STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165589	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oskaloosa Care Center	605 Highway 432 Oskaloosa, IA 52577

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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. 22506 Based on clinical record review and staff interviews, the facility failed to treat a resident in a dignified manner when they used excessive force to restrain the resident to obtain a urine sample. (Resident #1) The facility reported census was 81. Findings include: According to a Minimum Data Set (MDS) with a reference date of 10/23/24, Resident #1 had a Brief Mental Status (BIMS) score of 0 which indicated a severely impaired cognitive status. Resident #1 required moderate to maximal assistance transfers, mobility, dressing, toilet use and personal hygiene needs and was frequently incontinent of bladder and occasionally incontinent of bowel. Resident #1's diagnosis included Non-Alzheimer's dementia. According to a statement dated 8/19/24, written by Staff F, Certified Nurse Aide (CNA), Staff F indicated Resident #1 was not acting normally, shaking her left leg and was very upset. Staff F reported her concern to the charge nurse, Staff G, Licensed Practical Nurse (LPN), who told her the behavior was normal and to continue to monitor. Staff F indicated between 4:30 p.m. to 4:45 p.m. Resident #1 was taken to the bathroom and voided. Resident #1 continued to shake. Staff F again reported his concern to his charge nurse, Staff G, who again told her to just watch her. Staff F indicated to his knowledge, Staff G never came to the unit to assess Resident #1 during his shift. (10:00 p.m. to 6:00 a.m.). Staff F indicated he reported his concerns to the on-coming aides, Staff H and Staff I. Staff G, Licensed Practical Nurse, did not respond to requests for an interview, however according to nurse's notes and clinical record review, there were no notes or assessments of Resident #1's condition on 8/20/24, completed by Staff G. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to Progress Notes written by Staff D, Licensed Practical Nurse (LPN) on 8/20/24 at 7:30 a.m. Staff E or K, Shower Aide, summoned Staff D to the shower room, noting Resident #1 was not her normal self, had tremor like symptoms and complained of left lower leg pain. Staff D assessed Resident #1 and notified Resident #1's primary care physician (PCP). Resident #1's PCP stated he would be in that morning to see Resident #1. At 8:30 a.m. Resident #1's PCP visited and evaluated Resident #1 and gave no new orders and instructed Staff D to continue to monitor. At 12:30 p.m. Resident #1 was continuing to shake and Staff D again notified Resident #1's PCP. Resident #1's PCP provided no new orders and stated to continue to monitor. At 2:45 p.m. Staff D indicated while she was on break, another nurse, the MDS Coordinator, collected a urine sample on Resident #1. Staff D indicated she called Resident #1's PCP for an order and he declined. In an interview on 1/13/24 at 9:42 a.m. Staff D, Licensed Practical Nurse, was queried regarding a shift on 8/20/24 in which Resident #1 was not acting herself. Staff D stated she was working the 6:00 a.m. to 6:00 p. m. shift that day and assigned the memory care unit. Staff D recalled Resident #1 not being herself and notifying her PCP of her condition. Staff D stated while she was on her lunch break around 2:30 p.m. Another nurse, MDS Coordinator, got a urine sample from Resident #1. Staff D stated she was not aware of how the urine sample was obtained, but knew there was no order for it. Staff D called the PCP and asked about the urinalysis and he stated he did not give the order and to toss the urine sample. The next morning when she arrived at work, the overnight nurse, Staff C, stated she had concerns about Resident #1 having bruises and how the urine sample was obtained. In an interview on 1/13/25 at 10:43 a.m. Staff J, Shower Aide, was queried about Resident #1's condition and obtaining a UA on 8/20/24. Staff J stated that morning, she and Staff K were giving Resident #1 a shower. Resident #1 was not her normal self as she was swinging her left leg like she was in pain. Staff J stated she got the nurse, Staff D, who came in and looked at the resident and stated she would look into it. Staff J stated she and Staff K finished the shower and notified the memory care unit aides to come and get her. Staff J stated early that afternoon, she was approached by Staff L and told they needed a nurse to get a UA right away as they had Resident #1 laying down. The charge nurse, Staff D was on break, so Staff L went to the MDS Coordinator. The MDS Coordinator went to get supplies, then met Staff J, Staff L and Staff I in the room. Staff J stated she was on one side of the resident and holding Resident #1's leg. Staff J was uncertain what Staff L and Staff I were doing. Staff J stated she bent the knee of Resident #1 while spreading her legs for the MDS Coordinator, to be able to do the straight catheter. Staff J stated she did what was asked of her. Staff J stated it was not uncommon for aides to help by securing a resident's leg. According to Staff J, Resident #1 was erratic and noncompliant with the procedure, but not combative. In an interview on 1/13/25 at 12:40 p.m. Staff L, Certified Nurse Aide, was queried regarding collecting a urine sample from Resident #1 on 8/20/24. Staff L stated the girls, Staff H and Staff I, approached her and stated Resident #1 was supposed to get a urine sample and they had her in bed, but she was fighting and wanted up. Staff L stated they seemed a little panicked, so she found the MDS Coordinator and told her Resident #1 was supposed to get a UA. The MDS Coordinator responded and gathered supplies. Staff L stated Resident #1 was rowdy, kicking and swinging. Staff L stated she folded Resident #1's arms across her chest, while Staff J held her legs and the MDS Coordinator proceeded with the straight catheter. Staff L stated she did not grip or harm Resident #1's arms. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/10/25 at 1:10 p.m. the MDS Coordinator was queried regarding collecting a urine sample from Resident #1 on 8/20/24. The MDS Coordinator stated she recalled being up front filing papers when Staff L, CNA stated they needed to get a UA via straight cath for Resident #1, noting the resident was restless, but in bed and the nurse was on break. The MDS Coordinator stated she went down and with the help of Staff L and Staff J CNA, obtained the urine sample. The MDS Coordinator stated she saw the nurse, Staff D, LPN and told her she had collected the urine sample. That is when Staff D stated she had not called and got the order. The MDS Coordinator stated, Staff D made the call to the PCP and he stated to pitch it. The MDS Coordinator stated Resident #1 was swinging her arms and Staff L held her hands over hands onto Resident #1's chest and Staff J was holding Resident #1's leg. The MDS Coordinator stated she did not recall much else, noting she was focused on the peri area. The MDS Coordinator stated if a resident were too combative she would stop. In an interview on 1/13/25 at 4:32 p.m. Staff I, Certified Nurse Aide, was queried regarding collecting a urine sample from Resident #1 on 8/20/24. Staff I stated she and Staff H were the day shift (6:00 a.m. to 2:00 p.m.) aides on the memory care unit on 8/20/24. Staff I stated that morning she got a report that Resident #1 was up all night, restless and not eating. Staff I stated she got Resident #1 to the bathroom, cleaned up and dressed. After breakfast, Resident #1 was the first to get a shower and while showering, voided. Staff I stated Resident #1 never voided the rest of her shift and Staff H reported this to the nurse, Staff D. Staff I stated that the nurse, Staff D told them to lay her down and she would get an order to catheterize her for a UA. Staff I stated she and Staff H got Resident #1 into bed, but Resident #1 was restless, trying to get up, crying and uncomfortable while they waited. Finally Staff H went to get the nurse to obtain the UA. Staff D was on break, so Staff L got the MDS Coordinator and Staff J, CNA to come and help. Staff L had Resident #1's hands and arms crossed and pressed down forcibly into her chest as Staff J held Resident #1's left leg as the MDS Coordinator was cleaning her and attempting to obtain the urine via a straight catheter. Resident #1 was struggling and yelling. At one point, Resident #1 voided and Staff I questioned whether they should continue. The MDS Coordinator said yes and continued. Staff I stated she watched, but did not participate, noting it was horrifying to watch and she had never seen anyone obtain a urine sample with such force. Afterwards, Staff H made the comment to Staff L that it looked like Resident #1 had got her pretty good and Staff L responded something to the effect of that she got her better. Staff I stated in the days following, Resident #1 had multiple bruises all over her arms and on her left leg and ankle. In an interview on 1/13/25 at 6:18 p.m. Staff H, Certified Nurse Aide, was queried regarding collecting a urine sample from Resident #1 on 8/20/24. Staff H stated she and Staff I worked the day shift (6:00 a.m. to 2:00 p. m.) on the memory care unit that day. Staff H stated their nurse was Staff D. Staff H recalled Resident #1 being dry all day, which was very unusual. She reported this to the nurse, towards the end of her shift and Staff D stated she would get a UA and to put her into bed. Staff D stated she was going on break and if she had not returned right away, just keep Resident #1 in bed until she returned. Staff L asked what was going on and then took it upon herself to get the MDS Coordinator and Staff J to do the straight cath. They arrived and went into Resident #1's room, while Staff H remained with the other residents and Staff I remained in the room to observe. Staff H stated she heard Resident #1 screaming during the event. Afterwards when Staff L exited the room Staff H asked if she was ok and Staff L responded, if anything, I hurt her. Staff H thought this to be a really inappropriate comment. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/9/25 at 2:15 p.m. Staff B, Certified Nurse Aide, queried regarding collecting a urine sample from Resident #1 on 12/11/24. Staff B stated he recalled there being a urine sample in the cupboard when he arrived at work that day. Staff B stated there was a day a few months earlier in which he had concerns. Staff B stated on 8/20/24 at 1:50 p.m. he arrived at work and four staff members entered the room of Resident #1. He could hear Resident #1 yelling and after 10 minutes or so the staff members left and he went into her room. Resident #1 seemed traumatized, flailing her legs and she grabbed his wrist. Staff B stated he saw pink and red bruising on her arms and wrists and reported it to his nurse, Staff C. Staff B stated he wrote a statement and gave it to his nurse. Staff B