STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265696	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Platte City	220 O'Rourke Drive Platte City, MO 64079

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44993 Based on observation, interview, and record review, the facility failed to ensure two residents (Resident #3 and #2) were treated with dignity and respect when staff members were unnecessarily rough while providing care. This deficient practice affected two of 6 sampled residents. The facility census was 73. Review of the facility policy titled Resident Rights, dated 1/30/24, showed the facility staff will treat the resident with respect and dignity. Review of the facility policy titled Perineal Care, dated 1/20/25, showed: - The purpose of the policy was to ensure the residents receive safe and respectful perineal care; - The staff are to uphold the resident's dignity with professional standard in long-term care; - All residents who require assistance with perineal care will be provided with appropriate and person-centered care that promotes their comfort and dignity. 1. Review of Resident #3 Admission MDS, dated [DATE], showed: -A BIMS of 15 indicated no cognitive loss; -Dependent on staff for ADLs; -Diagnoses of segmental and somatic dysfunction of the lumbar region (problem with the lower back causing issues with nerves, muscles, joints, or their interaction), muscle weakness, need for assistance with personal care, falls, hypertension, renal disease (damage or disease of the kidneys). Review of the resident's baseline Care Plan, dated 3/28/25, showed need for assistance with personal care. During an interview on 4/3/25 at 3:28 P.M., the resident said: -CNA B had come into his/her room with CNA C to provide care on 4/1/25; (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA B rolled him/her really hard and fast; -CNA C told CNA B to quit being rough; -CNA B began yelling at CNA C and continued to provide care to him/her; -He/She was not afraid, but he/she did not like the way the staff were yelling over him/her. During an interview on 4/3/25 at 4:29 P.M., Nurse Aide (NA) A said: -CNA B was rough with residents when providing care and throws them around; -He/She reported to the Charge Nurse that CNA B was rough with residents, throwing them around in bed. During an interview on 4/3/25 at 4:53 P.M., LPN A said: -CNA C had reported to him/her CNA B was rough with a resident on 4/1/25; -He/She attempted to call the DON and Assistant DON multiple times without success on 4/1/25; -Resident #3 reported CNA B was really rough throwing him/her around in bed and he/she did not like it; -CNA B was very disrespectful and got into arguments in front of residents before. During an interview on 4/7/25 at 2:15 P.M., the resident said: -He/She needed cleaned up on 4/1/25; -He/She thought CNA B was going to pick him/her up and throw him/her; -CNA B threw him/her side to side and wiped his/her skin really hard and it hurt; -CNA B yelling at CNA C made him/her uncomfortable; -CNA B was excessively rough when providing care; -CNA B completed care hard and fast and it hurt. -He/She told the nurse CNA B turned him/her fast and cleansed his/her perineum with hard pressure. During an interview on 4/18/25 at 11:02 A.M., CNA B said: -He/She had worked with Resident #3: -He/She was moving Resident #3 on 4/1/25, and the resident's leg slipped, he/she grabbed the resident's leg again and pulled him/her over fast, the resident didn't yell out or complain; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA C told him/her not to be rough; -He/She told CNA C he/she was not being rough, but had to get the resident moved over to provide care; -He/She would never intentionally hurt a resident. During an interview on 4/3/25 at 5:00 P.M., the Administrator said: -She was aware of the complaint Resident #3 had regarding CNA B; -She felt it was a customer service issue and not abuse; -An investigation was done; -Education was provided to all staff on Abuse and Resident Rights. -She expected staff to be gentle and kind to all residents 2. Review of Resident #2's quarterly Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff), dated 3/8/25, showed: - The resident had a Brief Interview for Mental Statutes (BIMS) score of 11, indicating moderate cognitive impairment; - Diagnoses included: Parkinson's disease (disorder of the central nervous system that affects movement) and anxiety; - The resident was dependent on staff for his/her activities of daily living (ADLs-tasks completed daily to care for oneself); - The resident was incontinent of bowel and bladder. Review of the resident's impaired communication care plan, dated 1/14/25, showed: - The staff was to allow the resident adequate time to respond; - Anticipate the resident's needs; - Minimize environmental stimuli; - Provide clear, simple, and concise instructions for the resident. Observation on 4/5/25 at 8:54 P.M., showed: - CNA A entered the resident's room and put on gloves; - Certified