

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/07/2026
NAME OF PROVIDER OR SUPPLIER Garrison Mem Hosp Nsg Fac		STREET ADDRESS, CITY, STATE, ZIP CODE 407 3rd Ave SE Garrison, ND 58540	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policy, and resident and staff interview, the facility failed to ensure residents remain free from abuse for 7 of 7 sampled residents (Resident #1, #2, #3, #4, #5, #6 and #7) who were subjected to physical/verbal abuse by other residents. Failure to prevent resident-to-resident physical abuse resulted in altercations involving hitting, slapping, and scratching and placed all residents at risk for serious injury, pain, mental anguish, and emotional distress. During the on-site facility reported incident investigation survey, the team consulted with the State Survey Agency (SSA) and determined an Immediate Jeopardy (IJ) situation existed beginning on 05/24/26 when documentation identified Resident #1 placed her hands around Resident #7's neck. *06/29/26 at 5:00 p.m. the survey team notified the administrator and director of nursing (DON) of the IJ, provided the IJ template, and requested a plan of removal for the IJ. *06/30/26 at 4:45 p.m. the SSA received the removal plan and accepted the plan. The removal plan contained the following interventions for Resident #1: *One-to-one caregiver at all times. *Staff monitor and documented behavior every 15 minutes on Checks for Resident Safety documentation sheet.*The nurse manager will review behavior documentation every eight hours to determine the need to continue one-to-one caregiver.*Defined criteria and assessment time frames for removing one-to-one caregiver. *Education provided to all staff working on 06/30/26 and all on-coming staff. *Educated all staff with in-person training on reporting resident safety events, workplace violence events, one-to-one caregiver, documentation of behaviors, and criteria and assessment time frames for discontinuing one-to-one caregiver. *07/01/26 at 3:25 p.m., the survey team verified the implementation of the removal plan and the IJ removal. The deficient practice remained at an E scope and severity following the removal of the IJ. Findings include: Review of the facility policy titled Mandatory Reporting of Abuse, Neglect, Exploitation, Mistreatment, Misappropriation Prevention or Acts of Violence occurred on 07/01/26. This policy, dated November 2023, stated, . In response to allegations of abuse . or mistreatment, the facility must: . Ensure that all alleged violations involving abuse . or mistreatment . are reported immediately . Abuse against patients/residents can be initiated by various people within the facility. The facility supports and protects . residents . from harm during an investigation of alleged abuse. Patient/resident protection actions include immediately removing the patient/resident from contact with the alleged abuser during the investigation process . measures are taken to provide a safe, secure environment for the patient . Physical Abuse may include but not limited to hitting, kicking, slapping . Mistreatment means inappropriate treatment . of a resident . -Review of Resident #1's medical record occurred on June 29 - July 1, 2026 and identified a diagnosis of vascular dementia. A quarterly Minimum Data Set (MDS), dated [DATE], identified moderately impaired cognition. The current care plan stated, . I have impaired decision making related to dementia. I'm not able to make (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	safe decisions and this puts me at risk for injury. Resident #1's care plan failed to address wandering, rummaging, behaviors towards others, and individualized interventions for the behaviors. Review of Resident #1's nurses notes identified the following:*05/24/26 at 4:14 p.m. RN [registered nurse] received complaint from another resident [Resident #7] at nurses' station regarding [Resident #1]. Resident entered his room and told him he would not get dinner if certain things were not finished. Resident concerned [Resident #1] will position herself behind him triggering a PTSD [post-traumatic stress disorder] attack endangering both of them. Resident stated [Resident #1] has previously grabbed him around the neck.*05/27/26 at 9:27 p.m. resident [sic] entered day room and walked by another resident that has a hx [history] of combativeness, [Resident #1] said something to that resident [Resident #2] and they grabbed [Resident #1] by the arm, [Resident #1] then hit that resident [Resident #2] in the head.*06/01/26 at 8:00 p.m. upon entering the room this resident [Resident #1] is witnessed rummaging through her roommates [sic] [Resident #3] belongings by her roommates [sic] bed . it is also noticed that this resident [Resident #1] has spots of blood on right forearm, writer asked the roommate if she scratched her and her roommate stated that 'she hit me so you bet I scratched her.' .*06/04/26 at 6:12 p.m. witnessed resident hitting male resident [Resident #5] on his arms as she attempted to shut the patio door. Male resident struck her back. male resident has intact red discoloration on right upper arm.*06/12/26 at 11:15 a.m. [Resident #1] then went to the dining room. She walked up to another resident [Resident #6] and hit her in the left wrist and told resident '[profanity] you get out.*06/24/26 at 4:00 p.m. At 1500 [3:00 p.m.] Aide . saw . the resident [Resident #1] . slapped current resident [Resident #4] on the arm.-Review of Resident #2's medical record occurred on June 29 - July 1, 2026 and identified a diagnosis of dementia. An annual MDS, dated [DATE], identified severely impaired cognition. The current care plan stated, . has newly diagnosed Dementia. Avoid over-stimulation (e.g., noise, [NAME], other physically aggressive residents). A nurse's note, dated 05/27/26 at 9:36 p.m., stated, [Resident #2] was in the day room when another resident [Resident #1] walked by [Resident #2] and he grabbed this resident by the arm, she then hit him in the head . -Review of Resident #3's medical record occurred on June 29-July 1, 2026 and included diagnoses of multiple sclerosis and generalized anxiety disorder. A quarterly MDS, dated [DATE], identified intact cognition. A nurse's note, dated 06/01/26 at 8:00 p.m., stated, . [Resident #3] was hollering because her room mate [sic] [Resident #1] was by her bed and rummaging through her belongings. This resident stated that her roommate hit her so she scratched her deep enough to draw blood in several spots. During an interview on 06/29/26 at 11:41 a.m. Resident #3 confirmed the incident with Resident #1 on 06/01/26. She stated the facility moved her to a different room the next day, she doesn't feel safe when [Resident #1] is around, and Resident #1 continued to come into her room and take my bible. -Review of Resident #4's medical record occurred on June 29 - July 1, 2026, and included a diagnosis of Alzheimer's disease. A quarterly MDS, dated [DATE], identified intact cognition. A nurse's note, dated 06/24/26 at 4:03 p.m., stated, . Aide . entered room . and saw . the resident [Resident #1] . slapped current resident [Resident #4] on the arm. -Review of Resident #5's medical record occurred on June 29 - July 1, 2026, and included a diagnosis of unspecified mental disorder. A quarterly MDS, dated [DATE], identified intact cognition. A nurse's note, dated 06/04/26 at 9:44 a.m., stated, Resident outside on patio after dinner when a female resident walked out on patio and attempted to shut the door. [Resident #5] told the resident [Resident #1] attempting to shut door not to do so. Female resident responded by hitting resident on bilateral upper arms multiple times. Resident responded in kind striking the female resident on upper arms. The care plan failed to address Resident #5's physical behaviors toward other residents or individualized interventions to address them. -Review of Resident #6's medical record occurred on (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	June 29 - July 1, 2026 and included a diagnosis of dementia. A quarterly MDS, dated [DATE], identified severely impaired cognition. The current care plan stated, . have mental health disorders putting me at risk to make unsafe decisions and this puts me at risk for injury. The medical record lacked documentation of the altercation with Resident #1 on 06/12/26. -Review of Resident #7's medical record occurred on June 29 - July 1, 2026 and included a diagnosis of post-traumatic stress disorder. A quarterly MDS, dated [DATE], identified intact cognition. The current care plan stated, . Resident may have outbursts and or swing out at staff is [sic] frightened related to Post-traumatic stress disorder . Staff will not come up behind me with [sic] talking loudly this may cause to hit out. The medical record lacked documentation of Resident #7's report of an altercation with Resident #1 on 05/24/26. During an interview on 07/01/26 at 9:50 a.m., a nurse (#4) confirmed the altercation between Resident #1 and Resident #6 on 06/12/26. During an interview on 06/29/26 at 5:20 p.m., Resident #7 stated, [Resident #1] came up behind me and grabbed me by the neck. He motioned how Resident #1 placed her hands around his neck. He also stated, I have PTSD. She wanders into my room. He stated he was afraid of what might happen if his PTSD is triggered and he was unsure what he would do if triggered. During an interview of 07/01/26 at 2:05 p.m., a nurse (#6) confirmed Resident #7 did make the complaint documented in Resident #1's medical record and the nurse was unsure when Resident #1 placed her hands around his neck. During an interview on 06/29/26 at 5:10 p.m., an administrative nurse (#1) confirmed the resident-to-resident altercations between Residents #1, #2, #3, #4, #5, #6, and #7. She also confirmed the facility failed to update Resident #1's and Resident #5's care plans related to behaviors and include individualized interventions. The administrative nurse (#1) agreed the facility failed to implement interventions to address Resident #1's behaviors. The facility failed to effectively manage Resident 31's behaviors which resulted in repeated episodes of resident-to-resident abuse.		