STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325038	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Real	1650 Galisteo Street Santa Fe, NM 87505

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review; the facility failed to store and serve food under sanitary conditions when staff failed to ensure:1. Food items were labeled and dated in the kitchen refrigerators. 2. Food was stored appropriately and not left open to air in the kitchen refrigerator. 3. Staff personal belongings were not stored next to a food serving line.These deficient practices are likely to affect all 121 residents listed on the resident census list provided by the Administrator on 09/16/25 and are likely to lead to foodborne illnesses in residents if food is not being stored properly and safe food handling practices are not adhered to. The findings are: A. On 09/22/25 at 10:00 a.m., observation of the kitchen revealed the following: One sheet pan of food item that was not labeled or dated stored in the kitchen refrigerator. One pack of yellow American Sliced Cheese was open to air. One tobacco cigarette and cigarette lighter in the kitchen near the food serving line. B. On 09/22/25 at 10:02 a.m., during an interview, the Dietary Manager (DM) he stated that all food items should be stored appropriately, labeled, dated. The DM also stated that the cigarette and lighter should not be in the kitchen. c. On 09/23/25 at 8:23 AM during random observation of the facility kitchen the following was observed: 1. 4 tubes of hamburger meat were sitting in a sink with stagnant water defrosting This was confirmed by Dietary Manager (DM) at the time of observation. 2. A 32 oz,(ounce) bottle of vanilla and a 16 oz container of garlic powder were observed sitting on the bare floor in the dry storage room. This was confirmed by the Dietary Aide (DA) #1. 3. A container of chili beans was sitting on the preparation table with no label or date. DA (DA) #2 confirmed it was her own personal food item and she stated it should not have been sitting on the counter. 4. A package of cheese, and a block of butter was sitting on the grill open to air, alongside a egg sandwich. Sitting on steam table were 2 loaves of bread open to air. Confirmed by DM that packages should be sealed and not open to air. (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. A 5 gallon bucket of dish soap was sitting on the bare floor in the dish room this was confirmed by the DM, DM stated it should not have been sitting on the bare floor.

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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. Based on observations, record reviews and interviews, the facility failed to maintain a safe, controlled environment for 2 (R #10 and #17) of 2 (R #10 and #17) residents reviewed. The facility failed to:Notify staff of R#10's infection control status by not recognizing R#10's COVID condition and not posting at his doorway a notice of his infectious status.Ensure proper hand hygiene was performed by staff and that a glucometer was cleaned and disinfected which could potentially cause cross-contamination for residents.This deficient practice is likely to result in residents and staff being exposed to infectious diseases that could be transmitted between staff and residents. The findings are: R#10A) On 09/23/25 at 9:59am, observed R#10's call light was on and Licensed Practical Nurse (LPN) #6 went in the room to answer the call light. LPN #6 was wearing a disposable mask the entire time. Observed R#10 telling her that he has COVID-19 (an infectious viral disease that causes flu-like symptoms) and that she has to keep her distance.B) On 09/23/25 at 9:59am, interview with LPN #6 stated that she is an agency nurse and was told that for his condition they are only required to wear a disposable mask (single-use face coverings that create a physical barrier between the wearer's nose and mouth and their environment).C) On 09/23/25 at 10:02am, interview with R#10 stated that he has covid as of yesterday and has stated medications for it today.D) On 09/23/25 at 10:04am, record review of R#10's listed diagnosis revealed the following (includes, but not limited to): - COVID-19E) On 09/24/25 at 9:36am, observed Certified Nursing Assistant (CNA)#3 was wearing a disposable mask while providing perineal care (involves cleaning the genital and anal areas of a patient) to R#10. R#10 is on Transmission-Based Precaution (are implemented for residents who are known or suspected to be infected with certain pathogens) for COVID-19 . F) On 09/24/25 at 9:37am, during an interview with CNA#3, stated today is her first day back and no one told her about the precaution. Stated she is an agency staff. Stated she did not see the Transmission-Based Precaution posted outside R#10's room. Stated that she should wear an N95 for this type of infection when providing care.G) On 09/26/25 at 1:30pm, interview with the Infection Preventionist (IP) stated the following: - They use a messaging software called Re-group (a text system that sends group text to notify employees), to notify staff of COVID-19 related issues at work. - Travelers are not part of it, they are informed before they start their shift. - Once a provider places an order for PAXLOVID (an oral prescription medication used to treat mild to moderate COVID-19), IP is responsible for adding Transmission-Based Precaution (TBP) and should provide the necessary education and protocol associated to COVID-19. - Confirmed that per facility policy, there should be an order for TBP and nurses should help and place the order for TBP when they see a new order for PAXLOVID.- Confirmed that per facility policy, TBP includes wearing N95 (are masks that help protect against viruses like COVID-19).R#17H) On 09/23/25 at 11:18am during noon medication administration time, the surveyor observed the following: - LPN #6 checked R#17 blood glucose (a blood test that mainly screens for diabetes) using a glucometer (a portable device used to measure the amount of glucose [sugar] in the blood). - LPN #6 did not perform hand hygiene after removing her gloves. - LPN #6 placed the recently used glucometer back into the top drawer of her medication cart.I) On 09/23/25 at 11:19am, interview with LPN #6 stated she failed to wash her hands and disinfect the glucometer. Confirmed that per facility policy, she is required to perform hand hygiene between patient care and disinfect the glucometer after use using the facility approved disinfectant.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interviews and record reviews the facility failed to ensure its antibiotic stewardship program was implemented and monitored to prevent the unnecessary use of antibiotic. This deficient practice placed residents at risk for developing antibiotic-resistant infections and adverse drug events.The findings are: A) On 09/26/25 at 1:30pm during an interview with the facility's Infection Preventionist (IP) reported not having a system to track residents on antibiotics. The IP was unaware of the overall number of residents on antibiotic therapy in the past 6 months. The IP stated he has all the records on his desk and failed to produce any records and kept pointing to his stack of papers.B) On 09/26/25 at 1:30pm during an interview with the IP, he stated that the facility's antibiotic stewardship program is expected to meet once a month. He stated the last antibiotic stewardship meeting was held in January 2025 when the previous IP was still here. IP confirmed that per facility policy they are to meet once a month.C) On 09/29/25 at 11:00am, facility failed to produce any records pertaining to facility's antibiotic stewardship program.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interviews and observation, the facility failed to ensure that a qualified individual was designated as the Infection Preventionist (IP) responsible for the facility's Infection Prevention and Control Program (IPCP). The facility's noncompliance with this requirement has the potential to result in widespread transmission of communicable diseases and infections among residents.The findings are: Cross reference findings from F880 and F881A) On 09/26/25 at 1:30pm, during an interview with the Infection Preventionist (IP), he stated he did not finish the Infection Control class that was offered early this year. He stated he is the facility designated Infection Preventionist. Stated that the previous Infection Control Preventionist left January 2025. IP confirmed that he was required to attend and complete an infection control training to be assigned as the IP but failed to do so due to other non-IP related jobs assigned to him.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to maintain an environment that was clean, in good condition, and free from clutter for 1 (R #9) of 1 (R #9) resident reviewed for a homelike environment by: The facility was storing unused O2 (oxygen) concentrators (medical device used to deliver O2) in R #9's room. Two respiratory spirometers (instrument used to measure the volume of air that a person can inhale and exhale) were not stored in sealed bags and on top of an open tube of Clotrimazole Cream (antifungal medication) on R #9's shelf next to his bed. Failure to maintain the building in a clean and comfortable manner is likely to result in unsafe conditions and prevent residents from enjoying everyday activities. The findings are:A. Record review of R #9's face sheet revealed R #9 was admitted into the facility on [DATE]. B. On 09/23/2025 at 12:19 pm during an observation of R #9's room, two O2 concentrators were not in use and were stored in the corner of R #9's room. C. On 09/29/25 at 8:30 am during an observation of R #9's room, two O2 concentrators were still stored in the corner of R #9's room (since 09/23/25), two respiratory spirometers and a tube of Clotrimazole Cream 1% (percent) was opened and on a shelf next to R #9's bed. D. On 09/29/25 at 8:51 am during an interview with Certified Nursing Assistant (CNA) #2, she confirmed there were two unused O2 concentrators stored in the corner of R #9's room. CNA #2 stated she did not know why those O2 concentrators were stored in R #9's room, and they should not have been. E. On 09/29/25 at 9:31 am during an interview with Licensed Practical Nurse (LPN) #1, she confirmed R #9's two respiratory spirometers were not stored in bags and on top of the opened tube of Clotrimazole Cream 1%. LPN #1 also confirmed those items should not have been left open on R #9's shelf. F. On 09/29/25 at 3:12 pm during an interview with the Director of Nursing (DON), she stated unused O2 concentrators should not have been stored in R #9's room, R #9's respiratory spirometers should have been stored in sealed bags, and the tube of Clotrimazole Cream 1% should not have been left open on the shelf.