STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195537	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Guest House Care Center	10145 Florida Blvd Baton Rouge, LA 70815

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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 - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, interviews and record review, the facility failed to protect the resident's right to be free from physical and mental abuse by Resident #86 for 4 (#19, #46, #61, and #63) of 5 residents reviewed for abuse. Findings: Review of the Policy, Abuse- Prevention and Prohibition Policy and Procedure, dated 03/25/2023 revealed the following: Policy: To provide a safe, abuse free environment for all residents. Types of abuse- Abuse is the willful infliction of injury, intimidation with resulting in physical harm, pain or mental anguish. Our policy presumes that abuse of any resident, even a resident in a coma, causes physical harm, pain, or mental anguish. Verbal abuse is the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to residents regardless of their age, ability to comprehend or disability. Name calling, cursing or yelling at a resident in anger. Physical abuse may include hitting, slapping, pinching, biting, shoving, and kicking. Mental abuse includes but is not limited to humiliation, harassment.Examples: taunting or teasing a resident Resident #86 A review of Resident #86's Medical Record revealed the resident was admitted to the facility on [DATE] with diagnosis which included Alzheimer's Disease, Psychotic Disorder Not Due To A Substance Or Known Psychological Condition, Mild Neurocognitive Disorder Due To Known Psychological Condition With Behavioral Disturbance, Restlessness And Agitation, Cognitive Communication Deficit, and Anxiety Disorder. A review of Resident #86's Quarterly MDS with an ARD 04/22/2026, revealed, in part, the resident was assessed by the facility to have a BIMS of 9, which indicated he was moderately cognitively impaired. Further review revealed Resident #86 was ambulatory without assistance. A review of Resident #86's Nurses Notes dated 04/12/2026 revealed Resident #86 poured coffee on resident #63 outside in the courtyard. Video footage showed Resident #86 pour a beverage in the (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	direction of Resident #63. Video quality and camera angle could not determine if direct physical contact occurred. Resident #63 and #86 were immediately separated and monitored by staff. Resident #86 was transferred to the emergency room for further evaluation. A review of Resident #86's Psychiatric NP progress note dated 04/13/2026 revealed the following: Review of Systems: Positive irritability and psychiatric symptoms Mental Status: Mood: irritable Judgement: Impaired ability to make reasonable decisions: Moderate Narrative: Staff reported recent altercation with peer, increased irritability. A review of Resident #86's Nurses notes, dated 05/05/2026 revealed Resident #86 was pacing around the flower bed outside in the courtyard and hit Resident #46 twice in the back and hit S1ADM when he attempted to separate the residents. Resident #86 refused an assessment, S13NP was notified, and ordered to transfer Resident #86 to emergency room for further evaluation. A review of Resident #86's NP Progress Notes, dated 05/05/2026 revealed Resident #86 seen today after he punched Resident #46. Resident #86 is very agitated, yelling, cursing at staff and myself. Plan: Resident #86 will continue to have behaviors/outburst related to advanced cognitive impairment. Resident #86 placed under PEC today and sent to emergency room for further evaluation. Review of the State Reported Incident revealed the following: Description: physical abuse Investigation: On 05/05/2026 at 9:30 p.m., Resident #86 hit Resident #46 with a closed fist, took his glasses and hat, and would not give the items back. A review of Resident #86's Nurses notes, dated 05/07/2026 revealed Resident #86 went outside in the courtyard and knocked Resident #61's hat off. Resident #86 then began fighting with Resident #19. Residents were separated and Resident #86 was escorted back to his room. Resident #86 ran back outside and pushed Resident #61 out of his wheelchair and onto the ground. Resident #19 then kicked and punched Resident #86. Review of the State Reported Incident revealed the following: Description: physical abuse Investigation: On 05/07/2026, Resident #86 became aggressive with Resident #19. S5CNA separated Resident #19 and brought Resident #86 back to his room. S5CNA then left Resident #86 unattended to get the nurse. During this time Resident #86 went back outside and pushed Resident #61 out of his wheelchair and punched Resident #61. Resident #19 then punched Resident #86 in order to get Resident #86 off of Resident #61. A review of Resident #86's care plan, initiated on 10/08/2025 revealed: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Problem: Resident #86 has a behavior problem related to behaviors escalating this shift. Resident #86 seen lunging at residents and staff. Interventions: 10/08/2025 sent to the hospital for evaluation due to aggressive behaviors. 