STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385277	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Care and Rehabilitation	812 SE 48th Avenue Portland, OR 97215

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47000 Based on observation, interview and record review it was determined the facility failed to provide a homelike environment for 1 of 1 sampled resident (#16) reviewed for environment. This placed residents at risk for a lack of homelike environment. Findings include: The facility's 2/2021 Homelike Environment Policy indicated residents were provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Resident 16 was admitted to the facility in 1/2023 with diagnoses including vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain). Resident 16's 2/2/25 Annual MDS revealed the resident was in a persistent vegetative state (a chronic condition in which a person is awake but unaware of their surroundings). Random observations of Resident 16 from 2/24/25 to 2/27/25 between 8:43 AM through 4:42 PM revealed the resident to be in bed with her/his eyes open at times. The resident shared her/his room with three additional residents, and two of the four barriers she/he shared with her/his roommates were curtains. The other two barriers were walls. The small wall behind the head of the resident's bed revealed a cork board on which hung various papers, including information on aspiration precautions, the resident's case manager and passive range of motion exercises, with very little remaining space left on the wall. A small bedside table, located in between the resident's bed and one of the privacy curtains, had personal hygiene supplies on the surface top. Storage shelves lined the remaining wall in-and-on which were various medical and incontinence supplies, including items which belonged to the resident's roommates. On 2/24/25 at 1:14 PM, Witness 1 (Family Member) stated Resident 16's room looked like a storage room and it was very depressing. Witness 1 further stated she was unable to bring in any personal items for the resident because there was no place to put anything for happiness or wellness. On 2/26/25 at 10:20 AM, Staff 17 (CNA) stated Resident 16's room stored resident supplies for as long as I can remember, and the resident's closet was the only space available in her/his room for personal items. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 12:35 PM, Staff 1 (Administrator) observed Resident 16's room, acknowledged the room lacked space for the resident's personal items and stated the room was not homelike.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 38140 Based on observations, interviews and record review, it was determined the facility failed to protect the residents' right to be free from verbal abuse by a resident for 3 of 4 sampled residents (#s 3, 23 and 26) reviewed for abuse. This placed residents at risk for mental anguish and verbal abuse. Findings include: The facility's revised 4/2021 Recognizing Signs and Symptoms of Abuse/Neglect revealed all types of resident abuse were strictly prohibited. Policy Interpretation defined abuse as willful infliction of injury, intimidation or mental anguish. 1. Resident 41 admitted to the facility in 2020 with diagnosis including Alcohol Abuse with alcohol-Induced Psychotic Disorder (mental disorder characterized by disconnection from reality). Resident 3 admitted to the facility in 2021 with diagnoses including quadriplegia (all four limbs experience partial or complete loss of muscle function) and anxiety. On 6/20/24 at 11:23 AM the state agency received a FRI which alleged resident abuse. On 6/19/24 at 3:52 AM, Staff 10 (LPN) wrote a progress note in Resident 41's health record which revealed on 6/18/24 at 8:00 PM Resident 41 returned to the facility. Resident 41 yelled at staff and residents, including Resident 3. Resident 3 overheard Resident 41 yelling at the staff and Resident 3 came out of her/his room. Resident 41 started to threaten Resident 3 to beat [her/his] fucking ass. Staff 10 got between the residents and asked Resident 3 to return to her/his room. Staff 10 later assisted Resident 3 to complete a grievance form and the resident appeared visibly upset and verbally abused. Resident 3's 1/26/25 Annual MDS assessed her/him to make independent decision about her/his daily life with an ok memory. During the survey from 2/24/25 through 2/28/25 between the hours of 8:00 AM to 4:00 PM Resident 41 had been discharged and was not observed in the facility. Resident 3 was observed with no negative interactions with other residents. On 2/24/25 at 3:57 PM, Resident 3 stated she/he recalled the 6/18/25 incident with Resident 41. Resident 3 stated she/he felt verbally abused by Resident 41 in 6/2024 and felt unsafe at the time of the out of control behavior. On 2/26/25 at 2:56 PM, Staff 5 (Social Services) stated Resident 3 was verbally abused by Resident 41 during the 6/18/24 incident at 8:00 PM. On 2/27/25 at 3:52 PM, Staff 25 (CNA) recalled Resident 41 used abusive language towards staff and other residents, especially when she/he drank alcohol. Staff 25 could not directly recall the 6/18/24 incident. On 2/28/25 at 10:34 AM, Staff 1 (Administrator) confirmed on 6/18/24 Resident 3 was verbally