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	09/11/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview that facility failed to provide adequate linens for bariatric beds for 2 out of 2 residents reviewed with bariatric beds (Resident #3, Resident #41). The facility reported 18 residents who utilized bariatric beds in the facility. The facility identified a census of 66 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 revealed the resident scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. Per this assessment, the resident required substantial/maximal assistance to roll left and right. On 9/09/25 at 4:10 PM, Resident #3 in bed with no sheet below him on the mattress. He did have a bath blanket under parts of him but the mattress was exposed. On 9/10/25 at 7:32 AM, Resident #3 remained in bed with no sheet under, and mattress remained exposed. The resident had bath blanket under part of him. 2. On 9/10/25 at 7:49 AM, Resident #41 observed lying in bariatric bed with no sheet on the bed. The resident observed on bath blanket with no sheet on bed. On 9/10/25 at 9:44 AM Staff E, Certified Nursing Assistant (CNA) stated don't have a lot of bariatric sheets, and depended on the laundry and how fast they come back. Staff E explained East Hall had 2 sheets and there were 4 beds on this wing. Observation of the [NAME] hall linen closet with Staff E revealed there were no bariatric sheets in the linen closet.Per review of an email sent by the Regional Nurse Consultant on 9/11/25 at 2:33 PM, she reported the facility did not have inventory sheet for linens.The facility provided a list of residents which indicated 18 residents had bariatric beds in the facility. On 9/11/25 at 9:59 AM Staff O, Certified Medication Technician (CMT) stated ran out of bariatric sheets from laundry pretty frequently, and had a lot more bariatric beds than in the past. Staff O explained would try to use a flat sheet and tuck it in on the corners. On 9/11/25 at 10:05 AM Staff P, Licensed Practical Nurse (LPN), Assistant Director of Nursing (ADON) stated bariatric sheets were an issue with staying secured, and knew they ordered the full size regular sheets because they fit the beds much better. Staff P estimated had 5 maybe 6 bariatric beds on the [NAME] hall.On 9/11/25 at 11:08 AM, Staff T, Laundry Aide stated had a lot of bariatric sheets. Staff T explained they took them down, put in the linen closet, and further explained the supervisor did inventory of linens. On 9/11/25 at 11:15 AM, the Housekeeping Supervisor stated regarding fitted bariatric bed sheets, they honestly had not counted them, and needed to go through and mark them. The Housekeeping Supervisor explained there had been no complaints of running out of them per the staff, [Houskeeping Supervisor] didn't really know how many had at this time, they should have sheets available during the day, and if not available they could come get what they needed. On 09/11/2025 at 12:09 PM, the Director of Nursing (DON) stated they sent an email today about getting sheets ordered for the bariatric beds, and it was the bariatric beds that seemed to have a problem. Per the DON, the facility did not take inventory of the sheets, and DON would expect them to have sheets on their beds at all times and we should have a 3 day supply of linens. On 09/11/2025 at 1:12 PM, the Administrator stated was not aware of any problems with bariatric sheets, and further explained found out there was linen closets not being filled and was resolved. Per the Administrator, inventory linens were not being done since I have been here.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 clinical record review, staff and resident interviews, Payroll Based Journal (PBJ), and facility document review the facility failed to provide enough staff to care the residents for four out of eight residents reviewed Resident #20, #28, #34 and #54). The facility reported a census of 66 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #34 dated 6/26/25 listed diagnoses of cerebral palsy, cancer and neurogenic bladder. The Brief Interview for Mental Status (BIMS) assessment reflected a score of 15 out of 15, which indicated intact cognition. The MDS revealed Resident #34 was always incontinent of bowel and bladder. On 9/08/25 at 5:10 PM, Resident #34 reported nursing staff were less on the weekends, but her call light could take too long many days of the week, and many times of the day. She revealed the call light could take hours for staff to answer at least 4 times a week. On 9/11/25 at 2:00 PM, the Assistant Director of Nursing (ADON) reported the facility failed to have a staffing problem. She confirmed some of the resident had reported a concern with call lights and they did have resident complaints about staffing. She reported it may be a failure of the charge nurse to make the staff get up from the nurses station and get the call light. She reported staff calling in happened daily, but they got the shifts covered. On 9/11/2025 at 2:04 PM, the ADON reported the facility staffing was based on the census, the Patient Per Day (PPD). She reported the management company increased the PPD at the beginning of the year and she failed to know that until March or April. The ADON reported she put enough staff on the schedule, the staff can get cares done. The ADON said day shift got 5 Certified Nurse Aide (CNA)s, 3 nurses or 2 nurses, a medication aide and the 5 CNAs, at times they get more. She reported the second shift got 4 CNAs, 2 nurses and a medication aide. The night shift got a nurse and medication aide and 3 to 4 CNAs or 3 nurses and 3-4 CNAs a night. On 9/10/2025 at 12:29 PM, the Administer provided her explanation of why the facility triggered for excessively low weekend staffing due to the facility