STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265330	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Village Park	2041 Silva Lane Moberly, MO 65270

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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 - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one resident (Resident #1), in a review of 11 sampled residents, remained free from verbal, mental and physical abuse when Human Resource Manager (HR) A cursed, taunted, threatened and grabbed the resident by the shirt forcefully, putting him/her into a chair. The staff member aggressively and forcefully shoved the resident against the wall during a Code [NAME] (behavioral emergency). The facility census was 176. Review of the facility's policy titled, Abuse and Neglect, revised on 6/12/24, showed the following: -Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through technology; -Verbal abuse means the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. This includes profanity or speaking in a demeaning, nontherapeutic, undignified, threatening or derogatory manner in a resident's presence. Examples include harassing a resident; mocking, insulting ridiculing; yelling at a resident, with the intent to intimidate; threatening residents, including to but not limited to, depriving a resident of care or withholding a resident from contact with family and friends; and isolating a resident from social interaction or activities; -Physical abuse is purposefully, beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal inhumane manner. Physical abuse includes handling a resident with any more force than is reasonable for a resident's proper control, treatment or management; -Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation or abuse that is facilitated or caused by nursing home staff. Mental abuse includes the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. This includes hovering over the resident with intent to intimidate; threatening residents; (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 - Few	-The facility will identify events, occurrences, patterns and trends that may constitute mistreatment, exploitation, neglect, abuse, including injuries of unknown source and misappropriation of resident property; -Any employee involved in any abuse of a resident may be subject to suspension and termination even on the first offense. Review of the facility's Nonviolent Crisis Intervention Training, dated 2023, showed the following: -The training gives you the skills to build an effective culture of safety within your organization. It is designed to help professionals in any setting provide the best possible care, welfare, safety and security for individuals presenting a range of crisis behaviors; -The purpose of this program is to build on your knowledge and skills to recognize, prevent, and manage crisis behaviors using person centered and trauma informed responses; -Recognize that the person knows themselves best, respect the person's preferences and what's important to them, value the person's independence and need to flourish and use and approach based on their strengths; -Value the person's rights and dignity, always respond with respect, empathy and compassion; -Rational detachment, recognizing the need to remain professional by managing your own behavior and attitude; -When you rationally detach, you stay consistent and calm while maintaining self-control in the moment. This helps you not to respond in a way that causes the situation to escalate. You are also less likely to become another precipitating factor to the person in distress. Your consistent, calm behavior can ease their emotional response; -When rationally detached, you can objectively identify the crisis level the person is in and choose the approach best suited to that level; -Understand the precipitating factors of the person in distress, be aware of your own precipitating factors, and rationally detach to maintain professionalism. Through this integrated experience, your calm consistent behavior influences the behavior of the person in distress and can help them reach a level of calm; -Holding: A restrictive safety intervention necessary to restrict a person's range of movement to prevent infliction of harm to self or others; -Key principles: Maintain a supportive stance, position with your body turned to the side. Posture balanced and nonthreatening. Proximity manage the distance; -Seated low level restriction began in a supportive stance, position self to the side, sit close, apply the outside principle by placing your nearest hand on the inside of the person's wrist. Cup your hand to avoid gripping and squeezing. Keep upright and avoid leaning or bending the person forward; (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Seated medium level restriction begin in the low level of restriction, sit close, use your leg furthest from the person to remain balanced and stable. Apply the outside principle by placing the palm of your furthest hand at their elbow. Apply the inside principle by letting go of the person's wrist, bringing your nearest arm underneath, and resting your arm over the resident's forearm. Cup your hand to avoid gripping or squeezing. Use your body to maintain contact at their shoulder, hip, and thigh. Keep upright. Avoid leaning or bending the person forward; -Seated high level restriction began in the medium level of restriction. Sit close. Use your leg furthest from the person to remain balanced and stable. Apply the inside principle by using your closest hand to hold the person's wrist. Keeping your hands on the person's wrist and elbow, guide their arm back so their wrist is beneath their shoulder. Apply the outside principle by removing your hand from the person's elbow and replacing it with your body. Place the palm furthest hand on the person's fist. Cup your hand to avoid squeezing. Use your body to maintain contact at their shoulder, hip, and thigh. Keep upright. Avoid leaning or bending the person forward. 