STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195533	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Health Care at the Glen	403 E. Flournoy Lucas Shreveport, LA 71115

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - 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 record review, surveillance video review, observation, and interviews, the facility failed to protect the resident's right to be free from physical abuse and psychosocial harm by staff for 1 (#1) of 3 (#1, #2, #3) sampled residents. The actual harm resulted for Resident #1, who was cognitively impaired, on 01/09/2026 at approximately 7:58 a.m. when S4 CNA was observed on surveillance video physically abusing Resident #1. S4 CNA was observed to forcibly lift Resident #1 from a sitting to standing position three times by gripping Resident #1's left upper arm while yelling at Resident #1 Get up! resulting in multiple areas of bright purple purpura (bruising) to posterior left upper arm. S4 CNA further picked up Resident #1 by her underarms and S4 CNA dropped Resident #1 in wheelchair at the time of transfer. Because this type of inappropriate, unwanted physical abuse and being yelled at would reasonably cause anyone to have psychosocial harm, it can be determined that the reasonable person in Resident #1's position would have experienced severe psychosocial harm-dehumanization, and humiliation as a result of the physical abuse. The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. Findings:Review of the facility's Resident Abuse & Neglect Prevention & Detection policy revised 11/2022 revealed in part:Definition: Abuse - Willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.Physical Abuse - Hitting, slapping, pinching, and kicking. Controlling behavior through corporal punishment. Physical injury that results in substantial harm to the resident, or the genuine threat of substantial harm from physical injury to the resident, including an injury that is at variance with the history or explanation given. Failure to make a reasonable effort to prevent an action by another person that results in physical injury and substantial harm to the resident.Review of Resident #1's medical record revealed an admission date of 07/03/2025 to the facility's locked memory care unit. Further review of Resident #1's medical record revealed diagnoses including in part: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, other lack of coordination, Alzheimer's disease, and muscle weakness. Review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 0, indicating severe impaired cognition. Resident #1 was dependent on staff for bed-to-chair transfer. Resident #1 had adequate ability to hear, with no difficulty in normal conversation.Review of Resident #1's comprehensive care plan revealed Resident #1 was a fall risk and had an approach dated 10/22/2025 use gait belt for all transfers. Assist to transfer using one staff for transfer.Review of Resident #1's progress notes revealed a late entry note on 01/12/2026 at 7:41 a.m. note dated for 01/09/2026 at 5:26 p.m. by S1 Administrator . noted during assessment one approximately nickel-sized irregular shaped area of bright purple purpura to [Resident #1's] lateral upper left arm proximal to antecubital space. Further review revealed a late entry note on 01/12/2026 7:50 a.m. for 01/11/2026 at 2:50 p.m. by S1 Administrator .resident has multiple areas of bright purple purpura to posterior left upper arm.Review of Resident #1's weekly skin review dated 01/11/2026 by S8 LPN 4 small reddish purple areas noted to back of left [upper arm] just above the elbow.During an interview on 03/10/2026 at 1:10 p.m. S1 Administrator reported (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195533	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/16/2026

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Village Health Care at the Glen	403 E. Flournoy Lucas Shreveport, LA 71115