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 observation, record review, review of facility policy, and staff interviews, the staff failed to provide appropriate supervision for 1 of 1 sampled resident (Resident #1) who wandered. Failure to provide adequate staff supervision resulted in Resident #1 accessing unsafe areas, hazardous items, and urinating/defecating in common areas and other residents' rooms and placed Resident #1 and all residents at risk of accidents, falls, and/or injuries. During the on-site facility reported incident investigation survey, the team consulted with the State Survey Agency (SSA) and determined an Immediate Jeopardy (IJ) situation existed beginning on 05/02/26 when documentation showed the facility failed to provide adequate supervision for Resident #1 which resulted in access to unsafe areas and hazardous items (scissors, cords, and bags), and environmental hazards related to urinating/defecating in common areas and other resident rooms. *06/29/26 at 5:00 p.m. the survey team notified the administrator and director of nursing (DON) of the IJ, provided the IJ template, and requested a plan of removal for the IJ. *06/30/26 at 4:45 p.m. the SSA received the removal plan and accepted the plan. The removal plan contained the following interventions: *Locks placed and utilized on the doors of the clean linen closet, storage closet at the end of the west hallway, storage closet for the clean nursing/resident supply room, and closet/storage area by the dining room, staff break room, storage room with the ice machine, bath house, and beauty shop.*Utilized the lock on the shower room door.*Verified all doors closed and locked hourly and documented on the Door Lock Log.*One-to-one caregiver assigned to Resident #1 and the resident's behaviors monitored and documented every 15 minutes on Checks for Resident Safety documentation sheet. *The nurse manager will review behavior documentation every eight hours to determine the need to continue one-to-one caregiver.*Defined criteria and assessment time frames for removing one-to-one caregiver.*Education provided to all staff working on 06/30/26 and all on-coming staff. *Educated all staff with in-person training on locking, verifying and documenting all doors are closed and locked, reporting resident safety events and workplace violence events by entering them into the facility event reporting system, one-to-one caregiver, documentation of behaviors, and criteria and assessment time frames for discontinuing one-to-one caregiver. *07/01/26 at 3:25 p.m., the survey team verified the implementation of the removal plan and the IJ removal. The deficient practice remained at an E scope and severity following the removal of the IJ. Findings include: Review of the IRIS [Incident Reporting Information System] Event Reporting Tipsheet [sic] occurred on 07/01/26. This undated tip sheet stated, . An event report is simply a documented record of someone's perception of an unintended or unexpected incident. select the appropriate event type.The Behavioral event type is used to report a patient's behavior . What happens after an event is submitted? Email notification is sent to the director and manager/supervisor of the department to be notified for review . Each of these events is individually reported on at Leadership Huddle each morning. Review of the facility policy titled 1:1 Resident Supervision occurred 07/01/26. This undated policy stated, . The purpose of this policy is to outline the specific criteria, assessment process, and implementation standards for dedicated one-to-one (1:1) care and supervision for residents . ensures resident safety, provides appropriate management for behavioral symptoms . Triggers for initiation include: . Wandering/Elopement Risk: Unsafe wandering patterns that cannot be redirected by standard facility environmental safety measures.Care Planning . The Interdisciplinary Team (IDT) is responsible for updating the resident's care plan to include individualized, meaningful activities and interventions (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	tailored to the resident's strengths . Review of Resident #1's medical record occurred on June 29 - July 1, 2026, and identified a diagnosis of vascular dementia. A quarterly Minimum Data Set (MDS), dated [DATE], identified moderately impaired cognition. The current care plan, last reviewed by facility staff on 04/09/26, stated, . I have impaired decision making related to dementia. I'm not able to make safe decisions and this puts me at risk for injury. at risk for falls due to history of falls/dementia overestimates [sic] ability . Increased staff supervision with intensity based on resident need. Provide individualized toileting interventions based on needs/patterns . Provide one on one as needed . When frustration/fear is present evaluate for possible cause - (pain, toileting, hunger, thirst) . Transfers independently . Resident is continent of bowel and bladder. Monitor for needing help with toileting. ambulates independently . I will receive necessary setup, cueing, support and assistance level for activities of daily living . Resident #1's care plan failed to address wandering, rummaging, urinating/defecating in inappropriate places, behaviors towards others, and individualized interventions for the behaviors. Review of Resident #1's nurses notes identified the following:*05/02/26 at 8:53 a.m., . angry exhibiting verbal and physical aggression to staff related to cares. Resident exit seeking. began entering any room on unit not locked/closed. found in resident common bathroom with assistive device/[NAME] steady [sit-to-stand lift] placed underneath her feet. became verbally combative refusing assistance from RN [registered nurse] who removed assistive device from resident. found attempting to enter housekeeping closet/locked. entered storage closet attempting to get a rolling stool. combative and did not comprehend when reminded she had fallen from a stool the day before. got back in storage closet removing a broom which was taken away from her and area locked up. attempting to leave building via lobby elevator.*05/08/26 at 2:02 p.m., . continues to exhibit combative behaviors and resents nursing staff redirecting her from entering resident rooms/exhibiting unsafe behaviors. became very upset . this PM [afternoon] as resident presented with a plastic garbage bag of unknown origin over her head/around her neck.*05/09/26 at 2:09 p.m., . continues to exhibit verbally aggressive behaviors and appears to resent nursing staff when redirected out of other resident rooms/storage rooms which occurred [sic] this shift. exhibited exit seeking behaviors . found in another resident's room with her pants down squatting and peeing on the floor.*05/19/26 at 6:22 p.m., . sporadically agitated/aggressive throughout day with increase in activity/confusion PM. attempted to/entered resident rooms/storage closets. in activity room going through kitchen drawers and pocketing silverware. attempted to elope from facility via elevator .*05/23/26 at 1:02 p.m., . attempting to urinate in dayroom and multiple resident rooms. found in facility supply room pocketing medical supplies . urinated in the dining room at her table spot. found in kitchenette urinating and getting into paper towels etc.