STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465088	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission at Alpine Rehabilitation Center	25 East Alpine Drive Pleasant Grove, UT 84062

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did not ensure, 9 of 32 sampled residents, were free from abuse and neglect. Specifically, multiple residents with cognitive impairment were identified to have sexual contact and were not assessed for capacity to consent to a sexual relationship. In addition, 2 residents eloped from the facility and were returned to the facility without the staff's knowledge. These examples were cited at an Immediate Jeopardy level. Resident identifiers: 11, 21, 25, 27, 31, 33, 36, 42 and 49. NOTICE On 8/8/25 at 1:15 PM, Immediate Jeopardy (IJ) was identified when the facility failed to implement Centers for Medicare and Medicaid Services recommended practices to prevent various forms of abuse. Notice of the IJ in Abuse was given verbally and in writing to the facility Administrator, Director of Nursing, Director of Nursing in Training, and the Chief Executive Officer. On 8/8/25 at 4:46 PM, the Administrator provided the following abatement plan for the removal of the Abuse IJ effective on 8/8/25 at 11:59 PM. The community would add sexual abuse to the revised Abuse Policy and Procedure, all staff would be educated by a LCSW (Licensed Clinical Social Worker) on resident intimacy and sexuality guidelines, the revised policy and the sexual intimacy capacity for consent assessment prior to the next shift worked. QAPI (Quality Assurance and Performance Improvement) will review the revised Abuse Policy and Procedure, all allegations and abuse packets will be reviewed by the QAPI Committee weekly for the next 3 months and any identified concerns will be addressed by said committee. However, the IJ could not be abated based on additional findings of neglect, specifically elopement. On 8/12/25 at 2:30 PM, IJ was again identified when the facility failed to implement Centers for Medicare and Medicaid Services recommended practices to prevent various forms of neglect. Notice of the IJ in neglect, specifically, elopement, was given verbally and in writing to the facility Administrator, Director of Nursing, Director of Nursing in Training, and the Chief Executive Officer. On 8/13/25 at 10:47 AM, the Administrator provided the following additional abatement plan for the removal of the IJ effective on 8/13/25 at 11:59 PM. All residents, with a history of elopement attempts will be supervised at all times when they are outside of the community. All residents with elopement risk assessments were reviewed and updated as necessary on 8/12/25. Any residents at high risk for elopement will have their care plans updated to reflect interventions to reduce the risk of elopement. The three doors that exit the community will be monitored by a staff member at all times until the egress doors are either secured by badge system or fence installation. Moving forward all allegations of mistreatment, abuse, neglect, exploitation, elopement or other reportable incidents, will be thoroughly investigated per the following: 1. Reporting Responsibilities; 2. Reporting Decision Tool; and 3. Incident Reportability Algorithm. Any incidents of elopement will be reviewed by the QAPI Committee on a monthly basis and recommendations will be implemented. On 8/14/25 while completing the recertification survey, surveyors conducted an onsite revisit to verify that the Immediate Jeopardy had been removed. The surveyors determined that the Immediate Jeopardy was removed as alleged on 8/13/25 at 11:59 PM. Findings include: (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	IMMEDIATE JEOPARDY INCIDENTS OF SEXUAL CONTACT 1. Resident 33 was admitted to the facility on [DATE] with diagnoses which included Parkinson's with dyskinesia, dementia, psychotic disorder with delusions due to non psychological conditions, and anxiety disorder. Resident 33 had a BIMS completed on 6/14/25 which was 3 out of 15 which indicated severe cognitive impairment. Resident 33 had a MOCA (Montreal Cognitive Assessment) completed on 7/19/24 which was 7 out of 30 which indicated severe cognitive impairment. Medicare Meeting notes on 6/11/25 documented resident 33’s confusion and cognition continues to fluctuate. A physician note dated 6/9/25 revealed resident 33 had severe cognitive impairment and was progressively declining. No documentation could be located in the medical record where resident 33 had been evaluated for the capacity to consent to sexual activity. Resident 33's progress notes were reviewed and revealed the following: On 4/16/25 resident 33 was found kissing resident 27 while lying on top of her. On 6/25/25 resident 33 was seen in another resident's room with a female resident. The nurse walked in and found them in close proximity. Quickly redirected and separated residents from each other. The resident was very receptive to redirection and followed the staff into his room. On 6/26/25 resident 33 was found sitting on a bed holding hands and kissing resident 31. On 6/26/25 at 6:08 PM CNA (Certified Nursing Assistant) walked into the resident's room to find him and a female resident both undressed. The resident was sitting on his bed while female resident 31 was kneeling on the floor by his groin. On 6/28/25 resident 33 was found holding hands and kissing resident 31. On 7/28/25 resident 33 was found with his hand on resident 27’s shoulder/arm gently patting her. A Facility Reported Incident (FRI) dated 4/16/25 documented that a CNA noted that resident 27 had gone into resident 33’s room and laid down in his bed. The facility documented the following, she often likes to go to his room whether he was in or not and lay on his bed. This time he was found clothed laying in bed with her. There was no kissing or touching noted and resident 33’s denied kissing or touching. Both parties were noted to be calm and smiling. Immediately separate, investigate. Increase routine checks to 15 minutes. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A FRI dated 6/26/25 documented the CNA noted resident 31 was observed in resident 33’s room. The facility documented the following, resident 33 was sitting on the bed and resident 31 was kneeling on the floor by his groin. Both had their clothes off, when the CNA entered both residents asked the CNA to leave the room. The CNA told them to get dressed which they did. Abuse was unsubstantiated. The residents were in their right to choose in this case. A FRI dated 6/28/25 documented that resident 33 was standing beside resident 27 who was lying in bed, he had his hand on her shoulder or arm and was gently patting her. The facility documented resident 33 was helped out of the room. Residents were redirected. Abuse inconclusive, there was no inappropriate touching. Given resident 33’s cognitive impairment and history to engage socially with others in a well meaning manner, it was reasonable to conclude that his actions were non-threatening and likely intended to be comforting or friendly in nature. A care plan problem of exhibits/at risk for behaviors such as being affectionate/intimate with some female residents, transferring and walking without assistance while weak, or unsteady on his feet related to parkinsonism, anxiety, delusional disorders, and dementia was initiated on 11/21/23. The interventions of when being affectionate towards another resident, he will receive consent prior to any affection and staff to intervene if needed was initiated on 6/26/25. And ensure resident finds his own room, redirect away from rooms that aren't his was initiated on 7/28/25. On 8/6/25 at 10:59 AM, an interview was conducted with Registered Nurse (RN) 1 and 2. RN 1 stated resident 33 was mostly independent with care and needed partial assistance with showering. RN 1 stated that resident 33 did not have any behaviors. RN 2 stated resident 33 liked to spend time with resident 31 before she passed away, they were in a relationship. RN 1 stated administration had told them it was a consensual relationship. RN 1 stated resident 33 was oriented to person and could talk in full sentences but sometimes had a hard time getting the right words to come out. RN 2 stated resident 33 had been seen holding hands with resident 27 along with having the relationship with resident 31 before she passed. RN1 stated it would determine on the day whether resident 33 would be able to give consent himself or determine if a partner could give consent in a sexual relationship based on his cognitive ability. RN 2 stated it depended on the day whether resident 33 was completely with it. On 8/6/25 at 11:58 AM, an interview was conducted with CNA 3. CNA 3 stated resident 33 required limited assistance and that he did have sexual tendencies. CNA 3 stated that resident 33 would get excited when he saw a girl, he liked holding their hands and stuff. CNA 3 stated that sometimes resident 27 wandered into his room. CNA 3 stated that she had not seen anything happen between them. CNA 3 stated resident 33 was oriented to familiar faces but not where he was or the date and time. CNA 3 stated that resident 33 would not be able to determine if the resident he was in a sexual relationship with could or could not give consent. CNA 3 stated that resident 27 will go with whoever will ask her to go with her and she can not give consent at all. 2. Resident 27 was admitted to the facility on [DATE] with diagnoses that included neurocognitive disorder, anxiety disorder, personality disorder, vascular dementia and psychosis. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/04/25 at 7:51 AM, resident 25 opened the door to his room, 10B and said he needed some help. The staff went in, resident 25 stated, “I have someone in my bed.” Resident 27 was laying in bed 10A. No other resident was in bed with her. The resident whose bed resident 27 was in was not in the room. Resident 27 was escorted out of the room by staff. Resident 25 stated, “she always comes in my room, she goes wherever she wants to go.” Resident 27's medical records were reviewed between 8/4/25 and 8/20/25. On 7/9/24, an admission assessment revealed a BIMS score of 0, indicating resident 27 had severe cognitive impairment. Resident 27 was evaluated for mood and was unable to provide a response to the questions being asked. A behavior assessment revealed resident 27 demonstrated wandering behaviors that disrupted the privacy of other residents. Resident 27’s care plan revealed, “[Resident 27] exhibits alteration in thought process manifested by cognitive impairment r/t [related to] dementia; needs reminders/prompts/cues to choose activities; has depression/anxiety/psychotic disorder; has other behaviors at times.” Interventions included, “Redirect resident away from rooms that aren't hers.” No documentation could be located in the medical record where resident 27 had been evaluated for the capacity to consent to sexual activity. On 4/16/25 at 11:20 PM, a progress note revealed that the nurse on duty was notified by a CNA that resident 27 was found in resident 33’s bed and resident 33 was on top of resident 27 fully clothed. Resident 33 was witnessed kissing resident 27. Resident 33 admitted to kissing resident 33 a couple of times. Residents 27 and 33 were separated and put on 15 minute checks for 72 hours. The facility physician, the administrator, the Director of Nursing and families were notified. An “Incident Report Form” submitted to the State Survey Agency by the facility on 4/16/25 stated that resident 27 “likes to go to his room whether he is in or not and lay on his bed. This time he was found clothed laying in bed with her.” The report stated, “there was no kissing or touching noted and resident 33 denied kissing or touching. Both parties were noted to be calm and smiling.” Both parties were peacefully separated. The administrator interviewed the CNA, on an unknown date, who witnessed the residents. The CNA stated both residents were fully clothed and there was no inappropriate touching or kissing. The CNA also stated both residents looked comfortable and neither resident expressed discontent. In this case, abuse was not verified because the facility determined that both residents were comfortable and seeking to comfort each other and were easily redirected. The report also stated no harm was intended by either resident. A Nurse Practitioner’s progress note dated 4/22/25 revealed, “Chief complaint: Dementia and behaviors, Interval History: She appears to be at her baseline today. Has severe dementia and cognitive impairments. Her mood this morning is a [sic] very pleasant. She has to be redirected continually throughout the day doesn’t understand boundaries with other residents and the rooms.” (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 5/13/25, an “Incident Report Form” was submitted to the State Survey Agency by the facility reporting that resident 27 walked into resident 49’s room after going to bed in her room. Resident 27 was found laying in resident 49’s bed. Resident 49 was leaning next to her on the bed. Resident 49 was leaning close to her face, but no kissing or other touching was noted. Both residents were placed on 15 minute checks. The report stated resident 27 would be referred to another facility. It should be noted that there was no progress note in the resident's medical record regarding the incident on 5/13/25. The administrator interviewed a CNA and resident 49’s roommate at an unknown date and time. They CNA told the administrator that resident 49 had his pants down and was leaning close to resident 27’s head. Resident 27 was resting peacefully. There was no touching or kissing noted. The CNA redirected resident 27 out of the room. Resident 49 denied touching or kissing resident 27. Resident 49’s roommate also denied observing any touching or kissing. On 7/28/25, an “Incident Report Form” was submitted to the State Survey Agency by the facility reporting that on 7/26/25, a visitor entered a resident room to find resident 27 laying in a bed that was not hers. Resident 33 was found standing next to resident 27 with his hand on her shoulder, gently patting her. No other touching was noted. Neither resident was able to give a description. Resident 27 was assessed for injuries and abnormal behavior. None were noted. The residents were redirected out of the room. The incident report stated staff were to redirect resident 27 out of rooms that were not hers. No injuries were observed at the time of the incident. The physician, administration and family were notified. On 8/6/25 at 11:08 AM, an interview was conducted with CNA 1 who stated she had witnessed resident 27 and resident 49 in resident 49’s room on 5/13/25. CNA 1 stated she walked into resident 49’s room to check on him and found resident 27 asleep in his bed. Resident 49 had taken off his pants and his shirt and was in the process of taking off his socks. Resident 49 only had his brief on. CNA 1 stated that she walked over, aroused resident 27 and directed her out of resident 49’s room. CNA 1 stated resident 27 did not respond to resident 49 being undressed next to the bed. CNA 1 also stated she did not believe resident 49 could get up on the bed with resident 27. 3. Resident 31 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, dementia with mood disturbance, anxiety disorder, and mood disorder due to known physiological conditions. An admission MDS assessment dated [DATE] revealed a BIMS score of 3 which indicated severe cognitive impairment. Resident 31’s progress notes documented the following: a. On 6/19/25 at 5:49 PM, a Nursing Progress Note documented that resident 31’s daughter called and stated the resident’s confusion was getting worse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	b. On 6/25/25 at 9:03 AM, an Encounter Note documented that resident 31 was assessed using the St. Louis University Mental Status Examination (SLUMS) test and she scored 4 out of 30, suggesting dementia. The physician believed that a memory care unit was appropriate for her as far as her safety. Resident 31 was having episodes of agitation as well as crying periods because she did not know what was going on and did not understand why she was in the facility. c. On 6/25/25 at 12:06 PM, a Nursing Progress Note documented that resident 31 had been more sad and confused than usual and that she had been crying more, getting more confused and accusing staff of lying to her. d. On 6/25/25 at 7:18 PM, a Nursing Progress Note documented that resident 31 was removed from a male resident’s room and later that day she was found in another resident’s room with a male resident “in very close proximety [sic]”. e. On 6/26/25 at 5:19 PM, a Nursing Progress Note indicated, “Resident was found with a male resident in the residents room. A CNA walked in and found them sitting on the bed kissing. They were holding hands It appeared to be consensual. I talked privately with both residents and made sure they were both consenting and that is what they wanted to do. it was confirmed by both residents that they consented. I notified both families and they both gave their permission as long as the residents felt good about it. I tried to redirect them but they continued to be with each other. encouraged resident's to stay in public spaces. We will increase observation at this time.” f. On 6/26/25 at 9:16 PM, a Nursing Progress Note indicated, “CNA [name redacted] walked into male resident’s room to find him and [resident 31] both undressed. Male resident was sitting on his bed while [resident 31] was kneeling on floor by his groin. Both residents appeared happy and acting upon mutual consent. No signs of struggle. Both residents asked CNA to leave the room. CNA asked them to get dressed, and they complied. Both residents were interviewed and stated that they were not forced into anything, they enjoyed each other’s company and they both got undressed willingly. They both stated that they feel safe. Resident’s daughter [name redacted] notified of incident and she stated that her biggest desire was for her mom to be happy and safe. She stated that she felt her Mom was able to consent, and she had no concerns about the incident. She stated that her mom has been single for 20 years and it is good for her to have some companionship. administrator [name redacted] notified.” g. On 6/28/25 at 1:39 AM, a General Note documented that resident 33 was seen exiting resident 31’s room. Resident 31 was observed to be sleeping and not aware that resident 33 had been in her room. h. On 6/28/25 at 3:59 PM, a Nursing Progress Note documented that resident 31 was seen being affectionate with resident 33 by holding hands and kissing in private. i. On 7/8/25 at 6:45 AM, a Nursing Progress Note documented that resident 33 was found curled up in bed with resident 31 that morning. A care plan Focus for resident 31 was revised on 6/26/25 to include, “Resident exhibits behaviors such as wandering, rejecting cares, tearfulness, being affectionate/intimate with some male residents r/t Alzheimer's dementia.”; and a Goal of “The resident will have fewer episodes of behaviors by review date.” Interventions initiated on 6/26/25 included: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/26/25 at 9:13 AM, a complaint was called into the State Survey Agency (SSA) by an Adult Protective Services (APS) investigator. The APS investigator stated that they received a report that resident 11 was sexually assaulted by a fellow resident [resident 49]. The APS investigator reported that on 3/14/25 a CNA was checking on resident 49 and found him with his pants down on top of resident 11 and was attempting to initiate sexual contact. The APS investigator went to the facility on 3/24/25 and interviewed resident 11 and resident 49, and determined that both residents did not have the cognitive ability to consent to sexual activity. The APS investigator reported that the Director of Nursing (DON) had no knowledge of the incident but that the facility Admin was aware of it. The APS investigator reported that she asked the Admin what the plan was to keep resident 11 safe and why the resident’s rooms were still directly across from each other. The APS investigator reported that the Admin had stated that the sexual activity was consensual, but did not provide a clear response for how that determination was made. The APS investigator reported that the Admin had determined that the incident was consensual because resident 11 did not yell or push and had a history of this behavior. The APS investigator reported they felt like the Admin was trying to hide the fact it had occurred. The APS investigator reported that the concern was that there was no plan to keep the residents separated. The APS investigator reported that she spoke with resident 11’s family representative and they had been told that resident 49 had been moved away from resident 11. The APS investigator reported that on 3/24/25 when she was at the facility she went from resident 11’s room to resident 49’s room and no staff was present watching the residents. It should be noted that the APS investigator indicated in the report that resident 11’s room was directly across the hall from resident 49’s room. The APS investigator reported that the Admin stated that the safety plan included 1:1 activities, increased supervision and monitoring, and the separation of the rooms. On 8/5/25, the facility abuse investigation documentation was reviewed. No documentation could be found of an investigation into the incident between resident 11 and resident 49 on 3/14/25. On 5/27/25 at 3:30 PM, the facility abuse investigations documented an incident between resident 11 and resident 49. The facility critical incident report form documented that the Activities Coordinator (AC) was the staff who witnessed the incident. The description of the incident documented, [Resident 49] and [Resident 11] were facing each other holding hands when [Resident 49] reached around and grabbed her [Resident 11] bum. They were separated by rec therapy staff. The incident occurred in the dining room where activities were happening. The report documented that the actions taken were 15-minute checks were conducted on [Resident 49] and he was discharged from the facility. On 8/5/25, Resident #11's medical records were reviewed. On 3/9/25, resident 11’s admission MDS assessment documented that a BIMS was not conducted due to the resident being rarely/never understood. The assessment documented that the resident 11 had short term memory (STM) and long term memory (LTM) deficits. The assessment documented that resident 11 was not able to recall the current season, the name and faces of staff, and if they were in a nursing home or hospital. The assessment documented that the cognition skills for daily decision making was moderately impaired. The assessment documented that resident 11 had behavioral symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming and disruptive sounds and the behavior that occurred 1-3 days. Resident 11’s progress notes documented the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	a. On 3/6/25 at 10:30, the note documented, “Resident is pleasant and alert x 1[self]. She has a tbi and roams around. She has a short attention span & aphasia from stroke. no s/s [signs and symptoms] of pain. She is ambulatory without assistance. She has a good appetite.” b. On 3/15/25 at 10:10, the Nursing Progress Note documented, ”This nurse notified [name omitted], sister of resident, as she was the first one to answer the phone. Discussed with [name omitted] the encounter between resident and male resident the previous day. Sister confirmed she knew about encounter. Sister expressed that resident had encounters of that nature in previous setting. Family was not concerned about resident or encounter. MD [Medical Doctor] will see resident on next visit day. Family would like referral to OB/GYN [obstetrician/gynecologist] for possible birth control and/or ablation if preferred. ” c. On 3/15/25 at 10:14 AM, the Nursing Progress Note documented, “resident keeps going over to sit by a male resident and holding his hand. even after redirection she goes back.” d. On 3/31/25 at 1:01 PM, the Social Services Note documented, “[Resident 11] is new to the facility. [Resident 11] transferred from another skilled nursing facility. [Resident 11] has adjusted well to facility. [Resident 11] does have the occasional behaviors such as screaming and crying. This usually occurs when she needs something fixed and moved in her room. Staff is able to quickly assess the situation and provide a solution and comfort to [Resident 11]. [Resident 11] does also have sexual behaviors that are monitored by staff. [Resident 11] enjoys spending time in her room and participating in activities. [Resident 11] does need assistance with ADLs [activities of daily living], staff will assist with ADLs and [Resident 11] is cooperative and does well by pointing to what she needs. [Resident 11] family participated in recent IDT and is grateful for care she receives and wishes for [Resident 11] to remain long term in facility. e. On 4/4/25 at 1:08 PM, the Nursing Progress Note documented, “resident has been fine all morning up until about 20 minutes ago. I heard [Resident 11] yelling very loudly and out of control. As I walked up to try to console her she was very agitated yelling and screaming offensive language. I tried to offer her some meds, some snacks and even a change of scenery. I called the MD and got an order prn med and offered it to her and she took It. Within an hour later she was acting better and she was not yelling as much. Vital signs were within normal limits.” f. On 4/6/25 7:53 PM, the Nursing Progress Note documented, “Pt had another total meltdown swearing, screaming at everyone vulgar languge [sic] jumping at everyone in a threatening manner. Pt grabbed a pt [patient] box of playing cards [NAME] [sic] throgh [sic] it acrossed [sic] the room. Ativan given x2 some relief with second dose. Pt redirected by the nurse taken outside several times and given chocolate to calm pt. Pt had outbursts for over 2 hrs. Pt finally taken to her room and laid on her bed to calm down. Pt offered fluids since pt was exhauted [sic] after eratic [sic] behaviors. Able to get pt down to diner [sic] once pt calmed down. Will cont [continue] to monitor pt behaviors.” g. On 4/8/25 at 3:09 PM, the Nursing Progress Note documented, “This afternoon [Resident 11] became upset, and agitated. Yelling what sounded like ‘f*ck you, men. F*ck me. Mad mad.’ While putting up her middle finger. Staff walked with her out of the dining room into the hallway and outside for a walk. She became calmer and she we attempted to see what she was upset about, but with her limited vocabulary we were unable to specifically identify why she was reacting this way at this time.” (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	h. On 4/9/25 at 5:55 PM, the Nursing Progress Note documented, “resident became upset and started to shout and clap hands and saying ‘fuck you!’. charged at a male resident but a CNA directed her in another direction. she was able to be redirected after the third attempt. she went to her room and was drinking water.” i. On 5/27/25 at 5:51 PM, the Nursing Progress Note documented, “It was reported to this nurse that another resident was touching all over this resident and making this resident visibly uncomfortable. A few minutes later, resident was witnessed attempting to grab on to [sic] this resident's hand and then her shirt tail as she walked away. Separated residents and started this resident on q15min [every 15 minute] checks”. j. On 7/7/25 at 9:39 AM, the Nursing Progress Note documented, “Resident became very upset since another resident was in her room. [Resident 11] started screaming and cussing at other resident. Was able to get other resident out and redirect and reassure [Resident 11] who eventually calmed down. Separated the two resident as much as possible during the day.” On 3/14/25 at 2:30 PM, resident 11 had an incident report that documented, It was reported to nurse by CNA that she saw resident in other male resident's room [resident 49]. [Resident 49] was last at about 4:10pm. The had their pants off and were laying on top of each other. There was no penetration. When CNA walked in the room she told resident to pull her pants up. She did and [resident 49] got off her. There was no struggle. Normally if resident did not want something she yells and screams and hits. There was none of this. The immediate action taken documented, Resident was educated on interaction and that it was not okay. Resident was encouraged to be in day room with other residents and participating in activities. Staff to redirect resident away from other resident's room if necessary. It should be noted that the report documented that resident 49 was last seen at 4:10 PM and this timestamp was after the timestamp that the incident report was documented. On 3/24/25, resident 11 had a care plan initiated for “Resident exhibits/at risk for behaviors such as aggression, agitation, hypersexuality/affection at times, yelling profanities repeatedly, sitting herself on the ground or floors, digging around in the dirt of the flower beds/pulling leaves and branches off of plants in courtyard, and at times getting dirt on her clothing several times daily r/t [related to] history of hypersexuality in group settings, anxiety, depression, history of TBI, intellectual disabilities,

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined, for 7 of 32 sampled residents, that the facility did not implement their written policies and procedures to prevent abuse, neglect, and investigate and report allegations. Specifically, the facility did not have written policies and procedures that defined sexual abuse, how to evaluate a resident's capacity to consent to a sexual relationship and elopements. These examples were cited at an Immediate Jeopardy level. Resident identifiers: 11, 27, 33, 31, 36, 42 and 49. NOTICE On 8/8/25 at 1:15 PM, Immediate Jeopardy (IJ) was identified when the facility failed to implement Centers for Medicare and Medicaid Services recommended practices to implement policies and procedures to prevent various forms of abuse. Notice of the IJ in Abuse was given verbally and in writing to the facility Administrator, Director of Nursing, Director of Nursing in Training, and the Chief Executive Officer. On 8/8/25 at 4:46 PM, the Administrator provided the following abatement plan for the removal of the Abuse IJ effective on 8/8/25 at 11:59 PM. The community would add sexual abuse to the revised Abuse Policy and Procedure, all staff would be educated by a LCSW (Licensed Clinical Social Worker) on resident intimacy and sexuality guidelines, the revised policy and the sexual intimacy capacity for consent assessment prior to the next shift worked. QAPI (Quality Assurance and Performance Improvement) will review the revised Abuse Policy and Procedure, all allegations and abuse packets will be reviewed by the QAPI Committee weekly for the next 3 months and any identified concerns will be addressed by said committee. However, the IJ could not be abated based on additional findings of neglect, specifically elopement. On 8/12/25 at 2:30 PM, IJ was again identified when the facility failed to implement Centers for Medicare and Medicaid Services recommended practices to prevent various forms of neglect. Notice of the IJ in neglect, specifically, elopement, was given verbally and in writing to the facility Administrator, Director of Nursing, Director of Nursing in Training, and the Chief Executive Officer. On 8/13/25 at 10:47 AM, the Administrator provided the following additional abatement plan for the removal of the IJ effective on 8/13/25 at 11:59 PM. All residents, with a history of elopement attempts will be supervised at all times when they are outside of the community. All residents with elopement risk assessments were reviewed and updated as necessary on 8/12/25. Any residents at high risk for elopement will have their care plans updated to reflect interventions to reduce the risk of elopement. The three doors that exit the community will be monitored by a staff member at all times until the egress doors are either secured by badge system or fence installation. Moving forward all allegations of mistreatment, abuse, neglect, exploitation, elopement or other reportable incidents, will be thoroughly investigated per the following: 1. Reporting Responsibilities; 2. Reporting Decision Tool; and 3. Incident Reportability Algorithm. Any incidents of elopement will be reviewed by the QAPI Committee on a monthly basis and recommendations will be implemented. On 8/14/25 while completing the recertification survey, surveyors conducted an onsite revisit to verify that the Immediate Jeopardy had been removed. The surveyors determined that the Immediate Jeopardy was removed as alleged on 8/13/25 at 11:59 PM. Findings include: IMMEDIATE JEOPARDY INCIDENTS OF SEXUAL CONTACT 1. Resident 33’s medical record was reviewed from 8/4/25 through 8/20/25. Resident 33 was admitted to the facility on [DATE] with diagnoses which included Parkinson's with dyskinesia, dementia, psychotic disorder with delusions due to non psychological conditions, and anxiety disorder. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident 33 had a BIMS (Brief Interview for Mental Status) completed on 6/14/25 which was 3 out of 15 which indicated severe cognitive impairment. Resident 33 had a MOCA (Montreal Cognitive Assessment) completed on 7/19/24 which was 7 out of 30 which indicated severe cognitive impairment. Medicare Meeting notes on 6/11/25 documented resident 33’s confusion and cognition continued to fluctuate. A physician note dated 6/9/25 revealed resident 33 had severe cognitive impairment and was progressively declining. No documentation could be located in the medical record where resident 33 had been evaluated for the capacity to consent to sexual activity. Resident 33's progress notes were reviewed and revealed the following: On 4/16/25 resident 33 was found kissing resident 27 while lying on top of her. On 6/25/25 resident 33 was seen in another resident's room with a female resident. The nurse walked in and found them in close proximity. Quickly redirected and separated residents from each other. The resident was very receptive to redirection and followed the staff into his room. On 6/26/25 resident 33 was found sitting on a bed holding hands and kissing resident 31. On 6/26/25 at 6:08 PM CNA (Certified Nursing Assistant) walked into the resident's room to find him and a female resident both undressed. The resident was sitting on his bed while female resident 31 was kneeling on the floor by his groin. On 6/28/25 resident 33 was found holding hands and kissing resident 31. On 7/28/25 resident 33 was found with his hand on resident 27’s shoulder/arm gently patting her. A Facility Reported Incident (FRI) dated 4/16/25 documented that a CNA (Certified Nursing Assistant) noted that resident 27 had gone into resident 33’s room and laid down in his bed. The facility documented the following, she often liked to go to his room whether he was in or not and lay on his bed. This time he was found clothed laying in bed with her. There was no kissing or touching noted and resident 33’s denied kissing or touching. Both parties were noted to be calm and smiling. Immediately separate, investigate. Increase routine checks to 15 minutes. A FRI dated 6/26/25 documented the CNA noted resident 31 was observed in resident 33’s room. The facility documented the following, resident 33 was sitting on the bed and resident 31 was kneeling on the floor by his groin. Both had their clothes off, when the CNA entered both residents asked the CNA to leave the room. The CNA told them to get dressed which they did. Abuse was unsubstantiated. The residents were in their right to choose in this case. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A FRI dated 6/28/25 documented that resident 33 was standing beside resident 27 who was lying in bed, he had his hand on her shoulder or arm and was gently patting her. The facility documented resident 33 was helped out of the room. Residents were redirected. Abuse inconclusive, there was no inappropriate touching. Given resident 33’s cognitive impairment and history to engage socially with others in a well meaning manner, it was reasonable to conclude that his actions were non-threatening and likely intended to be comforting or friendly in nature. A care plan problem of exhibits/at risk for behaviors such as being affectionate/intimate with some female residents, transferring and walking without assistance while weak, or unsteady on his feet related to parkinsonism, anxiety, delusional disorders, and dementia was initiated on 11/21/23. The interventions of when being affectionate towards another resident, he will receive consent prior to any affection and staff to intervene if needed was initiated on 6/26/25. And ensure resident finds his own room, redirect away from rooms that aren't his was initiated on 7/28/25. 2. Resident 27 was admitted to the facility on [DATE] with diagnoses that included neurocognitive disorder, anxiety disorder, personality disorder, vascular dementia and psychosis. Resident 27’s medical record was reviewed between 8/4/25 and 8/20/25. On 7/9/24, an admission Minimum Data Set (MDS) assessment revealed a BIMS score of 0, indicating resident 27 had severe cognitive impairment. Resident 27 was evaluated for mood and was unable to provide a response to the questions being asked. A behavior assessment revealed resident 27 demonstrated wandering behaviors that disrupted the privacy of other residents. A review of resident 27’s care plan revealed, “The resident uses antidepressants, and anti-anxiety medications r/t [related to] anxiety, mood disorder, disrobing, and hypersexuality.” Interventions included: Administer psychotropic medications as ordered by physician. Monitor/document side effects and effectiveness Q-shift (every shift). Provide structured routine and activities to reduce idle time and overstimulation. Review in psychotropic committee at least quarterly. The goal was to be free from discomfort or adverse reactions to psychotropic therapy through the review date. This care area was initiated on 11/10/24. An assessment for the ability to consent to sexual activity could not be found in resident 27’s medical record. Resident 27’s progress notes were reviewed: On 4/16/25 at 11:20 PM, a nursing progress note revealed, “Nurse was notified by CNAs that resident from 6A was found in 18b’s bed and 18a was on top of 6a fully clothed. Resident 18a was witnessed kissing 6a. Resident 18a admitted to kissing 6a a couple of times. Residents were separated and 15 min [minute] checks for 72 hours were started. MD [medical doctor], ADMIN [administrator], DON [Director of Nursing] and family notified.” (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 5/19/25 at 4:09 PM, a Social Services progress note revealed, “RA [Resident Advocate] called family regarding a possible discharge from facility due to recent incident. Family would prefer that resident remains in facility but is also willing to look into other options. Referrals sent to [facilities redacted].” It should be noted there was not a progress note in the medical record regarding the “recent incident” referred to in the 5/19/25 progress note. On 7/28/25 at 5:18 PM, a nursing progress note revealed, “It was reported today that on Saturday, July 28, 2025 a visitor for resident [redacted] in room [ROOM NUMBER]A walked into room [ROOM NUMBER]A to find resident 27/6A lying in a bed that wasn’t hers. Resident 18A/[redacted] was standing next to the bed with his hand on 6A/27’s shoulder/arm gently patting her. No other touching noted. Resident assessed for injuries or abnormal behavior, none noted. Resident redirected out of room. Staff to redirect resident away from rooms that aren’t hers. [Physician], administration, and family notified.” Incident reports were reviewed for resident 27: On 4/16/25 at 8:31 PM, the facility reported to the State Survey Agency that resident 27 and resident 33 were found together lying in resident 33’s bed. The report stated that resident 27 often would go into resident 33’s room, whether or not he was in the room, and lay on his bed. Both residents were clothed. The incident report stated there was no touching or kissing noted and resident 33 denied touching or kissing resident 27. The report stated both residents were calm and smiling. CNA 10 asked resident 27 to leave the room, and both residents peacefully separated. CNA 10 was interviewed by the administrator at an unknown date and time, and stated she witnessed resident 27 and resident 33 lying on resident 33’s bed cuddling with each other. CNA 10 stated both residents were fully clothed, and she did not observe any inappropriate touching or kissing. CNA 10 stated both residents looked comfortable and content. CNA 10 asked resident 27 to leave the room, which she did. Resident 33 stated that resident 27 was a friend and comforted him. Both residents were poor historians and unable to fully recount what happened. Resident 27 was put on 15 minute checks. Responsible parties and families were notified. Abuse was not verified due to lack of inappropriate touching as witnessed or confirmed by the residents. The investigation stated both residents were comfortable and seeking to comfort each other, and were easily redirected. The report stated no harm was intended by either resident and both residents were at baseline. The intervention created as a result of this incident was to immediately separate, investigate, increase routine checks to 15 minutes, and keep resident 27 in the dining room when she leaves her room. On 5/13/25 at 11:20 PM, the facility reported to the State Survey Agency that resident 27 had walked into resident 49’s room after going to bed in her own room, and then was found in resident 49’s bed. Resident 49 was leaning next to her on the bed. The report stated that resident 49 was leaning close to her face, but was not touching or kissing resident 27. The report stated residents were being helped to bed during rounds. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interviews were conducted by the administrator with resident 49’s roommate and CNA 5. Resident 49’s roommate stated that resident 27 opened the door and entered the room, walked toward him, and then went over to resident 49 and laid down in resident 49’s bed. Resident 49 was already in bed and started to lean over resident 27 when CNA 5 walked into the room. The report stated that resident 49 had his pants down and was leaning close to resident 27’s head. Resident 27 was looking at resident 49 peacefully. The report stated there was no touching or kissing that took place. CNA 5 redirected resident 27 out of the room. Resident 49 denied touching or kissing resident 27. Resident 49’s roommate confirmed there was no touching or kissing. Abuse was not verified because there was no touching or kissing. The report stated resident 49 may have removed some of his clothing because it was hot. Resident 49 was known to have his pants down in his room occasionally. The report stated resident 49 did not force resident 27 into his bed or into his room, and resident 27 laid down intentionally and was calm. Neither resident had a change in their baseline behavior. The intervention created as a result of this incident was to monitor both residents and to discharge on e of the residents. On 7/28/25 at 3:43 PM, the facility reported an incident to the State Survey Agency that occurred on 7/26/25 between resident 27 and resident 33. A brief investigation was conducted with inconclusive results. The administrator determined there was no inappropriate touching. The investigation stated that resident 33 enjoys socializing with other residents and is often seen as a peace maker among the residents. Resident 33 left the situation willingly, and there was no evidence that anything other than one resident comforting another was occurring. The administrator concluded that because resident 33 has cognitive impairment and a history of engaging socially with others in a well-meaning manner, a reasonable conclusion would be that his actions were non-threatening and likely friendly in nature. The administrator stated no negative impact was observed or reported with resident 27. Both residents were acting at baseline after the incident occurred. An intervention of showing resident 33 to his room after dinner was put into place. Resident 27’s family member was interviewed and stated she had walked into her mother’s room and observed resident 33 standing next to resident 27 with his hand on her shoulder and arm. Resident 27’s family member stated she had not seen any inappropriate touching, but she had walked resident 33 out of the room and he left without hesitation. Resident 33 did not remember the incident and resident 27 was unable to say anything about the incident either. Neither resident showed any signs of distress. On 8/6/25 at 11:08, an interview was conducted with CNA 1 who stated she believed the medical director conducted assessments on the residents to determine their capacity to consent to sexual activity. 3. Resident 31 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, dementia with mood disturbance, anxiety disorder, and mood disorder due to known physiological conditions. An admission Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS score of 3 which indicated severe cognitive impairment. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident 31’s progress notes documented the following: a. On 6/25/25 at 9:03 AM, an Encounter Note documented that resident 31 was assessed using the St. Louis University Mental Status Examination (SLUMS) test and she scored 4 out of 30, suggesting dementia. The physician believed that a memory care unit was appropriate for her as far as her safety. Resident 31 was having episodes of agitation as well as crying periods because she did not know what was going on and did not understand why she was in the facility. b. On 6/25/25 at 7:18 PM, a Nursing Progress Note documented that resident 31 was removed from a male resident’s room and later that day she was found in another resident’s room with a male resident “in very close proximety [sic]”. c. On 6/26/25 at 5:19 PM, a Nursing Progress Note indicated, “Resident was found with a male resident in the residents room. A CNA walked in and found them sitting on the bed kissing. They were holding hands It appeared to be consensual. I talked privately with both residents and made sure they were both consenting and that is what they wanted to do. it was confirmed by both residents that they consented. I notified both families and they both gave their permission as long as the residents felt good about it. I tried to redirect them but they continued to be with each other. encouraged resident's to stay in public spaces. We will increase observation at this time.” d. On 6/26/25 at 9:16 PM, a Nursing Progress Note indicated, “CNA [name redacted] walked into male resident’s room to find him and [resident 31] both undressed. Male resident was sitting on his bed while [resident 31] was kneeling on floor by his groin. Both residents appeared happy and acting upon mutual consent. No signs of struggle. Both residents asked CNA to leave the room. CNA asked them to get dressed, and they complied. Both residents were interviewed and stated that they were not forced into anything, they enjoyed each other’s company and they both got undressed willingly. They both stated that they feel safe. Resident’s daughter [name redacted] notified of incident and she stated that her biggest desire was for her mom to be happy and safe. She stated that she felt her Mom was able to consent, and she had no concerns about the incident. She stated that her mom has been single for 20 years and it is good for her to have some companionship. administrator [name redacted] notified.” e. On 6/28/25 at 1:39 AM, a General Note documented that resident 33 was seen exiting resident 31’s room. Resident 31 was observed to be sleeping and not aware that resident 33 had been in her room. f. On 6/28/25 at 3:59 PM, a Nursing Progress Note documented that resident 31 was seen being affectionate with resident 33 by holding hands and kissing in private. g. On 7/8/25 at 6:45 AM, a Nursing Progress Note documented that resident 33 was found curled up in bed with resident 31 that morning. No documentation could be located in the medical record where resident 31 had been evaluated for the capacity to consent to sexual activity. 4. A. Resident 11 was admitted to the facility on [DATE] with diagnoses which included traumatic brain injury, cerebral infarction, aphasia, anxiety disorder, unspecified intellectual disabilities, and depression. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/26/25 at 9:13 AM, a complaint was called into the State Survey Agency (SSA) by an Adult Protective Services (APS) investigator. The APS investigator stated that they received a report that resident 11 was sexually assaulted by a fellow resident [resident 49]. The APS investigator reported that on 3/14/25 a CNA was checking on resident 49 and found him with his pants down on top of resident 11 and was attempting to initiate sexual contact. On 8/5/25, the facility abuse investigation documentation was reviewed. No documentation could be found of an investigation into the incident between resident 11 and resident 49 on 3/14/25. On 8/5/25, Resident #11's medical records were reviewed. On 3/9/25, resident 11’s admission MDS assessment documented that a BIMS was not conducted due to the resident being rarely/never understood. The assessment documented that the resident 11 had short-term memory (STM) and long-term memory (LTM) deficits. The assessment documented that resident 11 was not able to recall the current season, the name and faces of staff, and if they were in a nursing home or hospital. The assessment documented that the cognition skills for daily decision making was moderately impaired. The assessment documented that resident 11 had behavioral symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming and disruptive sounds and the behavior that occurred 1-3 days. Resident 11’s progress notes documented the following: a. On 3/6/25 at 10:30, the note documented, “Resident is pleasant and alert x 1[self]. She has a tbi [traumatic brain injury] and roams around. She has a short attention span & aphasia from stroke. no s/s [signs and symptoms] of pain. She is ambulatory without assistance. She has a good appetite.” b. On 3/15/25 at 10:10, the Nursing Progress Note documented, ”This nurse notified [name omitted], sister of resident, as she was the first one to answer the phone. Discussed with [name omitted] the encounter between resident and male resident the previous day. Sister confirmed she knew about encounter. Sister expressed that resident had encounters of that nature in previous setting. Family was not concerned about resident or encounter. MD [Medical Doctor] will see resident on next visit day. Family would like referral to OB/GYN [obstetrician/gynecologist] for possible birth control and/or ablation if preferred. ” (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission at Alpine Rehabilitation Center	25 East Alpine Drive Pleasant Grove, UT 84062

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 9/17/24, resident 11’s PASRR Level II documented a motor vehicle accident at age 9 which resulted in a TBI and stroke. Family reports an emotional age equivalent of nine, but she does present as younger with some items (i.e. wandering and getting lost in her own neighborhood), and older with others. … She did attempt to work at Deseret Industries for a time, but she did not do well in this setting and ended up being impregnated by another employee Following her TBI, [Resident 11] has been unable to independently manage hygiene tasks. ‘You have to stay on top of it all the time, or she won’t do it at all.’ [Resident 11] has no concept of money, how to manage it, count change, etc. Because of this, family has always managed her finances. [Resident 11] cannot shop alone, and requires supervision for this ADL [Activities of Daily Living] Safety awareness is quite poor, and [Resident 11] would be considered highly exploitable.… Informed decision making is impaired, as is her ability to learn and apply new information Following her TBI, she is no longer able to recognize when she is full. Because of this, she will often eat to the point of vomiting. She is also noted to sneak food in her bra (i.e. cookies and bread), and will add inappropriate food to daily meals (i.e. putting non salad items in a salad). [Resident 11] is often attention seeking and will claim others have raped her. When upset, [Resident 11] will ‘throw tantrums,’ yell, scream, hit, scratch, and throw items at others. She also takes items which do not belong to her, and will wander from the home and become lost. For this reason, she is currently in a memory care unit in the nursing home setting. Family report [Resident 11] is having conflicts and physical altercations with other residents, and that she is taking other resident’s belongings (other residents are also taking her belongings). If she feels left out of an activity (i.e. missing a visit from Santa Clause, not getting flowers for Mother’s day, etc.), she will often yell and scream.” The assessment determined that resident 11 required “Specialized Services” for an intellectual disability. No documentation could be found to demonstrate that resident 11 had been evaluated for the capacity to consent to sexual activity. B. Resident 49 was admitted to the facility on [DATE] with diagnoses which included traumatic brain injury, anoxic brain damage, chronic viral hepatitis, delusional disorders, psychotic disorder, major depressive disorder, opioid abuse, anxiety disorder, unspecified mood disorder, and antisocial personality disorder. The resident was discharged from the facility on 5/29/25. Resident 49’s medical records were reviewed. On 3/7/25, resident 49’s Quarterly MDS assessment documented a BIMS score of 3/15, which would indicate severe cognitive impairment. The assessment documented that resident 49 had difficulty focusing attention, being easily distractible or had difficulty keeping track of what was said. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/16/22, resident 49’s PASRR Level II documented that the resident had an anoxic brain injury/TBI that resulted from a heroin overdose that required resuscitation. The assessment documented that resident 49 had poor short term memory as a result of the anoxic brain injury. “He is very impulsive with no insight into his medical conditions and needs. He currently requires extensive assistance with all ADLs including dressing, grooming, toileting, bathing and medication management. The assessment documented that resident 49 was referred for a PASRR Level II due to a history of antisocial personality disorder, depression and anxiety. “Pt [patient] reports that he has struggled with poor mood and anxiety since the TBI. Prior to the TBI he had significant substance use concerns but does not recall episodes of significant depression/anxiety prior to the TBI. History is limited d/t [due to] pt’s inability to recall past or recent events. Pt does have an extensive legal history with past assaults and prison/jail time d/t assault and drug use/possession.” The assessment documented under current psychiatric functioning when resident 49 was asked about his mood he stated, “I need something…I’m emotionally disturbed.” The assessment documented that resident 49 may benefit from medication management, neurological testing and ongoing psychiatric care. No documentation could be found to demonstrate that resident 49 had been evaluated for the capacity to consent to sexual activity. On 8/05/25 at 1:11 PM, a telephone interview was conducted with the APS investigator who was the complainant. The APS investigator stated that she had a report of a sexual abuse incident between resident 11 and resident 49 from a staff member at the facility. The APS investigator stated she investigated and found that both residents were cognitively impaired. The APS investigator stated that her biggest concern was that they did not separate the residents after the incident occurred and they were still located across the hallway from each other when she went to the facility. The APS investigator stated that the Admin reported that resident 11 was very vocal when she liked something and could follow directions and that was their rationale for the incident being consensual. The APS investigator stated that resident 11’s guardian acknowledged that both resident 11 and resident 49 were cognitively impaired, but were under the impression that resident 49 had been moved away from resident 11 for safety. On 8/6/25 at 1:04 PM, an interview was conducted with the DON. The DON stated that resident 11 was able to understand questions and could respond with “good, good”. The DON stated that resident 11 could respond to questions with yes/no answers, and she had both STM and LTM deficits. The DON stated that resident 11 had verbal outburst, would clap her hands aggressively, yell, and curse. The DON stated that resident 11 would say “[NAME] mad, [NAME] mad, mad” and she would know to ask her to show her what was bothering her. The DON stated that resident 11’s developmental level would be contained in the PASRR. The DON stated that she recalled the incident of resident 11 lying in resident 49’s bed. The DON stated that the Admin conducted the abuse investigation. The DON stated that from what she recalled resident 11 was lying in resident 49’s bed but there were no signs of penetration. The DON stated that this incident of sexual activity was something that should have had an abuse investigation, and the State Survey Agency (SSA) should have been informed within 2 hours of the incident. The DON stated that this incident should have also been reported to the police department within 2 hours of the incident and she did not believe it was ever reported to the police. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The DON stated that resident 49 was oriented to person and had episodes of confusion. The DON stated that resident 49 had both STM and LTM deficits. The DON stated that resident 49 would not be able to problem solve, reason or understand risks. “He was impulsive and don’t believe he would think of those things.” The DON stated that the criteria for determining a resident’s capacity to consent to sexual activity was based on their BIMS score and consultation with the provider. The DON replied “no” when asked if resident 11 had the capacity to consent to sexual activity. The DON stated they determined that resident 11 lacked the capacity to consent to sexual activity after discussing it with the provider. The DON stated that they did not have any documentation of the capacity to consent assessment for resident 11. On 8/6/25 at 2:38 PM, a follow-up interview with the DON. The DON stated that she reviewed resident 11 and resident 49’s MDS assessments and determined that both residents had the same cognitive level. It should be noted that resident 49’s BIMS score of 3 determined a severe cognitive impairment and resident 11 did not have a BIMS assessment completed. The DON stated that resident 11 was able to determine if she wanted to do something or not and could say yes or no. The DON stated that she discussed the incident with the Administrator and it was not reported to the State Survey Agency (SSA). The DON stated that the decision to not report the incident to the SSA was based on the resident’s having the same cognitive level and ability to consent. The DON stated that the ability to consent was based on day to day interactions with the residents. On 8/7/25 at 9:25 AM, a telephone interview was conducted with CNA 6. CNA 6 stated that on 3/14/25, when they came on shift the resident 11 was in the dining room in an activity and resident 49 was in his room. CNA 6 stated that during dinner service, after 4:00 PM, she realized that they had not seen either resident for approximately 10 minutes. CNA 6 stated that she entered resident 49’s room with CNA 5 and CNA 11. CNA 6 stated that when they entered the room resident 11 was lying on the bed and resident 49 was lying on top of her. CNA 6 stated that resident 49 had his pants down and resident 11’s underwear was down exposing her genitals. CNA 6 stated that from her viewpoint she could see both residents genitals and could see resident 49 actively trying to penetrate resident 11’s vagina with his penis. CNA 6 stated that she believed no penetration occurred but there was skin to skin contact. CNA 6 stated that resident 11 was not talking to them and appeared to not be aware that they were talking to her. CNA 6 stated that resident 11’s communication was limited due to her TBI but she would repeat phrases, could say yes or no, nod head yes or no, and give a thumbs up. CNA 6 stat[TRUNCATED]

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, for 10 of 32 residents sampled, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, were reported immediately, but not later than 2 hours after the allegation was made, to the State Survey Agency. Specifically, the State Survey Agency was not notified of sexual relations between cognitively impaired residents, multiple resident elopements, injuries of unknown origin with some resulting in fractures, and a resident not secured in transportation vehicle. Resident identifiers: 2, 7, 11, 27, 31, 33, 36, 42, 47 and 49. NOTICE On 8/8/25 at 1:15 PM, Immediate Jeopardy (IJ) was identified when the facility failed to implement Centers for Medicare and Medicaid Services recommended practices to report various forms of abuse. Notice of the IJ in Abuse was given verbally and in writing to the facility Administrator, Director of Nursing, Director of Nursing in Training, and the Chief Executive Officer. On 8/8/25 at 4:46 PM, the Administrator provided the following abatement plan for the removal of the Abuse IJ effective on 8/8/25 at 11:59 PM. The community would add sexual abuse to the revised Abuse Policy and Procedure, all staff would be educated by a LCSW (Licensed Clinical Social Worker) on resident intimacy and sexuality guidelines, the revised policy and the sexual intimacy capacity for consent assessment prior to the next shift worked. QAPI (Quality Assurance and Performance Improvement) will review the revised Abuse Policy and Procedure, all allegations and abuse packets will be reviewed by the QAPI Committee weekly for the next 3 months and any identified concerns will be addressed by said committee. However, the IJ could not be abated based on additional findings of neglect, specifically elopement. On 8/12/25 at 2:30 PM, IJ was again identified when the facility failed to implement Centers for Medicare and Medicaid Services recommended practices to report various forms of neglect. Notice of the IJ in neglect, specifically, elopement, was given verbally and in writing to the facility Administrator, Director of Nursing, Director of Nursing in Training, and the Chief Executive Officer. On 8/13/25 at 10:47 AM, the Administrator provided the following additional abatement plan for the removal of the IJ effective on 8/13/25 at 11:59 PM. All residents, with a history of elopement attempts will be supervised at all times when they are outside of the community. All residents with elopement risk assessments were reviewed and updated as necessary on 8/12/25. Any residents at high risk for elopement will have their care plans updated to reflect interventions to reduce the risk of elopement. The three doors that exit the community will be monitored by a staff member at all times until the egress doors are either secured by badge system or fence installation. Moving forward all allegations of mistreatment, abuse, neglect, exploitation, elopement or other reportable incidents, will be thoroughly investigated per the following: 1. Reporting Responsibilities; 2. Reporting Decision Tool; and 3. Incident Reportability Algorithm. Any incidents of elopement will be reviewed by the QAPI Committee on a monthly basis and recommendations will be implemented. On 8/14/25 while completing the recertification survey, surveyors conducted an onsite revisit to verify that the Immediate Jeopardy had been removed. The surveyors determined that the Immediate Jeopardy was removed as alleged on 8/13/25 at 11:59 PM. Findings include: IMMEDIATE JEOPARDY INCIDENTS OF SEXUAL CONTACT 1. Resident 33 was admitted to the facility on [DATE] with diagnoses which included Parkinson's with dyskinesia, dementia, psychotic disorder with delusions due to non psychological conditions, and anxiety disorder. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident 33’s medical record was reviewed from 8/4/25 through 8/20/25. Resident 33 had a BIMS (Brief Interview for Mental Status) completed on 6/14/25 which was 3 out of 15 which indicated severe cognitive impairment. Progress notes revealed the following: On 6/25/25 resident 33 was seen in another resident's room with a female resident. The nurse walked in and found them in close proximity. Quickly redirected and separated residents from each other. The resident was very receptive to redirection and followed the staff into his room. On 6/26/25 resident 33 was found sitting on a bed holding hands and kissing resident 31. On 7/28/25 resident 33 was found with his hand on resident 27’s shoulder/arm gently patting her. These incidents were not reported to the State Survey Agency (SSA). On 8/18/2025 at 1:55 PM, an interview was conducted with the Administrator (Admin). The Admin stated he did not report or do an investigation for the incidents with resident 33 because he thought they were consensual and didn’t need to be reported or investigated. 2. Resident 31 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, dementia with mood disturbance, anxiety disorder, and mood disorder due to known physiological conditions. An admission Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS score of 3 which indicated severe cognitive impairment. Resident 31’s progress notes documented the following: On 6/25/25 at 9:03 AM, an Encounter Note documented that resident 31 was assessed using the St. Louis University Mental Status Examination (SLUMS) test and she scored 4 out of 30, suggesting dementia. The physician believed that a memory care unit was appropriate for her as far as her safety. Resident 31 was having episodes of agitation as well as crying periods because she did not know what was going on and did not understand why she was in the facility. On 6/25/25 at 7:18 PM, a Nursing Progress Note documented that resident 31 was removed from a male resident’s room and later that day she was found in another resident’s room with a male resident “in very close proximety [sic]”. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 6/26/25 at 5:19 PM, a Nursing Progress Note indicated, “Resident was found with a male resident in the residents room. A CNA [certified nursing assistant] walked in and found them sitting on the bed kissing. They were holding hands It appeared to be consensual. I talked privately with both residents and made sure they were both consenting and that is what they wanted to do. it was confirmed by both residents that they consented. I notified both families and they both gave their permission as long as the residents felt good about it. I tried to redirect them but they continued to be with each other. encouraged resident's to stay in public spaces. We will increase observation at this time.” On 6/26/25 at 9:16 PM, a Nursing Progress Note indicated, “CNA [name redacted] walked into male resident’s room to find him and [resident 31] both undressed. Male resident was sitting on his bed while [resident 31] was kneeling on floor by his groin. Both residents appeared happy and acting upon mutual consent. No signs of struggle. Both residents asked CNA to leave the room. CNA asked them to get dressed, and they complied. Both residents were interviewed and stated that they were not forced into anything, they enjoyed each other’s company and they both got undressed willingly. They both stated that they feel safe. Resident’s daughter [name redacted] notified of incident and she stated that her biggest desire was for her mom to be happy and safe. She stated that she felt her Mom was able to consent, and she had no concerns about the incident. She stated that her mom has been single for 20 years and it is good for her to have some companionship. administrator [name redacted] notified.” On 6/28/25 at 1:39 AM, a General Note documented that resident 33 was seen exiting resident 31’s room. Resident 31 was observed to be sleeping and not aware that resident 33 had been in her room. On 6/28/25 at 3:59 PM, a Nursing Progress Note documented that resident 31 was seen being affectionate with resident 33 by holding hands and kissing in private. On 7/8/25 at 6:45 AM, a Nursing Progress Note documented that resident 33 was found curled up in bed with resident 31 that morning. These incidents were not reported to the State Survey Agency. On 8/6/25 at 1:08 PM, the Admin was interviewed. The Admin stated sexual abuse was the intent to cause harm with resulting harm to a resident and the residents involved were consenting so it was not reported to the State. 3. A. Resident 11 was admitted to the facility on [DATE] with diagnoses which included traumatic brain injury, cerebral infarction, aphasia, anxiety disorder, unspecified intellectual disabilities, and depression. B. Resident 49 was admitted to the facility on [DATE] with diagnoses which included traumatic brain injury, anoxic brain damage, chronic viral hepatitis, delusional disorders, psychotic disorder, major depressive disorder, opioid abuse, anxiety disorder, unspecified mood disorder, and antisocial personality disorder. The resident was discharged from the facility on 5/29/25. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/26/25 at 9:13 AM, a complaint was called into the State Survey Agency (SSA) by an Adult Protective Services (APS) investigator. The APS investigator stated that they received a report that resident 11 was sexually assaulted by a fellow resident [resident 49]. The APS investigator reported that on 3/14/25 a CNA was checking on resident 49 and found him with his pants down on top of resident 11 and was attempting to initiate sexual contact. On 8/5/25, the facility abuse investigation documentation was reviewed. No documentation could be found of an investigation into the incident between resident 11 and resident 49 on 3/14/25. On 8/6/25 at 1:04 PM, an interview was conducted with the DON. The DON stated that she recalled the incident of resident 11 lying in resident 49’s bed. The DON stated that the Administrator conducted the abuse investigation. The DON stated that from what she recalled resident 11 was lying in resident 49’s bed but there were no signs of penetration. The DON stated that this incident of sexual activity was something that should have had an abuse investigation, and the SSA should have been informed within 2 hours of the incident. The DON stated that this incident should have also been reported to the police department within 2 hours of the incident and she did not believe it was ever reported to the police. On 8/6/25 at 2:38 PM, a follow-up interview with the DON. The DON stated that she discussed the incident with the Administrator and it was not reported to the SSA. Review of the facility Policy on Investigating Allegations of Resident Abuse, Actual Abuse and Neglect of a Resident documented that 1. In the event an incident that meets or has the potential to meet one of the definitions stated in the policy on abuse or neglect of a resident, the incident is reported to the Administrator and or designee. An investigation of the incident will be commenced promptly 2. Depending on the specifics of the incident, reporting to State agencies may occur and local law enforcement may be notified. It should be noted that the facility did not conduct an investigation into an allegation of sexual abuse or notify the State Survey Agency or local law enforcement. [Cross-refer F600] IMMEDIATE JEOPARDY ELOPEMENTS 4. Resident 42 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of vascular dementia with agitation anxiety disorder, psychotic disorder with delusions, and depressive disorder. Resident 42’s medical record was reviewed between 8/4/25 and 8/20/25. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/12/25 at 5:25 PM, an incident report revealed that resident 42 was seen attempting to climb the fence at the facility. “Before Certified Nursing Assistant [CNA] could get to him, he hopped over.” Resident 42 was brought back into the facility and began kicking the front door, demanding to get out. Resident 42 was unable to give a description of the event. In the description of the event it stated that the CNAs caught up with the resident and walked him back to the facility without issue. Orders were received to send resident [42] out for an evaluation for possible UTI [urinary tract infection]. Emergency Medical Services [EMS] was contacted and the resident left the facility at 5:50 PM.” No injuries were noted as a result of the elopement. It should be noted that the elopement on 3/12/25 was not reported to the State Agency (SA) On 5/10/25 at 6:00 PM, an incident report revealed that resident 42 “stepped on wood beside fence to climb over fence” and was found outside alert and walking without difficulty. Resident 42 had a skin tear to his right forearm. The report stated that new orders were placed, the area was cleaned with wound cleanser and steri-strips were applied with monitoring for 7 days. There was no bleeding at the site. The resident stated, “I went over the fence.” Resident 42 was then assisted back into the facility. It should be noted that the elopement on 5/10/25 was not reported to the SA. On 8/12/25 at 8:37 AM, an interview was conducted with the Minimum Data Set Coordinator who stated if a resident eloped, she would report it to the administration, meaning the Admin and the DON. On 8/12/25 at 1:19 PM, an interview was conducted with the Admin who stated he did not report or investigate the incidents for resident 42 or report them to the state and they should have been investigated and reported to the State Survey agency. 5. Resident 36 was admitted to the facility on [DATE] with diagnoses which included traumatic subdural hemorrhage with loss of consciousness, pain, generalized anxiety disorder, major depressive disorder, bipolar, and personal history of suicidal behaviors. Resident 36’s medical record was reviewed 8/4/25 through 8/20/25. Resident 36 had a BIMS completed on 7/31/25 and scored 4 out of 15 which indicated severe cognitive impairment. Resident 36 had a MOCA completed on 7/15/25 and scored 7 out of 30 which indicated severe cognitive impairment. On 11/19/24, resident 36’s elopement assessment documented that the resident had no history of wandering, could follow instructions, could communicate and had a medical diagnosis of cognitive impairment. Resident 36 scored low risk for elopement. On 1/24/25, resident 36’s quarterly elopement assessment documented that the resident had a history of elopement and had wandered off the grounds. The elopement assessment score was 35, which would indicate a high risk for elopement. Progress notes revealed the following: (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/22/24 at 10:33 AM, a physician progress note documented, “ .This is my initial assessment. He is now currently blinded in both eyes due to his self-inflicted gunshot wound to his head…” On 12/14/24 at 7:00 PM, the note documented, “Doorbell to front door rang, nurse answered door and wife and resident were standing there. Wife stated she brought resident back and reported he had walked all the way home. Patient was wrapped in a blanket. Resident told nurse he broke through the fence because he had to get home. Resident stated he was mad because his wife wasn't answering the phone and he had to leave.” On 4/12/25 at 6:34 PM, the note documented, “Rsident ([sic] found outside after knocking down fence. resident walking down street cna saw resident and notified nurse.” The incident report dated 4/12/25 revealed “CNA over the radio said ‘2b is outside of the building’. Upon investigation, resident was walking towards state street and refused to turn around and walk the other way. Two CNA’s and myself, had to hold him and keep him from going any further where he could possibly harm himself especially with his partial blindness. After many attempts at redirection from many staff members, resident finally agreed to return when a member from the admin team came out to talk to him.” On 7/6/25 at 9:30 PM, the note documented, “Resident alert and oriented kicked fence out and eloped. Father and administration notified, 911 notified was told police offier [sic] was on his way back with resident. ” On 7/7/25 at 5:35 PM, the note documented, “At 1640 [4:40 PM] CNA noted that [resident 36] was outside and wanted to make sure that we all could keep an eye on him as he has a history of trying to elope. He then began to try to take apart the fence. I asked what he what his plan is and why he was wanting to leave. He stated to go home and talk to his wife, i offered to help him contact his wife and other interventions. Myself and 3 other people attempted to intervene, and redirect, and attempted to tell him that it was unsafe for him and other residents, to have this fence broken, he continued and stated that he does not care that it is unsafe. Eventually he took the panels apart and stepped on the retaining wall. He then jumped down the wall…. He then walked directly into the road and myself and [Director of Rehab] had to take him by the arms so that he did not walk into traffic, I repeated that with his very limited vision this was very unsafe and you are putting yourself and us in danger. We were able redirect to walk on the sidewalk but he just kept repeating that he was walking home.” Note: The facility reported the 7/6/25 incident to the State Survey Agency. The incidents on 12/14/24 and 4/12/25 were not reported. On 8/12/25 at 1:19 PM, an interview was conducted with the Admin. The Admin stated the investigations were primarily done by talking with the nurses and looking into the events. The Admin stated they did a formal investigation on 7/6/25 for resident 36. The Admin stated he wasn’t totally aware of the elopement section of the reportable so because of that not being clear, he didn’t report them. The Admin stated because resident 36 was with a staff member they didn’t report the elopements. The Admin stated he did not report or investigate the incidents for resident 42 or report them to the state. The Admin stated that yes, these incidents should have been investigated and reported to the state survey agency. (continued on next page)

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	HARM INJURY OF UNKNOWN ORIGIN 6. Resident 2 was admitted to the facility on [DATE] with diagnoses which included Alzheimer’s disease, major depressive disorder, hypertension, and mood disorder due to known physiological condition. On 8/4/25 at 11:07 AM, an observation was conducted of resident 2 in the dining room doing an activity, she had a large purple bruise to her right eye. Resident 2's medical record was reviewed from 8/4/25 through 8/20/25. An admission MDS dated [DATE] indicated resident 2 had a BIMS score of 3. A BIMS score between 0 and 7 indicated severe cognitive impairment. An Incident Report dated 7/26/25 indicated, “Resident noted to have bruising and swelling to Rt eye. It further indicated, Resident stated that it occurred ‘a couple of days ago’ and that she ‘was not here when it happened’. Does state when asked about the bruising to right knee that she did fall. It further indicated, Notified Admin, Placed ice pack to rt eye, skin check performed- bruise to rt knee and scattered bruising to left forearm noted.” It further indicated that resident 2 was alert and Oriented to Person (It should be noted that there was no check mark next to Oriented to Situation, Place or Time). A Nursing Progress Note dated 7/26/25 at10:27 AM indicated, “Bruising noted to right eye as resident was walking down hall this morning. Resident stated that it happened a couple of days ago and that she wasn't here when it happened. Another nurse stated that the bruising was not there yesterday. Notified Admin and placed icepack to eye. Will notify other necessary parties.” On 8/6/25 at 2:11 PM, an interview was conducted with resident 2’s daughter. She stated the facility notified her that her mom had a fall and got a black eye. On 8/13/25 at 12:39 PM, an interview was conducted with the DON. The DON stated that if a resident could not tell them how a bruise of unknown origin occurred there would need to be an investigation completed. The DON further stated that if you cannot determine where the bruise came from then it should be reported to the State Agency. On 8/19/25 at 12:32 PM, an interview was conducted with the Admin. The Admin stated that the Interim DON was supposed to do the investigation into how resident 2 got a black eye. The Admin stated if we could not reasonably conclude that it was from a fall, it should have been reported to State. HARM INJURY IN TRANSPORTATION VEHICLE 7. Resident 7 was admitted to the facility on [DATE] with diagnoses which included multiple sclerosis, type II diabetes, peripheral vascular disease, and chronic pain syndrome. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident 7’s medical record was reviewed from 8/4/25 through 8/20/25. A progress note dated 2/11/25 revealed, “during transport to dialysis, resident reportedly fell out of his chair hitting his head and back. then transport pulledover [sic] and turned hazards on and got out of the van. grabbed chuck then put him back in his chair and buckled him back. Tookhim [sic] to his appointment then reported the incident to the nurses at the dialysis place. then when transport came back 15 minutes later, reported it to the nurses here. neuro checks initiated at 1600. first vital signs back to the facility after return was103 [sic], 100/64, 18, 95%, 96.5. no pain verbalized upon arrival.” A progress note dated 2/14/25 revealed, “The resident complained of pain in his head, neck, spine and back so I called the MD [medical doctor] and he ordered XRay of Skull, XRay of Neck, XRay of Cervical, thoracic and lumbar spine STAT [immediately].” … “The XRays came back and [provider] was sent the XRay results. He said there was no current acute problems. Everything looked fine. Continue treating with Tylenol for pain as needed.” A Facility Reported Incident (FRI) documented, “on 02/14/2025 at 10:45 am, the facility reported that on 02/12/2025 at 2:10 pm, [plant operations 2] who was taking resident 7 to a dr. appointment didn't properly secure front straps to the wheelchair and resident 7 picked his legs up and tipped backward. The Resident has a abrasion to back of head. Education given to [plant operations 2] and more training given.” On 8/18/2025 at 1:55 PM, the Admin stated he did report the incident with resident 7 falling over in the van but it was reported late. POTENTIAL FOR HARM ELOPEMENT 8. Resident 47 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included metabolic encephalopathy, type 2 diabetes mellitus, delirium due to known physiological condition, major depressive disorder, generalized anxiety disorder, chronic pancreatitis, essential hypertension, and cognitive communication deficit. Resident 47's medical record was reviewed from 8/4/25 through 8/20/25. An admission MDS assessment dated [DATE] indicated resident 47 had a BIMS score of 3. A BIMS score between 0 and 7 indicated severe cognitive impairment. It further indicated wandering behaviors were not exhibited. A Social Services Note dated 6/7/24 indicated, “…[Resident 47] is a high wander risk. He is often walking around the building and outside in the backyard. Staff is able to check on him frequently and provide activities to reduce risk of wandering. [Resident 47] has not left facility unattended.” (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A Nursing Progress Note dated 8/9/24 indicated, “Resident was found on state street in [City name redacted] by a staff member and brought back to the facility just as the nurse was looking for the resident. Resident was asked how he got out of the facility and the resident reports he exited the front door. He reports he does not remember who let him out…” A Nursing Progress Note dated 8/20/24 indicated, “resident attempted to elope and was found still on the facility premisis [sic] by a physical therapy personelle [sic] around 1805 [6:05 PM]. when asked how he got out he was not an accurate hisotrian [sic] and said he went through the front door but also said he jumped over the fence. upon further investigation, staff found an outside chair pushed up against the west fence and this is how we presume he got outside. Notified administration, ADON [Name redacted], and will continue checking his where abouts every hour. messaged management aboutgetting [sic] the outside chairs perminantely [sic] secured to the ground and kept away from the fences to prevent this from happening again in the future. Chairs are temporarily secured and unable to be moved at this time.” A Nursing Progress Note dated 10/2/24 indicated, “Resident was found 1.5 blocks from the facility walking towards the [Store name redacted] by the [City name redacted] police. Facility was called and a staff member went and picked resident up and brought him back to the facility…” On 8/19/25 at 12:25 PM, an interview was conducted with the Admin. The Admin stated the elopements on 8/9/24, 8/20/24, and 10/2/24 should have been reported to the State Survey Agency.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility in response to allegations of abuse, neglect, or mistreatment did not have evidence that all alleged violations were thoroughly investigated. Specifically, for 9 out of 32 sampled residents, allegations of sexual abuse, elopements, injuries of unknown origins and fractures were not investigated or the allegations were not investigated thoroughly. Resident identifiers: 2, 11, 27, 31, 33, 36, 42, 47 and 49. NOTICE On 8/8/25 at 1:15 PM, Immediate Jeopardy (IJ) was identified when the facility failed to implement Centers for Medicare and Medicaid Services recommended practices to investigate various forms of abuse. Notice of the IJ in Abuse was given verbally and in writing to the facility Administrator, Director of Nursing, Director of Nursing in Training, and the Chief Executive Officer. On 8/8/25 at 4:46 PM, the Administrator provided the following abatement plan for the removal of the Abuse IJ effective on 8/8/25 at 11:59 PM. The community would add sexual abuse to the revised Abuse Policy and Procedure, all staff would be educated by a LCSW (Licensed Clinical Social Worker) on resident intimacy and sexuality guidelines, the revised policy and the sexual intimacy capacity for consent assessment prior to the next shift worked. QAPI (Quality Assurance and Performance Improvement) will review the revised Abuse Policy and Procedure, all allegations and abuse packets will be reviewed by the QAPI Committee weekly for the next 3 months and any identified concerns will be addressed by said committee. However, the IJ could not be abated based on additional findings of neglect, specifically elopement. On 8/12/25 at 2:30 PM, IJ was again identified when the facility failed to implement Centers for Medicare and Medicaid Services recommended practices to investigate various forms of neglect. Notice of the IJ in neglect, specifically, elopement, was given verbally and in writing to the facility Administrator, Director of Nursing, Director of Nursing in Training, and the Chief Executive Officer. On 8/13/25 at 10:47 AM, the Administrator provided the following additional abatement plan for the removal of the IJ effective on 8/13/25 at 11:59 PM. All residents, with a history of elopement attempts will be supervised at all times when they are outside of the community. All residents with elopement risk assessments were reviewed and updated as necessary on 8/12/25. Any residents at high risk for elopement will have their care plans updated to reflect interventions to reduce the risk of elopement. The three doors that exit the community will be monitored by a staff member at all times until the egress doors are either secured by badge system or fence installation. Moving forward all allegations of mistreatment, abuse, neglect, exploitation, elopement or other reportable incidents, will be thoroughly investigated per the following: 1. Reporting Responsibilities; 2. Reporting Decision Tool; and 3. Incident Reportability Algorithm. Any incidents of elopement will be reviewed by the QAPI Committee on a monthly basis and recommendations will be implemented. On 8/14/25 while completing the recertification survey, surveyors conducted an onsite revisit to verify that the Immediate Jeopardy had been removed. The surveyors determined that the Immediate Jeopardy was removed as alleged on 8/13/25 at 11:59 PM. Findings include: IMMEDIATE JEOPARDY INCIDENTS OF SEXUAL CONTACT 1.Resident 33 was admitted to the facility on [DATE] with diagnoses which included Parkinson's with dyskinesia, dementia, psychotic disorder with delusions due to non psychological conditions, and anxiety disorder. Resident 33’s medical record was reviewed from 8/4/25 through 8/20/25. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident 33 had a BIMS (Brief Interview for Mental Status) completed on 6/14/25 which was 3 out of 15 which indicated severe cognitive impairment. Progress notes revealed the following: On 6/25/25 resident 33 was seen in another resident's room with a female resident. The nurse walked in and found them in close proximity. Quickly redirected and separated residents from each other. The resident was very receptive to redirection and followed the staff into his room. On 6/26/25 resident 33 was found sitting on a bed holding hands and kissing resident 31. On 7/28/25 resident 33 was found with his hand on resident 27’s shoulder/arm gently patting her. No investigation documentation for these incidents was provided by the facility. On 8/18/2025 at 1:55 PM, an interview was conducted with the Administrator (Admin). The Admin stated he did not report or do an investigation for the incidents with resident 33 because he thought they were consensual and didn’t need to be reported or investigated. 2. Resident 27 was admitted to the facility on [DATE] with diagnoses that included neurocognitive disorder, anxiety disorder, personality disorder, vascular dementia and psychosis. Resident 27’s medical records were reviewed between 8/4/25 and 8/20/25. On 7/9/24, an admission Minimum Data Set (MDS) revealed a BIMS score of 0, indicating resident 27 had severe cognitive impairment. Resident 27 was evaluated for mood and was unable to provide a response to the questions being asked. A behavior assessment revealed resident 27 demonstrated wandering behaviors that disrupted the privacy of other residents. Resident 27’s care plan revealed, “[Resident 27] exhibits alteration in thought process manifested by cognitive impairment r/t [related to] dementia; needs reminders/prompts/cues to choose activities; has depression/anxiety/psychotic disorder; has other behaviors at times.” Interventions included, “Redirect resident away from rooms that aren't hers.” On 4/16/25 at 8:31 PM, the facility reported to the State Survey Agency that resident 27 and resident 33 were found together lying in resident 33’s bed. The report stated that resident 27 often would go into resident 33’s room, whether or not he was in the room, and lay on his bed. Both residents were clothed. The incident report stated there was no touching or kissing noted and resident 33 denied touching or kissing resident 27. The report stated both residents were calm and smiling. Certified Nursing Assistant (CNA) 10 asked resident 27 to leave the room, and both residents were peacefully separated. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Admin interviewed CNA 10 on an unknown date and time, who stated she witnessed resident 27 and resident 33 lying on resident 33’s bed cuddling with each other. CNA 10 stated both residents were fully clothed, and she did not observe any inappropriate touching or kissing. CNA 10 stated both residents looked comfortable and content. CNA 10 asked resident 27 to leave the room, which she did. Resident 33 stated that resident 27 was a friend and comforted him. Both residents were poor historians and unable to fully recount what happened. Resident 27 was put on 15 minute checks. Responsible parties and families were notified. Abuse was not verified due to lack of inappropriate touching as witnessed or confirmed by the residents. The investigation stated both residents were comfortable and seeking to comfort each other, and were easily redirected. The report stated no harm was intended by either resident and both residents were at baseline. The intervention created as a result of this incident was to immediately separate, investigate, increase routine checks to 15 minutes, and keep resident 27 in the dining room when she leaves her room. On 5/13/25 at 11:20 PM, the facility reported to the State Survey Agency that resident 27 had walked into resident 49’s room after going to bed in her own room, and then was found in resident 49’s bed. Resident 49 was leaning next to her on the bed. The report stated that resident 49 was leaning close to her face, but was not touching or kissing resident 27. The report stated residents were being helped to bed during rounds. Interviews were conducted by the ADMIN with resident 49’s roommate and CNA 5. Resident 33’s roommate stated that resident 27 opened the door and entered the room, walked toward him, and then went over to resident 49 and laid down in resident 49’s bed. Resident 49 was already in bed and started to lean over resident 27 when CNA 5 walked into the room. The report stated that resident 49 had his pants down and was leaning close to resident 27’s head. Resident 27 was looking at resident 49 peacefully. The report stated there was no touching or kissing that took place. CNA 5 redirected resident 27 out of the room. Resident 49 denied touching or kissing resident 27. Resident 49’s roommate confirmed there was no touching or kissing. Abuse was not verified because there was no touching or kissing. The report stated resident 49 may have removed some of his clothing because it was hot. Resident 49 was known to have his pants down in his room occasionally. The report stated resident 49 did not force resident 27 into his bed or into his room, and resident 27 laid down intentionally and was calm. Neither resident had a change in their baseline behavior. The intervention created as a result of this incident was to monitor both residents and to discharge on e of the residents. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/28/25 at 3:43 PM, the facility reported to the State Survey Agency that an incident had occurred on 7/26/25 between resident 27 and resident 33 which included a brief investigation that had inconclusive results. The administrator determined there was no inappropriate touching. The investigation stated that resident 33 enjoyed socializing with other residents and was often seen as a peace maker among the residents. Resident 33 left the situation willingly, and there was no evidence that anything other than one resident comforting another was occurring. The administrator concluded that because resident 33 has cognitive impairment and a history of engaging socially with others in a well-meaning manner, a reasonable conclusion would be that his actions were non-threatening and likely friendly in nature. The administrator stated no negative impact was observed or reported with resident 27. Both residents were acting at baseline after the incident occurred. An intervention of showing resident 33 to his room after dinner was put into place. Resident 27’s family member was interviewed and stated she had walked into her mother’s room and observed resident 33 standing next to resident 27 with his hand on her shoulder and arm. Resident 27’s family member stated she had not seen any inappropriate touching, but she had walked resident 33 out of the room and he left without hesitation. Resident 33 did not remember the incident and resident 27 was unable to say anything about the incident either. Neither resident showed any signs of distress. 3. Resident 31 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, dementia with mood disturbance, anxiety disorder, and mood disorder due to known physiological conditions. An admission MDS assessment dated [DATE] revealed a BIMS score of 3 which indicated severe cognitive impairment. Resident 31’s progress notes documented the following: On 6/25/25 at 9:03 AM, an Encounter Note documented that resident 31 was assessed using the St. Louis University Mental Status Examination (SLUMS) test and she scored 4 out of 30, suggesting dementia. The physician believed that a memory care unit was appropriate for her as far as her safety. Resident 31 was having episodes of agitation as well as crying periods because she did not know what was going on and did not understand why she was in the facility. On 6/25/25 at 7:18 PM, a Nursing Progress Note documented that resident 31 was removed from a male resident’s room and later that day she was found in another resident’s room with a male resident “in very close proximety [sic]”. On 6/26/25 at 5:19 PM, a Nursing Progress Note indicated, “Resident was found with a male resident in the residents room. A CNA walked in and found them sitting on the bed kissing. They were holding hands It appeared to be consensual. I talked privately with both residents and made sure they were both consenting and that is what they wanted to do. it was confirmed by both residents that they consented. I notified both families and they both gave their permission as long as the residents felt good about it. I tried to redirect them but they continued to be with each other. encouraged resident's to stay in public spaces. We will increase observation at this time.” (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 6/26/25 at 9:16 PM, a Nursing Progress Note indicated, “CNA [name redacted] walked into male resident’s room to find him and [resident 31] both undressed. Male resident was sitting on his bed while [resident 31] was kneeling on floor by his groin. Both residents appeared happy and acting upon mutual consent. No signs of struggle. Both residents asked CNA to leave the room. CNA asked them to get dressed, and they complied. Both residents were interviewed and stated that they were not forced into anything, they enjoyed each other’s company and they both got undressed willingly. They both stated that they feel safe. Resident’s daughter [name redacted] notified of incident and she stated that her biggest desire was for her mom to be happy and safe. She stated that she felt her Mom was able to consent, and she had no concerns about the incident. She stated that her mom has been single for 20 years and it is good for her to have some companionship. administrator [name redacted] notified.” On 6/28/25 at 1:39 AM, a General Note documented that resident 33 was seen exiting resident 31’s room. Resident 31 was observed to be sleeping and not aware that resident 33 had been in her room. On 6/28/25 at 3:59 PM, a Nursing Progress Note documented that resident 31 was seen being affectionate with resident 33 by holding hands and kissing in private. On 7/8/25 at 6:45 AM, a Nursing Progress Note documented that resident 33 was found curled up in bed with resident 31 that morning. These incidents were not reported to the State Survey Agency. On 8/6/25 at 1:08 PM, the Administrator (Admin) was interviewed. The Admin stated sexual abuse was the intent to cause harm with resulting harm to a resident and the residents involved were consenting so it was not reported to the State and was not investigated. 4. A. Resident 11 was admitted to the facility on [DATE] with diagnoses which included traumatic brain injury, cerebral infarction, aphasia, anxiety disorder, unspecified intellectual disabilities, and depression. B. Resident 49 was admitted to the facility on [DATE] with diagnoses which included traumatic brain injury, anoxic brain damage, chronic viral hepatitis, delusional disorders, psychotic disorder, major depressive disorder, opioid abuse, anxiety disorder, unspecified mood disorder, and antisocial personality disorder. The resident was discharged from the facility on 5/29/25. On 3/26/25 at 9:13 AM, a complaint was called into the State Survey Agency (SSA) by an Adult Protective Services (APS) investigator. The APS investigator stated that they received a report that resident 11 was sexually assaulted by a fellow resident [resident 49]. The APS investigator reported that on 3/14/25 a Certified Nurse Assistant (CNA) was checking on resident 49 and found him with his pants down on top of resident 11 and was attempting to initiate sexual contact. On 8/5/25, the facility abuse investigation documentation was reviewed. No documentation could be found of an investigation into the incident between resident 11 and resident 49 on 3/14/25. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/6/25 at 1:04 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that she recalled the incident of resident 11 lying in resident 49’s bed. The DON stated that the Administrator conducted the abuse investigation. The DON stated that from what she recalled resident 11 was lying in resident 49’s bed but there were no signs of penetration. The DON stated that this incident of sexual activity was something that should have had an abuse investigation. On 8/6/25 at 1:08 PM, the Administrator (Admin) was interviewed. The Admin stated around 3/12/25 resident 49 was found on top of resident 11 in bed pulling his pants down and trying to undress her. The Admin stated prior to that resident 49 had tried to pull resident 11 into his room multiple times, rubbed her shoulder and tried to hold her hand. The Admin stated resident 49 gravitated towards resident 11 and their rooms were across the hall from each other. The Admin stated the incident was reported to him that night and the next day the Admin followed up with staff to determine how to keep the residents safe. The Admin stated he did not know what happened to keep them safe. The Admin stated there was no investigation into the incident. [Cross-refer F600] IMMEDIATE JEOPARDY ELOPEMENT 5. Resident 42 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of vascular dementia with agitation anxiety disorder, psychotic disorder with delusions, and depressive disorder. An admission MDS assessment dated [DATE] revealed a BIMS score of 3, indicating significant cognitive impairment. Resident 42’s care plan included, “Elopement: The resident is an elopement risk r/t vascular dementia, history of wandering/getting lost.” On 3/12/25 at 5:25 PM, an incident report revealed that resident 42 was seen attempting to climb the fence at the facility. “Before Certified Nursing Assistant [CNA] could get to him, he hopped over.” Resident 42 was brought back into the facility and began kicking the front door, demanding to get out. Resident 42 was unable to give a description of the event. In the description of the event it stated that the CNAs caught up with the resident and walked him back to the facility without issue. Orders were received to send resident [42] out for an evaluation for possible UTI (urinary tract infection). Emergency Medical Services (EMS) was contacted and the resident left the facility at 5:50 PM. No injuries were noted as a result of the elopement. On 3/12/25 at 5:29 PM, a progress note revealed, “CNA asked for help outside, as resident had jumped the fence out back. CNAs caught up with resident and escorted him inside. He is now kicking the front door and demanding to get out. Called guardian to make her aware-no answer, left vm [voice mail], spoke with DON [Director of Nursing]-said go ahead and send him out. Called EMS.” It should be noted that this incident was not reported to the State Agency. There was no investigation into the resident’s elopement. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 5/10/25 at 6:00 PM, an incident report revealed that resident 42 “stepped on wood beside fence to climb over fence” and was found outside alert and walking without difficulty. Resident 42 had a skin tear to his right forearm. The note states that new orders were placed, the area was cleaned with wound cleaner and steri-strips were applied with monitoring for 7 days. There was no bleeding at the site. The resident stated, “I went over the fence.” Resident 42 was then assisted back into the facility. It should be noted there was no progress note in the resident medical record regarding this incident, no report to the state agency, and no investigation related to how the resident was able to the resident’s elopement. On 8/12/25 at 1:19 PM, an interview was conducted with the Administrator (ADMIN) who stated investigations were primarily completed by talking with the nurses and looking into the events. The ADMIN stated he did not report or investigate the incidents for resident 42 or report them to the stated and they should have been investigated and reported to the State Survey agency. 6. Resident 36 was admitted to the facility on [DATE] with diagnoses which included traumatic subdural hemorrhage with loss of consciousness, pain, generalized anxiety disorder, major depressive disorder, bipolar, and personal history of suicidal behaviors. Resident 36’s medical record was reviewed 8/4/25 through 8/20/25. Resident 36 had a BIMS (Brief Interview for Mental Status) completed on 7/31/25 which was 4 out of 15 which indicated severe cognitive impairment. Resident 36 had a MOCA (Montreal Cognitive Assessment) completed on 7/15/25 which was 7 out of 30 which indicated severe cognitive impairment. On 11/19/24, resident 36’s elopement assessment documented that the resident had no history of wandering, could follow instructions, could communicate and had a medical diagnosis of cognitive impairment. Resident 36 scored low risk for elopement. On 1/24/25, resident 36’s quarterly elopement assessment documented that the resident had a history of elopement and had wandered off the grounds. The elopement assessment score was 35, which would indicate a high risk for elopement. Progress notes revealed the following: On 11/22/24 at 10:33 AM, a physician progress note documented, “ .This is my initial assessment. He is now currently blinded in both eyes due to his self-inflicted gunshot wound to his head…” On 12/14/24 at 7:00 PM, the note documented, “Doorbell to front door rang, nurse answered door and wife and resident were standing there. Wife stated she brought resident back and reported he had walked all the way home. Patient was wrapped in a blanket. Resident told nurse he broke through the fence because he had to get home. Resident stated he was mad because his wife wasn't answering the phone and he had to leave.” (continued on next page)

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	465088	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission at Alpine Rehabilitation Center	25 East Alpine Drive Pleasant Grove, UT 84062

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/12/25 at 6:34 PM, the note documented, “Rsident ([sic] found outside after knocking down fence. resident walking down street cna saw resident and notified nurse.” The incident report dated 4/12/25 revealed “CNA over the radio said ‘2b is outside of the building’. Upon investigation, resident was walking towards state street and refused to turn around and walk the other way. Two CNA’s and myself, had to hold him and keep him from going any further where he could possibly harm himself especially with his partial blindness. After many attempts at redirection from many staff members, resident finally agreed to return when a member from the admin team came out to talk to him.” On 7/6/25 at 9:30 PM, the note documented, “Resident alert and oriented kicked fence out and eloped. Father and administration notified, 911 notified was told police offier [sic] was on his way back with resident. ” On 7/7/25 at 5:35 PM, the note documented, “At 1640 [4:40 PM] CNA noted that [resident 36] was outside and wanted to make sure that we all could keep an eye on him as he has a history of trying to elope. He then began to try to take apart the fence. I asked what he what his plan is and why he was wanting to leave. He stated to go home and talk to his wife, i offered to help him contact his wife and other interventions. Myself and 3 other people attempted to intervene, and redirect, and attempted to tell him that it was unsafe for him and other residents, to have this fence broken, he continued and stated that he does not care that it is unsafe. Eventually he took the panels apart and stepped on the retaining wall. He then jumped down the wall…. He then walked directly into the road and myself and [Director of Rehab] had to take him by the arms so that he did not walk into traffic, I repeated that with his very limited vision this was very unsafe and you are putting yourself and us in danger. We were able redirect to walk on the sidewalk but he just kept repeating that he was walking home.” Note: The facility reported the 7/6/25 incident to the State Survey Agency. The incidents on 12/14/24 and 4/12/25 were not reported. On 8/11/25 at 12:45 PM, an interview was conducted with Registered Nurse (RN) 4. RN 4 stated that when a resident was missing from the facility they attempted to locate them. RN 4 stated that resident 36 was found further down the street and they had to call 911, at his father’s prompting, to get the resident back to the facility. RN 4 stated that the aide reported seeing resident 36 last at 8:30 PM, and they identified he was missing at 9:00 PM. RN 4 stated that resident 36, “breaks the fence” and “usually he's just down the street a little ways”. RN 4 stated that resident 36 had approximately 3 elopements where he had exited the facility. RN 4 stated that resident 36’s room was located next to an exit door to the locked courtyard and that the resident could go into the courtyard at any time. RN 4 stated that when resident 36 eloped they just went and found him and made sure he came back to the facility. RN 4 stated that she was not aware that staff had to step in front of him to prevent him from going into traffic. 7. Resident 47 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included metabolic encephalopathy, type 2 diabetes mellitus, delirium due to known physiological condition, major depressive disorder, generalized anxiety disorder, chronic pancreatitis, essential hypertension, and cognitive communication deficit. Resident 47's medical record was reviewed from 8/4/25 through 8/20/25. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An admission Minimum Data Set (MDS) assessment dated [DATE] indicated resident 47 had a BIMS score of 3. A BIMS score between 0 and 7 indicated severe cognitive impairment. It further indicated wandering behaviors were not exhibited. A Social Services Note dated 6/7/24 indicated, “…[Resident 47] is a high wander risk. He is often walking around the building and outside in the backyard. Staff is able to check on him frequently and provide activities to reduce risk of wandering. [Resident 47] has not left facility unattended.” A Nursing Progress Note dated 8/9/24 indicated, “Resident was found on state street in [City name redacted] by a staff member and brought back to the facility just as the nurse was looking for the resident. Resident was asked how he got out of the facility and the resident reports he exited the front door. He reports he does not remember who let him out…” A Nursing Progress Note dated 8/20/24 indicated, “resident attempted to elope and was found still on the facility premisis [sic] by a physical therapy personelle [sic] around 1805 [6:05 PM]. when asked how he got out he was not an accurate hisotrian [sic] and said he went through the front door but also said he jumped over the fence. upon further investigation, staff found an outside chair pushed up against the west fence and this is how we presume he got outside. Notified administration, ADON [Name redacted], and will continue checking his where abouts every hour. messaged management aboutgetting [sic] the outside chairs perminantely [sic] secured to the ground and kept away from the fences to prevent this from happening again in the future. Chairs are temporarily secured and unable to be moved at this time.” A Nursing Progress Note dated 10/2/24 indicated, “Resident was found 1.5 blocks from the facility walking towards the [Store name redacted] by the [City name redacted] police. Facility was called and a staff member went and picked resident up and brought him back to the facility…” On 8/19/25 at 12:25 PM, an interview was conducted with the Administrator (Admin). The Admin stated the elopements on 8/9/24, 8/20/24, and 10/2/24 should have been reported to State and investigated. POTENTIAL FOR HARM INJURY OF UNKNOWN ORIGIN 8. Resident 2 was admitted to the facility on [DATE] with diagnoses which included Alzheimer’s disease, major depressive disorder, hypertension, and mood disorder due to known physiological condition. On 8/4/25 at 11:07 AM, an observation was conducted of resident 2 in the dining room doing an activity, she had a large purple bruise to her right eye. Resident 2's medical record was reviewed from 8/4/25 through 8/20/25. An admission MDS dated [DATE] indicated resident 2 had a BIMS score of 3. A BIMS score between 0 and 7 indicated severe cognitive impairment. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An Incident Report dated 7/26/25 indicated, “Resident noted to have bruising and swelling to Rt eye. It further indicated, Resident stated that it occurred ‘a couple of days ago’ and that she ‘was not here when it happened’. Does state when asked about the bruising to right knee that she did fall. It further indicated, Notified Admin, Placed ice pack to rt eye, skin check performed- bruise to rt knee and scattered bruising to left forearm noted.” It further indicated that resident 2 was alert and Oriented to Person (It should be noted that there was no check mark next to Oriented to Situation, Place or Time). A Nursing Progress Note dated 7/26/25 at10:27 AM indicated, “Bruising noted to right eye as resident was walking down hall this morning. Resident stated that it happened a couple of days ago and that she wasn't here when it happened. Another nurse stated that the bruising was not there yesterday. Notified Admin and placed icepack to eye. Will notify other necessary parties.” On 8/6/25 at 2:11 PM, an interview was conducted with resident 2’s daughter. She stated the facility notified her that her mom had a fall and got a black eye. On 8/13/25 at 12:39 PM, an interview was conducted with the DON. The DON stated that if a resident could not tell them how a bruise of unknown origin occurred there would need to be an investigation completed. The DON further stated that if you cannot determine where the bruise came from they it should be reported to the State Agency. On 8/19/25 at 12:32 PM, an interview was conducted with the Administrator (ADM). The ADM stated that the Interim DON was supposed to do the investigation into how resident 2 got a black eye. The ADM stated if we could not reasonably conclude that it was from a fall, it should have been reported to State. It should be noted that no investigation documentation was provided. On 8/12/25 at 1:19 PM, an interview was conducted with the administrator (Admin). The Admin stated the investigations were primarily done by talking with the nurses and looking into the events. The Admin stated they did a formal investigation on 7/6/25 for resident 36. The Admin stated he wasn’t totally aware of the elopement section of the reportable so because of that not being clear, he didn’t report them. The Admin stated because resident 36 was with a staff member they didn’t report the elopements. The Admin stated he did not report or investigate the incidents for resident 42 or report them to the state. The Admin stated that yes, these incidents should have been investigated and reported to the state survey agency.