1. Review of Resident #1's Preadmission Screening and Resident Review (PASARR) Mental Illness Level II Evaluation, dated 9/14/21 showed the following: -Documented historical and current psychiatric diagnoses included bipolar disorder (a mental health condition that causes unusual shifts in mood, energy and activity levels), anxiety, impulse control disorder, major depressive disorder, attention deficit hyperactivity disorder, mild intellectual disability, oppositional defiant disorder (a behavioral disorder characterized by a persistent pattern of uncooperative defiant, and hostile behavior towards authority figures), borderline intellectual functioning; -The resident had a lifelong history of behavioral problems. The resident had self-harming behaviors, elopements, was aggressive with staff and had several mental health hospitalizations; -The resident will spit on others when he/she agitated or upset; -The resident communicates very well. The resident was able to provide some history, communicate needs, likes, and dislikes. The staff reported the resident has a history of verbal and physical aggression, but can be pleasant; -The resident follows simple and complex directions, stays on task/completes assignments and expresses needs and wants; -Provision of structured environment include provide individual personal space, sensory supports, maintain environment with low stimulation, establish consistent routines, provide schedule of daily tasks/activities, provide instruction at the individuals level of understanding, assess and plan for the level of supervision required to prevent harm to self or others. Review of the resident's undated Face Sheet showed the following: -The resident admitted to the facility on [DATE]; -The resident had a legal guardian. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by the facility staff, dated 4/13/25, showed the following: -Cognitively intact; -No signs or symptoms of delirium; -The resident feels down, depressed or hopeless nearly every day (12-14 days); -The resident feels bad about himself/ herself or that he/she was a failure or let himself/herself or family down two to six days out of seven days; -Delusions and hallucinations were not exhibited -Behavioral symptoms were not exhibited; -Rejection of care not exhibited; -No functional limitation in range of motion to upper or lower body; -No mobility devices used; -The resident required supervision or touching assistance (helper provides verbal cues or touching assistance as a resident completes an activity) during all activities of daily living. Review of the resident's care plan revised on 4/22/25 showed the following: -Current behaviors include anxiety, depression, lies, bad decision making, agitation, stealing from peers, manipulating staff by telling false hoods. Makes inappropriate comments to peers or about peers. Will say he/she was going to spit on people and will attempt to do so; -Coping skills: Karaoke, bingo, Yoga, and calls from family; -One on one interventions as needed; -Pharmaceutical interventions as needed; -Coping skills included karaoke, bingo, Yoga, watching television, listening to music, taking naps, word searches, talking to his/her parent; -The resident had manifestations of behaviors related to his/her mental illness that may create disturbances that affect others. Triggers include loud groups, yelling, being told no, money, soda, not being able to order food out, not having smoke break and having peers tell him/her what he/she can and cannot do (revised 4/22/25). Review of facility camera footage from 5/25/25, from the facility smoke room, provided by the facility, showed the following: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The video did not include sound: -At 12:49 P.M and nine seconds footage started. The resident was positioned in a chair with HR Manager A's body blocking view of the resident, close to the door in the resident smoke room. HR Manager A stood positioned in front of the resident with his/her left leg in between the resident's legs and his/her right leg straddling the resident's left leg with his/her back to the camera. Certified Medication Technician (CMT) B and Nurse Aide (NA) D stood just inside the open door of the smoke room. There were no other residents present; -At 12:49 and 27 seconds the video footage skipped to 12:50 P.M. and 23 seconds (approximately one minute of footage missing); -At 12:50 P.M. and 27 seconds HR Manager A stood in front of the resident with his/her back to the camera and then using his/her body, aggressively and forcefully shoved the resident's upper body against the wall while the resident was seated in a chair beside the smoke room door. The resident's right side was pressed against the wall and held