*05/24/26 at 10:22 a.m., . resident pulled her pants down in the middle of the hallway in front of the elevator and food cart and urinated on the floor while residents/staff were leaving dining room. Resident then attempted to defecate in the garbage can next to the food cart. opened south exit door this PM in an elopement attempt. appears to know south exit door code partially and continuously pushed at door until it opened. entered third floor elevator in elopement attempt . continued to attempt to elope by all exits remainder of afternoon. entered nurses station office and attempted to urinate in waste basket.*05/24/26 at 6:28 p.m., . found in another resident room defecating on floor/pants pulled down . resident picked her feces up from off the ground and attempted to hit CNA [certified nurse aide] with it. exited the other resident's room and entered activity room. attempted to enter facility storage area/other resident rooms touching doors/door knobs with soiled hands.*05/25/26 at 2:05 p.m., . attempted to elope in elevator X2 [two times]. wandered hallway exhibiting extreme aggression attempting to elope through exit doors multiple times. found a glass vase/filled it with water and took (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	it out on the patio to drink out of it. entering other resident rooms/found squatting in clean linen/brief closet.*05/28/26 at 10:03 a.m., . wondering [sic] into Staff break room . *05/29/26 at 5:54 p.m., . continues to attempt to elope via exit doors . found naked in hallway after lunch with wet pants discarded near her. found in storage closet with electric cords around her person reorganizing the closet per resident statement. not all facility storage areas have locks/keys. continues to sit in wheeled chairs behind nurses [sic] station. The stop barrier removed by resident.*05/30/26 at 6:31 a.m., . urinated next to a male resident in the hallway. seen bending down to her hands and knees and trying to clean the urine off the floor with her hands and also stepping in it with her bare feet as she had also removed her socks and shoes. found after this incident with a bag of popcorn that someone had thrown in the trash. found bending over and placing popcorn between all her toes as well as eating some of it.*05/30/26 at 5:51 p.m., . continues to enter resident rooms/kitchenette. found in dirty utility room this shift.*06/01/26 at 8:00 p.m., . had to be continually redirected out of others [sic] rooms or rooms that have supplies and the kitchenette.*06/03/26 at 4:11 a.m., . woke up and wandered down to the kitchenette, opened the door to the fridge and pulled her pants down, squatted and urinated and defecated on the floor in front of the fridge.*06/04/26 at 3:55 p.m., . continues to urinate/defecate in other resident restrooms/trash cans.*06/04/26 at 6:08 p.m., . found for second time this shift in same male resident's room. urinated/defecated on the resident's floor.*06/05/26 at 5:31 p.m., . caught urinating in trash can in day room.*06/06/26 at 5:25 p.m., . resident . removed her pants and urinated on the floor in the activity room.*06/07/26 at 6:20 p.m., . Continually wandering into other resident rooms and closets. had BM [bowel movement] in a trash can in another residents [sic] room. found taking items from other residents [sic] rooms and keeping items in her pockets. attempted to elope through locked unit doors. continues to wander at this time.*06/08/26 at 2:06 p.m., . urinated in dayroom prior to breakfast/refusing to allow nursing staff to provide cares. continues to wander in and out of resident rooms/taking resident belongings and toileting. found in a male resident's room prior to breakfast taking his candy. attempted to assist resident away from the candy and out of room at which point resident grabbed a pair of scissors in the male resident's room. resident defecated in activity room/grabbed paper towels to clean it up off a chair and floor.*06/10/26 at 6:36 p.m., Resident cut off her wanderguard [sic] in the dining room with a butter knife.*06/11/26 at 6:05 p.m., . found walking down hallway holding a fluorescent light bulb. attempted to retrieve the light bulb resident retreated to hallway bathroom and locked the door.*06/12/26 at 11:15 a.m., . took pants off and urinated in activity room. Resident in wheelchair sitting in hallway, patient began pushing resident down hallway. When staff tried to redirect her she became verbally aggressive . Patient attempted to hit resident in wheelchair but was unsuccessful.*06/13/26 at 3:46 p.m., . found and prevented from sitting in a chair with wheels she had taken from an undetermined area/moved it to the hallway and was attempting to seat [sic] in it.*06/13/26 at 8:00 p.m., . went into another residents [sic] bathroom and used the toilet, had a bowel movement on the floor . proceeded to dig in the linens . *06/14/26 at 12:50 p.m., . ate 2 [two] puzzle pieces in activity room this shift. continues to get into kitchenette/supply closets etc . *06/17/26 at 10:27 p.m., . found in activity room with pants down squatting in front of the heater peeing on the floor, she then grabbed a glove got down on her hands and knees and tried to wipe it up with a glove and veggie straws.*06/20/26 at 11:19 a.m., . Call light in other patient's bathroom noted when call light was checked patient was seen in bathroom with feces spread throughout bathroom and toilet. had BM on her clothes. Toilet was noted to be clogged by a large number of wipes, paper towels, toilet paper. found in public restroom with other items, toilet was clogged again in the public bathroom.*06/22/26 at 2:51 p.m., . resident was calm and stood at nurses [sic] station and voided on the floor.*06/23/26 (continued on next page)		

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility policy, and resident and staff interviews, the facility failed to provide appropriate dementia care and services for 1 of 1 sampled resident (Resident #1) with a diagnosis of dementia. Failure to develop and implement interventions to address Resident #1's dementia care needs resulted in the resident's inability to achieve her highest level of functioning as well as other residents resident in the facility. Findings include: Review of the facility policy titled Assessment and Plan of Care occurred on 07/01/26. This policy, dated September 2022, stated, . The comprehensive resident assessment . and plan of care will be developed to maintain or improve each resident's mental, psychosocial and physical well-being. The purpose of the assessment is to provide quality care to the residents as determined by their individual needs. Realizing that each . resident has multiple and changing needs . the care plan take [sic] into account all the physical, psychological, and social characteristics of the resident . The complete health care plan . serves as the guide for effective care, it should be an ongoing reflection of the resident . the health care plan is reviewed by staffing meetings on a timely basis and updated to reflect current problems, goals, and approaches. Procedure: . Social Services will: . Establish related social service goals and approaches . Updating the Care Plan . The care plan . must be maintained and updated on a timely basis . The resident's care . plan will be updated and reviewed at least every 30 days or as indicated by the resident's medical condition. Review of the facility policy titled 1:1 Resident Supervision occurred 07/01/26. This undated policy stated, . The purpose of this policy is to outline the specific criteria, assessment process, and implementation standards for dedicated one-to-one (1:1) care and supervision for residents, particularly those with advanced dementia. ensures resident safety, provides appropriate management for behavioral symptoms . Triggers for initiation include: . Severe Behavioral Symptoms: Frequent aggressive, agitated, or catastrophic reactions that pose an imminent risk to the resident or others. Wandering/Elopement Risk: Unsafe wandering patterns that cannot be redirected by standard facility environmental safety measures. Upon identification of a trigger, the Charge Nurse or Director of Nursing (DON) must conduct an immediate, person-centered assessment. This assessment aims to identify root causes of the behavior, such as pain, hunger, or overstimulation, ensuring that the facility has sufficient information to provide effective care. Care Planning . The Interdisciplinary Team (IDT) is responsible for updating the resident's care plan to include individualized, meaningful activities and interventions tailored to the resident's strengths . Review of Resident #1's medical record occurred on June 29 - July 1, 2026, and identified a diagnosis of vascular dementia. Current physician's orders included Rexulti (an antipsychotic) 2 milligrams (mg) daily, started on 06/24/26, no indication for use documented. The current care plan stated, . Category: ADLs [activities of daily living] Functional Status . I have impaired decision making related to dementia. I'm not able to make safe decisions and this puts me at risk for injury. Category: Falls . at risk for falls due to history of falls/dementia overestimates [sic] ability . Increased staff supervision with intensity based on resident need. Provide individualized toileting interventions based on needs/patterns . start date: 02/12/26 . Category: Cognitive Loss/Dementia Impaired cognition RT [related to] dementia . Adhere to structure of daily programs. Allow resident choices as able . Allow time to respond/complete tasks . Provide cues and reminders for activity schedule . Provide special environmental stimuli - alert to activity schedule. Provide one on one as needed . When frustration/fear is present evaluate for possible cause - (pain, toileting, hunger, thirst) . start date (continued on next page)		

