STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275012	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benefis Senior Services - Eastview	2621 15th Ave S Great Falls, MT 59405

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update a resident's code status from Full Code to DNR, in the facility's EHR for 1 (#5) of 23 sampled residents, and this failure increased the risk of the resident being resuscitated in a health crisis, when that was not the resident's preference or documented on the resident's POLST form. Findings include: During an interview on [DATE] at 4:07 p.m., staff member D stated if a resident wanted to change their POLST form status from what was entered on admission, he would go over the form with the resident and make sure it is signed by the provider the resident, or the resident's POA. Staff member D stated he was not the person who updated the residents code status in the facility's EHR. Staff member D further stated it was not his expectation that the residents code status on the information bar in the facility's EHR had not matched their POLST form. During an interview on [DATE] at 4:26 p.m., staff member B stated she didn't think there was a concrete process in place for updating the EHR when a resident changed their code status on the POLST form. A review of resident #5's EHR showed her code status as, FULL (has ACP docs). A review of resident #5's POLST form, dated [DATE], showed Section A the box for No CPR was checked. A review of a facility policy titled, Do Not Resuscitate (DNR) or Full or Limited Code, with an effective date of 6/2024, showed: POLICY: Resident's wishes regarding advanced directives and resuscitation will be identified and honored . II. Written information regarding Advanced Directives is given to each resident and family/caregiver upon admission. Advanced Directives and resuscitation status are documented in the medical record

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on interview and record review, the facility failed to safeguard a resident's personal property when items were missing or sent to laundry and not returned, for 1 (#30) of 23 sampled residents, and the resident was missing a blanket that was very important to him, which was upsetting, and related to his faith. Findings include: During an interview on 6/16/25 at 3:05 p.m., resident #30 said he was missing a blanket, probably some shirts, and the facility had not made any attempts to replace the missing items. Resident #30 stated, It (dirty laundry) goes and never comes back. Resident #30 said he was concerned about the blanket because it (the blanket) had personal meaning to him. During an interview on 6/18/25 at 8:06 a.m., staff member K said a general inventory of the resident's personal belongings was obtained during the admission process, and the inventory was in the electronic health record. Staff member K stated not every personal item was inventoried. During an interview on 6/18/25 at 9:41 a.m., resident #30 said the blanket he was missing was a Jesus blanket, it was yellow and tan in color and had been missing for several weeks. Resident #30 stated he did let a staff member know right away when he noticed it missing, and it went missing on a weekend. During an interview on 6/17/25 at 1:05 p.m., NF1 said she visits often and had seen resident #30 with the Jesus blanket many times. NF1 said resident #30 was a Catholic priest for 30 years, and the blanket meant a lot to him. During an interview on 6/18/25 at 1:08 p.m., staff member V stated when missing items are reported to her, she would let the nurse know. During an interview on 6/18/25 at 1:13 p.m., when asked about the process for missing items, staff member F, reviewed the missing items policy on her computer and stated it would warrant a call to laundry. During an interview on 6/18/25 at 1:45 p.m., staff member E stated there were reports of missing items from residents. During an interview on 6/18/25 at 1:55 p.m., NF2 stated he visited on a regular basis and recalled asking staff about the missing blanket, and staff stated it might be in laundry. NF2 stated he asked staff a second time, and staff replied they would look around. NF2 reported the staff tagged all his (the resident's) stuff and not all of it would come back from laundry. NF2 stated the missing blanket was, Very precious to him (resident #30). A request was made for a list of missing items on 6/18/25, and staff member A reported there was no list of missing items. Review of the facility's policy titled, [Facility name] Lost, Missing or Damaged Items, last revised 6/2025, showed: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. III. CNA/Floor Nurse . B. The CNA/Floor Nurse completes their section of the Lost and Found Report. They must notify the Unit Manager, Social Services, Activities and Laundry of the missing item. .IV. Unit Manager . 3. The Unit Manager and Resident/family member/representative will both sign the Lost and Found Report to show that the resolution has been reached and all parties are satisfied with the resolution . C. The Unit Manager maintains a running log of the missing and damaged items on their unit .