abused by Resident 41. Staff 1 stated she expected all residents to be free from abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 41 admitted to the facility in 2020 with diagnosis including Alcohol Abuse with alcohol-Induced Psychotic Disorder (mental disorder characterized by disconnection from reality). Resident 23 admitted to the facility in 2021 with diagnoses including heart failure and major depression. On 6/20/24 at 11:23 AM, the state agency received a FRI which alleged resident abuse. On 6/19/24 at 3:52 AM, Staff 10 (LPN) wrote a progress note in Resident 41's health record which revealed on 6/18/24 at 8:00 PM Resident 41 returned to the facility. Resident 41 yelled at staff and residents, including Resident 23. Resident 41 proceeded to leave the facility and stopped at Resident 23's room door and yelled to Resident 23 you are a fucking murderer and why don't you go murder some more people you fucking creep. Staff 10 later assisted Resident 23 to complete a grievance form and the resident appeared visibly upset and verbally abused. Resident 23's 1/15/25 BIMS indicated Resident was assessed to be cognitively intact. During the survey from 2/24/25 through 2/28/25 between the hours of 8:00 AM to 4:00 PM Resident 41 had been discharged and was not observed in the facility. Resident 23 was observed with no negative interactions with other residents. On 2/25/25 at 12:39 PM, Resident 23 stated she/he recalled the 6/18/25 incident with Resident 41. Resident 23 stated she/he felt verbally abused by Resident 41. On 2/26/25 at 2:56 PM, Staff 5 (Social Services) stated Resident 23 was verbally abused by Resident 41 during the 6/18/24 incident at 8:00 PM. On 2/27/25 at 3:52 PM, Staff 25 (CNA) recalled Resident 41 used abusive language towards staff and other residents, especially when she/he drank alcohol. Staff 25 could not directly recall the 6/18/24 incident. On 2/28/25 at 10:34 AM, Staff 1 (Administrator) confirmed on 6/18/24 Resident 23 was verbally abused by Resident 41. Staff 1 stated she expected all residents to be free from abuse. 3. Resident 41 admitted to the facility in 2020 with diagnosis including Alcohol Abuse with alcohol-Induced Psychotic Disorder (mental disorder characterized by disconnection from reality). Resident 26 admitted to the facility in 2023 with diagnoses including paraplegia (loss of muscle function in lower body) and PTSD (Post-Traumatic Stress Disorder, mental condition with intense emotional and/or physical reaction after a traumatic event or experience). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/20/24 at 11:23 AM, the state agency received a FRI which alleged resident abuse. On 6/19/24 at 3:52 AM, Staff 10 (LPN) wrote a progress note in Resident 41's health record which revealed on 6/18/24 at 8:00 PM Resident 41 returned to the facility. Resident 41 yelled at staff and residents, including Resident 26. Resident 26 asked Resident 41 to quiet down and Resident 41 proceeded to yell shut up and go do more heroin bitch. Resident 26 tried to get herself/himself out of bed and Staff 10 calmed Resident 26 enough to stop advancements to the hallway. Resident 41 went to her/his room, obtained her/his grabber stick, returned to Resident 26's doorway and threatened Resident 26 and Staff 10 by swinging the stick and yelling I'll beat you pussies. Come over here. Resident 41 then threw the grabber stick down the hallway and proceeded to leave the facility. Staff 10 later assisted Resident 26 to complete a grievance form and the resident appeared visibly upset and verbally abused. Resident 26's 12/1/24 Quarterly MDS BIMS score of 14, which indicated Resident was assessed to be cognitively intact. During the survey from 2/24/25 through 2/28/25 between the hours of 8:00 AM to 4:00 PM Resident 41 had been discharged and was not observed in the facility. Resident 26 was observed with positive interactions with other residents. On 2/24/25 at 10:21 PM, Resident 26 stated she/he recalled the 6/18/25 incident with Resident 41. Resident 26 stated she/he felt verbally abused by Resident 41. On 2/26/25 at 2:56 PM, Staff 5 (Social Services) stated Resident 26 was verbally abused by Resident 41 during the 6/18/24 incident at 8:00 PM. On 2/27/25 at 3:52 PM, Staff 25 (CNA) recalled Resident 41 used abusive language towards staff and other residents, especially when she/he drank alcohol. Staff 25 could not directly recall the 6/18/24 incident. On 2/28/25 at 10:34 AM, Staff 1 (Administrator) confirmed on 6/18/24 Resident 26 was verbally abused by Resident 41. Staff 1 stated she expected all residents to be free from abuse. 