Medication Technician (CMT) B entered the resident's room and put on gloves; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA A and CMT B assisted the resident to bed; - CMT B turned the resident to his/her side; - CNA A pulled the resident's pants down while CMT B rolled the resident back to his/her back; - CNA A pushed the resident's knees apart, unfastened the resident's incontinence brief, took a wipe form the package and scrubbed vigorously with an up and down motion along the resident's right side of groin; - CNA A threw the used wipe away and scrubbed vigorously up and down with a clean wipe the resident's left side of his/her groin and perineal area; - CMT B told the resident he/she was going to turn the resident and then turned the resident to the side; - CNA A removed another wipe from the package and scrubbed vigorously back and forth across the resident's; buttocks; - CNA A did not explain the procedure to the resident during this observation; - The CNA A did not verbalize to the resident during the perineal care. During an interview on 4/5/25 at 10:10 P.M., CMT B said: - CNA A was rough when he/she provided perineal care to the resident; - CNA A gets in a hurry to finish resident cares. During an interview on 4/5/25 at 10:56 P.M., Licensed Practical Nurse (LPN) A said: - Residents have complained about CNA A being too rough; - He/She had not witnessed CNA A providing cares to residents; - She would expect CNAs to complete perineal care in a way that was comfortable for the resident; - It was not appropriate to vigorously scrub Residents #2's perineal area, groin, and bottom. During an interview on 4/5/25 at 11:15 P.M., CNA A said: - He/She was trained to provide perineal care with one swipe per wipe; - He/She should not have scrubbed vigorously the resident's groin, perineal area, and bottom. During an interview on 4/5/25 at 11:26 P.M., the Director of Nursing (DON) said: - She expected the staff to treat all residents with dignity and respect; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- She did not expect CNA A to be rough when he/she provided perineal care for Resident #2; - She did not expect CNA A to scrub the resident's groin, perineal area, or bottom; - She expected cares to be carried out as gently as possible. MO252298 MO252340 MO251843 MO252096

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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** 44939 Based on interviews and record review, the facility failed to protect Resident #2's right to be free from sexual abuse by Resident #1, when Resident #1 was observed by staff sitting next to Resident #2, with his/her hand down the front of Resident #2's pants. The facility census was 63. Review of the facility's undated Abuse Prevention Program policy showed: -Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in physical harm, pain, or mental anguish. Instance 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 the use of technology; -Sexual abuse is defined as non-consensual sexual contact of any type with a resident; -The purpose of this policy is to protect the residents in this facility from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the residents, family members, legal guardians, surrogates, sponsors, friends, visitors or any other individual. 1. Review of Resident #1's Admission Minimum Data Set (MDS, a federally mandated assessment completed by staff), dated 12/26/24, showed: -The resident had diagnoses of heart disease (heart conditions that include diseased vessels, structural problems, and blood clots), senile degeneration of the brain (a general term for a group of neurological disorders that cause a decline in cognitive function), weakness, chronic fatigue, dementia (a group of thinking and social symptoms that interferes with daily functioning), malaise (a general sense of being unwell, often accompanied by fatigue, diffuse pain, or lack of interest in activities); -He/She had adequate hearing, clear speech, makes self understood and able to understand others; -He/She scored 3 on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly patients). This score indicates severely impaired cognitive skills; -He/She had displayed no behaviors. Review of the resident's undated comprehensive care plan showed: -The resident had a history of being resistive to cares related to anxiety and dementia; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had a history of behaviors related to dementia and can display physical aggression. 