04/12/2026 sent to the hospital for evaluation due to aggressive behaviors and Q hour safety checks for 72 hours was implemented. 05/05/2026 sent to the hospital for evaluation due to aggressive behaviors and Q hour safety checks for 72 hours was implemented. 05/07/2026 sent to the hospital for evaluation due to aggressive behaviors and Q hour safety checks for 72 hours was implemented. 05/13/2026 Resident #86 returned to facility and placed on 1:1 supervision. Discontinued 1:1 supervision on 05/22/2026 05/28/2026 Resident #86 placed on 1:1 supervision. On 05/31/2026 at 10:58 a.m., an observation was conducted of Resident #86 sitting on the bench outside in the courtyard with other residents, including Resident #46, and no staff in sight. On 05/31/2026 at 11:54 a.m., an observation was conducted of Resident #86 sitting on the bench outside in the courtyard with other residents and no staff in sight. On 05/31/2026 at 1:05 p.m., an observation was conducted of Resident #86 lying on the bench outside in the courtyard with other residents, including Resident #46, and no staff in sight. On 06/01/2026 at 10:00 a.m., an interview was conducted with Resident #86. Resident #86 stated he did not know how long he lived at the facility. He denied fighting, hitting other residents or taking other residents personal items. On 06/01/2026 at 12:28 p.m., an observation was conducted of Resident #86 outside in the courtyard with other residents and no staff in sight. A review of the 1:1 supervision scheduled revealed S22CNA was assigned to provide 1:1 supervision to Resident #86 on 05/31/2026 and 06/01/2026 from 6:00 a.m. to 2:00 p.m. An interview was conducted with S22CNA at 12:30 p.m. after she entered the courtyard. She stated on 05/31/2026 and 06/01/2026 she was assigned to 1:1 supervision of Resident #86 due to his history of aggressive behaviors with other residents. She confirmed she left Resident #86 unsupervised with other residents multiple times during her shift on 05/31/2026 and on 06/01/2026. Resident #63 A review of Resident #63's Medical Record revealed the resident was admitted to the facility on [DATE] with diagnosis which included Other Sequelae of Cerebral Infarction and Acquired Absence of Left Leg above the Knee. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #63's Annual MDS with an ARD 04/01/2026, revealed, in part, the resident was assessed by the facility to have a BIMS of 8, which indicated he was moderately cognitively impaired. Further review revealed Resident #63 was non ambulatory and required a wheelchair for mobility. A review of Resident #63's incident report, dated 04/12/2026 at 9:15 a.m. revealed Resident #63 reported a physical altercation between himself and Resident #86. Both Resident #63 and #86 were placed on hourly safety checks. On 06/02/2026 at 9:30 a.m., an interview were conducted with Resident #63. Resident #63 stated on 04/12/2026 Resident #86 stood over him in his wheelchair, threw coffee on him, and slapped him with an open fist outside in the courtyard. Resident #63 stated he did not know why Resident #86 did that. On 06/01/2026 at 11:54 a.m., an interview was conducted with S13NP. She stated on 04/12/2026, S2DON contacted her and reported Resident #63 and Resident #86 were outside in the courtyard when Resident #86 poured coffee on Resident #63 and both residents started swinging open fist at each other. She stated it was not abuse because there was no indication Resident #63 was affected by it. On 06/01/2026 at 12:05 p.m., an interview was conducted with S2DON. S2DON stated on 04/12/2026 Resident #63 and Resident #86 were outside in the courtyard when Resident #86 poured coffee on Resident #63 and both residents started swinging open fist at each other. S2DON stated neither Resident #63 nor Resident #86 had any injuries. S2DON stated both residents were placed on hourly monitoring for 72 hours. He further stated the incident was not abuse because there was not a willful intent by Resident #63 or Resident #86. On 06/02/2026 at 1:34 p.m., an interview was conducted with S1ADM. He stated on 04/12/2026 he was notified Resident #63 and Resident #86 were outside in the courtyard and had an altercation. He stated he placed both residents on increased hourly checks and interviewed both Resident #63 and #86. He stated he reviewed the video footage and Resident #86 was standing over Resident #63, who was sitting in his wheelchair, they exchanged words, and both residents started swinging open fist at each other but no contact was made. S1ADM stated standing over someone could be intimidating but not in this scenario and it was not abuse because there was not any willful action or ill intent. Resident #46 A review of Resident #46's Medical Record revealed the resident was admitted to the facility on [DATE] with diagnosis which included Vascular Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, Anxiety, Cognitive Communication Deficit, and Personal History Of Adult Psychological Abuse. A review of Resident #46's Quarterly MDS with an ARD 03/25/2026, revealed, in part, the resident was assessed by the facility to have a BIMS of 12, which indicated he was moderately cognitively impaired. A review of Resident #46's Nurses Note, dated 05/05/2026 11:56 a.m., revealed Resident #46 reported Resident #86 hit him in the back of the head when he was outside in the courtyard. A review of Resident #46's NP Progress Note dated 05/07/2026 revealed Resident #46 had a past medical history of mental delay/dementia. Resident #46 was seen today after Resident #86 hit Resident #46 outside in the courtyard. Resident #46 reported back pain and headache. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/31/2026 at 10:00 a.m., an interview was conducted with Resident # 46. Resident #46 stated he had brain damage from when he was a child. Resident #46 stated he knew Resident #86 and one day Resident #86 had a brick, acted like he was going to throw it and he ran away because he was scared. Resident #46 was not able to provide any other details of the incident. Resident #46 stated he saw Resident #86 knock Resident #61's hat off his head and Resident #86 acted like a bully. Resident #46 stated he was scared of Resident #86 and tried to stay away from Resident #86. On 05/31/2026 at 2:27 p.m., an interview was conducted with S3CNAS. S3CNAS stated on 05/05/2026 around 9:30 a.m., she passed the courtyard door and saw Resident #86 hit Resident #46 with a closed fist and take Resident #46's hat and throw it in the trash can. S3CNAS stated she immediately went outside to the courtyard and signaled for S1ADM to come outside. S3CNAS stated Resident #86 would not let anyone remove Resident #46's hat from the trash can, became more aggressive and began pacing in the courtyard. S3CNAS stated they contacted the local police department and the paramedics. On 06/01/2026 at 9:31 a.m., an interview was conducted with S8AB. S8AB stated Resident #86 did not get along with #46, got agitated when #46 was outside in the courtyard, took #46's hat and sunglasses away from him and would not return them. S8AB stated one day she saw Resident #46 outside walking in the courtyard when Resident #86 took Resident #46's sunglasses and would not give them back. S8AB stated Resident #46 told her he did not like Resident #86 because Resident #86 bullied him and it made Resident #46 sad. 0n 06/02/2026 at 12:44 p.m., an interview was conducted with S17CNA. S17CNA stated she witnessed Resident #86 take Resident #46's sunglasses away from him. S17CNA could not recall the date the incident occurred, but she reported it to S18CNA and S18CNA was able to retrieve Resident #46's sunglasses. On 06/02/2026 at 11:41 a.m., an interview was conducted with S18CNA. S18CNA stated one day S17CNA reported to her Resident #86 took Resident #46's sunglasses and would not return them. S18CNA stated she went outside to the courtyard and asked Resident #86 for Resident #46's sunglasses. She stated Resident #86 returned the sunglasses to her and she reported the incident to administration. On 06/02/2026 at 1:34 p.m., an interview was conducted with S1ADM. S1ADM stated on 05/05/2026, S3CNAS signaled him for assistance outside in the courtyard. S1ADM stated S3CNAS reported Resident #86 hit Resident #46 with a closed fist. S1ADM stated when he arrived outside in the courtyard, Resident #86 had taken Resident #46's hat and thrown it in the trash can. S1ADM stated Resident #86 would not let anyone remove Resident #46's hat from the trash can, became more aggressive and began pacing in the courtyard while wearing Resident #46's sunglasses. S1ADM notified S13NP who arrived outside in the courtyard and ordered Resident #86 to be sent to the hospital for an evaluation. S1ADM stated Resident #86 returned to the facility after a few hours and was placed on increased hourly monitoring for 72 hours. He confirmed hitting another resident was abuse but there had to be willful intent. S1ADM further stated that Resident #86 knocking hat's off other residents or taking other residents glasses invaded their space and was a type of bullying. On 06/02/2026 at 4:00 p.m., an interview was conducted with S20SW. S20SW stated Resident #46 was mentally slow but able to communicate his needs. S20SW reviewed Resident #46's medical record and confirmed he had a diagnosis of Personal History of Adult Psychological Abuse. S20SW stated Resident #86's bullying behavior could be intimidating only if Resident #46 did not know (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #86. S20SW confirmed knocking a hat off someone's head or taking someone's personal items were examples of bullying behavior but stated Resident #46 did not feel threatened and Resident #86 just had an off day. On 06/02/2026 at 5:06 p.m., an interview was conducted with S19LPN. S19LPN stated Resident #46 was childlike but communicated his needs. S19LPN reviewed Resident #46's medical record and confirmed he had a diagnosis of Personal History of Adult Psychological Abuse. S19LPN confirmed the diagnosis meant he was abused as an adult and would be more vulnerable to mental abuse if someone was bullying him. S19LPN stated on 05/28/2026 Resident #46 reported he was uncomfortable outside with