STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455001	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Beaumont	4195 Milam St Beaumont, TX 77707

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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 - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 2 residents out of 21 residents reviewed for environmental concerns in their rooms, 2 of 3 linen closets for adequate linen, 2 of 3 Halls for intact windows and courtyard for environment. 1. The courtyard used by the residents was unkempt and had tall grass, and weeds, and had trash in the weeds and in the bushes. 2. Resident #36 and Resident #41 rooms had an unrepaired trim and wall with missing paint and deep gouges in the sheet rock. 3. Linen closets were not stocked with white linen and linen was discolored with stains, and thin, and worn. 4. Hall 100 and 200, next to the exit door, had broken glass pane with cardboard and tape. These failures could place residents at risk of a diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, and unsafe. Findings included: 1. During an observation on 06/16/25 at 1:00 p.m., the grass in courtyard between hall 200 and 300 was approximately 20 inches high and the weeds were over 4 feet tall. There were plastic wrappers trash and, paper towels, and cigarette butts were buried in the vegetation. During an observation on 06/16/25 at 1:30 p.m., the resident smoking area courtyard between Hall 100 and Hall 200. In the smoking area, there wereas over 300 cigarette butts old and faded on the ground. The grass was 10 inches tall. During an interview on 06/16/25 at 2:00 p.m., Maintenance A said the maintenance department was responsible for ensuring the trash was picked up. He said this smoking area between Halls 100 and 200 was for the resident's' smoking area. He said the areas should be maintained and be homelike for the residents. He said tall grass could lead to pest coming into the building. He said a contract lawn service was supposed to [NAME]. He said about a month ago, they tried to run a weed eater, but the weed eater broke. (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 - Some	2. Record review of the face sheet dated 06/18/25 indicated Resident #36 was a [AGE] year-old male admitted on [DATE] was [AGE] years old with diagnoses of dementia (group of conditions with impaired brain functions), blindness and epilepsy (activity of nerve cells in the brain is disturbed and causes seizures). Record review of the annual MDS assessment dated [DATE] indicated Resident #36 was rarely/never understood with unclear speech. During an observation on 06/16/25 at 1:15 p.m., Resident #36's room had a missing section of the trim approximately 10 feet at the bottom of the sheet rock and the floor behind the bed. The opposite wall had a section of the sheetrock approximately 4 feet by 3 feet with gashes and missing paint. Record review of the face sheet dated 06/18/25 indicated Resident #41 was a female admitted on [DATE]. She was [AGE] years old with diagnoses of a stroke and high blood pressure. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #41 was understood, and understoodands others, andher speech was clear, and she was able to voice her needs. During an observation and interview on 06/16/25 at 1:20 p.m., Resident #41's bedroom had deep gashes in the dark blue wall behind the bed had approximately 10 - 12 inches, dark blue leaving white sheetrock was exposed. She said the wall needed to be fixed and painted . 3. During an observation on 06/17/25 at 10:30 a.m., the linen closets on Halls 100 and 200 had small amount of dingy linen. Hall 100 had 3 flat sheets- 2 old and 1 new flat. Hall 200 had 2 fitted sheets, no towels, and no flat sheets. During an observation on 06/18/25 at 11:30 a.m., Hall 200 had 3 fitted sheets and 2 bath towels that were discolored and had dark grey stains. During an interview on 06/17/25 at 11:15 a.m., CNA L said the linen closet did not have linen right now at that time and said she could go check the other halls. During an interview on 06/18/25 at 11:40 a.m., CNA J and CNA K said they must wait or get some linen off another hall if there was linen there. They said the laundry supervisor would have linen when she gets returned from the laundry mat. During a group interview on 06/17/25 at 8:59 a.m., 6 alert and cognitively intact residents. The 6 residents (Residents #15, #17, #23, #94, #35 and #26 (gave permission to be interviewed and named) said they were not satisfied with the grass around the building being so tall and not maintained. They said there could be snakes and roaches in the tall grass around the building. Resident # 17 and Resident #15 said the linen was dingy, and they have had a hard time getting linen for their beds. They said the sheets did not fit the beds properly and had holes in linen or were thin. Resident #26 said they needed new linens and towels without stains. 4. During an observation on 06/18/25 at 12:40 p.m., the glass pane by the exit door on Hall 100 and Hall 200 was broken and was covered with cardboard and tape. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/18/25 at 1:00 p.m., the Maintenance Director said the 2 broken windows by the exit doors off unit 100 and unit 200 had been broken longer than 5 months. He said those windows were broken when he was hired approximately 5 months ago. He said he had reported the broken windows to the Administrator. He said he was never given the glass to fix the windows. There was a piece of cardboard was taped over the broken area. He said all windows should be intact and not broken, so the environment would be homelike environment. He said the lawn and courtyards should be mowed by contract lawn maintenance and his department should have removed the trash and cigarettes debris. He said he was not aware Resident #36's room had a missing section of the trim approximately 10 feet at the bottom of the sheet rock and the floor behind the bed. The opposite wall had a section of the sheetrock approximately 4 feet by 3 feet with gashes and missing paint. He said he should have seen Resident #41's bedroom had deep gashes in the dark blue wall behind the bed had approximately 10 - 12 inches, leaving white sheetrock exposed. He said the resident rooms should be with paint and free of gashes or missing paint on the walls. During an interview on 06/18/25 at 2:00 p.m., the Administrator said she had been attempting to obtain a contract for lawn services and had one company coming out to [NAME], however, they did not show up. She said she would continue to obtain a lawn service, and have maintenance pick up the trash. She said she had notified the appliance repair person for the dryer which broke Friday. She said the parts had been ordered for the other dryers. She said the laundry supervisor would continue to go to the laundry mat. She said the appliance repair service should be here tomorrow. She said she the expectation was for the facility to be maintained with a homelike environment. She said the residents should have plenty of linen since the laundry supervisor was back from the laundry mat. She said her expectation was for there to be plenty of linen for the residents and she just ordered more linen after surveyor intervention. Record Review of the policy Homelike Environment indicated Policy Statement Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. 2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment.e. clean bed and bath linens that are in good condition.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 observation, interview and record review, the facility failed to ensure residents had the right to be free from abuse and neglect for 2 of 3 residents (Resident # 47, Resident #87, and Resident #106) reviewed for abuse. The facility failed to ensure Resident #47 was free from sexual abuse when Resident #106 touched her face, hair, and breast area inappropriately on 05/28/2025. The facility failed to ensure Resident #87 was free from physical abuse when Resident #87 and Resident #106 had a physical altercation on 06/05/2025. The noncompliance was identified as PNC. The IJ began on 05/28/2025 and ended on 06/05/2025. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk for emotional distress, fear, decreased quality of care, and further abuse. Findings included: Resident #47 Record review of Resident #47's face sheet, dated 06/18/2025, indicated a [AGE] year-old female who was originally admitted to the facility on [DATE] with more recent admission date of 01/29/2025. Resident #47 had diagnoses which included PTSD (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). Record review of Resident #47's quarterly MDS assessment, dated 04/04/2025, indicated she made herself understood and usually understood others. She had severe cognitive impairment, identified with a BIMS score of 6. She required supervision or touching assistance with most activities of daily living. Record review of Resident #47's care plan dated 02/23/2025 and revised on 05/30/2025 indicated Resident #47 had potential for episodes of PTSD related to previous rape (as triggered by unwanted, unexplained touch). She was not having any negative effects from history of PTSD. Interventions included encourage resident to verbalize feelings and provide verbal and physical reassurance. Ensure all staff was aware of Resident #47's PTSD potential triggers and attempt to alleviate to the extent possible. Also, Resident #47 was sexual assaulted by another male resident. Intervention included head-to-toe assessment performed by female nurse, psych consult, and resident removed from area to safe environment. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #47's undated witness statement indicated the following: . I was eating breakfast in the cafeteria at about 8:30 a.m., a white male [Resident #106] came up and sat on my right side. He told me he did not have a girlfriend and was glad he met me. I told him I was going outside to smoke, with him following me I gave him a cigarette believing he would go away, but he continued to follow me. He started rubbing my breast through my clothing even though I told him to stop. An employee saw what happened and told the administrator. Record review of Resident #47's progress notes dated 05/28/2025 at 09:00 a.m. authored by the DON indicated [Resident #47] had another male resident (Resident #106) rubbing her back during smoke break, then went to touch her breast area. He was immediately separated from her, and she was brought to the front Administrator's office for statement. She stated that she did not tell him it was okay to touch her breast area. Police department notified at this time. Head to toe assessment performed with no negative findings noted. Physician was notified and gave order to consult Psychiatric services. Nurse practitioner for Psych services was notified, Telehealth performed at this time, no new orders noted at this time. Resident #47 stated, I am ok, just don't want to think about it Psych NP will see her again on Friday. Record review of Resident #47's progress note dated 05/30/2025 at 10:44 a.m. and authored by Psych NP F indicated Patient [Resident #47] seen for follow up related to incident this week. Patient [Resident #47] is pleasant. She stated she had a history of past rape, and multiple times. She stated she is okay since he touched her, just made her think of the past. New diagnosis of PTSD, and new order for Xanax (used to treat anxiety and panic disorders) 0.25 mg - one tablet daily at 11:00 a.m. for 14 days to manage effective coping. Record review of Resident #47's progress note dated 06/02/2025 at 4:58 p.m. authored by the Social Worker indicated visited with resident [Resident #47] today. She states she is feeling better. She states she is sleeping well and not having any negative dreams. She voiced no issues at this time. Resident #106 Record review of Resident #106's face sheet, dated 06/18/2025, indicated a [AGE] year-old male admitted to the facility on [DATE]. Resident #106 had diagnoses which included metabolic encephalopathy (a brain disorder characterized by altered mental status due to various factors like electrolyte imbalances, organ dysfunction, or nutritional deficiencies) and personality disorder (a group of mental health conditions characterized by inflexible and unhealthy patterns of behavior and thinking that differ from cultural norms). Record review of Resident #106's admission MDS assessment, dated 05/16/2025, indicated he makes himself understood and understood others. He had no cognitive impairment, identified with a BIMS score of 12. He required partial/moderate assist with toileting, personal hygiene, and bathing. Record review of Resident #106's care plan dated 05/28/2025 indicated Resident #106 had an episodic behavior of grabbing, suicidal ideations, and aggression. Intervention was admission to behavioral hospital for evaluation and admission. Place on 1:1 care until admission. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #106's progress notes dated 05/28/2025 at 09:00 a.m. (as a late entry) authored by DON indicated Resident was witnessed by staff, rubbing a female resident's back, then went and placed hand on top of breast area during smoke break. Resident was immediately separated and placed 1:1 with CNA. When asked about the incident, he said it was consensual. I explained she did not see it that way and we had to notify the police. Resident stated I am going to my cave because I cannot commit suicide in the gym. Physician notified and received order to send to behavioral hospital. Record review of Resident #106's progress note dated 05/28/2025 and authored by Psych NP G indicated [AGE] year-old male presents for weekly visit. Patient has indwelling catheter in place. Another resident reported being inappropriate with her. Psych and police notified. Patient being sent to behavioral center. Record review of the facility's PIR (Provider Investigation Report), dated 06/04/2025, incident category as abuse, resident inappropriately touched another resident's breast and signed by the Administrator on 06/04/2025. PIR indicated the incident occurred 05/28/2025 at 09:00 a.m. in the smoking area. Record review of Resident #106's progress notes indicated readmission to facility from the behavioral center on 06/05/2025. Resident #106 was admitted to all-male secure unit for behaviors and monitoring. There were no changes to medicine regimen. Record review of Resident #106's care plan updated 06/05/2025 indicated goal/interventions to include placing in an all-male environment on secure unit to monitor behaviors and signs of depression such as isolation and crying. Resident #106 had a physical altercation with another resident. Interventions included monitor and document all behaviors, refer to psychiatric services, and was placed on 1:1 care. Record review of Resident #106's electronic clinical record indicated on 06/05/2025 he signed an Unauthorized Discharge/Release of Responsibility (AMA) form and discharged from facility. (AMA is against medical advice) During an observation and interview on 06/18/2025 at 9:45 a.m., Resident #47 was sitting in her room in her wheelchair. She said Resident #106 had come up beside her and touched her shoulder and breast. She said she had felt angry and fearful at the same time, and she did not want him touching her. Resident #47 said staff had intervened quickly. She said the incident was reported to the police and she was told Resident #106 was in another part of facility behind double locks. She said all she knew was that he was not in the facility. During an interview on 6/18/2025 at 10:30 a.m., the Administrator said Residents #47 and #106 had been talking in the dining area and Resident #106 followed Resident #47 to the smoking area. While outside, Resident #106 put his hand on Resident #47's breast. The Administrator said the incident was witnessed by ADON E. Residents were immediately separated, and Resident #106 was placed on 1:1 monitoring due to expressing suicidal ideation. When administrator interviewed Resident #106, he denied the allegation. She said the incident had been reported to police. She said the police had taken written statements from Resident #47 and ADON E. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/18/2025 at 1:30 p.m., ADON E said she was a witness to this incident. She said the residents were outside in the courtyard for smoke break. She said the maintenance man was with the residents at that time. She says he motioned for her to come outside when she was passing by the window facing the smoking area. She said about the time she got out to Resident #47, she saw that Resident #106 had his hand on her chest area. She said he was sitting by her side, and both were in wheelchairs. She said that he was touching the upper chest region area of Resident #47. She said Resident #106 normally did not come out of his room, and that he had just started coming out of his room a little more. She said he looked happy. She said Resident #106 was usually quiet. When asked about Resident #47's cognitive status, she said she is alert and interviewable. She stated her cognition would vary and sometimes she was all over the place. She said when she saw Resident #47, she did not seem afraid and was not crying. She said she wheeled Resident #47 straight to the Administrator's office to report. During an interview on 06/18/2025 at 2:05 p.m., Maintenance A said on 05/28/2025 at approximately 09:00 a.m., he had been supervising the residents who smoked. He said yesterday was the first time Resident #47 and Resident #106 had met. He said Resident #106 never comes out of his room. He said he observed Resident #106 getting close to Resident #47 which he thought was odd behavior. He said Resident #106 had touched the face and caressed hair of Resident #47. He said she looked uncomfortable and pulled away from Resident #106. Maintenance A said he saw ADON E passing near windows with outside view to the smoking area, and he motioned her [ADON E] to come outside. He said Resident #47 was a large busty woman and he did not see Resident #106 touch her breast nor put his hand inside her blouse at the time. He said ADON E acted quickly and took Resident #47 to the Administrator's office to report the incident. During an interview on 06/18/2025 at 2:23 p.m., RA H said she had served breakfast trays on 05/28/2025. She said Resident #47 and Resident #106 were sitting at the same table and having a cordial conversation and were laughing. She said this was the first time she had seen Resident #106 out of his room. RA H said she saw no discomfort between the two residents at breakfast. RA H said at around 09:00 a.m., she was instructed to monitor Resident #106 on a 1:1 basis. She said he was crying during her monitoring. She said he made statement that he was going to jail and was praying over the situation. She said Resident #106 required assistance for some activities of daily living. She said he had a foley catheter (inserted into bladder to drain urine) and would try to empty the drainage bag himself. During an interview on 06/18/2025 at 2:44 p.m., the SW said she visited with Resident #47 for several days following the incident on 05/28/2025. She said Resident #47 was doing well until incident which triggered uncomfortable memories. Resident #47 said she felt safe knowing Resident #106 was no longer residing at the facility. The SW said she was unaware of Resident #47 having a diagnosis of PTSD because she had never mentioned it to her. During an interview and record review on 6/18/2025 at 4:00 p.m., surveyor reviewed an undated Handwritten Witness Statement with ADON E. She said when the police came to the facility, he had requested ADON E to complete. In this statement she wrote As I walked past smoking area, I noticed [Resident #106] rubbing on Resident #47's neck, face, and breast region. I asked Resident #47 was this behavior consensual. She verbalized no. I removed Resident #47 from the smoking area and brought her to administrator office. After review of the written statement, ADON E verified her statement by signature and date. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #87 Record review of Resident #87's face sheet, dated 06/18/2025, indicated a [AGE] year-old male who was originally admitted to the facility on [DATE] with more recent admission date of 03/10/2025. Resident #87 had diagnoses which included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). Record review of Resident #87's discharge-return anticipated MDS assessment, dated 06/09/2025, indicated a short-term memory problem severely impaired for cognitive skills for daily decision making. He required supervision or touching assistance with most activities of daily living. Record review of Resident #87's care plan dated 06/05/2025 and indicated Resident #87 had a physical altercation with another resident. Interventions included to monitor and document all behaviors, placed on 1:1 care, seen by psych service NP, and new order received for behavioral center referral related to delusions. Resident #87 resided on the memory care unit related to unaware of his safety needs and wandering. Interventions included encourage social interaction, give simple specific instructions for accomplishing tasks, maintain consistent routines, orient to reality as needed, and prevent excessive stimulation. Record review of Resident #87's progress notes dated 06/05/2025 at 03:30 a.m. authored by LVN M indicated approached room [ROOM NUMBER] and Resident (#87) was standing near door skin tear noted to left and right hand. When asked what happened, resident did not respond. Sites cleaned and dressed. Head to toe evaluation done. Resident nose appeared to be red. No blood noted. Family notified. EMS called to transport resident to emergency room for eval. Record review of Resident #87's progress note dated 06/05/2025 at 04:40 a.m. authored by LVN M indicated raised area to forehead and small laceration to upper lip. When EMS arrived, resident refused to go to ER. This nurse asked resident what happened, he stated they had a man in my room that wouldn't leave. He then started a confused conversation regarding being chased in a car. Record review of Resident #87's progress note dated 06/05/2025 at 1:10 p.m. authored by Psych NP F indicated assessed patient due to incident this morning, and upon arrival he was pacing in room with aide present. Pt is confused with a BIMS of 3 (severe cognitive impairment). Pt is able to follow directions but does have times of delusions and is delusional currently about a car and police chase. Patient has a history of traumatic brain injury from years ago and schizoaffective. Patient has disorganized thought process and speech. I plan to send patient out for monitoring of delusions. I do not think he is a harm to others. Nursing staff are closely monitoring for any changes. Record review of Resident #87's clinical record indicated he was placed on 1:1 monitoring by staff from 06/05/2025 at 3:30 a.m. until transferred to behavioral center on 06/05/2025 at 1:30 p.m. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's Provider Investigation Report, dated 06/05/25, incident categorized as abuse and incident signed by the Administrator on 06/12/25. PIR indicated the incident occurred 06/05/25 at 3:20 a.m. on the secure unit. PIR indicated Resident #87, and Resident #106 had an un-witnessed resident-to-resident incident, both on the secure unit. Description of the Allegation: [Resident #106] was noted in the hallway by LVN M and stated that someone had come into his room. DON asked if the other patient hit him, and he stated: no, he swung first so I have a right to defend myself. So, I hit him. [Resident #87] would not give a statement at this time. PIR indicated LVN M provided head to toe assessment to Resident #87 and Resident #106 on 06/05/25 indicating Resident #87 had raised area noted to forehead and small laceration to upper lip, reddened nose and Resident #106 no visible injuries. PIR indicated Provider Response: patients were immediately separated, both patients were placed on one-on-one, roommate of Resident #106 was immediately removed, Neuro-checks initiated on Resident #87, both Residents immediately assessed for injuries and treated, MD/ RP/ PD/ Psych were notified, In-services, Safe surveys and Staff interviews initiated. PIR indicated Investigation Summary: Upon receipt investigation was immediately initiated. Admin interviewed Resident #106 on the incident. Mr. (Resident #106) stated, I was lying in bed, and he came into my room mumbling to himself. I screamed at him to leave, and he sat down in my wheelchair. So, I got up and hit him so he would leave. Admin asked if Mr. (Resident #87) hit him, Mr. (Resident #106) stated no. Admin asked him if he would go to the psych hospital, he stated no, there is no reason for me to go, I just want to go home and you can't keep me here. Admin went to get DON, and Social Worker in regard to possible discharge. Administrator, DON and Social Worker went back to speak with (Resident #106). Resident at this time has changed his statement to Mr. (Resident #87) came in his room, stood over his bed and would not leave then sat down in his wheelchair. Then proceeded to change statement again that he came in yelling and drug me out of the bed, while I was screaming, so I had to defend myself and I hit him, and I just want to go home now. Re-educated at this time it is not appropriate to touch other residents and psych would come see him and further explain the benefit of a behavioral hospital. Resident stated F**k you. I am not going anywhere but home and I want to go today, you cannot hold me here. Social worker asked how he would have care at home, and he said his friend is a caregiver and they live together. Explained we would notify MD for discharge orders and set up home health, but would take a little time, and he stated I am not waiting, I am leaving today. Friend was notified. Resident #106 discharged AMA home with Friend. APS was contacted. Admin went to interview Mr. (Resident #87) about what happened last night. Mr. (Resident #87) stated that he was in a car wreck in the middle of the night. I asked him if he was hurting or if he felt safe, Mr. (Resident #87) said yea, I am ok, but my car isn't. It's broke now. Admin reported the statement to charge nurse. Mr. (Resident #87) was sent out later for delusions per MD/ Psych. Admin then interviewed (Resident #106) roommate in regard to incident. Admin asked if he saw or heard anything. Roommate stated, I didn't hear or see anything, he couldn't have been too loud. Roommate BIMS of 10. Safe surveys completed with no negative findings. Staff interviews completed with no negative findings. In-servicing completed. Record review of Resident #87's 1:1 monitoring record indicated on 06/05/2025 at 3:30 a.m., he was placed on 1:1 monitoring until approximately 2:15 p.m. when he was transferred to the behavioral center for evaluation. Record review of Resident #106's 1:1 monitoring record indicated on 06/05/2025 at 3:30 a.m., he was placed on 1:1 monitoring until approximately 1:30 p.m. Resident #106's progress notes indicated multi entries of Resident #106 continuing with 1:1 monitoring by staff in his room. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Beaumont	4195 Milam St Beaumont, TX 77707

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #106's progress notes dated 06/05/2025 at approximately 10:50 a.m., Resident #106 had stated to staff that he understood he was leaving facility AMA and signed the form. Review of progress notes indicated Resident #106 left facility at approximately 1:40 p.m. with a friend. PIR indicated Provider investigation findings: Unconfirmed. PIR indicated Provider action taken post-investigation: Safe surveys completed with no negative findings, staff interviews completed with no negative findings and In-servicing completed. During an interview on 6/18/2025 at 10:00 a.m., LVN N and LVN O said the incident occurred on the night shift and were told during report at shift change the following morning. She said this was in Resident #87's previous room and speculate due to his dementia, he thought he was in his room. During an interview at on 06/18/2025 at 10:30 a.m., the Administrator said Resident #106 had changed his story several times. He said Resident #87 had come in and sat down, then that he was standing over him, also that he felt threatened and was defending himself, etc. He became upset and said he wanted to leave and go back to a motel and get stoned. During an interview on 06/19/25 at 8:39 a.m., LVN N said she worked the 6a to 2p shift on the memory care unit on 06/05/25. LVN N said Resident #87 had a history of delusions, self-propelled wheelchair, pacing and often wandered into other residents' (on the memory care) rooms because he thought they were his room, and he would start undressing himself to get in the bed. LVN N said staff would often re-direct Resident #87 out of other resident's rooms and to his own room. LVN N said on the morning of 06/05/25, Resident #87 did not know what happened and that he thought the police or Nazis were after him. LVN N said she notified the Resident's physician of the incident and was given orders to send him to a behavior hospital. LVN N said Resident #87 was not acting any different from his baseline, because he always had delusions and wandered. During an interview on 06/19/25 at 6:13 p.m., the Administrator said she was the Abuse Coordinator and was the one responsible for the investigation of the 06/05/25 altercation between Resident #87 and #106. The Administrator said Resident #106 had changed his statement multiple times. She stated one story was a man came into his room, stood over his bed, and hit him. Then later Resident #106 claimed he had to protect himself because Resident #87 tried to drag him out of bed and so he hit him. The Administrator said Resident #106 was mad, and refused to be transferred to the behavioral center for treatment. When he went to hospital, there were no medication changes. He was mad the police did not talk to him after incident. She stated the roommate [Resident #87] was interviewed and unaware of the incident until the resident screamed. Negative sex offender. UTI/ labs were off before the incident. The Administrator said there was nothing she would have done differently. She stated Resident #106 had no history of aggression and no issues with abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 06/19/25 at 11:25 a.m., CNA QQ said she worked the 10p to 6a shift on the Memory Care unit female hall, and on 06/05/25 CNA RR, on the men's side of the hall, called her to come help. CNA QQ said that Resident #87 was in Resident #106's room and Resident #87 was standing over Resident #106's, who was in bed. CNA QQ said she removed Resident #87 from the room and hollered for a nurse. CNA QQ said Resident #87 was bleeding from his face, lip and hands. CNA QQ said she could tell because there was blood coming from both his hands and his face. CNA QQ said they could use some help or use more help if they could get one more CNA to help monitor the residents because a lot of them wander into rooms. CNA QQ said that there's only two CNA's and one nurse working on the night shift. She said there's many residents that wander into other residents' rooms. She stated they redirected them and take them back to their room, they offer snacks, they may even get extra blankets if they're cold. During a phone interview on 06/19/25 at 1:43 p.m. LVN M said she was the nurse on duty 10p to 6a on 06/05/25 on the Memory Care unit. LVN M said she was leaving the nurses station and Resident #106 was coming towards the nurses' station from his room in a wheelchair with blood on his hands saying he had the right to defend himself. LVN M said Resident #106 told her Resident #87 came in his room swinging at him, he had the right to defend himself. LVN M said Resident #87 had a raised area on his head, skin tears on both arms, and had a small cut on the upper lip. LVN M said Memory Care unit staffing at night was one CNA for each hall and one nurse for the entire unit. LVN M said there is enough help to provide care with only one CNA, and when they must go to lunch, another staff from 200 hall would come to help. LVN M said Resident #87 had been in his room most of the night, and no one saw when he left his room and entered Resident #106's room. LVN M said after the altercation, Resident #106 and Resident #87 had been on one-to-one monitoring, but she could not remember which staff did the 1 to 1 monitoring. LVN M said at night, the LVN must do frequent rounds and frequent redirection of the residents who wander. During a phone interview on 06/19/25 at 12:45 p.m. CNA RR said she was working the floor 10p to 6a on 06/05/25 on the Memory Care unit, men's hall. CNA RR said she left her men's hall to go assist CNA QQ (women's hall) with care and LVN M came and got them to assist Resident #87 who was standing in the hall bleeding but not bad back to his room. CNA RR said Resident #106 was sitting in a wheelchair in the hall outside the door. She stated Resident #87 had said someone was in his room; Resident #106. CNA RR said Resident #106 told her Resident #87 was standing over him and he needed to defend himself, so he hit Resident #87. CNA RR said they helped put Resident #87 back in the wheelchair and put him in his room. CNA RR said Resident #87 had been in bed most of the night, but must had gotten up, and usually when Resident #87 does wander into someone else's room, they redirect him back to his room or they'll sit with them. CNA RR said she thought Resident #87 got up to use the bathroom and lost his way back to the bed, went to his old room where Resident #106 was. CNA RR said Resident #106 had never had contact or an altercation that she knew of with any other resident. CNA RR said she did the 1 to 1 monitoring and CNA QQ sat with Resident #106. The Administrator was notified a past non-compliance situation had been identified due to the above failures. It was determined these failures placed residents in an IJ situation on 05/28/2025 through 06/05/2025. The facility had implemented the following interventions: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident #47 immediately removed from the smoking area away from Resident #106 -Resident #47 skin assessment performed -Resident #106 was monitored 1:1 on 05/28/25 from 09:00 a.m. until transferred to behavioral center at around 6:00 p.m. -Physician, Responsible Party, Police Department and Psych Services notified. -Resident #47 and Resident #106 were seen by psych services on 05/28/2025 -Resident #106 was sent to behavioral center for evaluation and admission on [DATE] - safe surveys were initiated by SW -staff interviews initiated -On 05/28/2025, all staff were educated by DON on Resident Rights, Abuse, Neglect, Exploitation, and Abuse Reporting. -On 06/05/2025, Resident #87 was placed on 1:1 monitoring until approximately 2:15 p.m. when he was transferred to the behavioral center for evaluation. -On 06/05/25, Resident #106 was placed on 1:1 monitoring by staff in his room until he discharged . -On 06/05/2025, Resident #106 left the facility AMA at approximately 1:40 p.m. with a friend. Record review indicated on 06/05/2025, the DON held an in-service on the following with 46 employees in attendance: -resident rights; -abuse, neglect, and abuse reporting; and -managing behaviors and de-escalation. Attendees included 2 RNs, 6 LVNs, 1 MA, 21 CNAs, 4 rehabilitation staff, 4 dietary staff, 5 housekeepers, 1 AD, 1 SW, and 1 receptionist. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews conducted on 06/16/2025 from 09:00 a.m. through 06/20/2025 at 4:15 p.m., with the following staff through various shifts (6a-6p, 6p-6a, 6a-2p, 2p-10p, and 10p-6a) i floor tech T, ADON/ICP, LVN U, LVN ADON E, CNA V, CNA J, LVN W, CNA X, CNA L, CNA Y, RNA H, AD Z, DON, housekeeper AA, housekeeper BB, CNA V, Housekeeper CC, Housekeeper DD, Housekeeper EE, LVN FF, CNA GG, Environmental supervisor, Admissions, LVN HH, Housekeeper AA, LVN O, LVN KK, CNA LL, CNA MM, LVN N, CNA NN, Housekeeping OO, CNA PP, LVN M, CNA QQ and CNA RR, CNA SS, CNA PP, CNA WW, CNA K, CNA AA, CNA BB, CNA CC, CNA LL , LVN MMM, LVN M, LVN TT, LVN, R, LVN VV, MDS LVN JJJ, MDS LVN FF, RN UU, ADON E, ADON/ IP, Environmental supervisor, HK BB, HK XX, DM, Maintenance Assistant ZZ, Laundry DD, dietary aide EEE, Staffing, ST NNN, ST KKK, ABOM, Receptionist GG, Medical Records HH, PTA, and SW. The staff said they had been trained on abuse/neglect, abuse reporting, resident rights on hire and at least annually. The staff said they were retrained following the incidents that occurred on 05/28/2025 and 06/05/2025. The were able to voice what to do first such as separate the residents and get help as needed. They said they would report to nurses then report to the Abuse preventionist. They were able to identify different types of abuse i.e. verbal, sexual and physical. The noncompliance was identified as PNC. The IJ began on 05/28/2025 and ended on 06/05/2025. The facility had corrected the noncompliance before the survey began.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 2 of 3 resident (Residents #87 & #106) reviewed for accidents hazards and supervision. 1. The facility failed to provide adequate supervision on the facility's memory care unit, to prevent Resident #87, who had severe cognitive impairment from wandering into Resident #106 room at approximately 4:00 a. m. on 06/05/25. 2. The facility did not implement interventions to include adequate supervision prior to the incident or following the incident for all residents at risk for injuries related to wandering behaviors. An Immediate Jeopardy (IJ) was identified on 06/19/25 at 4:50 p.m. The IJ template was provided to the facility on [DATE] at 5:08 p.m While the IJ was removed on 06/20/25, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because the facility was continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk of emotional distress, fear, severe injury, hospitalization, and decline in quality of life. Findings included: Resident #87 Record review of Resident #87's face sheet, dated 06/21/25, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #87 had diagnoses which included Alzheimer (loss of cognitive functioning), schizoaffective disorder bi-polar type(mental health condition combination impacting a person's thoughts, emotions and behavior), cognitive communication deficit(difficulty communicating, understanding, speaking reading, writing and social interaction), psychosis(mental health condition characterized by a disconnection from reality) and anxiety(intense, excessive and persistent worry and fear about everyday situations). Record review of Resident #87's quarterly MDS assessment dated [DATE] indicated Resident #87 was understood and had the ability to understand others. He had a BIMS score of 3 of 15 indicating his cognition was severely impaired for daily decision making, and had disorganized thinking. Resident #87 had minimal difficulty hearing, impaired vision, and clear speech. Resident #87 used a wheelchair and exhibited behavior of wandering 1 to 3 days. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #87's care plan, revised 03/12/2025, reflected the following: Focus: The resident is/has potential to be physically aggressive r/t Anger, . Interventions: COMMUNICATION: provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated .Focus: Resident to resident altercation; physical altercation became agitated with a confused resident and hit them. Interventions: counsel resident on acceptable vs unacceptable behaviors, monitor for potential altercation between residents . Refer to psych care as needed. Record review of Resident #87's Progress Notes reflected the following: 06/05/2025 03:30 AM- approached room [ROOM NUMBER] resident was standing near door skin tear noted to left and right hand when asked what happened resident didn't respond resident cooperated and exited this room, sites cleaned and dressed head to toe eval done resident nose appeared to be red no blood noted. Family member OOO was notified 1st contact no answer DON notified of situation, EMS was call to transport resident to ER for eval neuoro checks iniated. This entry was written by LVN M. 06/05/2025 04:40 AM- raised area noted to forehead and small laceration to upper lip, when ems arrived resident refused to go to er, this nurse asked resident what happened this time he stated they had a man in my room that wouldn't leave then he started a confused conversation re being chased in a car. one on one staff with resident at this time neuro checks in progress. This entry was written by LVN M. 06/05/2025 12:57 PM- Resident Remains 1:1, is pacing with CNA at side and having delusions saying he was in a car wreck last night, then the germans are attacking, NP notified and is on way to round on resident. This entry was written by LVN N. 06/05/2025 2:24 PM- res transferred to behavioral hospital by their facility van called and gave report to the nurse there This entry was written by LVN N. Record review of Resident #87's Provider Notes reflected the following: 06/05/2025 1:10 PM- I assessed pt due to incident this am, and upon arrival he was pacing in room with aid present. I went into room and greeted me with kindness. pt is pleasant. pt denied any problems. pt denies any suicidal or homicidal thoughts, pt is confused with a BIMs of 3. pt is able to follow directions but does have times of delusions and is delusional currently about a car and police chase. Pt has a history of traumatic brain injury from years ago and schizoaffective. pt has disorganized thought process and speech. I plan to send resident out for monitoring of delusions. I do not think he is a harm to others, Nursing staff are closely monitoring pt for any changes. This entry was written by Psych NP F. Record review of the facility Incidents/Accidents reports reviewed for to June 2025 revealed there was no incident report regarding Resident #87's injuries, wandering or altercation. Resident #106 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #106's face sheet, dated 06/21/25, indicated a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #106 had diagnoses which included adjustment disorder with depressed mood(mental health condition characterized by emotional and behavioral symptoms) and personality disorder(mental health condition characterized by inflexible and unhealthy patterns of behavior and thinking that differ from cultural norms). Record review of Resident #106's admission MDS assessment dated [DATE] indicated Resident #106 was understood and had the ability to understand others. He had a BIMS score of 12 of 15 indicating his cogntition was moderately impaired for daily decision making, and had disorganized thinking. Resident #106 had adequate hearing, vision, and clear speech. Resident #106 used a wheelchair and exhibited no behavior of wandering. Record review of Resident #106's care plan, initiated 05/28/25, reflected the following: Focus: RESIDENT HAD AN EPISODIC BEHAVIOR OF GRABBING, SUICIADAL IDEALATIONS, AGGRESSION, Interventions: .NEW ORDER NOTED FOR EVALUATION AND ADMIT. Record review of Resident #87's Progress Notes reflected the following: 06/05/2025 3:21 AM- this nurse was leaving nurses station to make round this resident was coming down hall stated that another resident was in his room and swung at him so he hit him he continued screaming [NAME] have the right to defend myself man or woman i will knock the f out of them, this nurse ensured he was safe and could calm down small ampount of bllod was noted on his right hand . don was notified of situation and gave orders for this nurse to call the police to come out. This entry was written by LVN M. 06/05/2025 5:05 AM- Spoke with resident in regard to refusing to go to Hospital and he stated there was no need to, he was never touched by other resident and did not need psych services. Asked him again what happened, he stated, He came in my room, so I felt the need to defend myself so I did and will do again Asked what (Res #87) said to him, and he said he didn't say anything just came in here in the middle of the night. Denies any pain at this time, will continue with 1:1 monitoring and Psych to see today. This entry was written by DON. 06/05/2025 9:34 AM- Went to interview/assess resident with Administrator and social worker. Resident in room, with CNA FOR 1:1 monitoring. Resident at this time has changed his statement to Resident #87 came in his room, stood over his bed and would not leave then sat down in his wheelchair. Then proceeded to change statement again that he came in yelling and drug me out of the bed, while I was screaming, so I had to defend myself and I hit him, and I just want to go home now. Re-educated at this time it is not appropriate to touch other residents and psych would come see him and further explain the benefit of a behavioral hospital. Resident stated F. you, I am not going anywhere but home and want to go today, you cannot hold me here. Social worker asked how he would have care at home, and he said his friend is a caregiver and they live together. Explained we would notify MD for discharge orders and set up home health, but would take a little time, and he stated I am not waiting, I am leaving today. This entry was written by DON. 06/05/2025 10:09 AM- res in room no aggression noted res on 1:1 monitoring. This entry was written by LVN N. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	06/05/2025 1:16 PM- Pt seen at this time r/t incident this am. He would not speak to me about it, no visible distress noted. When I asked what happened he said I don't have to answer you because I am going home now and no longer under your care. pt denies any suicidal or homicidal thoughts, I attempted to re-question/re-assess and he told me to get out. I exited the room, aid remained in room, and pt was ok with aid in room. This entry was written by Psych NP F. 06/05/2025 3:46 PM- SW made report to statewide intake as resident left AMA today. This entry was written by Social Worker. Record review of the facility Incidents/Accidents reports reviewed for to June 2025 revealed there was no incident report regarding Resident #106's altercation or leaving AMA. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's Provider Investigation Report, dated 06/05/25, incident category as abuse and incident signed by the Administrator on 06/12/25. PIR indicated the incident occurred 06/05/25 at 3:20 a.m. on the secure unit. PIR indicated Resident #87 and Resident #106 had a un-witnessed resident-to-resident incident, both on the secure unit. Description of the Allegation: Resident #106 was noted in the hallway by [LVN M] and stated that someone had come into his room. DON asked if the other patient hit him, and he stated: no, he swung first so I have a right to defend myself. So I hit him. Resident #87 would not give a statement at this time. PIR indicated LVN M provided head to toe assessment to Resident #87 and Resident #106 on 06/05/25 indicating Resident #87 had raised area noted to forehead and small laceration to upper lip, reddened nose and Resident #106 no visible injuries. PIR indicated Provider Response: patients were immediately separated, both patients were placed on one-on-one, roommate of Resident #106 was immediately removed, Neuro-checks initiated on Resident #87, both Residents immediately assessed for injuries and treated, MD/ RP/ PD/ Psych were notified, In-services, Safe surveys and Staff interviews initiated. PIR indicated Investigation Summary:Upon receipt investigation was immediately initiated. Admininistrator interviewed Resident #106 on the incident. Mr. (Resident #106) stated, I was lying in bed and he came into my room mumbling to himself. I screamed at him to leave and he sat down in my wheelchair. So I got up and hit him so he would leave. Administrator asked if Mr. (Resident #87) hit him, Mr. (Resident #106) stated no. Admin asked him if he would go to the psych hospital, he stated no, there is no reason for me to go, I just want to go home and you can't keep me here. Administrator went to get DON, and Social Worker in regards to possible discharge. Administrator, DON and Social Worker went back to speak with (Resident #106). Resident at this time has changed his statement to Mr. (Resident #87) came in his room, stood over his bed and would not leave then sat down in his wheelchair. Then proceeded to change statement again that he (Resident #106) came in yelling and drug me out of the bed, while I was screaming, so I had to defend myself and I hit him, and I just want to go home now. Re-educated at this time it is not appropriate to touch other residents and psych would come see him and further explain the benefit of a behavioral hospital. Resident stated Fuck you. I am not going anywhere but home and I want to go today, you cannot hold me here.Social worker asked how he would have care at home, and he said his friend is a caregiver and they live together. Explained we would notify MD for discharge orders and set up home health, but would take a little time, and he stated I am not waiting, I am leaving today. Friend was notified. Resident #106 discharged AMA home with Friend. APS was contacted. Administrator went to interview Mr. (Resident #87) about what happened last night. Mr. (Resident #87) stated that he was in a car wreck in the middle of the night. I asked him if he was hurting or if he felt safe, Mr. (Resident #87) said yea, I am ok, but my car isn't. It's broke now. Admin reported the statement to charge nurse. Mr. (Resident #87) was sent out later for delusions per MD/ Psych. Admin then interviewed (Resident #106) roommate in regards to incident. Admin asked if he saw or heard anything. Roommate stated I didn't hear or see anything, he couldn't have been too loud. Roommate BIMS of 10. Safe surveys completed with no negative findings. Staff interviews completed with no negative findings. In-servicing completed, Provider investigation findings: Unconfirmed, action taken post-investigation: Safe surveys completed with no negative findings, staff interviews completed with no negative findings and In-servicing completed. Record review of the facility's employee sign-in sheet for the Memory Care Unit dated 06/04/25 indicated LVN M, CNA QQ, and CNA RR worked the 10p to 6a shift when the altercation between Resident #87 and Resident #106 to place. Record review of facility's census report dated 06/18/25 indicated the Memory Care unit had a census of 19 males and 16 females. The DON highlighted and identified 18 residents on the Memory Care unit who wander. (continued on next page)

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	455001	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Beaumont	4195 Milam St Beaumont, TX 77707

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/19/25 at 8:39 a.m., LVN N said she worked the 6a to 2p shift on the memory care unit on 06/05/25. LVN N said Resident #87 had a history of delusions, self-propelled wheelchair pacing and often wandered into other resident's (on the memory care) rooms because he thought they were his room and he would start undressing himself to get in the bed. LVN N said staff would often re-direct Resident #87 out of other resident's rooms and to his own room. LVN N said on the morning of 06/05/25 Resident #87 did not know what happened and that he thought the police or Nazis were after him. LVN N said she notified the Resident's physician of the incident and was given orders to send him to behavior hospital. LVN N said Resident #87 was not acting any different from his baseline, because he always had delusions and wandered. During an interview on 06/19/25 at 6:13 p.m., the Administrator said she was the Abuse Coordinator and was the one responsible for investigation of the 06/05/25 altercation between Resident #87 and #106. The Administrator said Resident #106 had changed his statement multiple times, one story was a man came into his room stood over his bed and hit him, then later Resident #106 claimed he had to protect myself because Resident #87 tried to drag him out of bed and so he hit him. The Administrator said Resident #106 was mad, refused behavior center. When he went to hospital no medication changes. He was mad the police did not talk to him after incident. Roommate was interviewed and unaware of incident until resident screamed. Negative sex offender. UTI/ labs were off before the incident. Admin said there was nothing she would have done differently Resident #106 had no history of aggression and no issues with abuse. During a phone interview on 06/19/25 at 11:25 a.m. CNA QQ said she worked the 10p to 6a shift on the Memory Care unit female hall and on 06/05/25 CNA RR on the men's side of the hall called her to come help, which left the women hall unattended. CNA QQ said that Resident #87 was in Resident #106's room and said Resident #87 was standing over Resident #106's who was in bed. CNA QQ said she removed Resident #87 from the room and hollered for a nurse. CNA QQ said Resident #87 was bleeding from his face, lip and hands. CNA QQ said she could tell because there was blood coming from both his hands and his face. CNA QQ said they could use some help or use more help if they could get one more CNA to help monitor the residents because a lot of them wander into rooms. CNA QQ said that there's only two CNA's and one nurse working on the night shift she said there's a large amount of residents that wander into other residents rooms they redirect them and take them back to their room, they offer snacks, they may even get extra blankets if they're cold. CNA QQ said on 06/05/25, 2 CNAs came from unit 100 to help until after the police and EMS had been there and then they went back to their hall and she went back to the women's side and she says no one sat with Resident #87 or Resident #106. During a phone interview on 06/19/25 at 1:43 p.m. LVN M said she was the nurse on duty 10p to 6a on 06/05/25 on the Memory Care unit. LVN M said she was leaving the nurses station and Resident #106 was coming towards nurses station from his room in a wheelchair with blood on his hands saying he had the right to defend himself. LVN M said Resident #106 told her Resident #87 came in his room swinging at him, he had the right to defend himself. LVN M said Resident #87 had a raised area on his head, skin tears on both arms, and had a small cut on the upper lip. LVN M said Memory Care unit staffing at night was one CNA for each hall and one nurse for the entire unit. LVN M said there is enough help to provide care with only one CNA, and when they have to go to lunch another staff from 200 hall would come to help. LVN M said Resident #87 had been in his room most of the night, and no one saw when he left his room and entered Resident #106's room. LVN M said after the altercation Resident #106 and Resident #87 had been on one to one but she could not remember which staff did the 1 to 1 monitoring. LVN M said at night the LVN has to do frequent rounds and frequent redirection of the residents who wander. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 06/19/25 at 12:45 p.m. CNA RR said she was working the floor 10p to 6a on 06/05/25 on the Memory Care unit, men's hall. CNA RR said she left her men's hall to go assist CNA QQ (women's hall) with care and LVN M came and got them to assist Resident #87 who was standing in the hall bleeding but not bad back to his room. CNA RR said Resident #106 was sitting in a wheelchair in the hall outside the door, and Resident #87 had said someone was in his room Resident #106. CNA RR said Resident #106 told her Resident #87 was standing over him and he needed to defend himself so he hit Resident #87. CNA RR said they helped put Resident #87 back in the wheelchair and put him in his room. CNA RR said Resident #87 had been in bed most of the night but must have gotten up, and usually when Resident #87 does wander into someone else's room they redirect him back to his room or they'll sit with them. CNA RR said she thinks Resident #87 got up to use the bathroom and lost his way back to the bed, went to his old room where Resident #106 was. CNA RR said Resident #106 had never had contact or an altercation that she knows of with any other resident. CNA RR said she did the 1 to 1 and CNA QQ sat with Resident #106 and they didn't call for extra staff. Interview on 06/19/25 at 5:30 p.m., the DON said that one nurse and two CNAs was sufficient because they had 35 residents in the Memory Care unit. She stated that they try to have additional staff on the day shift, the transportation person, when she is not doing transportation, is back there or hospitality aides. She stated that on the evening shift the nurses from hall 200 or 100 will go back there to help but it wasn't assigned to any particular person. The charge nurses were responsible to ensure the Memory Care unit was covered and if they couldn't get any one to help out they let me know. It was always one nurse and two CNAs, one for female side and other for male side. The DON said she was notified that Resident #87 had wandered into Resident #106 room and there was an altercation where Resident #106 hot Resident #87. The DON said LVN M was rounding and saw Resident #106 come out of his room saying he had to protect himself from Resident #87.The DON said LVN called the CNAs for Help and separated the residents She said Resident #106 had only been on the Memory Care unit for 2 days when the incident occurred. She said as an intervention, they placed both Resident #87 and #106 on 1:1 supervision until Resident #87 was sent to the hospital and #106 left AMA that same day. Record review of the facility's Abuse Neglect and Exploitation policy, revised dated April 2021, read in part, . 3. Ensure adequate staffing and oversight/support to prevent burnout stressful working situations and high turnover rates . Record review of the facility's Behavioral Assessment Intervention and monitoring policy dated revised dated March 2019, read in part, .11. The Director of Nursing or Designee will evaluate whether the staffing needs have changed based on acuity of the residents and their plans of care additional staff and our staff training will be provided if determined that the needs of the residents cannot be met with the current level of staff or staff training . An Immediate Jeopardy/Immediate Threat was identified on 06/19/25 at 4:50 p.m. The Administrator was notified of the Immediate Jeopardy on 06/19/25 at 5:08 p.m. The IJ template was provided to the facility on [DATE] at 5:18 p.m. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. The facility's Plan of Removal for the Immediate Jeopardy was accepted on 06/19/25 at 9:29 p.m. and reflected the following: Plan to Remove Immediate Jeopardy (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to adequately supervise residents to implement interventions to protect residents from injuries from resident-to-resident abuse. The facility did not implement interventions to include adequate supervision prior to the incident or following the incident for all residents at risk for injuries related to wandering behaviors. On 6/5/25, resident #87 was discharged to the behavioral hospital for evaluation. On 6/5/25, a full assessment and prompt medical attention was provided to resident #87 by the assigned LVN. On 6/5/25, resident #10 refused a full assessment by the nurse. Resident #87 and Resident #106 were immediately separated by the charge nurse and certified nursing assistants on 6/5/25. Resident #106 and resident #87 immediately had a staff member monitoring them one on one until resident #87 was discharged to the behavioral center for delusions/hallucinations, on 6/5/25. Resident #87 remains at the behavioral center at this time. On 6/19/25 the Director of Nursing, Regional Nurse Consultant, and Nursing Facility Administrator began conducting all staff in-service's for Abuse and Neglect, de-escalating resident behaviors, and monitoring residents while they wander, including residents who pace and potentially would wander into another resident's space. All staff will be in-serviced prior to the beginning of their next shift. Any new hires and/or agency staff will be in-serviced prior to their first shift on the floor, by the Director of Nurses or designee. The Director of Nursing or designee will question 3 random staff members weekly X4 weeks to ensure comprehension of the new procedures. On 6/19/25 an in-service was initiated by the Director of Nursing, Regional Nurse Consultant, and Nursing Facility Administrator to ensure staffing patterns are increased to ensure that there are two staff members present on each hall of the facility secured unit at all times. If there are two staff required to perform care on a resident, there will be another staff member called in to the secured unit to supervise while two are performing care. When one staff member steps out for any reason, another staff member will take their place in the secured unit, to ensure adequate supervision of wandering residents. Any new hires and/or agency staff will be in-serviced prior to their first shift on the floor, by the Director of Nurses or designee. The Director of Nursing or designee will question 3 random staff members weekly X4 weeks to ensure comprehension of the new procedures. On 06/19/2025 Ad-Hoc QAPI Held with Medical Director, Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Regional Nurse Consultant to review the alleged deficiency, policy and procedure and the plan of removal of immediacy. The Nursing Home Administrator will be responsible for ensuring the plan is completed on 06/19/2025. The RDO/Designee will provide oversight of Nursing Home Administrator and Director of Nurses, to ensure that the items on the plan of removal are reviewed and completed. Monitoring of the facility's Plan of Removal included the following: Observation and interview on the secure unit on 06/20/25 at 2:15 p.m. indicated Resident #87 and #106 no longer resided in the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observed and interview 06/20/25 at 2:15 p.m. with the RDO/Designee indicated she was in the facility rounding and providing oversight to Nursing Home Administrator and Director of Nurses, ensuring that the items on the plan of removal are reviewed and completed. Inservice sign-in sheet reviewed with 66 staff signatures indicating participation , and included staff to ensure staffing patterns are increased to ensure that there are two staff members present on each hall of the facility secured unit at all times. If there are two staff required to perform care on a resident, there will be another staff member called in to the secured unit to supervise while two are performing care. When one staff member steps out for any reason, another staff member will take their place in the secured unit, to ensure adequate supervision of wandering residents Interviews conducted on 06/20/2025 from 2:15 p.m. through 4:00 p.m. and 9:45 p.m. through 11:30 p.m. representing staff from various shifts (6a.m.-2p.m., 2p.m.-10p.m.,& 10p.m. -6a.m.) included the following staff: CNA SS, CNA PP, CNA RR, CNA WW, CNA K, CNA QQ, CNA AAA, CNA BBB, CNA CCC, CNA LLL, LVN MMM, LVN N, LVN M, LVN TT, LVN, R, LVN VV, MDS LVN JJJ, MDS LVN FFF, RN UU, ADON E, ADON/ IP, Environmental supervisor, HK BB, HK XX, DM, Maintenance Assistant ZZ, Laundry DDD, dietary aide EEE, Staffing, ST NNN, ST KKK, ABOM, Receptionist GGG, Medical Records HHH, PTA, SW. All staff were able to identify the different types of abuse, who to report any incidents of abuse de-escalating resident behaviors, and monitoring residents while they wander, including residents who pace and potentially would wander into another resident's space, what to do if they witness resident to resident abuse, what signs to watch for in residents to prevent resident to resident abuse,. Examples were given. To remove from reach of others, increase supervision of wandering by monitoring while they are wandering, and/or engaging in activity. Staff indicated they were to be aware of resident behaviors, monitor for behaviors, and how to de-escalate behaviors. Staff knew they were to separate residents immediately and ensure residents were safe. Staffing patterns were increased to ensure that there are two staff members present on each hall of the facility secured unit at all times. If there are two staff required to perform care on a resident, there will be another staff member called in to the secured unit to supervise while two are performing care. When one staff member steps out for any reason, another staff member will take their place in the secured unit, to ensure adequate supervision of wandering residents. All staff were able to identify the responsibilities for supervision and monitoring residents. Nursing staff identified that effective immediately 2 CNA were to be assigned to female hall and 2 CNAs to male hall of the Memory Care during the 10p to 6a shift due to increased amount patients with wandering. Staff interviewed said they had to be relieved before going on break/meal. All staff aware of supervising and monitoring is a preventive or proactive intervention. During an interview on 06/20/2025 at 10:05 p.m., the Administrator and DON said the corporate office approved to have 2 CNAs for each hall (male and female hall) assigned to the Memory Care unit 10:00 p.m. to 6:00 a.m., on the unit at night as a permanent change in scheduling. She said all staff had received the additional training as outlined on the POR except for a couple of staff that were out on leave and would receive the required training before returning to work. She stated next week she would start the questioning of 3 random staff members weekly X4 weeks to ensure comprehension of the new procedures and in-service information. Record review of the POR binder included: Record review of Ad-Hoc QAPI agenda sign in page dated 06/19/25 held with Medical Director, Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Regional Nurse Consultant to review the alleged deficiency, policy and procedure and the plan of removal of immediacy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Training records of 82 staff with completion dates ranging from 06/19/25-06/20/25 to identify the different types of abuse, who to report any incidents of abuse de-escalating resident behaviors, and monitoring residents while they wander, including residents who pace and potentially would wander into another resident's space, what to do if they witness resident to resident abuse, what signs to watch for in residents to prevent resident to resident abuse. Training records of 66 staff with completion dates ranging from 06/19/25-06/20/25 for staffing patterns being increased to ensure that there are two staff members present on each hall of the facility secured unit at all times. If there are two staff required to perform care on a resident, there will be another staff member called in to the secured unit to supervise while two are performing care. Responsibilities for supervision and monitoring residents. When one staff member steps out for any reason, another staff member will take their place in the secured unit, to ensure adequate supervision of wandering residents. An Immediate Jeopardy (IJ) was identified on 06/19/25 at 4:50 p.m. The IJ template was provided to the facility on [DATE] at 5:18 p.m. While the IJ was removed on 06/20/25, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents receiving enteral feeding received appropriate care and services to prevent complication of enteral feeding for 1 of 1 resident (Resident #2) reviewed for enteral feeding. The facility failed to ensure LVN Q mixed each crushed medications with water and administered one medication at a time when giving medications to Resident #2 through his G-tube (a tube inserted through the wall of the abdomen directly into the stomach which allows the delivery of nutrition, fluids, and medications directly into the stomach). The facility failed to ensure LVN Q administered Resident #2's G-tube medications by gravity, and instead she pushed the medications using the plunger of the syringe. These failures could place residents receiving enteral nutrition and medications at increased risk of not receiving proper nutrition, infection, and aspiration. Findings include: Record review of a face sheet dated 06/18/25 indicated Resident #2 was a [AGE] year-old male and admitted to the facility 08/26/21. His diagnoses included cerebral infarction (a type of stroke that occurs when blood flow to the brain is blocked causing brain tissue to die), dysphagia (difficulty or discomfort swallowing) and gastrostomy (G-tube). Record review of a care plan last revised 02/22/25 indicated Resident #2 was NPO (nothing by mouth) and was to receive all feedings, water, and medications via his G-tube. Interventions included to give medications as ordered. Record review of the most recent quarterly MDS dated [DATE] indicated Resident #2 had unclear speech and was sometimes understood and usually understood most conversation. He had a staff assessment for mental status indicating moderate cognitive impairment, required substantial/maximal assistance with most ADLs, and required a feeding tube for all nutrition and fluid intake. Record review of physician orders dated June 2025 indicated Resident #2 was NPO (nothing by mouth) and was to receive all feedings, water, and medications via G-tube. Orders indicated flush tubing with 30cc water before and after medication pass and 5cc water after each medication. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of medication administration and interview on 06/17/25 at 8:35 a.m., LVN Q crushed six medication tablets together and poured them in a measured drinking cup. She then added one scoop of laxative powder to the crushed tablet mixture. She then added 35ml of liquid medications to the medication powder in the measured drinking cup. She mixed the contents of the cup with water to the fill line of 200ml. She washed her hands and gowned and gloved. She checked placement of the G-tube by aspirating stomach contents and flushed the tubing with 30ml water. She then added the medication mixture to the open syringe connected to the G-tube and added more water to keep the mixture flowing. The mixture stopped flowing and she placed the plunger into the open end of the syringe, pushed it down approximately 1 inch and rocked the plunder side to side. The fluid began flowing again and stopped again. She repeated inserting the plunger into the open syringe approximately 1 inch and moved the plunger from side to side. The fluid began flowing again. She removed the syringe and the fluid flowed by gravity and stopped again. LVN Q again inserted the plunger into the syringe and moved it side to side. The rest of the medication flowed down the G-tube. She flushed the tubing with water and removed the syringe from the tubing and capped the tubing. During an interview on 06/17/25 at 9:00 a.m., LVN Q said Resident #2 did not have an order to cocktail his medications together. She said she normally gave meds one at a time, but she was being watched and was nervous, so she gave all the meds mixed together to get them given faster. She said the facility policy said G-tube meds should be given one at a time and the facility had checked her off on giving G-tube meds and she did them one at a time. She said she should have given the meds one at a time. She said Resident #2's G-tube usually flowed