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F 0600 Level of Harm - Actual harm Residents Affected - Few	the time of video was 01/09/2026 at 7:58 a.m. and S6Housekeeping was in the beginning of the video speaking with Resident #1, then S4 CNA enters the room.Review of the time stamped video with audio dated 01/09/2025 at 7:58 a.m. in part: 7:58:30 a.m. S4 CNA was observed entering Resident #1's room with linen under her left arm and proceeded to enter Resident #1's closet. Observation failed to reveal S4 CNA greeted/acknowledged Resident #1 upon entering the room. S6 Housekeeping was observed standing in front of Resident #1 blocking full view of Resident #1. Resident #1 appeared to be seated on the side of the bed. S6 Housekeeping and Resident #1 were observed to be in conversation (inaudible). 7:58:44 a.m. S6 Housekeeping was observed exiting Resident #1's room and Resident #1 came into full view of the camera. Resident #1 was sitting upright on the side of the bed wearing a nightshirt and brief and was observed smiling as S6 Housekeeper exited the room. Resident #1 laughed and stated to S6 Housekeeping I'll see you later. 7:58:50 a.m. Resident #1 was observed scratching her head and asked S4 CNA I can get something to eat anyway. Can't, I? Resident #1 looked to S4 CNA as she (S4 CNA) was walking out of the closet toward Resident #1 and S4 CNA failed to respond to Resident #1. 7:58:57 a.m. S4 CNA walked over to Resident #1 with linens, a brief and clothing under her left arm. S4 CNA blocked the view of Resident #1 and appeared to pull Resident #1 up by Resident #1's left arm by S4 CNA using her right arm. S4 CNA was observed lowering her right arm and Resident #1 remained in the bed. 7:59:01 a.m. S4 CNA yelled Get up and S4 CNA grabbed Resident #1's left upper arm and pulled Resident #1 forcefully in an upward motion. Resident #1 came into full view of the camera. Resident #1 stated Wait, and was observed to grimace. Resident #1 was unable to stand and propelled in a downward motion toward the floor as S4 CNA continued to hold onto Resident #1 by her left upper arm. Resident #1 asked S4 CNA to Wait. S4 CNA continued and pulled Resident #1 back into the bed by Resident #1's upper left arm. 07:59:06 a.m. S4 CNA called Resident #1 by her first name and yelled ____, get up!. S4 CNA pulled Resident #1 up by Resident #1's left upper arm and Resident #1 stated I know. I can. 07:59:11 a.m. S4 CNA continued to hold Resident #1 by the left upper arm and swung Resident #1 around back into bed when Resident #1 was unable to stand. 07:59:16 a.m. S4 CNA yelled at Resident #1 by her first name Get up, _____! Get up, ____!). Resident #1 was observed sitting in the bed with distressed facial gestures. S4 CNA dropped the linen and clothing onto the bed and walked away from Resident #1. 07:59:23 a.m. S4 CNA moved toward Resident #1's wheelchair, grabbed a pair of shoes from the wheelchair seat, and forcefully tossed the shoes on the ground. 07:59:26 a.m. S4 CNA unlocked Resident #1's wheelchair and began to move back toward Resident #1. 07:59:34 a.m. S4 CNA rammed Resident #1's wheelchair into the wooden footboard, shaking Resident #1's bed. 07:59:37 a.m. S4 CNA approached Resident #1 with wheelchair. Resident #1 recoiled and had a frightened look on her face. Resident #1 stated I can get up, if you don't mind. S4 CNA did not respond.07:59:40 a.m. S4 CNA placed unlocked wheelchair in front of Resident #1.07:59:41 a.m. S4 CNA leaned toward Resident #1 and lifted Resident #1 away from the bed by Resident #1's underarms. S4 CNA failed to use a gait belt. 07:59:43 a.m. S4 CNA dropped Resident #1 in the unlocked wheelchair, and an audible sound of impact was heard of Resident #1's buttocks against wheelchair.07:59:44 a.m. Resident #1 grimaced and stated Ow! 07:59:46 a.m. Resident #1 touched and rubbed her left arm with right hand, moaned, and appeared to express pain.07:59:48 a.m. S4 CNA gathered the linens, a brief and clothing off Resident #1's bed.07:59:54 a.m. S4 CNA began to pull Resident #1 backwards in the wheelchair.08:00:06 a.m. Resident #1 lifted her left arm away from her body08:00:06 S4 CNA pulled Resident #1 backwards in the wheelchair toward the bathroom and the wheelchair slammed against footboard08:00:07 a.m. Resident #1 pointed towards the door and stated Go out.08:00:14 a.m. Resident #1 placed her left hand on her forehead and expressed distressed facial gestures. Resident #1 appeared frightened. 08:00:20 a.m.S4 CNA rolled Resident #1 into the unlit bathroom in Resident #1's room.08:00:23 a.m. Resident #1 and S4 CNA are out of view of the camera. 08:00:26 a.m. Resident #1 asked Am I getting my bath in here?08:00:27 a.m. Lights turned on in the bathroom.08:00:28 a.m. Resident #1 stated Oh me! 08:00:30 a.m. video ended.An observation on 03/09/2026 at 8:27 a.m. Resident #1 was resting in bed with bed in lowest (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Village Health Care at the Glen		STREET ADDRESS, CITY, STATE, ZIP CODE 403 E. Flournoy Lucas Shreveport, LA 71115	