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure staff revised the care plan for 5 (R #'s 7, 8, 11, 37 and 60) of 5 (R #'s 7, 8, 11, 37 and 60) residents reviewed by:Staff failed to conduct a quarterly care plan meeting as required and in accordance with their admission date and Minimum Data Set (MDS) assessments for R #7, 8, 11 and 60.Not including use of table during family visits for R #37.This deficient practice is likely to result in residents' care and needs not being addressed if care plans are not updated. The findings are: R #7: A. Record review of R #7's face sheet revealed R #7 was admitted into the facility on [DATE]. B. Record review of R #7's electronic health record (EHR) revealed R #7 had quarterly MDS assessments completed on 12/21/24, 03/20/25, and 06/19/25. C. Record review of R #7's care plan meeting progress notes revealed R #7 had a care plan meeting on 03/06/25, and then not again until 08/28/25 (a care plan meeting should have been conducted between 03/06/25 and 08/28/25). D. On 09/23/25 at 11:11 am during an interview with R #7's sister, she stated she was contacted by the facility Social Services Director (SSD) to schedule a care plan meeting sometime in May for a June (2025) care plan meeting, but a care plan meeting did not occur after the call. E. On 09/24/25 at 4:15 pm during an interview with the SSD, she confirmed R #7 should have had a care plan meeting conducted between 03/06/25 and 08/28/25, but a care plan meeting was not conducted. R #8: F. Record review of R #8's face sheet revealed R #8 was admitted into the facility on [DATE]. G. Record review of R #8's EHR revealed R #8 had a quarterly MDS assessments completed on 03/04/25, 06/03/25, and 09/02/25. H. Record review of R #8's care plan meeting progress notes revealed R #8 had a care plan meeting on 12/05/24, and then not again until 08/28/25 (a care plan meeting should have been conducted between 12/05/24 and 08/28/25). I. On 09/23/25 at 11:13 am during an interview with R #8, he stated he did not have a care plan meeting for a long time, and he wanted to be involved in his care. J. On 09/24/25 at 4:20 pm during an interview with the Senior Social Services Director (SSSD), she confirmed R #8 should have had a care plan meeting completed sooner than 08/28/25. R #11: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	K. Record review of R #11's face sheet revealed R #8 was admitted into the facility on [DATE]. L. Record review of R #11's EHR revealed R #11 had a quarterly MDS assessments completed on 04/04/25 and 07/05/25. M. Record review of R #11's care plan meeting progress notes revealed R #11 had a care plan meeting on 10/10/24 and 01/23/25. N. On 09/24/25 at 4:24 pm during an interview with the SSD, she confirmed R #11 has not had a care plan meeting since 01/23/25 and R #11 should have. R #60: O. Record review of R #60's face sheet revealed R #60 was admitted into the facility on [DATE]. P. Record review of R #60's EHR revealed R #60 had a quarterly MDS assessments completed on 04/01/25 and 07/02/25. Q. Record review of R #60's care plan meeting progress notes revealed R #60's last care plan meeting occurred on 12/19/24. R. On 09/24/25 at 4:25 pm during an interview with the SSD, she stated R #60's last care plan meeting occurred on 03/24/25 and was not documented in R #60's EHR. The SSD confirmed R #60 should have had two care plan meetings occur since 03/24/25 but did not. S. Record review of R #37's face sheet dated 10/01/25 revealed she was admitted to the facility on [DATE] with the following diagnoses: Alzheimer's Disease (a progressive, chronic disease that affects memory and mental abilities). Dementia disease without behavioral disturbance. Epilepsy (a brain disorder that causes seizures (fits). T. On 09/22/25 at 1:35 pm during observation of dementia (a progressive disease which affects memory and mental abilities) care unit (a specialized unit that manages the care of dementia residents) R #37 met with her family member who was identified as R #37's daughter. R #37 sat in her wheelchair with a table across the arms of her wheelchair. The table appeared to secure R #37 in her wheelchair, preventing R #37 from getting up from her wheelchair. U. On 09/23/25 at 9:00 am during observation of the dementia care unit, R #37 sat in wheelchair in the lounge area alone and without a table across her wheelchair. V. Record review of R #37's care plan dated 09/25/25 revealed the care plan did not contain use of table on R #37's wheelchair when family is present and removal from R #37's wheelchair when family are not present. W. On 09/26/25 at 9:14 am during interview with Director of Nursing (DON), she stated she was aware that R #37's family would visit and place a table across R #37's wheelchair. DON stated this was the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	family's preference, and the facility had determined that family could attach the table when they are present and visiting provided the family removed the table when they stopped visiting R #37. DON reviewed R #37's care plan and acknowledged the care plan did not contain any plan for her family to place or remove the table over R #37's wheelchair, and the care plan did not contain any plan for staff to immediately remove the table if family left with the table still attached to R #37's wheelchair.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide quality care that meets professional standards for 5 (R #'s 9, 11,32, 97 and 125) of 5 (R #'s 9, 11, 32, 97 and 125) residents when the staff failed to:Obtain physician orders for R #9's use of Clotrimazole Cream (antifungal medication). Follow physician order for enteral feeding maintenance (ongoing process of providing nutrition to the residents who are unable to consume enough nutrients through their normal oral intake) for R #11.Follow physician order for oxygen use for R #32, #97 and #125.These deficient practices are likely to result in residents not maintaining their optimal health as planned by their medical provider. The findings are: R #9: A. Record review of R #9's face sheet revealed R #9 was admitted into the facility on [DATE]. B. Record review of R #9's physician orders revealed an order for the use of Clotrimazole Cream 1% (percent) was not found. C. On [DATE] at 09:30 am during an observation and interview with R #9, a tube of Clotrimazole Cream 1% was opened and on a shelf next to R #9's bed. R #9 confirmed that staff will put the cream on him sometimes. D. On [DATE] at 9:31 am during an interview with Licensed Practical Nurse (LPN) #1, she stated she did not know that R #9 was using Clotrimazole Cream 1%. LPN #1 confirmed R #9 should have physician orders for Clotrimazole Cream 1% use and the tube of Clotrimazole Cream 1% should not have been left open on R #9's shelf. E. On [DATE] at 3:11 pm during an interview with the Director of Nursing (DON), she stated R #9 should have physician orders for Clotrimazole Cream 1% use and there were no orders present. R#11 F. On [DATE], during an observation of R #11, he was asleep with his tube feeding currently running, the label on the tube feeding (also known as enteral nutrition, is a medical method of delivering liquid nutrition directly into the stomach or small intestine through a flexible tube when a person is unable to eat or swallow safely) bag was dated [DATE] and time 0200 (2:00am) at 9:25 am. G. Record review of R #11's physician's order revealed an order Enteral Feed: Spike Set Change Closed System/RTH: change feeding spike set as needed with each new bottle AND every night shift for maintenance of enteral feeding system. H. On [DATE] at 9:27am, during an interview, Registered Nurse (RN) #3, confirmed the date written on R #11's tube feeding spike set was [DATE] 0200. Stated that per the physician's order it should be replaced every 24 hours during night shift. Stated it should have been replaced this morning before her shift started. R #32 I. Record review of R #32's Minimum Data Set (MDS; a collection of tests and assessments to determine a person's overall needs and abilities), dated [DATE], revealed the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Brief Interview of Mental Status (BIMS; a section that measures memory) revealed a score of 3, severe cognitive impairment. Diagnoses of atrial fibrillation (an irregular heart rhythm), diabetes (a medical condition that prevents medical breakdown of sugars in the blood), and respiratory failure (sickness of the lungs that causes the lungs to not function properly). Dependent for all Activities of Daily Living (ADL)'s J. Record review of R #32's physician orders revealed the following: An order, dated [DATE], to admit to the facility. An order, dated [DATE], for oxygen continuously at 1 liter per minute (LPM) via nasal cannula (NC). May titrate (increase or decrease rate of flow) 1 to 6 LPM/NC to maintain oxygen saturation (percentage of oxygen to blood) greater than 89 percent (%). K. On [DATE] at 4:13 pm during interview with LPN #5 she stated that she is one of the unit managers of the facility. LPN #5 also stated that residents are expected to use the oxygen when ordered by their provider. LPN #5 stated that all nursing staff are expected to monitor residents who have provider orders to use oxygen, are responsible to apply oxygen to residents and to check that there is oxygen in their portable tanks. L. On [DATE] at 10:40 am during an observation of the 200 hall, R #32 sat in front of the nurse's station in a wheelchair. R #32 did not have an oxygen tank or nasal cannula (a plastic tube that delivers oxygen into the nose of the user) on her. M. On [DATE] at 3:01 pm during an observation of the 200 hall, R #32 sat in a wheelchair in front of the nurse's station. A loud thump was heard, and R #32 was observed lying face down in front of her wheelchair. R #32 did not have an oxygen tank or a nasal cannula with her. Registered Nurse (RN) #5 obtained R #32's vital signs (measurements of a person's vital physical needs.) R #32's oxygen level 78% (normal is greater than 88%). At 3:17 pm, staff brought a portable oxygen tank to R #32 and applied the nasal cannula. Staff were observed as they assessed R #32 and returned R #32 to her wheelchair and taken to her room. No injuries noted per RN #5 N. On [DATE] at 3:18 pm during interview, Licensed Practical Nurse (LPN) # 8 stated R #32 was to receive oxygen continuously. She stated R #32 should wear her nasal cannula at all times and R #32 was without her oxygen at the time of her fall. LPN was unsure if R #32 had been wearing O2 throughout the day. O. On [DATE] at 3:19 pm during interview, LPN #9 stated he was the nurse assigned to R #32. He stated R #32 was to be receive oxygen therapy at all times and R #32 was not on oxygen at the time of the fall on [DATE] at 3:01 pm and was unsure if R #32 not wearing oxygen at the time was the cause of the fall. R #97 P. On [DATE] at 12:20 pm, during an observation R #97 sat on the side of his bed, an oxygen concentration was at bedside running at 2 LPM (liters per minute) with nasal cannula wrapped around (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the concentrator. Q Record review of R #97's physician's order revealed an order Oxygen at 2 LPM/NC. May titrate 1-6 LPM/NC to maintain O2 SATs >89% every day and night shift Post Tx (treatment): Evaluate heart rate, respiratory rate, pulse oximetry, skin color, and breath sounds. R. On [DATE] at 12:15pm, during an interview, R #97 stated he just came back from the therapy room, and they said he does not need to be on oxygen. S. On [DATE] at 12:17 pm, during an interview, Registered Nurse (RN) #1 confirmed that the lowest R #97's oxygen can go to is 1 LPM according to the physician's order. RN #1stated that he will reach out to the provider if they need to change the order to as needed (PRN) instead of continuous. Resident is placed on 1 LPM now. T. On [DATE] at 3:20 pm, during an interview, the Director of Nursing (DON) stated she expects all nurses to follow physician's order as ordered. R #125 U. Record review of R #125's face sheet, dated [DATE], revealed she was admitted to the facility on [DATE] with the following diagnoses: Chronic obstructive pulmonary disease (a chronic progressive disease that cause difficulty breathing), Major depressive disorder (a mood disorder characterized by sadness and despair), Anxiety disorder (nervous fear), Insomnia (difficulty sleeping), Obesity (overweight), Muscle weakness. - #125 was discharged on [DATE] due to death. V. Record review of R #125's annual Minimum Data Set (MDS; a collection of personal assessments and tests that indicate a person's needs), dated [DATE], revealed: Brief Interview for Mental Status (BIMS; a brief test that indicates a person's memory) was 15, cognitively intact. Mood severity score of 10, moderate depression. R #125's required staff supervision when eating, partial staff assistance with oral hygiene, was dependent on staff for assistance with toileting, required substantial staff assistance with bathing and dressing. (continued on next page)