freely, and she felt giving all the meds at once had caused the flow to stop several times. She said she knew she was not supposed to plunge medications through the G-tube using the plunger, but she didn't think it would hurt the resident if she just inserted the plunger and rocked the plunger to get the liquid flowing. She said she did not feel that rocking the plunger created pressure in the G-tube, it just got the fluid flowing. She said possible negative outcome for cocktailing all the medications together could be a clogged G-tube. She said she did not see a possible negative outcome for rocking the plunger in the syringe of the G-tube. During an interview on 06/18/25 at 10:20 a.m., the DON said she expected all nurses to follow the facility policy when administering G-tube medications. She said the policy indicated to administer one medication at a time diluted by water and to never use the piston (plunger) of the syringe when flushing the G-tube or administering medications. She said LVN Q was observed during her orientation and yearly giving G-tube medications and during the observations she administered one medication at a time diluted in water and flushed the G-tube with water using gravity flow. She said giving all the medications at once could cause the G-tube to clog. She said using the plunger to unclog the G-tube could cause injury to the Resident. Record review of a skills observation of administering medications/feedings through an enteral feeding tube dated 05/01/25 indicated LVN Q was competent of administer medications though a G-tube. Record review of the facility policy titled Administering Medications through an Enteral Tube revised March 2015 indicated .The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube. Do not mix medications together prior to administering through the enteral tube. Administer each medication separately unless resident has a physician's or order to mix (cocktail) medication.This procedure is contraindicated if the tube is obstructed or improperly positioned.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 percent. There were 3 errors out of 27 opportunities, resulting in an 11.11% percent medication error involving 1 of 4 residents reviewed for medication pass. (Resident #28) LVN P administered Primidone (used to treat tremors) at 7:50 a.m. (the physician ordered Primidone be given daily at hour of sleep) and administered Artificial Tears 2 drops each eye instead of the ordered Pataday eye drops (itch relief eye drops) 1 drop each eye for Resident #28. These failures could place residents at risk for inaccurate drug administration resulting in decline in health and decreased quality of life. Findings included: Record review of a face sheet dated 06/18/25 indicated Resident #28 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included bipolar disorder (associated with episodes of mood swings ranging from depressive lows to manic highs), diabetes mellitus type 2 (chronic condition that affects the way the body processes blood sugar), myopia (a condition in which close objects appear clear, but far ones don't), and presence of intraocular lens (the eye's natural lens had been replaced with an artificial lens, most commonly during cataract surgery). Record review of a care plan last revised 12/12/24 indicated Resident #28 had an alteration in neurological status and was to be monitored for signs and symptoms of tremors. Record review of a care plan last revised 12/12/24 indicated Resident #28 had impaired visual function r/t myopia and had a prescription for Pataday eye drops. Record review of a quarterly MDS dated [DATE] indicated Resident #28 had a BIMS score of 13 indicating her cognitive function was intact and she required partial/moderate assistance with most ADLs. During an observation and interview on 06/19/25 at 07:50 a.m. LVN P administered medications to Resident #28. She administered Primidone 50mg ½ tablet orally. She then administered Artificial Tears 2 drops to each eye. LVN P said she was administering the Artificial Tears as a substitute for Pataday eye drops because Artificial Tears was the eye drop that the facility kept in stock. Record review of the June 2025 physician order summary on 06/20/25 at 07:50 a.m. indicated Resident #28 was to receive Primidone 50mg ½ tablet orally at hour of sleep for tremors and Pataday ophthalmic solution 0.7% 1 drop to both eyes one time a day for allergies. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Beaumont	4195 Milam St Beaumont, TX 77707

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 06/20/25 at 8:45 a.m., LVN P said she realized she had given the Primidone in error because it was ordered to be given at hour of sleep. She said she was nervous being watched and administering medications with printed paper MARs due to the Wi-Fi outage and gave the medication by mistake. LVN P said she was told by the Central Supply Assistant that the facility gave Artificial Tears in place of Pataday eye drops. She said she did not call the physician to obtain a substitution order for the eye drops. She said she gave 2 drops each eye because that was what she thought the order said. She said Resident #28 did not receive her medications as ordered by her physician. LVN P said she had worked at the facility for 2 months and that she had never been observed by the DON or administration giving medications. She said she trained with other charge nurses and then started administering medications without supervision. During an interview 06/20/25 at 10:20 a.m. the DON reviewed Resident #28's June 2025 MAR and said her Primidone was ordered to be given at hour of sleep and there was no order to Administer her Primidone in the morning. She said the facility kept Artificial Tears in stock, but to administer them in place of Resident #28's ordered Pataday 1 drop each both eyes daily the physician would have to be contacted and approve the substitution. She said Resident #28 had no order to indicate that Artificial Tears could be administered in place of her ordered Pataday eye drops. The DON said she would report the medication errors to the physician and the Administrator. She said she would also review the errors with LVN P and work with her in the classroom with medication administration. She said these medication errors could have a negative effect on Resident #28 and the nurses would continue to monitor her. During an interview on 06/20/25 at 10:35 a.m., the Central Supply Assistant said she had asked LVN P if she could call Resident #28's physician and ask if Artificial Tears could be substituted for her ordered Pataday eye drops. She said she kept the Artificial Tears in stock and the Pataday would be a special order. During an interview on 06/20/25 at 1:20 p.m., the Administrator said the DON had reported the medication errors made during observation of med pass. She said she expected that all Medications would be given as ordered by the physician. She said the possible negative outcome of medication errors was residents not receiving medications as ordered by the physician. Record review of an Administering Medications policy revised April 2019 indicated . Medications shall be administered in a safe and timely manner, and as prescribed 4. Medications are administered in accordance with prescriber orders, including any required timeframe

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles and provide separately locked, permanently affixed compartments for storage of controlled drugs for 1 of 21 residents (Resident #64) and 1 of 3 medication rooms reviewed for storage of medications and biologicals. 1. The facility failed to ensure the lockbox for controlled medications was permanently affixed to the refrigerator in the Hall 300 medication room. 2. The facility failed to ensure Resident #64's medication was secured inside the locked medication cart in the women's unit on Hall 300. These failures could place residents at risk of not receiving prescribed drugs or contaminated medication. Findings included: 1. During an observation and interview on 06/18/25 at 1:17 p.m. of the Hall 300 medication room the lockbox for controlled medications was locked but not permanently affixed to the refrigerator. LVN N said she had never seen the lockbox secured to the refrigerator. During an observation and interview on 06/18/25 at 1:27 p.m., the DON viewed the controlled medication lockbox for hall 300 in the refrigerator and said it had been secured to the refrigerator with bolts and she was unsure when the bolts were removed or how long it had not been affixed. She said it was required that the lockbox to be permanently affixed to the refrigerator to prevent drug diversion. She said she would immediately get maintenance to affix the lockbox to the refrigerator. During an interview on 06/18/25 at 2:30 p.m., the Administrator said she expected controlled medication lockboxes to be permanently affixed to medication room refrigerators as required by federal and state regulations. She said the possible negative outcome for not having the lockbox affixed inside the refrigerator could be drug diversion. 2. Record review of a face sheet dated 06/16/25 indicated Resident #64 was an [AGE] year-old-female readmitted on [DATE] with a diagnosis of hypertension (high blood pressure). Record review of physician orders dated 06/16/25 indicated Resident #64 was prescribed enalapril 20 mg two times a day for hypertension with a start date of 05/20/21. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #64 had severely impaired cognition with a diagnosis of hypertension. Record review of a care plan with a target date of 07/24/25 indicated Resident #64 had a history of hypertension and received enalapril. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 06/16/25 at 1:15 p.m. the women's side of the locked unit nurse's medication cart was parked beside the dining room unattended with a medication storage card of Enalapril (medication to lower blood pressure) 20 mg BID with 1 broken tab in the card not punched out lying on top of the medication cart. No staff was observed in sight of the medication cart. LVN R was observed retrieving resident's trays from the dining room. LVN R said she responsible for the nurse's medication cart. She said she walked away from the medication cart in doorway of the dining area to remove resident trays. LVN R said she should not have left the medication card on top of her nurse's medication cart unsecured. She said she pulled Resident # 64's medication card to get it replaced and should not have left it on top of her med cart. She said she was educated and knew not to leave medication unsecured. LVN R said the resident risk of a medication left unsecured on top of a medication cart was a resident could take it and possibly have an allergy to the medication or her blood pressure could drop if a resident took it that it did not belong to. During an interview on 06/18/25 at 10:30 a.m., the DON said LVN R should not have left Resident #64's medication card unsecured on the nurse medication cart. She said all nurses were educated on keeping all medication secured. The DON said the resident risk of a medication unsecured on top of nurse's medication cart was a resident could take it and potentially have an adverse reaction. During an interview on 06/18/25 at 10:42 a.m., the Administrator said the LVN's giving medication were responsible for ensuring all medication was secured and all residents were safe. She said the nurses were all educated on securing medication. She said the resident risk of a medication left unsecured was a resident could take it and potentially have side effects. The Administrator said her expectation was all medications locked and secured with no available access by any other staff or residents. Record review of a facility policy titled Medication Labeling and Storage dated revised 02/23 indicated, .The facility stores all medication and biological in locked compartments under proper temperature, humidity and light control. Only authorized personnel have access to keys.