Resident #86 unsupervised and would stay in his room when Resident #86 was unsupervised. S19LPN stated 1:1 supervision was started for Resident #86 on 05/28/2026 after Resident #46 reported he was afraid. On 06/03/2026 at 9:45 a.m., an interview was conducted with S13NP. S13NP stated on 05/05/2026 Resident #86 punched Resident #46. S13NP stated she immediately assessed Resident #46 following the incident and Resident #46 voiced he was scared of Resident #86 and was observed visibly shaken up. On 06/03/2026 at 11:23 a.m., an interview was conducted with S21PNP. S21PNP stated he was familiar with both Resident #86 and #46. S21PNP stated Resident #46 was childlike but able to communicate his needs. S21PNP confirmed he had a diagnosis of Personal History of Adult Psychological Abuse and stated abuse could trigger memories for Resident #46. Resident #61 A review of Resident #61's Medical Record revealed the resident was admitted to the facility on [DATE] with diagnosis which included Unspecified Sequelae of Cerebral Infarction, Generalized Anxiety Disorder, and Depression. A review of Resident #61's Quarterly MDS with an ARD 05/06/2026, revealed, in part, the resident was assessed by the facility to have a BIMS of 12, which indicated he was cognitively intact. Further review revealed Resident #61 was non ambulatory and required a wheelchair for mobility. A review of Resident #61's NP Progress Note dated 05/08/2026 revealed Resident #61 was seen today following an altercation last night with Resident #86. Resident #61 reported Resident #86 hit him a few times. Abrasions noted to the left side of Resident #61's face. A review of Resident #61's Nurses note dated 05/07/2026 revealed Resident #61 was outside in the courtyard when Resident #86 knocked his hat off his head, scratched Resident #61's left side of his face and later knocked Resident #61 out of his wheelchair onto the concrete. Resident #61 was assisted up in his wheelchair, provided first aid and neuro checks initiated. Resident #61 reported pain 4/10 on the pain scale, Tylenol administered as ordered. Resident #61 noted with an abrasion to right outer ankle, right elbow, bruise to left jaw, and two scratches to the left side of the face. On 05/31/2026 at 10:30 a.m., an interview was conducted with Resident #61. He stated on 05/07/2026 around 4 or 5 p.m., he was outside with Resident #19 sitting in his wheelchair when Resident #86 knocked his hat off his head and swung his fist at him. Resident #61 stated staff came outside, separated them, and escorted Resident #86 back to his room. Resident #61 stated Resident #86 was unattended and came back outside and pushed him out of his wheelchair and onto the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ground. He stated Resident #86 and Resident #19 were swinging closed fist at each other. Resident #61 stated staff came back outside, separated Resident #86 and #19 and assisted him back into his wheelchair. Resident #61 stated staff escorted him back inside the facility away from Resident #86. He stated he had a scrap on his elbow, ankle and left side of his face from the incident. Resident #19 A review of Resident #19's Medical Record revealed the resident was admitted to the facility on [DATE] with diagnosis which included Unspecified Sequelae of Cerebral Infarction and Other Psychoactive Substance Abuse, In Remission. A review of Resident #19's Quarterly MDS with an ARD 04/15/2026, revealed, in part, the resident was assessed by the facility to have a BIMS of 11, which indicated he was moderately cognitively impaired. A review of Resident #19's Nurses note dated 05/07/2026 revealed Resident #19 hit Resident #86 attempting to get Resident #86 off of Resident #61. Resident #19 noted with no injuries. A review of Resident #19's NP Progress Note dated 05/08/2026 Resident #19 was involved in an altercation on 05/07/2026. Resident #19 stated he was defending another resident and hit Resident #86. On 06/02/2026 at 3:19 p.m., an interview was conducted with Resident #19. He stated on 05/07/2026, he walked outside, Resident #86 slapped Resident #61's hat off his head, and slapped the s**t out of Resident #61. Resident #19 stated him and Resident #86 started swinging open fist at each other. Resident #19 stated S5CNA came outside, broke up the fighting and escorted Resident #86 back to his room. Resident #19 stated a few minutes later Resident #86 came back outside and pushed Resident #61 out of his wheelchair and onto the ground. Resident #19 stated Resident #86 punched him in the chest and he kicked and punched Resident #86 before staff separated them again. He stated he was not scared of Resident #86 but Resident #46 had told him he was scared of Resident #86. He stated he defended Residents #46 and #61 because Resident #86 picked on residents that could not take care of themselves. He stated Resident #86 thought everything belonged to him, slapped other residents around, called Resident #46 stupid, hit Resident #46, and would knock Resident # 46's hat off his head or take his sunglasses. He stated Resident #86 tried to bully him. On 06/01/2026 at 1:35 p.m., an interview was