by HR Manager A. -At 12:50 P.M. and 29 seconds the video footage skipped to 12:53 P.M. and four seconds (over three minutes of missing footage). The footage restarted and showed the resident seated in a chair in the middle of the smoke room with four staff positioned around the resident restraining him/her by holding his/her arms and legs. HR Manager A stood in front of the resident, leaned forward toward the resident; -At 12:54 P.M. and 29 seconds the footage skipped to 12:55 P.M. and 41 seconds (approximately a minute and 12 seconds of missing footage). The resident remained in a chair in the middle of the smoke room and staff continued to restrain the resident; HR Manager A sat in a chair in front of the resident; -Total amount of camera footage provided by the facility was approximately three minutes and one second. Review of the resident's Progress Note, dated 5/25/25 at 4:20 P.M., (late entry for incident that occurred at 2:30 P.M./as indicated on the initial reporting form) showed the following: -The resident sat in the smoke room and was asked to come out of room, the resident was verbalizing suicidal ideation and immediately the resident was placed with staff for protective oversight; -The resident spit on staff, the resident grabbed another resident's shirt and wouldn't let go. A different resident reached over and hit the resident on his/her head and pulled his/her hair; -A Code [NAME] was called and the residents were separated. Neurological checks were initiated. No injuries were noted and the resident denied pain or discomfort; -The resident continued to be with staff. Will continue plan of care. Review of the resident's Progress Note, dated 5/25/25 at 4:22 P.M., as a late entry, showed the following: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-During the incident, the resident continued being physically and verbally aggressive towards facility staff and peers after the initial incident. Facility staff removed the peers from the area for their safety, as to verbal de-escalation was not effective. As a last resort the resident was placed in a Crisis Prevention Institute (CPI, a restrictive safety intervention necessary to restrict a person's range of movement to prevent the infliction of harm to self or others) hold. The resident continued to attempt to be physically aggressive towards staff therefore the resident received an as needed (PRN) intramuscular (IM, medication delivered directly into the muscle tissue using a syringe and needle) as a last resort; -During this incident there was an allegation made that the team lead, Human Resource Manager (HR) A was abusive towards the resident. During an interview on 5/28/25 at 10:40 A.M. Resident #1 said the following: -On 5/25/25, he/she was angry because he/she wanted a second cigarette during smoke break and Nurse Aide D would not give him/her one; -He/She flipped over a chair and staff called Code Green; -He/She was very angry and was spitting at staff. HR Manager A told him/her If he/she spit on him/her again, HR Manager A would slam my head through the wall; -HR Manager A was the resident's friend. HR Manager A hurt the resident's feelings; -HR Manager A placed a face shield over his/her face because he/she was spitting; -He/She was so angry that he/she blacked out. During an interview on 6/3/25 at 9:20 A.M. the resident's guardian said the following: -He/She was aware of the allegation of abuse involving the resident and a staff member; -He/She had not spoken to the resident since the incident; -It was not appropriate for staff to make threatening comments towards the resident. Review of the resident's Care Plan last revised on 5/27/25 showed the following: -On 5/25/25 the resident was involved in a physical altercation with a peer due to spitting and being verbally aggressive; -The resident was placed one on one and skin and pain assessment was completed and interdisciplinary meeting was completed; -On 5/25/25, an allegation of abuse towards resident involving a staff member, HR Manager A suspended pending investigation. During an interview on 5/28/25 at 9:15 A.M. Floor Care Staff C said the following: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 5/25/25, he/she responded to a Code [NAME] call involving the resident; -HR Manager A responded to the code and was screaming and hollering as he/she came down the hall. This was not an appropriate way to respond to a code to start with. HR Manager A had a bad attitude. Staff were to respond to codes in a calm manner; -HR Manager A went into the smoke room and grabbed the resident's shirt close to the collar and pushed him/her into a chair aggressively. The resident just sat in the chair as HR Manager A yelled at the resident. HR Manager A said he/she didn't care about his/her job and didn't care if he/she lost his/her job. The resident started to spit on HR Manager A. Other staff entered the smoke room and shut the door; -He/She could hear HR Manager A yelling at the resident from outside the smoke room. HR Manager A was shaking he/she was so angry with the resident. He/She felt what HR Manager A did was abuse, so he/she reported it to administration. During an interview on 5/28/25 at 11:25 A.M. Nurse Aide (NA) D said the following: -On 5/25/25, Resident #1 and another resident got into a verbal argument and a physical altercation occurred between Resident #1 and two other residents. Resident #1 was throwing spit at the other residents and a Code [NAME] was called; -HR Manager A responded to the Code [NAME] and was the lead on the code. HR Manager A took the resident into the smoke room; -A few minutes later, HR Manager A called staff into the smoke room to put the resident in a hold. The resident spit at HR Manager A, this upset HR Manager A; -HR Manager A told the resident to go ahead and hit him/her as he/she was not afraid to lose his/her fucking job. It seemed like he/she wanted the resident to hit him/her so HR Manager A could retaliate; -HR Manager A was up in the resident's face more than he/she should have been; -HR Manager A's demeanor escalated the situation and caused the Code [NAME] to last much longer than it should have. NA F was tapping HR Manager A on the shoulder, trying to get his/her attention and remove him/her from the situation because HR Manager A was so upset; -HR Manager A crossed the line. HR Manager A's actions were very abusive. During an interview on 5/28/25 at 1:58 P.M. Certified Nurse Assistant (CNA) E said the following: -He/She was working at the facility when a Code [NAME] was called on another hall. He/She responded to the Code Green; -He/She went in the smoke room where the resident was, HR Manager A was holding the resident's head against the wall to keep the resident from spitting on staff. A staff member found a white paper mask and HR Manager A held the resident's face and put the mask on the resident; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-HR Manager A grabbed hold of the resident's shirt and forcefully threw the resident in the chair and asked staff to grab the resident by his/her arms; -HR Manager A was yelling at the resident and said that if the resident had assaulted him/her like he/she did to other residents, they would be going, [NAME], [NAME], [NAME], while taking a closed fist and hitting his/her own palm. The resident tried to take his/her mask off, and HR Manager A said the resident could try and bite off the mask, but that the resident didn't have any teeth; -HR Manager A removed the paper mask and put a face shield on the resident and the resident started kicking at him/her. HR Manager A held one of the resident's feet in between his/her legs; -CNA E grabbed the resident's left leg and Certified Medication Technician (CMT) B had the resident's right arm. NA D held the resident's left arm; -Licensed Practical Nurse (LPN) H, who was the charge nurse, had stepped out to get an order for an as needed (PRN) medication. HR Manager A continued to yell at the resident about his/her behavior and cursed and used the word fuck and bullshit and got in the resident's face; -LPN H gave the resident an injection and left the room. HR Manager A instructed staff to let go of the resident and told the resident if he/she started spitting again, that he/she didn't care about this job enough to get spit on and the resident would be unconscious. During an interview on 5/28/25 at 1:30 P.M. NA F said the following: -He/She was on a break and heard a Code [NAME] called for the unit he/she was working on; -He/She ran back to the hall and there was an altercation between Resident #1 and two other residents. Resident #1 started spitting at other residents. He/She went and got a mask for Resident #1. When he/she returned, the resident was being restrained; -HR Manager A got in the resident's face and said the resident could scream, curse, hit and spit on him/her, he/she didn't give a fuck about his/her job. The resident started calling HR Manager A names and HR Manager A started yelling more at the resident. He/She tried to tap HR Manager A out of the situation but he/she wouldn't leave. NA F backed off and left the smoke room because HR Manager A was his/her superior; -He/She continued to hear yelling and screaming from inside the smoke room but couldn't hear what was being said. During and interview on 5/29/25 at 11:15 A.M. CMT B said the following: -On 5/25/25, he/she responded to a Code [NAME] on another hall that was in the smoke room; -When he/she responded, he/she cleared the area of residents and got a chair for Resident #1 who was the resident that the code was called on. HR Manager A entered the the smoke room and with both of his/her (HR Manager A's) hands, slammed the resident down into the chair and was screaming at the resident about putting his/her hands on other resident; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-HR Manager A used his/her body weight to hold the resident against the wall. The resident began spitting. CMT B hollered for staff to get a mask or a towel, staff handed him/her a towel and HR Manager A grabbed it out of CMT B's hands and covered the resident's mouth and nose. Additional staff showed up and transferred the resident to another chair with arms; -HR Manager A sat in front of the resident yelling that he/she didn't care about this fucking job, and if the resident was going to treat him/her (HR Manager A) like trash, he/she would treat the resident like trash. HR Manager A was punching his/her hand in the resident's face in a threatening and aggressive manner; -This went on for a long time. LPN H was in and out of the smoke room and administered an injection to the resident; -The resident seemed more agitated and was fighting against staff while HR Manager A yelled at him/her; -CMT B felt the code lasted longer