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Casa Real	1650 Galisteo Street Santa Fe, NM 87505

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R #125 was always incontinent (unable to control) of bladder and bowel. R #125 was short of breath when laying flat. R #125 required oxygen therapy. W. Record review of R #125's provider orders, dated [DATE], revealed the following: - An order for oxygen at 1 to 6 liters per minute (LPM) continuously. May titrate (adjust) to maintain oxygen saturation (the amount of oxygen in the blood stream) greater than or equal to 90%, every day and night shift. - An order for supplemental oxygen 3 liters via nasal cannula every day and night shift for chronic obstructive pulmonary disease. X. Record review of R #125's daily care notes revealed: Dated [DATE] at 1:23 pm, a late entry. Writer was notified by CNA on south hall that R #125 sat in dining room without supplemental oxygen on. Resident was very diaphoretic (sweating heavily) and pale. Told nurse for south hall to immediately assess the resident and do paperwork. Writer told CNA to put oxygen on the resident immediately. Writer assessed the resident. Dated [DATE] at 10:15 am, late entry. Resident up in wheelchair in common area. Oxygen saturation measured 81%. R #125 stated she did not feel well, and her skin remained pale. Dated [DATE] at 11:34 am, R #125 was up in her wheelchair in the common area. The resident's oxygen saturation measured 89%. Oxygen increased to 4L/min. Respirations easier. The resident's lung sounds were very wheezy. Routine cough syrup given. Resident refused routine nebulizer. Dated [DATE] at 12:45 pm, staff assisted the resident to bed. R #125 stated she did not feel well. The resident's skin remained pale. R #125's oxygen saturation measured 81%. Oxygen increased to 5L. At 1:00 pm, the resident's oxygen saturation measured 91%. Dated [DATE] at 2:49 pm, staff administered nebulizer (a medical treatment that administers medication to the lungs to open lungs and airways to improve breathing) to R #125. The resident's oxygen saturation remained at 91%. The resident's skin was pale pink. Dated [DATE] at 5:07 pm, change of condition for shortness of breath. Dated [DATE] at 5:10 pm, resident in bed and the evening meal tray was on table. Resident attempted to feed self but had dyspnea (difficulty breathing). Oxygen saturation measured 81% at 5 liters. At 5:20 pm, on-call provider ordered the resident to be transferred to the hospital. At 5:30 pm, resident had continued dyspnea, skin was very pale. Dated [DATE] at 5:35 pm, pronounced deceased . Y. On [DATE] at 11:37 am during interview, Registered Nurse (RN) #3 stated she was the nurse assigned to provide care to R #125 on [DATE]. She stated she arrived for work in the morning, and LPN #4 told her that R #125 was without her oxygen for an unknown period of time on [DATE]. RN #3 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she checked on R #125, and the resident was in her room in bed. RN #3 stated R #125 reported she felt poorly, but the resident could not report any specific symptoms. RN #3 stated she checked R #125 throughout the day to frequently monitor her vital signs. RN #3 suggested R #125 go to the hospital, but R #125 refused. RN #3 stated she checked on R #125 in her room about 5:00 pm, and the resident had difficulty breathing. Z. On [DATE] at 11:47 am during interview with Nurse Practitioner (NP) she stated that R #125 had a diagnosis of Chronic Obstructive Pulmonary Disease and she would be more comfortable if her blood oxygen level was maintained at 88%. NP stated that if R #125's blood oxygen level fell much below 88% she could experience difficulty breathing, chest pain and discomfort. NP reported that she did not believe that R #125's passing was related to R #125 not having oxygen on the day before. AA. On [DATE] at 4:13 pm during interview, LPN #5 stated she was the nurse manager for the 200 unit of the facility on the evening of [DATE]. She stated she entered the dining lounge located by the nurse's station during her rounds during the dinner meal. LPN #5 stated an unknown CNA told her R #125 had been sitting in the lounge area without oxygen for an unknown period of time. LPN #5 stated she went to R #125 and did an assessment. She stated the resident's oxygen saturation measured in the low 80's, and the resident was slow to respond. LPN #5 directed staff to place R #125 back on her oxygen and to assist R #125 back to her room. LPN #5 stated R #125 had a provider order to maintain continuous oxygen. She stated R #125 should not be without supplemental oxygen and that all nursing staff are expected to monitor and encourage residents to use their oxygen. LPN #5 also stated that CNA's are expected to check on all assigned residents every two hours to monitor that the resident's oxygen supply is turned on, set at the ordered flow rate and have their oxygen nasal cannula (a tube that connects an oxygen supply to a person's nose).

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interviews, the facility failed to ensure the facility had sufficient staff to meet the needs of all residents residing in the facility when staff failed to: Offer baths or showers to residents as scheduled.These deficient practices are likely to negatively impact resident safety, comfort, and to impede processes such as timely incontinence care (assisting residents to the bathroom or changing adult briefs), regular turning schedules (moving or turning residents that need assistance and are unable to move on their own), showers, and appropriate assistance with meals.The findings are: A. Refer to F0677 for related findings. B. On 09/26/25 at 11:44 am during an interview with Certified Nursing Assistant (CNA) #1, she stated due to staffing shortages, resident baths and showers are the first things that are missed each day. CNA #1 confirmed residents complain due to missed showers. C. On 09/29/25 at 8:51 am during an interview with CNA #2, she confirmed residents miss baths and showers due to insufficient staffing. D. On 09/29/25 at 9:07 am during an interview with Licensed Practical Nurse (LPN) #1, she confirmed there is a shortage of staffing and residents are affected by it. LPN #1 also stated that resident brief changes are delayed, and resident baths/showers are missed due to low staffing. E. On 09/29/25 at 2:47 pm during an interview with the Director of Nursing (DON), she confirmed residents brief changes should not be delayed and resident's should be offered baths/showers as scheduled and to their preference.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to complete the required pharmacy review of resident medications for 2 (R #'s 4 and 7) of 5 (R #'s 2, 4, 7, 64, and 72) residents reviewed for pharmacy reviews when:The facility failed to provide completed pharmacy reviews for every resident in the facility during the months of October 2024, November 2024, and June 2025. The facility provider did not respond to pharmacist recommendations. The facility providers did not respond to pharmacist recommendations for several weeks after the pharmacist's recommendation. This deficiency practice is likely to result in residents receiving medications that are unnecessary for their health. The findings are:A. Record review of the facility pharmacist recommendations dated August 2024 through September 2025 revealed the following: No pharmacist recommendations were provided for any resident in the facility to review for October 2024, November 2024, and June 2025. Pharmacist recommendations dated 05/19/25 through 05/21/25 for all residents in the facility during that timeframe were not reviewed by the facility provider until June 12, 2025. Pharmacist recommendations dated 08/18/25 were not reviewed by the facility provider until September 05, 2025. R #4: B. Record review of R #4's face sheet revealed R #4 was admitted into the facility on [DATE]. C. Record review of R #4's physician orders dated 09/12/24 revealed R #4 was prescribed Lispro insulin 100 units/mL (per milliliter) as per sliding scale. D. Record review of R #4's pharmacist recommendation dated 12/30/24 revealed R #4 was prescribed a sliding scale of Lispro insulin, and the recommendation was to consider discontinuing the sliding scale order and limit finger stick blood glucose checks to as needed due to the 2024 Standards of Care Diabetes Care in Older Adults. Pharmacist recommendation was not responded to by a facility provider. E. Record review of R #4's Medication Administration Record (MAR) dated 01/01/25 through 09/30/25 revealed the following: January: Lispro insulin sliding scale order was unchanged per pharmacist recommendations. February: Lispro insulin sliding scale order was unchanged per pharmacist recommendations. March: Lispro insulin sliding scale order was unchanged per pharmacist recommendations. April: Lispro insulin sliding scale order was unchanged per pharmacist recommendations. May: Lispro insulin sliding scale order was unchanged per pharmacist recommendations. June: Lispro insulin sliding scale order was unchanged per pharmacist recommendations. July: Lispro insulin sliding scale order was unchanged per pharmacist recommendations. August: Lispro insulin sliding scale order was unchanged per pharmacist recommendations. September: Lispro insulin sliding scale order was unchanged per pharmacist recommendations. R #7: F. Record review of R #7's face sheet revealed R #7 was admitted into the facility on [DATE]. G. Record review of R #7's physician orders dated 11/16/24 revealed R #7 was prescribed Cetirizine (antihistamine medication used for allergies) 5 mg (milligrams) one time a day for Rhinitis (nose inflammation). H. Record review of R #7's pharmacist recommendation dated 12/30/24 revealed R #7 was prescribed Cetirizine 5 mg and for the facility to consider discontinuing the medication or changing the administration frequency to as needed. I. Record review of R #7's MAR dated 01/01/25 through 06/19/25 revealed R #7 was administered Cetirizine 5 mg every day during that time frame as ordered. Cetirizine 5 mg was finally discontinued on 06/15/25 but restarted on 06/20/25 and discontinued again on 07/25/25. J. On 09/29/25 at 3:17 pm during an interview with the Director of Nursing (DON), she stated that her expectation is the pharmacy recommendations are reviewed each month by a facility provider and responded to by a facility provider within a couple of days and not weeks later. The DON also stated they did not have the pharmacy recommendations available for October 2024, November 2024, and June 2025 but those months should have been available. The DON confirmed R #4 and R #7's pharmacy recommendations should have been acknowledged by a provider with the pharmacist recommendations implemented.