or continuous monitoring. The 3:00 p.m. to 11:00 p.m. shift had a staff member assigned to EM for Resident #22 and Resident #24. A review of the CNA assignment sheet, for the 11:00 p.m. to 7:00 a.m. shift, showed no staff assigned for 1:1 supervision for Resident #24. A review of the staffing sheet provided by the staffing coordinator showed on the 11:00 to 7:00 a.m. shift, Staff I, CNA was assigned EM for Resident #22 and Resident #24.- On 3/9/26, the 11:00 p.m. to 7:00 a.m. shift showed no staff member was assigned to Resident #24 for 1:1 supervision or EM.On 3/9/26, the facility provided a list of residents who required one-to-one supervision. A review of the list revealed one resident was documented.On 3/10/26 at 9:31 a.m., an interview was conducted with the Director of Nursing (DON). She said enhanced supervision is documented by the nursing staff in progress notes. The DON stated, Enhanced supervision is not really the same as one to one. She said 1:1 supervision meant one resident to one CNA. She said enhanced supervision is a CNA providing close supervision. She said enhanced supervision and 1:1 supervision is documented in the resident's care plan and did not require a physician order. The DON said when a resident is on enhanced monitoring, it is communicated through verbal reporting from nurse to nurse.On 3/9/26 at 11:00 a.m., an interview was conducted with Staff B, LPN. He said he had not seen one staff member providing supervision for two residents. He stated it, Would be hard to control both residents if need be. Staff B, LPN said staff are not supposed to have an assignment and supervise a resident who required 1:1. He stated it, Would be a safety concern, if staff had an assignment in addition to supervising a resident who required 1:1.On 3/9/26 at 12:33 p.m., an interview was conducted with Staff C, CNA. She confirmed she had been assigned 1:1 supervision for two residents in the same room on one occasion. Staff C, CNA said she would stay at the door to watch both residents. She said she tried to keep both residents in their room. Staff C, CNA said if one of the residents, that was supposed to be supervised, wandered outside of their room she assumed other staff were watching the resident who wandered. She said she documented on the residents at the end of the shift to include the care she provided to them. Staff C, CNA said the documentation is not specific to 1:1 supervision.On 3/9/26 at 1:53 p.m., a telephone interview was conducted with Staff D, CNA. She stated she was often instructed by one of the supervisors to provide 1:1 supervision, as well as patient care for other assigned residents. She said she had to bring a resident (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in the hallway with her, and take them room to room in their Geri chair while she provided care to other residents. Staff D, CNA said the supervisor would inform the staff a resident required 1:1 supervision because they felt they needed it. She said she would be informed by the staff member responsible for staffing of the resident who required 1:1 supervision. Staff D, CNA said in the past couple weeks the staff would rotate the 1:1 supervision assignment during their shift. She stated when they rotated the 1:1 assignment, You were still responsible for your own residents. She stated, Charting on the 1:1 is supposed to be done, but was not sure who was responsible for the documentation, especially when they rotated 1:1 supervision. She said she thought the task section is where 1:1 supervision would be charted in the electronic health system.On 3/10/26 at 11:27 a.m., an interview was conducted with Staff E, LPN/Unit Manager (UM). She said 1:1 supervision and enhanced monitoring was the same. She said 1:1 supervision is one staff member with the resident at all times. She said 1:1 supervision is initiated for behaviors such as resident-to-resident altercations, suicidal ideations, and elopement risk. She said on the unit there were currently three residents on 1:1 supervision to include Resident #22 and Resident #24. She said the risk manager (RM) would decide if a resident is placed on 1:1 supervision. Staff E, LPN/UM said the RM would let her know, as well as the staffing coordinator. She said the staffing coordinator would work on getting a staff member to provide 1:1 supervision. Staff E, LPN/UM said they would not have a staff member providing 1:1 supervision and be responsible for their assigned set of residents. When asked about one staff member assigned to two residents in different rooms she stated, Not on this unit. She said staff are made aware of the assignment through the staffing sheet. Staff E, LPN/UM said there would be EM or 1:1 by the staff member's name. She said one of the nurses could also assign a staff member to do enhanced monitoring. She stated, Anyone can do enhanced monitoring, it's not always a CNA. She said there was no required documentation specific to enhanced monitoring and usually there was no physician order.On 3/10/26 at 12:04 p.m., an interview was conducted with Staff F, Registered Nurse (RN)/UM. She said 1:1 supervision and enhanced monitoring was the same. She said a resident would require EM due to increased fall risk and no other interventions to put in place, as well as behavioral reasons such as suicidal ideation or persistent attempts to elope. She stated 1:1 supervision is a, Last resort, intervention for residents who fall or are considered an elopement risk. Staff F, RN/UM said the nurse assessed the resident and based on their assessment they would communicate with the nursing home administrator (NHA) to approve the 1:1 supervision/EM. She said 1:1 supervision/EM is a physician order. She said continuous monitoring or enhanced monitoring may be used, but they were the same. She said there would be an order in place for the nurses to document and 1:1/EM would be on the c