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop a baseline care plan within 48 hours of admission that included the instructions needed to provide effective and person-centered care of the resident, and to meet professional standards of quality care, for 1 (#84) of 23 sampled residents. Findings include: Review of resident #84's face sheet reflected resident #84 admitted on [DATE]. Review of resident #84's baseline care plan, effective 3/19/25 - 4/2/25, reflected the care plan was initiated on 3/19/25, eight days after the resident's admission, and finalized on 3/24/25. During an interview on 6/18/25 at 3:00 p.m., staff member B stated she was not aware the baseline care plan was not completed within 48 hours, or why it was not done. A review of resident #84's MDS assessment, dated 3/17/25, showed the resident had impaired cognition, dementia, anxiety, frequent pain, was supervised, set up, or independent for ADL's, he displayed behaviors and was marked as having depression and anxiety. These care areas may negatively impact a resident if not addressed to the level necessary by staff prior to the Comprehensive assessment or care plan being completed. Review of the facility's policy, Initial Assessment and Development of Interdisciplinary Resident Care Plans, dated 4/2025, reflected: - 1. Admitting licensed staff completes the nursing assessment and baseline care plan upon admission. A copy of the baseline care plan is provided (to) the resident within 48 hours of admission. [sic]

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan and follow the care plan for the resident, for 1 (#31) of 23 sampled residents. Findings include: 1. During an observation on 6/16/25 at 4:37 p.m., resident #31 was in another resident's room. Resident #31 was observed rummaging through the other residents' property. She was observed leaning forward, while sitting in her wheelchair, with her head near the floor, and close to falling out of the chair. Staff were not redirecting her out of the room or providing her diversional activities. During an observation on 6/17/25 at 9:12 a.m., resident #31 was observed behind the nursing station. Resident #31 was unable to be interviewed due to advanced dementia. A nurse removed resident #31 after she had been at the nursing station for a period of time. Resident #31 was not offered diversional activities during her time at the nursing station, or after. During an observation on 6/17/25 at 10:18 a.m., resident #31 was observed in the dining room. She was kicking a fidget sleeve along the floor. Resident #31 was bent over at the waist and was observed attempting to pick up the sleeve off the floor. No staff intervened to assist the resident or prevent a potential fall. No staff interventions were observed to re-direct the resident's behavior or to offer her diversional activities. During an interview on 6/17/25 at 2:10 p.m., staff member G said resident #31 cries and wanders down the hall in her wheelchair. Staff member G stated she tried a bunch of different medications to help the resident for her behaviors. Staff member G said the other residents did get upset at resident #31, and they would mostly yell at her, but they did throw things at her, like tissues, because she was crying. Staff member G stated staff tried to intervene between residents right away. The staff would also try to put #31 to bed, but she wouldn't stay there, and she would get up and sit on the edge of the bed. She would almost fall out of bed due to leaning so far forward. Staff kept the other residents' doors closed; it helped to keep resident #31 out of their rooms, and if a door was open, she would go into the other residents rooms. Review of resident #31's current care plan, with various dates for the problems, goals, and approaches, showed the staff were to re-direct the resident's inappropriate behavior, they were to provide behavioral interventions, and always monitor her where about's. The care plan showed the staff would encourage resident #31 to participate in diversional activities, and anticipate her needs as she could not always communicate them. The staff were to assess her emotions and mood and report concerns to the nurse. The resident was identified to be at risk for falls, and staff were to observe for safety concerns. The care plan showed the in-out alert was initiated to let staff know if she was out of the room. Although these care plan interventions were in place, they were not observed as utilized by staff for redirection, fall safety, or offering her activities of interest.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to review and revise comprehensive care plans for activities and food preferences for 5 (#s 39, 40, 74, 75, and 84) of 23 sampled residents. Findings include: 1. Review of resident #39's, Activities Care Plan, dated 2/22/24, reflected: - . Determine [Resident #39] activity preferences. During an interview on 6/17/25 at 11:51 a.m., resident #39 stated she went to bible study. Resident #39 stated she did not attend any other activities. The activity care plan did not show what other activities the resident was interested in. 2. Review of resident #75's, Activities Care Plan, dated 2/22/24, reflected: - . Determine [Resident #75] activity preferences. During an observation on 6/16/25 at 2:29 p.m., resident #75 was sitting on the side of her bed, anxious, shaking, with erratic breathing, saying unclear words, and the door was closed. Staff member H came in to assist the resident with a sit to stand lift. Staff member H placed resident #75 in her wheel chair, took her to the dining room, and left her at a table without anything to do. Resident #75 remained at the table without anything to do or drink until dinner service. The activity care plan did not show what other activities the resident was interested in for staff to utilize. 