STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265822	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgewood Health Care Center	11515 Troost Kansas City, MO 64131

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35013 Based on interview and record review, the facility failed to maintain resident dignity when Certified Medication Technician (CMT) E spoke to Resident #56 in an inappropriate manner, using foul language. This deficient practiced affected one sampled resident (Resident #56) out of seventeen sampled residents. The facility census was 153 residents. The Administrator was notified on 3/5/25 of the past noncompliance which began on 2/26/25. The facility immediately completed education for staff on the Dignity and Respect policy. The deficiency was corrected on 2/26/25. Review of the facility policy for Dignity and Respect, revised 6/29/23, showed: -The policy was created to ensure that all residents were treated with dignity and respect. -Every resident had the right to be treated with dignity and respect. Review of the facility policy for Customer Service, revised 7/31/23, showed: -The purpose of the policy was to set expectations for customer service and professional behavior expected of all facility staff. -Appropriate conduct was required while in person, by telephone or written correspondence. -Courtesy and respect for residents was required by staff at all times. 1. Review of Resident #56's Facility Admission Record showed he/she was admitted on [DATE] with the following diagnoses: -Dementia with Behavioral Disturbance (changes in behavior, mood, perception, and thought that can occur in individuals with dementia, often alongside cognitive decline). -Traumatic Brain Injury (TBI-traumatic brain injury (TBI - damage to the brain resulting from external mechanical force, such as rapid acceleration or deceleration, impact, blast waves, or penetration by a projectile). (continued on next page)

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

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F 0557 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 tool completed by facility staff and used for care planning), dated 2/28/24, showed he/she: -Was cognitively intact. -Had no negative behaviors during the look back period. Review of the resident's Individual Care Service Plan (ICSP), dated 3/4/25, showed: - If the resident made inappropriate comments towards female staff, please set clear limits and let him/her know this is inappropriate behavior, letting him/her know staff and residents were professional relationships. -The staff was to report to the charge nurse any changes in ability to communicate, possible factors which could cause communication issues, make communication worse or better. -The staff was to avoid attempting to over reorient the resident to current place and time as this could cause distress. -The staff was to assist with helping the resident stay on task. -The staff was to avoid arguing or getting defensive or confronting the resident. -The staff was to have been consistent, keep a routine as much as possible. -The staff was to be respectful, honest, and non-judgmental with the resident at all times, calmly redirecting the resident's inappropriate behavior. -The staff was to discuss any resident behavior that may have been inappropriate and ways to make his/her behaviors better. Review of the facility's Registered Nurse Investigation (RNI), dated 2/26/25 at 11:30 A.M., showed: -At around 9:45 A.M., on 2/26/25 while in the main dining room, Resident #56 said something unintelligible under his/her breath while near CMT E. -Upon overhearing the resident say something that he/she felt was derogatory and potentially directed at him/her, CMT E responded back to the resident, Shut your ass up! -The statement was overheard by the facility Administrator and CMT B. -There were no other witnesses. During an interview on 3/4/25 at 10:45 A.M., the facility Administrator said: -He/she entered the main dining room on 2/26/25 and was observing between 9:45 A.M. and 10:00 A.M. -He/she overheard CMT E say in the direction of the resident, Shut your ass up! (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she did not know what provoked that response as he/she did not hear what, if anything, was said by the resident. -He/she then went and asked CMT B if he/she heard what he/she thought he/she heard. -CMT B told the Administrator that yes, that was indeed what CMT E had said to the resident. -It was inappropriate behavior. -He/she would have expected CMT E to have not reacted to the resident even if he/she said something derogatory to the CMT. During an interview on 3/4/25 at 11:15 A.M., CMT B said: -He/she was passing medications in the main dining room around 10:00 A.M. -He/she heard the resident say something to CMT E like his/her having a fat butt, or something similar. -CMT E replied to what the resident saying, Shut your ass up! -He/she heard what CMT E said very clearly. -He/she was really surprised and figured CMT E knew not to talk to a resident that way. -The facility Administrator was there and asked if CMT B heard what CMT E said. During an interview on 3/4/25 at 11:50 A.M., the resident said: -He/she did not remember anything as he/she had a brain injury that damaged his/her memory. -He/she does not really remember anything for very long. MO00250240

