STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165280	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bettendorf Health Care Center	2730 Crow Creek Road Bettendorf, IA 52722

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, resident and staff interviews, the facility failed to treat 2 of 9 residents with dignity and respect when staff did not respond to Resident #6's request to stop washing her hip; and when a staff took Resident #3's cigar from him when he planned to leave the non-smoking facility campus to smoke. The facility reported a census of 56 residents. Findings include:1. Review of Resident #6's Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. The MDS list of diagnoses included: cellulitis to the right and left leg; and lymphedema. The MDS also identified Resident #6 as dependent on staff for transfers and showers; and required substantial/maximal assistance to roll left and right, and for personal hygiene. Review of Resident #6 Care Plan, initiated: 4/14/25 and revised: 4/7/26 revealed a Problem area to address: [Name redacted, Resident #6] has potential/actual impairment to skin integrity of the (all body regions) r/t (related to) edema. Interventions included, in part: Wash hips with soap and water each shift and change bandages. Do not scrub, wash gently. Revised: 11/11/25. During an observation on 4/21/26 at 7:42 AM, Resident #6 sat up in bed and wore a hospital gown. The resident had dry and intact wound dressings on each of her feet. Resident #6 covered from her waist to ankles with a bath blanket. Staff C, Licensed Practical Nurse (LPN) entered the room to administer medication. The resident asked Staff C to look at the area on her right hip. The area appeared reddened with a scant amount of serosanguinous (watery body fluid, mixed with a small amount of blood and appeared pink in color). Resident #6 informed Staff C, LPN that on 4/17/26 aides were rough when they scrubbed her right hip. The resident stated she asked them to be gentler, however, Staff E, Certified Nursing Assistant (CNA) kept scrubbing hard to the point where the area started to bleed. Resident #6 described the aide as not nice as they were scrubbing roughly. The resident stated she told the aids to stop, but they kept scrubbing. During an interview on 4/22/26 at 1:05 PM, Staff E, CNA reported she bathed Resident #6 on 4/17/26 and washed an open area beneath her abdomen. Staff E stated Resident #6 stated it hurt and Staff E felt this was normal for her. She could not recall if Resident #6 had asked her to stop rubbing so hard. Resident #6 stated Staff F, CNA was gentler. Staff E stated on 4/21/26, the Administrator informed her that Resident #6 reported she had scrubbed too hard when washing her causing her to bleed. Staff E stated she could not recall seeing any blood. Staff E stated that the Administrator sent her home on 4/21/26 pending the completion of the investigation. During an interview on 4/22/26 at 1:25 PM, Staff F, CNA reported on 4/17/26 he had assisted Staff E, CNA when she bathed Resident #6. Staff F explained Resident #6 said Staff E, CNA was rubbing her belly too hard and asked her to stop. Staff F reported this was the only time Resident #6 asked Staff (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E to stop. During an interview on 4/23/26 at AM, Staff B, CNA reported Resident #6 had complained on 4/17/26 that Staff E, CNA rubbed too hard when she washed up the resident, which caused her sides to bleed. Staff B stated he reported this to the Administrator. During an interview on 4/28/26 at 12:33 PM, the Director of Nursing (DON) stated if a resident complained that an aide was being too rough with cares and asked the aide to stop, she would expect the staff to stop. After the incident with Resident #6, she asked the facility Nurse Practitioner to assess her and she found no markings on her skin or any bleeding. 2. Review of Resident #3 MDS, dated [DATE] revealed a BIMS score of 15 out of 15, which indicated intact cognition. The MDS assessed Resident #3 without symptoms of delirium; always able to be understood by others and always understood others. Review of the electronic health record (EHR) Medical Diagnosis list revealed, in part the following diagnosis: alcoholic polyneuropathy (nerve damage caused by alcohol, which can cause symptoms which can include numbness, extreme sensitivity, and weakness) generalized muscle weakness and unsteadiness on feet. During an interview on 4/21/26 at 11:06 AM, Resident #3 stated he did not understand why other residents and staff are allowed to smoke at the facility, yet he had been told by the Administrator that the facility is non-smoking and he could not smoke. Resident #3 explained there is a covered porch area where people [residents] go to smoke. Resident #3 stated the Administrator did not tell him where he could smoke, or why the other residents could smoke but he was not allowed. Review of the EHR revealed the following: a. A General Progress Note entered on 4/25/16 at 11:37 AM: Resident outside on patio with his mother, resident had an unlit cigar at the time this nurse went out, [CNA name redacted, Staff D] and [name redacted, title or relationship not identified] states they seen him smoking a lit cigar, Both [Resident name redacted, Resident #3] and his mother were reminded that smoking is not allowed on facility grounds. His mother was being very rude to both CNA's making comments that they were both very strange and why are we treating [Resident name redacted, Resident #3] like he is in jail. I asked to lock up cigar, resident refused stated when he comes back in then he will allow me to lock it up and he wants to know why other residents and staff are allowed to smoke but not him. [staff name reacted] medical records and informed [name redacted] Administrator of situation. b. Social Services Note