experienced call offs on 1/12/25, 1/25/25, 2/1/25, 2/15/25, 2/22/25, 2/23/25, and 3/15/25. She reported the facility failed to track the hours of staff members that picked up shifts in nursing. She explained the Business office Manager (BOM) was a Certified Medication Technician (CMT), and housekeeping supervisor was a CMT, the transportation person was a CNA, and the activities director was a CNA. The Administrator reported the staff picked up some of the shifts. She revealed those hours were not always adjusted to the PBJ numbers. The PBJ dated Fiscal year (FY) Quarter 2 2025 (January 1 - March 31), triggered for Excessively low weekend staffing and a One Star Staffing Rating. The Facility Assessment updated 6/19/25, reflected the number of full time (FT) licensed nurses staff providing direct care for the building as 15 and the number of FT Nurse Aides (CNA) as 28. The facility failed to identity how many staff were needed on each shift to care for the residents. 2. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 scored a 15 out of 15 on a BIMS exam, which indicated cognition intact. (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 9/8/25 at 1:04 PM, Resident #20 stated her only concern was that some of the shifts didn't come in and check on the residents. Resident #20 stated the other night she was laying on her left side and couldn't reach her call light and called for help and no one came into her room for 4 hours. Resident #20 stated she knew how long it was because she looked at the clock. 3. The MDS assessment dated [DATE] revealed Resident #54 scored a 15 out of 15 on the BIMS exam, which indicated cognition intact. During an interview on 9/8/25 at 1:34 PM, Resident #54 stated she had to wait over an hour before for the call light and she knew it was that long because she watched the clock. Resident #54 stated it happened on all three shifts. Resident #54 stated this morning they checked her brief and then she had to tell the staff to change her after lunch. 4. The MDS assessment dated [DATE] revealed Resident #28 scored a 15 out of 15 on the BIMS exam, which indicated cognition intact. During an interview on 9/8/25 at 11:11 AM, Resident #28 stated her call light could be on for 45 to 1 hour. Resident #28 stated the third shift was the worst, and last Saturday they only had two aides and one nurse on the third shift. During an interview on 9/11/25 at 9:08 PM, Staff R, CNA queried on the staffing levels on third shift and Staff R stated she thought it was horrible, but the facility said they were fully staffed. Staff R stated they usually had 3 CNA on third shift, but sometimes there were only 2 CNA and it made it harder to get to the call lights. Staff R stated she didn't know how long the call lights would be on if Staff R was in another hall helping another CNA, but Staff R thought she could get to the call lights within 15 minutes.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, clinical record review, and staff interviews, the facility failed to ensure pureed meat was reheated to 165 degrees for fifteen seconds when held for hot service after the temperature of the pureed meat dropped below 135 degrees Fahrenheit. The facility reported a census of 66 residents. Findings include: During an observation on 9/9/25 at 10:43 AM, Staff A, Dietary [NAME] prepared pureed meat for the lunch service. The turkey slices temped at 181 degrees. After the Staff A finished with her preparation of the puree meat, Staff A placed the prepared meat onto the steam table and did not take the temperatures of the meat prior to placing on the steam table. The Facility Spring/Summer 2025 menu revealed the following menu for Tuesday Week 3: Herbed turkey, baked potato, sour cream, sugar snap peas. During an observation on 9/9/25 at 11:32 AM, Staff A took the temperatures of the foods on the steam table prior to lunch service. The pureed turkey temped at 131.2 degrees. During an observation 9/9/25 at 11:45 AM, Staff A plated 3 pureed meals first. During an observation on 9/9/25 at 12:25 PM, Staff A conducted post temperatures after the lunch service completed. The pureed turkey temped at 141 degrees. During an interview on 9/11/25 at 8:44 AM, Staff A, Dietary [NAME] queried if she needed to reheat the puree up to a certain temperature after she processed it and Staff A stated she didn't know, because she had never been told. Staff A stated she just knew the holding temperatures and thought it was between 135 and 170 degrees. During an interview on 9/11/25 at 8:54 AM, the Dietary Supervisor queried if the pureed meat needed to be reheated to a certain temperature and the Dietary Supervisor stated yes, it the meat was not up to temperature. The Dietary Supervisor queried on what the meat should be brought up to and the Dietary Supervisor stated 140 degrees or higher. The Dietary Manager stated if the meat started out at 165 it just needed to be held at 140 degrees or higher. During an interview on 9/11/25 at 1:11 PM, the Administrator stated the the meat did not have to brought back up to temperature and the holding temperature needed to be 135 or hot items. The Administrator queried if meats needed to be a higher temperature and the Administrator stated it depended on the type of meat.Per email from the Regional Director of Operations on 9/11/25 at 1:20 PM, revealed on the temperature log form it indicates it needs to hold at 135 degrees, and she didn't believe the facility had a separate policy that she could locate for food temperatures.