

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335184	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026
NAME OF PROVIDER OR SUPPLIER Van Duyn Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 5075 West Seneca Turnpike Syracuse, NY 13215	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on record review and interviews during the abbreviated survey the facility failed to ensure residents were free from abuse for one (1) of one (1) resident (Resident #1) reviewed. Specifically, Resident #1's head was forcefully pushed backward by Certified Nurse Aide #2 during care resulting in scratches and redness to Resident #1's face. The facility's failure to protect residents from abuse resulted in harm that is Immediate Jeopardy and Substandard Quality of Care for Resident #1 and placed all 418 residents in the facility at risk for the likelihood of serious injury, serious harm, serious impairment, or death. Findings include: The facility policy Prevention of Abuse, Neglect, Exploitation, Mistreatment and Misappropriation Policy, revised 02/2026, documented residents were to be free from abuse, neglect, exploitation, mistreatment, and misappropriation of property to prioritize the emotional, physical, and psychological well-being of all residents in accordance with federal and state guidance. The willful infliction of injury, involuntary seclusion, intimidation, or punishment resulting in physical harm, pain, or mental anguish. Abuse applies to all residents, regardless of mental or physical condition. Physical Abuse was the use of physical force that may result in bodily injury, physical pain, or impairment. Resident #1 had diagnoses including traumatic brain injury and anxiety. The 01/22/2026 Minimum Data Set (a resident assessment tool) documented the resident had severely impaired cognition, had verbal and behavioral symptoms directed toward others, and was dependent or required moderate assistance for activities of daily living. The Comprehensive Care Plan revised 02/13/2026 documented the resident had behaviors related to their traumatic brain injury with cognitive deficits including verbal aggression and physical aggression towards staff. Interventions included two (2) caregivers for care, no male care givers; and 1:1 during the night shift due to falls at night. The 02/04/2026 facility Incident Report completed by Registered Nurse Investigator #11 documented on 02/04/2026 at 7:00 AM, Certified Nurse Aide #1 and Certified Nurse Aide #2 (male) were providing care to Resident #1 during the last rounds of the nightshift. Resident #1 became combative during their incontinence brief change. Certified Nurse Aide #1 interlocked their hands with the resident to de-escalate the situation and Resident #1 spit at Certified Nurse Aide #2. Certified Nurse Aide #2 was witnessed by Certified Nurse Aide #1 pushing Resident #1's face down with their hand. Certified Nurse Aide #1 instructed Certified Nurse Aide #2 to leave the room. Licensed Practical Nurse #3 came to the room due to hearing screaming. Resident #1 told Licensed Practical Nurse #3 the certified nurse aide was yelling at them, disrespecting them, and scratched their face twice. Certified Nurse Aide #1 reported the incident to Registered Nurse/Assistant Director of Nursing #5 (time of report was not documented). Registered Nurse/Assistant Director of Nursing #5 assessed Resident #1 who had an abrasion below their right eye and on the right cheek, redness to the tip of their nose, redness to the left eyebrow and below the left eye, two (2) abrasions above the lip on the right and a scratch from the bottom right lip extending to the chin. The resident was assessed for emotional distress and appeared to be agitated. The resident was assessed by the Medical Director on 02/06/2026. The 02/04/2026 timecard for Certified Nurse Aide #2 documented they clocked out at 7:10 AM. There was no documented evidence Certified Nurse Aide #2 left the premises at 7:10 AM. During an interview on 02/19/26 at 10:35 AM, Certified Nurse Aide #1 stated on 02/04/2026 at around (continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>6:50 AM, they went to see who the 1:1 for Resident #1 was on the over the night shift. Certified Nurse Aide #2 asked them for assistance with changing Resident #1. Resident #1 was lying naked across their bed and stated they did not want to be touched. They told Certified Nurse Aide #2 they should reapproach the resident later, but Certified Nurse Aide #2 wanted to proceed due to time constraints. Certified Nurse Aide #1 stated Resident #1 allowed them to roll them but when they went to pull the resident's brief up, the resident started swinging. They asked the resident to stop, and the resident stated they did not want the certified