3. Review of resident #74's, Activities Care Plan, dated 6/4/25, reflected: - . Determine [Resident #74] activity preferences. During an interview on 6/17/25 at 1:25 p.m., NF3 stated resident #74, . really needs to have activities and loves bowling, sewing, grocery shopping, and social activities. She is really a social person. NF3 stated no one had contacted her about activities of interest for resident #74. NF3 stated she was so upset she had shared her concerns tearfully in the middle of the grocery store with the previous administrator who was going to email the director of activities. NF3 stated she had not heard anything to date, and it had been more than a week ago. The activity care plan did not show what other activities the resident was interested in. 4. Review of resident #40's, Activities Care Plan, dated 9/4/24, reflected: - . Determine [Resident #40] activity preferences. During an observation and interview on 6/16/25 at 3:10 p.m., resident #40 was in his room watching television in his recliner. Resident #40 stated he enjoyed the activities, when they have some. Resident #40 stated the facility did not have much for activities for him (that he was interested in), so he watched television most of the time. The activity care plan did not show what other activities the resident was interested in for staff to utilize, or what staff could offer him within his identified areas of interest. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of resident #84's, Care Plan, dated 3/11/25, reflected there was no activity plan established for the resident. During an interview on 6/18/25 at 11:18 a.m., staff member I stated activities were discussed during resident council meetings. Staff member I stated residents who did not attend, or were not able to attend, did not participate in the discussion around activity preferences. Staff member I stated she was not aware of the preferences assessment in the EHR system until yesterday (6/17/25) or that individualized resident preferences needed to be care planned. Review of the facility's policy, titled, [Facility name] Life Enrichment (Activities), dated 6/2025, reflected: - . Life Enrichment Program should include an ongoing resident centered activities program that incorporate the residents' interest, hobbies and cultural preferences which is integral to maintaining and/or improving a resident's physical, mental and psychosocial well-being and independence. Activities are to be both facility-sponsored group and individual activities and independent activities. - . After completion of the initial Life Enrichment Assessment form the Life Enrichment Coordinator will be ready to identify and record problems/needs, goals, and approaches on the care plan as it relates to activities.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. During an observation on 6/17/25 at 2:10 p.m., three residents were sitting in the dining room. The television was on, and a German speaking movie was playing. The movie contained sexual scenes. The staff changed the channel to music. During an interview and observation on 6/17/25 at 2:30 p.m., staff member U said the most common activity on the memory care unit was Trivia. Staff member U said the staff take some of the residents to the main floor for church and dog visits. Staff member U said not many of the residents residing on the unit go on the outings, but two of the residents went fishing that day. The activity calendar showed a trip to Walmart was scheduled. During record review and observation on 6/18/25 at 10:35 a.m., the activity calendar showed the activity scheduled for the residents was crafts. During an observation on 6/18/25 at 10:35 a.m., five residents were sitting at the dining room tables on the dementia unit. No staff were present, no crafts were being done, and no other activities were being offered to residents on the secure unit. During an interview on 6/18/25 at 11:00 a.m., staff member Q said the residents go off the memory care unit for crafts. Staff member Q said the residents who don't go off the unit have 1:1 visits with staff. Staff member Q said trivia is played by the staff showing a picture to the residents, letting them guess what the picture is, and then talking about the picture. 