conducted with S5CNA. S5CNA stated Resident #86 was aggressive with Resident #46 and #61. S5CNA stated Resident #86 would walk by Resident #46 and #61 and knock their hat off their head, laugh and/or take something away from them. S5CNA stated #86 would also pass by Resident #46 and call him a tattletale. S5CNA confirmed Resident #86's behaviors were intimidating, bulling and abusive. S5CNA stated Resident #86 had these behaviors when staff were not around and when staff watched him he did not have the behaviors toward Resident #46 and #61. S5CNA stated she completed an hourly safety check at 6:00 p.m., and at 6:37 p.m. a resident came inside from the courtyard and reported Resident #86 and Resident #19 were fighting. S5CNA stated when she walked outside Resident #86 and #19 were both standing and swinging with open hands at each other. S5CNA stated she got between them, separated them and then escorted Resident #86 to his room. S5CNA stated she told Resident #86 to stay in his room and he said, I might but no guarantee. S5CNA stated she left Resident #86 unattended to get the nurse and when she was walking back down the hall, Resident #86 was back outside fighting again. S5CNA stated when she arrived outside Resident #61 was on the ground and his wheelchair was knocked (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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure a resident received puree food prepared in a form designed to meet individual needs for 1 (#100) of 2 residents reviewed for nutrition. This deficient practice had the potential to affect 10 residents who consume puree food from the facility's kitchen.Findings:Review of Resident #100's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Cerebral Infarction and Dysphagia. Review of Resident #100's current, physician orders revealed the following, in part:Start Date: 04/03/2026; Pureed texture, Nectar/Mildly Thick ConsistencyReview of Resident #100's current Care Plan revealed the following, in part:Problem: The resident has nutritional problem or potential nutritional problem r/t puree.Interventions: Provide and serve diet as ordered.On 06/01/2026 at 12:08 p.m., an observation was made of Resident #100 eating lunch in the dining room. Observation of her lunch revealed the red beans were noted with small lumps throughout and white rice appeared sticky and grainy throughout. Additionally, the greens served appeared stringy with stems still visible.On 06/01/2026 at 12:25 p.m., an observation was made of a puree trial tray provided by the facility's kitchen staff. Observation of the pureed solids revealed the red beans were noted with small lumps throughout and white rice appeared sticky and grainy throughout. Additionally, the greens served appeared stringy with stems still visible.On 06/01/2026 at 12:17 p.m., an interview was conducted with S9SP. She stated she noticed Resident #100's puree solids served during lunch appeared chunky. She stated puree solids should be smooth throughout. She further stated puree solids should not be sticky, grainy, lumpy or stringy. She confirmed Resident #100 is on a pureed diet. She confirmed failure to provide an appropriate pureed consistency increases the risk of choking and/or aspiration.On 06/01/2026 at 12:55 p.m., an interview was conducted with S11DM. She stated she was responsible for training all new, dietary staff on how to properly prepare pureed solids. She stated she did not thoroughly inspect the puree solids prepared for lunch and should have. She confirmed puree solids should not be sticky, grainy, lumpy or stringy.On 06/03/2026 at 8:21 a.m., an interview was conducted with S2DON. He stated he expected his kitchen staff to serve pureed solids that are smooth throughout in order to minimize risk of choking and/or aspiration. He confirmed 10 residents consume puree food from the facility's kitchen.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations, interviews, and record review the facility failed to ensure residents had a clean, and homelike environment for 1 (#72) of 1 Resident's reviewed for Environment. Findings: On 05/31/2026 at 12:27p.m., an observation was conducted of Resident #72's bathroom which revealed the ceiling had splotchy gray colored substance covering approximately 2/3 the ceiling. On 06/01/2026 at 12:00 p.m., a second observation was conducted of Resident #72's bathroom which revealed the ceiling had a splotchy gray colored substance covering approximately 2/3 of the ceiling. On 06/02/2026 at 1:00 p.m., a review of the facility's maintenance log for the previous three months revealed no evidence of Resident #72's bathroom ceiling was reported for maintenance. On 06/02/2026 at1:58 p.m., an interview was conducted with S15MS. S15MS confirmed on 06/01/2026, and 06/02/2026 he was in Resident #72's bathroom fixing her toilet and never noticed the ceiling. He confirmed the staff had not put in a work order for the ceiling, and he did not complete proactive rounds of resident's rooms unless the staff notified him of an issue. He confirmed Resident #72's bathroom ceiling needed to be treated as the substance appeared to be mold or mildew which should not be on the bathroom ceiling. On 06/02/2026 at 4:30 p.m., an interview was conducted with S1ADM. S1ADM confirmed he was unaware of the substance on Resident #72's bathroom ceiling. He confirmed the bathroom ceiling should not contain the substance.