entered on 4/22/26 at 11:52 AM: Social Worker spoke with resident and reminded resident of of non-smoking campus policy. Resident had a cigarillo on person and advised it could be secured in nurse's medication room. Cigarallo provided to nurse [name redacted]. Social Worker will continue to assist as needed. c. General Progress Note entered on 4/17/26 at 12:22 PM: Resident on porch outside dining room smoking with a visitor. Informed resident we are a non-smoking campus and he is not permitted to smoke on the property. During another interview on 4/27/26 at 10:17 AM, Resident #3 stated he was outside with a visitor, with an unlit cigar, they were going to get off the facility property so he could smoke and the Social (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Worker told him he couldn't have it and had to take it away. The resident stated he gave the cigar to the visitor to hold on to it for him and the Social Worker said she had to take the visitor's cigarettes away, which the visitor refused. The resident stated he now understood that he could smoke off of facility property and felt the staff continued to be demeaning to him and treated him like a child in regard to smoking. The resident stated he had not and would not smoke inside the facility or share his smoking materials with anyone and didn't understand why staff treated him that way. During an interview 4/28/26 at 11:18 AM, the Social Worker stated she took the resident's cigar because the Administrator told her to. When asked if she had removed any other resident's smoking materials, she said she had removed 2 other resident's smoking materials in the past. During an interview on 4/28/26 at 12:33 PM, the Director of Nursing (DON) reported she had heard about the issue with Resident #3 and could not explain why the Social Worker would have taken his cigar away from him. The DON explained residents are not allowed to have cigars or cigarettes on their person and maybe there was not a smoking assessment completed, education completed and care plan updated. The DON stated Resident #3 did not have an assessment done because we did not know he was smoking.

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility policy review and staff interviews, the facility failed to ensure that a resident with a physician order for a nebulizer treatment scheduled for four times daily had been assessed for the ability to self-administer the medicated treatment for 1 of 15 (Resident #13) reviewed for medication administration. The facility reported a census of 56 residents.Findings include:Review of Resident #13's Minimum Data Set (MDS), dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated a mild cognitive impairment. The list of diagnoses included anxiety, depression and asthma. The MDS indicated Resident #13 dependent on staff for all activities of daily living with the exception of substantial/maximal assistance for eating. The MDS indicated Resident #13 received Hospice care. Review of Resident #13 Care Plan, dated 3/26/26 revealed a Problem area to address [Name redacted, Resident #13] has impaired cognitive function though[t] processes as evidenced by short/long term memory deficit, impaired decisions making and/or impaired ability to understand others related to a dx (diagnosis) of HX of CVA (history of stroke) and drug use. HX: metabolic encephalopathy. Interventions included: a. Cue, orient and supervise as needed. Date initiated: 3/26/2026.b. Monitor/document/report as necessary any changes in cognitive function, specifically changes in the following: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Date initiated: 3/26/2026.c. Use task segmentation to support short term memory deficits as appropriate. Break them into one at a time. Date initiated: 3/26/2026.Review of Resident #13's Care Plan, dated 3/16/26 included a Problem area to address [Name redacted, Resident #13] has the potential for infection related to a history of upper respiratory infection, pneumonia, cellulitis. Interventions included, in part: Administer treatments as ordered, initiated 3/26/2026.Review of Physician Orders revealed, in part: DuoNeb solution 0.5-2.5 (a mix of Ipratropium 0.5 milligrams (mg) per milliliter (ml) and Albuterol 2.5 mg/ml used to dilate airways and ease breathing) suspended in 3 ml solution inhaled via nebulizer 4 times a day every 6 hours and 6 a.m., 12 noon, 6 p.m. and 12 a.m. Start Date: 3/3/26.During an observation on 4/21/26 at 8:19 AM, Resident #13 in bed, positioned flat. The nebulizer machine on, while the face mask laid on the bed. Duoneb solution observed to be present in the aerosol chamber, and mist noted have moved through the tubing and exited out through the face mask. No staff present. During on observation on 4/22/26 at 2:58 PM, Resident #13 in bed, with the head of the bed at a 30-degree angle. The nebulizer machine sat on the floor, turned on with Duboneb solution visible in aerosol chamber. Resident #13 held the mask with both hands out approximately 20 inches from his mouth. No staff present. At 3:12 PM, Resident #13 remained in bed with nebulizer machine on and the mask rested on the floor. No staff present. During an observation on 4/28/26 at 5:36 AM, Resident #13 in bed. The nebulizer machine on, with the mask positioned on the resident's face. No staff present.During an interview on 4/28/26 at 5:43 AM, Staff M, Registered Nurse stated she had to go back to check on the resident because he had a history of taking the nebulizer mask off during the treatment. Review of the clinical record revealed the lack of a Self-Medication Administration assessment, Care Plan direction to address the self-administration for a Duoneb nebulizer treatment, and a Physician Order for Resident #13 to self-administer his medications. Review of the facility policy, titled Self Administration of Medication Policy, dated 2025, directed staff to:a. When determining if self-administration is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider the following:b. The medications appropriate and safe for self-administration;c. The resident's physical capacity to: swallow without difficulty, open medication bottles, administer injections;d. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for;e. The resident's capability to follow directions and tell time to know when medications need to be taken;f. The resident's comprehension of instructions for the medications they are taking, including the dose, (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	timing, and signs of side effects, and when to report to facility staff.g. The resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs.h. The resident's ability to ensure that medication is stored safely and securely.i. The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record.j. Upon notification of the use of bedside medication by the resident, the medication nurse records the self-administration on the MAR. k. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medication. The following conditions are met for bedside storage to occur:1. The manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if locked storage is ineffective.2. The medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and resident and staff interviews, the facility failed to complete a thorough investigation of an allegation of abuse made by Resident #7. The facility failed to interview all staff working on the night of the allegation and all residents residing in the same hallway to ensure they felt staff and had no concerns with how treated by staff. The facility reported a census of 56 residents. Findings include: Review of a facility self-reported incident, dated 3/29/26, revealed:a. At approximately 3 a.m. on 3/29/26, Administrator was informed by nurse that resident [Resident #7] had called her daughter who in turn called the nurse because the resident was upset. The resident used her white board to write yell and cut. When asked to show where she was cut she wrote push. She told nurses Black girl and then said push' and pointed to her left shoulder.b. Nurses completed a full body assessment which revealed no injuries or skin concerns. Subsequent skin checks have revealed no injuries or skin concerns. c. In a follow up interview with [name redacted, Resident #7], [name redacted, Resident #7] said the CNA (Certified Nursing Assistant) [name redacted, Staff K] did not change her, but she stood her up out of her recliner. [Name redacted, Resident #7] then said [name redacted, Staff K] pushed her down into her chair using her hands on [name redacted, Resident #7] chest. Upon further questioning, she couldn't remember if [name redacted, Staff K] had changed her or if she even helped her into the chair. She then commented I miss him so much.d. Interview with [name redacted, Staff K] indicates that she responded to resident's call light. [name redacted, Staff K] commented to resident that she had just been changed. The resident yelled at [name redacted, Staff K] that she needed to be changed. [name redacted, Staff K] helped the resident to stand up. The resident was bare footed and began to slip. [name redacted, Staff K] prevented resident from falling. [name redacted, Staff K] changed [name redacted, Resident #7]. [name redacted, Resident #7] then released [name redacted, Staff K] hand and plopped herself down in her chair. Interviews with other CNAs indicate that this is how they assist [name redacted, Resident #7] and that [name redacted, Resident #7] will at times plop herself down into her chair. [name redacted, Staff K] did not realize that [name redacted, Resident #7] was cares in pairs. [name redacted, Staff K] said she was holding onto [name redacted, Resident #7] waist and never touched her above the waist .e. Interviews with other residents on North Hall revealed no concerns regarding any cares received recently.Review of Resident #7's Minimum Data Set, dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. The list of diagnoses included: cerebrovascular accident (a stroke), aphasia (difficulty with speech), hemiplegia (paralysis on 1 side of the body), anxiety and depression. The assessment revealed the resident was usually able to make herself understood and usually understood others. The MDS indicated Resident #7 required substantial/maximal staff assistance for all activities of daily living (ADL's) with the exception of staff supervision/touch assistance required for eating.Review of Resident #7's Care Plan, dated 3/31/26 revealed a Problem area to address [Name redacted, Resident #7] has a self-care deficit as evidenced by requiring assistance with ADL's, impaired balance during transitions requiring assistance and/or walking, incontinence. Interventions included, in part: TOILETING: 1 person assist. Provide peri-care with every incontinent episode and as necessary; and TRANSFERS: 1 person assist stand pivot transfer (SPT). Date Initiated: 3/31/26. During an interview on 4/22/26 at 8:40 AM, Resident #7 became visibly distraught when asked to describe what happened with a staff member during the night on 3/29/26. The resident communicated that the staff member yelled at her, called her names such as stupid, took her pop away from her and poured it out for no reason. She told her she needed to be changed, that she was wet, and the staff member yelled at her, told her she was just changed, then had her stand up from the chair and changed her brief. The resident then said she pushed and pointed to her shoulder area. When asked if the staff member had hurt her, the resident didn't respond or answer. Then the resident (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	held up 1 finger, then shook her finger as if to mean no, no, no, then held up 2 