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, staff interviews, and the facility policy, the facility failed to clean the ceiling vents and oven hood and maintain the dishwasher sanitizer at the appropriate sanitizing level. The facility reported a census of 66 residents. Findings include: During the initial tour of the kitchen on 9/8/25 at 9:45 AM, the low temperature dishwasher tested for the sanitizer level. The strip tested and the color of the strip was gray and did not rise to the level 25 PPM (parts per million). The Dish machine PH log for September 2025 revealed initial [Initials redacted] on the 8th on the breakfast and lunch times with the number 150 next to the initials. During the initial tour of the kitchen on 9/8/25 at 9:45 AM, observation revealed the ceiling vents had thick dust on and around them above the steam table, and the hood above the oven and stove covered with dust and grime. During an interview on 9/8/25 at 10:07 AM, the Dietary Supervisor informed the dishwasher did not reach the appropriate PPM level. The Dietary Supervisor went and got the Maintenance Supervisor, he changed out the rinse aid, reran the dishwasher, the PPM did not reach 25 PPM, and was still gray in color. The Dietary Supervisor stated she would call someone in and get the machine checked out. The Dietary Supervisor confirmed she would not use the dishwasher until the machine was fixed. During an interview on 9/8/25 at 11:32 AM, the Dietary Supervisor stated Maintenance found a broken hose and fixed it as best as he could. During an interview on 9/8/25 at 11:34 AM, the Dietary Supervisor stated a repair man was coming to the facility to fix the tube and make sure nothing else got cut off. The Dietary Supervisor ran the dishwasher again, the PPM read between 25-50 PPM, and the Dietary Supervisor confirmed the color on the strip needed to be darker and needed to be at least 50 PPM. The Dietary Supervisor confirmed they would not use the dishwasher until the repair man fixed it. During an interview on 9/8/25 at 2:32 PM, the Dietary Manager stated the dishwasher was repaired, and the repair man stated the tubing was bent and the chemicals might have been bad. The dishwasher ran twice, the sanitizer strip checked, and read between 75-100 PPM. The Dietary Manager queried on how long the dishwasher had been broken and the Dietary Manager stated it couldn't of been long because her staff checked it everyday. The Dietary Supervisor queried where the tubing was broken, and she stated the tubing was broken near the end that went into the chemical bottle. The Customer Service Report dated 9/8/25 at 1:30 PM revealed: a. Customer: machine no testing for sanitizer- O PPMb. Solution: Replaced cracked product line, replaced squeeze tube, replaced straw going into bucket, put new jug of [Name Redacted] (sanitizer) on machine, and primed and tested 100 PPM. During an observation on 9/9/25 at 12:18 PM, the kitchen ceiling vents were covered with thick layers of dust and the hood above the stove and oven covered in dust/greasy film. During an observation on 9/10/25 at 11:27 AM, the kitchen ceiling vents were covered with thick dust and a thick film/dust on the hood above the oven and stove. During an interview on 9/10/25 at 7:57 PM, Staff G, Dietary Aide queried on the deep cleaning schedule and Staff G stated they used to deep clean every week. Staff G asked about the ceiling vents and Staff G stated maintenance took care of them. Staff G asked about the stove hood and Staff G stated they used to clean it, but Staff G didn't know how often. Staff G queried how often she checked the sanitizer strip for the dishwasher and Staff G stated everyday. During an observation on 9/11/25 at 8:50 AM, Staff H, Dietary Aide queried when he checked the sanitizer strip for the dishwasher and Staff H stated he checked the strip after Staff H did all the dishes. Staff H queried why he checked after the dishes were all done, and Staff H stated because normally then the sanitizer strip would be in range. When informed the dishwasher sanitizer log was already initialed for the breakfast and lunch on 9/8/25, Staff H confirmed he wrote down the number before tested the strip. Staff H queried on why he continued to do the dishes after the sanitizer test strip color was gray, Staff H stated he didn't know, and he was just finishing the dishes. During an interview on 9/11/25 at 8:54 AM, the Dietary Supervisor queried when the staff checked the dishwasher strips, and the Dietary Supervisor stated before breakfast, lunch, and supper (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dishes. The Dietary Supervisor asked about the sanitizer strip being logged for breakfast and lunch on 9/8/25 and the Dietary Supervisor stated she already spoken to staff about that. The Dietary Supervisor queried about the thick dust around the ceiling vents above the steam table, and the Dietary Supervisor confirmed she wouldn't want the dust to fall down. The Dietary Supervisor queried on the stove hood, the Dietary Supervisor stated the facility had an outside company come in and clean it, and didn't know the last time they came. During an interview on 9/11/25 at 11:42 AM, the Administrator informed of the dust around the ceiling vents and on the hood above the stove/oven. The Administrator stated she didn't know what the Dietary Supervisor's cleaning schedule looked like, but the Administrator stated she thought the vents and hood should be cleaned weekly or whatever was on the Dietary Supervisor's list. During an interview on 9/11/25 at 1:11 PM, the Administrator stated the dishwasher sanitizer should be between 50-100 PPM.The Facility Nutritional Services Sanitation Policy dated 3/31/21 revealed:a. Cleaning of equipment condensers, lights, vents/fans, ceiling, ice machine, etc. shall be completed by the Maintenance Department as determined by the Administrator and in accordance to meet minimum standards of Federal, State, and Local guidelines and ordinances governing food service.b. Equipment shall be cleaned, sanitized, delimed, etc. in accordance with manufacturer recommendations. Detergents and sanitizers shall be used in the correct dilutions consistent with Federal and State guidelines and ordinances governing food service.c. Exhaust system and hoods shall be clean, operational, and maintained in good repair.