5. During an observation and interview on 6/16/25 at 2:35 p.m., resident #42 said she did not know any activities were offered at the facility. Resident #42 said she was trying to find the television remote so she could turn this shit off. Resident #42 said she liked country music and not the content the staff turned her television to. Resident #42 said she had to lay in bed too much as far as she was concerned. Resident #42 said if she could walk, the staff would not be able to keep her in bed. Review of resident #42's MDS, with an assessment reference date of 5/5/25, showed it was very important for resident #42 to listen to music she likes, and it was not important at all to do activities with a groups of people. Review of resident #42's flow sheet for the resident's activity attendance showed resident #42 attended two 1:1 activities and three group activities in May 2025. In June 2025, resident #42's flow sheet showed she attended six group activities and one 1:1 visit with staff. The documentation showed the resident attended groups more often than the 1-1 visits, even though she did not feel group activities were important. Review of the facility's policy, [Facility name] Life Enrichment (Activities), dated 6/2025, reflected: Life Enrichment Program should include ongoing resident centered activities program that incorporate the residents' interest, hobbies and cultural preferences which is integral to maintaining and/or improving a resident's physical, mental and psychosocial well-being and independence. Activities are to be both facility-sponsored group and individual activities and independent activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, interviews, and record review, the facility failed to provide activities to meet the needs of the residents for 7 (#s 39, 40, 42, 74, and 75) of 23 residents. Findings include: 1. During an observation and interview on 6/16/25 at 3:10 p.m., resident #40 was in his room watching television in his recliner. Resident #40 stated he enjoyed the activities, When they have some. Resident #40 stated the facility did not have much for activities for him, so he watched television most of the time. Resident #40 stated he was not offered many activities to go do and would go if they were offered. 2. During an interview on 6/17/25 at 11:51 a.m., resident #39 stated she went to bible study. Resident #39 stated she did not attend any other activities and was not aware of other activities. 3. During an interview 6/17/25 at 1:25 p.m., NF3 stated resident #74, . really needs to have activities and loves bowling, sewing, grocery shopping, and social activities. She is really a social person. NF3 stated no one had contacted her about activities of interest for resident #74. NF3 stated she was so upset she had shared her concerns tearfully in the middle of the grocery store with the previous administrator who was going to email the director of activities. NF3 stated she had not heard anything to date, and it had been more than a week ago. 4. During an observation on 6/16/25 at 2:29 p.m., resident #75 was sitting on the side of her bed, anxious, shaking, with erratic breathing, saying unclear words, and the door was closed. Staff member H came in to help using the sit to stand lift. Staff member H placed resident #75 in her wheel chair and took her to the dining room and left her at a table without anything to do. Resident #75 remained at the table. During an interview on 6/16/25 at 1:53 p.m., staff member J stated the facility provided movies on Mondays and popcorn was provided. Staff member J stated trivia was an activity provided for the memory care unit on Sundays. Staff member J stated there was only one person scheduled to work on Sundays, Mondays, Fridays, and Saturdays. Staff member J stated when only one person was available, the activity was combined with the activity provided to residents outside the memory unit, if the residents were able to come off the unit. Staff member J stated the number of residents who could come out for an activity was 2-3 because of the risk and supervision needed. Staff member J stated the remaining residents did not receive activities. Staff member J stated the activities staff were often pulled to provide transportation, and the activities were canceled. During an interview on 6/18/25 at 11:18 a.m., staff member I stated activities were discussed during resident council meetings. Staff member I stated residents who did not attend, or were not able to attend, did not participate in the discussion around activity preferences. Staff member I stated memory care residents often did not have activities because the nursing staff would lay them down immediately after meals, so they were not available to attend activities. Staff member I stated she was often pulled to the floor to cover the nursing department shifts, and the life enrichment aides were frequently pulled to provide transportation and serving meals. Staff member I stated she was not aware of the resident preferences assessment in the EHR system, which was to be completed for each resident, until yesterday, or that resident preferences needed to be care planned. During an interview on 6/18/25 at 4:10 p.m., staff member K stated the facility wasn't completing the assessment for activities for the residents because it was missed during the transition from the old EHR system to the new EHR system. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Entertainment Flow-sheet History, dated 5/19/25-6/18/25, reflected: - Resident #74 did not have any activities for 27 of the 30 days in the month. - Resident #40 did not have any activities for 28 days out of 30 days in the month. - Resident #75 did not have any activities for 25 out of 30 days in the month. - Resident #39 did not have any activities for 25 out of 30 days in the month. During an interview on 6/19/25 at 10:10 a.m., staff member A stated activities staff were pulled to other tasks, when necessary, .because care comes first. Staff member A stated the facility was in the process of hiring two more life enrichment staff to ease the workload.