and caused the situation to escalate more due to HR Manager A's actions of cursing and yelling. During an interview on 5/28/25 at 2:40 P.M. LPN H said the following: -He/She was the charge nurse working on 5/25/25; -He/She was called to a Code [NAME] on the resident's hall, he/she was in an out of the smoke room getting an injection for the resident and checking on the other residents that were on the hall; -He/She assessed the resident after the Code [NAME] and there was no bruising or injury identified at that time. During an interview on 5/28/25 at 10:15 A.M. and 12:00 P.M. and 5/29/25 at 5:30 P.M., the Administrator said the following: -He interviewed all the staff that were involved, with the information that he/she had and only two staff members alleged abuse occurred; -He didn't review the camera footage from the smoke room because the resident denied that abuse occurred; -He didn't feel he/she had enough proof to indicate abuse and HR Manager A denied being abusive towards the resident. MO254860

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a thorough investigation of an allegation of staff to resident abuse. Two staff members reported Human Resource (HR) Manager A was abusive to one resident (Resident #1) of 11 sampled residents during a Code [NAME] (behavioral emergency). The facility did not interview or obtain written statements from all witnesses that were present during the Code [NAME] or review video camera footage of the incident. The facility census was 176. Review of the facility's policy titled, Abuse and Neglect, revised on 6/12/24, showed the following: -Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse; -The facility will investigate all allegations and types of incidents listed above in accordance to facility procedure for reporting and response; -The administrative investigation will consist of any pertinent information describing the situation being investigated, the names of all staff involved and residents involved, the root cause of the incident, the recommendations of the investigation including the facts that prove or disprove the alleged situation occurred, the plan of correction or action by the administrative staff, all statements attached from residents and staff involved. 1. Review of Resident #1's undated Face Sheet showed the following: -The resident admitted to the facility on [DATE]; -The resident had a legal guardian. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by the facility staff, dated 4/13/25, showed the following: -Cognitively intact; -No signs or symptoms of delirium; -Delusions and hallucinations were not exhibited -Behavioral symptoms were not exhibited; -Rejection of care not exhibited; -No functional limitation in range of motion to upper or lower body; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No mobility devices used; -The resident required supervision or touching assistance (helper provides verbal cues or touching assistance as a resident completes an activity) during all activities of daily living. Review of facility camera footage from 5/25/25, from the facility smoke room, provided by the facility, showed the following: -The video did not include sound: -At 12:49 P.M and nine seconds footage started. The resident was positioned in a chair with HR Manager A's body blocking view of the resident, close to the door in the resident smoke room. HR Manager A stood positioned in front of the resident with his/her left leg in between the resident's legs and his/her right leg straddling the resident's left leg with his/her back to the camera. Certified Medication Technician (CMT) B and Nurse Aide (NA) D stood just inside the open door of the smoke room. There were no other residents present; -At 12:49 and 27 seconds the video footage skipped to 12:50 P.M. and 23 seconds (approximately one minute of footage missing); -At 12:50 P.M. and 27 seconds HR Manager A stood in front of the resident with his/her back to the camera and then using his/her body, aggressively and forcefully shoved the resident's upper body against the wall while the resident was seated in a chair beside the smoke room door. The resident's right side was pressed against the wall and held by HR Manager A. -At 12:50 P.M. and 29 seconds the video footage skipped to 12:53 P.M. and four seconds (over three minutes of missing footage). The footage restarted and showed the resident seated in a chair in the middle of the smoke room with four staff positioned around the resident restraining him/her by holding his/her arms and legs. HR Manager A stood in front of the resident, leaned forward toward the resident; -At 12:54 P.M. and 29 seconds the footage skipped to 12:55 P.M. and 41 seconds (approximately a minute and 12 seconds of missing footage). The resident remained in a chair in the middle of the smoke room and staff continued to restrain the resident; HR Manager A sat in a chair in front of the resident; -Total amount of camera footage provided by the facility was approximately three minutes and one second. -NA F was observed in the smoke room. Review of the resident's Progress Note, dated 5/25/25 at 4:22 P.M., as a late entry, showed the following: (continued on next page)

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North Village Park	2041 Silva Lane Moberly, MO 65270