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff and resident interviews, and facility policy review the facility failed to ensure residents remained free from verbal abuse, mental abuse, and neglect by facility staff for three of five residents reviewed for staff treatment (Resident #6, Resident#28, Resident #34). The facility reported a census of 66 residents.Findings include: 1. The Minimum Data Set (MDS) assessment for Resident#34 dated 6/26/25 listed diagnoses of cerebral palsy, cancer and neurogenic bladder. The Brief Interview for Mental States (BIMS) assessment reflected a score of 15 out of 15, which indicated intact cognition. The MDS revealed Resident #34 was always incontinent of bowel and bladder. Review of documentation dated 6/30/25 provided as part of a Facility Reported Incident regarding Resident #34 revealed, On 6/30/2025, Social Services was given a grievance form from [Name Redacted], Activity Director regarding resident [Resident #34]. Resident reported to Activity Aide that on second shift Sunday night (June 29), [Staff D], CNA (Certified Nursing Assistant) told resident that she had to earn [Resident #34's] respect and that no one liked her. Resident further stated that [Staff D] told her no one was going to come in and take care of her. The resident also said that she doesn't want to get anyone in trouble; she would just like respect. Administrator interviewed resident, [Resident #34]. Resident stated [Staff D] came into her room around 6:45 pm on 6.29.25 and asked [Resident #34] why she was talking to other staff members about her when the resident knows what she is saying is not true. Resident was telling other staff that [Staff D] said, All you do is poop and roll around. According to the resident, [Staff D] proceeded to tell her that no one liked her, and they were not going to come in to care for her. Resident further states that [Staff D] told her that [Staff D] is going to continue to be on East hall and that she was going to write up a grievance on the resident. Resident feels she was verbally and emotionally abused and states that she is afraid of this CNA Resident's roommate was also interviewed who stated that it sounded to her like [Staff D] was badgering the resident. Review of a statement by Staff D dated 7/2/25 revealed, in part, On Sunday 6/29/25 I came to worked about 1/2way through my shift a housekeeper had come to me stating that [Resident #34] was going around to anyone that would listen to her that I was saying all she does is eat (and) poop. I waited untill <sic> the call light came on for that room myself and [Name Redacted] who was training answered the call light I had let [Resident #34] know that I would be filing a grievance on her because she was going around telling any employee who would listen to her [Resident #34] then screamed at me that I dont treat her with respect or dignity I turned and left the room. On 9/08/25 at 4:59 PM, Resident #34 named Staff D, Certified Nurse Aide (CNA) as the staff that failed to treat her with respect and dignity telling others all she did at the facility is eat, poop and roll around. Resident #34 described Staff D as inappropriate and the rudest thing. She felt horrible after she knew that's how Staff D talked about her to other. On 9/09/25 at 11:28 AM, Resident #4 explained she didn't hear the start of [Staff D] and [Resident #34's] conversation, she just heard that [Resident #34] was going to file a grievance on [Staff D]. Then [Staff D] got in [Resident #34's] face within a few feet and said she would file one right back on [Resident #34], then they turned and left the room. On 9/10/25 at 5:40 PM, Resident #34 sat at the table in in the dining room in her wheelchair. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/10/25 at 9:29 AM, Staff C, Licensed Practical Nurse (LPN) confirmed she worked on 6/29/25 on Resident #34's hall. She said Staff D worked on Resident #34's hall, and she revealed Resident #34 told her Staff D treated her rudely. On 9/10/25 at 10:21 AM, Staff E, CNA reported Resident #34 told Staff D, she treated her disrespectfully. On 9/10/25 at 10:12 AM, Staff F, CNA confirmed she worked on 6/29/25 with Staff D. She revealed Staff D used the words ate and pooped in reference to Resident #34. She indicated Resident #34 took it the wrong way. Staff F said that Staff D reported Resident #34 ate, pooped and rolled around today. Staff F reflected the CNA meant she ate all her meals and had bowel movements (BM) 3 times today. Staff F reported Resident #34 took the conversation the wrong way. Staff F reported Staff D needed to use better language when talking about residents. On 9/11/25 at 8:28 AM, Staff D, CNA confirmed she worked on 6/29/25. Staff D confirmed Resident #34 went to others in the facility and told them that she was going around telling anyone that Resident #34 just ate and poop. Staff D said she never said that to Resident #34. Staff D reported Resident #34 yelled at her the she failed to respect her and failed to treat her with dignity. Staff D revealed the facility suspended her for incident on 6/29/25 and then the facility terminated her. On 9/11/25 at 2:40 the Director of Nursing reported she expected all the staff to treat resident with respect and dignity. The Progressive Discipline Report & Plan for Staff D, dated 7/8/25, revealed the following date of incident: 6/29/25. The report revealed the employee had been terminated. The Incident Summary revealed the following: [Staff D] was reported