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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. Based on observations, interviews, and record review, the facility failed to remove access to hand sanitizer containers, or hazardous liquids if consumed, when there was a resident residing in the area who had a recent history of drinking hand sanitizer, for 1 (#40) for 23 sampled residents. Findings include: Review of resident #40's Hospitalist History and Physical, dated 6/30/25, reflected: - . #Alcohol use disorder, with recent hospitalization due to drinking hand sanitizer. During an observation on 6/16/25 at 4:18 p.m., hand sanitizer bottles were found on the top of the unattended medication cart, and two bottles of hand sanitizer were at the nursing station, within reach of anyone passing by. During an observation on 6/17/25 at 7:28 a.m., one alcohol bottle was on top of an unattended medication cart located in the dining room. One bottle of hand sanitizer was within reach of residents at the nursing station. One bottle of [NAME] Diamonds perfume was in an open cabinet at the end of the hall, accessible to residents. During an observation on 6/17/25 at 7:38 a.m., staff member L was passing medications, leaving the medication cart unattended in the dining room, while going into resident rooms. One bottle of hand sanitizer was sitting on top of the medication cart. Resident #40 was sitting immediately next to the medication cart in the dining room. Resident #40 got up from the dining table and went to his room, ambulating without assistance or supervision. During an observation on 6/17/25 at 7:40 a.m., one bottle of hand sanitizer was sitting on the counter next to the entry door to the kitchen, within reach of residents. During an interview on 6/17/25 at 9:15 a.m., staff member L stated the hand sanitizer dispensers on the walls in the hallways were empty because resident #40 had a history of drinking the hand sanitizer. Staff member L stated resident #40 was seen filling a cup with hand sanitizer recently. During an interview on 6/17/25 at 10:50 a.m., staff member B stated resident #40 was drinking hand sanitizer. Staff member B stated there should not be any hand sanitizer bottles within resident reach and it should be kept in drawers. During an interview on 6/18/25 at 4:00 p.m., staff member A stated there was not a policy specific to keeping hazardous chemicals from resident access for hand sanitizer.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 2. During an initial observation on 6/16/25 at 2:00 p.m., resident #8 did not have access to any fluids while she was in her room. A review of resident #8's dietary information showed resident #8 was to receive thickened fluids. Review of resident #8's care plan, dated 2/25/24, showed the staff were to assist with and encourage food and fluid intake on mildly thick liquids. The care plan directed the staff to observe for signs and symptoms of dehydration. The staff were also to monitor and adjust the fluid intake and output. During an observation on 6/18/25 at 10:30 a.m., resident #8 had a pitcher of water at her bedside. The water in the pitcher was regular consistency, and it was not mildly thickened, as ordered. During an interview on 6/17/25 at 8:24 a.m., staff member I said some residents should have water pitchers. Staff member I said the water pitchers disappeared and some residents just don't have a pitcher. During an interview on 6/17/25 at 2:10 p.m., staff member G said the residents should at least have a cup or a large water jug at their bedside. Staff member G said the residents will come to the staff and ask for something to drink. Staff member G said she was not aware which residents were at risk of dehydration. Based on observations, interviews, and record review, the facility failed to ensure a resident residing on the memory care unit had access to, and the provision of, mildly thickened fluids, for 1 (#8), and the resident received an unthickened liquid; and the facility failed to ensure one resident received adequate assistance for meals and maintaining her nutritional status contributing to a 6.5% weight loss (severe), for 1 (#74) of 23 sampled residents, and the resident's EHR documentation showed she had a weight loss. The lack of the provision of fluids in resident rooms may affect any resident on the unit who wanted something to drink, and they did not have it available or were unable to ask for it. Findings include: 1. During an observation on 6/17/25 at 8:47 a.m., resident #74 was still in bed, with no breakfast, and there was nothing for the resident to drink in the room. There was a new water cup in the room, but it was empty and unopened. During an observation on 6/17/25 at 8:57 a.m., resident #74 was in bed sleeping. Her breakfast tray was brought to the room and left on the bedside table. Staff did not assist the resident with the meal. During an observation on 6/17/25 at 9:26 a.m., resident #74 was still asleep in her bed, with her breakfast tray still untouched. A review of resident #74's EHR weights showed the following: - 5/22/25: 122 lbs., 6.5% loss in last month (continued on next page)