46053 4. Resident 26 was admitted to the facility in 8/2023 with diagnoses including paraplegia, incomplete (a condition involving partial loss of movement and sensation in the lower half of the body due to spinal cord damage) and post-traumatic stress disorder (a mental health condition that can develop after experiencing or witnessing a traumatic event). Resident 26's 8/29/23 Admission MDS and 11/29/23 Quarterly MDS indicated she/he was cognitively intact. A facility investigation completed by Staff 3 (LPN/RCM) indicated on 2/8/24 Resident Resident 41 yelled at Staff 23 (LPN) in a verbally abusive manner which Resident 26 could hear from her/his room. Resident 26 told Resident 41 to stop yelling at Staff 23. Resident 41 entered Resident 26's room and yelled at her/him that she/he was a heroine addict, only had a seventh-grade education and should overdose and die. Staff 23 used a two-way radio to request staff assistance to remove Resident 41 from Resident 26's room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 11:52 AM, Resident 26 stated she/he recalled the incident and stated Resident 41 crossed the threshold to my room and blocked me off. Resident 26 stated, I can't handle being blocked in. Resident 26 stated Resident 41 yelled at her/him using abusive language and with a high level of disregard for anyone's feelings but [her/his] own. On 2/28/25 at 10:49 AM, Staff 14 (CNA) stated Resident 41 yelled at Staff 23 for no reason and Resident 26 stuck up for Staff 23. Staff 14 stated Resident 41 yelled at Resident 26 because Resident 41 didn't like to be told what to do or not to do and was belligerent. Staff 14 stated Resident 41 should not have yelled at Resident 26 the way she/he did. On 2/28/25 at 10:57 AM, Staff 2 (DNS) stated the verbal interaction upset Resident 26. Staff 2 stated Resident 41 used verbally abusive language towards Resident 26 and could not rule out verbal abuse. Staff intervened by positioning themselves between the two residents but were unable to prevent Resident 41 from continuing to use abusive language. Staff 2 stated it was unacceptable for Resident 41 to speak to anyone in such a manner

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 38140 Based on interviews and record review it was determined the facility failed to report allegations of verbal abuse within the mandated timeframe for 4 of 4 sampled residents (#s 3, 23, 26 and 41) for 1 of 2 Facility Reported Incident (FRI) reports reviewed for abuse. This placed residents at risk for further abuse. Findings include: The facility's revised 4/2021 Recognizing Signs and Symptoms of Abuse/Neglect revealed it was expected for all personnel to report any signs and symptoms of abuse to their supervisor or the director of nursing services immediately. The facility's revised 9/2022 Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigation Policy and Procedures directed staff to report allegations of abuse to the state agency within two hours. On 6/19/24 at 3:52 AM, Staff 10 (LPN) wrote a progress note in Resident 41's health record which revealed on 6/18/24 at about 8:00 PM Resident 41 had been out of the facility and returned to the facility. Resident 41 proceeded to verbally and physically threatened staff, Resident 3, Resident 23 and Resident 26. On 6/20/24 at 11:23 AM, the state agency (SA) received a FRI for the 6/18/24 at 8:00 PM alleged abuse with Resident 41, Resident 3 Resident 23 and Resident 26. On 2/28/25 at 10:13 AM, Staff 2 (DNS) confirmed the FRI for the 6/18/24 allegations of abuse was submitted to the SA late. She stated she expected all allegations of abuse to be reported to the SA within the required two hour reporting time line.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46053 Based on interview and record review it was determined the facility failed to ensure a resident-centered care plan was implemented for 1 of 4 sampled residents (#21) reviewed for abuse. This placed residents at risk for not being provided appropriate bed mobility assistance. Findings include: Resident 21 was admitted to the facility in 5/2022 with diagnoses including hepatic encephalopathy (a disorder that occurs when the liver is unable to filter toxins from the blood resulting in their build up in the brain and causing confusion, disorientation and other changes) and a spinal fracture. Resident 21's 1/6/24 Annual MDS indicated she/he was cognitively intact. A review of Resident 21's care plan dated 11/14/2022 revealed she/he required assistance from two staff members for bed mobility and she/he was to receive cares in pairs. A facility investigation created and signed by Staff 2 (DNS) on 2/15/24 indicated Staff 22 (Agency CNA) attempted to reposition Resident 21 by herself by guiding her/his hand to grab the headboard and having her/him pull herself/himself up in bed. Staff 22 was in Resident 21's room without another staff member at the time she attempted to reposition Resident 21. The facility investigation indicated after the interaction, Resident 21 did not want Staff 22 in her/his room again. On 2/28/25 at 9:20 AM, Staff 22 stated she worked with Resident 21 at the time of the reported incident and knew Resident 21 was to receive cares in pairs and required assistance from two staff to reposition her/him in bed. Staff 22 stated she decided to reposition her/him without the assistance of another CNA. Staff 22 stated she asked Resident 21 to reach over her/his head to grab and pull up on the headboard because she/he was not positioned appropriately in the bed. Staff 22 stated Resident 21 could not reach the headboard so she guided her hand to the headboard. On 2/28/25 at 10:41 AM, Staff 2 confirmed Staff 22 did not follow Resident 21's care plan to have two people in her/his room at all times.