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on interviews, and record reviews, the facility failed provide sufficient support personnel to carry out the functions of the food and nutrition service safely and effectively for 3 out of 12 dietary staff (Dietary staff D, Dietary staff B, and Dietary staff C). The facility did not ensure Dietary staff D, Dietary staff B, or Dietary staff C had current food handler permits. This failure could place residents who consumed food prepared from the kitchen at-risk of foodborne illness or nutritional deficiencies. Findings included: Review of the food handler's certificates of completion provided by the facility on 06/16/2025 at 1:00 p.m., indicated the following: Dietary staff D had a food handler certificate that expired on 01/08/2025. Dietary staff B had a food handler certificate that expired on 01/10/2025. Dietary staff C had a food handler certificate that expired on 01/10/2025. An attempted telephone interview on 06/18/2025 at 09:57 a.m. with Dietary staff B was unsuccessful. An attempted telephone interview on 06/18/2025 at 09:58 a.m. with Dietary staff C was unsuccessful. During a telephone interview on 06/18/2025 at 10:00 a.m. with Dietary staff D, he said he had mistakenly thought his food handler certificate would not expire until September 2025. He said he must have looked at it incorrectly. Dietary staff D said he had been employed at facility since 2016. He said a negative outcome of not having an updated food handler certificate would be potential for food-borne illnesses and cross contamination. During an interview on 06/18/25 at 09:00 a.m., the DM said the 3 dietary staff (Dietary staff D, Dietary staff B, and Dietary staff C) with expired food handlers' certificates had been working on a full-time basis since the expiration dates of January 2025. She said she had mentioned to them that their certificates needed to be renewed and was told they assumed they were good until the end of 2025. She said she failed to follow through on making sure they were renewed. She said the employees were responsible for keeping their certificates up to date, however she should have reviewed to ensure they were. The DM stated she relied on her staff to ensure their trainings were up to date. She said cross contamination and not being up to date with latest material as an ongoing training basis could pose negative outcome for residents who eat meals prepared from facility kitchen. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/19/2025 at 3:00 p.m., the Administrator stated she expected the DM to ensure the dietary staff had their food handler certificates within 30 days of hire and before they expired. The Administrator stated the importance of obtaining and maintaining the food handler certificate training was to teach staff how to prevent food-borne illness and cross contamination. Record review of facility policy titled Education and Training dated revised 10/2022 indicated the following. All employees will be provided education and training upon hire and ongoing to ensure that they have the appropriate competencies and skill sets to carry out the functions of the food and nutrition services, taking into consideration the needs of the resident population.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 2 residents reviewed for infection control. (Resident #49) The facility failed to ensure CNA S performed proper hand hygiene while assisting to feed Resident #49. This failure could place residents at risk for cross contamination and the spread of infection. Findings include: Record review of a face sheet dated 06/16/25 indicated Resident #49 was a [AGE] year-old-female readmitted on [DATE] with a diagnosis of dementia (a group of thinking and social symptoms that interfere with daily function). Record review of the quarterly MDS assessment dated [DATE] indicated Resident #49 was severely impaired of cognition with a diagnosis of dementia and needed maximum assistance with eating. Record review of a care plan with a target date of 07/07/25 indicated Resident #49 had required a regular diet and had a history of refusing assistance. During an observation and interview on 06/16/25 at 10:10 a.m., Resident #49 was sitting in her wheelchair, she said the food was good here and she got plenty to eat. During an observation and interview on 06/16/25 at 12:30 p.m., CNA S said she was responsible for providing care for Resident #49 today. She was assisting feeding Resident #49 by scooping food with Resident# 49's spoon and feeding Resident #49. After about 3 minutes she got up, walked to another resident, performed hand hygiene with ABH gel and sat down and assisted feeding the resident by scooping food with her spoon and feeding the resident. After a few minutes CNA S got up, walked to Resident #49 without performing hand hygiene, and assisted feeding her. After a few minutes CNA S got up, walked to another resident, performed hand hygiene with ABH gel and started assisting feeding her. After a few minutes CNA S got up, did not perform hand hygiene, walked over to Resident #49 and started assisting feeding her by scooping food with her spoon without hand hygiene a second time. After surveyor intervention CNA S, when asked if she forgot anything or missed anything, she said she did not perform hand hygiene between residents. She said she was educated and knew to perform hand hygiene between each resident. CNA S said her most recent reeducation on hand hygiene was last month. She said she was checked off on feeding residents with the DON on hire. CNA S said the potential resident risk was possible cross contamination between residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/18/25 at 10:30 a.m., the DON said CNA S should have performed hand hygiene between each resident. She said the ADON/ IP did audits randomly to monitor staff performing resident care and ensured staff were performing hand hygiene with care as required. She said the CNAs were checked off on hand hygiene on hire, yearly and as needed. The DON said all staff have been educated to perform hand hygiene between residents. She said the resident risk was a potential to break infection control. The DON said her expectation was staff to perform hand hygiene per policy before and after an interaction with a resident. During an interview on 06/18/25 at 10:36 a.m., ADON/ IP said she was the infection preventionist and ADON. She said CNA S should have cleaned her hands between residents during resident care. The ADON/ IP said she and the DON trained the staff on infection control and hand hygiene and checked off all staff on hand hygiene. She said the staff was educated on hand hygiene between resident care. The ADON/ IP said the resident risk of improper hand hygiene while feeding a resident was the potential sharing of germs or pass an infection from one resident to another. During an interview on 06/18/25 at 10:42 a.m., the Administrator said CNA S should not have fed a resident without performing hand hygiene per policy. She said CNA S was responsible for ensuring proper hand hygiene with resident care. The Administrator said all staff have received hand hygiene education. She said the resident risk of improper hand hygiene during resident care was the potential to pass bacteria or spread germs between residents. The Administrator said her expectation was all staff follow the policy of the facility and complete hand hygiene as required and instructed. Record review of a facility policy titled, Handwashing/Hand Hygiene dated 2001, indicated, . 1. Hand hygiene is indicated: a. immediately before touching a resident; b. before performing an aseptic task . c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. after touching a resident's environment; .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observations, interviews, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 laundry room reviewed for essential equipment. The facility did not ensure 4 of 4 dryers were working in safe operating condition. This failure could place the residents at risk not receiving their clothes in a timely manner. Findings included: During a group interview on 06/17/25 at 8:59 a.m., 6 alert and cognitive intact residents. Residents said the facility had building sprayed a couple weeks ago. Resident # 17 and Resident #15 said the linen was dingy, and they have had a hard time getting linen for their beds. They said the sheets did not fit the beds properly and had holes in linen or were thin. Resident # 26 said they need new linens and towels without stains. During an observation on 06/17/25 at 10:00 a.m., the Laundry Supervisor said all 4 dryers were broken as she pointed to the broke dryers. During an interview on 06/17/25 at 11:15 a.m., CNA L said the linen closet did not have linen right now and said she could go check the other halls. During an interview on 06/18/25 at 11:40 a.m., CNA J and CNA K said they must wait or get some linen off another hall if there is linen there. They said the laundry supervisor will have linen when she gets back from the laundry mat. During an interview on 06/18/25 at 1:00 p.m., Maintenance Supervisor was aware the dryers in the laundry were all broken the last dryer went down Friday. He said the laundry supervisor had been using the laundry mat since Friday to dry the linen and personal clothes for the residents. During an interview on 06/18/25 at 2:00 p.m., the Administrator said she had notified the appliance repair person for the dryer which broke Friday. She said the parts had been ordered for the other dryers. She said the laundry supervisor would continue to go to the laundry mat. She said she expectation was for the facility to be maintained with a homelike environment. She said the resident should have plenty of linen now, they put more out linen, and she just ordered more linen after surveyor intervention. Record Review of the policy Homelike Environment indicated Policy Statement Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. 2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment.e. clean bed and bath linens that are in good condition.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 of 1 staff smoking area reviewed for environmental concerns. The designated staff smoking area was unkempt and had trash buried in the tall grass and weeds, This failure placed the staff and visitors at risk of uncomfortable environment. Findings included: During an observation on 06/16/25 at 1:00 p.m., the grass in courtyard between hall 200 and 300 was approximately 20 inches high and the weeds were over 4 feet tall. There were plastic wrappers trash and, paper towels, and cigarette butts were buried in the vegetation. During an interview on 06/16/25 at 2:00 p.m., Maintenance A said the maintenance department was responsible for ensuring the trash was picked up. He said this smoking area between hall 200 and 300 was for the staff and visitors smoking area. He said the areas should be maintained and be homelike for the residents. He said tall grass could lead to pest coming into the building. He said a contract lawn service was supposed to [NAME]. He said about a month ago, they tried to run a weed eater, but the weed eater broke. During an interview on 06/18/25 at 2:00 p.m., the Administrator said she had been attempting to obtain a contract for lawn services and had one company coming out to [NAME], however, they did not show up. She said she would continue to obtain a lawn service, and have maintenance pick up the trash. She said she the expectation was for the facility to be maintained with a homelike environment. Record Review of the policy Homelike Environment indicated Policy Statement Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. 2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment.e. clean bed and bath linens that are in good condition.