STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Specialty Care Community	3815 West Broadway Avenue Robbinsdale, MN 55422

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure efforts to resolve a grievance for missing personal possessions was addressed, acted upon, and resolved for 1 of 1 resident (R1) whose family voiced concerns regarding missing personal property. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], indicated severe cognitive impairment, and physical and verbal behaviors (hitting, kicking, pushing, screaming at others, grabbing, abusing others sexually), one-to-three days during the seven-days assessment look-back period. These behaviors put the resident and others at significant risk for physical injury and disrupted care or the living environment. R1 wandered four-to-six days during the seven-day look-back period which intruded on the privacy of others. R1's Preferences Evaluation dated 3/26/26, indicated it was very important to have music. R1 had his personal radio in his room. R1's care plan dated 3/31/26, indicated R1 had behavioral symptoms related to dementia including being combative during cares, resistance to redirection, swinging out at staff, and throwing items. R1's diagnoses included dementia with agitation. Interventions included redirect resident to sit in common area with book/magazine, signage on R1's door to indicate which room was his, divert attention, remove from the situation, and take to an alternate location as needed (PRN). During an interview on 4/1/26 at 11:29 a.m., family member (FM)-A stated when R1 admitted on [DATE], R1 came with plenty of clothes as well as a personal radio for his room. FM-A labeled each piece of clothing and personal item with R1's name. On the following Friday, 3/27/26, when FM-A visited, R1 removed clothes from his closet and laid them on the bed because he wanted to go home. By the following Sunday, 3/29/26, R1 had no clothes in his closet, had only one pair of underwear in his drawer, and his dentures, personal radio, and Army hat were missing from his room. FM-A stated she told the nurse and nurse manager for the unit about the missing items on Monday 3/30/26. FM-A provided the facility with a list of items that were missing, including T-shirts, jackets, underwear, shirts, and four pairs of jeans. FM-A stated it was a locked unit and was concerned about how most of his clothes were missing in a week's time. FM-A stated staff explained they looked in other resident rooms and didn't find any of his belongings. During an observation and interview on 4/1/26 at 2:39 p.m., FM-A told nursing assistant (NA)-B about R1's missing belongings. NA-B explained she was not told R1 had items missing before FM-A's conversation today. During an observation and interview on 4/1/26 at 2:49 p.m., registered nurse (RN)-A entered the unit and intervened in the discussion between FM-A and NA-B. RN-A explained the staff were looking for R1's clothing and would keep trying. FM-A stated the clothes had been missing since 3/27/26 and were reported as missing with a list of the missing belongings to RN-A on 3/30/26. FM-A asked RN-A why none of the clothes had been located. RN-A explained the staff would keep trying to find R1's clothes and RN-A would ask maintenance staff to check if any of R1's clothes were sent out with the linens. FM-A stated R1's boom box was also missing and R1 really liked to listen to his music. FM-A stated the clothing was worth a couple of hundred dollars, was all labeled. FM-A stated she brought new clothes to the unit this day and would take pictures of each item before she left. During an interview on 4/1/26 at 2:57 p.m., RN-A stated she learned of the missing clothing on 3/27/26 and (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acknowledged she had not completed a grievance form at the time. RN-A stated she had not asked maintenance staff to look for R1's missing items as she had not thought of that idea previously but did when she was talking to FM-A on 4/1/26. During an interview on 4/2/26 at 1:20 p.m., the director of nursing (DON) stated when family noticed missing items, family alerts staff, who tells the nurse manager (NM). Staff were to look for the items in the resident's room, laundry, and kitchen depending upon the item missing. The DON stated staff had not discussed a grievance related to R1's missing items. If the NM was aware of the missing items, the NM would notify the interdisciplinary team, which met twice weekly, or the clinical team which met daily. If the NM knew on 3/30/26, staff should have known about the missing items on 3/31/26. The DON stated a grievance form should have been completed when the missing items were reported and was unsure if one had been completed. On 4/2/26 at 2:41 p.m., during a subsequent interview, the DON acknowledged the NM had not completed a grievance form on 3/30/26. A social worker completed a grievance form on 4/2/26 with the NM. The Missing Items policy dated 4/7/25, indicated when an item was reported as missing, but not misappropriated, the staff would complete a Suggestion or Concern Form (Grievance Form) and the search for the missing item should be done immediately and thoroughly.