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to complete the required pharmacy review of resident medications for 5 (R #'s 4, 7, 39, 63, and 105) of 8 (R #'s 2, 4, 7, 39, 63, 64, 72, and 105) residents reviewed for pharmacy reviews when:The facility failed to provide completed pharmacy reviews for every resident in the facility during the months of October 2024, November 2024, and June 2025.The facility provider did not respond to pharmacist recommendations.The facility providers did not respond to pharmacist recommendations for several weeks after the pharmacist's recommendation. Initiate a gradual dose reduction (GDR; the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the medication can be discontinued altogether) for an antipsychotic (used to treat psychotic disorders) medication as recommended by the pharmacist and ordered by the physician.If consultant pharmacist recommendations and physicians' orders are not implemented in a timely manner, residents are likely to be administered medications they do not need, experience potential unnecessary drug interactions, and adverse side effects.The findings are: A. Record review of the facility pharmacist recommendations dated August 2024 through September 2025 revealed the following: No pharmacist recommendations were provided for any resident in the facility to review for October 2024, November 2024, and June 2025.Pharmacist recommendations dated 05/19/25 through 05/21/25 for all residents in the facility during that timeframe were not reviewed by the facility provider until June 12, 2025.Pharmacist recommendations dated 08/18/25 were not reviewed by the facility provider until September 05, 2025. R #4: B. Record review of R #4's face sheet revealed R #4 was admitted into the facility on [DATE]. C. Record review of R #4's physician orders revealed the following: 01/02/25: Aripiprazole Oral Tablet (antipsychotic medication) 2 mg (milligrams), give 2 mg by mouth two times a day. Order was discontinued on 07/31/25. 07/31/25: Aripiprazole Oral Tablet 2 mg, give by mouth two times a day for Major Depression. Order is still active. D. Record review of R #4's pharmacist recommendation dated 07/24/25 revealed R #4 was prescribed Aripiprazole 2 mg, the pharmacist stated R #4's use of the medication required indication for use and to consider a GDR. R #4's pharmacist review was not acknowledged by a facility provider. R #7: E. Record review of R #7's face sheet revealed R #7 was admitted into the facility on [DATE]. F. Record review of R #7's pharmacist recommendations revealed the following:02/21/25: Pharmacist recommendation stated PRN psychotropic orders need a 14 day stop date, a physician will need to re-evaluate Lorazepam (benzodiazepine medication used to treat anxiety, insomnia, severe agitation, and active seizures). R #7's pharmacist recommendation was not acknowledged by a facility provider. 04/17/25: Pharmacist recommendation stated PRN psychotropic orders need a 14 day stop date, a physician will need to re-evaluate Lorazepam. R #7's pharmacist recommendation was not signed and acknowledged by a facility provider until 05/07/25 (20 days after recommendation). R #39: G. Record review of R #39's face sheet revealed R #39 was admitted into the facility on [DATE] and was discharged on 09/04/25. H. Record review of R #39's pharmacist recommendations revealed the following: 01/23/25: R #39 was currently taking Hydroxyzine (antihistamine used to treat anxiety, allergic reactions, and as a sedative before surgery) for anxiety. Please evaluate current diagnosis, behaviors, and usage patterns to evaluate continued use of the medication. Provide duration for PRN (as needed) order. R #39's pharmacist recommendation was not acknowledged by a facility provider. 02/01/25: R #39 has been taking the antipsychotic Quetiapine (antipsychotic) 25 mg since 05/21/24 and Escitalopram (antidepressant) 10 mg daily since 07/15/24, please evaluate the current does and consider a GDR. R #39's pharmacist recommendation was not acknowledged by a facility provider. I. Record review of R #39's physician orders revealed the following: 05/21/24: Quetiapine oral tablet 25 mg, give 1 tablet by mouth at bedtime for dementia, aggression. Order was not discontinued until 03/27/25. 08/10/24: Escitalopram oral tablet 10 mg, give 1 tablet by mouth one time a day for sadness, tearfulness. Order was not (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discontinued until 07/27/25.11/11/24: Hydroxyzine oral tablet 25 mg, give 1 tablet by mouth every 6 hours as needed for agitation, anxiety. Order was not discontinued until 03/12/25. R #63: J. Record review of R #63's face sheet revealed R #63 was admitted into the facility on [DATE]. K. Record review of R #63's pharmacist recommendations dated 01/24/25 revealed R #63 has been taking the antipsychotic/antidepressant Quetiapine 50 mg (antipsychotic) and Escitalopram 10 mg (antidepressant) daily since 05/21/24. Please evaluate the current doses and consider a GDR. R #63's pharmacist recommendation was not acknowledged by a facility provider. L. Record review of R #63's physician orders revealed the following: 01/04/25: Escitalopram 10 mg, give 1 tablet by mouth one time a day for Depression, feeling lonely isolated, sad. Order is still active. 03/24/25: Quetiapine 25 mg, give 2 tablets by mouth two times a day for Agitation related to Dementia. Order was not discontinued until 07/25/25. R #105: M. Record review of R #105's face sheet revealed R #105 was admitted into the facility on [DATE]. N. Record review of R #105's pharmacist recommendations dated 02/23/25 revealed R #105 has been taking the antidepressant Trazodone 25 mg nightly for insomnia (inability to sleep), attempt a dose reduction. R #105's pharmacist recommendation was not acknowledged by a facility provider. O. Record review of R #105's physician orders revealed the following: 05/23/24: Trazodone 50 mg, give 0.5 tablet by mouth at bedtime for insomnia related to dementia. Order is still active. P. On 09/29/25 at 3:18 pm during an interview with the Director of Nursing (DON), she stated that her expectation is the pharmacy recommendations are reviewed each month by a facility provider and responded to by a facility provider within a couple of days and not weeks later. The DON also stated they did not have the pharmacy recommendations available for October 2024, November 2024, and June 2025 but those months should have been available. The DON confirmed R #'s 4, 7, 39, 63, and 105's pharmacy recommendations should have been acknowledged by a provider with the pharmacist recommendations implemented to prevent unnecessary psychotropic medication use.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, and interviews, the facility failed to properly store medications in the facility medication cart by ensuring all expired medications are taken out of the medication cart, and not pre-pouring medications. This deficient practice is likely to result in expired medications and medical supplies being used in resident care resulting in residents being at risk of possible infections and not receiving the full benefits of medication. The findings are: A) On 09/22/25 at 10:06am, during an observation of the medication cart located on the south unit station. The following items were found: - an unlabeled, undated medication cup containing 4 white tablets. - an insulin (insulin is a natural hormone that turns food into energy and manages your blood sugar level) pen for R#71, with no date of first use and no date for when to discard after 28 days. - an insulin pen for R #123, with no date of first use and no date for when to discard after 28 days.B) On 09/22/25 at 10:06am, during an interview with Registered Nurse (RN) #3 stated the following: - that those medications in the medication cup were from yesterday and are meant to be discarded. - confirmed that per facility policy they should not pre-pour (a practice where medications are prepared in advance for administration) medications. - confirmed that insulin pens are to be labelled when: it is first used and must be discarded after 28 days.C) On 09/22/25 at 10:31am, during an observation of the medication cart located on the north unit station. An Insulin pen for R#74 with expiration date 06/24/25 was found.D) On 09/22/25 during an interview with Licensed Practical Nurse (LPN) #1 verified that the medication was expired.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure 1 (R #12) of 3 (R #1, 5 and 12) residents reviewed was appropriately discharged when the facility:Provided R #12 a 30-day discharge notice after R #72 wandered into his room and both residents were engaging in sexual behaviors with one another.Requested that R #12 be administered medication to lessen his sexual drive but didn't allow enough time for the medication to take effect before issuing an immediate discharge notice.Ordered for R #12 to have one to one staffing, but while staff stepped away from R #12, R #72 went into R #12's room and both residents were caught engaging in sexual behaviors. Immediately discharged R #12 home with his wife without proper notice, opportunity to prepare for his arrival and option to appeal decision.Discharging a resident without notice and without adequate evidence to justify an immediate discharge, likely puts residents at risk of an unsafe discharge and disruption in care.The findings are: N. On 12/18/25 at 9:09 am during interview with R #12's wife, she stated They [facility] never said anything about him being discharged . They called me late in the afternoon to come pick him up. I said there was no way to pick him up. They said they would bring him and send him home. R #12's wife stated They said they couldn't have him any longer. I went to see him every week, sometimes twice a week. They called and said he tried to molest some gal [R #72]. They got her out of the room. They called a week later. I guess she [R #72] walked [down the hall] and the door was open and he tried to molest her. I told her [Social Services Director] 'I don't believe you.' He could hardly walk. He had a wheelchair. I had to help him with everything. I told the gal [SSD] that called, 'He could hardly move so how could he make a pass at some gal. I don't believe you.' This gal [R #72] would walk the hallway all the time and go into people's rooms. I asked 'where were you [referring to staff when R #72 wandered into husband's room]?' R #12's wife confirmed that she was called about the discharge but was not provided a written discharge notice. She stated that it wasn't safe to send R #12 home without more notice. She stated He was happy to be home but I was leery because I didn't know if I could take care of him. I was happy with him being there [at the facility] and I would have preferred if he had stayed there [at the facility]. I didn't know I could do anything [to contest the discharge]. O. On 01/06/25 at 3:25 pm during interview with the SSD, she stated The first [discharge] notice was given to wife after the first incident [on 06/22/25]. When I talked to his wife, she was very tearful. She said he [R #12] has never acted like that before and had never displayed sexual behaviors. She was baffled by it. The second incident [06/30/25] he was caught with the same resident that he was still on one to one [one staff monitoring]. He could still wheelchair himself around and this incident occurred again. That's when the Administrator said to contact his wife [for an immediate discharge]. She [Administrator] felt he was putting other residents at risk. We [with R #12's wife] did talk about a [discharge] plan because she was in her 80s [age] and needed help transferring [moving resident]. The plan was to discharge him with hospice and with his medications. She said she wasn't prepared to bring him home and would need services. Hospice was to meet him there. When asked how it was determined that R #12 was the aggressor in the incident with R #72, she stated that R #12 was more oriented than R #72. When shown R #12's BIMS score, SSD confirmed that R #12 had severe cognitive impairment. SSD repeatedly mentioned that R #12 went into R #72's room (contradicting record review and interview that for both incidents R #72 went into R #12's room). P. On 01/06/26 at 4:18 pm during a re-interview with the Administrator, she reported that she had just started working at the facility in