by a resident for telling that resident that she did not respect her and that the resident had to earn [Staff D's] respect. [Staff D] also told the resident that none of the employee's at the facility liked her and none of them would even come and provide care for her. [Staff D] then told the resident that she was going to put her to bed at that time, despite protests from the resident saying she did not want to go to bed at that time. [Staff D] then told the resident that she would be filing a report on her for yelling at her. [Staff D] later told the administrator that she heard froother <sic> employees that the resident told them that [Staff H] said to her that all she did was eat and poop. [Staff D] did not deny saying this when she brought it up. The Progressive Discipline Report & Plan further revealed the following per the Code of Conduct and/or Employee Handbook Violations section: #18: Engaging in physical harassment, sexual harassment, disruptive or abusive behavior, or disrespect towards fellow employees, residents, visitors or others. #19. Engaging in resident physical, emotional, or verbal abuse; resident neglect; or by violating any of the Resident Rights. Also written in the section was the following: Violating the [Name Redacted] training on customer service expectations. The Corrective Action Plan section documented, [Staff D] has been coached and warned previously for how she treats others in our building. Due to the continuation of this behavior and the fact this unacceptable attitude was directed towards a resident, it has been decided to terminate [Staff D] at this time. Review of the Facility Policy titled Abuse, Neglect, and Exploitation approved 8/30/18, and revised 4/29/25, revealed the following: Mental Abuse: The use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation including abuse that is facilitated or enabled through the use of technology. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS assessment dated [DATE] revealed Resident #28 scored a 15 out of 15 on the BIMS exam, which indicated cognition intact. The Care Plan revealed a focus area dated 8/11/25 for history/potential for behavior problem and antagonizing other residents. The interventions dated 8/11/25 revealed if reasonable, discuss disruptive behavior(s) and explain/reinforce why behavior is unacceptable; and intervene as necessary to protect the rights and safety of others; and approach/speak in a calm manner; divert attention; and remove from situation and take to alternate location as needed. During an interview on 9/8/25 at 10:53 AM, Resident #28 queried on how staff treated her and Resident #28 stated the receptionist called her a *itch and the receptionist said she would kick Resident #28 in the hip if Resident #28 came around the desk. Resident #28 stated she thought the situation was handled, but she was called up to the office to discuss the receptionist coming about to the facility. Resident #28 stated if the facility let the receptionist come back, Resident #28 would leave the facility because Resident #28 wouldn't tolerate being threatened. During an interview on 9/10/25 at 3:25 PM, Staff J, Receptionist queried on the incident that occurred between Staff J and Resident #28. Staff J stated she thought Staff J and Resident #28 were friends because Resident #28 would come and talk with Staff J at the desk. Staff J stated the day before the incident Resident #28 was upset about another resident being near her cup at that the receptionist desk. Staff J stated the day of the incident Resident #28 came up to Staff J and told Staff J to apologize to Resident #28 and Staff J said she didn't have anything to apologize for. Staff J stated Resident #28 then threaten to punch Staff J in the stomach and Staff J had a [medical condition]. Staff J asked if Staff J yelled or cussed at Resident #28 and Staff J stated no. Staff J stated after the incident she went home and has not worked since. During an interview on 9/10/25 at 3:41 PM, Staff K, CNA stated she witnessed the incident with Staff J and Resident #28. Staff K stated she heard Resident #28 say something about another resident trying to touch her drink on the receptionist's desk and Staff J moved around the desk and said something to Resident #28, but didn't hear it. Staff K said she heard Staff J say, she wasn't going to play like this and lose her job. Staff K stated, Staff J shouldn't of talked like that in front of the residents and Staff J shouldn't of said anything to Resident #28. During an interview on 9/10/25 at 7:48 PM, Staff L, CNA stated she didn't think Staff J raised her voice at Resident #28, but at one point Staff J did tell Resident #28 to get out of her face. During an interview on 9/10/25 at 7:54 PM, Staff G, Dietary Aide queried about the incident with Resident #28 and Staff J and Staff G stated she didn't hear much except both Resident #28 and Staff J yelling at each other. During an interview on 9/11/25 at 10:14 AM, the Housekeeping Supervisor queried on the incident between Resident #28 and Staff J and the Housekeeping Supervisor stated she heard Staff J tell Resident #28 to “get the f**k away from the desk”. During an interview on 9/11/25 at 11:52 AM, the Administrator queried on the thoughts of the incident between Staff J and Resident #28, and the Administrator stated her investigation revealed inappropriate language used by Resident #28 and Staff J. The Administrator stated she concluded that Staff J was trying to do her job and got frustrated and expressed her frustration onto the resident. The Administrator asked if it was appropriate to cuss at residents and the Administrator (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated no, she wouldn't say that. The Administrator stated Staff J should have asked for additional assistance or asked the Administrator to come back into work. Review of the Facility Policy titled Abuse, Neglect, and Exploitation approved 8/30/18, and revised 4/29/25, revealed the following: Review of the Facility Policy titled Abuse, Neglect. and Exploitation approved 8/30/18, and revised 4/29/25, revealed the following: Verbal Abuse: Use or oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. 