nurse aides touching them. Resident #1 spat in Certified Nurse Aide #2's face. Certified Nurse Aide #2 put their hand on the resident's face and pushed it aggressively. Resident #1 became red in the face and more agitated after having their face pushed. They stated they pushed Certified Nurse Aide #2 away from the resident and told them to leave. They did not know where Certified Nurse Aide #2 went after they left the room. During a follow up interview on 02/24/2026 at 2:56 PM, they stated the resident had lacerations and scratches all over their face and neck. They stated they knew a resident could not be held down like that and it was abuse. They had informed both Licensed Practical Nurse #3 and Registered Nurse/Assistant Director of Nursing #5. During an interview on 02/24/2026 at 3:09 PM, Licensed Practical Nurse #3 stated on the morning of 02/04/2026, they heard someone scream just before the night shift change and determined it was Resident #1. As they got to the resident's room, Resident #1 stated the [expletive] scratched them in the face. There was redness and scratches on the resident's face. The resident was very agitated, used foul language, and stated they were disrespected by staff. Licensed Practical Nurse #3 stated they informed Licensed Practical Nurse Assistant Unit Manager #4 of the incident when they came in for their shift sometime after 7:00 AM that morning. During an interview on 02/24/2026 at 3:22 PM, Licensed Practical Nurse Assistant Unit Manager #4 stated they were informed around 7:30 AM on 02/04/2026 there were some problems overnight with Resident #1 and Certified Nurse Aide #2, but they were not informed abuse occurred. They were informed by Registered Nurse/Assistant Director of Nursing #5 Resident #1 had red marks and an open area to the side of their mouth. As soon as an allegation was made, the staff member should be put on suspension pending the investigation. Licensed Practical Nurse Assistant Unit Manager #4 stated Certified Nurse Aide #2 was not in the facility when they arrived for work, but they would have been removed immediately if they had known. During a phone interview on 02/25/2026 at 9:49 AM, Certified Nurse Aide #2 stated on 02/04/2026 around 6:50 AM, they were providing care to Resident #1 with another certified nurse aide. Resident #1 was swinging their arms around. They stated they did not push the resident's face or hurt them in any way. They did not know where the marks on the resident's face came from. They stated no one told them to leave the facility; they left because their shift was over. During an interview on 02/25/2026 at 11:19 AM, Registered Nurse/Assistant Director of Nursing #5 stated around 11:30 AM to 12:00 PM, Certified Nurse Aide #1 informed them that Resident #1 spit in Certified Nurse Aide #2's face and Certified Nurse Aide #2 held Resident #1's face down with their hand while the resident was swinging. Certified Nurse Aide #1 told Certified Nurse Aide #2 to get out of the room. Certified Nurse Aide #1 stayed with the resident to calm them down. During an interview on 02/25/2026 at 1:23 PM, the Administrator stated Certified Nurse Aide #2 left the unit and had clocked out on the time clock at 7:10 AM on 02/04/2026. Generally, after a staff member clocks out at the time clock, they leave the building. They believed Certified Nurse Aide #2 left the building after clocking out, but they could not say for sure. During a phone interview on 02/26/2026 at 10:25 AM, Nurse Practitioner #9 stated if there was alleged abuse, they should assess the resident to ensure they were okay. They were notified the next day Resident #1 had complained they were assaulted by a certified nurse aide on the night shift. The resident had abrasions. If there was an allegation of abuse, the employee should be pulled off the floor and off the premises until the investigation was completed. If there were no witnesses to where Certified Nurse Aide #2 went after they clocked out, they could not ensure the certified nurse aide left the building. During a phone interview on 02/26/2026 at 10:41 AM, the Medical Director stated if there was alleged abuse by staff against a resident, the staff member (continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>should be notified they were being investigated and kept away from the residents until it was determined there was no risk. Medical staff should be notified of the allegation and of any injuries. 