stated Staff C also wrote a statement, but he was told they ripped it up. Staff B stated the ADON and a shower aide were two of the four he remembered going into Resident #1's room. In an interview on 1/9/25 at 3:49 p.m. Staff C, Licensed Practical Nurse, was queried regarding a urine sample collected from Resident #1 on 8/20/24. Staff C stated she remembered that evening and working a 6:00 p.m. to 6:00 a.m. shift on the memory care unit. Staff C stated Staff D, the 6:00 a.m. to 6:00 p.m. nurse, was outside vaping when she arrived to work and was upset because earlier that day, while she was on a break, the aides went to the MDS coordinator and obtained a urine sample from Resident #1 without her input or an order. Staff D indicated that Resident #1 was not her usual self that day, was not walking well, restless and her insomnia was more intense. They thought she might have a urinary tract infection. Staff D indicated she had been in contact with the PCP that day, he had seen Resident #1 that morning and he directed her to continue to monitor her and he would see her the next day. When finding out about the urine sample, Staff D contacted the PCP and informed him what had happened. The PCP told her to throw it out since he had not provided an order to collect the urine. Staff C stated she was very busy and finally around 8:00 p.m. to 9:00 p.m. she had a chance to speak with Staff B, CNA. Staff B asked her if she had seen the bruising up and down the forearm and wrist of Resident #1. Staff B went on to report several people were in Resident #1's room holding her down to get the catheter inserted for the urinalysis. Staff C stated she assessed Resident #1, filled out the skin sheets, notified the DON, filled out the physician notification form, filled out an incident report and wrote 7 pages of nurse ' s notes describing the event. Staff C stated that overnight shift, Resident #1 was surprisingly lucid and talkative. Staff C stated she texted the DON noting Resident #1 had a history of physical abuse and she felt obtaining the urine sample via a straight catheter and holding her down may have been re-traumatizing. The next evening, Staff C stated she arrived around 6:00 p.m. and met Staff D outside. According to Staff C, Staff D told her that management requested she re-write her nurse ' s note from last evening and that they had removed all of her documentation from Resident #1's record. Staff C stated she was working up front that evening, but during her shift checked Resident #1's record and her notes had been removed. Shortly after this event, Staff C stated she no longer wanted to be a part of a facility that would alter records and not look after the best interests of their residents. Staff C stated she had copies of her notes and documents and text she sent to the DON and would forward the documents to the surveyor.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 22506 Based on clinical record reviews and staff interviews, the facility failed to meet professional standards and practices as documentation was intentionally falsified and clinical records removed for 2 of 8 residents reviewed. (Resident #1, #2) The facility reported census was 81. Findings include: 1. According to a Quarterly Minimum Data Set (MDS) with a reference date of 10/23/24, Resident #1 had a Brief Mental Status (BIMS) score of 0 which indicated a severely impaired cognitive status. Resident #1 required moderate to maximal assistance with transfers, mobility, dressing, toilet use and personal hygiene needs and was frequently incontinent of bladder and occasionally incontinent of bowel. Resident #1's diagnosis included Non-Alzheimer's dementia. In an interview on 1/9/25 at 3:49 p.m. Staff C, Licensed Practical Nurse (LPN), stated she remembered the evening of 8/20/24 and working a 6:00 p.m. to 6:00 a.m. shift on the memory care unit. Staff C stated Staff D, the 6:00 a.m. to 6:00 p.m. nurse, was outside vaping when she arrived to work and was upset because earlier that day, while she was on a break, the aides went to the MDS coordinator and obtained a urine sample from Resident #1 without her input or an order. Staff D indicated that Resident #1 was not her usual self that day, was not walking well, restless and her insomnia was more intense. They thought she might have a urinary tract infection. Staff D indicated she had been in contact with the PCP that day, he had seen Resident #1 that morning and he directed her to continue to monitor her and he would see her the next day. When finding out about the urine sample, Staff D contacted the PCP and informed him what had happened. The PCP told her to throw it out since he had not provided an order to collect the urine. Staff C stated she was very busy and finally around 8:00 p.m. to 9:00 p.m. she had a chance to speak with Staff B, CNA. Staff B asked her if she had seen the bruising up and down the forearm and wrist of Resident #1. Staff B went on to report several people were in Resident #1's room holding her down to get the catheter inserted for the urinalysis. Staff C stated she assessed Resident #1, filled out the skin sheets, notified the DON, filled out the physician notification form, filled out an incident report and wrote 7 pages of Nurse's Notes describing the event. Staff C stated that overnight shift, Resident #1 was surprisingly lucid and talkative. Staff C stated she texted the DON noting Resident #1 had a history of physical abuse and she felt obtaining the urine sample via a straight catheter and holding her down may have been re-traumatizing. The next evening, Staff C stated she arrived around 6:00 p.m. and met Staff D outside. According to Staff C, Staff D, LPN told her that management requested she re-write her Nurse's Note from last evening and that they had removed all of her documentation from Resident #1's record. Staff C stated she was working up front that evening, but during her shift checked Resident #1's record and her notes had been removed. Shortly after this event, Staff C stated she no longer wanted to be a part of a facility that would alter records and not look after the best interests of their residents. Staff C stated she had copies of her notes and documents and text she sent to the DON and would forward the documents to the surveyor. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/15/25 at 1:39 p.m. the Director of Nursing (DON) was queried regarding the removal of records from Resident #1's clinical record following an event on 8/20/24 in which Resident #1 was restrained while trying to straight cath her for a urine sample. Records included Staff C's Nurse's Notes dated 8/21/24 at 3:37 a.m., three non-pressure skin condition reports reflecting bruising on Resident #1's arms discovered on 8/20/24, General Incident Report dated 8/21/24 at 9:27 p.m. signed by the DON and an Injury Investigation completed by Staff C on 8/20/24 at 9:00 p.m. and signed by the DON on 8/21/24. The DON denied removing any records involving the events on 8/20/24 and stated she vaguely remembered the event. The DON stated this was the event which staff did a straight catheter and was allegedly too rough. The DON stated she spoke with everyone and did not believe staff were too rough and claimed there were no bruising or injuries. Clinical record review conducted 1/15/24 found no Nurse's Notes dated 8/21/24 at 3:37 a.m. written by Staff C, no non-pressure skin condition reports reflecting bruising on Resident #1's arms discovered on 8/20/24, no General Incident Report dated 8/21/24 at 9:27 p.m. signed by the DON and no Injury Investigation form completed by Staff C on 8/20/24 at 9:00 p.m. and signed by the DON on 8/21/24, despite all these forms and documentation being provided to the surveyor by Staff C on 1/10/24. 2. According to a Quarterly Minimum Data Set (MDS) with a reference date of 11/27/24, Resident #2 had a Brief Mental Status (BIMS) score of 3 which indicated a severely impaired cognitive status. Resident #2 required moderate assistance with transfers, mobility, dressing, toilet use and personal hygiene needs and was frequently incontinent of bladder and occasionally incontinent of bowel. Resident #2's diagnosis included Alzheimer's and Non-Alzheimer's dementia. In a statement written 12/14/24 at 3:30 p.m. Staff P, Certified Nurse Aide, stated she witnessed Resident #3 approach Resident #2, grabbed her arm and pulled her out of her chair. Resident #2 fell to the ground onto her side. Staff P ran over and tried to get Resident #3 to move away, but he pushed her, than sat in Resident #2's chair and bent over and punched her ankle. Staff P assisted Resident #2 off the ground and into another chair. Staff O Licensed Practical Nurse (LPN) and Staff Q, Certified Med Aide (CMA) entered the unit. Staff P told them Resident #3 had pulled Resident #2 out of her chair and punched Resident #2's ankle. Staff O looked at the ankle, noting a bruise was developing and then she and Staff Q left the unit. About 10 minutes later Staff O came back in and said she was going to document it as a fall, noting she did not want to report this to the cops. Staff O asked Staff P to write a statement that she had fell . Staff P stated she did not feel this was a good idea. In a statement written by Staff Q, CMA, stated on 12/14/24 she and Staff O, LPN were at the medication cart when they heard a scream. They entered the unit to find Resident #2 on the floor, Resident #3 beside her and Staff P next to Resident #2. Staff P stated Resident #3 had pulled Resident #2 out of her chair. Staff P assisted Resident #2 into a chair, Staff O went over to talk to Resident #2 and she went back to the medication cart. A few minutes later, Staff O came back to the desk and called the DON. She described what had happened as Staff Q stated she left to get supplies. When she returned, Staff O stated the DON told her to document the incident as a fall to avoid having to contact the police. Staff Q stated she did not think that was a good idea and continued charting. According to Nurse's Notes dated 12/14/24 at 9:40 p.m. written by Staff O, Resident #2 slid out of her chair at 3:55 p.m., landing on her bottom. Staff O stated the incident was witnessed by her. Resident #2 was assessed and noted 4.0 centimeter by 3.5 centimeter on her outer right lower leg. Resident #2 assisted back into her chair. DON notified. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/15/25 at 3:48 p.m. Staff O, Licensed Practical Nurse, was queried regarding an event on 12/14/24 in which Resident #2 was pulled out of her chair by Resident #3. The event was documented as Resident #2 sliding out of her chair with no mention of the physical altercation. Staff O stated it was just her for 2 pods and hall 3 and one aide on the unit. Staff O stated she was at the nurse's station when the aide informed her Resident #2 was on the floor. Staff O was informed that Resident #3 had grabbed her arms and pulled her out of the chair. A small bruise (4.0 cm x 3.5 cm) was noted on her right leg. Staff O queried why she documented it as a fall and she responded, I do not know why I documented it that way. Staff O denied being instructed by anyone to alter her documentation.