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47000 Based on observation, interview and record review it was determined the facility failed to ensure residents who were unable to carry out ADLs independently received personal grooming assistance for 1 of 2 sampled residents (#16) reviewed for ADL care. This placed residents at risk for lack of grooming care needs. Findings include: Resident 16 was admitted to the facility in 1/2023 with diagnoses including vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain). A physician order dated 1/16/25 revealed Resident 16 was to receive a hair removing face cream as needed for facial hair removal. Resident 16's 2/2/25 Annual MDS indicated the resident was in a persistent vegetative state (a condition in which a person is awake but has no awareness of their surroundings or themselves) and was dependent on staff assistance for all of her/his ADL needs. Resident 16's 2/23/25 ADL Self Care Performance Deficit Care Plan revealed the resident required full assistance from one person to shave. On 2/24/25 at 12:07 PM, Resident 16 was observed in her/his room in bed. Facial hair was observed to cover the resident's chin, jawline and parts of her/his neck and cheeks. On 2/24/25 at 1:14 PM, Witness 1 (Family Member) stated Resident 16 would never let people see whiskers on [her/his] chin, and she was disappointed seeing [the resident] with a full beard. Witness 1 stated Resident 16 use to get nasty razor sores when she/he shaved and preferred to use a hair removal cream instead. On 2/25/25 at 3:54 PM, Staff 20 (CNA) stated nurses were responsible to apply the hair removal cream to Resident 16 but she had never seen them use it. On 2/25/25 at 4:08 PM, Staff 21 (LPN) stated Resident 16 had an order for hair removal cream, she was responsible for applying the cream, but she had not used it yet because she was nervous to use it. On 2/25/25 at 4:38 PM, Staff 2 (DNS) observed and acknowledged Resident 16's facial hair and stated the resident was in need of a shave.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38140 Based on observation, interview and record review, it was determined the facility failed to provide an ongoing program to support individual activity interests and preferences for 2 of 3 sampled residents (#s 16 and 27) reviewed for an activity program. This placed residents at risk for a decreased quality of life and social isolation. Findings include: 1. Resident 27 admitted to the facility in 2022 with diagnoses including a stroke and disease of the pharynx (throat). A 10/10/22 Activities Admission Assessment revealed Resident 27 was nonverbal, dependent on staff and needed one-to-one visits. Resident 27 enjoyed hand massages, manicures, to watch television, listen to audio books and music, visits with family, a Pastor and pets. Resident 27's 10/24/24 Annual MDS assessed her/him with memory problems and rarely to never understood her/his ability to talk. Staff assessed Resident 27's leisure and diversional activity preferences as she/he enjoyed to listen to music, animals, to do things with groups of people, to participate in her/his favorite activities and to spend time outdoors. The 1/17/25 SNF (Skilled Nursing Facility) Activity Quarterly Review indicated Resident 27 had not experienced a change in her/his level of activity participation and was dependent on staff for care. The resident liked one-to-one and in-room visits, therapy animal visits, and sensory activities. Resident 27's interests included country and classic rock music, soap operas, murder mysteries, comedies, head and hand massages, her/his nails manicured, visits from the Pastor and her/his family. Resident 27's 2/25/25 care plan revealed she/he was dependent on staff for activities, cognitive stimulation and social interaction related to her/his cognition and immobility. The goal was for her/him to attend two weekly group activities. Staff were directed if she/he was not able to attend activities, the Activity Director would meet with the resident once or twice a week and provide television shows, music, and movies played for her/him while she/he was awake in her/his room. The care plan directed staff to the resident's preferred radio stations which included country and classic rock. Resident 27's preferred activities were head and hand massages, nails manicured, pet visits, family visits, sensory activities, listen to country and classic rock music, Pastor visits, one-to-one visits, to watch preferred television stations with soap operas, murder mysteries and comedies. The Activity Participation records revealed from 1/27/25 through 2/26/25 (30 days) Resident 27 participated in the following activities: -Spiritual Care on 2/6/25 and 2/20/25. -Movie/Video on 2/13/25 and 2/24/25. During the survey from 2/24/25 through 2/28/25 between 8:00 AM to 4:00 PM Resident 27 was not observed out of her/his bed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 2/25/25 at 9:19 AM,10:46 AM, 12:35 PM, 3:08 PM and on 2/26/25 at 8:47 AM revealed Resident 27 was observed awake in her/his bed with no television or music in the room and no social interactions. On 2/26/25 at 1:49 PM, Resident 27 was observed in her/his bed while the roommate's music played very loud soul music (not her/his preferred music type). On 2/27/25 at 10:29 AM, Staff 14 (CNA) stated Resident 27 sometimes would get out of bed on Tuesday and