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F 0744 Level of Harm - Actual harm Residents Affected - Few	02/12/26 . Category: ADLs Functional Status . Self Care Deficit RT dementia . Resident is continent of bowel and bladder. Monitor for needing help with toileting. start date 02/12/26 . Category: Activities Is independently capable of pursuing her own self directed activity. May need reminders of Group Program times. Family will provide her with Bismarck Tribune newspaper. Has radio in room to listen to music and news . Invite to all Group Programs allowing her to choose which ones she will attend . Remind her of Church Service in the Chapel the first Sunday of the month . Walks the hallways for exercise . Watches TV [television], has her favorite programs she watches . When weather is nice staff can offer to go for walk with her outdoors . When weather is nice, she will sit outdoors on the patio . Works on Word Finds & [and] Crossword Puzzle Books . start date 02/16/26 . Review of Resident #1's nurses' notes, dated 05/01/26-06/26/26, identified the following:*05/01/26 at 5:38 a.m., . went to sit in chair in dayroom after using the restroom, residents [sic] hands and shirt were covered in BM [bowel movement], staff approached resident to get her to go take a shower. resident [sic] became upset and wandered into another residents room and woke him up while trying to avoid staff.*05/01/26 at 8:02 p.m., . ambulating in corridors naked refusing to [sic] redirection.*05/02/26 at 8:53 a.m., . exit seeking. began entering any room on unit not locked/closed. found in resident common bathroom with assistive device/[NAME] steady [sit-to-stand lift] placed underneath her feet . Resident found attempting to enter housekeeping closet/locked. entered storage closet attempting to get a rolling stool . got back in storage closet removing a broom . exit seeking . attempting to leave building via lobby elevator.*05/02/26 at 5:39 p.m., . has been wondering [sic] from room to room and taking other patient's property. took first dose of ordered seroquel [an antipsychotic] .*05/03/26 at 6:26 a.m., . agitated . stripped in common area and was resistant to redirection .*05/04/26 at 5:42 a.m., . irritable, resistant to redirection, entering other Resident's [sic] rooms and rifling through their belongings.*05/05/26 at 1:39 p.m., . witnessed coming out of the kitchenette with pants halfway pulled down found to have urinated in the drawer . wandering in and out of other resident rooms . redirected to dayroom. Provider on call notified of resident's combativeness, bizarre behavior, and restlessness. Provider ordered . lorazepam [an antianxiety medication] prn [as needed] q 6 hrs [every six hours] . Family notified and agreeable with orders.*05/05/26 at 5:25 p.m., . verbally and physically aggressive with staff. wandering from room to room and actively exit seeking. became verbally aggressive with another resident. Called on call provider and TO [telephone order] received to administer 1mg IM [intramuscular] ativan [an antianxiety medication].*05/05/26 at 5:25 p.m., . wandering around unit, going in and out of resident rooms, redirection not effective. threatening other residents, and upsetting other residents. witnessed going through cupboards and drawers in the activity room and other residents belongs [sic] - redirection out of rooms not effective . becomes combative. attempting to exit seek- pushing code on wall to exit. Provider on call notified, provider ordered IM ativan. (Provider ordered labs and imaging with no new orders noted).*05/06/26 at 10:12 a.m., . seen by rounding provider for behaviors, provider ordered increase to seroquel from 12.5 to 25 mg BID [two times a day].*05/08/26 at 2:20 p.m., . very upset with RN [registered nurse] this PM [afternoon] as resident presented with a plastic garbage bag of unknown origin over her head/around her neck.*05/09/26 at 2:09 p.m., . redirected out of other resident rooms/storage rooms which occurred [sic] this shift. exhibited exit seeking behaviors PM. found in another resident's room with her pants downsquatting and peeing on the floor.*05/09/26 at 5:30 p.m., . hostile and entering other resident rooms with increased frequency.*05/10/26 at 5:14 p.m., . continues to enter other resident rooms and staff only areas of floor. found in facility kitchenette attempting to lower pants to toilet on floor. entered another resident room and did not comprehend she could not urinate on the floor.*05/14/26 at 6:18 p.m., . received new MD [medical (continued on next page)		

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F 0744 Level of Harm - Actual harm Residents Affected - Few	doctor] order for Rexulti 0.5 mg daily pending insurance approval. If approved resident Seroquel order will be titrated down to 25 mg BID for 7 days followed by Seroquel to decrease to 25 mg daily for 7 days followed by DC [discontinuation] of Seroquel.*05/18/26 at 10:41 a.m., . Rexulti order has been approved by insurance/Rexulti 0.5 mg to begin 052026 [05/20/26] with seroquel titration beginning on this date. Seroquel DC on 060326 [06/03/26].*05/19/26 at 6:22 p.m., . sporadically agitated/aggressive throughout day with increase in activity/confusion PM. attempted to/entered resident rooms/storage closets. in activity room going through kitchen drawers and pocketing silverware. attempted to elope from facility via elevator.*05/23/26 at 1:02 p.m., . verbally combative/aggressive . attempting to urinate in dayroom and multiple resident rooms. found in facility supply room pocketing medical supplies . retrieved supplies from resident. resident agitation/anxiety increased. spent afternoon wandering hallway and entering rooms that were not hers. urinated in the dining room at her table spot. found in kitchenette urinating and getting into paper towels etc .*05/24/26 at 10:22 a.m., . pulled her pants down in the middle of the hallway in front of the elevator and food cart and urinated on the floor while residents/staff were leaving dining room. then attempted to defecate in the garbage can next to the food cart. opened south exit door . appears to know south exit door code partially and continuously pushed at door until it opened. entered third floor elevator . continued to attempt to elope by all exits remainder of afternoon. entered nurses station office and attempted to urinate in waste basket. Redirection to patio/food unsuccessful. entering other resident rooms/attempting to get into facility refrigerator becoming visibly angry when redirected.*05/24/26 at 4:14 p.m., . received complaint from another resident at nurses' station regarding [Resident #1]. Resident entered his room and told him he would not get dinner if certain things were not finished. Resident concerned [Resident #1] will position herself behind him triggering a PTSD [post-traumatic stress disorder] attack endangering both of them. Resident stated [Resident #1] has previously grabbed him around the neck.*05/24/26 at 6:28 p.m., . found in another resident room defecating on floor/pants pulled down . resident picked her feces up from off the ground and attempted to hit CNA [certified nurse aide] with it. exited the other resident's room and entered activity room. attempted to enter facility storage area/other resident rooms touching doors/door knobs with soiled hands. administered PRN ativan 0.5 mg. received additional 1X [one time] MD order for 0.5 mg oral ativan/1845 [6:45 pm.].*05/25/26 at 2:05 p.m., . resident wandering in patient rooms/exhibiting verbal aggression. attempted to elope in elevator X2 [two times]. prevented from pulling her pants all the way down in front of her brother. wandered hallway exhibiting extreme aggression attempting to elope through exit doors multiple times. found a glass vase/filled it with water and took it out on the patio to drink out of it. entering other resident rooms/found squatting in clean linen/brief closet.*05/27/26 at 9:27 p.m., . entered day room and walked by another resident that has a hx [history] of combativeness, [Resident #1] said something to that resident and they grabbed [Resident #1] by the arm, [Resident #1] then hit that resident in the head.*05/29/26 at 5:54 p.m., . confusion unchanged. continues to wander in other resident rooms/takes other resident belongings/eats other resident food. agitation grows during episodes of incontinence. remains incontinent. attempts to use facility/other resident chairs/WC [wheelchairs] as toilets. believes facility is her work place. Successful redirection occurs when resident is open to chores/working. redirections semi effective. continues to attempt to elope via exit doors. found naked in hallway after lunch with wet pants discarded near her. found in storage closet with electric cords around her person reorganizing the closet per resident statement. not all facility storage areas have locks/keys. continues to sit in wheeled chairs behind nurses station. The stop barrier removed by resident.*05/30/26 at 6:31 p.m., . into other residents rooms this shift. taking their belongings and (continued on next page)		