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a qualified health professional conducts resident assessments. 22506 Based on clinical record reviews and staff interviews, the facility failed to meet professional standards and practices as documentation was intentionally falsified and clinical records removed for 2 of 8 residents reviewed. (Resident #1, #2) The facility reported census was 81. Findings include: 1. According to a Quarterly Minimum Data Set (MDS) with a reference date of 10/23/24, Resident #1 had a Brief Mental Status (BIMS) score of 0 which indicated a severely impaired cognitive status. Resident #1 required moderate to maximal assistance with transfers, mobility, dressing, toilet use and personal hygiene needs and was frequently incontinent of bladder and occasionally incontinent of bowel. Resident #1's diagnosis included Non-Alzheimer's dementia. In an interview on 1/9/25 at 3:49 p.m. Staff C, Licensed Practical Nurse (LPN), C stated she remembered the evening of 8/20/24 and working a 6:00 p.m. to 6:00 a.m. shift on the memory care unit. Staff C stated Staff D, LPN, the 6:00 a.m. to 6:00 p.m. nurse, was outside vaping when she arrived to work and was upset because earlier that day, while she was on a break, the aides went to the MDS coordinator and obtained a urine sample from Resident #1 without her input or an order. Staff D indicated that Resident #1 was not her usual self that day, was not walking well, restless and her insomnia was more intense. They thought she might have a urinary tract infection. Staff D indicated she had been in contact with the PCP that day, he had seen Resident #1 that morning and he directed her to continue to monitor her and he would see her the next day. When finding out about the urine sample, Staff D contacted the PCP and informed him what had happened. The PCP told her to throw it out since he had not provided an order to collect the urine. Staff C stated she was very busy and finally around 8:00 p.m. to 9:00 p.m. she had a chance to speak with Staff B, CNA. Staff B asked her if she had seen the bruising up and down the forearm and wrist of Resident #1. Staff B went on to report several people were in Resident #1's room holding her down to get the catheter inserted for the urinalysis. Staff C stated she assessed Resident #1, filled out the skin sheets, notified the DON, filled out the physician notification form, filled out an incident report and wrote 7 pages of nurse ' s notes describing the event. Staff C stated that overnight shift, Resident #1 was surprisingly lucid and talkative. Staff C stated she texted the DON noting Resident #1 had a history of physical abuse and she felt obtaining the urine sample via a straight catheter and holding her down may have been re-traumatizing. The next evening, Staff C stated she arrived around 6:00 p.m. and met Staff D outside. According to Staff C, Staff D told her that management requested she re-write her Nurse's Note from last evening and that they had removed all of her documentation from Resident #1's record. Staff C stated she was working up front that evening, but during her shift checked Resident #1's record and her notes had been removed. Shortly after this event, Staff C stated she no longer wanted to be a part of a facility that would alter records and not look after the best interests of their residents. Staff C stated she had copies of her notes and documents and text she sent to the DON and would forward the documents to the surveyor. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/15/25 at 1:39 p.m. the Director of Nursing (DON) was queried regarding the removal of records from Resident #1's clinical record following an event on 8/20/24 in which Resident #1 was restrained while trying to straight cath her for a urine sample. Records included Staff C's Nurse's Notes dated 8/21/24 at 3:37 a.m., three non-pressure skin condition reports reflecting bruising on Resident #1's arms discovered on 8/20/24, General Incident Report dated 8/21/24 at 9:27 p.m. signed by the DON and an Injury Investigation completed by Staff C on 8/20/24 at 9:00 p.m. and signed by the DON on 8/21/24. The DON denied removing any records involving the events on 8/20/24 and stated she vaguely remembered the event. The DON stated this was the event which staff did a straight catheter and was allegedly too rough. The DON stated she spoke with everyone and did not believe staff were too rough and claimed there were no bruising or injuries. Clinical record review conducted 1/15/24 found no Nurse's Notes dated 8/21/24 at 3:37 a.m. written by Staff C, LPN, no non-pressure skin condition reports reflecting bruising on Resident #1's arms discovered on 8/20/24, no General Incident Report dated 8/21/24 at 9:27 p.m. signed by the DON and no Injury Investigation form completed by Staff C on 8/20/24 at 9:00 p.m. and signed by the DON on 8/21/24, despite all these forms and documentation being provided to the surveyor by Staff C on 1/10/24. 