3. The Minimum Data Set (MDS) dated [DATE] for Resident #6 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated cognitively intact. It further indicated diagnoses including: hypertension (high blood pressure), diabetes, anxiety disorder, and depression. The Care Plan created 4/5/22, initiated 8/3/22, and revised 3/11/24 revealed, ADL (activities of daily living) self-care performance deficit Activity Intolerance, Impaired balance, Limited Mobility, Right Below Knee amputation. The Intervention created 4/5/22 and revised on 12/2/24 revealed the following for bed mobility: requires staff assistance to turn and reposition in bed. The Intervention dated 3/11/24 and revised 9/8/25 revealed the following for transfers: 2 assist HOYER (mechanical lift): BLUE SLING ONLY. On 09/09/25 at 8:27 AM, Resident #6 stated on Sunday staff did not get him out of bed at all, they told him they did not have enough staff, and most days it was 10:00 to 10:30 AM before could get up to his chair due to not enough staff. Resident #6 observed in bed waiting for breakfast tray. On 9/10/2025 2:00 PM, Staff I, Registered Nurse (RN) stated she was aware of Resident #6 not getting up on Sunday and staff telling him it was because of low staffing. This was not the case they had a Certified Nursing Assistant (CNA) on the [NAME] hall. Staff I also offered to help get him up but the CNA working did not want to get him up. She stated it was the attitude and the backlash from the CNA on why things didn't get done. She had reported this to the Director of Nursing (DON) and it had not helped. She had not gone further up the chain of command. You can't tell the aides what to do related to the backlash you get from them. On 09/11/2025 at 12:16 PM the Director of Nursing (DON), RN stated even when staff were short they should still get residents up for the day even if they are late, [facility] didn't really run short staff, and administration also had gone out and helped to get residents up. On the weekends there was a manager on duty and were fully staffed. There were three nurses on then and one of the nurses needed to be in the dining room for the meal. We have heard of issues with CNA not doing things and refusing to cooperate with the nurses but it has been addressed or is in the works of being addressed. Review of the Facility Policy titled Abuse, Neglect, and Exploitation approved 8/30/18, and revised 4/29/25, revealed the following: Deprivation of Good and Services: Deprivation by staff of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Example includes staff has the knowledge or ability to provide care and services, but choose not to do it, or acknowledge the request for assistance from a resident(s) which result in care deficits to the resident(s).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews and facility policy review the facility failed to provide incontinence care for two out of two residents reviewed (Resident #2 and Resident #20). The facility reported a census of 66 residents.Findings include:1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 listed diagnoses of cerebrovascular accident (CVA),anxiety, and depression. The Brief Interview for Mental Status (BIMS) exam revealed a score of 14 out of 15, which indicated intact cognition. The MDS reflected Resident #2 was always incontinent of bowel and bladder. The Care Plan for Resident #2 initiated 2/9/22, revised 3/1/22, revealed, ADL (activities of daily living) self-care performance deficit Impaired balance, Limited Mobility, stroke. The Intervention dated 12/12/24 directed utilize check and change to manage incontinency. The Intervention dated 12/11/24 directed assist of 1 staff for personal hygiene. On 9/10/25 at 1:09 PM, Resident #2 laid in her bed, Staff B, Certified Nursing Assistant (CNA) washed her groin and turned the resident on her right side. Staff N, Licensed Practical Nurse (LPN) completed wound care. Staff B placed a brief under Resident #2 and rolled her onto her back. At 1:17 PM, Staff B reported Resident # 2 voided urine, she needed to wash her, and changed the brief and the incontinent pad under her. Staff B rewashed the groin, changed the brief and the incontinent pad under Resident #2, and failed to wash her buttocks. On 9/10/25 at 1:25 PM, Staff B, CNA reported she found Resident #2's depend wet when she got in her room. Staff confirmed she washed the front and thought she washed Resident #2's back side. She reported when she turned her for the wound care she voided urine again. Staff B said Resident #2 needed a new incontinence pad and new brief. She reported she failed to wash her back side the last time. On 9/11/25 at 10:21 AM, Staff M, Licensed Practical Nurse (LPN) confirmed incontinence cares were completed after every incontinent episode. She said she expected all parts of the skin washed that came in contact with urine or bowel movement (BM). On 9/11/25 at 10:30 AM, Staff E, CNA reported they complete peri care anytime a resident was incontinent of urine or BM. On 9/11/25 at 2:45 PM, the Director of Nursing (DON) confirmed she expected the staff to complete peri care after each incontinent episode. 