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to report allegations of mental and physical abuse to the State Survey Agency immediately, but no later than 2 hours, for 3 (#19, #61, and #63) of 5 residents reviewed for abuse. The provider failed to ensure staff:Reported allegations of abuse when Resident #86 physically abused Resident #63 on 04/12/2026; and Reported allegations of abuse when Resident #86 physically abused Residents #19 and #61 on 05/07/2026. Findings:Cross Reference F600 Review of the Policy, Abuse- Prevention and Prohibition Policy and Procedure, dated 03/25/2023 revealed the following:Policy: to provide a safe, abuse free environment for all residents. It you suspect verbal, physical or mental abuse of a resident contact the administrator immediately. Types of abuseAbuse is the willful infliction of injury, intimidation with resulting in physical harm, pain or mental anguish. Our policy presumes that abuse of any resident, even a resident in a coma, causes physical harm, pain, or mental anguish. Verbal abuse is the use of oral, written or gestured language that willfully includes disparaging or derogatory terms to residents regardless of their age, ability to comprehend or disability. Name calling, cursing or yelling at a resident in anger. Physical abuse may include hitting, slapping, pinching, biting, shoving, and kicking. Mental abuse includes but is not limited to humiliation, harassment.Examples: taunting or teasing a resident7. Reporting / Response- the facility employee or covered individual who becomes aware of abuse shall IMMEDIATELY report the matter to the facility administrator. The administrator shall immediately initiate a report to the state agency but not less than 2 hours after forming the suspicion of a crime if the alleged violation involves abuse (physical, verbal abuse and mental abuse) 1.Resident #86A review of Resident #86's Medical Record revealed Resident #86 was admitted to the facility on [DATE]. Resident #63A review of Resident #63's Medical Record revealed Resident #63 was admitted to the facility on [DATE]. A review of Resident #63's incident report, dated 04/12/2026 at 9:15 a.m. revealed Resident #63 reported a physical altercation between himself and Resident #86. A review the facility's State Agency Reported Incidents reviewed from June 2025 to June 2026 revealed no reported incident on 04/12/2026 regarding the physical altercation between Resident #63 and #86. On 06/02/2026 at 9:30 a.m., an interview was conducted with Resident #63. Resident #63 stated on 04/12/2026 Resident #86 stood over him in his wheelchair, threw coffee on him, and slapped him with an open fist outside in the courtyard. On 06/01/2026 at 11:54 a.m., an interview was conducted with S13NP. She stated on 04/12/2026, S2DON contacted her and reported Resident #63 and Resident #86 were outside in the courtyard when Resident #86 poured coffee on Resident #63 and both residents started swinging open fist at each other. 2.Resident #19A review of Resident #19's Medical Record revealed Resident #19 was admitted to the facility on [DATE]. Resident #61 A review of Resident #61's Medical Record revealed Resident #61 was admitted to the facility on [DATE]. A review the facility's State Agency Reported Incidents from June 2025 to June 2026 revealed no reported incident on 05/07/2026 regarding Residents #19, #61, and #86. On 05/31/2026 at 10:30 a.m., an interview was conducted with Resident #61. He stated on 05/07/2026 around 4 or 5 p.m., he was outside with Resident #19 sitting in his wheelchair when Resident #86 knocked his hat off his head and swung his fist at him. Resident #61 stated staff came outside, separated them, and escorted Resident #86 back to his room. Resident #61 stated Resident #86 was unattended and came back outside and pushed him out of his wheelchair and onto the ground. He stated Resident #86 and Resident #19 were swinging closed fist at each other. He stated he had a scrap on his elbow, ankle and left side of his face from the incident. On 06/02/2026 at 3:19 p.m., an interview was conducted with Resident #19. He stated on 05/07/2026, he walked outside, Resident #86 slapped Resident #61's hat off his head, and slapped the s**t out of Resident #61. Resident #19 stated him and Resident #86 started swinging open fist at each other. Resident #19 stated S5CNA came outside, broke up the fighting and escorted Resident (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#86 back to his room. Resident #19 stated a few minutes later Resident #86 came back outside and pushed Resident #61 out of his wheelchair and onto the ground. Resident #19 stated Resident #86 punched him in the chest and he kicked and punched Resident #86 before staff separated them again. On 06/01/2026 at 1:35 p.m., an interview was conducted with S5CNA. S5CNA stated on 05/07/2026 at 6:37 p.m. a resident came