2. According to a Minimum Data Set (MDS) with a reference date of 11/27/24, Resident #2 had a Brief Mental Status (BIMS) score of 3 which indicated a severely impaired cognitive status. Resident #2 required moderate assistance with transfers, mobility, dressing, toilet use and personal hygiene needs and was frequently incontinent of bladder and occasionally incontinent of bowel. Resident #2's diagnosis included Alzheimer's and Non-Alzheimer ' s dementia. In a statement written 12/14/24 at 3:30 p.m. Staff P, Certified Nurse Aide (CNA), stated she witnessed Resident #3 approach Resident #2, grabbed her arm and pulled her out of her chair. Resident #2 fell to the ground onto her side. Staff P ran over and tried to get Resident #3 to move away, but he pushed her, than sat in Resident #2's chair and bent over and punched her ankle. Staff P assisted Resident #2 off the ground and into another chair. Staff O and Staff Q entered the unit. Staff P told them Resident #3 had pulled Resident #2 out of her chair and punched Resident #2's ankle. Staff O looked at the ankle, noting a bruise was developing and then she and Staff Q left the unit. About 10 minutes later Staff O came back in and said she was going to document it as a fall, noting she did not want to report this to the cops. Staff O asked Staff P to write a statement that she had fell . Staff P stated she did not feel this was a good idea. In a statement written by Staff Q, Certified Med Aide (CMA), Staff Q, LPN stated on 12/14/24 she and Staff O were at the medication cart when they heard a scream. They entered the unit to find Resident #2 on the floor, Resident #3 beside her and Staff P next to Resident #2. Staff P stated Resident #3 had pulled Resident #2 out of her chair. Staff P assisted Resident #2 into a chair, Staff O went over to talk to Resident #2 and she went back to the medication cart. A few minutes later, Staff O came back to the desk and called the DON. She described what had happened as Staff Q stated she left to get supplies. When she returned, Staff O stated the DON told her to document the incident as a fall to avoid having to contact the police. Staff Q stated she did not think that was a good idea and continued charting. According to Nurse's Notes dated 12/14/24 at 9:40 p.m. written by Staff O, Resident #2 slid out of her chair at 3:55 p.m., landing on her bottom. Staff O stated the incident was witnessed by her. Resident #2 was assessed and noted 4.0 centimeter by 3.5 centimeter on her outer right lower leg. Resident #2 assisted back into her chair. DON notified. (continued on next page)

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/15/25 at 3:48 p.m. Staff O, Licensed Practical Nurse, was queried regarding an event on 12/14/24 in which Resident #2 was pulled out of her chair by Resident #3. The event was documented as Resident #2 sliding out of her chair with no mention of the physical altercation. Staff O stated it was just her for 2 pods and hall 3 and one aide on the unit. Staff O stated she was at the nurse's station when the aide informed her Resident #2 was on the floor. Staff O was informed that Resident #3 had grabbed her arms and pulled her out of the chair. A small bruise (4.0 cm x 3.5 cm) was noted on her right leg. Staff O queried why she documented it as a fall and she responded, I do not know why I documented it that way. Staff O denied being instructed by anyone to alter her documentation.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 22506 Based on clinical record review and staff interviews, the facility failed to ensure residents are appropriately assessed and provided interventions to maintain their optimal health and well being for 1 of 8 residents reviewed. (Resident #1) The facility reported census was 81. Findings include: According to a Quarterly Minimum Data Set (MDS) with a reference date of 10/23/24, Resident #1 had a Brief Mental Status (BIMS) score of 0 which indicated a severely impaired cognitive status. Resident #1 required moderate to maximal assistance transfers, mobility, dressing, toilet use and personal hygiene needs and was frequently incontinent of bladder and occasionally incontinent of bowel. Resident #1's diagnosis included Non-Alzheimer's dementia. According to a statement dated 8/19/24, written by Staff F, Certified Nurse Aide (CNA), Staff F indicated Resident #1 was not acting normally, shaking her left leg and was very upset. Staff F reported her concern to the charge nurse, Staff G, Licensed Practical Nurse (LPN), who told her the behavior was normal and to continue to monitor. Staff F indicated between 4:30 p.m. to 4:45 p.m. Resident #1 was taken to the bathroom and voided. Resident #1 continued to shake. Staff F again reported his concern to his charge nurse, Staff G, who again told her to just watch her. Staff F indicated to his knowledge, Staff G never came to the unit to assess Resident #1 during his shift. (10:00 p.m. to 6:00 a.m.). Staff F indicated he reported his concerns to the on-coming aides, Staff H,CNA and Staff I, CNA. Staff G, Licensed Practical Nurse, did not respond to requests for an interview, however according to Nurse's Notes and clinical record review, there were no notes or assessments of Resident #1's condition on 8/20/24, completed by Staff G.