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-During the incident, the resident continued being physically and verbally aggressive towards facility staff and peers after the initial incident. Facility staff removed the peers from the area for their safety, due to verbal de-escalation not being effective. As a last resort the resident was placed in a Crisis Prevention Institute (CPI, a restrictive safety intervention necessary to restrict a person's range of movement to prevent the infliction of harm to self or others) hold. The resident continued to attempt to be physically aggressive towards staff, therefore the resident received an as needed (PRN) intramuscular (IM, medication delivered directly into the muscle tissue using a syringe and needle) as a last resort; -During this incident there was an allegation made that the team lead, that Human Resource Manager (HR) A was abusive towards the resident. Review of the facility's investigation, dated 5/27/25, showed the following: -Date of incident was 5/25/25; -Persons involved: Resident #1 and HR Manager A; -Notified on 5/27/25 at 8:00 A.M., type of incident was alleged abuse; -Narrative note: During altercation Resident #1 was having on 5/25/25 with two peers, it was alleged by Certified Nurse Assistant (CNA) E and Floor Care Staff C that HR Manager A had thrown the resident into a chair and held his/her hand over the resident's mouth because he/she was spitting. When speaking with the resident he/she said that he/she did not feel like he/she was abused by HR Manager A. The resident said he/she was not thrown, and that HR Manager A did hold a towel up to his/her face, but it in no way impeded his/her ability to breathe; -Conclusion/outcome of the investigation: After further investigation and resident interview that facility had made the decision to unsubstantiate the claim of abuse. Review of the statements collected by the facility for the investigation showed the facility did not obtain a written statement from CMT B or NA F regarding the alleged abuse involving HR Manager A. During an interview on 5/28/25 at 2:35 P.M. NA F said the following: -He/She was on a break and heard a Code [NAME] called for the unit he/she was working on; -He/She ran back to the hall and there was an altercation between Resident #1 and two other residents. Resident #1 started spitting at other residents. He/She went and got a mask for Resident #1. When he/she returned, the resident was being restrained; -HR Manager A got in the resident's face and said the resident could scream, curse, hit and spit on him/her, he/she didn't give a fuck about his/her job. The resident started calling HR Manager A names and HR Manager A started yelling more at the resident. He/She tried to tap HR Manager A out of the situation but he/she wouldn't leave. NA F backed off and left the smoke room because HR Manager A was his/her superior; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She continued to hear yelling and screaming from inside the smoke room but couldn't hear what was being said; -No one asked him/her to provide a statement regarding the allegation of abuse involving HR Manager A. During and interview on 5/29/25 at 11:15 A.M. CMT B said the following: -On 5/25/25, he/she responded to a Code [NAME] on another hall that was in the smoke room; -When he/she responded, he/she cleared the area of residents and got a chair for Resident #1 who was the resident that the Code [NAME] was called on. HR Manager A entered the the smoke room and with both of his/her (HR Manager A's) hands, slammed the resident down into the chair and was screaming at the resident about putting his/her hands on other resident; -HR Manager A used his/her body weight to hold the resident against the wall. The resident began spitting. CMT B hollered for staff to get a mask or a towel, staff handed him/her a towel and HR Manager A grabbed it out of CMT B's hands and covered the resident's mouth and nose. Additional staff showed up and transferred the resident to another chair with arms; -HR Manager A sat in front of the resident yelling that he/she didn't care about this fucking job, and if the resident was going to treat him/her (HR Manager A) like trash, he/she would treat the resident like trash. HR Manager A was punching his/her hand in the resident's face in a threatening and aggressive manner; -This went on for a long time. LPN H was in and out of the smoke room and administered an injection to the resident; -The resident seemed more agitated and was fighting against staff while HR Manager A yelled at him/her; -CMT B felt the Code [NAME] lasted longer and was escalated more due to HR Manager A's actions of cursing and yelling at the resident; -He/She didn't provide a statement to administration regarding the allegation of abuse against HR Manager A as no one questioned him/her specifically about this; -He/She thought Licensed Practical Nurse (LPN) H would have reported HR Manager A's abusive behavior as LPN H was above CMT B. During an interview on 5/28/25 at 10:15 A.M. and 12:00 P.M. and 5/29/25 at 5:30 P.M., the Administrator said the following: -He interviewed all the staff that were involved, with the information that he had and only two staff members alleged abuse occurred; -He didn't review the camera footage from the smoke room; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He didn't feel he/she had enough proof to indicate abuse and HR Manager A denied being abusive towards the resident.