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to assess, develop and implement person-centered care plans to meet the needs of 6 of 16 residents (R1, R2, R3, R5, R7 and R8) reviewed who received treatment and services related to dementia. Findings include:R1R1's care plan included diagnosis dementia with behavior disturbances. R1's care plan indicated the following areas of concern and interventions:3/24/26 impaired cognitive function/dementia with impaired decision-making, agitation, irritability, cue, orient, and supervise as needed (PRN) and reassess resident for needs like hunger, thirst, toileting needs, discomfort3/24/26 activity of daily living (ADL) deficits: bathing, dressing, oral care, personal hygiene, toilet use, and transfers; one staff to assist with ADLs, and set-up assistance for eating3/24/26 at risk for falls; monitor for significant changes in gait, mobility, balance, and lower extremity joint function, with an actual fall on 3/25/263/24/26 monitor closely during meals for chewing/ swallowing difficulties3/26/26 difficulty playing cards, socializing and prefers time in room, Enjoys socializing.3/31/26 behavioral symptoms related to dementia, combative during cares, resistance to redirection, swinging out at staff, throwing items, and swearing; redirect resident to sit in common area with book/magazine, signage on R1's door to indicate which room was his, divert attention, remove from the situation, and take to an alternate location as needed (PRN) R1's progress notes indicated the following:On 3/28/26 at 1:08 p.m., indicated R1 went into R2's room, staff heard a loud noise and went into R2's room and found R1 on the floor with R2 stomping on R1's face. R1 got up and wandered around in the common area.On 3/28/26 at 2:20 p.m., R1 wandered around the unit into other residents' rooms, removed clothes and items from his room and scattered them in the dining room. R1 attempted to tilt another resident from a chair and pushed staff when they intervened.On 3/28/26 at 9:03 p.m., R1 was more aggressive, carried tables, wanted to climb on the tables, pushed lounge chairs out of place, and wanted to hit the window by the TV with a chair.On 3/30/26 at 7:56 p.m., after FM-A left, R1 began kicking windows, broke the blinds, and did not respond to redirection. Staff provided 1:1 supervision hoping R1 would calm down, but when dinner was delivered, R1 threw his dinner plate, picked up a trash can and threw it in the direction of another resident, and picked up a pole and swung it in the direction of other residents. 911 was called and R1 was transferred to the hospital.3/31/26 at 1:16 p.m., interdisciplinary team (IDT) review note indicated R1 had behaviors, medications were used to manage resident with diagnoses that included dementia with behavioral agitation and indicated the current behavior management plan and medications were not effective. The progress noted indicated R1 was in the most appropriate unit and room the facility had to offer and presented risk to the unit related to wandering and difficulty to redirect.4/1/26 at 11:17 a.m., R1 walked about the unit, exit-seeking, was difficult to redirect and struck out at staff during redirection to leave a peer's room. Staff continue to supervise and redirect as needed.4/1/26 at 12:13 p.m., R1 continued to wander into other rooms and took belongings from closets and bathrooms. Staff offered to assist R1 with toileting, R1 refused, and then urinated in a garbage can. Offering snacks and diversional activity was ineffective.4/1/26 at 12:33 p.m., resident intermittently unplugged the unit camera, and made threats to punch the unit radio and staff had to follow resident. R1 punched a structural column, and hit books on the table. Close monitoring by staff to continue.4/1/26 at 12:57 p.m., nurse practitioner was updated on R1's mood and behavior and continued to be very agitated. Close supervision continued to keep residents and peers safe. R1's Activities Initial Review assessment dated [DATE] indicated R1 enjoyed being outside, reading in the evening, watching occasional TV, watching war movies, football, and playing cards. R1's Preferences Evaluation dated 3/26/26 indicated it was very important to have books, newspapers, and magazines to read, preferred action/adventure books and a local newspaper. It was very important to have music. R1's medical record failed to include a behavior assessment to (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicate possible triggers and effective interventions for R1's behaviors. During an interview on 3/31/26 at 3:23 