fingers. When asked if she meant there were supposed to be 2 staff in the room, but the staff member was by herself, the resident nodded her head up and down, to indicate yes.During an interview on 4/22/26 at 9:05 AM, a family representative and Power of Attorney (POA) stated they received a phone call from the resident in the middle of the night on 3/29/26. The family representative described Resident #7 as hysterical and crying. The family representative stated they had never heard the resident so upset. The resident reported the staff that took care of her yelled at her, cursed at her, called her stupid, and had pushed her. The family representative was unable to determine if the resident was hurt and called the nurse on duty right away, told her what the resident reported and asked her to go check on the resident.During an interview on 4/22/26 at 9:20 AM, the Administrator provided a copy of the 5-Day investigative report submitted to the State Agency in response to a request for the facility investigative file regarding the 3/29/26 allegations of abuse made by Resident #7. The Administrator stated she spoke to staff and residents and they did not have any concerns. The Administrator stated she did not have the staff provide written statements. The Administrator denied the State Agency access to her investigative file related to the 3/29/26 incident. Upon request, on 4/22/26 at 9:33 AM, via email the Administrator provided a list of three staff she interviewed - Staff K, CNA, Staff J, RN and Staff Q, LPN; and a list of 8 residents who could be interviewed based on their cognitive status. The 7 residents resided on the same hall as Resident #7. During an interview on 4/22/26 at 10:02 AM, the Director of Nursing (DON), stated she had not worked at the facility very long when the alleged incident occurred. The DON stated Staff K, CNA had been directed to leave the facility and suspended at that time, she has not returned to work.Review of the March 2026 Daily Assignments revealed from 10:00 PM on 3/28/26 to 6:00 AM on 3/29/26 the following staff worked: Staff K, Certified Nursing Assistant (CNA); Staff O, CNA; Staff P, CNA; Staff J, Registered Nurse (RN); and Staff Q, Licensed Practical Nurse, LPN.During an interview on 4/22/26 at 12:25 PM, Staff P, CNA confirmed she worked third shift on 3/28/26 which stated at 10:00 PM and ended on 3/29/26 at 6:00 AM. Staff P denied having been interviewed by facility staff about the allegations made by Resident #7 on 3/29/26.During an interview on 4/22/26 at 12:33 PM, Staff J, RN stated she. Staff worked on the night shift that started 3/28/26 and ended at 6 AM on 3/29/26. Staff J stated she had assessed Resident #7, along with Staff Q, Licensed Practical Nurse (LPN). Staff J stated a Resident 7's family representative called and reported the resident was upset. Staff J stated when they entered the room the resident was very upset, she had never seen her that upset before. As they spoke to her the resident kept looking towards the door as if she was afraid. They used a communication board to ease the resident's ability to communicate. Staff J recalled Resident #7 reported that the staff member yelled at her, pushed her in the shoulder area, and said that she cut her. Staff J explained Resident #7 has expressive aphasia and they thought the resident tried to say that she hurt her when she said cut. They did a full body assessment of the resident at that time and did not find any redness, bruises or any signs of injury on her body. They called the administrator and were directed to send Staff K, CNA home. During an interview on 4/22/26 at 1:25 PM, Staff R, CNA, confirmed she worked third shift on 3/28/26 which stated at 10:00 PM and ended on 3/29/26 at 6:00 AM. Staff R denied having been interviewed by facility staff about the allegations made by Resident #7 on 3/29/26.During an interview on 4/23/26 at 11:33 AM, the Social Worker stated she spoke with Resident #7 after she heard about the incident on 3/29/26. The Social Work recalled Resident #7 reported that she was physically hurt and her feelings were hurt by the actions of a staff member. The Social Worker described Resident #7 as tearful as they discussed the issue, and said she wasn't fearful of who hurt her. The Social Worker stated she offered Resident #7 counseling and supportive services from the therapist contracted by the facility, and the resident has had one session with the therapist with more planned. During an interview on 4/23/26 at 6:21 PM, Staff O, CNA, confirmed she worked third shift on 3/28/26 which stated at 10:00 PM and ended on 3/29/26 at 6:00 AM. Staff R denied having been interviewed by facility staff about the allegations made by Resident #7 on 3/29/26.During an (continued on next page)

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Staff Q stated she and Staff J, RN completed a head-to-toe assessment, and they did not find any marks anywhere on the resident. She asked Staff K what happened when she was in the resident's room, she said the resident had her call light on, she requested to be changed and she had just changed the resident. Staff K explained that to the resident, and then went ahead and changed her again. Staff K had reported as Resident #7 stood during the process she started to slip. Staff K stated she had to stop the resident from falling, and in the process her hand came in contact with the resident's waist area to prevent a fall, the action was not intended to hurt her. During an interview on 4/28/26 at 2:34 PM, the Administrator stated when she did abuse investigations she followed their checklist, she spoke to staff, anyone around the scene, in the building at that time, and interviewed any residents able to be interviewed from the same hall that would have had care by the identified staff member. The Administrator stated she asked the resident