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety 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** 35013 Based on observation, interview and record review, the facility failed to ensure two residents (Residents #49 and Resident #14) out of 17 sampled residents were free from abuse. On [DATE], Resident #49 was sexually abused by his/her roommate, Resident #50. Resident #49 reported to facility staff that Resident #50 fondled his/her private area over his/her underwear around 12:00 A.M. Facility staff failed to implement interventions to protect the resident, resulting in Resident #50 sexually abusing Resident #49 again at 1:00 A. M., and again at 2:00 A.M. Resident #49 told Resident #50 to leave and kicked the resident in the stomach. On [DATE], Resident #52 threw a hard plastic cup at Resident #14, hitting him/her in the mouth which resulted in the resident receiving two sutures to close a deep cut in his/her upper lip. The facility census was 153 residents. The Administrator was notified on [DATE] at 4:45 P.M. of the Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE], as confirmed by surveyor onsite verification. Review of the facility Resident Rights Policy, dated [DATE], showed: -Purpose was to ensure that resident rights are protected. -Resident has the right to be free from verbal, sexual, mental and physical abuse, corporal punishment and involuntary seclusion. -See Abuse and Neglect policy. Review of the facility Abuse and Neglect Policy, dated [DATE], showed: -Abuse is the willful infliction of injury, intimidation or punishment with resulting physical harm, pain or mental anguish. -Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. -Physical abuse is purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner. -Physical abuse also includes, but is not limited to, hitting, slapping, punching, biting, and kicking. -Sexual abuse was non-consensual contact of any type with a resident including any kind of unwanted touching of the genital area. -All residents had the right to be free from sexual abuse. -The alleged perpetrator was to be immediately removed from the victim. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's undated handbook for Crisis Prevention Intervention (CPI- the technique taught and used to de-escalate and/or physically redirect residents with mental illness who have an escalated behavior) showed: -Safety interventions range from verbal and environmental non-restrictive interventions to non-restrictive disengagements and restrictive interventions. The goal is to choose the safety intervention that is a last resort, reasonable and proportionate. -Disengagements and restrictive interventions are not risk-free and are highly traumatic for everyone involved. It can affect a person physically and mentally. These effects can be long lasting or even life-threatening. -Many individuals in your care might have already been through traumatic experiences. A disengagement or restrictive intervention can trigger previous traumatic experiences. -Holding. A restrictive safety intervention necessary to restrict a person's range of movement to prevent the infliction of harm to self or others. -Standing Hold: Medium Level Restriction - Staff begin in the low level restriction. Apply the Outside Principle by placing the palm of your furthest hand at the resident elbow. Apply the Inside Principle, bringing your nearest arm underneath and resting your arm over the person's forearm. Cup your hand to avoid gripping and squeezing. Stand close, adjusting your furthest leg so you remain balanced and stable. Use your body to maintain contact at the shoulder, hip and thigh. Encourage the person to keep their arms in front of their body. 1. Review of Resident #49's Preadmission Screening and Resident Review (PASRR - a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care), dated [DATE], showed: -He/she had the following diagnoses: --Major Depressive Disorder (MDD), also known as clinical depression, is a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in previously enjoyable activities). --Anxiety Disorder. --Psychotic Disorder. -He/she had a stroke in 2023 and was unable to use the left side of his/her body. -Due to the effects of the stroke, he/she needed assistance with all of his/her daily activities. Review of Resident #49's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff and used for care planning), dated [DATE], showed he/she: -Was cognitively intact. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/she had no negative behaviors over the review period. Review of Resident #50's PASRR dated [DATE], showed he/she had diagnoses of: --Neurocognitive Disorder with Lewy Bodies Dementia (a progressive brain disorder characterized by the accumulation of abnormal protein deposits called Lewy bodies in the brain which can cause a wide range of symptoms such as sleep disorders and hallucinations and delusions). --Schizophrenia (a severe psychiatric disorder with symptoms of emotional instability, detachment from reality, and withdrawal into the self). --Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety). --Psychotic Disorder (a group of symptoms that describe a severe mental disorder where a person loses touch with reality). --Schizoaffective Disorder (a mental condition that causes loss of contact with reality and mood problems). --Bi-Polar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). -He/she required 24-hour monitoring and care due to the severity of his/her dementia. -He/she was a registered sex offender in another state from [AGE] years prior. -He/she required assistance with everything from hygiene and medication administration, to finding his/her room and bathroom due to his/her severe Lewy Bodies dementia. -He/she was only oriented to person. Review of Resident #50's quarterly MDS dated [DATE], showed he/she: -Was not cognitively intact. -Showed no negative behaviors over the review period. Review of Resident #50's undated Individualized Service Care Plan (ISCP) showed: -Overall monitoring. --Watch for any adverse reactions to psychotropic medications such as an unsteady gait, shuffling gait, falls, refusal to eat, behavior symptoms not usual to the resident. --Observe and report changes in usual routine, sleep patterns, decease in functional abilities, decrease in range of motion, withdrawal or resistance to care. --Do resident face checks. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Monitoring Safety. --Signs and symptoms of dementia include memory loss, difficulty communicating, or finding words, difficulty handling complex tasks, issues with planning and organizing, issues with coordination and motor functions, confusion and disorientation, personality changes, depression, anxiety, inappropriate behavior, agitation and hallucinations. Review of the facility's Registered Nurse Investigation (RNI), dated [DATE], showed: -A little after 12:00 A.M., on [DATE], Resident #49 informed Certified Nursing Assistant (CNA) R that Resident #50 had fondled his/her private area around midnight. -CNA R informed Licensed Practical Nurse (LPN) D. -The alleged incident was not escalated. -When the Director of Nursing (DON) was making his/her morning rounds, Certified Medication Technician (CMT) F informed the DON of what happened. -An investigation began and the day shift nurse performed a room change. -Resident #50 was moved to a private room and placed on one-to-one staff observation. -The Medical Nurse Practitioner (NP) happened to be in the facility and spoke with both residents. -Resident #49 reported that Resident #50 fondled his/her private area over his/her underwear around 12:00 A.M., and he/she reported it to CNA R. -He/she stated that no staff came to see the resident after he/she reported the incident. -The resident stated Resident #50 fondled him/her again at 1:00 A.M., and 2:00 A.M., Resident #50 had his/her hand under the covers and over his/her underwear near his/her private area. -He/she stated that at 2:00 A.M., after the incident, he/she told Resident #50 to leave and kicked him/her in the stomach. During an interview on [DATE] at 1:30 P.M., the DON said: -Around midnight on [DATE] Resident #49 was fondled over his/her underwear by Resident #50. -Resident #49 told his/her aide who told the charge nurse, but the charge nurse dismissed it. -Resident #49 told him/her that no one ever came down to speak to him/her about what happened, and he/she was never moved out of the room where it happened. -Resident #49 told Resident #50 to get away and even said he/she kicked Resident #50 in the stomach, but he/she was never moved out of the room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The DON did not find out about it until he/she was making morning round between 9:15 A.M., and 10:15 A. M., when he/she began his/her investigation and moved Resident #50 out of the room. Review of Resident #49's written statement, dated [DATE], showed: -Around midnight Resident #50 was over his/her bed with Resident #50's hand under the blanket fondling the resident. -He/she pressed his/her call light and CNA R came to speak with him/her. -CNA R said he/she told LPN D, but nothing happened after that. -Around 1:00 A.M., the same thing happened. -He/she yelled at Resident #50 and the resident stopped. -At 2:00 A.M., Resident #50 had his/her head under the blanket with his/her head down there. -Resident #49 yelled, what the fuck are you doing? and kicked the resident in the stomach. -Resident #50 was touching him/her over his/her underwear. -The police came and gave him/her case number. During an interview on [DATE] at 11:15 A.M. Resident #49 said: -He/she was sound asleep around 12:00 A.M., when he/she woke up to Resident #50's hand under the covers with Resident #50's hand over Resident #49's underwear over his/her genital area. -He/she told the resident to get away and immediately put his/her call light on, and CNA R came down to see him/her. -He/she told CNA R what had happened and CNA R said he/she would go tell the charge nurse. -Again, around 1:00 A.M., the same thing happened where the resident woke up to Resident #50 with his/her hand under the covers with his/her hand over Resident #49's underwear on top of his/her genital area. -Once again, the resident told Resident #50 to get away and smacked at his/her hand. -Resident #50 paced around the room for a minute then got into his/her bed. -Resident #49 once again informed CNA R what happened and CNA R said he/she had told the charge nurse before and would tell the charge nurse again. -At 2:00 A.M., Resident #49 woke up to Resident #50 having his/her head under the covers with his/her head near Resident #49's genital area. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-This time, Resident #49 kicked at the resident and told him/her to get the fuck out, to which Resident #50 left the room and Resident #49 fell asleep. -At no time did the charge nurse come in a speak with him/her and he/she spent the whole night in the same room as the man who sexually assaulted him/her. -It made him/her feel really weird and he/she decided that if Resident #50 did anything again, Resident #49 had a pen on his/her table that he/she was going to use to stab Resident #50 in the neck. During an interview on [DATE] at 2:25 P.M., CNA R said: -At around midnight on [DATE], Resident #49 turned his/her call light on and said that Resident #50 had touched his/her genitals over his/her underwear, stating, he/she tried to touch my piece! -The resident told CNA R he/she had told Resident #50 to get the fuck off me! -He/she immediately went and told LPN D what happened to Resident #49. Review of the Resident #50's written statement dated [DATE] showed, he/she said nothing happened. I just want a room. During an interview on [DATE] at 3:10 P.M., Resident #50 said: -Nothing happened! -That's ridiculous! -I have no idea where I am or what room I am in! During an interview on [DATE] at 1:38 P.M., LPN D said: -Resident #50 was confused. -Resident #49 was alert and oriented. -CNA R told him/her around 6:30 A.M., on [DATE] when he/she was counting pills. There was a lot going on during that time, so CNA R had to whisper to him/her what happened. -CNA R reported to him/her that the resident said somebody touched him/her and LPN D had told CNA R to hold on a minute. -He/she was told during shift change so he/she forgot to tell the next shift. -He/she did not remember CNA R telling him/her before 6:30 A.M. During an interview on [DATE] at 2:15 P.M., the NP said: -He/She was aware of Resident #50's history and sex offender status. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Staff was to provide positive feedback for positive behaviors. -He/she stated no real triggers, however he/she did not like to be treated like he/she couldn't do things just because he/she was in a wheelchair. Review of Resident #14's quarterly MDS, dated [DATE], showed he/she: -Was cognitively intact. -Had no negative behaviors over the review period. -Was totally dependent on one to two staff members for all daily activities. -Used a power wheelchair. Review of Resident #52's undated Facility Admission Record showed he/she was admitted [DATE] with the diagnoses of a stroke. Review of Resident #52's Nursing Care Plan, dated [DATE], showed: -The resident had symptoms related to his/her bi-polar disorder, TBI, and depression. -The staff was to assist him/her with staying on task, maintaining a routine, decreasing stimulation when he/she was showing anxiety, offer music, and warm baths. -The staff was not to argue with the resident. -The staff was to be aware of body stance and the resident's personal space. -The staff was to offer activities to keep him/her from getting bored. -The staff was to offer non-invasive coping mechanisms first to try to reduce anxiety level and assist the resident in finding the cause of the anxiety. -The resident had a history of a resident-to-resident altercation, so staff was to watch for signs of escalation. -His/her safety plan showed his/her triggers were when people shove him/her. -His/her coping skills were smoking, watching television, and talking to someone. Review of Resident #52's quarterly MDS, dated [DATE], showed he/she: -Was cognitively intact. -Had no negative behaviors over the review period. -Ambulated via wheelchair. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Had movement limitations on one arm and both legs. Review of Resident #52's Nurse's Notes, dated [DATE] at 1:18 P.M., showed: -LPN I was alerted to come to the resident's room. -Before arriving to the room, the resident was being removed from the room. -The police were called and upon interview, the resident admitted to getting upset with Resident #14 and throwing a cup which had hit Resident #14 in the mouth. -The resident was moved to another room and Resident #14 went to the hospital. Review of Resident #14's Nurse's Notes, dated [DATE] at 6:05 P.M., showed: -At approximately 1:00 P.M., LPN I was called to the resident's room and upon arrival noticed the resident had blood coming from his/her mouth. -Prior to arriving to the room the resident's roommate, Resident #52 was being removed from the residents' room. -Upon assessment of the resident's mouth, it appeared the resident's tooth had gotten lodged in his/her lower lip. -The NP was notified and gave an order to have the resident sent to the hospital for evaluation and possible sutures. -The police were also notified and took the residents' statements. -The resident was sent to the hospital at approximately 1:30 P.M. -Resident #52 was moved to another room. Review of the facility's RNI, dated [DATE], showed: -At around 1:16 P.M. on [DATE], Resident #52 threw a cup at Resident #14 and busted his/her upper and lower lips. -The provider was notified, and Resident #14 was sent out to the hospital for evaluation and treatment. During an interview on [DATE] at 2:28 P.M., Resident #14 said: -His/her roommate threw a heavy plastic drinking cup at him/her and cut his/her lip. -He/she had to go to the hospital and get two stitches in his/her lip. (continued on next page)