June. She stated that she was not aware of R #12 having any sexual behaviors towards staff or residents prior to June 2025 but she had heard about him being (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inappropriate with staff. She reported that after the first incident [06/22/25] she investigated and did not think that it was abuse [resident to resident] because the other resident was not observed fighting or pushing R #12 away however she acknowledged that R #72 did not have capacity to consent either way. The Administrator stated that R #12 was placed on a one to one and the facility worked with hospice to get him on medication to reduce sexual behaviors. The Administrator acknowledged that R #12 had only been on the medication for a couple days when the incident on 06/30/25 happened, resulting in an immediate discharge. The Administrator confirmed that they were concerned that R #12 would continue to have behaviors and staff were reporting that they felt unsafe. The Administartor confirmed that she never personally spoke to R #12 during his stay. When asked about the one-to-one staffing not monitoring R #12 on 06/30/25, the Administrator reported that the staff member went on break and didn't alert the nurse. The Administrator acknowledged that the incident on 06/30/25 occurred due to the intervention implemented by the facility [one to one staffing] failed when staff allowed R #12 to go to his room unsupervised. When asked how it was determined to be an appropriate discharge to discharge a resident that was determined to meet criteria to be placed on a locked unit in a nursing home and was having unsafe behaviors home with his elderly wife with minimal notice to prepare, the Administrator responded, We talked to the medical director about what would be the best outcome. Q. On 01/07/26 at 1:26 pm, received email from Administrator clarifying that after R #12 was administered the Depo shot on 06/28/25, he was monitored for 24 hours and since he seemed to be doing better, he was downgraded from 1:1 staff to line of sight monitoring. The Administrator also shared that R #72 consistently wanders in and out of rooms on the unit and often lies in other resident's beds or picks up their [other residents] belongings as she wanders. R. On 01/07/26 at 2:59 pm, Surveyor requested copy of order change from 1:1 to line of sight, and evidence of R #12 touching staff and the interventions implemented prior to 06/22/5. No additional evidence was provided. A. Record review of R #12's face sheet, dated 09/26/25, revealed R #12 was admitted to the facility on [DATE] with the following diagnoses: Dementia (a chronic progressive disease that affects memory) with other behavioral disturbance. Paroxysmal atrial fibrillation (a type of irregular heart rhythm). Restlessness and agitation. Chronic kidney disease (failure of the kidneys to properly function). History of pulmonary embolism (blood clot in the lungs). Encounter for palliative care (medical care that focuses on care and relief from serious illnesses). - R #12's assigned care providers were Medical Director (MD) and Nurse Practitioner (NP). - R #12 was discharged from the facility on 06/30/25 to private home with home health services. B. Record review of R #12's Discharge Minimum Data Set (MDS; a review of overall health and care needs), dated 06/30/25, revealed Brief Interview for Mental Status (BIMS; a short test that measures (continued on next page)

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	325038	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Real	1650 Galisteo Street Santa Fe, NM 87505

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a person's memory and thinking) revealed a score of 1, severe cognitive impairment. C. Record review of R #12's care plan, created on 06/23/25, revealed the following: - Nurse reported he was touching another residents [sic] Intervention for one-to-one (1:1; resident monitoring of behavior by assigning a staff to be with the resident at all times) due to reports of inappropriate behaviors (no description). Continued until further investigation into specific types of behaviors. -The care plan did not identify any other sexual behaviors or interventions. - The care plan did not identify R #12's discharge plan. D. Record review of the Care Plan for R #72 identified the following: -R #72 likes to stroll around the unit and finds comfort in holding items like a stuffed animal or baby doll at times. -Independent with ambulation and she does not use a walker or wheelchair. -R #72 exhibits, or has the potential to exhibit physical behaviors related to cognitive loss/dementia Poor impulse control. Nursing reports she does disrobe. Initiated on 02/10/25 E. Record review of the facility self-report to the State Agency revealed: -Dated 06/22/25 revealed Resident [R #72] was a participant in an incident involving another resident in which they were attempting to engage in a potentially intimate relationship. Staff separated residents, place make resident [R #12] on a 1;1, notified the provider, DON, Admin and families. Review of medications with the provider. -Follow up investigation dated 06/27/25 identified R #72 has a BIMs of 0. -Dated 06/30/25 revealed Resident [R #72] was a participant in an incident involving another resident in which they were attempting to engage in a potentially intimate relationship. Male resident [R #12] removed from the room, placed on 1:1 and redirected to a different area. Both residents assessed for any injuries, none present. Both residents are located in the memory care area. -Follow up investigation dated 07/07/25 revealed R #72 was involved in an altercation with R #12, R #12 attempted to engage in an intimate relationship with R #72. R #12 had his pants down partially, R #72 pants remain intact and both resident were engaged in kissing on R #12's bed and were separated by the Hospice Nurse who found them within minutes of R #72 leaving the dining room and going in search of R #12. F. Record review of R #12's daily care notes revealed the following: - Review of nursing notes prior to 06/22/25 revealed staff did not document any notes of inappropriate or unwanted sexual behavior by R #12. - Dated 06/22/25, an after-hours telehealth (a provider contact that takes place by phone or internet) (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	visit for R #12. Nursing staff reported R #12 was found on top of a female resident [R #72] with his pants down, attempting to initiate sexual contact. Staff immediately intervened and relocated R #12 to a different area within the memory care unit. Administration was notified of the incident as were families of both residents. Per administrative direction, the nursing staff was instructed to monitor both residents as they are in a memory care unit where such behaviors are managed differently. No injuries were reported or observed to either resident. Administration specifically directed nursing staff not to notify law enforcement regarding the incident. Assessment: The behavior was likely related to his underlying neurocognitive disorder. Counseling: Discussed with nursing staff that the behaviors were often manifestations of underlying neurocognitive disorders and required specialized management approaches rather than punitive measures. Orders: Nursing staff instructed to monitor patient (R #12) closely and observe for any signs of agitation, anxiety or repeated attempts at inappropriate sexual behavior. - Dated 06/22/25 at 3:15 pm, a change in condition for other reasons. R #12 was found in his room. R #12 was on top of the resident [R #72] with pants down and private area exposed. R #12 tried to pull down the female resident's pants and grabbed at the female resident's private parts. Primary provider notified and responded to follow facility protocol and call back with any changes. Another note at 3:16 pm regarding the incident revealed R #12 was separated from the female resident and placed on 1:1 with staff. - Dated 06/22/25 at 11:27 pm, R #12 did not have any behaviors in the evening. He was on 1:1 and in his room asleep. - Dated 06/23/25 at 10:37 am, R #12 was agitated, and anxious. Staff notified the Hospice Nurse. - Dated 06/23/25 at 4:59 pm, R #12 was anxious and had unwanted behaviors. - Dated 06/24/25 at 1:35 am, R #12 was pleasant and did not have any unwanted behaviors. - Dated 06/24/25 at 4:39 am, R #12 touched himself in the presence of staff. - Dated 06/24/25 at 2:40 pm, R #12 experienced unwanted behaviors. The resident was fixated on the incident that happened on Saturday (06/22/25) and kept saying why nobody understood he did not do it. - Dated 06/25/25 at 2:43 pm, R #12 remained on 1:1 for inappropriate behavior. At bedtime, resident began playing with himself while staff were present at bedside. The staff asked the resident to refrain from the act in presence of others. The resident ignored staff and continued. The staff stepped out into hall until the resident stopped. Again at 2:30 am, the resident rubbed on self and moaned. The staff again stepped out of the room until resident stopped. - Dated 06/28/25 at 5:46 pm, a change of condition for abnormal vital signs: The resident had hypertension (high blood pressure) and was tired, weak, confused, and drowsy. R #12 complained of dizziness. Staff notified the Hospice Care Nurse and gave R #12 medications. - Dated 06/29/25 at 1:45 pm, R #12 was pleasant and did not demonstrate unwanted behaviors. - Dated 06/29/25 at 4:52 pm, R #12 was pleasant, did not have a change in mood, and did not demonstrate unwanted behaviors. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Dated 06/29/25 at 6:05 pm R #12 was pleasant, did not have a change in mood, and did not demonstrate unwanted behaviors. - Dated 06/30/25 at 1:04 pm, a change of condition for behavioral symptoms. R #12's hospice provider did not place new orders, and the facility Nurse Practitioner (NP) ordered R #12 be placed on 1:1 monitoring. - Dated 07/01/25 at 9:14 am, the Interdisciplinary Team (IDT; a team consisting of multiple professionals who meet and review care and plans for long term residents) review of incident with resident (R #12) physically touching a female resident. (Date was not noted.) The resident was immediately placed on 1:1 [staffing] and given an immediate discharge. G. Record review of R #12's medical record revealed the following: - Dated 06/22/25, Notice of Intent to Discharge stated R #12 and his spouse were notified the effective Date of Discharge was 30 days from 06/22/25. Discharge was made for the safety of individuals in the facility which was endangered due to the clinical or behavioral status of the resident. A discharge planning conference will be held on (No Date Given). Any person of the resident's choice may attend this conference. The letter was signed by the facility Social Services Director (SSD) and instructions to verbal and hand deliver. The letter provided information to appeal the decision to discharge. - Dated 06/30/25, Notice of Intent to Discharge stated R #12 and his spouse were notified the effective Date of Discharge was 30 days from 06/22/25. Discharge was made for the safety of individuals in the facility which was endangered due to the clinical or behavioral status of the resident. A discharge planning conference will be held on (No date given) Any person of the resident's choice may attend this conference. The letter was signed by the facility Social Services Director (SSD) and noted verbal delivery since the wife lived two hours away and did not drive. Also hand delivered. The letter provided information to appeal the decision to discharge. - Dated 06/30/25, Discharge orders for (name of R #12). Discharge to home with hospice. Home health care services for