2. Review of Resident #2's quarterly MDS, dated [DATE], showed: -He/She had diagnoses of spastic quadriplegic cerebral palsy (the most severe form of cerebral palsy, affecting all four limbs, the trunk, and often the face, causing significant muscle stiffness and usually resulting in an inability to walk, often accompanied by other developmental disabilities like speech problems and intellectual impairment), dysphagia (difficulty swallowing), pain, repeated falls, non-traumatic subarachnoid hemorrhage (bleeding that occurs in the brain without trauma), dysarthria (weakness in the muscles used for speech, which often causes slowed or slurred speech), anarthria (loss of control over the muscles used for speaking), convulsions (a burst of uncontrolled electrical activity between brain cells (also called neurons or nerve cells) that causes temporary abnormalities in muscle tone or movements (stiffness, twitching or limpness), behaviors, sensations or states of awareness), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), amnesia (memory loss); -He/She had adequate hearing, unclear speech, sometimes is able to make self understood and usually understands others; -He/She scored zero on the BIMS, indicating severely impaired cognitive skills; -He/She had displayed no behaviors. Review of the residents comprehensive care plan, dated 10/24/24, showed: -He/She had a history of exhibiting sexually inappropriate behaviors, such as making inappropriate sexual comments to staff and at times will attempt to lay down in other resident's beds; -Resident #2 was able to answer questions by nodding yes or shaking his/her head no. 3. Review of the facility investigation, dated 1/12/25, showed: -On 1/12/25 at approximately 5:00 P.M., Resident #1 was observed by staff with his/her hand down Resident #2's pants. Certified Medication Technician (CMT) A was at the nurses' desk, counting medications. Resident #3 came to the nurses' desk and told CMT A that Resident #1 had his/her hand down Resident #2's pants. CMT A went to Resident #1 and redirected him/her from Resident #2. CMT A then assisted Resident #2 to the dining room as it was meal time; -During an interview with the Administrator, Resident #1 was unable to recall the incident with Resident #2. He/She denied touching another resident inappropriately; -During an interview with the Administrator, Resident #2 indicated no one had touched him/her inappropriately. He/She also indicated he/she felt safe in the facility; -Resident #1 was placed on 15 minute check observation. He/She was also moved to a private room with a private bath. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/25 at 12:17 P.M., CMT A said: -Resident #3 approached CMT A while he/she was at the nurses' station and said Resident #1 had his/her hand down Resident #2's pants. CMT A approached Residents #1 and #2 and observed Resident #1's hand down Resident #2's pants. CMT A asked Resident #1 to remove his/her hand from Resident #2's pants. CMT A then assisted Resident #2 to the dining room. CMT A then informed the charge nurse of the incident; -CMT A had not witnessed Resident #1 be inappropriate with other residents before this incident. During an interview on 1/15/25 at 12:19 P.M., Certified Nurses Assistant (CNA) A, said: -He/She was standing at the nurses desk when Resident #3 approached the desk. Resident #3 stated he/she needed help because Resident #1 had his/her hand down Resident #2's pants. CNA A looked over and observed Resident #1 sitting next to Resident #2 with his/her hand down Resident #2's pants. CMT A then went over to the residents and redirected Resident #1 and assisted Resident #2 to the dining room as it was almost meal time. During an interview on 1/15/25 at 12:21 P.M., Resident #3 said: -He/She was sitting in the front living room area, watching television with other residents. He/She saw movement and looked over and saw Resident #1 with his/her hand down the front of Resident #2's pants. Resident #1 went to the nurses desk and asked CMT A for help. During an interview on 1/15/25 at 12:30 P.M., Resident #1 said: -He/She had no recollection of being inappropriate with another resident; -No one at the facility has been inappropriate with him/her. He/She felt safe at the facility. During an interview on 1/15/25 at 12:45 P.M., the Administrator said it was his/her expectation that residents are safe in the facility and not touched inappropriately by other residents. MO247928

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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** 47195 Based on interview and record review, the facility failed to report an injury of unknown origin, when the facility staff became aware on 2/27/25 that one resident (Resident #1) had a right leg femur fracture. The facility census was 67. Review of facility policy, Abuse, Neglect, and Exploitation, revised 1/17/25, showed: -Reporting of all alleged violations to the administrator, state agency, adult protective services, and to all other required agencies within specified time frames: -Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or -Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. -The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. 