10 New York Codes, Rules and Regulations 415.4(b)(1)(i)_____The facility performed the following steps to lift the Immediate Jeopardy for F600 issued 02/27/2026 at 5:15 PM:- As of 02/27/2026, Resident #1 had a head-to-toe assessment and psychosocial evaluation to ensure no further harm occurred. - As of 02/25/2026, the facility policy for abuse was revised to include that failure to follow a resident's care plan can place residents at risk for abuse and employees who were alleged of abuse were to have an immediate escort from the facility by security and placed on administrative leave pending completion of the investigation.- Certified Nurse Aide #2's employment was terminated on 02/19/2026 - As of 02/28/2026, 100% of in-house staff were educated on the abuse prevention policy, reporting abuse within appropriate timeframes, and the importance of following the care plan. - As of 02/28/2026, an immediate review had been completed to identify individuals with the specific need for no male care and current staff assignments were evaluated to match residents based on care plan and needs.- On the evening of 03/01/2026 they reached 85% of their total staff educated on abuse prevention policy, reporting abuse within appropriate timeframes, and the importance of following the care plan. - On 03/02/2026 Staff education list was reviewed and verified against the post-test and staff listing with no discrepancies. - Staff education was verified on site on 03/02/2026; Multiple certified nurse aides, licensed nursing staff, security, and housekeeping were interviewed regarding abuse and reporting abuse with no concerns noted. The Administrator was notified the Immediate Jeopardy was lifted retroactively to 03/01/2026 on 03/04/2026 at 12:58 PM.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review and interviews, the facility failed to ensure an incident of staff abuse toward a resident was immediately reported to the State Agency, law enforcement, and the Administrator for one (1) of one (1) resident (Resident #1) reviewed. Specifically, Certified Nurse Aide #1 witnessed Certified Nurse Aide #2 abuse Resident #1, and the incident was not reported to facility Administration, law enforcement, and New York State Department of Health until approximately five (5) hours after the incident occurred. Additionally, the required five (5)-day investigative report was not submitted until 12 days following the witnessed abuse. Refer to: F600 Free from Abuse and Neglect F656 Develop/ Implement Comprehensive Care Plan. Findings include: The facility policy Prevention of Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation, revised 02/2026, documented the facility recognized all allegations of abuse, with or without injury, as falling into the immediate reporting category. All employees reported allegations of abuse immediately, but no later than two (2) hours after the allegation was made to the Administrator, Director of Nursing, and Registered Nurse Supervisors/ Unit Managers. Resident #1 had diagnoses including traumatic brain injury, anxiety, restlessness, and agitation. The 01/22/2026 Minimum Data Set Assessment (a resident assessment tool) documented the resident had severe cognitive impairment, had verbal behavioral symptoms directed toward others, and other behavioral symptoms not directed toward others. The 02/04/2026 at 1:52 PM Facility Reported Incident to the New York State Department of Health completed by the Director of Nursing documented the incident occurred on 02/04/2026 at 7:00 AM and the Administrator was first made aware of the incident at 12:30 PM on 02/04/2026. The 02/04/2026 facility incident investigation completed by Registered Nurse Investigator #11 documented a resident incident occurred on 02/04/2026 at 7:00 AM. Certified Nurse Aide #1 witnessed Certified Nurse Aide #2 make physical contact with Resident #1's face. Certified Nurse Aide #1 told Certified Nurse Aide #2 to leave the room. Licensed Practical Nurse #3 came to the room after they heard a male voice yelling. When they entered the room, the resident reported the staff was yelling at them, disrespecting them, and scratched their face twice. The resident was physically assessed by Assistant Director of Nursing #5 who noted an abrasion below the right eye and to the right cheek, redness to the tip of their nose, left eyebrow, and below the left eye. Additionally, two abrasions above the lip on the right, and a scratch from the bottom right lip extending to their chin. Based on interviews, record review, witness statements, and internal investigation, the facility determined Resident #1 sustained multiple skin alterations to their face related to physical contact made by Certified Nurse Aide #2. The Five (5)-day Nursing Home Investigative Report was submitted by the Director of Nursing to New York State Department of Health on 02/16/2026 (12 days after the incident). During an interview on 02/24/2026 at 2:56 AM, Certified Nurse Aide #1 stated they started their shift on 02/04/2026 around 6:50 AM. Resident #1 was naked in the bed and Certified