safety, nursing assessment, track and reinforce medications and medication management by hospice agency. Therapy evaluation and treatment for transition to home: gait training, development home exercises, etc. by hospice agency. Nursing discharge notes and medications: discharge with medications, except narcotics. The document was signed by the Director of Nursing for the physician and dated 06/30/25. H. On 09/26/25 at 3:00 pm during an interview, Hospice Nurse (HN) #1 stated she was the hospice nurse managing R #12's care in June 2025. HN #1 stated R #12 was a resident living in the facility's closed dementia unit. She stated she followed his care and progress for the hospice team from the time of his admission until his discharge on [DATE]. HN #1 stated staff notified her of the incident involving R #12 and a female resident [R #72] on 06/22/25. She stated R #12 continued as a resident on the closed dementia unit and was assigned a staff to monitor and provide 1:1 observation. HN #1 stated the DON contacted her and asked about starting R #12 on medroxyprogesterone (Depo provera-a medication which can be used to manage sexual behaviors of men). HN #1 stated she discussed the request with the Hospice Doctor who agreed to a trial of the medication. HN #1 stated she returned to the facility on [DATE] to meet with R #12. She stated she entered the resident's [R #12] room and found R #12 lying in bed with a female resident [R #72] of the dementia unit. HN #1 stated she separated the two and asked staff to assist. HN #1 stated the Administrator notified her that R #12 (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was to be discharged immediately. HN #1 stated she was told by (could not recall) that R #12 could not remain in the facility any longer, because his behavior was disruptive and threatening to other residents. HN #1 stated the hospice service could not provide any other alternative with such short notice, so she arranged for R #12 to return to his home. She stated she could not provide transportation to his home on short notice, so the facility agreed to transport him to his home. HN #1 stated she felt the discharge was inappropriate, because R #12 lived in a small town in a rural area. She stated the resident did not have any home health services in place when he arrived home. I. On 09/29/25 at 8:40 am during interview, the Administrator stated R #12 was discharged on 06/30/25 after several instances of inappropriate sexual contacts with staff and another resident in the dementia care unit. The Administrator stated R #12's hospice provider was notified well in advance of his discharge, so they could prepare the resident for discharge to his home or another facility. J. On 09/29/25 at 12:14 pm during interview, HN #2 stated she was familiar with R #12's care at the facility. She stated she was aware the facility gave R #12 a 30-day notice of discharge on [DATE] due to his inappropriate sexual behaviors. HN #2 stated she was aware R #12 started medroxyprogesterone shortly after the 30-day notice given 06/22/25, with the goal of curbing his (R #12's) sexual behaviors. HN #2 stated the facility notified R #12's wife of the discharge on [DATE], and the facility notified the hospice service by phone on 06/30/25 that R #12 was to be discharged immediately. She stated there was not any time to plan for the discharge, there was not a meeting to discuss the discharge, and there was no opportunity to appeal the discharge. HN #2 stated R #12 was transported to his home on [DATE]. K. On 09/29/25 at 12:48 pm during interview, Director of Nursing (DON) stated she was aware R #12 had made sexual suggestions and touched female staff prior to 06/22/25. The DON stated this was an ongoing problem. The DON stated she was made aware R #12 and a female resident [R #72] on the dementia unit were found together in bed in R #12's room on 06/22/25. She stated she contacted the hospice service and discussed the possible introduction of medroxyprogesterone to help control R #12's behavior. She stated it took a few days to make contact and arrange for the order to start. The DON stated the use of medroxyprogesterone was a long-term treatment that usually required weeks to see any positive changes in behavior. The DON stated she was aware of a second incident between R #12 and the same female resident [R #72] on 06/30/25. The DON stated she contacted the hospice doctor and received a telephone order on the same day for R #12 to be discharged to home with home hospice services. L. Record review of Physician Order dated 06/28/25 for Medroxyprogesterone Acetate Intramuscular (in the muscle) Suspension (shot) 150 milligram/milliliter. M. On 09/29/25 at 1:55 pm during an interview, the Administrator stated she was informed R #12 was becoming more sexually aggressive. The Administrator stated R #12 was placed on 1:1 monitoring after the first incident of 06/22/25. She stated on 06/30/25, R #12's assigned 1:1 monitor was distracted and was helping another resident when R #12 walked away from her and went to his room. The Administrator stated HN #1 found R #12 in his room with the same female resident [R #72]. The Administrator stated it was determined R #12 could not be managed at the facility, and his care would be safer elsewhere. The Administrator stated the SSD gave the second notice of discharge. She stated R #12 was discharged on 06/30/25 and transported by facility staff to his home.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review and interview, the facility failed to provide written notice of discharge to the resident's representative for 1(R #12) of 3(R #1, 5 and 12) residents reviewed for discharged . If the facility is not providing written notice of discharge of a resident, then residents and their representatives will not have the contact information to appeal the decision without having to ask. The findings are: A. Record review of R #12's face sheet, dated 09/26/25, revealed R #12 was admitted to the facility on [DATE] with the following diagnoses:Dementia (a chronic progressive disease that affects memory) with other behavioral disturbance.Paroxysmal atrial fibrillation (a type of irregular heart rhythm).Restlessness and agitation.Chronic kidney disease (failure of the kidneys to properly function). History of pulmonary embolism (blood clot in the lungs).Encounter for palliative care (medical care that focuses on care and relief from serious illnesses).B. Record review of R #12's daily care notes date 06/22/25 at 3:15 pm, a change in condition for other reasons. R #12 was found in his room. R #12 was on top of the resident [R #72] with pants down and private area exposed. R #12 tried to pull down the female resident's pants and grabbed at the female resident's private parts. Primary provider notified and responded to follow facility protocol and call back with any changes. Another note at 3:16 pm regarding the incident revealed R #12 was separated from the female resident and placed on 1:1 with staff.C. Record review of R #12's medical record dated 06/22/25 revealed Notice of Intent to Discharge stated R #12 and his spouse were notified the effective Date of Discharge was 30 days from 06/22/25. Discharge was made for the safety of individuals in the facility which was endangered due to the clinical or behavioral status of the resident. A discharge planning conference will be held on (No Date Given). Any person of the resident's choice may attend this conference. The letter was signed by the facility Social Services Director (SSD) and handwritten instructions verbal and hand deliver. The letter provided contact information (address, phone and email for (2) agencies to appeal the decision to discharge.D. Record review of R #12's daily care notes dated 06/30/25 at 2:31 pm revealed Male resident has been in line of site of nursing staff until 1230 (pm)when he went to his room and closed his door. Staff was assisting another resident at the time in a room across the hallway. Female resident [R #72] in dining room until 1245 (pm) with CNA and went wandering down the hall. Staff busy helping residents in dining room. [Name of Registered Nurse (RN) from Hospice agency] arrived at the facility to see patient at 1245. [name of Hospice RN] states she found resident in bed B lying down with another female resident [R #12] kissing and trying to put his hands down the female residents' pants. Resident has his pants partially down.E. Record review of R #12's medical record dated 06/30/25 revealed Notice of Intent to Discharge addressed to R #12 and his spouse identifies 30-day notice from date (left blank). Discharge was made for the safety of individuals in the facility which was endangered due to the clinical or behavioral status of the resident. A discharge planning conference will be held on (No date given). Any person of the resident's choice may attend this conference. The letter was signed by the facility Social Services Director (SSD) and a handwritten note verbal- lives 2 hrs (hours) away. Wife does not drive/also hand delivered. The letter provided contact information for (3) agencies to appeal the decision to discharge.F. On 12/18/25 at 9:09 am during interview with R #12's wife, she stated They [facility] never said anything about him being discharged . They called me late in the afternoon (on 06/30/25) to come pick him up. I said there was no way to pick him up. They said they would bring him and send him home. R #12's wife stated They said they couldn't have him any longer. I went to see him every week, sometimes twice a week. They called and said he tried to molest some gal. They got her out of the room. They called a week later. I guess she [other resident] walked and the door was open and he tried to molest her. I told her [Social Services Director] 'I don't believe you.' He could hardly walk. He had a wheelchair. I had to help him with everything. I told the gal [SSD] that called, 'He could (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hardly move so how could he make a pass at some gal. I don't believe you.' This gal would walk the hallway all the time and go into people's rooms. I asked 'where were you [referring to staff when resident wandered into husband's room]?' R #12's wife confirmed that she was called about the discharge but was not provided a written discharge notice. She stated that it wasn't safe to send R #12 home without more notice. She stated He was happy to be home but I was leery because I didn't know if I could take care of him. I was happy with him being there [facility] and I would have preferred if he had stayed there [facility]. I didn't know I could do anything [to contest the discharge].G. On 01/06/25 at 3:25 pm during interview with the SSD, she stated The first notice was given to wife after the first incident. When I talked to his wife, she was very tearful. She said he [R #12] has never acted like that before and had never displayed sexual behaviors. She was baffled by it. The second incident he was caught with the same resident that he was still on one to one [one staff monitoring]. He could still wheelchair himself around and this incident occurred again. That's when the Administrator said to contact his wife [for an immediate discharge]. She [Administrator] felt he was putting other residents at risk. We [with R #12's wife] did talk about a [discharge] plan because she was in her 80s and needed help transferring. The plan was to discharge him with hospice and with his medications. She said she wasn't prepared to bring him home and would need services. Hospice was to meet him there [at the home after he was transported]. SSD confirmed that she sent both written notices [from 06/22/25 and 06/30/25] with the driver to give to R #12's wife [on 06/30/25 when he was dropped off].