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F 0744 Level of Harm - Actual harm Residents Affected - Few	attempting to rearrange their rooms or take side tables into the hallway. urinated next to a male resident in the hallway. found after this incident with a bag of popcorn that someone had thrown in the trash. found bending over and placing popcorn between all her toes as well as eating some of it. combative when popcorn was taken from her.*05/30/26 at 5:51 p.m., . continues to enter resident rooms/kitchenette. found in dirty utility room this shift.*05/31/26 at 3:18 p.m., . continues entering other resident rooms/using other resident bathrooms.*06/01/26 at 8:00 p.m., . witnessed rummaging through her roommates belongings by her roommates bed with no pants or brief on . it is also noticed that this resident has spots of blood on right forearm, writer asked the roommate if she scratched her and her roommate stated that 'she hit me so you bet I scratched her'. had to be continually redirected out of others rooms or rooms that have supplies and the kitchenette.*06/03/26 at 4:11 a.m., . woke up and wandered down to the kitchenette, opened the door to the fridge and pulled her pants down, squatted and urinated and defecated on the floor in front of the fridge.*06/04/26 at 3:55 p.m., . wandered into the room of two residents/sat in one of the residents arm chairs and began going through her personal belongings. The two residents of the room called for assistance from nursing staff. Resident frightened/anxious/potential consequences of someone getting hurt. continues to urinate/defecate in other resident restrooms/trash cans. taking food from numerous resident trays/eating it in dining room at meal time.*06/04/26 at 6:08 p.m., . found for second time this shift in same male resident's room. Room had been cleansed after prior urination episode. urinated/defecated on the resident's floor. wandering hallways.*06/04/26 at 6:12 p.m., . witnessed resident hitting a male resident on his arms as she attempted to shut the patio door. Male resident struck her back.*06/05/26 ay 6:14 p.m., . found in male resident room with a shirt/no underwear/pants sitting naked on his bed trying to get dressed/toilet. The resident of the room used call light and was visibly anxious.*06/06/26 at 5:25 p.m., . observed stripping off her clothes in the activity room. Staff was attempting to assist when resident became combative. removed her pants and urinated on the floor in the activity room.*06/07/26 at 6:20 p.m., . agitated this shift. Continually wandering into other resident rooms and closets. had BM in a trash can in another residents room. Family on unit and witnessed behaviors. found taking items from other residents rooms and keeping items in her pockets. attempted to elope through locked unit doors. continues to wander at this time.*06/08/26 at 2:06 p.m., . urinated in dayroom prior to breakfast/refusing to allow nursing staff to provide cares. continues to wander in and out of resident rooms/taking resident belongings and toileting. found in a male resident's room prior to breakfast taking his candy. staff attempted to assist resident away from the candy and out of room at which point resident grabbed a pair of scissors in the male resident's room. staff backed away and waited for her to leave room/drop scissors which did occur. Resident received PRN Ativan . resident defecated in activity room/grabbed paper towels to clean it up off a chair and floor.*06/10/26 at 6:36 p.m., Resident cut off her wanderguard [sic] in the dining room with a butter knife. Wander guard was replaced and secured .*06/11/26 at 6:05 p.m., . became agitated . arguing with other residents. unable to redirect . found walking down hallway holding a fluorescent light bulb. attempted to retrieve the light bulb resident retreated to hallway bathroom and locked the door.*06/12/26 at 11:15 a.m., . have made attempts to redirect patient from other resident rooms. has . taken important items from other resident. During breakfast patient took pants off and urinated in activity room. wondering [sic] and aggressive . Resident in wheelchair sitting in hallway, patient began pushing resident down hallway. staff tried to redirect . became verbally aggressive . attempted to hit resident in wheelchair but was unsuccessful. went to the dining room. walked up to another resident and hit her in the left wrist on her watch and told resident '[profanity] you get out'.*06/13/26 at 8:00 p.m., . went into another residents [sic] bathroom and used the toilet, had a (continued on next page)		

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F 0744 Level of Harm - Actual harm Residents Affected - Few	bowel movement on the floor, had gotten it all over herself . wandered down the hall with no bottoms and and bm smeared down leg and on feet into the dining room and proceeded to dig in the linens . while another resident and his family were in the dining room playing cards and visiting. PRN ativan was given.*06/13/26 at 10:29 p.m., . tries to sit and rest, looks exhausted, states she is tired but continues to get up and wander aimlessly. has [sic] been redirected to rest with a blanket, given a snack and drink. addressed [sic] toileting. no [sic] needs identified.*06/14/26 at 12:50 p.m., . wandering hallways/entering resident rooms and taking their belongings/wearing and soiling their clothing/shoes. Other residents in facility expressing concern/removing and hiding their personal items in their rooms/not going to eat in dining room in order to watch over their belongings. refused activity redirection/folding towels. ate 2 [two] puzzle pieces in activity room this shift. frightened male resident this AM entering his room and taking his belongings. received PRN 0.5 mg lorazepam this AM. told a visitor in the hallway to get the [profanity] out of here . continues to get into kitchenette/supply closets etc..*06/17/26 at 10:27 p.m., . found in activity room with pants down squatting in front of the heater peeing on the floor, she then grabbed a glove got down on her hands and knees and tried to wipe it up with a glove and veggie straws.*06/18/26 1:33 p.m., . wandering hallways/entering residents [sic] rooms. Exit seeking this afternoon. Multiple intervention initiated and unsuccessful. PRN Ativan 1 mg given and is effective.*06/19/26 at 6:11 p.m., . PRN lorazepam decreased anger but behaviors continue. stripped naked and wandered hallway after her dinner resistive to cares/verbal aggression.*06/20/26 ay 11:19 a.m., . continued wandering hallways. Call light in other patient's bathroom noted when call light was checked patient was seen in bathroom with feces spread throughout bathroom and toilet. attempting to clean area and had BM on her clothes. left bathroom and continued wondering [sic] in other patient room. redirected from other patient room and wondered [sic] down to her room gathering many belongings from other patients. Attempted to give patient PRN ativan patient slapped ativan out of hands onto the ground yelling profanities at staff. TO received to administer 1 mg IM ativan. 1 mg IM ativan administered . continues to refuse allow staff to change patient's clothing as they are soiled with BM.*06/21/26 at 10:14 p.m., . is going into all bathrooms and turning on water and undressing to 'clean up'. became aggressive when attempting to remove her. Found in multiple rooms lying on other residents [sic] beds while they were occupied. Many residents unhappy with this behavior. PRN Ativan given. Many redirection tactics attempted before Ativan was given.*06/23/26 at 9:35 a.m., . anxious and ativan prn given . trying to put chair into kitchen food cart then observed coming out of another residents [sic] room and urine noted on floor and bed in that room.*06/24/26 at 2:18 p.m., . [nurse practitioner] recert [recertification visit] on resident. Orders A1C [glycated hemoglobin.] [a lab test to check blood sugars over time] and TSH [thyroid stimulating hormone] [a lab test to monitor thyroid gland function] and increase rexluti to 2mg daily.*06/24/26 at 4:00 p.m., At 1500 [3:00 p.m.] Aide . saw . the resident [Resident #1] . slapped current resident [Resident #4] on the arm.*06/25/26 at 1:33 p.m., . has sitter in place. very anxious . Roaming and attempting to enter various rooms. Multiple interventions attempted and unsuccessful. PRN Ativan given and effective.*06/26/26 at 2:24 a.m., All staff assisting multiple residents when this resident was found in another residents room. When assisting her out of room it was found that she had urinated on the other residents bed while resident was in it. Review of Resident #1's medication administration records, dated May 1 - June 29, 2026, identified the following:*05/05/26 Ativan (lorazepam) (an antianxiety medication) 0.5 mg oral tablet four times a day as needed for vascular dementia. Renewed every 14 days. Administered 11 times in May and 30 times in June. (discontinued 06/29/26). *05/05/26 lorazepam 1 mg injection one time for agitation, physical and verbal aggression, wandering, exit seeking, vascular dementia.*05/24/26 and 06/12/26 (continued on next page)		