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	275012	A. Building B. Wing	06/19/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 6/8/25: 115 lbs., which was another loss of 7 lbs. in 17 days. During an observation and interview on 6/17/25 at 4:05 p.m., resident #74 was sitting on her bed. The resident had no drinks available at the bedside. NF3 had just arrived and dressed resident #74. NF3 voiced concerns that resident #74 was so dehydrated over the weekend, the nurse on duty was offering to start IV fluids. NF3 stated she had been pushing fluids and trying to get resident #74 back to her baseline status. NF3 stated she had not been approached by dietary staff yet, and resident #74 was a picky eater. NF3 stated, You would think they would want to know what she likes to drink and eat. NF3 stated she keeps soda pop and protein drinks in the personal refrigerator for resident #74, but the resident's mental status would require the staff to come in and encourage her to drink. During an observation and interview on 6/18/25 at 12:54 p.m., resident #74 was in the dining room, her plate of food untouched, but she was eating her Jello cup. Resident #74 stated, I don't know what that shit is referencing the food on the plate, then the resident requested the surveyor get her mashed potatoes and a sandwich. During an interview on 6/17/25 at 7:40 a.m., staff member L stated the residents on the memory care unit did not have drinks at the bed side, but they were offered fluids with meals. During an interview on 6/17/25 at 10:40 a.m., staff member B stated residents residing on the memory care unit were not given fluids at the bedside because residents wandered into other resident rooms, and consume any drinks in the room. The facility was concerned about infection control. A request was made by the surveyor for a policy on maintaining resident hydration, but not received prior to the end of the survey.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 2. During an observation on 6/16/25 at 4:37 p.m., resident #31 was in another resident's room. Resident #31 was observed rummaging through the property in the room. Resident #31 was in a wheel chair, and she was wedged between the other resident chair, and the bed. She was observed leaning far forward with her head near the floor, almost falling out of the chair forward. During an observation on 6/17/25 at 9:12 a.m., resident #31 was observed behind a nurse's station. Resident #31 was unable to be interviewed due to advanced dementia. A nurse removed resident #31 after she had been at the nursing station for some time. Resident #31 was not offered diversional activities during the time she was at the nursing station or after. During an interview on 6/17/25 at 2:10 p.m., staff member G said resident #31 cries and wanders down the hall in her chair. The nurse tried a bunch of different medications to help the resident, and said the other residents did get upset at #31. Staff member G stated they, Mostly they yell at her, but they did throw things at her, like tissues because she was crying. We tried to intervene between residents right away. The staff tried to put her to bed but she wouldn't stay there. She just got up and sat on the edge of the bed and almost fell out of bed because she leaned so far forward. The other residents' doors were kept closed because it helped keep resident #31 out of their rooms. Resident #31 would go into other resident rooms, especially if the door was open. During an observation on 6/17/25 at 3:35 p.m., resident #31 was propelling herself down the hall. Resident #31 was moaning and had a sad facial expression. Staff member W readjusted the lift sling resident #31 was dragging behind her chair. Staff member W was talking to another resident during this interaction, not resident #31. Resident #31 proceeded to propel herself down the hall. Review of resident #31's care plan, dated 1/8/25, showed resident #31 will have her psychosocial well-being needs met as needed. Staff were to offer reassurance during times of anxiety and weeping. Social services was care planned to follow up with resident #31 as needed. During an interview on 6/19/25 at 12:01 p.m. staff member D said he remembered resident #31 and remembered her crying. Staff member D said social services did not take an active role in emotional issues. The social services department concentrated on resolving resident #31's dental issues. Staff member D said social services were not involved in the psychosocial aspect of medication administration. Staff member D said the psychotropic drugs were managed by the director of nursing and doctor. Behavioral health and social services notes were requested for #31. No behavioral health notes were received showing resident #31 was assessed and interventions initiated to assist with her continued behaviors and frequent crying. Based on observations, interviews, and record review, the