p.m., licensed practical nurse (LPN)-A stated he knew R1 was returning to the unit on the evening of 3/31/26 and anticipated the unit would have a lot of action. R1 would likely be raiding trays in the kitchen. LPN-A stated on 3/28/26, R1 went into R2's room, R2 did not like it, so R2 pushed R1 which caused R1 to fall. R1 often went into other residents' rooms and liked to go into the kitchen area to play with the dishes. They all look normal, but their minds aren't working correctly so anything is possible. LPN-A stated staff could not predict what the residents would do, but there were always behaviors which included residents wandering into other resident rooms and taking things that did not belong to them, hitting staff, swearing, and hollering on the unit. LPN-A stated, When [residents] fight, we separate them and take them to their rooms. They don't know what they've done, they have already forgotten. During an interview on 3/31/26 at 3:31 p.m., nursing assistant (NA)-A stated staff tried to stop R1 from entering other residents' rooms and tried to get R1 out of the rooms right away when he did get in the rooms. He keeps us very busy. We have to watch him all the time. NA-A stated with resident-to-resident altercations, physical or verbal, staff had to get between them to try to distract attention away from each other. NA-A stated he was supposed to report resident altercations to the nurse and nurse manager who would come to the unit and talk to the staff and residents and update care plans depending upon the specific altercation. NA-A stated on 3/30/26, R1 took a table and tried to hit staff with it, and staff intervened by taking the table away. We had to try hard to protect the other [residents]. NA-A stated during the incident on 3/30/26, R1 was hitting a window with any object he could find, and with his fist. The nurse administered as needed (PRN) Haldol (antipsychotic) and Benadryl, NA-A felt these medications didn't work and seemed to make the behavior worse. The nurse called 9-1-1 for help. NA-A stated the care planned interventions for R1 and R5 were to follow and redirect them. NA-A stated following and redirecting did not stop R1's or R5's behaviors. During an interview on 4/1/26 at 11:29 a.m., FM-A stated she went to the facility the day R1 admitted , on 3/23/26. When FM-A arrived at the unit R1 was in another resident's room. On 3/24/26, FM-A noted R1 was wandering on the unit, with the aide in another resident's room and a nurse on the unit. FM-A observed R1 go into another resident's room, the staff observed this but did not redirect R1 out of the other resident's room. On 3/28/26, when FM-A visited, she observed a nurse and another staff on the unit. The nurse was doing their job, and the other staff was standing near the desk for nearly two hours, not interacting with residents. FM-A stated during all her visits, there did not appear to be any activities on the unit. FM-A stated she was going to try to visit daily because FM-A felt the care R1 was receiving was minimal and did not meet R1's needs when it came to R1's behaviors. FM-A told the nurse manager on 3/30/26, the unit needed more staff. R1 was taken to the hospital on 3/30/26. FM-A stated the explanation given by the facility was the facility could not manage R1's behaviors. R2R2's care plan included diagnoses dementia with agitation and post-traumatic stress disorder (PTSD). R2's care plan indicated the following areas of concern and interventions:3/26/26 impaired cognitive function/dementia; cue, reorient, and supervise PRN3/26/26 ADL deficits: bathing and dressing; staff set-up and supervise bath, set-up assistance for eating, cues and reminders with set-up assistance PRN for personal hygiene3/26/26 behavior symptoms: pacing and wandering into rooms; intervene as necessary to protect the rights and safety of others, divert attention, remove from situation and take to alternate location PRN, redirect resident3/26/26 assist to cut up food and open packaging at meals3/31/26 sign on bedroom door that indicated, [R2]'s room R2's Activities Initial Review dated 3/27/26 indicated R2 liked work tasks, going on walks and wished to participate in group activities. R2 wanted 1:1 time with staff and liked independent activities. R2's Resident Preferences Evaluation dated 3/27/26, indicated it was somewhat important to have books, newspapers, and magazines to read and preferred action/adventure, drama, mystery and Western books. The evaluation indicated it was very important to be around animals and get fresh air when the weather was good, and somewhat important to listen to rock music. R2's medical record failed to include a behavior assessment to indicate possible (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	triggers and effective interventions for R2's behaviors. During an interview on 4/1/26 at 11:33 a.m., FM-B stated staff was notified R2 