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F 0744 Level of Harm - Actual harm Residents Affected - Few	lorazepam 0.5 mg oral tablet one time for verbal and physical aggression with staff, vascular dementia.*05/02/26 quetiapine (Seroquel) (an antipsychotic) 25 mg one half oral tablet three times a day (no indication for use or diagnosis) (discontinued 05/06/26). *05/06/26 quetiapine (Seroquel) 25 mg oral tablet three times a day for vascular dementia, titration of dose for discontinuation began 05/21/26, completed 06/03/26. *05/21/26 Rexulti 0.5 mg oral tablet one time a day (no indication for use or diagnosis), increased to 1 mg daily on 06/10/26, increased to 2 mg daily on 06/24/26. Review of Resident #1's provider progress notes, dated 05/14/26 - 06/24/26, identified the following: *05/14/26 - nurse practitioner note - . seen on rounds today, 5/14/2026, for dementia with secondary associated behaviors. Per nursing staff and third-floor nursing home staff the patient is increasingly combative both verbally and physically. currently taking quetiapine 25 mg 3 times daily and it does not seem to adequately be controlling the patient's dementia related behaviors. Plan: . Start Rexulti 0.5 mg daily. We may adjust dose after 7 days if necessary just ask a provider's input. Titrate off of Seroquel by going down to 25 mg twice daily x 7 [times seven] days. Then decrease further by 25 mg daily x 7 days then stop medication. *06/10/26 - nurse practitioner note - . evaluated on rounds today, 6/10/2026, for dementia with behavior disturbance. Patient was tolerating Seroquel 3 [three] times daily but due to . regulations patient was transition [sic] to Rexulti. Patient is currently on Rexulti 0.5 mg daily and still having significant behavior disturbance. Plan: . Increase Rexulti dose to 1 mg daily and reassess in 1 week. (The medical record lacked documentation of reassessment in one week). *06/24/26 - nurse practitioner note - . examined on rounds today . for increasing behaviors. Per nursing staff the patient will frequently eat food and drink from other residents [sic] plates during mealtime. She is also frequently digging through the garbage and disrobing. Patient was assessed disrobing by this writer while she was in the dining room. Patient is currently taking Rexulti 1 mg daily. She also has as needed lorazepam 1 mg 4 times a day as needed. Plan: . Increase Rexulti to 2 mg daily. Observation of Resident #1 on 06/29/26 showed the following: *11:45 a.m., The resident stood by south hallway doors attempted to open the doors. A CNA (#2) attempted to redirect the resident. The resident became agitated. *11:53 a.m., The resident wandered into Resident #3's room. The CNA (#3) entered the room to answer the call light and redirected Resident #1 from the room into the hallway. Resident #1 hit out at the CNA. The CNA propelled Resident #3 from the room and closed the door. Resident #1 again attempted to enter the room, the CNA redirected the resident and Resident #1 hit out at the CNA, then sat down on a chair in the hallway. *12:03 p.m., The resident stood at an unattended maintenance cart which had a battery operated drill on top of it. The resident ambulated into room [ROOM NUMBER], a nurse (#10) redirected the resident into the hallway. The resident ambulated to the dining room, sat at her table, and ate her noon meal. *12:51 p.m., The resident wandered in the hallway and dining room accompanied by a CNA (#9) who provided 1:1 supervision. The resident attempted to wander into Resident #4's room, which had a mesh gate across the doorway. The CNA (#9) attempted to redirect the resident away from the door, the resident became agitated, and another CNA (#3) assisted to redirect the resident to the activity room for bingo. The CNA (#9) sat with the resident in the activity room. During an interview on 06/29/26 at 11:41 a.m. Resident #3 stated she doesn't feel safe when [Resident #1] is around, and Resident #1 continued to come into her room and take my bible. During an interview on 06/29/26 at 5:20 p.m., Resident #7 stated, [Resident #1] came up behind me and grabbed me by the neck. He motioned how Resident #1 placed her hands around his neck. He also stated, I have PTSD. She wanders into my room. He stated he was afraid of what might happen if his PTSD is triggered and he was unsure what he would do if triggered. During an interview on 07/01/26 at 2:05 p.m., a nurse (#6) stated the electric cords documented on 05/29/26 as around her person (continued on next page)		

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F 0744 Level of Harm - Actual harm Residents Affected - Few	were around Resident #1's neck and her Seroquel was stopped because the resident did not have a psychiatric consult. She confirmed the facility did have telemedicine psychiatric services available. During interviews on 06/29/26 at 12:18 p.m. and 5:10 p.m., and the morning of 07/07/26, an administrative nurse (#1) stated Resident #1 had declined cognitively and her behaviors had escalated. She stated the facility's social worker designee assigned to the nursing home lives in Nebraska and is unaware if a licensed social worker visited the facility. She agreed Resident #1's behavior posed a risk to all residents, Resident #1's care plan failed to identify her behaviors or individualized interventions to address the behaviors, and the facility failed to implement interventions to address Resident #1's behaviors and the safety risk posed to all residents. The facility failed to assess and monitor patterns and trends of behaviors in an effort to minimize these behaviors, recognize unmet needs, or prevent situations/triggers which may lead to behaviors or physical aggression toward staff and other residents. The facility failed to develop an effective behavior management program, consistently implement purposeful and meaningful activities in an attempt to manage the behaviors exhibited by Resident #1, evaluate the behavior management program on an on-going basis, and modify interventions as needed. The facility failed to ensure Resident #1 did not infringe upon the rights of others while still allowing her to achieve her highest level of well-being. These failures resulted in physical contact between Resident #1 and other residents and many residents experiencing fear, anxiety, frustration, and anger related to Resident #1's wandering and physically aggressive behaviors. Refer to F600, F689, and F745		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on staff interviews, the facility failed to have a designated staff member trained in the assessment of residents' psychosocial needs and in the provision of services to meet those needs and failed to have on-site quarterly consultation from a qualified social worker. Failure to have a designated staff member and failure to have on-site consultation from a qualified social worker has the potential for residents to experience unrecognized changes in their mental and psychosocial health. Findings include: During an interview the morning of 07/07/26, an administrative nurse (#1) stated the facility does not have a social work designee, but they have a social worker in Nebraska who is assigned to the nursing home. The administrative nurse stated she is unaware if a licensed social worker visited the facility. A phone interview with another administrative nurse (#7) on 07/07/26 at 12:41 p.m. confirmed the facility does not currently have a social work designee and that a social worker in Nebraska is available, by phone, as needed. Refer to F744		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on review of the current Facility Assessment and staff interview, the facility failed to review and update the facility assessment annually. Failure to review and update the assessment annually may result in the facility's inability to provide the resources necessary to care for the residents. Findings include: Review of the current Facility Assessment showed a review date of 12/03/24. During an interview on 07/07/26 at 3:15 p.m., an administrative staff member (#8) confirmed staff failed to review or update the Facility Assessment since 12/03/24.