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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 0600 Level of Harm - Actual harm Residents Affected - Few	position and wheels locked. During an interview on 03/11/2026 at 12:25 p.m. S1 Administrator confirmed S4 CNA physically abused Resident #1 by yelling Get up! multiple times and grabbing, lifting, and twisting Resident #1's left arm in an attempt to transfer, unsafely and improperly. S1 Administrator further confirmed Resident #1 looked frightened during the event. During a telephone interview on 03/11/2026 at 2:42 p.m. S2 DON confirmed the video established Resident #1 received physical abuse from S4 CNA on 01/09/2026. During an interview on 03/12/2026 at 11:14 a.m. S1 Administrator reported a reasonable person subjected to the physical abuse and verbal aggression, which occurred on 01/09/2026 to Resident #1 from S4 CNA, would have experienced physical abuse and psychosocial harm.During an interview on 03/16/2026 at 3:45 p.m. S8 LPN confirmed a weekly skin review performed on 01/11/2026 for Resident #1 found 4 small reddish purple areas on the back of left upper arm just above the elbow looked like finger prints. During an interview on 03/16/2026 at 4:28 p.m. S2 DON reported Resident #1's weekly skin review on 01/11/2026 found 4 small reddish purple areas on the back of left upper arm just above the elbow could have been from S4 CNA's finger prints.During the survey, in-service records and QA monitoring records were reviewed, and it was determined that the facility had implemented the following actions to correct the deficient practice.Review of the facility's Plan of Correction-Physical Abuse Allegation [Resident #1] QA meeting revealed with a completion date of 01/22/2026: Intervention: 1. Address how corrective actions were accomplished for resident affected:01/09/2026 12:38 p.m. allegation received. Employee identified as S4 CNA. Employee placed on suspension pending investigation-removed from facility/removed from schedule. Clocked out 12:52 p.m.01/09/2026 Local Police Department notified of allegation; Responded 4:48 p.m.01/09/2026 Body audit for injuries conducted by S2 DON or Designee. (Completed 01/09/2026)01/09/2026 Abuse screen conducted by S10 Assistant Administrator. (Completed 01/09/2026)2. Describe how other residents with potential to be affected will be identified and what will be done for them: 01/09/2026 recent incidents reviewed for locked memory care unit.S2 DON and S1 Administrator identified other residents assigned to S4 CNA with the potential to be affected. S2 DON or designee to conduct body audit for signs of potential abuse of residents assigned to S4 CNA 01/09/2026 and daily for 72hrs. (Completed 01/12/2026) S10 Assistant Administrator to conduct abuse Screenings x1 with interviewable residents of locked memory care unit. (Completed 01/09/2026)Resident #1 reviewed for fall intervention - trial of discontinuing alarms - dismantled bed alarm. 