inside from the courtyard and reported Resident #86 and Resident #19 were fighting. S5CNA stated when she walked outside Resident #86 and #19 were both standing and swinging with open hands at each other. S5CNA stated she got between them, separated them and then escorted Resident #86 to his room. S5CNA stated she left Resident #86 unattended to get the nurse and when she was walking back down the hall, Resident #86 was back outside fighting again. S5CNA stated when she arrived outside Resident #61 was on the ground and his wheelchair was knocked over. S5CNA stated Resident #86 was still swinging his closed fist at Resident #61. On 06/01/2026 at 12:05 p.m., an interview was conducted with S2DON. S2DON stated on 04/12/2026 Resident #63 and Resident #86 were outside in the courtyard when Resident #86 poured his coffee on Resident #63 and they both started swinging open fist at each other. S2DON stated on 05/07/2026, there was an alteration that happened outside with Resident #19, #61 and #86. S2DON stated Resident #86 did something with Resident #61's hat, S5CNA separated them and escorted Resident #86 back to his room. He stated Resident #86 then walked past S5CNA, went back outside, pushed Resident #61 out of his wheelchair and was swinging closed fist at Resident #61 who was down on the ground. S2DON stated then Resident #19 punched Resident #86 in the face. S2DON reported S1ADM would be responsible for reporting incidents to the state agency. On 06/02/2026 at 1:34 p.m., an interview was conducted with S1ADM. S1ADM stated he was responsible for reporting abuse allegations to the state agency. He stated on 04/12/2026 Resident #63 and Resident #86 were outside and had an altercation. He stated he reviewed the video footage and Resident #86 was standing over Resident #63, who was sitting in his wheelchair, they exchanged words, and both started swinging open fist at each other but no contact was made. S1ADM it was not abuse because there was not any willful action or ill intent and was not reported to the state agency. S1ADM stated on 05/07/2026, there was an alteration with Resident #19, #61 and #86. S1ADM stated Resident #86 did something with Resident #61's hat, S5CNA separated them and escorted Resident #86 back to his room. He stated Resident #86 then walked past S5CNA, went back outside, pushed Resident #61 out of his wheelchair and was swinging closed fist at Resident #61 who was down on the ground. S1ADM stated then Resident #19 punched Resident #86 in the face. S1ADM stated Resident #61 had scratches on his elbow and a small laceration on his face and Resident #85 had a gash on his forehead. He confirmed he did not report to the state agency on 05/07/2026 because he did not know he needed to.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure interventions for dysphagia were implemented as identified on the care plan and in physician orders for 1 (#65) of 2 residents reviewed for tube feeding. Findings: Review of Resident #65's Clinical Record revealed she was admitted to the facility on [DATE] and had diagnoses, which included Alzheimer's Disease, Cerebral Infarction, Dysphagia, and Gastronomy status. Review of Resident #65's Quarterly MDS with an ARD of 12/31/2025 revealed a BIMS of 8, which indicated her cognition was moderately impaired. Review of Resident #65's current, physician orders revealed the following, in part: Start date: 04/01/2025; NPO diet related to Dysphagia following Cerebral Infarction Review of Resident #65's current Care Plan revealed the following, in part:Date initiated: 12/16/2024Problem: The resident requires tube feeding via PEG. Resident is NPO.Interventions: The resident needs assistance with tube feeding. See MD orders for current feeding orders. On 05/31/2026 at 12:12 p.m., an observation was made of Resident #65 in her room. An unsealed bottle of mouthwash was observed on Resident #65's bedside table within her reach. On 06/02/2026 at 10:03 a.m., an interview was conducted with S9SP. She stated all residents with an NPO diet are meant to have Nothing by mouth. She confirmed mouth wash should not be accessible to NPO residents due to increased risk of aspiration. On 06/02/2026 at 10:06 a.m., an observation was made of Resident #65 in her room with S10LPN. An unsealed bottle of mouth wash was observed on Resident #65's bedside table within her reach. An interview was conducted, at this time, with S10LPN. She confirmed Resident #65 was on an NPO diet and should not have access to any liquids she could ingest. She confirmed the bottle of mouth wash was accessible and within reach for Resident #65's use and should not have been. On 06/03/2026 at 8:21 a.m., an interview was conducted with S2DON. He confirmed NPO meant Nothing by mouth. He confirmed Resident #65 was on an NPO diet and should not have had mouth wash accessible and within her reach in her room