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policy, resident representative interview, and staff interview, the facility failed to notify the resident's physician and/or resident representative for 6 of 6 sampled residents (Resident #1, #2, #3, #4, #5, and #6) involved in resident-to-resident altercations. Failure to notify the physician and/or the resident representative of the altercations does not allow the physician or the representative to make informed decisions regarding medical care. Findings include: Review of the facility policy titled Notification of Changes occurred on 07/01/26. This policy, dated May 2026, stated, . The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring such notification include: . A change of room or roommate assignment . Additional considerations: a. Competent individuals: a. The facility must still contact the resident's physician and notify resident's representative . Review of the facility policy titled Mandatory Reporting of Abuse, Neglect, Exploitation, Mistreatment, Misappropriation Prevention or Acts of Violence occurred on 07/01/26. This policy, dated November 2023, stated, . Physical Abuse may include but not limited to hitting, kicking, slapping . Procedure: Notify patient/resident provider . Notify patient/resident representative . -Review of Resident #1's medical record occurred on June 29 - July 1, 2026, and identified a diagnosis of vascular dementia. A quarterly Minimum Data Set (MDS), dated [DATE], identified moderately impaired cognition. Review of Resident #1's nurses notes identified the following:*05/27/26 at 9:27 p.m. entered day room and walked by another resident that has a hx [history] of combativeness, [Resident #1] said something to that resident [Resident #2] and they grabbed [Resident #1] by the arm, [Resident #1] then hit that resident [Resident #2] in the head.*06/01/26 at 8:00 p.m. upon [sic] entering the room this resident is witnessed rummaging through her roommates [Resident #3] belongings by her roommates bed . it is also noticed that this resident [Resident #1] has spots of blood on right forearm, writer asked the roommate if she scratched her and her roommate stated that 'she hit me so you bet I scratched her'.*06/04/26 at 6:12 p.m. witnessed resident hitting a male resident [Resident #5] on his arms as she attempted to shut the patio door. Male resident struck her back. attempting to assess but resident paranoid/aggressive. male resident has intact red discoloration on right upper arm.*06/12/26 at 11:15 a.m. Patient [Resident #1] then went to the dining room. walked up to another resident [Resident #6] and hit her in the left wrist .*06/24/26 at 4:00 p.m. At 1500 [3:00 p.m.] Aide . saw . the resident [Resident #1] . slapped current resident [Resident #4] on the arm. The medical record lacked documentation the facility notified Resident #1's provider and/or representative of the altercations with Residents #2, #3, #4, #5, and #6. During an interview on 06/20/26 at 12:26 p.m., Resident #1's representative stated that the facility failed to notify her of the altercations between Resident #1 and Residents #2, #3, #5 and #6, but did notify her for the altercation with Resident #4. She further stated after the incident with Resident #3, the facility moved Resident #3 to a different room and gave Resident #1 a different roommate and failed to notify her of the change. -Review of Resident #2's medical record occurred on June 29 - July 1, 2026, and identified a diagnosis of dementia. An annual MDS, dated [DATE], identified severely impaired cognition. A nurse's note, dated 05/27/26 at 9:36 p.m., stated, resident [sic] [Resident #2] was in the day room when another resident [Resident #1] walked by [Resident #2] and he grabbed this resident by the arm, she then hit him in the head . The medical record lacked documentation the facility notified Resident #2's provider and/or representative of the altercation (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with Resident #1. -Review of Resident #3's medical record occurred on June 29 - July 1, 2026, and included diagnoses of multiple sclerosis and generalized anxiety disorder. A quarterly MDS, dated [DATE], identified intact cognition. A nurse's note, dated 06/01/26 at 8:00 p.m., stated, . this resident [Resident #3] was hollering because her room mate [sic] [Resident #1] was by her bed and rummaging through her belongings. This resident stated that her roommate hit her so she scratched her deep enough to draw blood in several spots. The medical record lacked documentation the facility notified Resident #3's provider of the altercation with Resident #1. -Review of Resident #4's medical record occurred on June 29 - July 1, 2026, and included a diagnosis of Alzheimer's disease and a court appointed guardian. A quarterly MDS, dated [DATE], identified intact cognition. A nurse's note, dated 06/24/26 at 4:03 p.m., stated, . Aide . entered room . and saw . the resident [Resident #1] . slapped current resident [Resident #4] on the arm. The medical record lacked documentation the facility notified Resident #4's provider and guardian of the altercation with Resident #1. -Review of Resident #5's medical record occurred on June 29 - July 1, 2026, and included a diagnosis of unspecified mental disorder. A quarterly MDS, dated [DATE], identified intact cognition. A nurse's note, dated 06/04/26 at 9:44 a.m., stated, Resident outside on patio after dinner when a female resident walked out on patio and attempted to shut the door. Resident [Resident #5] told the resident [Resident #1] attempting to shut door not to do so. Female resident responded by hitting resident on bilateral upper arms multiple times. Resident responded in kind striking the female resident on upper arms. The medical record lacked documentation the facility notified Resident #5's provider and representative of the altercation with Resident #1. -Review of Resident #6's medical record occurred on June 29 - July 1, 2026, and included a diagnosis of dementia. A quarterly MDS, dated [DATE], identified severely impaired cognition. The medical record lacked documentation of the altercation with Resident #1, and notification to Resident #6's provider and representative of the altercation. During an interview on 07/01/26 at 9:50 a.m., a nurse (#4) confirmed the altercation between Resident #1 and Resident #6 on 06/12/26 and stated she did not notify Resident #6's provider as no injury and not sure if she notified Resident #6's representative. During an interview on 06/29/26 at 5:10 p.m., an administrative nurse (#1) stated she expected staff to notify resident providers and representatives of all altercations and changes in condition.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policy, and staff interview, the facility failed to report incidents of potential abuse to officials including the State Survey Agency (SSA) for 4 of 4 sampled residents (Resident #1, #2, #6 and #7) reviewed for resident-to-resident altercations. Failure to report incidents of potential physical abuse to the State agency placed all residents at risk of abuse, mental and emotional distress, and/or physical injury. Findings include: Review of the facility policy titled Mandatory Reporting of Abuse, Neglect, Exploitation, Mistreatment, Misappropriation Prevention or Acts of Violence occurred on 07/01/26. This policy, dated November 2023, stated, . It is the legal responsibility of every . employee to report in a timely manner any reasonable suspicion of abuse or . acts of violence . In response to allegations of abuse . or mistreatment, the facility must: . Ensure that all alleged violations involving abuse . or mistreatment . are reported immediately to the administrator of the facility and to other officials (including to the State survey and certification agency .) . Physical Abuse may include but not limited to hitting, kicking, slapping . Mistreatment means inappropriate treatment . of a resident . -Review of Resident #1's medical record occurred on June 29 - July 1, 2026 and identified a diagnosis of vascular dementia. A quarterly Minimum Data Set (MDS), dated [DATE], identified moderately impaired cognition. Review of Resident #1's nurses notes identified the following:*05/24/26 at 4:14 p.m. received complaint from another resident [Resident #7] at nurses' station regarding [Resident #1]. Resident entered his room and told him he would not get dinner if certain things were not finished. Resident concerned [Resident #1] will position herself behind him triggering a PTSD [post-traumatic stress disorder] attack endangering both of them. Resident stated [Resident #1] has previously grabbed him around the neck.