01/09/2026. S2 DON reported Resident #1's family agreed with the plan.3. Measures that will be put in place or system changes that will be made to ensure practice will not recur:All Nursing employees - abuse training.Begin 01/09/2026. Employees who do not demonstrate competency to be retrained. (Completed 01/14/2026)Abuse policy reviewed - meets requirements.Continue abuse training on hire annually- monitored by S2 DON. (Ongoing)Angel rounds weekly x4 weeks - S2 DON or Designee S1 Administrator or designeeContinue safe transfer training on hire and monitored by S2 DONContinue gait belt training on hire (Ongoing).4. Indicate how the facility plans to monitor its performance to ensure solutions are sustained. Plan for ensuring corrective action is achieved and sustained. How corrective measures will be monitored. What QA program will be put in place (who, how, how often, what will be done if problems discovered?)Walking Angel rounds started on 01/09/2026, then weekly x4 Administrator/designee then monthly as part of QA. Any issues will be addressed as found. (X4 completed 01/30/2026 and ongoing monthly) Dementia education -S2 DON/S1 Administrator started education on 01/09/2026 for current memory care unit staff. Implement dementia education with all nursing staff within, 1st 90 days of here hire. Provide dementia education with all nursing staff. (Completed with locked memory care unit Staff 7am - 3pm staff, 01/22/2026) 5. Completion date: see each area for completion dateQA Committee meeting:01/09/2026: Summary of investigation video received and reviewed. S4 CNA used inappropriate transfer techniques, failed to communicate with resident during procedure, handled resident in a rough manner. Body audit summary, Resident #1: No new injury that can be attributed to incident. Existing old bruise left hand and wrist. Existing left x-ray wrist negative for fracture. Body (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Village Health Care at the Glen		STREET ADDRESS, CITY, STATE, ZIP CODE 403 E. Flournoy Lucas Shreveport, LA 71115	

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F 0600 Level of Harm - Actual harm Residents Affected - Few	audit summary other residents who received care by S4 CNA on 01/09/2026- no physical indicators of abuse.Abuse screenings/Interviews for all 23 Residents on locked memory care unit. Resident #1: denied abuse or mistreatment. No behavior observed to indicate withdrawal, fear, stress, tearfulness or agitation. Resident #1 calm, smiling, in common area, Conversational.Abuse interview dated 01/09/2026- 23 Residents on locked memory care unit. - 1 Resident stated he did not want to answer. 11 Residents were able to respond denied abuse or mistreatment. 23 Residents on locked memory care unit. 1- Did not want to answer 11 - Unable to respond/not interviewable11 - Report feeling safeStaff interview Summary on locked memory care unit - No Staff report witnessing abuse.01/14/2026 Employee (S4 CNA) terminated. S4 CNA did not use training provided to communicate or transfer. No injury. No mental anguish. - Implement gait belt training locked memory care unit CNAs- Implement transfer training refresher with nursing staffSchedule dementia education to begin 01/20/2026Signed by: S1 Administrator, S10 Assistant Administrator, S2 DONValidation of review of the facility's Plan of Correction-Physical Abuse Allegation [Resident #1] QA meeting revealed: 1. Address how corrective actions were accomplished for resident affected: Review of the facility's reported incident binder of Resident #1's reported incident revealed date of discovery on 01/09/2026 at 12:28 p.m. Review of the facility's timesheet for S4 CNA's time sheet revealed a clocked out time of 12:52 p.m. on 01/09/2026. Review of the facility's certified letter to S4 CNA confirming termination on 01/14/2026.Review of the facility's reported incident binder revealed a police report was filed on 01/09/2026 at 4:17 p.m.Review of Resident #1's skin audit on 01/09/2026 revealed no new skin areas noted. Review of the reported incident binder revealed Abuse interview dated 01/09/2026 for 23 Residents on locked memory unit completed.2. Describe how other residents with potential to be affected will be identified and what will be done for them: During a telephone interview on 03/11/2026 at 2:42 p.m. with S2 DON reported QA meeting on 01/09/2026 reviewed locked memory care unit for falls and incidents/events for any patterns, including abuse; no concerns noted. Confirmed by review of the facility's incident list for dates 10/01/2026 through 01/09/2026 revealed no concerns. Review of the facility's body audits for Residents S4 CNA cared for on 01/09/2026 were completed on 01/09/2026, 01/10/2026 and 01/11/2026. Review of the reported incident binder revealed abuse interview dated 01/09/2026 for 23 Residents on locked memory unit completed.Review of Resident #1's discontinued physician's orders revealed discontinued orders on 01/12/2026 and 01/14/2026 after Resident #1's chair and bed alarm trials. 