didn't like others in his room, and part of R2's care plan was to keep others out of his room. FM-B stated she wondered where all the staff were, and if staff were watching the residents, another resident should not be able to go into R2's room. During an interview and observation on 4/1/26 at 2:57 p.m., registered nurse (RN)-A stated R1 and R2 had an altercation on 3/28/26, after R1 went into R2's room. The intervention to keep others out of R2's room was to put mesh across R2's doorway with a stop sign on it to remind residents to stay out of R2's room. RN-A showed the mesh was in place but was inside R2's closed room door. There was no mesh with stop sign on the front of the door where it could be seen without having to first open the door. RN-A stated the mesh being inside the door defeated the purpose. R2 stated it felt like the mesh was in place to keep him in his room, so RN-A removed the mesh stop sign and stated she would have to find another intervention to keep residents out of R2's room. R3R3's admission MDS dated [DATE], indicated R3 was cognitively intact with fluctuating disorganized thinking. R3 had physical behaviors directed towards others one-to-three days during the assessment seven-days look-back period. These behaviors put the resident at risk for physical illness or injury and significantly disrupted the care or living environment of other residents. R3 walked independently for short distances but required supervision for walking 50 feet or more. R3's diagnoses included dementia. R3's care plan indicated the following areas of concern and interventions:1/2/26 a history of an altercation when a resident walked into his room; intervene to protect the rights and safety of others1/2/26 ADL deficits: dressing, eating, personal hygiene; set-up for ADLs and provide oral care reminders1/5/26 experienced physical aggression on the unit by peer on the unit1/5/26 monitor closely while eating for chewing/swallowing difficulties, coughing, choking1/20/26 at risk of falls; resident advised to not bend over to pick up dropped objects; had an actual fall on 2/3/26 while trying to pull up pants in the bathroom2/13/26 behavior symptoms, history of resident-to-resident altercation after a resident walked into his room; intervene as necessary to protect the rights and safety of others, divert attention, remove from situation and take to alternate location PRNR3's progress notes indicated the following:12/30/25 at 8:32 p.m., R3 transferred from Good [NAME] Society in [NAME] Lea with diagnoses of dementia and diabetes.1/1/26 at 1:40 p.m., R2 was confused to time and place.1/1/26 at 9:59 p.m., a family member noticed a bruise below the left eye measuring 1 centimeter (cm) by 3 cm. It was an unwitnessed injury and it was not clear how it happened. R2 removed the window screen and opened the window early and could have been the cause of the injury.1/2/26 at 1:14 p.m., during a skin inspection R2 reported he was hit in the eye when he hit another resident back and they were both falling to the ground. R2 was unclear when it happened. There were no reports of incidents of this nature since admission. R3's Activity Interest Data Collection Tool dated 1/5/26 indicated R3 enjoyed taking rides in the community, fishing, hunting, shopping, being outdoors, hiking, listening to music, and auto racing. R3's medical record failed to include a behavior assessment to indicate possible triggers and effective interventions for R3's behaviors. During an interview on 3/31/26 at 2:48 p.m., R3 stated [date unknown] R1 came in his room and tried to take his pillow, so R3 forced R1 out of his room. R1 did drop the pillow, but came back two more times to try to take it. R3 stated R1 came into his room another day and urinated on his floor. Another night, R1 tried to crawl in R3's bed. R3 stated staff intervened after the altercation over the pillow. R3 stated he was told to push his call light when other residents came to his room and staff would come to remove them. R3 wanted to know how staff could keep other residents out of his room, before they tried to enter. R5R5's admission MDS dated [DATE], indicated severe cognitive impairment, and physical behaviors and wandering four-to-six days during the assessment seven-days look-back period. R5 required staff assistance with all ADLs, mobility and transfers, utilized a wheelchair for some mobility, and required staff supervision for ambulation and was frequently incontinent of bowel and bladder. R5's diagnoses included dementia with agitation. R5's care plan indicated the following areas of concern and interventions:1/29/26 impaired cognition and behavior related to dementia; interventions to break (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cueing, extensive to total assistance of one staff with toileting and management of incontinence brief, provide incontinence cares upon rising, before and