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents received care, consistent with professional standards of practice to promote prevention and healing of pressure ulcers for 1 (#22) of 1 resident reviewed for pressure ulcers. This deficient practice had the ability to further affect any of the 3 resident's in the facility who were being treated for Pressure Ulcers. Findings: Review of the facility's Policy titled Skin Protocol with effective date 03/13/2026, revealed the following, in part: Purpose: To maintain healthy skin integrity, to prevent skin breakdown, to heal skin breakdown and prevent further skin breakdown. Procedure: 4. Residents will be turned/ repositioned every two hours or as appropriate. Review of Resident #22's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses which included Parkinson's Disease and Pressure Induced Deep Tissue Damage of Right Heel. Resident #22 received a diagnosis of Pressure Ulcer of Sacral Region Stage IV on 05/20/2026. Review of Resident #22's Quarterly MDS with ARD of 05/25/2026 revealed Resident #22 had a BIMS of 14 indicating she was cognitively intact. Further review revealed Resident #22 required substantial, maximal assistance from staff to roll from lying on back to left and right side. Review of Resident #22's Care Plan included the following problems and approaches, in part: Problem: Resident had a Stage IV to Sacrum related to immobility. Approach: Turn or reposition every 2 hours or as appropriate, and follow facility policies/ protocols for prevention/ treatment of skin breakdown. Review of Resident #22's Current Physician Orders revealed the following, in part: Start date: 04/03/2026- Turn/ reposition every 2 hours or as appropriate, monitor every shift related to decreased mobility, incontinence, high risk for breakdown and skin integrity. Review of Resident #22's skin assessment completed on 04/03/2026 per S2DON revealed the following, in part: Resident #22 was a new admission with Deep Tissue Injuries to Left and Right Heel, and Left Heel Unstageable Deep Tissue Injury. Intact skin with healed wounds noted to sacrum. Review of Resident #22's skin assessment completed on 06/01/2026 per wound care Nurse Practitioner revealed the following: Sacral stage IV measured 5.5 cm x 8 cm x 1.9cm, Right Heel resolved, Left Heel stage III measured 4 cm x 6 cm x 0.1 cm. On 06/02/2026 at 9:55 a.m., an observation was made of S12RN performing wound care to Resident #22. At 10:15 a.m. after wound care was performed S12RN, repositioned Resident #22 onto her left side with a wedge under her right side. On 06/02/2026 at 12:21 p.m., an interview was conducted with S7AB. She stated Resident #22 should be turned every 2 hours but she only turned or reposition Resident #22 at minimum every 3 hours due to other duties to be completed. On 06/02/2026 at 12:30 p.m., an observation was made of S7AB entering Resident #22's room with her meal tray in hand, and exiting the room. Resident #22 observed to be onto her left side with a wedge under her right side. On 06/02/2026 at 12:43 p.m., an observation was made of S12RN entering Resident #22's room, exiting room at 1:07 p.m. with Resident #22's meal tray in her hand. Resident #22 observed to be onto her left side with a wedge under her right side. On 06/02/2026 at 1:12 p.m., an observation and interview was conducted with Resident #22 lying in bed on her left side with wedge under her right side. Resident #22 stated she had not been turned since after her wound care was performed on 06/22/2026 at 9:55 a.m. On 06/23/2026 at 1:18 p.m., an observation was made of S10LPN entering and exiting Resident #22's room. Resident #22 observed to be onto her left side with a wedge under her right side. On 06/02/2026 at 1:23 p.m., an observation was made of Resident #22 lying in her bed on her left side with wedge under her right side. On 06/02/2026 at 1:24 p.m., an observation was made of S7AB entering Resident #22's room and exiting Resident #22's room. Resident #22 observed to be onto her left side with a wedge under her right side. On 06/02/2026 at 1:37 p.m., an observation was made of S10LPNand S12RN entering Resident #22's room. Resident #22 observed to be onto her left side with a wedge under her right side. On 06/02/2026 at 1:38 p.m. an observation was made of S7AB entering Resident #22's room as well. Observed Resident #22 stating to S12RN and S10LPN, You all know I (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	can't turn her by myself. On 06/02/2026 at 1:47 p.m., an observation was made of S10LPN exiting resident's room, and Resident #22 was repositioned on her right side with wedge under her left side. On 06/02/2026 at 1:49 p.m., an interview was conducted with S12RN. She stated staff had just turned and repositioned Resident #22. She confirmed Resident #22 was in the same position since wound care was completed at 10:15 a.m., and was not repositioned again until 1:37 p.m. S12RN further confirmed that Resident #22 was high risk for skin impairment, and had poor nutrition, and not turning or repositioning resident could worsen her Pressure Ulcers. S12RN also confirmed Resident #22 should have been repositioned or turned every 2 hours as per her Plan of Care. On 06/03/2026 at 2:30 p.m., an interview was conducted with S4ADON. S4ADON confirmed she expected staff to turn and reposition residents every 2 hours, especially Resident #22 who had skin impairment.