Nurse Aide #2 asked them to help put an incontinence brief on the resident. The resident got agitated and attempted to spit in Certified Nurse Aide #2's face and Certified Nurse Aide #2 forcefully pushed the residents face with their hands. They told Certified Nurse Aide #2 to leave the room. The resident had scratches on their face. That was abuse, staff could not hold residents down. Licensed Practical Nurse #3 was aware of the incident because they came into the room when they heard the commotion. They stated they reported the incident to Assistant Director of Nursing #5 on 02/04/2026 when they arrived around 8:00 AM. During an interview on 02/24/2026 at 3:09 PM, Licensed Practical Nurse #3 stated they heard Resident #1 scream, so they went to the room. The resident told them staff scratched their face. There was redness and scratches on the resident's face. They stated abuse should be reported to their manager or a supervisor immediately, but they did not notify a supervisor because they did not know when the supervisor's shift was over. They waited for Licensed Practical Nurse Assistant Unit Manager #4 to come into work and told them (could not recall (continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>the time). They should have called the facilities main line and asked to be transferred to the supervisor when they were made aware of the incident, but they did not. During an interview on 02/24/2026 at 3:22 PM, Licensed Practical Nurse Assistant Unit Manager #4 stated they arrived on 02/04/2026 around 7:30 AM. They were informed by Licensed Practical Nurse #3 there were issues with a male certified nurse aide overnight at 9:20 AM but was not made aware of any abuse allegations involving Resident #1 until Assistant Director of Nursing #5 told them about the incident but they could not recall what time that was. They stated abuse needed to be reported immediately. During a telephone interview on 02/25/2026 at 10:46 AM, Registered Nurse Supervisor #8 stated they worked the night shift the date of the alleged incident but was not notified of any allegations of abuse. During an interview on 02/25/2026 at 11:19 AM, Assistant Director of Nursing #5 stated they were notified of the alleged abuse between 11:30 AM- 12:00 PM on 02/04/2026 by Certified Nurse Aide #1 and Certified Nurse Aide #12. They were not sure when the incident occurred but stated they came to work at 8:00 AM so it must have occurred on the 11:00 PM - 7:00 AM shift. Staff should have notified Registered Nurse Supervisor #8 and the Director of Nursing immediately. They were not notified timely. Allegations of abuse were reported within the facility immediately and reported within two (2) hours to the Department of Health. The Director of Nursing was responsible for submitting allegations of abuse to the Department of Health. During an interview on 02/25/2026 at 12:53 PM, the Director of Nursing stated Assistant Director of Nursing #5 called them regarding the alleged abuse between 12:30 PM and 1:00 PM on 02/04/2026. The staff involved were immediately called to provide statements. They stated they called law enforcement at that time and were in the process of reporting to the Department of Health. The incident occurred around 7:00 AM. Once they were made aware of the incident, they acted upon it timely. The investigation conclusion determined probable abuse. During a telephone interview on 02/26/2026 at 10:25 AM, Nurse Practitioner #9 stated they were notified of the abuse incident with Resident #1 the next day around 11:00 AM or 12:00 PM as it happened on the night shift. The resident had some abrasions to their face after they complained they were assaulted by a male aide on the night shift. On 02/22/2026 at 11:34 AM, The Director of Nursing showed the surveyor their cellular phone call log that confirmed a phone call to law enforcement at 1:10 PM on 02/04/2026 (five (5) hours after the incident occurred). 10 New York Codes, Rules, and Regulations 415.4(b)(2)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on record review and interview during the survey the facility failed to implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, for one (1) of one (1) resident (Resident #1) reviewed. Specifically, Resident #1's care plan documented the resident was to have no male caregivers. During the night shift (11:00 PM-7:00 AM) on 02/03/2026, male Certified Nurse Aide #2 was assigned to provide 1:1 supervision for Resident #1. On 02/04/2026 at 7:00 AM Certified Nurse Aide #2 was witnessed by Certified Nurse Aide #1 abusing Resident #1. The facility's failure to ensure comprehensive care plans were implemented resulted in harm that is Immediate Jeopardy and Substandard Quality of Care for Resident #1 and placed all 418 