2. The MDS assessment dated [DATE] revealed Resident #20 scored a 15 out of 15 on the BIMS exam, which indicated cognition intact. The MDS indicated the resident dependent with toileting hygiene and always incontinent of bowel and bladder. The MDS revealed diagnoses for depression and Parkinson's disease without dyskinesia, without mention of fluctuations. The Care Plan revealed a focus area dated 8/23/24 for Activities of Daily Living (ADL) self-care performance deficit due to disease process (Parkinson, weakness, history of falls), and limited mobility. The interventions dated 9/10/24 revealed the resident did not use bed pan, toilet or commode and to utilize check and change to manage incontinency. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/8/25 at 1:04 PM, Resident #20 stated it depended on the staff when she got changed every couple of hours. During an interview on 9/10/25 at 10:56 AM, Resident #20 laid in bed and stated staff changed her right before breakfast, which was around 8:30 AM. Resident #20 stated the staff changed her at least twice in a shift. During an observation on 9/10/25 at 12:50 PM, Resident #20 sat up in her chair and ate her lunch. During an observation on 9/10/25 at approximately 1:00 PM, Staff E, CNA took the mechanical lift into Resident #20 room. During an interview on 9/10/25 at 1:35 PM, Staff S, CNA queried on when Resident #20 changed today during Staff S's shift. Staff S stated Resident was checked and changed after breakfast this morning, then Staff S and Staff E didn't realize therapy had gotten Resident #20 up until after Staff E went to get Resident #20 lunch tray. Staff S stated therapy would have gotten Resident #20 up between 9 AM and 11 AM. Staff S stated they were going to change her after lunch, but Resident's bed was deflated and they didn't want to put Resident #20 in bed and hurt her. Staff S stated she wasn't sure if Resident #20 had been changed yet. When asked how often residents were changed in her shift, Staff S stated it depended, but usually in the morning before breakfast, lunch and before shift ended. When asked how often residents needed checked and changed, Staff S stated every 2 hours. During an interview on 9/10/25 at 1:57 PM, Staff E stated check and changes needed done every 2 hours and for some residents more often. Staff E confirmed Resident #20 required check and change. Staff E asked when Resident #20 checked and changed today, and Staff E stated he didn't know when therapy got Resident #20 up and Resident #20 was still eating when he went to get her tray. Staff E stated when he went to get Resident #20 up, Resident #20 bed was deflated and didn't want to lay her on the deflated bed. Staff E asked if Staff E changed Resident #20 brief today and Staff E stated Staff S changed Resident #20 around 10, and then Staff E went into her room around 12:30 to check and change her, but Resident #20 refused. During an interview on 9/11/25 at 11:29 AM, the Director of Nursing (DON) confirmed check and changes needed completed every 2 hours. The DON asked how she thought check and changes were going and the DON stated it depended on the shift and the DON was working with the shifts to make sure the staff knew the policy and procedures. The DON asked how often Resident #20 should be checked and changed and the DON stated Resident #20 always incontinent and needed check at a minimum of every 2 hours. During an interview on 9/11/25 at 2:16 PM, the Regional Nurse Consultant stated the did not have a policy for the time frame of check and changes and to refer to the care plan. The Regional Nurse Consultant stated the professional standard of care is no longer than 2 hours. The Facility Incontinent Cares dated 7/21/22 revealed: a. Cleanse Perineal Area with a Perineal Cleanser. b. Females: Separate Labia, Cleanse one side and then the other, Cleanse center of the Labia wiping towards the Rectal Area. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Cleanse Perineal Area from Front to Back. d. Cleanse Thighs, Rectal Area & Buttocks.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview the facility failed to utilize proper technique when dispensing oral medications to prevent spread of infections. The facility also failed to maintain a catheter bag off the ground to prevent infections for 1 of 2 residents reviewed for catheters (Resident #3). The facility reported a census of 66 residents.Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #3 indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. It further indicated diagnoses including: atrial fibrillation (irregular heart beat), heart failure, urinary tract infection and chronic obstructive pulmonary disease. Per the assessment, the resident had an indwelling catheter. Review of the Order Summary Report with active orders as of 9/11/25 revealed an order for foley catheter to be changed every 30 days and as needed.The Care Plan for Resident #3, date initiated 7/7/25, indicated the resident needed catheterization. The interventions failed to direct staff for placement of the catheter. On 9/09/25 at 8:09 AM, Resident #3 observed in bed, and resident's catheter bag resting on the ground and no privacy bag covering it. Resident #3 stated staff were too busy to take care of it. On 9/09/25 Resident #3 sat on the side of bed with feet hanging down uncovered, and feet rested on the catheter bag which was on the ground uncovered. On 9/09/25 at 11:52 AM, Resident #3 laid in bed and had catheter bag on the ground not covered.On 9/11/25 at 9:58 AM Staff O, Certified Medication Technician (CMT) stated catheter bags should be maintained below level of the bladder and off the floor, a dignity bag or privacy cover over it at all times, and it should never be on the floor or uncovered. On 9/11/25 at 10:10 AM, Staff P, Licensed Practical Nurse (LPN) , Assistant Director of Nursing (ADON) stated catheter bags at bedside should not touch the floor, should be up on the bed or wheelchair, and should always be covered by a dignity bag. On 