Thursdays. The CNA's would take her/him to the dining room and she/he looked like she/he enjoyed being around other people. On 2/27/25 at 10:34 AM, Staff 6 (Activity Director) stated Resident 27 was dependent on staff and when time allowed she/he should receive one-to-one visits because he could not get her/him up and out of bed. Staff 6 stated he sometimes completed one-to-one visits with Resident 27 which usually consisted of turning her/his roommate's television on. Staff 6 confirmed Resident 27 could not see the roommate's television. Staff 6 could not identify sensory stimulation type of activities identified to provide in the care plan for Resident 27. Staff 6 could not recall the last time he attempted sensory types of activities. Staff 6 stated he did not provide audio books or music for Resident 27. Staff 6 stated the resident's care plan goal to attend a group activity weekly was based on staff availability to get her/him out of bed. Staff 6 stated he did not invite Resident 27 or request any CNA to assistance to get Resident 27 out of bed to attend any group activity this past week. Staff 6 could not identify Resident 27's activity preferences or recall the last time the resident received a manicure or a hand massage. On 2/27/25 at 11:36 PM, Staff 1 (Administrator) confirmed the lack of activity participation for Resident 27. She stated she expected more opportunities for sensory stimulation and social interactions for Resident 27. 47000 2. Resident 16 was admitted to the facility in 1/2023 with diagnoses including vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain). A care conference note dated 8/6/24 revealed Resident 16 enjoyed to watch television and listen to music in her/his room and she/he had the biggest smile when she/he was out of bed and able to enjoy community activities. Resident 16's 11/4/24 Activity Quarterly Review revealed the resident enjoyed television, music, hand massages and church services. The resident also enjoyed to watch and visit with other residents in the facility's common area during group activities and to listen to people read. Resident 16's 2/2/25 Annual MDS indicated the resident was in a persistent vegetative state (a condition in which a person is awake but has no awareness of their surroundings or themselves). Resident 16's 2/23/25 Activity Care Plan revealed the following: -The resident was to attend a group activity once a week. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident was to receive a one-to-one visit from Staff 6 (Activities Director) once a week. -The resident's activity interests included television, manicures, music and visits with her/his pastor. -The resident enjoyed to watch the [NAME] Show on television. The facility's 2/2025 Activity Calendar revealed the following scheduled activities: -2/24/25: 1:30 PM Group Jeopardy Championship Game -2/25/25: 1:30 PM Tabletop Bowling Championship -2/26/25: 2:00 PM Write Around Portland (Writing Group) A review of Resident 16's Activity Task Logs from 1/27/25 through 2/26/25 revealed the resident participated in music and watched a movie on one occasion and participated in spiritual care on two occasions. No evidence was found in Resident 16's clinical record to indicate the resident received one-to-one visits from Staff 6, manicures or hand massages. Random observations of Resident 16 on 2/24/25 from 12:07 PM to 4:42 PM and on 2/25/25 from 8:43 AM to 1:24 PM revealed the resident was in her/his room in bed. No music played. The resident's eyes were open at times and the resident looked toward her/his television, which was turned off. The resident was unable to answer any questions about her/his activity preferences and interests. On 2/24/25 at 1:14 PM, Witness 1 (Family Member) stated Resident 16 enjoyed music, television, pets, children and church, and she had never been interviewed about Resident 16's activity preferences. Witness 1 stated the only thing Resident 16 was able to look at in her/his room was the television and it was often turned off. On 2/25/25 at 4:08 PM, Staff 21 (LPN) stated Resident 16 loved music, especially [NAME] and R&B stuff but was not for certain. Staff 21 stated Resident 16 also enjoyed television, especially the news, soap operas and the [NAME] Show. On 2/26/25 at 10:20 PM, Staff 17 (CNA) stated Witness 1 told her Resident 16 enjoyed soul and Motown music and to watch music videos on television. Staff 17 further stated Witness 1 informed her the resident did not like the [NAME] Show. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at 10:34 AM, Staff 6 stated residents who were dependent on staff received one-to-one visits, which included Resident 16. Staff 6 stated he completed one-to-one visits with Resident 16 once a week and the visits consisted of turning her/his television on if it was noted to be off. Staff 6 stated he could not recall the last time he attempted a sensory activity, except for one related to smells, and confirmed no additional types of sensory activities were attempted with the resident. Staff 6 stated he knew it was important for Resident 16 to attend weekly church services but he had not interviewed her/his family about additional activity preferences. Staff 6 stated the resident either smiled or slept when in a group activity and stated her/his ability to attend group activities was dependent on staff availability and resident showers. Staff 6 stated the resident's care plan goal of attending a group activity weekly was based on staff availability and not on the resident's preference. Staff 6 stated he did not invite Resident 16 or request any CNA to assist the resident to get out of bed to attend any group activity this week, and could not remember the last time the resident received a manicure or a hand massage. On 2/27/25 at 12:35 PM, Staff 1 (Administrator) stated one-to-one visits needed to consist of more than television, Resident 16's ability to participate in group activities should not be limited by staff availability and the facility needed to offer additional sensory activities to dependent and/or cognitively impaired residents.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. 38140 Based on observation, interview, and record review it was determined the facility failed to provide medically-related social services to attain or maintain the highest practicable mental and psychosocial well-being for 4 of 6 sampled residents (#s 3, 16, 22 and 26) reviewed for abuse and dental. This placed residents at risk for lack of psychosocial needs and decreased dignity. Findings include: The facility's 9/2021 Social Services Policy indicated medically-related social services were provided to maintain or improve each resident's ability to control everyday physical, mental and psychosocial needs. The social worker/social services staff were responsible for the following: -To make referrals and obtain needed services from outside entities. -To provide or arrange for mental and psychosocial counseling services as needed. -To identify and seek ways to support resident needs through the assessment and care planning process. -To identify and promote individualized, non-pharmacological approaches to care that meet the mental and psychosocial needs of each resident. 1. Resident 3 was admitted to the facility in 1/2022 with diagnoses including anxiety, major depression and substance abuse. Resident 3's 11/8/22 Behavior Management Contract described her/him as verbally aggressive towards staff and Social Services were to meet with the resident weekly if she/he chose to. Resident 3's 1/26/25 Annual MDS assessed her/him to make independent decision about her/his daily life with an ok memory. No evidence was found in Resident 3's clinical record to indicate the resident's mental and psychosocial needs were comprehensively assessed, including an assessment of the resident's trauma and potential trauma triggers. The 2/27/25 care plan identified Resident 3 to experience the following problems and interventions Social Services was to use to address the problem: -Inappropriate behaviors, Resistive to care related to depression, anxiety and insomnia: one-to-one support as needed, flexibility in ADL care routine to accommodate her/his mood. -Ineffective coping characterized by verbal aggression/abuse related to drug/alcohol withdrawal: Provide one-to-one time, discuss any concerns, fears, issues regarding health or other subjects as needed, encourage her/him to express their feelings, provide options of times care can be done and flexibility, Risk Management as needed. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/26/25 at 10:58 AM, Staff 5 (Social Services) stated Resident 3 had no indication for potential behavioral triggers in the resident's health record. Staff 5 stated he does not do one-to-one visits with residents and if a resident needed a one-to-one he would make a referral to the mental health consultant. Staff 5 was not able to provide information where behavior monitors were completed or what concise information, he used to assess the residents behaviors. Staff 5 could not identify interventions to assist Resident 3 when she/he experienced stressful behaviors. On 2/28/25 at 9:39 AM, Staff 11 (CNA) stated Resident 3 experienced behaviors almost daily and cursed at staff and refused care often. Staff 11 stated the behavior was not documented to their knowledge. On 2/28/25 at 9:39 AM, Staff 14 (CNA) stated Resident 3had behaviors almost everyday. Staff 14 stated staff reported behavior concerns to the charge nurse and CNAs had not charted behaviors for residents who experienced problematic behaviors. On 2/28/25 at 10:34 AM, Staff 1 (Administrator) stated she expected Resident 3 to have a strong care plan for behaviors. Staff 1 stated behaviors were to be documented, and Staff 5 was expected to provide one-to-one visits as needed. 