facility failed to provide the necessary behavioral health care and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, for 2 (#84 and #31) of 23 sampled residents. Findings include: (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/18/25 at 10:50 a.m., resident #84 was observed walking down the hall, yelling over his shoulder for someone to, shut the [expletive] up. Resident #84 then stood hovering over three female residents at the table in the dining room and stated, . shut the [expletive] up and leave me alone. Resident #84 was then digging in the buckets where the dirty breakfast dishes were located. There were dirty plates and silverware on the cart, and he was touching soiled items and dishes. Resident #84 took a plastic cup out of the white garbage bucket and investigated the other buckets. He took out the black garbage sack. He took the bucket, turned it upside down and emptied it outside the courtyard door. He was still cursing loudly. Resident #84 then took the other red bucket, and then a CNA stopped him. There had been an interaction between a visitor and resident #84, and the visitor was mocking resident #84 saying blah, blah, blah, while the resident was continuing to say, shut the [expletive] up. The CNA got him a water pitcher, and the resident proceeded to several 100 ccs of water. The interaction between the visitor and the resident was reported to the facility. Review of resident #84's EHR Psychosocial Needs Care Plan, dated 3/11/25, reflected: [Resident #84] will have his psychosocial well-being needs met as needed. Social Services will follow up with [#84] and his family as needed. Review of resident #84's Nursing notes, dated 6/13/25 - 6/18/25, reflected: - 6/13/25: Resident #84 was physically and verbally aggressive to staff and swung a wooden sculpture at staff. - 6/14/25: Resident #84 was wandering in and out of resident rooms, agitated. - 6/17/25: Resident #84 entered another resident's room and defecated in the personal refrigerator. Resident #84 later physically assaulted a CNA. - 6/18/25: Resident #84 was yelling at three female residents in the dining room. - 6/18/25: resident #84 had, verbal and physical aggression toward staff and residents from suppertime through 6:30 p.m. - security was called. The progress note(s) showed staff reported these behaviors occurred nightly. During an interview on 6/19/25 at 11:24 a.m., staff member D stated his role with behavior health for residents would be on a consult basis. Staff member D stated the facility would request a consultation for behaviors, and he would offer suggestions or ideas to address the resident's behaviors. Staff member D stated he was not aware of the behaviors documented for resident #84, and had not been sent a request for a consultation, to address the resident's behaviors. Staff member D stated he was only aware of the need to address the resident's legal guardianship and financial work on the social security.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Based on interview and record review, the facility failed to ensure a referral was made for cognitive rehabilitation with a speech therapist for 1 (#5) of 23 sampled residents. This deficient practice increased the risk of the resident having a cognitive decline due to the lack of speech therapy treatment. Findings include: A review of a Behavioral Health OP (Outpatient) Psychosocial Evaluation, for resident #5, dated 1/27/25, signed by NF4, and cosigned by NF5, showed: Reason for evaluation: Depression, schizophrenia, bipolar . Plan: According to the information gathered in this evaluation, appears that patient would benefit from cognitive rehabilitation with a speech therapist and medication management with a psychiatrist. Will refer to cognitive rehabilitation with speech therapist [sic] During an interview on 6/18/25 at 11:07 a.m., staff member D stated he could not find speech therapy referrals or notes for resident #5. During an interview on 6/19/25 at 8:53 a.m., NF5 stated she was not able to find a referral for speech therapy from her facility for resident #5. NF5 relayed there may have been confusion between her facility and the provider for resident #5, as to who should have made a referral for speech therapy. NF5 stated the almost six-month delay from her facility's provider recommending speech therapy for resident #5, is not what should happen. During an interview on 6/19/25 at 9:21 a.m., staff member B stated the referral for speech therapy for resident #5 had not been done by the facility. Staff member B stated that it was her understanding the outpatient facility that performed the evaluation was supposed to implement the speech therapy referral.