1. Review of Resident #1's Quarterly Minimum Data set (MDS), a federally mandated assessment tool completed by staff, dated 2/9/25, showed: - Cognition severely impaired: - The resident had impaired range of motion on both upper and lower extremities; -Dependent on a wheelchair; -Dependent on staff for all acitivities of daily living, transfers, and mobility. -He/she received scheduled pain medication; -He/she had no falls in last six months; -Diagnoses included: Quadriplegia (paralysis of all four limbs), aphasia (a language disorder that affects a person's ability to communicate), and unspecified pain (pain that did not have clear cause or diagnosis). Review of the residents care plan, dated 1/9/25, showed: -The resident is at risk for impaired circulation; -Staff are to administer pain medications per physician orders; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff are to encourage and maintain bed rest, with leg elevated per order; - The reisdent is at risk for falls due to paralysis; - Staff are to use of mechanical lift for transfers; Review of physician's orders, dated 3/3/25, showed: - An order dated 11/22/24, to assess for pain every shift; - An order dated 1/10/25, to wrap legs from toes to knee on in am and off in pm, two times a day for swelling of feet; - An order dated 1/10/25, to administer Acetaminophen oral liquid 160 milligram (MG)/5 milliliter (ML), give 20 ml via gastrostomy tube (g-tube) (a surgically inserted tube that allows direct access to the stomach for feeding, medication administration, and other purposes) every 4 hours as needed for pain or fever; - An order dated 1/10/25, to administer Gabapentin tablet 600 mg, give 1 tablet via peg-tube three times a day for pain in legs and feet; - An order dated 1/10/25, to administer Hydroco/apap 5-325 mg (UD), give 0.5 tablet via G-tube two times a day for pain related to unspecified pain; - An order dated 1/10/25, to administer Hydroco/apap 5-325 mg, give 1 tablet via G-tube as needed for pain related to unspecified pain; - An order dated 1/10/25, to administer Hydrocodone-acetaminophen oral tablet 5-325 mg, give 1 tablet via G-tube every 8 hours as needed for pain / allow adequate time for resident response. Review of progress notes, dated 1/20/25-2/27/25, showed: -On 1/20/25 at 06:30 A.M., Registered Nurse (RN) A wrote - entered room and observed resident laying on floor on mechanical lift pad under resident. CNA reported to RN A the mechanical lift started to tip and CNA lowered resident to floor. No injuries noted and resident denied pain. Assist of three per mechanical lift to wheelchair. -On 2/27/25 at 12:24 A.M., Resident complained of pain in right knee, found on assessment that right knee was swollen and tender to touch. Notified physician, obtained order for radiograph (x-ray) of right knee. While assessing resident found resident was at 84% on room air. Resident was placed on oxygen via nasal cannula and order obtained for chest radiograph. -On 2/27/25 at 1:09 A.M., Resident took oxygen off was sweaty and hard wheezes on expiration. Oxygen saturations were at 82 %. Resident removed oxygen and would not allow nasal cannulas back on. Physician notified and orders obtained to send resident to emergency room . Review of hospital records, dated 2/27/25-3/2/25, showed: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 2/27/25, patient evaluated in emergency room for right distal femur fracture. Unknown date of injury or mechanism. Resident was agitated and noted to have knee redness and swelling. Radiograph in emergency department revealed distal femur fracture, bicondylar displaced. -On 2/27/25, Review of imaging results of radiograph of right knee, showed: mildly displaced distal right femoral metadiaphyseal fracture; -Plan of closed bicondylar facture of distal femur showed recommended non-operative management, hinged knee brace per ortho, will need frequent skin check near brace due to risk of wounds/skin break down, and pain control. During an interview on 3/3/25, at 3:03 P.M., Certified Nurse Aide (CNA) A said: -The resident recently had been found to have a leg fracture; -Nobody knew how the fracture of resident's leg occurred; -Resident had been fine prior to shower; -Upon return from shower resident had flailed their arms and legs; -The resident kept saying that they hurt; -The resident was always in pain but appeared to have new pain that day; -The residents fracture was discovered that night after their shower; -The resident had swollen area on their leg before they were sent out to hospital. During an interview on 3/3/25 at 3:20 P.M., CNA B said: -The resident had a right broken femur; -No one knew what happened to cause the fracture to resident; -Resident received a shower that morning and had been fine before the shower; -Later after shower resident complained their leg was hurting; -The Director of Nursing (DON) had spoken with them and wanted to know how many times they had touched resident. During an interview on 3/3/25 at 2:37 P.M., Administrator said: -The resident was evaluated in the emergency roiagnom on [DATE] for a right distal femur fracture; -The injury was from an unknown date or mechanism; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident showed signs of agitation and noted to have knee redness