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on interviews and record reviews, the facility failed to notify the physician of abnormal laboratory (lab) values for three residents (#7, #18 and #26) out of eight residents sampled. Findings Included:During an interview on 3/10/26 at 12:58 p.m. the Director of Nursing (DON) said for abnormal laboratory test values the nursing staff are expected to notify the doctor as soon as possible and the notification should be documented in the medical records.1) A review of Resident #7's admission record showed an admission date 2/4/26 with a primary diagnosis of left ilium (pelvic) fractureA review of Resident #7's lab report results revealed on 3/7/26 reported at 5:55 p.m. a TSH (thyroid stimulating hormone) level was 26.99, reference range 0.45-5.33 uI/ml (units/milliliter).A review of Resident #7's nursing note, dated 3/9/26 at 3:32 p.m. showed Received order to increase Levothyroxine to 200 mcg (micrograms) daily and repeat lab in a week.A review of Resident #7's nursing note dated 3/9/26 at 6:53 p.m. showed son made aware of increase on Levothyroxine and lab to be repeated in a week.Review of Resident #7's care plan revealed the following focus- [Resident #7] has hypothyroidism, initiated on 2/17/26. The care plan's goal is [Resident #7] will be compliant with thyroid replacement therapy through the next review date. The interventions include obtain and monitor lab/diagnostics work as ordered. Report results to medical doctor (MD) and follow up as indicated.A review of Resident #7's order summary report dated 3/11/26 showed an order 3/9/26 for Levothyroxine 200 mcg give 1 tablet by mouth daily was ordered.A review of the Resident #7's Medication Administration Record (MAR) showed on 3/9/26 Levothyroxine 200 mcg one tablet administration started.2) A review of Resident #18's admission record showed an admission date of 1/3/26 with a primary diagnosis of hypothyroidism.A review of Resident #18's nursing note, dated 2/19/26 at 11:57 a.m. showed Resident observed to have increased confusion. Advanced Registered Nurse Practitioner (ARNP) notified and requested labs to be ordered .A review of resident #18's order summary report, dated 3/9/26 showed an order for urinalysis with microscopic examination (UA with micro) dated 2/25/26.A review of resident #18's lab results report, reported 2/25/26 at 1:33 p.m. showed abnormal results for urine blood, urine protein, urine mucous and calcium oxalate crystals.A review of Resident #18's nursing note, dated 2/26/26 at 1:53 p.m. showed Urine results sent to ARNP .3) A review of Resident #26's admission record showed an initial admission date 1/3/26 diagnosis of idiopathic gout, right ankle and foot. A review of Resident #26's physician note, dated 3/5/26 at 11:02 a.m. showed admission labs reviewedA review of Resident #26's labs reported on 3/5/26 at 12:20 p.m. showed the following abnormal test results RBC (red blood count) 3.19 M/uL- reference range (RR) 4.20-5.40, Hgb (hemoglobin) 10.2 g/dL- RR 12.0-16.0, HCT (hematocrit) 30.9%- RR 37.0-47.0, and Hemoglobin A1c 6.2% -RR 4.0-6.0 and BUN (blood urea nitrogen) 33 mg/dL-reference range (RR) 6-20A review of Resident #26's nursing note, dated 3/6/26 at 6:42 a.m. showed Results was sent to [doctor].A review of Resident #26's labs reported on 3/7/26 at 4:53 p.m. showed BUN 36 mg/dL and at 5:03 p.m. RBC 3.38 M/uL, Hgb 10.9 g/dL, HCT 33.0% and Hemoglobin A1c 6.1%.A review of Resident #26's daily Medicare Managed care note, dated 3/7/26 at 8:57 p.m. the space to document any new lab: .is empty. During an interview on 3/11/26 at 9:05 a.m. Staff F, Registered Nurse (RN), Unit Manager said the doctor is notified of laboratory tests results as soon as possible.During an interview on 3/9/26 at 7:22 a.m. Staff B, Licensed Practical Nurse (LPN) said nurses can review lab results on the dashboard. He notifies the doctor when lab results are received and if new orders are given a change in condition note is completed During an interview on 3/10/26 at 12:58 p.m., the Director of Nursing (DON) said staff are expected to notify the physician as soon as abnormal test results are received. Review of a facility policy titled Nursing-Clinical Documentation, undated showed the following: Policy -The facility clinical staff will document the provision of care and services according to nursing standards and regulatory requirements. When completed, documentation will accurately reflect the clinical care and other services provided to the resident and ensure that the appropriate (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	information is available to all interdisciplinary team members. Documentation in the medical record of each resident should provide:1. A complete account of the resident's care treatment and response to the care. 2.-Information for the physician when prescribing medications and managing care and treatments.3.-A description of care and services that can be used for measuring the quality of care provided to the resident .6.-Elements to support quality medical care. Documentation Guidelines: 5. Documentation should be done as soon as possible following any event, evaluation, assessment or change in condition.