residents in the facility at risk for the likelihood of serious physical and psychological harm, serious injury, serious impairment, or death. Refer to: F 600 Findings include: The facility policy Care Planning/Care Conference Policy, revised 01/27/2026, documented the facility utilized a person-centered approach to care planning. The interdisciplinary team worked in conjunction with the resident and resident's family/designated representative, as appropriate to provide an individualized comprehensive resident assessment and care planning process to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The facility policy Dignity and Respect, revised 01/2026, documented residents have the right to be cared for in a manner that enhances their quality of life, free from humiliation, harassment or threats. Residents also have the right to be free from physical, mental and verbal abuse and be treated with dignity, respect and consideration at all times. Resident #1 had diagnoses including traumatic brain injury and anxiety. The 01/22/2026 Minimum Data Set (a resident assessment tool) documented the resident had severely impaired cognition, had verbal and behavior symptoms directed toward others, required moderate assistance or was dependent for most activities of daily living. The 01/23/2026 Comprehensive Care Plan documented the resident had behaviors related to their traumatic brain injury with cognitive deficits that included verbal aggression and physical aggression towards staff. Interventions included two (2) caregivers for care, no male caregivers, and 1:1 during the night shift due to falls at night. The undated care instructions documented two (2) staff for all care and no male caregivers. The 02/01/2026, 02/09/2026, and 02/12/2026 certified nurse aide assignment sheet documented male Certified Nurse Aide #14 was assigned to Resident #1 during the 7:00 AM-3:00 PM shifts. The 02/03/2026 certified nurse aide assignment sheet documented Certified Nurse Aide #4 (male) was assigned to Resident #1 as their 1:1 for the night shift on 11:00 PM-7:00 AM. The 02/04/2026 Incident Report and witness statements documented on 02/04/2026 at 7:00 AM, Certified Nurse Aide #1 and Certified Nurse Aide #2 were providing care to Resident #1 care on the last rounds of the nightshift when Resident #1 became combative. Certified Nurse Aide #1 interlocked their hands with the resident to de-escalate the situation and Resident #1 spit at Certified Nurse Aide #2. Certified Nurse Aide #2 was witnessed pushing Resident #1's face down with their hand. During an interview on 02/24/2026 at 10:37 AM, Assistant Director of Nursing stated Resident #1 appeared more agitated and aggressive towards males, which their spouse agreed was true. The care plan was updated to include no male caregivers. This information was documented on the special information on the care card, which certified nurse aides had access to. During a follow up interview on 02/25/2026 at 11:19 AM, Assistant Director of Nursing #5 stated they did not know male caregivers were assigned to the resident. Care plans should be followed as they instructed staff how to care for the residents. During an interview on 02/24/2026 at 2:56 PM, Certified Nurse Aide #1 stated they were assisting Certified Nurse Aide #2, who was assigned 1:1 for Resident #1 on the nightshift. Resident #1 became combative during care and spit into Certified Nurse Aide #2's face. Certified Nurse Aide #2 forcefully pushed Resident #1's face into the pillow causing scratches over the resident's face and neck. During an interview on 02/24/2026 at 3:09 PM, Licensed Practical Nurse #3 stated they asked Licensed (continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Practical Nurse Assistant Unit Manager #11 why the resident had a male 1:1 on 02/04/2026 as they were not to have male caregivers. They stated Licensed Practical Nurse Unit Manager #11 checked Resident #1's care plan and confirmed the resident was not supposed to have male caregivers. During an interview on 02/24/2026 at 3:22 PM, Licensed Practical Nurse Unit Manager #11 stated there was a previous incident where the resident was using foul, offensive language toward male Certified Nurse Aide #14. They stated after this they made the resident no male caregivers. The overnight nurse or licensed practical nurse team leader on the floor was responsible for assigning the 1:1 for the resident. During a telephone interview on 02/25/2026 at 10:46 AM, Registered Nurse Supervisor #8 stated the unit assignments were planned out, but they usually let the floor staff decide what certified nurse aide did the 1:1 for the shift. They were unaware Resident #1 was not to have male caregivers. They heard Resident #1 had negative interactions with male