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	265822	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgewood Health Care Center	11515 Troost Kansas City, MO 64131

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/she had just asked Resident #52 to move out of the way and that was when Resident #52 threw the cup at him/her. -He/she has no idea why Resident #52 threw the cup. Observation on [DATE] at 2:28 P.M. of Resident #14's lip showed: -Two small sutures in his/her upper lip. -Some slight swelling and redness were noted for both his/her upper and lower lip. During an interview on [DATE] at 11:25 A.M., Resident #52 said: -Resident #14 rammed into Resident #52 with his/her electric wheelchair. -When he/she did that, Resident #52 got angry and threw the cup. During an interview on [DATE] at 4:00 P.M., the DON said this was abuse as Resident #14 was injured to the point of needing sutures. During an interview on [DATE] at 4:20 P.M., the Administrator said: -He/she would have expected that no abuse occurred in the first place, but it did not seem these two residents had any issues in the past. -There were no witnesses, but the residents were separated as soon as Resident #14 notified the staff of what happened. -He/she believed this was an abusive situation as Resident #14 required a hospital visit and sutures to his/her lip. During an interview on [DATE] at 2:15 P.M., the NP said: -He/she was surprised at this altercation as these residents did not have a history of altercations. -He/she understood the concern given Resident #14 needed sutures for his/her lip. -He/she understood how this was an abusive situation since Resident #14 needed stitches. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). MO00250145, MO00250206

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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** 35013 Based on interview and record review, the facility failed to report an allegation of sexual abuse timely for one sampled resident (Residents #49), out of seventeen sampled residents. On 2/25/25, Resident #49 told Certified Nurse Aide (CNA) R of the abuse and CNA R told Licensed Practical Nurse (LPN) D. CNA R and LPN D did not immediately report the allegation to administrative staff. The facility census was 153 residents. The Administrator was notified on 3/5/25 of the past noncompliance which began on 2/25/25. The facility immediately completed education for all staff on the Abuse, Neglect policy reporting procedures. The deficiency was corrected on 2/25/25. Review of the facility Abuse and Neglect Policy, dated 6/12/24, showed: -Sexual abuse was non-consensual contact of any type with a resident including any kind of unwanted touching of the genital area. -All residents had the right to be free from sexual abuse. -The facility was to report all alleged violations to a superior staff member immediately. -The licensed nurse was responsible for escalating the report to the Director of Nursing (DON). 1. Review of Resident #49's Preadmission Screening and Resident Review (PASRR - is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care), dated 12/5/23, showed: -He/she had the following diagnoses: --Major Depressive Disorder (MDD), also known as clinical depression, is a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in previously enjoyable activities). --Anxiety Disorder. --Psychotic Disorder. -He/she had a stroke in 2023 and was unable to use the left side of his/her body. -Due to the effects of the stroke, he/she needed assistance with all of his/her daily activities. Review of Resident #49's quarterly Minimum Data Set (MDS), a comprehensive assessment of resident needs, dated 12/27/24, showed he/she was cognitively intact. Review of Resident #50's PASRR, dated 6/12/24, showed he/she had diagnoses of: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Neurocognitive Disorder with Lewy Bodies Dementia (a progressive brain disorder characterized by the accumulation of abnormal protein deposits called Lewy bodies in the brain which can cause a wide range of symptoms such as sleep disorders and hallucinations and delusions). --Schizophrenia (a severe psychiatric disorder with symptoms of emotional instability, detachment from reality, and withdrawal into the self). --Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety). --Psychotic Disorder (a group of symptoms that describe a severe mental disorder where a person loses touch with reality). --Schizoaffective Disorder (a mental condition that causes loss of contact with reality and mood problems). --Bi-Polar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). -He/she required 24-hour monitoring and care due to the severity of his/her dementia. -He/she was a registered sex offender in another state from [AGE] years prior. -He/she required assistance with everything from hygiene and medication administration, to finding his/her room and bathroom due to his/her severe Lewy Bodies dementia. -He/she was only oriented to person. Review of Resident #50's quarterly