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS; a comprehensive review of the resident's health and functional status) assessment was submitted for finalization within 14 days for 1 (R #5) of 1 (R #5) residents reviewed for Minimum Data Set. If MDS assessments are not completed and submitted in a timely manner, then the resident is likely to receive less than optimal care. The findings are:A. Record review of R #5's face sheet revealed R #5 was admitted into the facility on [DATE] and was discharged on 07/10/25. B. Record review of R #5's electronic health record (EHR) MDS Assessments page revealed the following: 06/27/25 Entry MDS submitted within 14 days and accepted.07/10/25 Discharge Return Anticipated MDS was completed but was not submitted within 14 days as required. R #5 did not return to the facility. C. On 09/29/25 at 3:48 pm during an interview with the MDS Coordinator (MDSC), she confirmed R #5's MDS discharge was not submitted and should have been submitted within 14 days.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to provide daily care needs including showers, brief changes and urostomy (a medical device used to collect urine after a urostomy, which is a surgical procedure that creates an opening (stoma) in the abdomen for urine to exit the body) bag changes for 3 (R #'s 4, 11, 36) of 3 (R #'s 4, 11, and 36) residents reviewed for care needs.Failure to provide for resident's daily care needs can result in residents feeling dirty, unclean and ashamed.The findings are: R #4: A. Record review of R #4's care plan dated 09/05/25 revealed R #4 requires assistance for ADL (Activities of Daily Living) care in bathing, grooming, personal hygiene, dressing, eating, locomotion-movement, toileting related to Dementia with behavioral disturbances. B. Record review of R #4's Documentation Survey Report (ADL tracking form) dated 09/08/25 through 09/24/25, revealed the following: Three out of 16 days, R #4 was not toileted/changed for approximately 12 hours. Four out of 16 days, R #4 was not toileted/changed for approximately 10 hours. Four out of 16 days, R #4 was not toileted/changed for approximately 9 hours. Two out of 16 days, R #4 was not toileted/changed for approximately 8 hours. C. On 09/24/25 at 3:39 pm during an interview with Licensed Practical Nurse (LPN) #5, she stated R #4 is incontinent and should be checked at least every two hours for toileting/changing. R #11: D. Record review of R #11's care plan dated 07/11/25 revealed R #11 s totally dependent for Activities of Daily Living care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to Quadriplegia (paralysis of all four limbs), Traumatic Brain Injury (brain injury caused by external force), contractures (a condition of shortening and hardening of muscles), muscle spasticity (condition characterized by involuntary muscle stiffness, spasms, and contractions), and bed bound. E. Record review of the R #11's Documentation Survey Report, from 09/08/25 through 09/23/25, revealed the following: One out of 16 days, R #11 was not toileted for approximately 22 hours. One out of 16 days, R #11 was not toileted for approximately 20 hours. One out of 16 days, R #11 was not toileted for approximately 18 hours. Two out of 16 days, R #11 was not toileted for approximately 14 hours. Three out of 16 days, R #11 was not toileted for approximately 13 hours. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Two out of 16 days, R #11 was not toileted for approximately 12 hours. Two out of 16 days, R #11 was not toileted for approximately 9 hours. F. Record review of R #11's skin assessment dated [DATE], revealed R #11 had developed moisture associated skin damage to the front right thigh. G. On 09/24/25 at 1:23 pm during an interview with Licensed Practical Nurse (LPN) #1, she stated the facility nursing staff are supposed to assist R #11 with transfers daily, especially for toileting. LPN #1 also stated not assisting a resident with toileting or changing for 9 hours or more is too long of a time to wait. H. On 09/24/25 at 1:45 pm during an interview with CNA #7, she confirmed R #11 should be checked for toileting/changing needs at least every two hours and as needed. R #36: I. Record review of R #36's shower schedule revealed R #36 should be offered a bath/shower every day and as needed. J. Record review of R #36's Documentation Survey Report dated 08/01/25 through 09/30/25 revealed the following: 08/01/25 through 08/31/25: R #36 was offered/received 6 baths/showers out of 31 opportunities. 09/01/25 through 09/28/25: R #36 was offered/received 7 baths/showers out of 25 opportunities. K. Record review of R #36's physician orders revealed R #36's Urostomy bag should be changed as needed. L. Record review of R #36's Treatment Administration Record (TAR) dated 08/01/25 through 09/28/25 revealed, the facility did not document any assistance with urostomy changes for R #36. M. On 09/23/25 at 10:28 am during an interview with R #36, he stated the facility never helps him with his urostomy bag or give him baths/showers because they say they are always short staffed. N. On 09/24/25 at 3:29 pm during an interview with CNA #8, she stated the CNAs should notify the nurses when there are issues with R #36's urostomy. O. On 09/26/25 at 10:15 am during an interview with LPN #4, she stated R #36's urostomy bag should be monitored every day and changed every other day. LPN #4 also confirmed R #36's urostomy bag changes should be documented in the TAR. P. On 09/28/25 at 3:42 pm during an interview with the Director of Nursing (DON), she stated all residents should be assessed for brief [NAME] and toileting at least every two hours and as needed. The DON also stated residents should be offered/given baths/showers per the facility schedule and urostomy bag changes should be documented in the TAR. The DON confirmed her expectations were not met regarding R #4, R #11, and R #36.

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	325038	A. Building B. Wing	01/06/2026

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on interview and record review the facility failed to follow-up on an issue that that was brought up by the family during a meeting with staff for 1 (R #64) of 1 R (#64) resident if the facility is not following up on issues that affect the residents well being and quality of life then it is likely that the resident will feel unheard and that their issues do not matter to the facility. The findings are: A. Record review of R #64's review of MDS section B1000 dated 09/15/25 reveals she wears corrective lenses.B. On 09/23/25 at 9:38 AM during an interview with R #64's Power of Attorney (POA) she stated that she had had a care conference meeting with the facility for R #64. She stated that she had let the facility know that there was a scratch on R #64's glasses and she would like her to be taken to the eye doctor to get new glasses. C. Record review of Care Conference Meeting notes dated 09/04/25 reveals obtain consult as need/indicated and treatment. D. On 09/24/2025 at3:51 PM during an interview with the Social Services Director (SSD) she stated that the family had talked about R #64 needing to get her glasses replaced because they had a scratch on them and it was affecting her vision SSD stated that POA was going to give her the providers name and SSD would make an appointment for R #64. SSD stated that she still had not made an appointment for R #64 nor had she followed up with the POA to get the providers name and number. SSD further stated that it was facility protocol to follow up at least the same week.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to adequate supervision to prevent resident to resident sexual contact for 2(R #12 and 72) of 2(R #12 and 72) residents reviewed. If the facility is not providing adequate supervision to prevent sexual contact between residents determined to not have the capacity to consent to such contact, then residents are at risk of unwanted contact. The findings are:A. Record review of R #12's face sheet, dated 09/26/25, revealed R #12 was admitted to the facility on [DATE] with the following diagnoses:Dementia (a chronic progressive disease that affects memory) with other behavioral disturbance.Paroxysmal atrial fibrillation (a type of irregular heart rhythm).Restlessness and agitation.Chronic kidney disease (failure of the kidneys to properly function). History of pulmonary embolism (blood clot in the lungs).Encounter for palliative care (medical care that focuses on care and relief from serious illnesses).- R #12's assigned care providers were Medical Director (MD) and Nurse Practitioner (NP).- R #12 was discharged from the facility on 06/30/25 to private home with home health services. B. Record review of R #12's Discharge Minimum Data Set (MDS; a review of overall health and care needs), dated 06/30/25, revealed Brief Interview for Mental Status (BIMS; a short test that measures a person's memory and thinking) revealed a score of 1, severe cognitive impairment. C. Record review of R #12's care plan, created on 06/23/25, revealed the following:- Nurse reported he was touching another residents [sic] Intervention for one-to-one (1:1; resident monitoring of behavior by assigning a staff to be with the resident at all times) due to reports of inappropriate behaviors (no description). Continued until further investigation into specific types of behaviors. D. Record review of the Care Plan for R #72 identified the following:-R #72 likes to stroll around the unit and finds comfort in holding items like a stuffed animal or baby doll at times.-Independent with ambulation and she does not use a walker or wheelchair.-R #72 exhibits, or has the potential to exhibit physical behaviors related to cognitive loss/dementia Poor impulse control. Nursing reports she does disrobe. Initiated on 02/10/25 E. Record review of the facility self-report to the State Agency revealed:-Dated 06/22/25 revealed Resident [R #72] was a participant in an incident involving another resident in which they were attempting to engage in a potentially intimate relationship. Staff separated residents, place make resident [R #12] on a 1;1, notified the provider, DON, Admin and families. Review of medications with the provider.-Follow up investigation dated 06/27/25 identified R #72 has a BIMs of 0.-Dated 06/30/25 revealed Resident [R #72] was a participant in an incident involving another resident in which they were attempting to engage in a potentially intimate relationship. Male resident [R #12] removed from the room, placed on 1:1 and redirected to a different area. Both residents assessed for any injuries, none present. Both residents are located in the memory care area. -Follow up investigation dated 07/07/25 revealed R #72 was involved in an altercation with R #12, R #12 attempted to engage in an intimate relationship with R #72. R #12 had his pants down partially, R #72 pants remain intact and both resident were engaged in kissing on R #12's bed and were separated by the Hospice Nurse who found them within minutes of R #72 leaving the dining room and going in search of R #12. F. Record review of R #12's daily care notes revealed the following: - Dated 06/22/25, an after-hours telehealth (a provider contact that takes place by phone or internet) visit for R #12. Nursing staff reported R #12 was found on top of a female resident [R #72] with his pants down, attempting to initiate sexual contact. Staff immediately intervened and relocated R #12 to a different area within the memory care unit. Administration was notified of the incident as were families of both residents. Per administrative direction, the nursing staff was instructed to monitor both residents as they are in a memory care unit where such behaviors are managed differently. No injuries were reported or observed to either resident. Administration specifically directed nursing staff not to notify law enforcement regarding the incident. Assessment: The behavior was likely related to his underlying neurocognitive disorder. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Counseling: Discussed with nursing staff that the behaviors were often manifestations of underlying neurocognitive disorders and required specialized management approaches rather than punitive measures. Orders: Nursing staff instructed to monitor patient (R #12) closely and observe for any signs of agitation, anxiety or repeated attempts at inappropriate sexual behavior.- Dated 06/22/25 at 3:15 pm, a change in condition for other reasons. R #12 was found in his room. R #12 was on top of the resident [R #72] with pants down and private area exposed. R #12 tried to pull down the female resident's pants and grabbed at the female resident's private parts. Primary provider notified and responded to follow facility protocol and call back with any changes. Another note at 3:16 pm regarding the incident revealed R #12 was separated from the female resident and placed on 1:1 with staff. - Dated 06/22/25 at 11:27 pm, R #12 did not have any behaviors in the evening. He was on 1:1 and in his room asleep.- Dated 06/25/25 at 2:43 pm, R #12 remained on 1:1 for inappropriate behavior. At bedtime, resident began playing with himself while staff were present at bedside. The staff asked the resident to refrain from the act in presence of others. The resident ignored staff and continued. The staff stepped out into hall until the resident stopped. Again at 2:30 am, the resident rubbed on self and moaned. The staff again stepped out of the room until resident stopped. - Dated 06/30/25 at 1:04 pm, a change of condition for behavioral symptoms. R #12's hospice provider did not place new orders, and the facility Nurse Practitioner (NP) ordered R #12 be placed on 1:1 monitoring.- Dated 07/01/25 at 9:14 am, the Interdisciplinary Team (IDT; a team consisting of multiple professionals who meet and review care and plans for long term residents) review of incident with resident (R #12) physically touching a female resident. (Date was not noted.) The resident was immediately placed 1:1 and given immediate discharge. G. On 09/29/25 at 1:55 pm during an interview, the Administrator stated she was informed R #12 was becoming more sexually aggressive. The Administrator stated R #12 was placed on 1:1 monitoring after the first incident of 06/22/25. She stated on 06/30/25, R #12's assigned 1:1 monitor was distracted and was helping another resident when R #12 walked away from her and went to his room. The Administrator stated HN #1 found R #12 in his room with the same female resident [R #72]. The Administrator stated it was determined R #12 could not be managed at the facility, and his care would be safer elsewhere. She stated R #12 was discharged on 06/30/25 and transported by facility staff to his home. H. On 12/18/25 at 9:09 am during interview with R #12's wife, she stated They [facility] called and said he tried to molest some gal [R #72]. They got her out of the room. They called a week later. I guess she [R #72] walked [down the hall] and the door was open and he tried to molest her. I told her [Social Services Director] 'I don't believe you.' He could hardly walk. He had a wheelchair. I had to help him with everything. I told the gal [SSD] that called, 'He could hardly move so how could he make a pass at some gal. I don't believe you.' This gal [R #72] would walk the hallway all the time and go into people's rooms. I asked 'Where were you [referring to staff when R #72 wandered into husband's room]?' I. On 01/06/26 at 2:44pm during interview with Registered Nurse (RN) #5 regarding R #72, She is a wanderer. When asked if R #72 has ever been harmed by another resident on the unit, she replied Usually we [staff] are pretty much on top of it [watching her] and distract her. I know residents have tried to hit her before, but I can't remember her ever being harmed. RN #5 confirmed that R #72's has advanced dementia and would be unable to engage in affection or sexual relationship with another person. J. On 01/06/25 at 3:25 pm during interview with the SSD, she stated The first [discharge] notice was given to wife after the first incident [on 06/22/25]. When I talked to his wife, she was very tearful. She said he [R #12] has never acted like that before and had never displayed sexual behaviors. She was baffled by it. The second incident [06/30/25] he was caught with the same resident that he was still on one to one [one staff monitoring]. He could still wheelchair himself around and this incident occurred again. That's when the Administrator said to contact his wife [for an immediate discharge]. She [Administrator] felt he was putting other residents at risk. K. On 01/06/26 at 4:18 pm during a re-interview with the Administrator, when asked about the one-to-one staffing not monitoring R #12 on 06/30/25, the Administrator reported that the staff member went on break and didn't alert the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse. L. On 01/07/26 at 1:26 pm, received email from Administrator clarifying that after R #12 was administered the Depo shot on 06/28/25, he was monitored for 24 hours and since he seemed to be doing better, he was downgraded from 1:1 staff to line of sight monitoring. The Administrator also shared that R #72 consistently wanders in and out of rooms on the unit and often lies in other resident's beds or picks up their [other residents] belongings as she wanders. M. On 01/07/26 at 2:59 pm, Surveyor requested copy of order change from 1:1 to line of sight. No additional evidence was provided.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to provide dialysis (a treatment that helps remove waste products and excess fluids from the blood when the kidneys are not functioning properly) services consistent with professional standards for 1 (R#3) of 1 (R#3) resident reviewed for dialysis care. The facility failed to provide a system of communication between the facility and the dialysis provider. This deficient practice is likely to result in resident condition not being communicated between the facility and dialysis center causing residents to receive inadequate care before, during and after dialysis services.The findings are: A) Record review of R #3 face sheet dated 09/24/25, revealed she was admitted to the facility on [DATE] with multiple diagnoses including, but not limited to:Cardiomyopathy (Heart muscle disease)Chronic ulcer of buttock (also known as bedsore that dorms on the buttocks area due to prolonged pressure on the skin and underlying tissues)Hyperlipidemia (a condition in which there are high levels of lipids, fat particles, in the blood)Essential hypertension (a chronic condition of persistently high blood pressure with no identifiable cause)Type 2 diabetes mellitus (a long term condition in which the body has trouble controlling blood sugar and using it for energy)Anemia (a condition in which the blood doesn't have enough healthy red blood cells)Mood disorder (is any of a group of conditions of mental and behavioral disorder where the main underlying characteristic is a disturbance in the person's mood)Chronic Kidney Disease 4 (a chronic, progressive disease of the kidneys causing kidney failure)B) Record review of R #3's physician's orders revealed an order dated 05/03/25, Dialysis days: M (Monday), W (Wednesday), F (Friday) time for pick up 05:30 am. Transport to (name of dialysis facility). C) Record review of R #3 care plan revealed:12/31/23 R #3 diagnosed with anemia related to chronic kidney disease. She continues to self-sabotage and refusing dialysis. She will go to dialysis when she wants and continues to refuse often.01/10/24 R #3 is at nutritional risk related to therapeutic diet, skin breakdown, weight fluctuations with history of edema (swelling caused by excess fluid trapped in the body's tissues, End Stage Renal (kidney) Disease now on hemodialysis (a treatment that helps remove waste products and excess fluids from the blood when the kidneys are not functioning properly), and nausea/vomiting.04/20/24 R #3 exhibits or is at risk for dehydration (a condition when your body loses more fluids than it takes in) as evidence by use of diuretic (medication that increase urine output) medication. Has repeat cycles of nausea (an unpleasant feeling of needing to vomit) and vomiting (when your body expels what's in your stomach) which increases her risk of dehydration along with fluid restrictions due to Chronic Kidney Disease.08/05/24 R#3 is resistive to care, refuses medications and is non-compliant with smoking policy. Refusing insulin. Continues to refuse insulin and refusing bowel medications despite opioid use. Refusing dialysis and she has been educated. 10/11/24 R#3 exhibits or is at risk for impaired renal function related to Acute (sudden or brief in onset) Kidney Injury/Chronic Kidney Disease, Nephrotic (a kidney disorder that causes the body to excrete too much protein in the urine) Syndrome. Recent hospitalization with acute renal failure, Chronic Kidney Disease now stage 5 and requires dialysis which she is refusing. Update: She has now agreed to start dialysis as of 4/22/25. Her schedule is every Mon-Wed-Fri pick up at 6:00am. She continues to refuse dialysis on and off, self-sabotage.D) Record review of R#3 Electronic Medical Record (EMR) completed on 09/24/25 at 2:05 pm failed to locate consistent documentation of any communications between the facility and R #3's dialysis provider. Record review of filed dialysis communication log from 06/01/25 thru 09/23/25 revealed that the dialysis communication log for dates: 06/04, 06/11, 06/13, 06/16, 06/20, 06/30, 07/02, 07/07, 07/09, 07/11, 07/18, 07/25, 07/30, 08/06, 08/18, 08/20, 08/22(hospitalized), 08/25, 08/27, 09/05, 09/08, 09/10, 09/17 and 09/19 were missing.E) On 09/24/25 at 11:39am RN #3 stated the resident gets picked up for dialysis before her shifts start and returns around 11:00 am. Stated that R #3 returns with dialysis communication form and is scanned into the resident's EMR. States she assesses the resident upon arrival that includes vital signs and the arteriovenous (AV) (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fistula (irregular connection between an artery and a vein). Stated that anything abnormal from their assessment, they are to communicate to the Nursing Practitioner (NP) and wait for an order. During after hours they call the on-call provider if there's anything dialysis related situation or emergencies. F) On 09/24/25 at 2:59pm interview with the Director of Nursing (DON), stated that all residents that goes to the dialysis are sent with a dialysis communication log that includes pre-treatment information such as weight, vital signs and to-go meal if applicable to their chair time. Stated that upon arrival of these residents, the nurses are expected to assess them including vital signs and checking for bruit and trill. When they come back with anything abnormal findings, they report it to NP or after hours provider. The nurses are then to file the dialysis communication log for medical records to scan. If medical records did not receive any dialysis communication log, they have to notify the DON. Stated that medical records expect those communication logs three times weekly. DON stated that they had inconsistent medical records personnel and will try to find those missing dialysis communication logs.G) On 09/29/25 at 8:36am, facility failed to produce missing dialysis communication logs that were requested.