questions do you have concerns about staff being rough, or are you fearful of anyone. The Administrator stated the residents and staff that she interviewed related to the alleged incident did not have concerns for abuse or treatment by staff. The Administrator reviewed her investigative file and reported she conducted the following resident interviews:Resident's name redacted - had no concerns, and said staff don't check on him.Resident's name redacted - said she'd sat in the bathroom for a long time, had no concerns or issues.Resident's name redacted - said everyone was great, she'd received a bed bath that day.Resident's name redacted - said he wasn't feeling well, did not have concerns.Resident's name redacted - said he didn't have concerns, and the 3rd shift CNA's listened to music on their phones.Resident's name redacted - said the aides play music on the night shift and he didn't see staff much at night.Resident's name redacted - said it could take staff some time to get to the residents, family member visited in their room and witnessed her questions.Resident's name redacted - said he was applying to go to another long-term care facility, said he was supposed to get his medication at 10 p.m. and sometimes they were late.During resident interviews conducted by the State Agency, 3 of the 8 residents reported interviewed by the Administrator denied talking to facility staff about any concerns they may have about staff treating them rough or being abusive. All 3 residents denied having any concerns with how staff treated them or reported any abusive incidents.Review of the facility policy titled, Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, dated 3/18/26 revealed a Purpose statement which declared: To achieve compliance with state and federal requirements for preventing, identifying, investigation and reporting abuse in all [facility corporate name redacted] facilities.The Rational section of the policy revealed, in part:a. All Residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms .b. It shall be the policy of this facility to implement written procedures that prohibit abuse, neglect, exploitation, and misappropriation of resident property.c. These procedures shall include the screening and training of employees, protection of Residents and the prevention, identification, investigation, and timely reporting of abuse, neglect, mistreatment, and misappropriation of property, without fear of recrimination or intimidation.The Key Definition section revealed, in part: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. This also includes the deprivation (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bettendorf Health Care Center	2730 Crow Creek Road Bettendorf, IA 52722

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.The Investigation Protocol sections directed, in part:The Administrator will complete documentation of the allegation of Resident abuse and collect any supporting documents relative to the alleged incident.Attempt to obtain witness statements (oral and/or written) from all known witnesses.The facility will establish and enforce an environment that encourages individuals to report allegations of abuse without fear of recrimination or intimidation.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, resident and staff interviews, the facility failed to follow up on hospital discharge orders for 1 of 1 residents (Resident #3) reviewed. After a September 2025 hospitalization Resident #3 discharged with recommendations to be evaluated by a rheumatologist and podiatrist. The facility reported a census of 56 residents.Findings include:Review of Resident #3, Minimum Data Set, dated [DATE] revealed a BIMS score of 15 out of 15, which indicated intact cognition. The MDS assessed Resident #3 without symptoms of delirium; always able to be understood by others and always understood others. Review of the electronic health record (EHR) Medical Diagnosis list revealed, in part the following diagnosis: alcoholic polyneuropathy (nerve damage caused by alcohol, which can cause symptoms which can include numbness, extreme sensitivity, and weakness) generalized muscle weakness and unsteadiness on feet. Review of hospital discharge records, dated 8/16/25 revealed a History of Present Illness section, which documented, in part.Diffuse psoriasis noted. The Active Problems listed included, in part: hand arthritis and psoriasis. Review of a [name of geriatric clinic redacted] encounter notes, dated 11/12/25, Orders – Requisitions section included, in part: Rheumatology referral – was previously ordered, date is pending, and Podiatry to see patient – order left. During an interview on 4/21/26 at 11:06 AM, Resident #3 stated he had been at the facility for over 7 months and had yet to see a rheumatologist or a podiatrist. Resident #3 noted to have 1 centimeter raised areas, dark pink covering up to 50% of each arm. Resident #3 stated the areas itched and he hoped a rheumatologist could do something to help him. During an interview on 4/21/26 at 11:27 AM, the Administrator stated the order for a rheumatologist was ordered when the resident admitted on [DATE]. She stated she would check into it and provide information; she knew they had worked on it. On 4/21/26 at 1:00 PM, the Administrator stated when the resident admitted to the facility in August of 2025, he had Medicaid in the community but not for the facility. She explained the facility had not been notified Resident #3 had the change in Medicaid in place until January of 2026, which had been made retroactive back to November 2025. The Administrator stated the facility attempted to set up an appointment with the rheumatologist but the process got lost amid other pressing matters which occurred at the time. That being said they did not try to make a Rheumatologist referral until January when he had Medicaid