caregivers, they triggered the resident, and they became agitated. They stated care plans should be followed to ensure residents' needs were met. During an interview on 02/25/2026 at 12:53 PM, the Director of Nursing stated the care card directed care and all staff, certified nurse aides, the licensed practical nurses and the Registered Nurse Supervisor, were supposed to look at it at the beginning of their shift prior to care. The certified nurse aide assigned to the resident for the shift, the certified nurse aide assigned to be the resident's 1:1, and the licensed practical nurse should have all seen Resident #1 was not to have male caregivers. The licensed practical nurse or an advanced certified nurse aide were the ones who made the floor assignments. They were unsure who made the assignments for the night shift on 02/03/2026. They stated the assignment of Certified Nurse Aide #2 as the 1:1 was not a care plan violation as the 1:1 was for falls, not care. The resident had a female certified nurse aide assigned for their care. When male Certified Nurse Aide #2 was assisting Certified Nurse Aide #1, they were only buckling the resident's brief which was not considered providing care. During an interview on 02/26/2026 at 10:25 AM, Nurse Practitioner #9 stated Resident #1 was care planned to have no male caregivers and should not have had a 1:1 who was male. Male caregivers triggered the resident since the resident was admitted to the facility. They were confused as to why a male certified nurse aide was involved. It was important to follow the residents' care plan to ensure their safety. During an interview on 02/26/2026 at 10:41 AM, the Medical Director stated they heard that Resident #1 was not supposed to have male caregivers. If the care plan documented a resident was to not have male caregivers, they should not have male caregivers. 10 New York Codes, Rules and Regulations 415.11(c)(1)The facility performed the following steps to lift the Immediate Jeopardy for F656 issued 02/27/2026 at 5:15 PM:- As of 02/27/2026, Resident #1's care plan was reviewed to ensure all interventions, including the no-male caregivers was clearly documented and communicated to all staff. - As of 02/28/2026, 100% of in-house staff were educated on adhering to care plans, residents who required no male care and where it was documented, and reviewing care cards for their assignment prior to starting care with the care card acknowledgement sign off. - As of 02/28/2026, an immediate review had been completed to identify individuals with the specific need for no male care.- Unit assignment sheets were verified to have the no male caregiver residents clearly identified as compared against the master list provided by the facility. - On the evening of 03/01/2026 they reached 85% of their total staff educated for adhering to care plans residents who required no male care and where it was documented and reviewing care cards for their assignment prior to starting care with the care card acknowledgement sign off. - On 03/02/2026 Staff education list was reviewed and verified against the post-test and staff listing with no discrepancies. - Staff assignments were verified against the no male caregiver list to ensure no residents who were care planned to not have male care were given care by male staff with no discrepancies. - Care Card acknowledgement sign-off sheets were verified against the staff assignment sheets to verify they were being completed. - On 03/02/2026 Staff education was verified on site; Multiple certified nurse aides, licensed nursing staff, and Unit Managers were interviewed with concerns noted regarding retention related to review the resident care cards and signing off they had done so. - On 03/02/2026, (continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>the care card acknowledgement sheet for 7 North 11 PM to 7 AM shift was blank and not signed by staff. - On 03/02/2026, the care plans of the residents identified to not want male care were reviewed to ensure the information was clearly documented on the care plan and care card. Two residents identified did not have the information on their care card or care plan. - On 03/03/2026 the Administrator provided a plan to re-educate the staff regarding reviewing the care card prior to their shift, an audit for ensuring the designation for no male was clearly identified on the care plan and signing the care card acknowledgement sheet process. - On 03/04/2026 they reached 91% of their total staff for re-education. - On 03/04/2026 Staff education was verified on site; Multiple certified nurse aides and licensed nursing staff were interviewed with no concerns noted. The Administrator was notified the Immediate Jeopardy was lifted on 03/04/2026 at 12:58 PM.</p>		