9/11/25 at 12:14 PM, the Director of Nursing (DON) stated catheter bags should be maintained below the level of the bladder up off the floor, and covered at all times. The facility provided an undated policy titled Indwelling Urinary Catheter Care and Removal which directed staff to keep the catheter and drainage tubing free from kinks to allow free flow of urine, and keep the drainage bag below the level of the patient's bladder to prevent backflow of urine into the bladder, which increases the risk of urinary tract infections (UTI). Don't place the drainage bag on the floor, to reduce the risk of contamination and subsequent UTI. 2.) On 9/10/25 at 8:11 AM Staff O, Certified Medication Technician (CMT) during medication pass she dispensed pill into hand and then placed in a medication cup. On 9/10/25 8:43 AM Staff O, CMT during medication put pills in her hand to administer to a resident. Staff O transferred the pills from the medication cup into her hand to help resident take them and then assisted to put in residents mouth. On 9/11/25 at 9:56 AM Staff O, CMT stated I take medication out of the packs and put directly into the cup. If it is in a bottle put the medication on the lid and then put in the cup. You should not put it in your hand and then put in the cup. On 9/11/25 at 10:07 AM Staff P, Licensed Practical Nurse (LPN) stated medications should be handled with gloved hands or should be punched out of the pack into the medication cup or take from envelope or bottles directly into the medication cup. If assisting a resident to get the medications in their mouth should use a spoon unless a resident requests it in their hands. On 9/11/25 at 12:03 PM the DON stated when staff dispense medication they should never touch with their hands and should put in a medication cup. The facility provided a policy titled Medication Administration - General Guidelines revised 10/2017 failed to address the handling of medications or direct staff how to dispense medications.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on employee file review, staff interviews, and facility policy review the facility failed to ensure a staff member completed the required Dependent Adult Abuse training withing six months of hire for one of eight staff reviewed (Staff S, Certified Nurse Aide). The facility reported a census of 66 residents.Findings include:Review of Staff S, Certified Nurse Aide (CNA)'s employee file listed she started on 2/27/25. The file failed to include Dependent Adult Abuse (DAA) certificate of training. The facility provided a document that reflected Staff S started on 2/20/25.The Time Card Report dated 9/10/25 revealed Staff S worked 7.75 hours that day.On 9/11/2025 at 9:59 AM, Human Resource Specialist reported new staff were required to complete the DAA training within 6 months of hire.On 9/11/25 at 10:15 AM, the Administrator reported Staff S attempted to complete the training and the system shut down on her. The Administrator confirmed Staff S failed to get the DAA training finished. The facility provided the policy titled Abuse, Neglect and Exploitation dated 4/29/25, directed facility staff shall be provided education upon hire, and at least annually thereafter, regardingResident's Rights, including freedom from abuse, neglect, mistreatment, misappropriation of property, exploitation and the related reporting requirements and obligations.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interviews, Payroll Based Journal (PBJ), and the Facility Assessment the facility failed to assess and identify the number of nursing staff needed during the week, weekends, and the different shifts. The facility reported a census of 66 residents.Findings include: The Facility assessment dated [DATE] reflected the building needed 15 full time (FT) Nurses and 28 FT Certified Nurses Aides. The Facility Assessment lacked the number of nurses and CNAs needed based on days, nights, or weekends to care for the residents. The PBJ Fiscal Year (FY) Quarter 2 2025 (January 1 - March 31) triggered for excessively low weekend staffing. On 9/08/2025 at 5:10 PM, Resident #34 reported nursing staff are less on the weekends, but her call light can take too long many days of the week, and many times of the day. She revealed the call light could take hours for staff to answer at least 4 times a week. During an interview on 9/8/25 at 1:34 PM, Resident #54 stated she had to wait over an hour before for the call light and she knew it was that long because she watched the clock. Resident #54 stated it happened on all three shifts. Resident #54 stated this morning they checked her brief and then she had to tell the staff to change her after lunch. On 9/10/2025 at 12:29 PM, the Administer explained the facility triggered for excessively low weekend staffing due to staff called in. The Administrator reported because of budget changes, they started scheduling more staff in April. On 9/11/2025 at 1:11 PM, the Administrator confirmed the Facility Assessment failed to address the number of staff needed per shift, and reported she edited it. On 9/11/2025 at 1:18 PM, the Administrator reported staffing was based on the number of resident and the type of resident on the halls. The Facility assessment dated [DATE] revealed the following per the Purpose section: The facility assessment . is a complete review of the internal human and physical resources required by the facility to care for the residents completely during the day (including nights and weekends) and emergency operations. The facility assessment identifies your capabilities as a skilled nursing service provider. The Facility Assessment will be the basis for your surveyors to ascertain whether you are prepared to completely take care of the population you have identified that you will serve.