coverage (5 months after his facility admission). During an interview on 4/27/26 at 7:49 AM, the Administrator stated the facility had an appointment with a rheumatologist for Resident #3 on 4/28/26. During an interview on 4/27/26 at 10:17 AM, Resident #3 stated he was also supposed to see a podiatrist During an interview on 4/27/26 at 10:25 AM, the Administrator stated Resident #3 had been scheduled to see a Podiatrist on 1/5/26 but was not seen as he did not have Medicaid approved at the time of (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the appointment. The Administrator added Resident #3 had an appointment rescheduled for 3/9/26 and was not sure why that appointment did not occur. The Administrator later communicated by email that Resident #3 had an podiatrist appointment scheduled for May 18, 2026 During an interview on 4/27/26 at 12:52 p.m., the Director of Nursing (DON) stated she expected staff to follow physician orders unless clarification was required, and to get the clarification if so. If there was a referral for podiatry, she would expect the resident's name to be put on the Podiatrist's list to be seen at the next visit, unless it was urgent and then they should check to see where they could refer the resident to.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review and staff interviews, the facility failed to ensure 1 of 1 residents (Resident #5) attended dialysis on time and as scheduled, and to complete thorough pre and post dialysis assessments for 1 of 1 resident (Resident #5) reviewed for dialysis related care. The facility reported a census of 56 residents.Findings include:Review of Resident #5's Minimum Data Set (MDS), dated [DATE] revealed a list of diagnoses which included renal insufficiency (kidney failure which required dialysis), diabetes mellitus and paraplegia (paralysis of one half of the body). The Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicated the intact cognition. The MDS indicated Resident #5 received dialysis while a resident. Review of the April 2026 Medication Administrator Record (MAR) revealed:a. Dialysis Days: MWF (Monday, Wednesday, Friday) time for pick up: 9:30.Start Date: 2/23/26.b. Post-Dialysis: Assess thrill/bruit (common dialysis related assessment for the fistula [a surgically created connection of an artery to a vein used for dialysis access] site. Thrill is a palpable vibration can feel with fingertips, while a bruit is a whooshing sound hear with stethoscope). Chart + if present and - if absent. Notify [redacted name of dialysis provider] if absent. Assess access site fistula and document N for normal, B for s/sx (signs/symptoms) bleeding, or I for s/ss infection and notify dialysis for bleeding or infection. Assess cognition and document A for alert; C for confused, or D for disoriented. One time a day every Mon, Wed, Fri for ESRD (end stated dialysis)/hemodialysis. Start Date: 3/4/26.c. Assess thrill/bruit. Chart + if present and - if absent. Notify [redacted name of dialysis provider] if absent. Assess access site fistula and document N for normal, B for s/sx bleeding, or I for s/ss infection and notify dialysis for bleeding or infection. Assess cognition and document A for alert; C for confused, or D for disoriented. One time a day every Mon, Wed, Fri for ESRD /hemodialysis. Start date: 3/11/26. A review of the April 2026 MAR revealed the following:a. Post Dialysis assessment not thoroughly completed on:1. April 6, 2026 for Cognition, Site, Thrill.2. April 10, 2026 for Bruit, Cognition, Site, Thrill3. April 15, 2026 for Bruit, Cognition, Site, Thrill4. April 17, 2026 for Bruit, Cognition, Site, Thrill5. April 20, 2026 for Bruit, Cognition, Site, Thrillb. Pre-Dialysis assessment not thoroughly completed on1. April 10, 2026 for Thrill2. April 13, 2026 for Thrill3. April 17, 2026 for Site4. April 22, 2026 NA documented for Bruit, Thrill and weight. No documentation in clinical record to explain lack of assessment in these areas. During an interview on 4/17/26 at 12:45 PM, a Dialysis provider staff stated Resident #6 missed her transportation to an appointment due to not being ready on time. During an interview on 4/21/26 at 8:22 AM, Resident #5 stated she is late to dialysis once or twice a week. The resident explained she is supposed to be in her dialysis chair at 10:00 AM, but she often does not get to the center until 10:30 AM. Resident #6 stated the head nurse at dialysis wants her to be at the center by 9:30 AM so she can get started on time. During an interview on 4/23/26 at 8:57 AM, Staff A, Registered Nurse (RN) stated when a resident returned from dialysis, the nurse should assess and document on the Medication Administration Record the resident's vital signs, weight, site for thrill and bruit, appearance and dressings.During an interview on 4/28/26 at 12:33 PM, the Director of Nursing (DON) reported she expected nurses to document post dialysis assessments on the flow sheets on paper. She was not sure if there was anything documented on the MARs and TARs other than checking the fistula. She would expect this to be documented immediately upon return. The DON stated if a resident had dialysis scheduled at 9:30 AM she would expect the resident to be up and ready by 8:00 AM and ready for pick up by 8:4f5 AM. The [NAME] added residents that need dialysis are transported to the center through a transportation service. When asked how many times has Resident #5 been late for dialysis she was not sure. Review of the facility policy titled, Hemodialysis, dated 2025 included a Policy statement which declared: This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing, mental, and psychosocial needs of residents receiving hemodialysis.The Purpose section directed, in part: The facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include: The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility.