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to provide protective oversight of one resident (Resident #23), in a sample of 25 resident, when the resident burned the back of his/her left hand with a cigarette during a supervised smoke break. The resident said he/she was mad so he/she burned his/her hand. The resident had a history of self-harm and burned himself/herself earlier in the year with a cigarette. The facility failed to ensure all residents' smoking materials, including a nicotine vape pen (also known as an e-cigarette, a battery-operated device that heats a liquid into an aerosol that the user inhales. The liquid, often called e-liquid or e-juice, typically contains nicotine, flavorings, and other chemicals) were collected from the resident and secured at the end of smoking breaks. Resident #23 was observed by the surveyor with a vape pen in his/her possession, twice on 7/1/25 when it was not a scheduled resident smoking time, and the resident was not monitored by staff. The facility census was 178. Review of the facility policy Smoking Safety Regulations, revised 6/29/23, showed the following:-The facility will provide direct supervision for smoking by residents classified as not responsible;-Immediately after the resident's smoking session is completed, the Certified Nurse Aide (CNA) is to properly dispose of the cigarette and residue in the designated metal container. Review of the facility policy, Effectively Manage the Use of E-Cigarettes, revised 6/26/24, showed the following:-The facility will permit residents the use of e-cigarettes under the following conditions: -The resident and/or legal guardian are responsible for the purchase of the e-cigarettes, refills and chargers; -All e-cigarettes will be kept at a centralized station and/or location deemed to be safe for keeping and monitoring of usage; -The facility's established smoking protocols will be followed, including specialized unit policies and in accordance with the resident's plan of care. 1. Review of Resident #23's Pre-admission Screening and Resident Review (PASARR) Level II (the assessment aims to confirm the presence of serious mental illness, intellectual disability, developmental disability, or related conditions and evaluate the need for nursing facility services, and determine if specialized services are required beyond what a nursing facility can provide), dated 10/15/18, showed the following:-Diagnoses included bipolar disorder (mental health condition that causes extreme shifts in mood, energy, activity levels, and concentration), post-traumatic stress disorder (PTSD) (mental health condition that can develop after experiencing or witnessing a traumatic event), major depressive disorder (serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and other symptoms that interfere with daily life), psychotic disorder (group of mental illnesses characterized by a loss of contact with reality, involving symptoms like delusions, hallucinations, and disorganized thinking), schizophrenia (chronic and severe mental illness that affects how a person thinks, feels, and behaves), attention deficit hyperactivity disorder (ADHD) (psychiatric condition with patterns of developmentally inappropriate levels of inattentiveness, hyperactivity, or impulsivity), autism (developmental disability that affects how people interact with others, communicate, learn, and behave), and mild intellectual disability;-The resident had difficulty with impulse control and tended to act out instead of verbalizing feelings;-On 8/11/18, he/she became more depressed, made vague suicidal comments, and made superficial scratches on his/her left arm with a torn soda can. Review of the resident's Care Plan, dated 11/11/24, showed the following:-The resident was at risk for harm: self-directed due to behavior potentially causing harm;-Encourage the resident to verbalize cause for aggression;-If the resident posed a potential threat to injure self or others, notify the provider;-If safe, allow the resident personal space;-Minimize environmental stimuli;-He/She was a smoker;-Instruct the resident about the facility policy on smoking locations, times, and safety concerns;-Notify the charge nurse immediately if it is suspected the resident violated the facility smoking policy;-Observe clothing and skin for signs of cigarette burns. Review of the resident's Nurse Note, dated 3/4/25 at 2:44 P.M., showed the following:-The resident tried to burn the top of his/her hand while smoking;-He/She was upset because the staff did not give him/her one of their cigarettes;-He/She was smoking with staff supervision because of his/her actions;-The staff notified the guardian, and the guardian said if the resident did not stop trying to hurt himself/herself while smoking, they would order him/her a nicotine patch and the resident would not be able to smoke. Review of the resident's Smoking and Safety Assessment, dated 4/8/25 at 11:29 A.M., showed the resident used tobacco and vape products and the resident displayed burned skin, clothing, furniture or other. The assessment did not specify if the resident needed to be supervised while smoking. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by the facility staff, dated 4/11/25, showed the