*05/27/26 at 9:27 p.m. resident [sic] entered day room and walked by another resident that has a hx [history] of combativeness, [Resident #1] said something to that resident [Resident #2] and they grabbed [Resident #1] by the arm, [Resident #1] then hit that resident [Resident #2] in the head.*06/12/26 at 11:15 a.m. [Resident #1] then went to the dining room. She walked up to another resident [Resident #6] and hit her in the left wrist and told resident '[profanity] you get out.' -Review of Resident #2's medical record occurred on June 29 - July 1, 2026 and identified a diagnosis of dementia. An annual MDS, dated [DATE], identified severely impaired cognition. A nurse's note, dated 05/27/26 at 9:36 p.m., stated, [Resident #2] was in the day room when another resident [Resident #1] walked by [Resident #2] and he grabbed this resident by the arm, she then hit him in the head . -Review of Resident #6's medical record occurred on June 29 - July 1, 2026 and included a diagnosis of dementia. A quarterly MDS, dated [DATE], identified severely impaired cognition. The medical record lacked documentation of the altercation with Resident #1 on 06/12/26. -Review of Resident #7's medical record occurred on June 29-July 1, 2026 and included a diagnosis of post traumatic stress disorder. A quarterly MDS, dated [DATE], identified intact cognition. The medical record lacked documentation of Resident #7's report of an altercation with Resident #1 on 05/24/26. During an interview on 07/01/26 at 9:50 a.m., a nurse (#4) confirmed the altercation between Resident #1 and Resident #6 on 06/12/26. During an interview of 07/01/26 at 2:05 p.m., a nurse (#6) confirmed Resident #7 made the complaint documented in Resident #1's medical record, and the nurse was unsure when Resident #1 placed her hands around his neck. During an interview on 06/29/26 at 5:10 p.m., an administrative nurse (#1) confirmed the facility failed to report the incidents between Resident #1 and Residents #2, #6, and #7 to the SSA.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility policy, and staff interview, the facility failed to investigate incidents of alleged violations of potential abuse for 4 of 4 sampled residents (Resident #1, #2, #6 and #7) reviewed for resident-to-resident altercations. Failure to investigate resident to resident altercations for potential abuse placed all residents at risk of abuse, mental and emotional distress, and/or physical injury. Findings include: Review of the facility policy titled Mandatory Reporting of Abuse, Neglect, Exploitation, Mistreatment, Misappropriation Prevention or Acts of Violence occurred on 07/01/26. This policy, dated November 2023, stated, . It is the legal responsibility of every . employee to report in a timely manner any reasonable suspicion of abuse or . acts of violence . In response to allegations of abuse . or mistreatment, the facility must: . Ensure that all alleged violations involving abuse . or mistreatment . are reported immediately to the administrator of the facility and to other officials (including to the State survey and certification agency .) . Have evidence that all alleged violations are thoroughly investigated . prevent further potential abuse . or mistreatment while the investigation is in progress. Report the results of all investigations to the administrator . and to other officials in accordance with state law (including the State survey and certification agency) within 5 working days of the incident . -Review of Resident #1's medical record occurred on June 29 - July 1, 2026, and identified a diagnosis of vascular dementia. A quarterly Minimum Data Set (MDS), dated [DATE], identified moderately impaired cognition. Review of Resident #1's nurses notes identified the following:*05/24/26 at 4:14 p.m. received complaint from another resident [Resident #7] at nurses' station regarding [Resident #1]. Resident entered his room and told him he would not get dinner if certain things were not finished. Resident concerned [Resident #1] will position herself behind him triggering a PTSD [post-traumatic stress disorder] attack . Resident stated [Resident #1] has previously grabbed him around the neck.*05/27/26 at 9:27 p.m. resident [sic] entered day room and walked by another resident that has a hx [history] of combativeness, [Resident #1] said something to that resident [Resident #2] and they grabbed [Resident #1] by the arm, [Resident #1] then hit that resident [Resident #2] in the head.*06/12/26 at 11:15 a.m. [Resident #1] then went to the dining room. She walked up to another resident [Resident #6] and hit her in the left wrist and told resident '[profanity] you get out.' -Review of Resident #2's medical record occurred on June 29 - July 1, 2026, and identified a diagnosis of dementia. An annual MDS, dated [DATE], identified severely impaired cognition. A nurse's note, dated 05/27/26 at 9:36 p.m., stated, resident [sic] [Resident #2] was in the day room when another resident [Resident #1] walked by [Resident #2] and he grabbed this resident by the arm, she then hit him in the head . -Review of Resident #6's medical record occurred on June 29 - July 1, 2026, and included a diagnosis of dementia. A quarterly MDS, dated [DATE], identified severely impaired cognition. The medical record lacked documentation of the altercation with Resident #1. -Review of Resident #7's medical record occurred on June 29-July 1, 2026, and included a diagnosis of post-traumatic stress disorder. A quarterly MDS, dated [DATE], identified intact cognition. The medical record lacked documentation of Resident #7's report of an altercation with Resident #1 on 05/24/26. During an interview on 07/01/26 at 9:50 a.m., a nurse (#4) confirmed the altercation between Resident #1 and Resident #6 on 06/12/26. During an interview of 07/01/26 at 2:05 p.m., a nurse (#6) confirmed Resident #7 made the complaint documented in Resident #1's medical record and the nurse was unsure when Resident #1 placed her hands around Resident #7's neck. During an interview on 06/29/26 at 5:10 p.m., an administrative nurse (#1) confirmed staff failed to report the altercations between Resident #1 and Residents #2, #6, and #7 to administration, and the facility failed to investigate the altercations.		

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Based on record review, the facility failed to ensure a physician completed the initial comprehensive in-person visit within 30 days of the resident's admission and complete an in-person visit at least once every 60 days thereafter for 2 of 7 sampled residents (Resident #1 and #6). Failure to ensure residents receive the required physician visits may result in a delay of treatment and negative outcomes for the residents. Findings include: -Review of Resident #1's medical record occurred on 07/07/26 and identified an admission date of 02/09/26. The record showed a nurse practitioner completed the initial comprehensive in-person visit on 02/11/26 and monthly in-person visits through June 2026. The record identified the first in-person visit by a physician occurred on 07/01/26 (almost five months after the resident's admission). -Review of Resident #6's medical record occurred on 07/07/26 and identified an admission date of 01/22/26. The record showed a nurse practitioner completed the initial comprehensive in-person visit on 01/28/26 and monthly in-person visits through March 2026. The record identified the first in-person visit by a physician occurred on 04/11/26 (almost three months after the resident's admission). The facility failed to ensure the physician completed the initial comprehensive in-person visit and the required in-person visit every 60 days.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and review of nurse staffing records, the facility failed to ensure staff posted accurate nurse staffing information on 47 of 47 days (May 23 - July 7, 2026) reviewed. Failure to ensure current facility census and nurse staffing information is updated daily and accurate at the beginning of each shift infringes on residents' and visitors' rights to access /review staffing patterns of the facility. Findings include: Observation on the afternoon of 07/07/26 showed nursing staff information, dated May 23 - July 7, 2026, located on a clipboard on the wall across from the nurses' station. Review of the staffing information showed all 47 days failed to identify actual hours worked by direct care staff for all shifts and failed to identify the facility census on nine of 47 days.		