after meals, at bedtime and PRN3/5/25 bowel incontinence; extensive assistance in management of incontinence hygiene 3/11/25 ADL deficit: eating; tray set up and may need encouragement and cues to continue eating R7's medical record failed to include a behavior assessment to indicate possible triggers and effective interventions for R7's behaviors. During an interview on 4/2/26 at 12:33 p.m., the FM-C stated she visited several times a week and did not see activity staff on the unit but occasionally R7 went for ice cream in the facility. FM-C stated the facility should have more social activities for residents. R7 liked to ride motorcycles, fish, shop, and was very active. FM-C felt the facility did not do any activities related to those interests. R7 also liked criminal shows on TV but when FM-C visits, R7 is generally lying on his bed in his room and had not seen R7 in the day room. He needs to keep getting up and when they stop encouraging him, he will quit being able to move. R8R8's quarterly MDS dated [DATE], indicated severe cognitive impairment, dependence upon staff for activities of daily living and indicated R8 did not ambulate. R8 had diagnoses that included dementia. R8's care plan indicated the following areas of concern and interventions:4/15/25 limited physical mobility; staff assistance for mobility on the unit and self-propels for short distances4/29/25 ADL deficit: bathing; one staff total assist4/29/25 at risk for falls; remind resident to not bed over to pick up dropped items, resident unable to use call light to summon assistance, staff to check on resident during frequent rounds and anticipate needs; history of fall when found on floor with bedding wrapped around upper torso7/16/25 ADL deficits: bed mobility, personal hygiene, toilet use, and dressing; one staff assist, and two staff assistance with total lift for transfers10/24/25 potential for pressure ulcer; assist to turn and reposition at least every two hours and PRN1/13/26 ADL deficit: eating; extensive assistance of one staff5/13/26 elected hospice services due to terminal prognosis R8's Activity Interest Data Collection Tool dated 4/16/25 indicated R8 preferred to spend time with others, liked rides in the community, fishing, baseball, cycling, swimming, libraries, and being outdoors. R8 liked crafts, listening to classical/ easy listening music, movies, gardening, and playing the harmonica. Also, R8 enjoyed card games, cards, BINGO, fictional books, discussing the news, and word puzzles. During an interview on 4/1/26 at 1:20 p.m., FM-D stated there were some staff who were not good at redirecting the residents and just let the residents go where they wanted. During an observation on 4/1/26 at 1:26 p.m., R1 was pacing near R8's visitors and told R8's visitors repeatedly and loudly it was time to leave, and the visitors took R8 and moved to another area. R1 said, That's it, that's the way, keep on pushing him away from here. Staff did not intervene. R1 continued to wander around the unit, muttering nonsensical words. During an interview on 4/2/26 at 12:44 p.m., FM-D stated R1 was talking to another of R8's family members from behind the couch, the FM was annoyed by R1's behavior. If R1 persisted, FM-D stated they would have intervened because staff did not. FM-D stated they were unsure what R1 would have done if they had stayed in the area. Further, FM-D stated care was better since R8 elected to receive hospice care, and hospice staff could help with care, including baths. During observations and interviews on 4/1/26 from 1:10 p.m. to 2:49 p.m., the following occurred:1:10 p.m. NA-B and NA-C were sitting at the nurse's station. No other staff were on the unit. NA-B got up to clean the dining room tables. Two residents were asleep with their heads resting on a dining room table. One resident was asleep in a chair in the sitting area. Another resident wandered towards the exit door.1:28 p.m. R5 was in the kitchen area moving things around on the countertop.1:30 p.m. both NA-B and NA-C were back in the common area from providing care to R6. NA-B moved R5 from the kitchen area. NA-C sat back at the nurse's station.1:37 p.m. R5 approached NA-B who was sitting at the nurse's station and NA-B asked what R5 wanted. R5 walked away and sat in the dining area.1:38 p.m. NA-B handed R5 a book and went back to the nurse's station and sat down. R1 was wandering around the unit and attempted to enter another resident's room. NA-C intervened by blocking his entrance. NA-C and R5 walked away together, and NA-C returned to the nurse's station.1:46 p.m. NA-C was seated at the nurse's station, NA-B took water to a resident sitting at a table, and then returned to the nurse's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Specialty Care Community	3815 West Broadway Avenue Robbinsdale, MN 55422