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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, clinical record review, resident, family and staff interviews, the facility failed to answer call lights in a timely manner for 4 of 6 dependent residents reviewed (Resident #6, Resident #9, Resident #13, and Resident #14) for call lights. The facility reported a census of 56 residents. Findings included:1. The Minimum Data Set (MDS), dated [DATE] identified Resident #6 as cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. The list of diagnoses included: cellulitis to the right and left leg and lymphedema. The MDS identified Resident #6 dependent on staff for transfers, and required substantial/maximal staff assistance for toileting and personal hygiene. Review of Resident #6's Care Plan, dated 4/16/26, revealed a Problem area to address [Name redacted, Resident #6] is incontinent of bowels and is at risk for impaired skin, rashes, irritation in the peri-area. Interventions included, in part: Keep call light within reach to use to notify using if [name redacted, Resident #6] needs to use the toilet/has an incontinence episode. During an observation and interview on 4/17/26 at 1:19 PM, Resident #6 sat up in bed, wearing a clean hospital gown and covered with blankets from waist to feet and dressings dry and intact to both feet. She reported on Sundays, she has to wait more than a few hours, sometimes up to 3 hours for staff to answer her call light. They are supposed to check and change her every 2 hours. This usually happens on night shift. She has complained about it before and nothing changes. Resident #6 also reported the staff will usually take more than 15 minutes to answer her call light and this happens at least once a week. They will come in and turn off the call light, say they'll be back and they'll never come back. During an interview on 4/23/26 at 8:46 AM, Staff I, Certified Nursing Assistant (CNA) reported Resident #6 had reported she was not getting her call lights answered in a timely manner, that staff should answer call lights within 15 minutes and that any staff member should be expected to answer a call light. 2. Review of Resident #9's MDS, dated [DATE] identified as cognitively intact with a BIMS score of 15 out of 15. The list of diagnoses included: renal insufficiency (kidney failure), diabetes mellitus and spinal stenosis. The MDS identified Resident #9 dependent on staff for toileting and transfers, and required substantial/maximal assistance with personal hygiene. During an interview on 4/17/26 at 12:52 PM, a family representative for Resident #9's reported the resident had been incontinent with urine and had to wait an hour and a half for staff to come to her room. The family representative reported the staff told Resident #9 they have other patients they have to take care of and she is not the only one. The family representative added another family member called the nurses station to let them know that Resident #9 was ready to get out of bed. There was another time where the resident waited to get into bed, turned on her call light at 8:00 PM and then waited until 11:00 PM to be assisted into bed. During an interview on 4/28/26 at 8:56 AM, Staff H, CNA reported Resident #9 complained to her that she would be left sitting up in her wheelchair until 11:00 PM waiting for help to get to bed. Staff H stated Resident #9 reported she had her call light on for 2 hours before staff helped her and it usually happened on second and third shift. (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 Grievance's revealed on 4/7/26, Resident #9 submitted a Grievance. The Summary of Grievance read: [name redacted, Resident #9] stated she was not put to bed until after 11. States that she called nursing station 3 x (times) before going into the hall to yell for help. 3. Review of Resident #14's MDS, dated [DATE] identified the resident as cognitively intact with a BIMS score of 15 out of 15. The list of diagnoses included: cancer, diabetes mellitus and cerebral palsy. The MDS identified Resident #14 dependent on staff for assistance with all activities of daily living (ADL's), with the exception of eating. Review of Resident #14's Care Plan revealed a Problem area, initiated 12/15/25 to address: [Name redacted, Resident #14] has a self-care deficit as evidenced by requiring assistance with ADL's, impaired balance during transitions requiring assistance and/or walking, incontinence. Interventions included, in part: a. BED MOBILITY: 1 person assist. Date Initiated: 12/15/25. b. TOILETING: 1 person assist. Provide peri-care with every incontinent episode and as necessary. Date Initiated: 12/15/25. c. TRANSFERS: 2 person assist with hoyer (a brand name of a full body mechanical lift which has become a genericized trademark to refer to any full body mechanical lift). Date Initiated: 12/15/25. During a continuous observation that started on 4/21/26 at 9:50 AM, Resident #14 call light activated. At 9:59 AM call light remained on, with an alarm sounded. Call