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that for 3 of 32 sampled residents, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment. The comprehensive care plan must describe the services that were to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being. Specifically, care plans were not updated when there was a change in the resident's condition and therefore were not reflective of the services required for the residents to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Resident identifiers: 12, 42, and 47.Findings included:1. Resident 42 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of vascular dementia with agitation anxiety disorder, psychotic disorder with delusions, depressive disorder, lumbar spondylolysis, and polyneuropathy. Resident 42’s medical records were reviewed between 8/4/25 and 8/20/25. Resident 42's care plan initiated on 2/26/25 documented that the resident was at risk for falls related to medication use, dementia history of falls, poor cognition, and unsteady gait. Interventions in place included keeping his bed in low and locked position, encouraging resident to wait for assistance, wearing well fitting shoes, and increased supervision by facility staff. Resident 42’s progress notes and incident reports revealed the following: On 3/19/25 at 2:25 PM, a nursing progress note revealed, “nurse called into the dining room and was found that resident was on the floor. It was reported that he hit his head. Has been restless today and trying to stand over and over. Has sat himself on the floor several times before this fall. Resident 42’s care plan was not updated after the fall on 3/19/25. On 8/5/25 at 7: 05 PM, a nursing progress note revealed, “Resident stood up from chair in dining room and fell. Staff called for nurse, resident did not hit his head. Resident 42’s care plan was not updated after the fall on 8/5/25. On 8/10/25 at 3:42 PM, a nursing progress note revealed, “Staff was notified that resident was trying to step up onto window ledge in dining and lost his balance and fell. Unable to say if he hit his head. Resident 42’s care plan was not updated after the fall on 8/10/25. On 8/14/25 at 11:43 AM, an interview was conducted with Licensed Practical Nurse (LPN) 4 who stated resident 42 was a high fall risk. LPN 4 stated most of the precautions in place had come from the hospice company caring for resident 42, such as the fall mat next to his bed, ensuring his room was clear of fall hazards. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/20/25 at 1:39 PM, an interview was conducted with the Director of Nursing (DON) who stated interventions should be in the care plan related to the falls on 8/5/25 and 8/10/25. The DON stated that to prevent falls for resident 42 right now staff were addressing his needs, assisting with toileting, addressing pain, monitoring agitation, keeping his bed in the lowest position, and prompting him to attend activities. The DON stated staff were tag-teaming resident 42 in the dining room to intervene quickly. The DON stated at the end of the alert charting assessment period, the IDT (interdisciplinary team) met and talked about what interventions should be for the recent fall, then the interventions were discussed in a staff huddle so all staff are aware of the new intervention. The DON stated the DON IT (Director of Nursing In Training) was going to investigate resident 42’s recent falls and put interventions into the care plan and they may just not have been put in yet. 2. Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included alcohol dependence with Korsakoff Syndrome, alcohol-induced persisting amnesic disorder, mild dementia with agitation, major depressive disorder, psychotic disorder with delusions, altered mental status, and seizures. On 8/19/25 at 11:27 AM, an observation was made of resident 12 in his room. Resident 12 was laying on a mattress on the floor next to his bed with his limbs hanging over the edges. No staff were observed in his room or in the hallway. After staff were notified of resident 12’s position by surveyor, a CNA was observed to go into his room at 11:31 AM. Resident 12's medical record was reviewed from 8/4/25 through 8/20/25. An Annual Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) assessment could not be conducted because the resident was rarely/never understood. It further indicated a short and long-term memory problem and Cognitive Skills for Daily Decision Making was Severely impaired. It further indicated resident 12 had impairments to both sides of his upper and lower extremities, required substantial/maximal assistance to roll left and right in bed, was dependent to transfer from bed to chair, and was dependent on staff to use his manual wheelchair. A Nursing Progress Note dated 5/2/25 at 2:19 PM indicated, “resident rolled unto [sic] fall mat next to bed. no injuries noted. denies pain at this time. smiling and saying ‘i love you’ over and over. assisted him back into bed with a three person transfer. is resting comfortably in bed”. An Alert Charting document dated 5/10/25 at 1:00 AM indicated, “resident found in between bed and wall. resident did not sustain any injuries. resident was helped back into bed and neuros were initiated. Interventions to ensure brakes are initiated and ensure proper body positioning.” An Incident Report dated 7/3/25 at 10:00 PM indicated, “Resident found by cna lying between mattress and wall”. A Nursing Progress Note dated 7/9/25 at 2:14 PM indicated, “Resident found by cna lying betweenof [sic] beds and wall mattresassisted [sic] to bed,[sic] , neuro == xhecks [sic] started , appropriate administration notifed [sic], [medical doctor name redacted] notified assured wheels to bed are locked properly”. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Nursing Progress Note dated 7/14/25 at 11:14 AM indicated, “Resident fouond [sic] lying on floor slipped out of recliner no change in status, neuro checks normmal [sic], no signs of pain or discomfort. No injury noted”. A Nursing Progress Note dated 8/3/25 at 4:13 PM indicated, “CNA reported that she found resident laying on floor beside bed. Fall mat was not placed beside bed at this time. Assessed for injuries and none present at this time. Vitals taken and neuros started. Hoyer lift used to assist into WC [wheelchair]…” A Nursing Progress Note dated 8/7/25 at 5:03 AM indicated, “CNA staff were doing rounds and found resident on the floor; staff contacted nurse and nurse came in and assessed resident & initiated neuro checks per protocol (unwitnessed fall) vital signs were within normal limits…”. A Nursing Progress Note dated 8/13/25 at 8:53 AM indicated, “Resident found on floor mat next to bed. Assessed resident. No injuries noted. Took VS [vital signs], which were within normal limits. Notified DON [Director of Nursing] and MD [Medical Doctor]. Family declined to be notified of falls. Neuro checks initiated.”. The Care Plan Report indicated, “The resident is at risk for falls r/t history of falls, dependent for transfers, hx [history] of alcohol use, seizures, side effects of medications. Date Initiated: 08/10/2024 Revision on: 08/13/2025”. The Goal indicated, “The resident will not sustain serious injury through the review date. Date Initiated: 06/18/2024 Revision on: 07/10/2025…” Interventions included: a. Ensure proper body positioning. Date Initiated: 05/10/2025 It should be noted that this intervention was initially initiated on the care plan as of 11/28/24. b. Instruct resident to change positions slowly. Date Initiated: 07/03/2025 c. Ensure body positioning is adjusted frequently while in recliner. Date Initiated: 07/13/2025 It should be noted that this intervention was initially initiated on the care plan as of 5/29/25. d. Increase checks on resident while in bed to ensure proper body positioning and bed locked and in lowest position Date Initiated: 08/03/2025 It should be noted that this intervention was initially initiated on the care plan as of 11/7/24 and 12/18/24. It should be noted that there were no new interventions implemented on the falls care plan for the falls on 5/2/25, 5/10/25, 7/3/25, 7/9/25, 7/14/25, 8/3/25, 8/7/25, or 8/13/25. On 8/18/25 at 12:45 PM, an interview was conducted with the DON. The DON stated that after each fall, the fall interventions were reviewed and a new intervention should be put into the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/5/25 at 9:10 AM, an observation was made of resident 12 in the dining room. He was receiving full assistance to eat breakfast by the DON. His food was minced and moist and he was observed to be chewing and swallowing his food with no coughing or difficulties observed. The Care Plan Report indicated, “The resident is at risk for falls r/t history of falls, dependent for transfers, hx of alcohol use, seizures, side effects of medications. Date Initiated: 08/10/2024 Revision on: 08/13/2025”. The Goal indicated, “The resident will not sustain serious injury through the review date. Date Initiated: 06/18/2024 Revision on: 07/10/2025…” An intervention included, “10/2/2024: Make sure resident has adequate hydration and nutrition in the form of bowl of nuts and water in his cup. Date Initiated: 10/02/2024 Revision on: 04/21/2025”. A Physician’s Order dated 12/9/24 at 11:05 AM indicated a Mechanical Soft/Minced & Moist 5 texture diet. A Nutritional Status note dated 7/9/25 at 7:43 PM indicated, “Nurse performed the heimlich maneuver, resident coughed and started to breath. Had aids reposition resident at a 90% angle, slowdown and do smaller bites. Informed admin and doctor. Will refer to speech therapy for a swallow evaluation.” A Physician’s Order dated 8/12/25 at 11:35 AM indicated a Puree/Puree 4 texture, Nectar/Mildly Thick 2 consistency diet. On 8/13/25 at 1:53 PM, an interview was conducted with Licensed Practical Nurse (LPN) 4. LPN 4 stated resident 12 was fully dependent on staff to eat and was on a pureed diet. LPN 4 stated he takes his medications crushed and in pudding. On 8/14/25 at 10:30 AM, an interview was conducted with Registered Nurse (RN) 5. RN 5 stated she was not aware of resident 12 having a choking incident but thought he was on a puree diet. On 8/19/25 at 11:40 AM, an interview was conducted with LPN 3. LPN 3 stated care plans should be reviewed quarterly and as needed. LPN 3 stated the DON and dietitian should update care plans as well. On 8/19/25 at 2:21 PM, an interview was conducted with the Registered Dietician (RD). The RD stated resident 12 was on a puree diet and that a bowl of nuts was not appropriate. On 8/19/25 at 2:54 PM, an interview was conducted with the DON. The DON stated the bowl of nuts was an intervention that was left over from before. The DON stated she would resolve that intervention. 3. Resident 47 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included metabolic encephalopathy, type 2 diabetes mellitus, delirium due to known physiological condition, major depressive disorder, generalized anxiety disorder, chronic pancreatitis, essential hypertension, and cognitive communication deficit. Resident 47's medical record was reviewed from 8/4/25 through 8/20/25. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An admission MDS assessment dated [DATE] indicated resident 47 had a BIMS score of 3. A BIMS score between 0 and 7 indicated severe cognitive impairment. It further indicated wandering behaviors were not exhibited. A Social Services Note dated 6/7/24 indicated, “…[Resident 47] is a high wander risk. He is often walking around the building and outside in the backyard. Staff is able to check on him frequently and provide activities to reduce risk of wandering. [Resident 47] has not left facility unattended.” A Behavior Note dated 6/18/24 indicated, “Resident brought all of his things out by the front door and began trying to force the door open. I was able to redirect him and assist him in taking his things back to his room…He is more calm at this time but has been hovering the nurses station and wanting to talk and tell me about how he will be leaving this place soon to go to ‘the real Utah’.” A Behavior Note dated 6/19/25 indicated, “Resident exit seeking. He yelled at med tech rude comments when trying to guide him away from the front door which he was blocking people from entering or exiting. I was able to ask resident to move away from the door and took his things back to his room…”. A Physician progress Note dated 6/25/24 indicated resident 47 had been more aggressive and had characteristic behaviors of sundowning and exit seeking. A Nursing Progress Note dated 6/27/24 indicated, “Resident very combative, wants to get out of this place. When nurse asked pt [patient] to please move from infront [sic] of her cart, resident pushed the nurse into the cart. Resident continued to threaten nurse and swing at her and the CNA's…” A Nursing Progress Note dated 7/11/24 indicated, “…[Resident 47] has been asking people to open the door for him recently. But has not been combative with staff, just frustrated when they do not let him out. He often tells staff there is someone waiting for him just outside the door, which is not true.” It should be noted that there were no new approaches documented on the care plan for exit seeking behaviors since admit date of 4/22/24. A Nursing Progress Note dated 7/12/24 indicated, “Resident had been sitting next to the nurses cart dozing off. Nurse started to prep residents medications and turned to talk with resident. Staff search the facility for resident to no avail. A code [NAME] was called by nurse and the police were called. Eventually, resident was found at [City name redacted] [Store name redacted] [The store was approximately 6.8 miles from the facility]. Resident reports he went out the front door. He also reported that he took a bus to [City name redacted]. DON notified, MD notified, Family notified, Management notified and searched for resident. ” A Nursing Progress Note dated 8/3/24 indicated, “Resident went to Conference Room, opened the window, kicked the screen off, and climbed the window going outside. Staff members went outside right away, and helped resident back inside the building…” (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It should be noted that there were no new approaches documented on the care plan after this incident. A Behavior Note dated 8/5/24 indicated, “Resident found standing on the planter box in the backyard and trying to hop over the fence. I was able to get him back down but he initially tried harder to hop the fence when he saw us until I climbed onto the planter with him. He then allowed us to help him down…” It should be noted that there were no new approaches documented on the care plan after this incident. A Nursing Progress Note dated 8/9/24 indicated, “Resident was found on state street in [City name redacted] by a staff member and brought back to the facility just as the nurse was looking for the resident. Resident was asked how he got out of the facility and the resident reports he exited the front door. He reports he does not remember who let him out…”. A Nursing Progress Note dated 8/20/24 indicated, “resident attempted to elope and was found still on the facility premisis [sic] by a physical therapy personelle [sic] around 1805 [6:05 PM]. when asked how he got out he was not an accurate hisotrian [sic] and said he went through the front door but also said he jumped over the fence. upon further investigation, staff found an outside chair pushed up against the west fence and this is how we presume he got outside. Notified administration, ADON [Name redacted][Assistant Director of Nursing], and will continue checking his where abouts every hour. messaged management aboutgetting [sic] the outside chairs perminantely [sic] secured to the ground and kept away from the fences to prevent this from happening again in the future. Chairs are temporarily secured and unable to be moved at this time.” It should be noted that there were no new approaches documented on the care plan after this incident. A Nursing Progress Note dated 8/20/24 indicated, “we did hourly checks until he stopped exit seeking which was at 2100 [9:00 PM]. we checked every hour since 1800 [6:00 PM] shortly after he tried eloping…”. A Behavior Note dated 8/28/2024 indicated, “Resident has been exit seeking and becoming more and more determined to leave as he has bumped people leaving, circled around the door, and even pushed people to get through. He is also bringing his items out from his room and leaving them by the front door in an attempt to leave with his things. MD and NP [Nurse Practitioner] notified of worsening behavior.” A Nursing Progress Note dated 8/28/24 indicated, “resident is extremely anxious and agitated tonight. tried exiting the building twice. tried opening a locked door to the conference room and almost broke it because he was agressively [sic] pulling the handles. redirects with multiple people repeating the same direction.” A Behavior Note dated 9/2/24 indicated, “Resident caught climbing planters and trying to hop the fence…”. (continued on next page)

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Mission at Alpine Rehabilitation Center	25 East Alpine Drive Pleasant Grove, UT 84062

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It should be noted that there were no new approaches documented on the care plan for exit seeking behaviors since 8/12/24. A Nursing Progress Note dated 10/2/24 indicated, “Resident was found 1.5 blocks from the facility walking towards the [Store name redacted] by the [City name redacted] police. Facility was called and a staff member went and picked resident up and brought him back to the facility…”. The care plan Problems initiated on 4/22/24 indicated, “Resident exhibits/at risk for behaviors such as wandering, agitation, aggression, refusal of cares, wandering, exit seeking and elopement, related to delirium, insomnia, cognitive communication deficit” and “The resident is an elopement risk r/t wandering and exit seeking behaviors, history of elopement.” Approaches were updated after the first documented elopement on 7/11/24 and initiated on 7/12/24 which included: a. Memory care unit; b. Orient and reorient on an ongoing basis; c. Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes; and d. Re-educate resident regarding safety and risk of leaving. Approaches were updated after the second documented elopement on 8/9/24 and initiated on 8/12/24 which included: a. If reasonable, discuss The resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident; b. 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; c. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. No new Approaches were updated on the care plan after the third documented elopement on 8/20/24. Approaches were updated after the fourth documented elopement on 10/2/24 and initiated on 10/2/24 which included: a. Evaluate all windows to make sure they are secured within guidelines for wander safety. Re-secure window resident went through. An incident report dated 7/11/24 indicated, “Window stops placed at all windows…” On 8/14/25 at 2:42 PM, LPN 4 stated she did not know who updated the care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/18/25 at 12:45 PM, an interview was conducted with the DON. The DON stated after an incident occurs, it would be reviewed to see what happened, discussed in morning meeting, and then new interventions would be put into the care plan. On 8/19/25 at 12:25 PM, an interview was conducted with the Administrator (Admin). The Admin stated interventions should have been implemented after the resident attempted to hop over the fence by standing on the planter on 8/5/24.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that for 1 of 32 sampled residents the facility failed to ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition. Specifically, a resident was not assisted to eat during mealtimes. Resident identifier: 12.Findings included:On 8/13/25 at 10:35 AM, an observation of resident 12 was made in his room. Resident 12 was laying in bed, awake, and smiled and laughed in response to questions.On 8/13/25 at 11:07 AM, an observation and interview was conducted with Licensed Practical Nurse (LPN) 4. Resident 12 was observed in his room, laying in bed, awake. LPN 4 stated she was not sure if he had eaten breakfast yet. In a follow-up interview at 11:51 AM, LPN 4 stated he had not eaten breakfast yet because the CNA's (Certified Nurse Assistant) could not wake him up this morning, but the kitchen was making him something to eat.On 8/14/25 at 9:47 AM, an observation of resident 12 was conducted. Resident 12 was being brought out of his room via wheelchair with two CNA's. One of the CNA's was overheard to ask resident if he was ready for breakfast. Resident 12 was then observed to be brought into the dining room and assisted to eat breakfast.On 8/18/25 at 9:48 AM, an interview was conducted with CNA 9. CNA 9 and another staff member were standing outside of resident 12's room with a breakfast tray and bathing supplies. CNA 9 stated they were going to be taking his breakfast into him now.Resident 12's medical record was reviewed 8/4/25 through 8/20/25.Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included alcohol dependence with Korsakoff Syndrome, alcohol-induced persisting amnesic disorder, mild dementia with agitation, major depressive disorder, psychotic disorder with delusions, altered mental status, and seizures.An Annual Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) could not be conducted because the resident was rarely/never understood. It further indicated a short and long-term memory problem and Cognitive Skills for Daily Decision Making was Severely impaired. It further indicated resident 12 was dependent on staff to eat, had impairments to both sides of his upper and lower extremities, required substantial/maximal assistance to roll left and right in bed, was dependent to transfer from bed to chair, and was dependent on staff to use his manual wheelchair.An Interdisciplinary Care Conference document dated 7/14/25 indicated, [Resident 12] has had an increase in behaviors. He has been shouting out more often. Staff has learned that when he is shouting it is usually due to hunger or dehydration. Staff is able to provide food or drink and [Resident 12] is able to be comforted.[Resident 12] relies heavily on staff assistance for all ADLs [Activities of Daily Living] and staff is able to provide that care.A care plan Problem indicated, The resident has an ADL [Activities of Daily Living] self-care performance deficit r/t [related to] Korsakoff syndrome, dementia, agitation, restlessness, psychotic disorder with delusions, muscle weakness, altered mental status. Date Initiated: 06/18/2024 Revision on: 08/04/2025; and had Approaches which included, EATING: The resident is usually able to eat with dependent assistance. Date Initiated: 06/18/2024 Revision on: 08/04/2025.A Meal Task document dated 8/19/25 indicated resident 12 had breakfast at 9:00 AM on 8/13/25, breakfast and lunch at 1:56 PM on 8/14/25, and breakfast at 11:20 AM on 8/18/25.On 8/14/25 at 10:13 AM, an interview was conducted with CNA 1. CNA 1 stated resident 12 needed full assistance for eating. CNA 1 stated he did not get breakfast on 8/13/24 because a meal ticket did not print out for him. CNA 1 stated they usually get him up at about 9:30 AM to feed him breakfast. CNA 1 stated they would get him up when she was done getting everyone else up and out to breakfast and then she would have to wait for someone else to be free because he was a 2-person assist. CNA 1 stated she feeds resident 12 when she can sit down and feed him. CNA 1 stated resident 12 was awake at about 8:30 AM this morning.On 8/14/25 at 10:30 AM, an interview was conducted with Registered Nurse (RN) 5. RN 5 stated resident 12 could not feed himself. RN 5 stated resident 12 tended to get agitated but would calm down after he ate.On 8/14/25 at 2:42 PM, an interview was conducted with LPN 4. LPN 4 stated the CNA's were assigned to ensure each resident ate and if a resident did not eat, they were supposed to let the nurse know.On 8/19/25 at 1:11 PM, an interview was conducted with CNA 1. CNA 1 reviewed the Meal Task document and stated the times that are listed on the document are not accurate and do not reflect the times the resident ate because she waits until the end of her shift to document.On 8/19/25 at 1:29 PM, an interview was conducted with the Dietary Manager (DM). The DM stated she did not know what happened but resident 12 missed breakfast on 8/13/25 because when she cut the meal cards, his card disappeared somehow. The DM stated it was her expectation that the CNA would