and swelling; -A radiograph (a picture or image produced using x-rays) in the emergency department revealed a right distal femur fracture; -The hospital records indicated the fracture was closed so it had to be an old fracture; -On January 27th, 2025 the resident got tangled up in reclining wheel chair during a mechanical lift transfer and staff lowered resident all the way to the ground; -The resident did not fall but was lowered to the ground during the transfer; -There had been no complaints of pain from resident after the mechanical lift incident in January; -The resident experienced frequent pain; -The DON interviewed staff to determine if any abnormal event had happened; -She was unsure why a report regarding the injury of unknown origin was not made; -She had been waiting to get report back from hospital; -She had phoned her corporate contact and was advised to wait for radiology report; -She did not suspect abuse or neglect of resident; -She was not sure if they should have reported the injury of unknown origin. During an interview on 3/3/25 at 3:39 P.M., DON said: -He/She was notified by the nurse on February 26, 2025 that resident was not feeling well and had swelling of leg; -The resident's family notified the facility from the hospital that resident had fracture on February 27, 2025; -The resident's family inquired with facility when they called if the facility was aware of any possible falls for resident; -He/She started investigation by interviewing aids who had worked the floor; -He/She did not find anything from anyone that led to a transpiring event; -He/She did not report injury of unknown origin because they were waiting to hear from the hospital orthopedic doctor; -He/She discussed unknown injury with corporate and administrator and was advised to wait and see what information they received from hospital; (continued on next page)

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	265696	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Platte City	220 O'Rourke Drive Platte City, MO 64079

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She learned resident had a closed fracture on Monday; - The Administrator was responsible for doing facility reporting; -He/She and administrator deferred to corporate and made team decisions prior to making any reports; -The resident had no known injuries to his/her femur in past. MO240279

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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** 47195 Based on interview and record review, the facility failed to complete a thorough investigation when one resident (Resident #1) sustained a femur fracture of unknown origin and failed to maintain documentation that an alleged violation was thoroughly investigated. The facility census was 67. Review of facility policy, Abuse, Neglect, and Exploitation, revised 1/17/25, showed: -Possible indicators of abuse included: physical injury of a resident, of unknown source; -An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. -Written procedures for investigations include: -Identifying staff responsible for the investigation; -Exercising caution in handling evidence that could be used in a criminal investigation; -Investigating different types of alleged violations; -Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; -Focusing investigation on determining if abuse, neglect, exploitation, and/or mistreatment had occurred, the extent, and cause; and -Providing complete and thorough documentation of the investigation. 1. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool completed by staff, dated 2/9/25, showed: -Cognition Severely Impaired: -They had impaired range of motion on both upper and lower extremities; -Dependent on a wheelchair; -Dependent on staff for all cares, transfers, and mobility; -They received scheduled pain medication; -They had no falls in last six months; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included: Quadriplegia (paralysis of all four limbs), aphasia (a language disorder that affects a person's ability to communicate), and unspecified pain (pain that did not have clear cause or diagnosis). Review of care plan, dated 1/9/25, showed: -The resident was at risk for impaired circulation; -Staff to administer pain medications per order, if non-medication interventions were ineffective; -Encourage and maintain bed rest, with leg elevated per order; -The resident was at risk for falls due to paralysis; -Use of mechanical lift for transfers; Review of nursing progress notes, dated 1/20/25-2/27/25, showed: -On 1/20/25 at 06:30 A.M., Registered Nurse (RN) A wrote- entered room and observed resident laying on floor on mechanical lift pad under resident. CNA reported to RN A that the mechanical lift started to tip and CNA lowered resident to floor. No injuries noted and resident denied pain. Assist of three per mechanical lift to wheelchair. -On 2/27/25 at 12:24 A.M., Resident complained of pain in right knee, found on assessment that right knee