light activated for a total of 9 minutes. At 10:07 AM call light remained on, with an alarm sounded. Staff A, Registered Nurse and the Director of Nursing (DON) walked by the room without checking in with the Resident #14. Call light activated for a total of 17 minutes. At 10:12 AM call light remained on, with alarm sounded. The Human Resources Coordinator walked by the room without checking in with Resident #14. Call light activated for a total of 22 minutes. At 10:14 AM, call light remained on, with alarm sounded. Staff A, RN and the DON walked down the hallway of Resident #14 room and checked with a different resident. Staff A and the DON did not check in with Resident #14. Call light activated for a total of 24 minutes. At 10:15 AM, Staff D, CNA entered Resident #14's room to check on her and turned off the call light. Call light activated for a total of 25 minutes. During an interview on interview on 4/21/26 at 10:29 AM, Resident #14 the longest she had to wait to get her call light answered was 3 hours. Resident #14 stated a lot of staff have quit, and she has to wait for someone to answer her call light 3 to 4 times a week. The resident stated she always waits 2 or 3 hours, it's terrible. During an interview on 4/22/26 at 3:27 PM, Staff C, Licensed Practical Nurse (LPN) stated staff are expected to answer call lights within 15 minutes. When asked if she felt there was enough staff to provide residents with the care they need, she reported there were enough CNAs, however, she felt the nurses could use more help. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/26 at AM, Staff B, CNA reported staff should answer call lights within 15 minutes, that any staff member can answer a call light, however, not everyone does. He also reported a few residents have complained that aides will come in, turn off the call light and say they will be back and the aides will not come back During an interview on 4/28/26 at 12:33 PM, the DON stated she would expect the staff to answer call lights within 2 minutes. The DON stated when a resident has their call light on any staff member should be able to answer it. She would expect the staff to check on a resident who has their call light on, rather than walk by without checking on them. Regarding the grievance on Resident #9, she reported she waited as long as 20 minutes to get her call light answered. She did complain that she was left to sit up in her wheelchair until 11:00 PM, but it was actually 9:00 PM, by then she had her call light on for a few hours. The DON explained she terminated a CNA for saying she'll be back and then never came back. She recalled Resident #9 told her she did not mind being up a little bit, but it was ridiculous to be kept up that late. She requested to be assisted to bed by 9:00 PM. Other residents that have also complained to her about their call lights not getting answered in a timely manner were Resident #6 and Resident #14. 4. Review of Resident #13's MDS, dated [DATE] revealed a BIMS of 12 out of 15 which indicated a mild cognitive impairment. The list of diagnoses included: anxiety, depression and asthma. The MDS indicated Resident #13 dependent on staff for all ADL's with exception of substantial/moderate staff assistance required for eating. During a continuous observation that started on 12:48 PM on 4/27/26, Resident #13 in his room, lying in bed. Resident #13 activated his call light. At 12:53 PM, call light remained on. Call light activated for a total 5 minutes. At 12:58 PM, call light remained on. Call light activated for a total 10 minutes. At 1:02 PM, call light remained on. Call light activated for a total 14 minutes. At 1:06 PM, call light remained on. Call light activated for a total 18 minutes. At 1:10 PM, call light remained on. Call light activated for a total 22 minutes. At 1:13 PM, call light remained on. Call light activated for a total 25 minutes. At 1:16 PM, call light remained on. Call light activated for a total 28 minutes. At 1:19 PM, Staff B, CNA and Staff I, CNA entered the resident's room, closed the door, and the call light was turned off. Call light activated for a total of 31 minutes before staff responded. A review of the facility policy titled, Call Lights: Accessibility and Timely Response, dated 2025, revealed a Policy statement which declared: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. The Policy Explanation and Compliance Guideline section directed, in part: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified. b. Process for responding to call lights: 1. Turn off the signal light in the resident's room. 2. Identify yourself and call the resident by name. 3. Listen to the resident's request and respond accordingly. Inform the resident if you cannot meet the need and assure him/her that you will notify the appropriate personnel. 4. Inform the appropriate personnel of the resident's need. 5. Do not promise something you cannot deliver. 6. If assistance is needed with a procedure, summon help by using the call light. Stay with the resident until help arrives.