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	station.1:51 p.m. R3 exited his room and told the NAs, who were sitting at the nurse's station, he just had a big bowel movement.1:52 p.m. therapeutic recreation (TR)-A staff came to the unit and offered to play a game with the residents who were sitting at the dining room tables. TR-A invited other residents to join the activity. 1:59 p.m. TR-A was working with residents on the activity but was interrupted to followed R5 to a resident's room. TR-A asked R5 if he wanted to go to his own room, and offered to get his wheelchair for him. NA-B and NA-C were sitting at the nurse's station. 2:01 p.m. NA-B helped R5 to his room and told TR-A they liked to encourage R5 to walk. During an interview on 4/1/26, at approximately 9:30 a.m., medical director (MD)-A stated R1's facility nurse practitioner (NP) called him on 3/29/26, and asked how to manage R1's behaviors. MD-A informed NP, R1's low doses of medications, Haldol 1 milligrams (mg) and Benadryl 25 mg, could be doubled. After the change in doses didn't make a difference in R1's behaviors, R1 was intrusive to other residents and his behaviors were not manageable, the facility sent R1 back to the hospital. The hospital did not notify the facility before they sent R1 back to the facility, and if they had, MD-A would have intervened with a physician-to-physician call to inform the hospital the facility could not take R1 back. MD-A stated the facility is staffed well, but was unable to manage 1:1 staffing with R1 24-hours a day. MD-A felt it was irresponsible to expect that from the facility. R1 was throwing chairs, throwing tables, and going into rooms of residents who were reasonably stable, but were not stable anymore when he entered their rooms. MD-A stated if the medication changes did not work, the facility could request orders to change them. The MD-A stated he was not aware the units did not have many activities. During an interview on 4/1/26 at 2:04 p.m., NA-C stated R1 went into other resident's rooms, took other residents' belongings, and tried to drag residents off their beds. NA-C stated he told nursing staff on the unit, and the nurse manager, R1 needed a 1:1 for safety and only medication helped because when staff redirected R1, he tried to fight staff or hit them. Activities on the unit helped, and they were supposed to come on Mondays, Wednesdays, and Fridays, for one activity in the morning, and one in the evening but had not been coming recently. During an interview on 4/1/26 at 2:18 p.m., NA-B stated staff assisted residents with one activity in the morning while they monitor the residents on the unit. Activity staff was supposed to come to do to one activity in the evenings, but didn't always come. NA-B stated three of the residents wandered around the unit and into other residents' room, and one resident, R1, could become physically aggressive. The residents' behaviors were worse in the evenings. NA-B stated some residents did not like it when other residents wandered into their rooms, wandering behavior sometimes caused arguments, especially in the evenings. During an interview on 4/1/26 at 2:57 p.m., RN-A stated R1 had been in two altercations since admission, and R1's behaviors were unpredictable. The other two residents who wandered on the unit also required close supervision. R1's unit also required two staff for transfers for three different residents. Each of those transfers could take ten minutes each time, and then no one was left watching the other residents. RN-A stated with unpredictable behaviors and the level of assistance needed by the residents, the unit was busy. During an interview on 4/1/26 at 3:22 p.m., LPN-B stated she told the nurse manager she was overwhelmed with R1's behaviors. If one resident required two staff for a transfer or other cares, there was often no one available to monitor other residents. Staff could call the other unit for help, but if staff were busy, they could not assist. During an interview on 4/2/26 at 9:44 a.m., NA-B stated when residents have behaviors, staff needed a list of ways to intervene with each resident and when one thing didn't work, staff could try the next intervention. This unit needs more attention than ever. During an interview on 4/2/26 at 9:55 a.m., RN-C stated the unit almost never had activities, but it would be helpful to have more to keep residents occupied and to keep them from wandering. RN-C stated the unit had an activity on 4/1/26 because the surveyor was present, but the unit didn't normally have activities. During an interview on 4/2/26 at 1:20 p.m., the director of nursing (DON) stated as far as she was aware, all the residents' cares were done, and no family or staff had complained about other residents or their behaviors. The staff were expected to work together, and if two staff were required to be in one room, the staff were (continued on next page)

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