STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455416	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Ft. Worth	8001 Western Hills Blvd Fort Worth, TX 76108

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - 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 observations, interviews and record reviews, the facility failed to ensure that residents were free from abuse for two (Resident #1 and #2) of six residents reviewed for abuse and neglect. The facility failed to protect Resident #1 and #2 from abuse on 05/22/25 when both residents got into a physical altercation and fell to the ground. As a result, Resident #1 sustained a superior endplate fracture suspected at T4 vertebral body (top part of the T4 spinal bone is cracked/broken) and right periorbital hematoma (black right eye). An IJ was identified on 05/28/25. The IJ template was provided to the facility on [DATE] at 1:30 PM. While the IJ was removed on 05/29/25, 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. The failure placed residents at risk for abuse, neglect, and emotional and psychological harm. Findings included: On 05/28/2025 at 1:11 PM Video footage identified by the DON as having occurred during the incident was reviewed on the DON's cell phone. The residents observed in the video were identified by the DON. The video revealed: 0:10 Resident#2 walking on hallway and enters Resident#1 room. No other staff or residents were observed in view. Min 1:06 Resident#1 appeared to be holding Resident#2 by her neck/head and pushing her out of Residents#1's room, Resident#2 had her hands grabbing Resident#1. The residents hit the wall across the hall from Resident#1's room. Resident#2 fell onto her buttocks, then Resident#1 appeared to hit her head on the wall and fell on top of Resident #2 then rolled to the side. min1:45 CNA F walks into frame. Both residents were observed sitting up. Resident #1 appeared to be holding Resident#2's hands then Resident#2 punched Resident #1 on the face. Resident #1 grabbed Resident#2's hand then the video clip ends. (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's face sheet, dated 05/28/25, reflected the resident was a [AGE] year-old female who originally admitted to the facility on [DATE]. Record review of Resident #1's MDS Assessment, dated 03/31/25, reflected she had a BIMS score of 05, indicating severe cognitive impairment. Her MDS indicated she had signs and symptoms of delirium and wandering. Her diagnoses included Non-Alzheimer's Dementia, Orthostatic Hypotension(a sudden drop in blood pressure when a person stands up after sitting or lying down), Traumatic Brain Injury(,damage to the brain caused by an external physical force, often a blow or impact to the head) Depression, Bipolar Disorder(a mental health condition characterized by extreme mood swings, ranging from periods of elevated mood to periods of depression), Psychotic Disorder, Insomnia due to mental disorder'. Record review of Resident #1's care plan, initiated 1/30/2025, reflected the following: Focus: 1/30/25- [Resident #1] had a Behavior problem as evidenced by physical aggression towards other resident/ staff, verbally aggressive towards staff and other residents, coming out of the room without clothes on. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Record review of Resident #1's Progress Notes reflected the following: 05/22/25 at 9:30PM - The writer heard a loud scuffle, and when the writer looked on the camera the writer observed both residents sitting on the doorway on the floor across from each other. The residents [sic] were immediately separated, and the resident was assisted back into bed. The MD was contacted but has not responded. The DON and administrator were made aware of the incident. The resident daughter (daughters name) was called but did not answer. Writer left a voicemail. This entry was written by LVN B 05/22/2025 10:10PM The writer rounded on the resident and rechecked blood pressure. The resident blood pressure is substantially lower than when the incident happened, and the resident c/o's of a headache, so the resident was sent to the ER for evaluation and treatment. DON and the administrator were notified. This entry was written by LVN B. Record review of Resident #1's hospital records, dated 05/22/25, reflected the following: Patient was a [AGE] year-old female who presents to the Emergency department via EMS due to an assault at 7:00 PM by another pt at her rehab facility. EMS was called a few hours after the assault a night nurse check. She is c/o neck pain and a headache. She is only oriented to self. She was given 1 push dose epi (drug used to treat low blood pressure or heart rate), 4L fluid, 4L of O2 and 5 levophed (drug used to treat severe low blood pressure). She denies smoking and drug usage. Per EMS pt had a blood pressure of systolic 56. Record review of Radiology Results Report, CT spine cervical without contrast dated 05/22/2025 reflected: Right periorbital hematoma (bruising around the eye), Superior endplate fracture suspected at T4(fourth thoracic vertebral body). Record review of Resident #1's History and physical assessment dated [DATE] of the skin reflected small laceration with hematoma on the left orbit. (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 #2's face sheet, dated 05/28/25, reflected the resident was a [AGE] year-old female who originally admitted to the facility on [DATE] then readmitted [DATE]. Record review of Resident #2's MDS Assessment, dated 02/15/25, reflected she had a BIMS score of 01, indicating severe cognitive impairment. Her MDS indicated she had signs and symptoms of delirium and wandering. Her diagnoses included Non-Alzheimer's Dementia, Depression, anxiety, Altered Mental Status unspecified. Record review of Resident #2's care plan, initiated 11/17/2022, and revised on 05/24/2025 reflected the following: Focus: [Resident #2] Behaviors: has behavior problem OF Wandering, Physical Aggression toward residents, Verbal aggression towards other residents and staff. Interventions include to Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Record review of Resident #2's Progress Notes reflected the following: 05/22/2025 10:09PM Note Text: The resident was observed on the floor with another in the hallway. She was assessed for apparent injury; none was noted. The resident was redirected back to the dining area. She does not complain of pain or discomfort and is moving all four extremities at her normal baseline. The provider, DON, administrator, and Resident#2 FM (family members name) were notified. Resident#2s (family members name) not answer, and a voicemail was left to call the facility regarding fall. This entry was written LVN B 05/24/2025 12:50pm Late entry Note Text: Spoke with [NAME], NP, with] COMPANY NAME] regarding resident#2 incident with another resident. No new orders his time. This entry was written by DON. 05/26/2025 8:30PM Resident#2 continues ABT. She was given fluids multiple times this shift. Bruising still visible on forehead and hands. Resident was closely monitored to prevent falls. This entry was entered by LVN G 05/27/2025 03:43 am Note Text: Resident#2 continues ABT TX for UTI. Resident resting in bed with eyes closed. Respirations are even and unlabored at 18. No sis of pain or distress noted at this time. Bruising remains visible on forehead and hands. Resident was closely monitored to prevent falls. This entry was