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure sufficient staff were employed with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain the highest practicable mental and psychosocial well-being for residents who resided on locked behavioral health units. Hall Monitor A was the only staff assigned to the [NAME] Senior 300-Hall when he/she called a Code [NAME] (behavioral emergency) for one resident (Resident #15) in a sample of 24 residents who was experiencing a behavioral health crisis in the outside smoke area. Additional staff did not respond to the Code [NAME] to assist Hall Monitor A. Hall Monitor A became upset, left the unit and left residents unsupervised. A resident-to-resident physical altercation occurred while Hall Monitor A left the unit unsupervised. The facility census was 178.Review of the facility's undated policy, Hall Monitor Duties, showed the following:-The purpose of the hall monitor was to always know the location of every resident and to ensure the safety of all residents;-Get report from the nurse/designee at the beginning of the shift;-Answer call lights and assist the residents with their needs;-Update the nurse with changes in resident behaviors;-Before leaving the hall/floor for any reason a Certified Nurse Aide (CNA)/designee must take over the duties of the hall monitor. Before leaving the floor/unit the charge nurse must be notified;-Monitor the residents' smoke break as needed and directed by the charge nurse. Review of the facility assessment, last updated 06/27/25, showed the following:-The average daily census or number of occupied beds was 177 residents;-Common diagnoses/conditions of residents included psychosis (hallucinations, delusions etc.), impaired cognition, mental disorder, depression, bipolar disorder (a mental health condition characterized by extreme mood swings between mania and depression), schizophrenia (a chronic mental disorder that disrupts a person's ability to think, feel and behave clearly), post-traumatic stress disorder (PTSD, a mental health condition that can develop after experiencing or witnessing a traumatic event), anxiety disorder, behaviors that require interventions, personality disorder (a mental health condition characterized by inflexible and unhealthy patterns of thinking, functioning, and behaving), schizoaffective disorder (a mental health condition characterized by symptoms associated with schizophrenia and mood disorders like depression and mania), borderline personality disorder (a mental health condition characterized by a pervasive pattern of instability in emotions, self-image, and relationships, alongside impulsive behaviors);-The average number of residents with behavioral health needs was 37; -Resident support/care needs considerations included mental health and behavioral health. Manage the medical conditions and medication related issues causing psychiatric symptoms and behavior, identify and implement interventions to support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma, other psychiatric diagnoses, intellectual or developmental disabilities. Facility completed Interdisciplinary Team (IDT) meeting with residents needing assistance with their behavior and mental health. Facility provides access for residents to sign up for counseling. The facility offers a behavior management group weekly;-Provide person centered/directed care: Psychological/social/spiritual support. Build relationship with each resident, get to know him/her and engage resident in conversation. Find out what resident's preferences and routines are and what makes a good day for the resident. Find out what upsets the residents and incorporate this information into the care planning process. Make sure staff caring for the resident has this information. Record and discuss treatment and care preferences. Support emotional and mental well-being and support helpful coping mechanisms. Prevent abuse and neglect;-Consider staffing needs based on resident assessment and care plans. Consider staffing needs for each shift and adjust as necessary based on changes to resident population. Consider staffing needs for each unit and adjust as necessary based on changes to resident population;-Direct care staff hours per resident day or total hours per discipline included:-Day shift: 1 Registered Nurse (RN), 2 Licensed Practical Nurses (LPNs), 11 CNAs/Nursing Assistant (NAs), 4 Certified Medication Technician (CMTs);-Night shift: 2 LPNs, 11 CNAs;-Staff are assigned as needed to halls and areas where they are most skilled for the milieu, staff are rotated to another hall as needed or per request. Acuity of resident determines ultimately where staff are assigned;-Education and in-services included:-Communication-effective communication for direct care staff. Communicating with older adults with dementia, 1 hour-required by rules of participation;-Compliance and ethics training, 1 hour-required;-Workplace violence, .5 hours required by Human Resources;-Compliance/HIPPA, HR/Resident Rights/Abuse;-Monthly and as needed (PRN)