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain sanitary linens during the handling and processing of laundry, as to prevent the spread of infection for the residents residing at the facility. Findings include: 1. During an observation and interview on 6/18/25 at 9:27 a.m., with staff member A, M, Q, R, and S, the following observations were made: - Floors throughout the clean side of the laundry room were riddled with trash/debris on the floor, including used masks, paper, dirty laundry, used paper towels, and dust balls. - Staff member N was preparing clean sheets to enter the folding machine, and the clean sheets were dragging on the unclean floor. - Staff member O dropped clean laundry out of the dryer, onto the unclean floor. Staff member O then picked the clean laundry up and placed them in the clean linen bin with other clean items. - Staff member O was walking through the clean linen area while putting her hair in a ponytail. Staff member O then began to fold the clean laundry, without performing hand hygiene first. - Staff member P was preparing gowns to place them into the folding machine, and the clean gowns were dragging on the unclean floor. - The counter in the clean folding room was missing the edging around the sides on the table, creating an un-cleanable surface. During an interview on 6/18/25 at 9:57 a.m. with staff members Q, R, and S, staff members R and S stated they had not been following the laundry department or completing regular observations. Staff member S stated, Based on the observations we just had (above), we sure will be adding it to our list. During an interview on 6/18/25 at 9:57 a.m., staff member A stated there were obvious infection control issues during the walk through, and he would be following up with the team to address the infection control requirements. A request was made for a policy related to the cleaning of the laundry room, but a policy was not received prior to the end of the survey. 2. During an observation on 6/17/25 at 3:31 p.m., a laundry cart, which contained clean laundry, was observed outside of the room labeled linen. The cart was observed with clean clothes on hangers, which were hanging on the side, and the back of the cart was uncovered. During an observation on 6/18/25 at 1:50 p.m., an uncovered laundry cart was observed in the activity room across the hall from room [ROOM NUMBER]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/18/25 at 1:53 p.m., staff member E stated the laundry cart should be covered. Staff member E said, We keep it covered, but sometimes residents see it and uncover it. Review of the facility's policy titled, [Facility Name]-Linen and Personal Clothing Standards, last revised on 6/2025, showed: .Procedure: I. Nursing A. Places clean linen on linen carts to take to individual rooms. Linen carts will remain covered . G. Ensures laundry cart remains covered when not in use

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 4. During an observation on 6/16/25 at 3:35 p.m., resident #77's call light was hanging off the light located over the bed. Resident #77 was lying in bed and could not reach the call light for use. During an interview on 6/17/25 at 2:10 p.m., staff member G said there were alarms attached to the resident's door, and the bathroom doors. Staff member G stated the cognitive residents should have a call light. Staff member G said the staff just check on the residents every couple of hours. Review of a facility policy, [Facility Name] Patient Call System, dated 6/2025, reflected: . The DON will verify the system is in working condition at all times . .The call system is located near the patient's bed and in the restroom . Based on observations, interviews, and record review, the facility failed to ensure residents had call lights available for 4 (#s 40, 74, 75, 77) of 23 sampled residents. This deficient practice prevented residents from contacting staff for assistance when they wanted to. Findings include: 1. During an observation on 6/16/25 at 2:05 p.m., resident #40 did not know where his call light was located. The call light was under equipment, on a countertop, in the corner of the room. Resident #40 stated if he needed help, he did not know how to call for help. When asked how he would call for help, resident #40 stated, I guess I can't, maybe (I'd) yell. 2. During an observation on 6/16/25 at 2:21 p.m., resident #74 was in her room trying to get up from her bed. Resident #74 had no call light in her room. Resident #74 called out for help and two CNAs came to assist her. Resident #74 stated, I just yell out until someone comes, if I need help. 3. During an observation on 6/16/25 at 2:29 p.m., resident #75 was sitting on the side of her bed, anxious, shaking with erratic breathing, saying unclear words, with the door closed. There was no call light in the room. The bed alarm was not sounding. This surveyor notified staff member H on duty who assisted resident #75 into her wheelchair, who then moved the resident to the dining room table. During an interview on 6/16/25 at 2:35 p.m., staff member C stated they do not have call lights in the memory unit. Staff member C stated residents were checked on every two hours. During an interview on 6/16/25 at 3:00 p.m., staff member B stated residents do not always know how to use the call lights appropriately, and the staff should be rounding on the residents regularly.