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 22506 Based on clinical record review and staff interviews, the facility failed to ensure a resident with physical aggression tendencies towards other residents was adequately supervised to prevent reoccurrences. (Residents #2, #3, #4, #7) The facility reported census was 81. Findings include: 1. According to a Significant Change Minimum Data Set (MDS) with a reference date of 11/5/24, Resident #3 had a Brief Mental Status (BIMS) score of 3 which indicated a severely impaired cognitive status. Resident #3 required moderate to maximal assistance with transfers, mobility, dressing, toilet use and personal hygiene needs and was frequently incontinent of bladder. The MDS documented that the resident had verbal, and physical behavioral symptoms directed towards others 1 to 3 times a week. Resident #3's diagnosis included Non-Alzheimer's dementia, diabetes mellitus, arthritis and psychotic disorder. Resident #3's Plan of Care indicated Resident #3 has behaviors manifested in wandering, physical and verbal aggression towards staff and residents: hitting, kicking, resistive to cares and showers, exit seeking and sexually inappropriate behaviors with female staff with goals to have a positive experience daily and interventions which include administer medications as ordered, intervene as necessary to protect the rights and safety of others, keep other residents at arms length as I feel threatened when they enter my space and when I become agitated intervene before agitation escalates;guide away from source of distress. Resident #3's Working Care Plan indicated instructions to keep distance between Resident #3 and other residents with no context within the comments section. 2. According to a Quarterly Minimum Data Set (MDS) with a reference date of 11/27/24, Resident #2 had a Brief Mental Status (BIMS) score of 3 which indicated a severely impaired cognitive status. Resident #2 required supervision to moderate assistance with transfers, mobility, dressing, toilet use and personal hygiene needs and was frequently incontinent of bladder and occasionally incontinent of bowel. The MDS documented that the resident had physical behavior towards others 1 to 3 days per week, and verbal behaviors towards other 4 to 6 days per week. Resident #2's diagnosis included Alzheimer's and Non-Alzheimer's dementia. Resident #2's Plan of Care indicated Resident #2 with behaviors manifested in refusals to interact with others,, yelling and resisting cares. Resident #2 may strike out or be physically/verbally aggressive to staff and residents with goals to have a positive experience daily and interventions which include administering medications as ordered and when becoming upset r/t stimulation, encourage resident to rest or move to another area of the unit. Resident #2's Working Care Plan indicated instructions to keep other residents out of her personal space. Comments indicated to try and keep at arms length from other residents when she is agitated and use 1:1 to help calm her. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. According to a Quarterly Minimum Data Set (MDS) with a reference date of 1/8/25, Resident #4 had a Brief Mental Status (BIMS) score of 3 which indicated a severely impaired cognitive status. Resident #4 required moderate to maximal assistance with transfers, mobility, dressing, toilet use and personal hygiene needs and was frequently incontinent of bladder and occasionally incontinent of bowel. The MDS documented the resident had physical behaviors towards others 4 to 6 times a week, and verbal behavior towards others 1 to 3 times per week. Resident #4's diagnosis included Non-Alzheimer's dementia and psychotic disorder. Resident #4's plan of care indicated Resident #4 with behaviors manifested in yelling out and resisting cares. Resident #4 may strike out, hit, kick or show physical/verbal aggression towards staff with goals to have a positive experience daily and interventions which include administering medications as ordered. Resident #4's Working Care Plan indicated instructions to come out of the unit to allow separation between her and other residents to de-escalate anxiety. 4. According to a Quarterly Minimum Data Set (MDS) with a reference date of 10/30/24, Resident #7 had a Brief Mental Status (BIMS) score of 2 which indicated a severely impaired cognitive status. Resident #7 required supervision with transfers and mobility and dependent assistance with dressing, toilet use and personal hygiene needs. Resident #7 was always incontinent of bladder and occasionally incontinent of bowel. The MDS documented the resident had physical behavior towards others 4 to 6 times per week, and verbal behavior towards others 1 to 3 times per week. Resident #7's diagnosis included Non-Alzheimer's dementia and arthritis. Resident #7's Plan of Care indicated Resident #7 may be resistive to cares and showers and behaviors manifested in hitting, striking out, yelling out and biting with goals to have a positive experience daily and interventions which include intervening as necessary to protect the rights and safety of others. Resident #7's Working Care Plan indicated no instructions related to physical aggression directed towards other residents. 1. According to an incident report dated 11/15/24 at 5:05 p.m. Resident #3 grabbed Resident #2's arm and Resident #2 responded by kicking Resident #3. The two were separated. Staff noted no injury. Staff failed to keep other residents at arms length as identified in Resident #3's plan of care. The facility also failed to adapt Resident #3's Plan of Care to prevent reoccurrences. 2. According to an incident report dated 11/29/24 at 4:15 p.m. Resident #3 approached Resident #2 and when asked what Resident #3 wanted, Resident #3 backhanded Resident #2 in the arm. The two were separated. Staff noted no injury. Staff failed to keep other residents at arms length as identified in Resident #3's Plan of Care. The facility also failed to adapt Resident #3's Plan of Care to prevent reoccurrences. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. In a statement written 12/14/24 at 3:30 p.m. Staff P, Certified Nurse Aide, stated she witnessed Resident #3 approach Resident #2, grabbed her arm and pulled her out of her chair. Resident #2 fell to the ground onto her side. Staff P ran over and tried to get Resident #3 to move away, but he pushed her, than sat in Resident #2's chair and bent over and punched her ankle. Staff P assisted Resident #2 off the ground and into another chair. Staff failed to keep other residents at arms length as identified in Resident #3's Plan of Care. The facility also failed to adapt Resident #3's Plan of Care to prevent reoccurrences. 4. According to an incident report dated 12/24/24 at 5:00 p.m. Resident #2 was sitting in a chair and yelled out as Resident #3 was passing by. Resident #3 reached across the railing and smacked Resident #2's arm and shoulder. The two were separated. Staff noted no injury. Staff failed to keep other residents at arms length as identified in Resident #3's Plan of Care. The facility also failed to adapt Resident #3's Plan of Care to prevent reoccurrences. 5. According to an incident report dated 12/25/24 at 10:50 a.m. Resident #3 walked up to Resident #4 and hit her forearm. The two were separated. Staff noted no injury. Staff failed to keep other residents at arms length as identified in Resident #3's Plan of Care. The facility also failed to adapt Resident #3's plan of care to prevent reoccurrences. 6. According to an incident report on 1/1/25 at 1:45 p.m. Resident #3 took a cookie from Resident #2 and when Resident #2 took it back, Resident #3 slapped Resident #2 in the arm. The two were separated. Staff noted no injury. Staff failed to keep other residents at arms length as identified in Resident #3's Plan of Care. The facility also failed to adapt Resident #3's Plan of Care to prevent reoccurrences. 7. According to an incident report on 1/4/25 at 4:35 p.m. Resident #4 was sitting in her merry walker when Resident #3 came up from her behind and struck Resident #4 in her shoulder. The two were separated. Staff noted no injury. Staff failed to keep other residents at arms length as identified in Resident #3's Plan of Care. The facility also failed to adapt Resident #3's Plan of Care to prevent reoccurrences. 8. According to an incident report dated 1/7/25 at 7:24 p.m. Resident #3 grabbed Resident #7's wheel walker. Resident #7 told Resident #3 to get away and Resident #3 responded by striking Resident #7 in her face three times. The two were separated. Staff noted no injury. Staff failed to keep other residents at arms length as identified in Resident #3's Plan of Care. The facility also failed to adapt Resident #3's Plan of Care to prevent reoccurrences. 9. According to an incident report dated 1/20/25 at 3:50 p.m. Resident #3 was standing at the doorway to the memory care unit and as Resident #4 propelled herself by, she lightly touched Resident #3, startling him. Resident #3 turned and swung his arm into Resident #4's chest. Staff failed to keep other residents at arms length as identified in Resident #3's Plan of Care. The facility also failed to adapt Resident #3's Plan of Care to prevent reoccurrences. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/16/25 at 2:00 p.m. the Assistant Director of Nursing (ADON) was queried regarding resident to resident events and protocols to address the events. The ADON stated the event would be documented and residents assessed for injury. They would notify the physician, family and administrative staff. The ADON stated the interdisciplinary team would get together and discuss the event and they may look into medication adjustments. The ADON was presented with multiple events in which Resident #3 had struck other residents with no interventions placed in his Plan of Care to ensure adequate supervision to prevent reoccurrences. The ADON offered no other intervention options that could be done to keep residents safe. In an interview on 1/22/25 at 2:30 p.m. Staff T, Certified Medication Aide, stated she usually is responsible for passing medications on the memory care unit and other halls adjacent to the unit. Staff T stated because of some of the behaviors in the memory care unit, she brings her medication cart into the unit, to the center of the common area to pass medications, so she can better help monitor residents. Staff T stated Resident #3 can become aggressive towards other residents unprovoked, so it is important to pay attention and redirect other residents from his space. Staff T stated the aggression was a new behavior, noting a few months ago he was stable and not spontaneously aggressive. According to Staff T, Resident #3 had gotten sick and they took away some of his medications which seemed to increase his aggression. They are now trying to reintroduce his medications and are hoping for this to help decrease his aggression. Staff T stated she thought they needed items like a busy box that residents and Resident #3 can mess with which will keep their minds engaged. On 1/22/25 at 1:20 p.m. Staff E, Certified Nurse Aide, stated she had often worked on the memory care unit and is familiar with the residents. Staff E stated Resident #3 can be aggressive and when he escalates he needs to be separated from other residents. Staff E was queried what other interventions were in place to keep residents safe. Staff F stated to just stay alert of where Resident #3 is. Staff E stated it was acceptable for Resident #3 to be next to other residents when calm.