entered by LVN H 05/28/2025 04:31 am Note Text: Resident#2 continues PABT TX for UTI day 1/3. Resident resting in bed with eyes closed. Respirations are even and unlabored at 18. No s/s of distress noted at this time. Bruising remains visible on forehead and hands. Resident was closely monitored to prevent falls. Medicated 1 for generalized pain. Nursing will continue to monitor. This entry was entered by LVN H (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a phone interview on 05/27/2025at 9:50am with Hospital Social Worker revealed that Residents#1's FM stated that she was confused. When she admitted at the hospital Resident#1 stated that she was assaulted by her boyfriend. Hospital Social Worker stated that Resident #1 also told the nurse that she was assaulted by her baby's father. The Hospital Social Worker stated that Residents# 1 FM stated that after she had the brain injury Resident#1 would make up stories. Hospital Social Worker stated that Resident #1's FM told her that that FM received a call from the nursing home that Resident #1 was in an altercation, and she had black eye. When the Hospital Social Worker met with Resident#1 on 05/23/2025, the resident was talking and answering questions but then she would change her answers. The Hospital Social Worker stated that Resident #1 had a compression fracture of her thoracic spine and that the resident remained admitted at the hospital. In a phone interview on 05/27/2025 at 11:49 AM with Resident #1's FM revealed that the facility left a voicemail on Thursday 5/22/2025 that Resident#1 had gotten in a scuffle with another resident, and she had a black eye. Resident #1's FM stated the next day Friday 05/23/2025 the hospital called the FM and told her that Resident#1 was admitted at the hospital. Resident #1's FM stated that Resident#1 was initially admitted to ICU, but she had been transferred to a regular room. Resident #1's FM stated that Resident#1 right eye was swollen and bruised, and that Resident #1 also had bruises on her arms. Resident #1's FM stated that Resident #1 had been at the facility for over a year. Resident #1's FM stated Resident #1 had gotten into altercations before, but no one was injured. Resident #1's FM stated that when she was at the facility in the past there was no staff watching the residents. Resident #1's FM stated that Resident#1 had a history of a brain injury, and she remembered her name only. Resident #1's FM stated that she called the nursing facility but they never responded to her calls, they called her on Saturday (05/25/25) and the administrator told her that Resident#1 fell and said she was going to do an investigation. Resident #1's FM stated that she told the administrator that the injuries did not look like she fell. Resident #1's FM told the administrator that it was unacceptable they put her daughter's life in jeopardy, and she was not happy at all. In an interview on 05/27/2025 at 10:49AM with LVN A revealed that she has been employed for about 8 month and worked 6am-2 pm Monday through Friday in the Locked unit. LVN A stated that the altercation between Resident #1 and #2 had happened on the evening shift when she was not there. She stated that Resident #1 had a diagnosis of dementia and traumatic brain injury from car accident. LVN A stated that Resident#1 was physically aggressive to residents, staff or to anyone who did not understand what she wanted. LVN A stated that before Resident #1's behavior was controlled, she would agitate other residents like move their food and push other residents. LVN A stated that she spoke to the nurse practitioner who reviewed and adjusted Resident#1's medication and she has had less behaviors. . LVN A stated that there was one CNA and one nurse on the locked unit. LVN A did not feel like the staffing was sufficient based on the needs and supervision of the residents. In an interview on 05/27/2025 at 11:20am with CTA C she said she had been employed for a year and worked in transportation and when she was not taking residents to appointments, she helped in the locked unit. CTA C stated that she was not at the facility when the altercation happened. CTA C stated that sometimes there had been altercations in memory care. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a phone interview on 05/27/2025 at 12:23pm with CNA F revealed that she had been employed for a year and she worked the evening shift from 2-10 pm. CNA F stated that around 7: 30PM she was documenting on the computer at the nurses' station when she heard a scuffle. She noted that Resident#2 who was not on the couch where she had been sleeping. CNA F glanced at the camera, and she saw Resident#1 and Resident#2 on the floor. CNA F stated she separated the two residents while they were still on the floor. CNA F stated that she was the only staff on the unit at the time of the altercation. CNA F stated that nurse (LVN B) told her she had gone to get medication, she was gone for about 15 min to 30 mins. CNA F stated that she wanted the residents to be safe and not fight again. CNA F stated she walked Resident#1 to her room, assisted to her to bed then told Resident#2 to go towards the dining area. CNA F then called the nurse (LVN B) via telephone and reported that she had found the residents on the floor. CNA F stated that at 8pm while doing her rounds she saw the bump on Resident #1's head and the black eye and reported immediately to LVN B. LVN B assessed Resident#1 and made some phone calls then the nurse mentioned that she was going to send Resident#1 to the hospital. CNA F stated that the bump on Resident#1 did not show when she initially separated the residents. CNA F stated that Resident #2 would walk on the hall; she was a high fall risk and could be combative. Resident#1 and Resident#2 had a history of aggression towards each other, and they needed to be separated. CNA F stated that there had been previous altercations between Resident#1 and Resident#2 and the staff separated them to make sure they were safe. CNA F stated that she had been documenting on Residents#2's aggression and refusing care. CNA F stated that Resident#1 showed aggression towards Resident#2 sometimes. CNA F felt that she could manage the unit but with dementia units it would be better to have additional staff because the midst of dealing with the altercation she had another resident who was trying to get up. CNA F stated that the unit was staffed with one CNA and one nurse per shift. CNA F stated sometimes there was only one staff member on the unit, when the other one steps out for lunch. CNA F stated the residents were not one on one care supervision. An attempt on 05/27/2025 at 12:12pm to interview LVN B via telephone was unsuccessful. Second attempt on 05/27/2025 at 12:52PM to interview LVN B via telephone was unsuccessful. A third attempt on 5/27/2025 2:37 PM was made to LVN B via telephone and was unsuccessful. In an interview on 5/27/2025 at 2:13pm with the DON revealed that on 05.22.2025 at around 9 pm she was notified by LVN B, that Resident#1 wandered to Resident#2's room and there was an altercation. The DON stated that she instructed the nurse to document, complete an incident report, notify MD, the resident's family, and administrator. The DON stated that Resident#1 had had aggressive cycles, and they were worse when she was on her monthly periods. The DON stated that Resident#2 had a tendency to agitate other residents but neither Resident #1 nor Resident #2 sought to be aggressive toward each other. The DON stated that Resident#2 wandered and tried to take other residents' belongings which irritated other residents. The DON stated that following the incident LVN B and CNA F had been suspended pending investigation and the other staff had in-serviced on Abuse and neglect, managing resident behavior, and fall precaution. The DON stated that on the locked unit the nurse was to be at the nurse station to monitor the residents in the dining room, and the CNA was to sit on the hallways to watch any resident on the hallway. The DON stated that if the nurse left the unit another nurse was to come and monitor the residents until the nurse returned. She stated the risk to the residents if the unit was left unsupervised was there can be accidents and the residents can be hurt. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a phone interview on 05/27/2025 at 2:43PM with Resident #2's FM revealed that Resident #2 had dementia, she wanders a lot and goes into other residents' rooms. Resident #2's FM stated that she used to get into altercations, but he was not aware of any altercation lately. Resident #2's FM stated that he was at the facility every other day to help feed Resident#2 lunch. Resident #2's FM stated that there was not enough staff to supervise when he was there. In an interview on 05/27/2025 at 4:34 pm with the Administrator revealed that she initially reported the incident as an unwitnessed fall. Administrator stated that LVN B called and said there was a scuffle between Resident #1 and #2, and residents were observed on the floor. Administrator stated when the nurse interviewed Resident#1, the resident said she was hit. Administrator stated the nurse told her there were no injuries. Administrator stated that the nurse called her later and said she was sending Resident#1 to the hospital because her blood pressure had dropped. Administrator stated that the diagnostic report from the hospital showed that there was a T4 fracture, but it wasn't clear if it was new or old. Administrator stated that the hospital admitting diagnosis was hypotension (low blood pressure), but it also mentioned assault, and the resident told the hospital that the family did it. Administrator stated that CNA F said she heard a scuffle and when she looked at the video and she saw Resident#1 and Resident#2 on the floor. The Administrator stated that Resident#2 wanders and had behaviors that could provoke other residents. The Administrator stated that there were always two staff on the locked unit. The Administrator stated she felt that they had sufficient staffing with 10 residents on the locked unit. The Administrator stated that it was okay to have one staff on the unit if the other staff was to leave for a short break as long as there was one staff left in the unit. In an observation and interview on 05/27/2025 at 5:30 PM of Resident#1 at the hospital, revealed she was alert and awake and responded to her name. Resident#1 was observed with large bruising to right eye, bruising to both arms and bruising to her left leg. When asked what happened Resident #1 pointed at her FM and said, she did it. FM was at bedside stated that the resident would not be returning to the facility because the family did not feel like she was going to be safe. In an interview on 05/28/2025 at 8:09 AM with Hospital Case Manager revealed that Resident#1 was admitted with injuries including Right periorbital hematoma, suspected T4 fracture that was undetermined, and it was not being treated, but the resident had orders to follow up with x-rays after discharge. Hospital Case Manager mentioned that the FM did not want the resident to return to the facility. Hospital records requested and provided by staff. Record review of the facility's incidents/accidents report from 03/27/25 to 05/27/25 reflected there were no other situations that involved Resident #1 or Resident #2. Record review of the facility's policy, revised September 2022, and titled Resident to Resident Altercations Reflected: All altercations, including those that may represent resident-to-resident abuse, are investigated, and reported to the nursing supervisor, the director of nursing services and to the administrator. Intervention includes: 1.Facility staff monitor residents for aggressive/inappropriate behaviors towards other residents, family members, visitors, or to the staff 2.Behaviors that may provoke a reaction by residents or others include: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting race or ethnic group, intimidating. b. Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects. c. Sexually aggressive behavior such as making sexual comments, inappropriate touching/grabbing. d. Taking, touching, or rummaging through other's property; and e. Wandering into others' rooms/space. 3.Occurrences of such incidents arc promptly reported to the nurse supervisor, director of nursing services, and to the administrator. The administrator will report the incident in accordance with the criteria established under Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating. 4.If two residents are involved in an altercation, staff: a. Separate the residents, and institute measures to calm the situation. b. Identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals involved in the altercation. c. Notify each resident's representative and attending physician of the incident. d. Review the events with the nursing supervisor and director of nursing services and evaluate the effectiveness of interventions meant to address distressed behavior for one or both residents. e. Consult with the attending physician to identify treatable conditions such as acute psychosis that may have caused or contributed to the problem. f. Make any necessary changes in the care plan approaches to any or all of the involved individuals. g. Document in the resident's clinical record all interventions and their effectiveness. h. Consult psychiatric services as needed for assistance in assessing the resident, identifying causes, and developing a care plan for intervention and management as necessary or as may be recommended by the attending physician or interdisciplinary care planning team. Record review of the facility's policy, revised April 2022, Titled Falls and Fall Risk, Managing Reflected: Resident-Centered Approaches to Managing Falls and Fall Risk I. Upon admission, Fall Risk Evaluation will be completed to determine risk for falls. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/29/2025 at 1:15PM an interview with DON revealed that the one nurse and one CNA was sufficient because they had 10 residents in the locked 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. She stated that on the evening shift the nurses from upfront go back there to help. The charge nurses were responsible to ensure the unit was covered. If there is an issue getting someone back there, they let me know. It was always one nurse and one CNA. On the male unit there was one nurse and two CNAs because there were 20 residents. The DON stated that she had not been able to contact LVN B. The DON stated that LVN B had no disciplinary action Interview on 05/29/2025 at 1:10PM with the Administrator revealed that she did not know how long LVN B was gone from the unit when the altercation happened. She stated that peak hours will be from 7am to 7 pm because those are the most active hours. She stated that when the altercation happened the one staff was sufficient to intervene because the unit was calm and most residents were in bed. The facility POR for immediate jeopardy was accepted and on 05/29/25 at 9:49AM and reflected the following: Identify residents who could be affected. All Residents on the unit have the potential to be affected. The Facility census on 05/28/25 on the memory care unit was 11. Resident #1 was sent to the hospital for evaluation on 5/22/25 by Physician and remains in the hospital. Identify what action was taken to prevent further abuse: Resident #2 was placed on one-to-one monitoring on 5/24/25 on the 6/2 shift. Resident #2 was evaluated by psychiatry services on 05/26/25 with no new recommendations issued. Upon readmission, Resident #1 will be evaluated by psychiatry, and any new recommendations will be initiated. Nurse Consultant conducted 100% resident rounds on the unit to determine if further allegations of abuse were made. This was completed on 05/28/25. Safe surveys were conducted on the unit on 5/24/25 by Nurse Consultant. A skin sweep was completed by the Nurse Consultant on 05/24/25 with no additional findings. The Administrator reviewed the results of the completed safe surveys and skin sweep with no additional findings on 05/28/25. An additional 12 hours of staff will be added to the staffing pattern to allow for additional supervision of the residents during peak hours. This will be initiated on 5/29/25. The DON/Designee will be responsible for monitoring the new staffing pattern. The Nurse and Aide who worked the unit on 5/22/25 were suspended on 5/23/25 pending further investigation. In-Service conducted. (continued on next page)

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	455416	A. Building B. Wing	05/29/2025

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Abuse Coordinator and DON were educated on 05/28/25 by the Nurse Consultant on how to investigate suspicions of abuse and the importance of thorough investigation and interventions to prevent Abuse/Neglect and supervision to prevent resident-to-resident altercations. In-service was conducted by the Administrator/ADON on Managing Aggressive Behavior. Beginning on 5/23/25, [psychology services company name] provided additional training on de-escalation techniques, which was completed on 5/28/25. In-servicing was initiated by Administrator/DON on Abuse investigation, interventions, and completion of Incident Reports beginning 05/25/25 and completed on 5/28/25. In-service will be provided to all staff on Immediate Notification of Allegations to the Facility Abuse Coordinator or designee when not in a facility or available, Investigating Allegations of Abuse and Neglect, Reporting of Abuse, Neglect, and Misappropriation, and notification of proper local and state entities by DON and ADON. Agency staff who work in the facility or staff on PTO or LOA will have in-service training completed prior to working the floor by the DON/Designee. The DON/Designee will in-service the staffing coordinator and unit nurses regarding the new staffing pattern. Abuse and Neglect training will be a part of the new hire orientation, effective immediately, and no staff will be allowed to work until the Administrator has verified that training has occurred. This training will include all aspects of Reporting Abuse, Investigating Abuse, and resident protection from abuse/neglect. This will be completed at the time of hire by HR/DON and verified by the Administrator. Any resident who is deemed an imminent threat to others will be placed on one-to-one monitoring until alternate placement can be arranged or the threat is no longer viable. Monitoring of the facility's Plan of Removal included the following: Interviews with the following staff from 05/29/25 at 10:46 AM to 4:04 PM who worked all shifts and all days of the week revealed they had been in-serviced on de-escalation techniques for when a resident has aggressive behaviors towards another resident, abuse and neglect, and resident-to-resident altercations: LVN A, LVN G, LVN N , CTA C, CNA D, CNA E, CNA F, CNA L, CNA M, CNA K, RN I, RN J, Receptionist, housekeeping, DON, and the Administrator. Record review of a QAPI Agenda, dated 05/28/25, reflected Administrator and DON were in attendance. Record review of in-service sign in sheets, dated 05/24/25, and titled Accidents and Incident and Resident to Resident altercation reflected both the DON and Administrator had signed. Record review of Accident and Incidents - Investigating and Reporting in-service dated 05/24/25-05/28/2025, reflected 95 staff had been in-serviced. (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-to-Resident Altercations in-service, dated 05/24/25-05/28/2025, reflected 95 staff had been in-serviced. Record review of a Falls and Fall Risk Managing in-service, dated 05/23/25 - 05/28/2025 reflected 95 staff had been in-serviced. Record review of an in-service sign in sheets, dated 05/28/25, and titled Reporting and Investigation of Abuse and Neglect Managing Difficult behavior Supervision and Preventing Abuse reflected both the DON and Administrator had signed. 5/29/2025 12:13 PM Observed Resident#2's FM assisting Resident #2 with lunch tray. Resident#2 appeared well groomed, calm, and followed direction. Resident#2's FM stated that the bruises on her face were from previous falls and that psychiatrist had discontinued some of Resident#2's medication after her last hospitalization. 5/29/2025 12:08 PM interview with LVN A revealed that there were 11 residents in the unit. The unit was staffed with one nurse and two CNAs. She stated that is she had requested to have additional staff on the unit. She stated that when she left the unit to clock out, she notified CNA. She stated that Resident#1 and Resident#2 did not get along and she kept them separated in the daytime because they used to fight over the couch, so LVN A moved the couch and got two separated chairs. 5/29/2025 4:20pm Interview with on-call physician cove[TRUNCATED]

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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 observations, interviews, and record review, the facility failed ensure each resident received adequate supervision and assistance devices to prevent accidents for 2 residents (Resident #1 and #2) of 6 residents reviewed for adequate supervision. The facility failed to provide adequate supervision to Resident #1 and Resident #2 when both residents got into a physical altercation and fell to the ground. As a result, Resident #1 sustained a superior endplate fracture suspected at T4 vertebral body (top part of the T4 spinal bone is cracked/broken) and right periorbital hematoma (black right eye). An IJ was identified on 05/28/25. The IJ template was provided to the facility on [DATE] at 5:05pm. While the IJ was removed on 05/29/25, 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 severe injury, hospitalization, and decline in quality of life. Findings included: On 05/28/2025 at 1:11 PM Video footage identified by the DON as having occurred during the incident was reviewed on the DON's cell phone. The residents observed in the video were identified by the DON. The video revealed: 0:10 Resident#2 walking on hallway and enters Resident#1 room. No other staff or residents were observed in view. Min 1:06 Resident#1 appeared to be holding Resident#2 