2. Resident 26 was admitted to the facility in 8/2023 with diagnoses including PTSD (Post-Traumatic Stress Disorder, mental condition with intense emotional and/or physical reaction after a traumatic event or experience), bipolar disorder (extreme mood swings) and substance abuse. Resident 26's 8/24/23 SNF (Skilled Nursing Facility) Social Service History indicated the resident had a military history, experienced several traumas in life and had an unstable medical condition. Resident 26 identified meditation, fresh air, music and visits with family were helpful to cope with anxiety related to her/his trauma experience. Resident 26's 12/1/24 Quarterly MDS revealed the resident was cognitively intact, able to make herself/himself understood and ability to understand others without difficulty. The 12/2/24 SNF Social Services Quarterly Summary for Resident 26 indicated she/he experienced no new trauma and to continue the care plan. No evidence was found in Resident 26's clinical record to indicate the resident's mental and psychosocial needs were comprehensively assessed, including an assessment of the resident's trauma and potential trauma triggers. A 2/21/25 Psychiatric Consultant report revealed Resident 26 was seen for anxiety management and faced challenges with communication with friends and family when she/he were under the influence. The 2/26/25 care plan identified Resident 26 to experience the following problems and interventions Social Services was to use to address the problem: -Inappropriate behaviors, Resistive to care related to depression: one-to-one support as needed, flexibility in ADL care routine to accommodate her/his mood. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Ineffective coping characterized by verbal aggression/abuse related to depression: Provide one-to-one time, refer to mental health as indicated. -Ineffective coping characterized by physical aggression/abusive related to anger: Approach her/him slowly and from the front, be sure to have her/his attention before speaking or touching, provide options for times of care, refer to mental health, if strategies do not work reapproach, keep requests simple. -Ineffective coping, acts sad/depressed related to medical conditions: education for medication, engage in conversation, encourage a change in environment, reach out to family. On 2/26/25 at 10:58 AM, Staff 5 (Social Services) confirmed Resident 26's health records showed no indication of triggers for PTSD, and the helpful tools identified in the initial trauma assessment to aid in coping with anxiety were included in the care plan. Staff 5 stated he does not do one-to-one visits with residents and if a resident needed a one-to-one, he would make a referral to the mental health consultant. Staff 5 could not identify interventions to assist Resident 26 when she/he experienced stressful behaviors. No additional information was provided. On 2/28/25 at 10:34 AM, Staff 1 (Administrator) stated she would expect Resident 26 to have a strong care plan for mental health and for the Staff 5 to provide one-to-one visits as needed. 47000 3. Resident 16 was admitted to the facility in 1/2023 with diagnoses including vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain). A care conference note dated 11/11/24 and written by Staff 5 (Social Services) indicated Resident 16 was to receive dental care as available. Resident 16's 2/2/25 Annual MDS indicated the resident was in a persistent vegetative state (a condition in which a person is awake but has no awareness of their surroundings or themselves) and she/he had obvious or likely cavity or broken natural teeth. The Dental CAA indicated a referral to a dentist was warranted in order to minimize risks and to maintain her/his current level of functioning. On 2/24/25 at 12:07 PM, Resident 16 was observed in her/his room in bed. The inside of the resident's mouth was unable to be visualized and the resident was unable to answer any questions about her/his oral care. On 2/24/25 at 1:14 PM, Witness 1 (Family Member) stated she made a request to Staff 1 (Administrator) and Staff 5 that Resident 16 be seen by a dentist months ago but she/he had not received any dental treatment. On 2/25/25 at 4:08 PM, Staff 21 (LPN) stated Resident 16 did not have the best teeth and her/his teeth were cracked, broken and missing. Staff 21 further stated she could not remember if the resident had ever been seen by a dentist. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/26/25 at 11:39 AM, Staff 5 stated he was responsible for scheduling and tracking resident dental appointments. Staff 5 further stated he had not made a dental referral for Resident 16 following the resident's 2/2/25 Annual MDS. On 2/28/25 at 12:00 PM, Staff 1 (Administrator) stated she expected Staff 5 to schedule dental appointments following the request of a dental referral. 4. Resident 22 was admitted to the facility in 9/2023 with diagnoses including diabetes. Resident 22's 9/16/24 Annual MDS revealed the resident had obvious or likely cavity or broken natural teeth. The Dental CAA indicated a referral to a dentist was warranted in order to minimize risks and to maintain her/his current level of functioning. Resident 22's 9/23/24 Dental Problem Care Plan indicated arrangements for dental care were to be made as needed. Resident 22's 12/17/24 Quarterly MDS revealed the resident was cognitively intact. On 2/24/25 at 10:18 AM, Resident 22 was observed in her/his room in bed and observed to be missing multiple teeth. The resident stated she/he told Staff 5 (Social Services) she/he wanted to see a dentist months ago, but had not not seen a dentist, and never heard back from Staff 5 about a timeframe of when she/he would see a dentist. On 2/26/25 at 10:31 AM, Staff 17 (CNA) stated Resident 22 complained about her/his teeth in 12/2024 and she informed a nurse. Staff 17 stated she did not know if the resident had seen a dentist. On 2/26/25 at 11:35 AM, Staff 5 stated he was responsible for scheduling and tracking resident dental appointments. Staff 5 further stated he had not made a dental referral for Resident 22 following the resident's 9/16/24 Annual MDS. On 2/28/25 at 12:00 PM, Staff 1 (Administrator) stated she expected Staff 5 to schedule dental appointments following the request of a dental referral.