was swollen and tender to touch. Notified physician, obtained order for radiograph (x-ray) of right knee. While assessing resident found resident was at 84% on room air. Resident was placed on oxygen via nasal cannula and order obtained for chest radiograph. -On 2/27/25 at 1:09 A.M., Resident took oxygen off was sweaty and heard wheezes while breathing. Oxygen saturations were at 82 %. Resident removed oxygen and would not allow nasal cannulas back on. Physician notified and orders obtained to send resident to emergency room . Review of hospital records, dated 2/27/25-3/2/25, showed: -On 2/27/25, patient evaluated in emergency room for right distal femur fracture. Unknown date of injury or mechanism. Resident was agitated and noted to have knee redness and swelling. Radiograph in emergency department revealed distal femur fracture, bicondylar displaced. -On 2/27/25, Review of imaging results of radiograph of right knee, showed: mildly displaced distal right femoral meta diaphyseal fracture; -Plan of closed bicondylar facture of distal femur showed recommended non-operative management, hinged knee brace per ortho, will need frequent skin check near brace due to risk of wounds/skin break down, and pain control. Review of facility investigation showed a one page typed document showed: -Staff Interview (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #1 (investigative event) dated 2/27/25: -Hospital nurse was unable to provide information and confirm fracture until orthopedic doctor confirmed. -CNA C: (Night shift) did not work with resident on that shift. -CNA D: (Night shift) did not notice anything unusual, when caring for Resident #1. -CNA E: (Night shift) did not work on Resident #1's hall. -CNA F: (Night shift) did not work on Resident #1's hall. -CNA B: (Night/Day shift) did not notice anything unusual. The nurse was notified of any discomfort from Resident #1. -CNA G: (day shift/shower aide) resident #1 did not show any signs of pain when showering resident. -CNA H: -did not work on that hall. -No date or times were documented of interview statements; -There was no additional information provided from facility investigation. During an interview on 3/3/25, at 3:03 P.M., Certified Nurse Aide (CNA) A said: -The resident recently had been found to have a leg fracture; -Nobody knew how the fracture of resident's leg occurred; -Facility staff came around and asked if the aides knew anything about how fracture occurred with resident; -He/she did not complete a written statement regarding residents fracture; -He/she would report suspected abuse to charge nurse, administrator, DON, or Assistant DON; -Facility staff always have the aides write a written statement if an event occurred, even if they did not witness event. During an interview on 3/3/25 at 3:20 P.M., CNA B said: -The resident had a broken femur; -He/she nor other staff knew what happened to cause the fracture to resident; -The Director of Nursing (DON) had spoken with him/her and wanted to know how many times he/she had touched resident; (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 did not complete any written statement of event for the investigation. During an interview on 3/3/25 at 2:37 P.M., the Administrator said: -The resident was evaluated in the emergency roiagnom on [DATE] for a right distal femur fracture; -The injury was from an unknown date or mechanism; -The residents family mentioned to the DON the possibility of the resident getting hurt when the mechanical lift tipped back in January; -A radiograph (a picture or image produced using x-rays) in the emergency department revealed distal femur fracture; -The DON interviewed staff to determine if any abnormal event had happened leading to the injury; -The DON had completed the investigation; -She does not suspect abuse or neglect of the resident. During an interview on 3/3/25 at 3:39 P.M., the DON said: -He/She was notified by the nurse on February 26, 2025 that resident was not feeling well and had swelling of leg; -The residents family notified her from the hospital that resident had fracture on February 27, 2025; -When the reisdent's family called, they and asked they were aware of any possible falls for resident; -He/She investigated the injury of unknown origin by verbally interviewing aids who had worked with resident; -He/She did not collect written statements from staff as part of her investigation; -He/She did not have any additional documents regarding the investigation. -He/She did not have any documentation of mechanical lift incident that occurred in January other than what was in the progress notes; -He/She did not know what CNA was involved in the lift transfer in January; -He/She did not find anything out during interviews that led him/her to believe there was a transpiring event causing resident's injury of unknown origin; -One shower aid that was interviewed did not witness anything unusual with the resident; (continued on next page)

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