by her neck/head and pushing her out of Residents#1's room, Resident#2 had her hands grabbing Resident#1. The residents hit the wall across the hall from Resident#1's room. Resident#2 fell onto her buttocks, then Resident#1 appeared to hit her head on the wall and fell on top of Resident #2 then rolled to the side. min1:45 CNA F walks into frame. Both residents were observed sitting up. Resident #1 appeared to be holding Resident#2's hands then Resident#2 punched Resident #1 on the face. Resident #1 grabbed Resident#2's hand then the video clip ends. Record review of Resident #1's face sheet, dated 05/28/25, reflected the resident was a [AGE] year-old female who originally admitted to the facility on [DATE]. (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 #1's MDS Assessment, dated 03/31/25, reflected she had a BIMS score of 05, indicating severe cognitive impairment. Her MDS indicated she had signs and symptoms of delirium and wandering. Her diagnoses included Non-Alzheimer's Dementia, Orthostatic Hypotension(a sudden drop in blood pressure when a person stands up after sitting or lying down), Traumatic Brain Injury(,damage to the brain caused by an external physical force, often a blow or impact to the head) Depression, Bipolar Disorder(a mental health condition characterized by extreme mood swings, ranging from periods of elevated mood to periods of depression), Psychotic Disorder, Insomnia due to mental disorder'. Record review of Resident #1's care plan, initiated 1/30/2025, reflected the following: Focus: 1/30/25-[Resident #1] had a Behavior problem as evidenced by physical aggression towards other resident/ staff, verbally aggressive towards staff and other residents, coming out of the room without clothes on. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Record review of Resident #1's Progress Notes reflected the following: 05/22/25 at 9:30PM - The writer heard a loud scuffle, and when the writer looked on the camera the writer observed both residents sitting on the doorway on the floor across from each other. The residents [sic] were immediately separated, and the resident was assisted back into bed. The MD was contacted but has not responded. The DON and administrator were made aware of the incident. The resident daughter (daughters name) was called but did not answer. Writer left a voicemail. This entry was written by LVN B 05/22/2025 10:10PM The writer rounded on the resident and rechecked blood pressure. The resident blood pressure is substantially lower than when the incident happened, and the resident c/o's of a headache, so the resident was sent to the ER for evaluation and treatment. DON and the administrator were notified. This entry was written by LVN B. Record review of Resident #1's hospital records, dated 05/22/25, reflected the following: Patient was a [AGE] year-old female who presents to the Emergency department via EMS due to an assault at 7:00 PM by another pt at her rehab facility. EMS was called a few hours after the assault a night nurse check. She is c/o neck pain and a headache. She is only oriented to self. She was given 1 push dose epi (drug used to treat low blood pressure or heart rate), 4L fluid, 4L of O2 and 5 levophed (drug used to treat severe low blood pressure). She denies smoking and drug usage. Per EMS pt had a blood pressure of systolic 56. Record review of Radiology Results Report, CT spine cervical without contrast dated 05/22/2025 reflected: Right periorbital hematoma (bruising around the eye), Superior endplate fracture suspected at T4(fourth thoracic vertebral body). Record review of Resident #1's History and physical assessment dated [DATE] of the skin reflected small laceration with hematoma on the left orbit. Record review of Resident #2's face sheet, dated 05/28/25, reflected the resident was a [AGE] year-old female who originally admitted to the facility on [DATE] then readmitted [DATE]. (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 #2's MDS Assessment, dated 02/15/25, reflected she had a BIMS score of 01, indicating severe cognitive impairment. Her MDS indicated she had signs and symptoms of delirium and wandering. Her diagnoses included Non-Alzheimer's Dementia, Depression, anxiety, Altered Mental Status unspecified. Record review of Resident #2's care plan, initiated 11/17/2022, and revised on 05/24/2025 reflected the following: Focus: [Resident #2] Behaviors: has behavior problem OF Wandering, Physical Aggression toward residents, Verbal aggression towards other residents and staff. Interventions include to Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Record review of Resident #2's Progress Notes reflected the following: 05/22/2025 10:09PM Note Text: The resident was observed on the floor with another in the hallway. She was assessed for apparent injury; none was noted. The resident was redirected back to the dining area. She does not complain of pain or discomfort and is moving all four extremities at her normal baseline. The provider, DON, administrator, and Resident#2 FM (family members name) were notified. Resident#2s (family members name) not answer, and a voicemail was left to call the facility regarding fall. This entry was written LVN B 05/24/2025 12:50pm Late entry Note Text: Spoke with [NAME], NP, with] COMPANY NAME] regarding resident#2 incident with another resident. No new orders his time. This entry was written by DON. 05/26/2025 8:30PM Resident#2 continues ABT. She was given fluids multiple times this shift. Bruising still visible on forehead and hands. Resident was closely monitored to prevent falls. This entry was entered by LVN G 05/27/2025 03:43 am Note Text: Resident#2 continues ABT TX for UTI. Resident resting in bed with eyes closed. Respirations are even and unlabored at 18. No sis of pain or distress noted at this time. Bruising remains visible on forehead and hands. Resident was closely monitored to prevent falls. This entry was entered by LVN H 05/28/2025 04:31 am Note Text: Resident#2 continues PABT TX for UTI day 1/3. Resident resting in bed with eyes closed. Respirations are even and unlabored at 18. No s/s of distress noted at this time. Bruising remains visible on forehead and hands. Resident was closely monitored to prevent falls. Medicated 1 for generalized pain. Nursing will continue to monitor. This entry was entered by LVN H In a phone interview on 05/27/2025at 9:50am with Hospital Social Worker revealed that Residents#1's FM stated that she was confused. When she admitted at the hospital Resident#1 stated that she was assaulted by her boyfriend. Hospital Social Worker stated that Resident #1 also told the nurse that she was assaulted by her baby's father. The Hospital Social Worker stated that Residents# 1 FM stated that after she had the brain injury Resident#1 would make up stories. Hospital Social Worker stated that Resident #1's FM told her that that FM received a call from the nursing home that Resident #1 was in an altercation, and she had black eye. When the Hospital Social Worker met with Resident#1 on 05/23/2025, the resident was talking and answering questions but then she would change her answers. The Hospital Social Worker stated that Resident #1 had a compression fracture of her thoracic spine and that the resident remained admitted at the hospital. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a phone interview on 05/27/2025 at 11:49 AM with Resident #1's FM revealed that the facility left a voicemail on Thursday 5/22/2025 that Resident#1 had gotten in a scuffle with another resident, and she had a black eye. Resident #1's FM stated the next day Friday 05/23/2025 the hospital called the FM and told her that Resident#1 was admitted at the hospital. Resident #1's FM stated that Resident#1 was initially admitted to ICU, but she had been transferred to a regular room. Resident #1's FM stated that Resident#1 right eye was swollen and bruised, and that Resident #1 also had bruises on her arms. Resident #1's FM stated that Resident #1 had been at the facility for over a year. Resident #1's FM stated Resident #1 had gotten into altercations before, but no one was injured. Resident #1's FM stated that when she was at the facility in the past there was no staff watching the residents. Resident #1's FM stated that Resident#1 had a history of a brain injury, and she remembered her name only. Resident #1's FM stated that she called the nursing facility but they never responded to her calls, they called her on Saturday (05/25/25) and the administrator told her that Resident#1 fell and said she was going to do an investigation. Resident #1's FM stated that she told the administrator that the injuries did not look like she fell. Resident #1's FM told the administrator that it was unacceptable they put her daughter's life in jeopardy, and she was not happy at all. In an interview on 05/27/2025 at 10:49AM with LVN A revealed that she has been employed for about 8 month and worked 6am-2 pm Monday through Friday in the Locked unit. LVN A stated that the altercation between Resident #1 and #2 had happened on the evening shift when she was not there. She stated that Resident #1 had a diagnosis of dementia and traumatic brain injury from car accident. LVN A stated that Resident#1 was physically aggressive to residents, staff or to anyone who did not understand what she wanted. LVN A stated that before Resident #1's behavior was controlled, she would agitate other residents like move their food and push other residents. LVN A stated that she spoke to the nurse practitioner who reviewed and adjusted Resident#1's medication and she has had less behaviors. . LVN A stated that there was one CNA and one nurse on the locked unit. LVN A did not feel like the staffing was sufficient based on the needs and supervision of the residents. In an interview on 05/27/2025 at 11:20am with CTA C she said she had been employed for a year and worked in transportation and when she was not taking residents to appointments, she helped in the locked unit. CTA C stated that she was not at the facility when the altercation happened. CTA C stated that sometimes there had been altercations in memory care. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a phone interview on 05/27/2025 at 12:23pm with CNA F revealed that she had been employed for a year and she worked the evening shift from 2-10 pm. CNA F stated that around 7: 30PM she was documenting on the computer at the nurses' station when she heard a scuffle. She noted that Resident#2 who was not on the couch where she had been sleeping. CNA F glanced at the camera, and she saw Resident#1 and Resident#2 on the floor. CNA F stated she separated the two residents while they were still on the floor. CNA F stated that she was the only staff on the unit at the time of the altercation. CNA F stated that nurse (LVN B) told her she had gone to get medication, she was gone for about 15 min to 30 mins. CNA F stated that she wanted the residents to be safe and not fight again. CNA F stated she walked Resident#1 to her room, assisted to her to bed then told Resident#2 to go towards the dining area. CNA F then called the nurse (LVN B) via telephone and reported that she had found the residents on the floor. CNA F stated that at 8pm while doing her rounds she saw the bump on Resident #1's head and the black eye and reported immediately to LVN B. LVN B assessed Resident#1 and made some phone calls then the nurse mentioned that she was going to send Resident#1 to the hospital. CNA F stated that the bump on Resident#1 did not show when she initially separated the residents. CNA F stated that Resident #2 would walk on the hall; she was a high fall risk and could be combative. Resident#1 and Resident#2 had a history of aggression towards each other, and they needed to be separated. CNA F stated that there had been previous altercations between Resident#1 and Resident#2 and the staff separated them to make sure they were safe. CNA F stated that she had been documenting on Residents#2's aggression and refusing care. CNA F stated that Resident#1 showed aggression towards Resident#2 sometimes. CNA F felt that she could manage the unit but with dementia units it would be better to have additional staff because the midst of dealing with the altercation she had another resident who was trying to get up. CNA F stated that the unit was staffed with one CNA and one nurse per shift. CNA F stated sometimes there was only one staff member on the unit, when the other one steps out for lunch. CNA F stated the residents were not one on one care supervision. An attempt on 05/27/2025 at 12:12pm to interview LVN B via telephone was unsuccessful. Second attempt on 05/27/2025 at 12:52PM to interview LVN B via telephone was unsuccessful. A third attempt on 5/27/2025 2:37 PM was made to LVN B via telephone and was unsuccessful. In an interview on 5/27/2025 at 2:13pm with the DON revealed that on 05.22.2025 at around 9 pm she was notified by LVN B, that Resident#1 wandered to Resident#2's room and there was an altercation. The DON stated that she instructed the nurse to document, complete an incident report, notify MD, the resident's family, and administrator. The DON stated that Resident#1 had had aggressive cycles, and they were worse when she was on her monthly periods. The DON stated that Resident#2 had a tendency to agitate other residents but neither Resident #1 nor Resident #2 sought to be aggressive toward each other. The DON stated that Resident#2 wandered and tried to take other residents' belongings which irritated other residents. The DON stated that following the incident LVN B and CNA F had been suspended pending investigation and the other staff had in-serviced on Abuse and neglect, managing resident behavior, and fall precaution. The DON stated that on the locked unit the nurse was to be at the nurse station to monitor the residents in the dining room, and the CNA was to sit on the hallways to watch any resident on the hallway. The DON stated that if the nurse left the unit another nurse was to come and monitor the residents until the nurse returned. She stated the risk to the residents if the unit was left unsupervised was there can be accidents and the residents can be hurt. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a phone interview on 05/27/2025 at 2:43PM with Resident #2's FM revealed that Resident #2 had dementia, she wanders a lot and goes into other residents' rooms. Resident #2's FM stated that she used to get into altercations, but he was not aware of any altercation lately. Resident #2's FM stated that he was at the facility every other day to help feed Resident#2 lunch. Resident #2's FM stated that there was not enough staff to supervise when he was there. In an interview on 05/27/2025 at 4:34 pm with the Administrator revealed that she initially reported the incident as an unwitnessed fall. Administrator stated that LVN B called and said there was a scuffle between Resident #1 and #2, and residents were observed on the floor. Administrator stated when the nurse interviewed Resident#1, the resident said she was hit. Administrator stated the nurse told her there were no injuries. Administrator stated that the nurse called her later and said she was sending Resident#1 to the hospital because her blood pressure had dropped. Administrator stated that the diagnostic report from the hospital showed that there was a T4 fracture, but it wasn't clear if it was new or old. Administrator stated that the hospital admitting diagnosis was hypotension (low blood pressure), but it also mentioned assault, and the resident told the hospital that the family did it. Administrator stated that CNA F said she heard a scuffle and when she looked at the video and she saw Resident#1 and Resident#2 on the floor. The Administrator stated that Resident#2 wanders and had behaviors that could provoke other residents. The Administrator stated that there were always two staff on the locked unit. The Administrator stated she felt that they had sufficient staffing with 10 residents on the locked unit. The Administrator stated that it was okay to have one staff on the unit if the other staff was to leave for a short break as long as there was one staff left in the unit. In an observation and interview on 05/27/2025 at 5:30 PM of Resident#1 at the hospital, revealed she was alert and awake and responded to her name. Resident#1 was observed with large bruising to right eye, bruising to both arms and bruising to her left leg. When asked what happened Resident #1 pointed at her FM and said, she did it. FM was at bedside stated that the resident would not be returning to the facility because the family did not feel like she was going to be safe. In an interview on 05/28/2025 at 8:09 AM with Hospital Case Manager revealed that Resident#1 was admitted with injuries including Right periorbital hematoma, suspected T4 fracture that was undetermined, and it was not being treated, but the resident had orders to follow up with x-rays after discharge. Hospital Case Manager mentioned that the FM did not want the resident to return to the facility. Hospital records requested and provided by staff. Record review of the facility's incidents/accidents report from 03/27/25 to 05/27/25 reflected there were no other situations that involved Resident #1 or Resident #2. Record review of the facility's policy, revised September 2022, and titled Resident to Resident Altercations Reflected: All altercations, including those that may represent resident-to-resident abuse, are investigated, and reported to the nursing supervisor, the director of nursing services and to the administrator. Intervention includes: 1.Facility staff monitor residents for aggressive/inappropriate behaviors towards other residents, family members, visitors, or to the staff 2.Behaviors that may provoke a reaction by residents or others include: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting race or ethnic group, intimidating. b. Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects. c. Sexually aggressive behavior such as making sexual comments, inappropriate touching/grabbing. d. Taking, touching, or rummaging through other's property; and e. Wandering into others' rooms/space. 3.Occurrences of such incidents arc promptly reported to the nurse supervisor, director of nursing services, and to the administrator. The administrator will report the incident in accordance with the criteria established under Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating. 4.If two residents are involved in an altercation, staff: a. Separate the residents, and institute measures to calm the situation. b. Identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals involved in the altercation. c. Notify each resident's representative and attending physician of the incident. d. Review the events with the nursing supervisor and director of nursing services and evaluate the effectiveness of interventions meant to address distressed behavior for one or both residents. e. Consult with the attending physician to identify treatable conditions such as acute psychosis that may have caused or contributed to the problem. f. Make any necessary changes in the care plan approaches to any or all of the involved individuals. g. Document in the resident's clinical record all interventions and their effectiveness. h. Consult psychiatric services as needed for assistance in assessing the resident, identifying causes, and developing a care plan for intervention and management as necessary or as may be recommended by the attending physician or interdisciplinary care planning team. Record review of the facility's policy, revised April 2022, Titled Falls and Fall Risk, Managing Reflected: Resident-Centered Approaches to Managing Falls and Fall Risk I. Upon admission, Fall Risk Evaluation will be completed to determine risk for falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455416	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday of Ft. Worth	8001 Western Hills Blvd Fort Worth, TX 76108

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2.The interdisciplinary team will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 3.If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once). 4.Examples of initial approaches might include exercise and balance training, a rearrangement of room fur-niture, improving footwear, changing the lighting, etc. 5.In conjunction with the consultant pharmacist and nursing staff, the attending physician will identify and adjust medications that may be associated with an increased risk of falling or indicate why those medications could not be tapered or stopped, even for a trial period. 6.If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. 7.If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. 8.In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. The Administrator and DON were notified of an Immediate Jeopardy (IJ) on 5/28/2025 at 4:48PM, due to the above failures and the IJ Templated was provided at 5:00PM. In an interview on 5/29/20205 at 11:30 AM with Regional Nurse Consultant revealed that she had worked for the company for almost three years. Regional Nurse Consultant stated when she came on Saturday 05/24/2025 she did all skin assessments, all safe surveys, and in-serviced the Staff. She stated that she did an assessment on Resident#2 that revealed a small laceration, bruise left eye hematoma on the eyebrow. All bruising's on her forehead were from previous falls. She stated that saw the video footage of the altercation on 05/29/2025. She stated that she wished the altercation did not happen. She stated that the CNA F said the nurse had gone on break and the CNA F was the one that heard the scuffle and intervened and then she told the nurse. She stated that the staffing patterns are always a nurse and one CNA on the memory unit. When the staff left for lunch, there should always be one person on the unit. She stated that she did not feel there was a risk when the incident occurred because the residents were in bed, but dementia residents have a tendency to wander. She stated that the facility was aware that Resident#1 and Resident#2 had behaviors. Resident#2 was the typical dementia patient, she would wander and get into stuff, she doesn't purposely seek to attack a person. Resident#1 was more alert than Resident#2 she was able to respond to questions and communicate. She stated that things are going to happen on the dementia units. She did not think there was an immediacy because interventions have been put in place to show that the facility was going to mitigate any further incidents. Resident#2 was put on one-on-one monitoring to prevent her from wandering and going into other residents' rooms. She stated that the facility added 12 hours for supervision in the memory unit during peak hours, from 7am to 7pm, because most of the residents go to bed early and staff were to take lunch and breaks while that additional staff was present. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/29/2025 at 1:15PM an interview with DON revealed that the one nurse and one CNA was sufficient because they had 10 residents in the locked 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. She stated that on the evening shift the nurses from upfront go back there to help. The charge nurses were responsible to ensure the unit was covered. If there is an issue getting someone back there, they let me know. It was always one nurse and one CNA. On the male unit there was one nurse and two CNAs because there were 20 residents. The DON stated that she had not been able to contact LVN B. The DON stated that LVN B had no disciplinary action Interview on 05/29/2025 at 1:10PM with the Administrator revealed that she did not know how long LVN B was gone from the unit when the altercation happened. She stated that peak hours will be from 7am to 7 pm because those are the most active hours. She stated that when the altercation happened the one staff was sufficient to intervene because the unit was calm and most residents were in bed. The facility POR for immediate jeopardy was accepted and on 05/29/25 at 9:49AM and reflected the following: Identify residents who could be affected. All Residents on the unit have the potential to be affected. The Facility census on 05/28/25 on the memory care unit was 11. Resident #1 was sent to the hospital for evaluation on 5/22/25 by Physician and remains in the hospital. Identify what action was taken to prevent further abuse: Resident #2 was placed on one-to-one monitoring on 5/24/25 on the 6/2 shift. Resident #2 was evaluated by psychiatry services on 05/26/25 with no new recommendations issued. Upon readmission, Resident #1 will be evaluated by psychiatry, and any new recommendations will be initiated. Nurse Consultant conducted 100% resident rounds on the unit to determine if further allegations of abuse were made. This was completed on 05/28/25. Safe surveys were conducted on the unit on 5/24/25 by Nurse Consultant. A skin sweep was completed by the Nurse Consultant on 05/24/25 with no additional findings. The Administrator reviewed the results of the completed safe surveys and skin sweep with no additional findings on 05/28/25. An additional 12 hours of staff will be added to the staffing pattern to allow for additional supervision of the residents during peak hours. This will be initiated on 5/29/25. The DON/Designee will be responsible for monitoring the new staffing pattern. The Nurse and Aide who worked the unit on 5/22/25 were suspended on 5/23/25 pending further investigation. In-Service conducted. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Abuse Coordinator and DON were educated on 05/28/25 by the Nurse Consultant on how to investigate suspicions of abuse and the importance of thorough investigation and interventions to prevent Abuse/Neglect and supervision to prevent resident-to-resident altercations. In-service was conducted by the Administrator/ADON on Managing Aggressive Behavior. Beginning on 5/23/25, [psychology services company name] provided additional training on de-escalation techniques, which was completed on 5/28/25. In-servicing was initiated by Administrator/DON on Abuse investigation, interventions, and completion of Incident Reports beginning 05/25/25 and completed on 5/28/25. In-service will be provided to all staff on Immediate Notification of Allegations to the Facility Abuse Coordinator or designee when not in a facility or available, Investigating Allegations of Abuse and Neglect, Reporting of Abuse, Neglect, and Misappropriation, and notification of proper local and state entities by DON and ADON. Agency staff who work in the facility or staff on PTO or LOA will have in-service training completed prior to working the floor by the DON/Designee. The DON/Designee will in-service the staffing coordinator and unit nurses regarding the new staffing pattern. Abuse and Neglect training will be a part of the new hire orientation, effective immediately, and no staff will be allowed to work until the Administrator has verified that training has occurred. This training will include all aspects of Reporting Abuse, Investigating Abuse, and resident protection from abuse/neglect. This will be completed at the time of hire by HR/DON and verified by the Administrator. Any resident who is deemed an imminent threat to others will be placed on one-to-one monitoring until alternate placement can be arranged or the threat is no longer viable. Monitoring of the facility's Plan of Removal included the following: Interviews with the following staff from 05/29/25 at 10:46 AM to 4:04 PM who worked all shifts and all days of the week revealed they had been in-serviced on de-escalation techniques for when a resident has aggressive behaviors towards another resident, abuse and neglect, and resident-to-resident altercations: LVN A, LVN G, LVN N , CTA C, CNA D, CNA E, CNA F, CNA L, CNA M, CNA K, RN I, RN J, Receptionist, housekeeping, DON, and the Administrator. Record review of a QAPI Agenda, dated 05/28/25, reflected Administrator and DON were in attendance. Record review of in-service sign in sheets, dated 05/24/25, and titled Accidents and Incident and Resident to Resident altercation reflected both the DON and Administrator had signed. Record review of Accident and Incidents - Investigating and Reporting in-service dated 05/24/25-05/28/2025, reflected 95 staff had been in-serviced. (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-to-Resident Altercations in-service, dated 05/24/25-05/28/2025, reflected 95 staff had been in-serviced. Record review of a Falls and Fall Risk Managing in-service, dated 05/23/25 - 05/28/2025 reflected 95 staff had been in-serviced. Record review of an in-service sign in sheets, dated 05/28/25, and titled Reporting and Investigation of Abuse and Neglect Managing Difficult behavior Supervision and Preventing Abuse reflected both the DON and Administrator had signed. 5/29/2025 12:13 PM Observed Resident#2's FM assisting Resident #2 with lunch tray. Resident#2 appeared well groomed, calm, and followed direction. Resident#2's FM stated that the bruises on her face were from previous falls and that psychiatrist had discontinued some of Resident#2's medication after her last hospitalization. 5/29/2025 12:08 PM interview with LVN A revealed that there were 11 residents in the unit. The unit was staffed with one nurse and two CNAs. She stated that is she had requested to have additional staff on the unit. She stated that when she left the unit to clock out, she notified CNA. She stated that Resident#1 and Resident#2 did not get along and she kept them separated in the daytime because they used to fight over t[TRUNCATED]