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 47000 Based on observation, interview and record review it was determined the facility failed to obtain dental services for 2 of 2 sampled residents (#s 16 and 22) reviewed for dental services. This placed residents at risk for unmet dental needs. Findings include: The facility's 12/2016 Dental Services Policy indicated routine and emergency dental services were to be available to meet resident oral health needs in accordance with the resident's assessment and plan of care, and social services representatives were to assist residents with appointments and transportation arrangements for dental services. 1. Resident 16 was admitted to the facility in 1/2023 with diagnoses including vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain). A care conference note dated 11/11/24 and written by Staff 5 (Social Services) indicated Resident 16 was to receive dental care as available. Resident 16's 2/2/25 Annual MDS indicated the resident was in a persistent vegetative state (a condition in which a person is awake but has no awareness of their surroundings or themselves) and she/he had obvious or likely cavity or broken natural teeth. The Dental CAA indicated a referral to a dentist was warranted in order to minimize risks and to maintain her/his current level of functioning. Resident 16's 2/23/25 Care Plan revealed the resident had oral health problems and required total assistance from one person with oral care. On 2/24/25 at 12:07 PM, Resident 16 was observed in her/his room in bed. The inside of the resident's mouth was unable to be visualized and the resident was unable to answer any questions about her/his oral care. On 2/24/25 at 1:14 PM, Witness 1 (Family Member) stated she made a request to Staff 1 (Administrator) and Staff 5 that Resident 16 be seen by a dentist months ago but she/he had not received any dental treatment. On 2/25/25 at 4:08 PM, Staff 21 (LPN) stated Resident 16 did not have the best teeth and her/his teeth were cracked, broken and missing. Staff 21 further stated she could not remember if the resident had ever been seen by a dentist. On 2/26/25 at 11:26 AM, Staff 3 (LPN/RCM) stated she was aware of Witness 1's request for Resident 16 to be seen by a dentist. Staff 3 stated she thought the resident was on the list to regularly be seen by the facility's in-house dental provider but she was not certain and did not know the last time the resident had been seen by a dentist. Staff 3 stated Staff 5 was responsible for scheduling and tracking resident dental appointments. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 11:39 AM, Staff 5 stated he was aware Witness 1 wanted Resident 16 to be seen by a dentist. Staff 5 stated he was not sure the last time the resident was seen by a dentist, and he was responsible for scheduling dental appointments for all residents. Staff 16 was unaware of the recommendation for a dental referral from the resident's 2/2/25 Annual MDS and he had not made a dental referral for Resident 16. On 2/26/25 at 1:01 PM, Staff 2 (DNS) acknowledged a dental referral for Resident 16 had not been made and should have been following her/his 2/2/25 Annual MDS. 2. Resident 22 was admitted to the facility in 9/2023 with diagnoses including diabetes. Resident 22's 9/16/24 Annual MDS revealed the resident had obvious or likely cavity or broken natural teeth. The Dental CAA indicated a referral to a dentist was warranted in order to minimize risks and to maintain her/his current level of functioning. Resident 22's 9/23/24 Dental Problem Care Plan indicated arrangements for dental care were to be made as needed. Resident 22's 12/17/24 Quarterly MDS revealed the resident was cognitively intact. On 2/24/25 at 10:18 AM, Resident 22 was observed in her/his room in bed and observed to be missing multiple teeth. The resident stated she/he told Staff 5 (Social Services) she/he wanted to see a dentist months ago, but had not not seen a dentist, and never heard back from Staff 5 about a timeframe of when she/he would see a dentist. On 2/26/25 at 10:31 AM, Staff 17 (CNA) stated Resident 22 complained about her/his teeth in 12/2024 and she informed a nurse. Staff 17 stated she did not know if the resident had seen a dentist. On 2/26/25 at 11:31 AM, Staff 3 (LPN/RCM) stated Resident 22 needed to be seen by a dentist and Staff 5 (Social Services) was responsible for coordinating and scheduling all dental visits for residents. On 2/26/25 at 11:35 AM, Staff 5 stated he had not asked Resident 22 about her/his teeth or interest to be seen by a dentist because that usually comes from the CNAs. Staff 5 stated the resident was last seen by a dentist in 4/2024 and he was not aware the resident needed to be seen again. On 26/25 at 1:14 PM, Staff 2 (DNS) stated a dental referral for Resident 22 had not made and should have been following her/his 9/16/24 Annual MDS.