MDS, dated [DATE], showed he/she was cognitively intact and had no negative behaviors over the review period. Review of the Registered Nurse Investigation (RNI), dated 2/25/25, showed: -A little after 12:00 A.M., on 2/25/25, Resident #49 informed CNA R that Resident #50 had fondled his/her private area around midnight. -CNA R informed LPN D. -The alleged incident was not escalated. -When the DON was making his/her morning rounds, Certified Medication Technician (CMT) F informed the DON of what had happened. During an interview on 12/27/25 at 1:30 P.M., the DON said: -Around midnight on 2/25/25 Resident #49 was fondled over his/her underwear by Resident #50. -Resident #49 told his/her aide who told the charge nurse, but the charge nurse dismissed it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #49 told him/her that no one ever came down to speak to him/her about what happened. -The DON did not find out about it until he/she was making morning round between 9:15 A.M., and 10:15 A. M., when he/she began his/her investigation. Review of Resident #49's written statement, dated 2/25/25, showed: -Around midnight Resident #50 was over his/her bed with Resident #50's hand under the blanket fondling the resident. He/she pressed his/her call light and CNA R came to speak with him/her. -CNA R said he/she told LPN D, but nothing happened after that. -Around 1:00 A.M., the same thing happened. He/she yelled at Resident #50 and the resident stopped. -At 2:00 A.M., Resident #50 had his/her head under the blanket with his/her head down there. Resident #49 yelled, what the fuck are you doing? and kicked the resident in the stomach. During an interview on 2/28/25 at 11:15 A.M., Resident #49 said: -He/she was sound asleep around 12:00 A.M., when he/she woke up to Resident #50's hand under the covers with Resident #50's hand over Resident #49's underwear, over his/her genital area. -He/she told the resident to get away and immediately put his/her call light on. CNA R came down to see him/her. -He/she told CNA R what had happened and CNA R said he/she would tell the charge nurse. -Again, around 1:00 A.M., the same thing happened. Once again, he/she told Resident #50 to get away and smacked at his/her hand. -Resident #49 once again informed CNA R what happened, and CNA R said he/she had told the charge nurse before and would tell the charge nurse again. -At 2:00 A.M., he/she woke up to Resident #50 having his/her head under the covers with his/her head near Resident #49's genital area. This time, Resident #49 kicked at the resident and told him/her to get the fuck out, to which Resident #50 left the room and Resident #49 fell asleep without informing CNA R the last time. -At no time did the charge nurse come in a speak with him/her and he/she spent the whole night in the same room with Resident #50. During an interview on 2/28/25 at 2:25 P.M., CNA R said: -Around midnight on 2/25/25 Resident #49 turned his/her call light on and said Resident #50 had touched his/her genitals over his/her underwear, stating, he tried to touch my piece! -He/she immediately went and told LPN D what happened. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she probably should have called the DON when the residents had not been separated towards the end of the shift. -He/she did report what happened to CMT F that morning during report. During an interview on 2/28/25 at 1:38 P.M., LPN D said: -CNA R told him/her around 6:30 A.M. on 2/25/25 when he/she was counting pills. There was a lot going on during that time, so CNA R had to whisper to him/her what happened. -CNA R reported to him/her the resident said somebody touched him/her and LPN D had told CNA R to hold on a minute. -He/she was told during shift change, so he/she forgot to tell the next shift. He/she had not reported the abuse. -He/she did not remember CNA R telling him/her before 6:30 A.M. He/she knows CNA R did not tell him/her earlier, because he/she was busy sending someone to the hospital. -He/she and CNA R sat most of the night, so there was no way CNA R told him/her earlier. -When CNA R told him/her, he/she was sure he/she told CNA R to check on the residents. -There were a million things going on. He/she should have stopped what he/she was doing and listened better and do one thing at a time. -There was a lot of people telling him/her a lot of different things. During an interview on 3/5/25 at 4:00 P.M., the DON said: -He/she would have expected that as soon as CNA R told LPN D that LPN D would have immediately notified him/her. -All the staff had all of the Administrative staff's phone numbers so there was no reason he/she was not notified until the morning of 2/25/25 around 9:15 A.M. During an interview on 3/5/25 at 4:20 P.M., the Administrator said: -He/she would have expected the staff to have notified Administrative staff immediately after the incident happened. -It was inappropriate for LPN D to dismiss CNA R's report and not notify the DON or Administrator. During an interview on 3/14/25 at 2:15 P.M., the Nurse Practitioner said: -He/she would have expected LPN D to have immediately notified the abuse coordinator. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she would have expected CNA R to follow up with LPN D or Resident #49 to ensure someone from Administration was notified. MO00250145