3. Measures that will be put in place or system changes that will be made to ensure practice will not recur:Throughout survey dates 03/09/2026 through 03/16/2026 multiple staff were interviewed across all shifts including 8 CNAs and 5 LPNs to verify inservices on abuse were completed after 01/09/2026. Review of the facility's inservice dated 01/09/2026 with the topic abuse: reporting, recognizing, and reporting with facilitators S2 DON and S3 ADON revealed instructions complete each exam and turn in to S2 DON or S3 ADON. Take a copy of each packet. All CNA and Nursing staff signed log in sheet. Review of the exams revealed signed/dated by employee and verified by administrative staff; All nursing staff signatures on form. During an interview on 03/11/2026 at 12:25 p.m. S1 Administrator reported all staff inservices on abuse were completed on 01/22/2026. Review of S4 CNA, S5 CNA, and S11 CNA employee records revealed training of abuse on hire and updated annually. Review of safety rounds for dates, 01/09/2026, 01/16/2026, 01/23/2026, and 01/30/2026 revealed no concerns. Review of S4 CNA, S5 CNA, and S11 CNA employee records revealed training of gait belt training on hire. 4. Indicate how the facility plans to monitor its performance to ensure solutions are sustained. Plan for ensuring corrective action is achieved and sustained. How corrective measures will be monitored. What QA program will be put in place (who, how, how often, what will be done if problems discovered?)During an interview on 03/11/2026 at 12:25 p.m. with S1 Administrator reported QA meeting continued to discuss safety round findings.Review of S4 CNA, S5 CNA, and S11 CNA employee records revealed training of dementia on hire and updated annually.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, observation, and interviews, the provider failed to develop and implement a comprehensive person centered care plan for each resident as evidenced by failing to implement care plan intervention for falls for 1 (#1) Resident out of 3 residents reviewed for falls.Findings: Review of Resident #1's medical record revealed an admission date of 07/03/2025 to the facility. Further review of Resident #1's medical record revealed diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, other lack of coordination, Alzheimer's disease, and muscle weakness.Review of Resident #1's comprehensive care plan revealed Resident #1 was a fall risk with approach dated 10/22/2025 fall mat to each side of bed when in bed.An observation on 03/09/2026 at 8:27 a.m. revealed Resident #1 was resting in bed with eyes closed. Further observation failed to reveal a fall mat in place to both sided of the bed.An observation on 03/09/2026 at 2:20 p.m. in Resident #1's room with S5 CNA failed to reveal fall mats in place in Resident #1's room.During an interview on 03/09/2026 at 2:20 p.m. S5 CNA confirmed Resident #1's room failed to have fall mats in place.During an interview on 03/09/2026 at 3:05 p.m. S3 ADON acknowledged Resident #1's care plan contained an intervention of a fall mat in place.An observation in Resident #1's room on 03/09/2026 at 3:10 p.m. with S3 ADON failed to reveal fall mats in place in Resident #1's room. S3 ADON confirmed Resident #1's room failed to have fall mats in place and should have.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to ensure a resident's environment remained free of accident hazards by failing to ensure a resident's room floor maintained non-skid traction for 1 (Resident #3) of 3 residents reviewed for falls. Findings: Review of the facility's Falls and Fall Risk, Managing policy dated March 2018 revealed in part: Policy Statement: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.Policy Interpretation and Implementation:DefinitionAccording to the MDS, a fall is defined as:Unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force (e.g., a resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.Fall Risk Factors1. Environmental factors that contribute to the risk of falls include:a. wet floors;3. Medical factors that contribute to the risk of falls include:e. balance and gait disorders, etc. Resident #3 was admitted to the facility on [DATE] with diagnosis including in part, displaced mid-cervical fracture of left femur, subsequent encounter for closed fracture with routine healing, and unspecified dementia. Review of Resident #3's Significant Change MDS assessment dated [DATE] revealed Resident #3 had a BIMS score of 10, indicating moderately impaired cognition. Further review of Resident #3's Significant Change MDS Assessment revealed Resident #3 required partial assist by staff for transfers and walking at least 10 feet once standing.Review of Resident #3's comprehensive care plan revealed Resident #3 had a history of falling related to impaired balance and gait with a start date of 01/22/2026 and an intervention for staff to observe frequently and place in supervised area when out of bed. Review of Resident #3's medical record revealed Resident #3 had 2 falls on 01/21/26 and 1 fall on 01/29/2026, 02/21/2026 and 02/22/2026. Review of Resident #3's fall risk assessment dated [DATE] revealed Resident #3 was a high risk for falls. An observation on 03/09/2026 at 12:00 p.m. revealed Resident #3 asleep in a recliner chair in Resident #3's room. Further observation revealed Resident #3's entire floor from entry through the walkway to Resident's #3's recliner was dry, however, slippery, shiny and had little traction upon access. During an observation of Resident #3's floor with S5CNA on 03/09/2026 at 12:10 p.m., S5CNA acknowledged Resident #3's floor was dry and slippery throughout. During an interview on 03/09/2026 at 12:10 p.m., S5CNA reported Resident #3 could slip and fall. During an observation with S6Housekeeping of Resident #3's floor on 03/09/2026 at 12:15 p.m. S6Housekeeping acknowledged Resident #3's floor was shiny and slippery through the walkway and by the bed. During an interview on 03/09/2026 at 12:15 p.m., S6Housekeeping reported she had mopped Resident #3's floor this morning with facility's standard floor cleaning solution. During an observation on 03/09/2026 at 2:10 p.m. Resident #3's floor revealed a dry reflective shine along the walk pathway of Resident #'3 floor. Further observation revealed the area was slippery with little to no traction. Further observation revealed Resident #3 was standing up by the recliner next to the bed. During an interview on 03/09/2026 at 2:10 p.m. Resident #3 reported sometimes the floor is slippery and sometimes the floor feels like glue and my shoes get stuck. During an observation of Resident #3's floor with S7LPN on 03/09/2026 at 2:50 p.m., S7LPN acknowledged the flooring was slippery with little traction. During an interview on 03/09/2026 at 2:50 p.m. S7LPN reported Resident #3's slippery floor posed a fall risk. During an observation of Resident #3's room with S3ADON on 03/09/2026 at 3:10 p.m., S3ADON acknowledged Resident #3's floor was slick with little traction throughout the walking pathway into the room and around the bed. During an interview on 03/09/2026 at 3:10 p.m., S3ADON acknowledged Resident #3's floor was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	slippery and Resident #3 was at high risk for falls. During an observation of Resident #3's room with S1Administrator on 03/09/2026 at 3:45 p.m., S1Administrator acknowledged Resident #3's floor was shiny and slippery. During an interview on 03/09/2026 at 3:45 p.m., S1Administrator reported facility floors had never been waxed and were mopped with house cleaner. S1Administrator acknowledged the condition of Resident #3's floor was a fall hazard. During an interview on 03/09/2026 at 4:00 p.m., S9Housekeeping Supervisor reported she had examined Resident #3's room and confirmed Resident #3's floor was slippery. An observation on 03/10/2026 at 2:40 p.m. revealed Resident #3's floor had shiny reflective areas and a slippery surface throughout the room. During an interview on 3/10/2026 at 2:45 p.m., S1Administrator acknowledged Resident #3's floor was slippery and Resident #3 had a history of falls in Resident #3's room and bathroom.