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that each resident received adequate supervision to prevent accidents. Specifically, for 6 out of 32 sampled residents, three residents with cognitive impairment eloped from the facility, this was at an immediate jeopardy level for two of these residents. A resident was not secured in a facility van and suffered a head injury, this was at a harm level. Two residents experienced falls with no interventions put into place and one resident had injuries of unknown origin. Resident identifiers: 7, 11, 12, 36, 42 and 47. NOTICE On 8/12/25 at 2:30 PM, IJ was identified when the facility failed to implement Centers for Medicare and Medicaid Services recommended practices to ensure that each resident received adequate supervision to prevent accidents, specifically elopement. Notice of the IJ was given verbally and in writing to the facility Administrator, Director of Nursing, Director of Nursing in Training, and the Chief Executive Officer. On 8/13/25 at 10:47 AM, the Administrator provided the following additional abatement plan for the removal of the IJ effective on 8/13/25 at 11:59 PM. All residents, with a history of elopement attempts will be supervised at all times when they are outside of the community. All residents with elopement risk assessments were reviewed and updated as necessary on 8/12/25. Any residents at high risk for elopement will have their care plans updated to reflect interventions to reduce the risk of elopement. The three doors that exit the community will be monitored by a staff member at all times until the egress doors are either secured by badge system or fence installation. Moving forward all allegations of mistreatment, abuse, neglect, exploitation, elopement or other reportable incidents, will be thoroughly investigated per the following: 1. Reporting Responsibilities; 2. Reporting Decision Tool; and 3. Incident Reportability Algorithm. Any incidents of elopement will be reviewed by the QAPI Committee on a monthly basis and recommendations will be implemented. On 8/14/25 while completing the recertification survey, surveyors conducted an onsite revisit to verify that the Immediate Jeopardy had been removed. The surveyors determined that the Immediate Jeopardy was removed as alleged on 8/13/25 at 11:59 PM. IMMEDIATE JEOPARDY ELOPEMENTS 1. Resident 36 was admitted to the facility on [DATE] with diagnoses which included traumatic subdural hemorrhage with loss of consciousness, pain, generalized anxiety disorder, major depressive disorder, bipolar, and personal history of suicidal behaviors. On 8/5/25 from 9:00 AM until approximately 10:30 AM, an observation was made of the west door. A walkie talkie on the nurses cart was observed to be alerting that the west door was alarming. No staff were observed to look at the door or go out the door to look for residents. Resident 36’s medical record was reviewed 8/4/25 through 8/20/25. Resident 36 had a BIMS (Brief Interview for Mental Status) completed on 7/31/25 which was 4 out of 15 which indicated severe cognitive impairment. Resident 36 had a MOCA (Montreal Cognitive Assessment) completed on 7/15/25 which was 7 out of 30 which indicated severe cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/19/24, resident 36’s elopement assessment documented that the resident had no history of wandering, could follow instructions, could communicate and had a medical diagnosis of cognitive impairment. Resident 36 scored low risk for elopement. On 1/24/25, resident 36’s quarterly elopement assessment documented that the resident had a history of elopement and had wandered off the grounds. The elopement assessment score was 35, which would indicate a high risk for elopement. Progress notes revealed the following: a. On 11/22/24 at 10:33 AM, a physician progress note documented, “ .This is my initial assessment. He is now currently blinded in both eyes due to his self-inflicted gunshot wound to his head…” b. On 12/9/24 at 6:00 PM, the note documented, “resident attempted to elope by climbing a tree. he was on the fence saying he wanted to leave and be put in ‘jail instead of stay here.’ the staff got him down, but he is refusing to come inside. we got a prn [as needed] order from [provider] for ativan, but resident is refusing to take it.” c. On 12/14/24 at 7:00 PM, the note documented, “Doorbell to front door rang, nurse answered door and wife and resident were standing there. Wife stated she brought resident back and reported he had walked all the way home. Patient was wrapped in a blanket. Resident told nurse he broke through the fence because he had to get home. Resident stated he was mad because his wife wasn't answering the phone and he had to leave.” c. On 12/15/24 at 5:33 PM, the note documented, “Resident was trying to break down the fence in the backyard to ‘get out of this place’. he was unsuccessful. staff tried to talk to him and get him to come back inside but he refused. staff stayed with him and called his wife [name redacted], she came down and wasable [sic] to calm him down and get him to come inside. Resident then apologized to staff for his behavior. currently in a pleasant mood and stated that he won't try to break out of the building tonight. His wife said she will come visit him again tomorrow. Administrator [name omitted] notified.” d. On 1/25/25 at 11:46 AM, the note documented, “resident escalated and was shoving the fence so hard that it took five staff to hold the fence latch. family were called and they tried redirecting him with no success. [Medical Doctor] was called and after he tried redirecting him with no success he ordered haldol 5mg [miligram] IM [Intramuscular injection] injection. this was given in the left gluteal muscle. he is now in his room in a recliner with an aid by his side.” e. On 1/26/25 at 7:08 PM, the note documented, “Pt [patient] was calm in the a.m [morning] took all meds willingly including Ativan. By late afternoon pt became very agitated insisting he was leaving and went outside and was climbing over the fence. 2 cna's [Certified Nursing Assistant] were able to assist him down. pt made several attempts over a 2 hr period when validation and redirecting weren't effective, IM Haldol 0. 5mg given with results after an hour pt finally came back inside and is resting in his bed at this time. Report given to noc [night] nurse on incident.” f. On 4/12/25 at 6:34 PM, the note documented, “Rsident [sic] found outside after knocking down fence. resident walking down street cna saw resident and notified nurse.” (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	g. On 5/30/25 at 5:30 PM, the note documented, “Resident was found outside down the street a little way after apparently escaping through the fence after trying to break the fence down.staff was with him and trying to get him to come back when he broke through it. Resident reported he was trying to go home and that is why he was doing that. I was told that he was trying to go home so I asked him why he was trying to get home. He just said he was tired of being here. I tried calling his wife but she didn't answer. I notified the Dr. and administration. We took his vitals and they were within normal limits.” h. On 7/6/25 at 9:30 PM, the note documented, “Resident alert and oriented kicked fence out and eloped.Father and administration notified, 911 notified was told police offier [sic] was on his way back with resident.” i. On 7/7/25 at 5:35 PM, the note documented, “At 1640 [4:40 PM] CNA [Certified Nurse Assistant] noted that [resident 36] was outside and wanted to make sure that we all could keep an eye on him as he has a history of trying to elope. He then began to try to take apart the fence. I asked what he what his plan is and why he was wanting to leave. He stated to go home and talk to his wife, i offered to help him contact his wife and other interventions. Myself and 3 other people attempted to intervene, and redirect, and attempted to tell him that it was unsafe for him and other residents, to have this fence broken, he continued and stated that he does not care that it is unsafe. Eventually he took the panels apart and stepped on the retaining wall. He then jumped down the wall…. He then walked directly into the road and myself and [Director of Rehab] had to take him by the arms so that he did not walk into traffic, I repeated that with his very limited vision this was very unsafe and you are putting yourself and us in danger. We were able redirect to walk on the sidewalk but he just kept repeating that he was walking home.” Note: The facility only reported the 7/7/25 incident to the State Survey Agency. On 12/25/24, a care plan for risk for elopement related to impaired cognition due to traumatic subdural hemorrhage was initiated. The interventions identified on the care plan included: allow resident to verbalize feelings, initiated on 7/6/25; answer call light promptly, initiated on 12/15/24; anticipate resident's need and ensure needs are met, initiated on 7/7/25; check on resident every 15 minutes, initiated on 4/13/25; distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, initiated on 4/13/25; educate all staff on resident's elopement risk and specific behaviors/triggers such as family unavailable for phone calls, initiated on 4/12/25; Memory care unit, initiated on 5/30/25; monitor for signs and symptoms of pain or discomfort, 12/15/24; orient and reorient on an ongoing basis, initiated on 3/20/25; and re-educate resident regarding safety and risk of leaving, initiated on 12/15/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/11/25 at 12:45 PM, an interview was conducted with Registered Nurse (RN) 4. RN 4 stated that when a resident was missing from the facility they attempted to locate them. RN 4 stated that resident 36 was found further down the street and they had to call 911, at his father’s prompting, to get the resident back to the facility. RN 4 stated that the aide reported seeing resident 36 last at 8:30 PM, and they identified he was missing at 9:00 PM. RN 4 stated that resident 36, “breaks the fence” and “usually he's just down the street a little ways”. RN 4 stated that resident 36 had approximately 3 elopements where he had exited the facility. RN 4 stated that resident 36’s room was located next to an exit door to the locked courtyard and that the resident could go into the courtyard at any time. RN 4 stated that when resident 36 eloped they just went and found him and made sure he came back to the facility. RN 4 stated that she was not aware that staff had to step in front of him to prevent him from going into traffic. RN 4 stated that interventions to prevent elopement were to “keep a close eye on him, talk to him a lot so he doesn't want to leave.” RN 4 stated that usually when resident 36 gets upset, he wants to leave. RN 4 stated that resident 36 was going through a divorce so he got upset. On 8/12/25 at 1:19 PM, an interview was conducted with the Administrator (Admin). The Admin stated the investigations were primarily done by talking with the nurses and looking into the events. The Admin stated they did a formal investigation on 7/6/25 for resident 36. The Admin stated he wasn’t totally aware of the elopement section of the reportable so because of that not being clear, he didn’t report them. The Admin stated because resident 36 was with a staff member they didn’t report the elopements. The Admin stated he did not report or investigate the incidents for resident 42 or report them to the state. The Admin stated that yes, these incidents should have been investigated and reported to the state survey agency. 2. Resident 42 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of vascular dementia with agitation anxiety disorder, psychotic disorder with delusions, and depressive disorder. Resident 42’s medical records were reviewed between 8/4/25 and 8/20/25. Resident 42 had a BIMS completed on 3/2/25 which was 3 out of 15, which indicated severe cognitive impairment. Resident 42 had a MOCA completed on 12/13/24 which was 13 out of 30, which indicated moderate cognitive impairment. An elopement assessment dated [DATE] revealed that resident 42 had no history of wandering and was considered a low risk for elopement. An admission Elopement assessment dated [DATE] categorized resident 42 as low risk, with no history of wandering and had not wandered since admission to the facility. No other elopement assessments were found in resident 42’s medical records. Resident 42’s care plan included, “Elopement: The resident is an elopement risk r/t [related to] vascular dementia, history of wandering/getting lost.” Approaches to the care area included: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Complete wander risk assessment on admission and at least quarterly. Wander risk is: (specify: High, moderate, low) Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: (none listed) Identify pattern of wandering: is it purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. Orient and reorient on an ongoing basis. Place resident near nurses station to monitor. The goal for this care area was that the resident would not leave the facility unattended through the review date. Initiated 2/26/25. A review of resident 42’s progress notes revealed, on 3/12/15 at 5:29 PM,“CNA asked for help outside, as resident had jumped the fence out back. CNAs caught up with resident and escorted him inside. He is now kicking the front door and demanding to get out. Called guardian to make her aware - no answer, left vm [voice mail]. Spoke with DON - said go ahead and send him out. Called for EMS [emergency medical services].” An incident report dated 3/12/25 revealed, “Resident was seen attempting to climb the fence. Before CNA could get him, he hopped over. Once back in the facility, resident began kicking the front door, demanding out.“ The resident left the facility at 5:25 PM. The CNA’s caught up with the resident and were able to walk him back into the facility without issue. Orders were received to send the resident out to evaluate for possible UTI (urinary tract infection). Staff called EMS and the resident left the facility at 5:50 PM. An incident report dated 5/10/25 revealed, “Resident stepped on wood beside fence to climb over fence found outside alert and walking without difficulty. Skin tear to right forearm. New orders placed. Area cleaned with wound cleanser. Steri-strip applied with monitor for 7 days. No bleeding at site.” The resident stated, “I went over the fence.” It should be noted that no progress note was found regarding the incident on 5/10/25. No documentation could be found to indicate that resident 42's elopements were investigated and reported to the State Survey agency. On 8/4/25, at 7:15 AM, an observation was made of west outside door alarming frequently about every 5 minutes. During that time, there was nobody observed entering or exiting the west door, nor was there anyone observed to be near the west door. On 8/4/25 at 8:58 AM, an interview was conducted with RN 6 who was in the west hallway, regarding the alarm. RN 6 stated the alarm was to alert staff when a resident entered or exited the west door. At approximately 9:20 AM, the west door alarm stopped alarming completely and was not heard the remainder of the day. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission at Alpine Rehabilitation Center	25 East Alpine Drive Pleasant Grove, UT 84062

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/5/25 at 8:00 AM, a resident was observed exiting the west door and west outside door was heard. Shortly thereafter, the resident was observed re-entering the door, but there was no alarm when the door was opened. On 8/11/25 at 10:00 AM, west outside door was observed to be alarming, then again at 10:02 AM, again at 10:04 AM, again at 10:05 AM, again at 10:06 AM, again at 10:07 AM, again at 10:08 AM, Five doors were visualized, 2 in the dining room, 1 on the west hallway, 1 on the east hallway, and the door to the foyer and main entrance. No staff were near any of the doors, or looking at any of the doors to see if someone was entering or exiting. None of the doors opened during this time. All staff made no signs of noticing the alarm. Again at 10:10 AM, west outside door was heard with no staff response. On 8/12/25 at 8:37 AM, an interview was conducted with the Minimum Data Set Coordinator (MDSC). The MDSC stated resident 36 and resident 42 had eloped. The MDSC stated that when an elopement occurred, staff would get on the radio and let other staff know, follow the resident and notify the administration, and get the police involved if it was necessary. For resident 36, she stated they have reinforced the fence so he was unable to disassemble it and cannot push the panels through and they are very selective about who they admit to the facility. She stated all the staff know who have the tendencies to wander and keep an eye out for them and where they are. They look outside, and look for residents who are pacing. She stated they monitor any residents who can ambulate and can go outside on their own. She stated 15 minute checks were done for 72 hours and then the resident was re-assessed depending on the circumstance. If the provider needed to get involved, or labs needed to be drawn, they determined what needs to be done next. Elopements were documented in the risk management and in the progress notes. They would also be documented in the physician notes. The west door alarms when anyone goes out, and continues to alarm until someone clears it. Someone was required to go outside and see who went outside. When staff unlock the front door they are supposed to stand there until the person enters or exits and make sure the door was completely closed and locked before they leave. Staff in-services are provided depending on what happens during the month. They also do huddles for what happens in the week and focus on occurrences and remind staff about what things need to be focused on. Residents are assessed for wandering and elopement on admission. If she witnesses a resident elopes she would follow the resident and request another resident to come and help. She would notify the other staff and administration. The MDSC stated that if she was notified that there was an elopement, she would take the role of making sure the residents at the facility remained calm and cared for while the others were taking care of the elopement. She stated she did not know what a code [NAME] was, but could get back to me on that. She stated the IDT (Interdisciplinary) team updated the care plan, and that she was the primary person as the MDS coordinator. She reports elopements to the administration, meaning the DON and the administrator. FALLS: Resident 42's progress notes and incident reports revealed the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/19/25 at 2:25 PM, a nursing progress note revealed, “nurse called into the dining room and was found that resident was on the floor. It was reported that he hit his head. Neuro checks were initiated immediately. Vital signs within normal limits except for blood pressure being low. Pushed 500 ml [milliliters] oral fluids. He has no complaints of pain. Has been restless today and trying to stand over and over. Has sat himself on the floor several times before this fall.An incident report dated 3/19/25 at 12:30 PM, described the incident documented in the progress note. Action taken: neuro checks, vital signs, physician and POA [power of attorney] notified. No injuries were observed at time of incident. The resident was described as being confused.Resident 42’s care plan was not updated after the fall on 3/19/25. On 8/5/25 at 7: 05 PM, a nursing progress note revealed, “Resident stood up from chair in dining room and fell. Staff called for nurse, resident did not hit his head. Obrain [sic] vitals, resident was hypotensive. Assessed for injuries-none found. Resident appeared drowsy but was responsive to verbal commands. Helped resident get up and assessed gait and steadyness [sic]. Resident was taken to his room to lay down in bed. Guardian notified.”Resident 42’s care plan was not updated after the fall on 8/5/25. On 8/10/25 at 3:42 PM, a nursing progress note revealed, “Staff was notified that resident was trying to step up onto window ledge in dining and lost his balance and fell. Unable to say if he hit his head. Assessed for injuries with none noted. Vitals taken and baseline for resident. Neuros started. Hospice, DON [Director of Nursing], and Admin [Administrator] notified.”Resident 42’s care plan was not updated after the fall on 8/10/25. On 8/14/25 at 11:43 AM, an interview was conducted with Licensed Practical Nurse (LPN) 4 who stated resident 42 was a high fall risk. LPN 4 stated most of the precautions in place had come from the hospice company caring for resident 42, such as the fall mat next to his bed, ensuring his room is clear of fall hazards. LPN 4 stated resident 42’s blood pressure medications had been discontinued and his blood pressure had improved. LPN 4 stated staff help resident 42 walk to and from meals, and help him sit down and stand up. LPN 4 stated resident 42 was at risk for dehydration so his fluid intake was monitored. On 8/20/25 at 1:39 PM, an interview was conducted with the Director of Nursing (DON) who stated interventions should be in the care plan related to the falls on 8/5/25 and 8/10/25. The DON stated the staff try to intervene with resident 42 as much as he will allow them to. The DON stated that resident 42 will swing at staff if he does not want assistance, and would also pinch staff. The DON stated staff make sure resident 42 does not need anything. The DON stated sometimes resident 42 was ambulatory and sometimes he would eat by himself. The DON stated that to prevent falls for resident 42 right now staff were addressing his needs, assisting with toileting, addressing pain, monitoring agitation, keeping his bed in the lowest position, and prompting him to attend activities. The DON stated staff were tag-teaming resident 42 in the dining room to intervene quickly. The DON stated at the end of the alert charting assessment period, the IDT would meet and talk about what interventions should be for the recent fall, then the interventions are discussed in a staff huddle so all staff are aware of the new intervention. The DON stated the DON IT (Director of Nursing In Training) was going to investigate resident 42’s recent falls and put interventions into the care plan, they may just not have been put in yet. HARM (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Resident 7 was admitted to the facility on [DATE] with diagnoses which included multiple sclerosis, type II diabetes, peripheral vascular disease, and chronic pain syndrome. Resident 7’s medical record was reviewed from 8/4/25 through 8/20/25. A Facility Reported Incident (FRI) documented, “on 02/14/2025 at 10:45 am, the facility reported that on 02/12/2025 at 2:10 pm, [Plant Operations 2] who was taking resident 7 to a dr. appointment didn't properly secure front straps to the wheelchair and resident 7 picked his legs up and tipped backward. The Resident has a abrasion to back of head. Education given to [Plant Operations 2] and more training given. ” A progress note dated 2/11/25 revealed, “during transport to dialysis, resident reportedly fell out of his chair hitting his head and back. then transport pulledover [sic] and turned hazards on and got out of the van. grabbed chuck then put him back in his chair and buckled him back. Tookhim [sic] to his appointment then reported the incident to the nurses at the dialysis place. then when transport came back 15minutes later, reported it to the nurses here. neuro checks initiated at 1600. first vital signs back to the facility after return was103 [sic], 100/64, 18, 95%, 96.5. no pain verbalized upon arrival.” A progress note dated 2/14/25 revealed, “The resident complained of pain in his head, neck, spine and back so I called the MD [medical doctor] and he ordered XRay of Skull, XRay of Neck, XRay of Cervical, thoracic and lumbar spine STAT [immediately].” … “The XRays came back and {provider] was sent the XRay results. He said there was no current acute problems. Everything looked fine. Continue treating with Tylenol for pain as needed.” A quarterly Minimum Data Set (MDS) dated [DATE] documented resident 7 was a partial assist with mobility and used a wheelchair and walker for mobility. On 8/4/25 at 9:00 AM, an interview was conducted with resident 7. Resident 7 stated that he had been in an accident in the facility van about 9 months ago. Resident 7 stated that Plant Operations 2 forgot to buckle his wheelchair into place and when the van moved forward resident 7 fell backward, his feet went up into the air and he hit his head on the ramp. Resident 7 stated he got a sore on the top of his head but he did not remember if there was pain or if he had an x-ray completed. Resident 7 stated it was an accident and it never happened again. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/14/2025 at 10:25 AM, an interview was conducted with Plant Operations (PO) 2. The PO 2 stated he was no longer an employee at the facility but he did remember the incident with resident 7. PO 2 stated he had transported resident 7 to dialysis and had forgotten to secure the wheelchair after he put it in the van. PO 2 stated he was in charge of transporting the residents to medical appointments and that the facility did do verbal education on how to secure the wheelchairs in the vans but there was no demonstration. PO 2 stated there were these anchors in the floor and you would lock the tires with the brakes, then you would put the anchors from the floor onto the wheelchair and tighten them and then you would put a seatbelt across the resident. PO 2 stated there were 2 anchors in front and 2 anchors in the back and the lap belt would go under the arm rests and over the resident. PO 2 stated you did not anchor to the tires because they could roll but you would anchor to a secure spot that you could find on the wheelchair. PO 2 stated the residents were facing forward in the van so he could see their face in the mirror. PO 2 stated when he first started working at the facility he did not hook the front anchors and that was when resident 7 rolled and hit his head. PO 2 when he started to drive he looked in his rearview mirror and saw resident 7's feet in the air. PO 2 stated after it happened he pulled over to the side of the road and got resident 7 sat back up. PO 2 stated that resident 7 had a sore on the top of his head but he seemed ok. PO 2 stated he got resident 7 buckled in and took him to dialysis. PO 2 stated he told the dialysis staff to watch resident 7 and then he told the nurse at the facility what had happened when PO 2 returned. PO 2 stated he did not call anyone to come have resident 7 assessed since it was not that big of an injury. PO 2 stated the facility does training that if a resident falls at the facility we are not supposed to move them in case they have hurt their head or have a spinal injury but that did not count when we are in the van. PO 2 stated after the incident we did another training on how to secure the wheelchairs properly. This time they taught me that I needed to secure all 4 points, not just some of them. I can't remember if they taught me that the first time was too long ago. PO 2 stated it was an accident. On 8/14/2025 at 8:42 AM, an interview was conducted with PO 1. PO 1 stated his job was to drive residents to their appointments. PO 1 stated that they had a van that they put the chair in and they had a straps, 2 in the front and 2 in the back, to tie it down. PO 1 stated the residents were usually facing forward when they ride in the van. PO 1 stated resident 7 usually sits up front in the passenger set of the van with a seatbelt. PO 1 stated they did train him on how to secure wheelchairs into the transport van before he started to do it. On 8/18/2025 at 10:05 AM, an interview was conducted with the DON. The DON stated the process for transportation was before they drove any residents they received education on how to put the residents into the van, how to lock them down, how the locking mechanisms and the seatbelts work and all of those things. The DON stated she could not be sure but she believed PO 2 had received the information. On 8/18/2025 at 2:16 PM, an interview was conducted with the Admin. The Admin stated they educated PO 2 prior to him transporting resident 7 but they do not have any documentation of it. The Admin stated they did more education after the incident and went out to the van and demonstrated how to secure a resident the correct way. The Admin stated that it should not have happened but it did. [NAME] stated the transporters were all educated on how to transport the residents. The Admin stated if there was an accident the staff are supposed to call for assistance and get the resident evaluated. A document titled, Facility Driver Orientation Checklist” was provided by the facility on 8/6/25. The checklist was not filled out or signed by the PO 2. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A document titled, “Safe Transport of Residents” with a date of 2/18/25 was signed by PO 2. Please note this document was signed after the incident occurred with resident 7. POTENTIAL FOR HARM 4. Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included alcohol dependence with Korsakoff Syndrome, alcohol-induced persisting amnesic disorder, mild dementia with agitation, major depressive disorder, psychotic disorder with delusions, altered mental status, and seizures. On 8/19/25 at 11:27 AM, an observation was made of resident 12 in his room. Resident 12 was laying on a mattress on the floor next to his bed with his limbs hanging over the edges. No staff were observed in his room or in the hallway. After staff were notified of resident 12’s position by surveyor, a Certified Nurse Assistant (CNA) was observed to go into his room at 11:31 AM. Resident 12's medical record was reviewed from 8/4/25 through 8/20/25. An Annual MDS dated [DATE] indicated a BIMS could not be conducted because the resident was rarely/never understood. It further indicated a short and long-term memory problem and Cognitive Skills for Daily Decision Making was Severely impaired. It further indicated resident 12 had impairments to both sides of his upper and lower extremities, required substantial/maximal assistance to roll left and right in bed, was dependent to transfer from bed to chair, and was dependent on staff to use his manual wheelchair. A Nursing Progress Note dated 5/2/25 at 2:19 PM indicated, “resident rolled unto [sic] fall mat next to bed. no injuries noted. denies pain at this time. smiling and saying ‘i love you’ over and over. assisted him back into bed with a three person transfer. is resting comfortably in bed”. An Alert Charting document dated 5/10/25 at 1:00 AM indicated, “resident found in between bed and wall. resident did not sustain any injuries. resident was helped back into bed and neuros were initiated. Interventions to ensure brakes are initiated and ensure proper body positioning.” An Incident Report dated 7/3/25 at 10:00 PM indicated, “Resident found by cna lying between mattress and wall”. A Nursing Progress Note dated 7/9/25 at 2:14 PM indicated, “Resident found by cna lying betweenof [sic] beds and wall mattresassisted [sic] to bed,[sic] , neuro == xhecks [sic] started , appropriate administration notifed [sic], [medical doctor name redacted] notified assured wheels to bed are locked properly”. A Nursing Progress Note dated 7/14/25 at 11:14 AM indicated, “Resident fouond [sic] lying on flo[TRUNCATED]

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that for 2 of 32 sampled residents the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that this was not possible or resident preferences indicated otherwise. Specifically, 2 residents experienced significant weight loss and one of the residents required cueing to eat and did not receive it. Resident identifiers: 25 and 33. Findings included:1. Resident 33 was admitted to the facility on [DATE] with diagnoses which included Parkinson's with dyskinesia, dementia, psychotic disorder with delusions due to non psychological conditions, and anxiety disorder. Resident 33’s medical record was reviewed from 8/4/25 through 8/20/25. Resident 33 had a BIMS (Brief Interview for Mental Status) completed on 6/14/25 and scored a 3 out of 15 which indicated severe cognitive impairment. Medicare Meeting notes on 6/11/25 documented resident 33’s confusion and cognition continued to fluctuate. A physician note dated 6/9/25 revealed resident 33 had severe cognitive impairment and was progressively declining. Resident weight was 186.6 pounds on 2/9/25 and 171.0 pounds on 8/6/25 - this is a 14.4 pound weight loss in 6 months with no new interventions put into place. Skin and Weight notes revealed the following: 2/13/25: Weight: 186.6 pounds. Showing fluctuations over the past week, ranging from 186-192 lbs. Weight was overall stable. Appetite was good and eats all meals. Skin was intact. Will continue to monitor weekly until stable. 2/21/25: Weight: 192.2 pounds. (Incorrect weight documented) Weight was stable this week. Weight on 02/11 struck out due to inconsistencies. Appetite was good and eats all meals. Skin was intact. Will continue to monitor weekly until stable. 2/25/25: Weight: 184.2 pounds. Weight was stable this week x [times] 3. Appetite was good and eats all meals. Skin was intact. Will continue to monitor weekly until stable. 3/7/25: Weight: 183.2 pounds. Weight was stable this week. Appetite was good and eats all meals. Skin was intact. Will continue to monitor monthly. 4/3/25: Weight: 180.0 pounds. Weight was stable this week. Appetite was good and eats all meals. Skin was intact. Will continue to monitor monthly. 5/9/25: Weight: 174.0 pounds. Weight was stable this week. Appetite was good and eats all meals. Has had two falls this month possibly related to current UTI (urinary tract infection) being treated with Macrobid, cipro. Skin was intact. Will continue to monitor monthly. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/15/25: Weight 176.4 pounds, Weight was stable this week. Appetite was good and eats all meals. Has had two falls this month possibly related to current UTI being treated with Macrobid, cipro. Skin was intact. Will continue to monitor monthly. 5/22/25: Weight 177.2 pounds. Weight was stable this week. Cueing was required for all meals as he will get up and walk to his room before drinking or eating anything. UTI symptoms have cleared. Increase in anxiety r/t [related to] being able to communicate like he used to. Skin was intact. Will continue to monitor monthly. 5/30/25: Weight 178.2 pounds, Weight was stable this week. Cueing was required for all meals as he will get up and walk to his room before drinking or eating anything. Increase in anxiety r/t to being able to communicate like he used to. Skin was intact. Will continue to monitor monthly. 6/4/25: Weight: 176.6 pounds. Weight was stable this week. Cueing was required for all meals as he will get up and walk to his room before drinking or eating anything. Increase in anxiety r/t to being able to communicate like he used to. Skin was intact. Will continue to monitor monthly. 7/1/25: Weight 175.8 pounds. Resident weight was stable this review period. Skin intact. Monitoring monthly, will continue monthly review. 8/8/25: Weight 171.0 pounds. Was triggering for 10% weight loss in past 180 days but weight has stabilized. No new concerns. Resident 33 had a care plan focus area of nutritional problem or potential nutritional problem r/t T2DM (type 2 Diabetes Mellitus), Parkinsonism, heart disease w/ [with] heart failure, UTI, depressive disorder, dementia, anxiety, hyperlipidemia, and GERD (gastroesophageal reflux disease) which was last revised on 11/26/24. Interventions in place for this problem included: Monitor/record/report to MD (medical doctor) PRN (as needed) s/sx (signs/symptoms) of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3lbs (pounds) in 1 week, > (greater than) 5% (percent) in 1 month, >7.5% in 3 months, >10% 6 months was initiated on 11/27/23 and no update or revision was documented. Assistive Devices: Inner lipped plate, built up utensils was initiated on 8/1/25 and revised on 8/5/25. It should be noted during the survey resident 33 was not observed to eat with specialized dinnerware and was seen served meals on ordinary plates with traditional utensils and Styrofoam bowls. From 7/22/25 to 8/20/25 Resident 33 was documented as eating between 76 - 100% of his meals 23 out of those 30 days and continued to decrease in weight. Progress notes documented: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/25 … “His memory seems to be declining. nursing tells me he forgets that he has talked to them about something that happened anhour (sic) ago. He is losing weight. he tells me he is not hungry. May consider mirtazapine At risk for nutritional deficits due tocognitive (sic) dysfunction.” On 8/4/25 … “He's at risk for malnutrition due to his Parkinson's disease and dementia…” Physician orders were reviewed and no order for Mirtazapine was documented. On 8/13/25 at 10:15 AM, an interview was conducted with Nursing Assistant (NA) 6. NA 6 stated resident 33 could feed himself and did not need assistance. NA 6 stated he was a pretty good eater and would eat most of his food. NA 6 stated that resident 33 was able to eat on the regular plates and use the regular utensils at the facility. NA 6 stated she was unsure how much weight resident 33 had lost. On 8/20/25 at 12:50 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that there were items in the refrigerator to offer the residents for the continental breakfast. The foods included sandwiches, pudding, cottage cheese and cheese. CNA 1 stated that there was no place to document if residents ate the continental breakfast. CNA 1 stated that only residents who could feed themselves eat it. CNA 1 stated the evening snack offered at 7 PM was the same as the continental breakfast. CNA 1 stated resident 33 sometimes needed cueing but was able to eat independently. CNA 1 stated that resident 33 was not offered the continental breakfast because he slept in and came to eat the breakfast only. On 8/20/25 at 1:15 PM, an interview was conducted with the Registered Dietician (RD). The RD stated for a long time the facility was a part of [NAME] alternative program, but they were not apart of that anymore. The RD stated when transitioning away from that program they kept the 5 meals per day. They have been doing that for a long time, it was in place and working really well for the residents. The RD stated they had kept the 5 meals per day set-up which was a continental breakfast for early risers and included breakfast, lunch, dinner, and the night snack. The RD stated she did not feel like she should keep the items like the muffins and such so she took that off the schedule. The RD stated the residents could ask for food as soon as staff were there. The RD stated the residents were able to get eggs, toast, cereal, yogurt before breakfast. The RD stated that when the breakfast menu was served, residents could eat that meal also. The RD stated the residents were not required to eat both meals. The RD stated meal charting was completed for breakfast, lunch and dinner in the record and she would need to get more information on where they were charting additional snacks. The RD stated it was meeting the caloric and protein needs that the menus provided. The RD stated that when approving the menus the menu needed to have 2000 calories and 80 grams of protein per day as a weekly average. The RD stated that these values were based only on the breakfast, lunch and dinner. The RD stated that some of the snacks did not have a vegetable component offered, and the main meal for getting vegetables was dinner. (continued on next page)

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Mission at Alpine Rehabilitation Center	25 East Alpine Drive Pleasant Grove, UT 84062

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RD stated that resident 33 had been losing weight. Resident 33 was stable for a while, a couple months ago, but starting in May 2025 he had weight loss and then he was stable between 171 and 177 until the beginning of June. The RD stated he had been around 171 over the last month and had been more stable now for the last few weeks. The RD stated resident 33 has had less ability to communicate recently. The RD stated resident 33 was given adaptive equipment of build up utensils and a lipped plate. The RD stated resident 33 was started on Ritalin on 5/26/25 to help with some depressive symptoms, and unfortunately that can cause a decrease in appetite. The RD stated resident 33’s meal percentage intake was scattered but about half the meals were between 76-100% eaten and the other meals split between 25-50% and 51-75% eaten. The RD stated that when a resident finished eating the CNA should ask if the resident wanted more food. The RD stated that the skin and weight meetings were done weekly but she attended every other week. 2. Resident 25 was admitted to the facility on [DATE] with diagnoses which included fracture of right humerus, type 2 diabetes mellitus, difficulty in walking, major depressive disorder, Alzheimer’s disease, history of transient ischemic attack and cerebral infarction, and chronic kidney disease stage 3. On 8/4/25 at 8:22 AM, an observation was conducted of resident 25. Resident 25 was observed to walk to the dining room. At 8:49 AM, resident 25 left the dining room before being served breakfast. At 8:59 AM, staff walked with resident 25 back into dining room. At 9:06 AM, resident 25 had his breakfast sitting in front of him, he was not eating or drinking. At 9:49 AM, resident 25 continued looking around the room, he had not eaten his breakfast that was in front of him. Resident 25 then stood up and left the dining room, and staff was observed to bring him his walker. On 8/5/25 at 8:31 AM, an observation was conducted of resident 25. He was sitting in the dining room with the Director of Nursing (DON) who was cueing him to eat. The DON got up and left resident 25’s side, he stopped eating and was looking around the room. At 8:48 AM, resident 25 was observed to unsuccessfully attempt to eat food with a butter knife. At 8:53 AM, the DON walked by and cued the resident to eat and he started to eat again. At 9:15 AM, the Dietary Manager (DM) asked resident 25 if he was done eating and asked if he would drink more chocolate milk, he declined, and the DM cleaned up his plate. His plate was observed and he had eaten approximately 85% of the main egg dish, 75% of the watermelon, 50% of the milk, 0% of the chocolate milk, and 85% of the apple juice. On 8/14/25 at 12:09 PM, an observation was made of resident 25 sitting in the dining room. He was served one egg roll and a bowl of fruit salad. At 12:22 PM, he was observed to have eaten 100% of his egg roll and 0% of his fruit salad. On 8/18/25 at 9:28 AM, an observation was made of resident 25 eating on his own in the dining room and then he got up and left with no staff intervention. At 9:33 AM, a staff member picked up his breakfast plates and stated it was resident 25’s and that they would report an intake of 75% to his CNA (Certified Nurse Assistant) so they could document it. Resident 25's medical record was reviewed from 8/4/25 through 8/20/25. A Weight Summary indicated:a. 6/12/25 155.4 lbs. (pounds)b. 6/16/25 153.2 lbs.c. 7/6/25 150.3 lbs.d. 7/11/25 151.4 lbs.e. 7/17/25 145.8 lbs.f. 8/6/25 143 lbs.g. 8/8/25 143 lbs.h. 8/14/25 141.4 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Skin and Weight Review dated 7/17/25 indicated his “Most Recent Weight” was 151.4 lbs. on 7/11/25 and that his “Change in Weight” was “Stable”. It further indicated an “Average Percentage of Meal Intake” was 51-75%. It further indicated, “Restorative Shake BID [twice a day], Dr [doctor] started remeron to help with depression and appetite [sic]”. It further indicated the “Average Percentage of Supplement Intake” was 0-25% and an “Average Percentage of Snack Intake” was 26-50%. It further indicated his “Level of Eating Assistance” was “Independent” and “Set Up Only”. It further indicated that resident 25 was receiving wound care related to a partial thickness surgical wound. It further indicated, “Resident has been able to start ambulating with assistance and appears to be more active. Restorative shakes were started on the 7/9. Intake is 50-100% per shake. Mirtazepine started on 7/11 to promote appetite. Resident having some increased confusion. Continue to encourage oral intake and monitor weekly.” A Skin and Weight Review dated 7/23/25 indicated his “Most Recent Weight” was 145.8 lbs. on 7/17/25 and that his “Change in Weight” was “2% gain in 7 days”. It further indicated an “Average Percentage of Meal Intake” was 51-75%. It further indicated, “Restorative Shake BID, Dr started remeron to help with depression and appetite [sic]”. It further indicated the “Average Percentage of Supplement Intake” was 0-25% and an “Average Percentage of Snack Intake” was 26-50%. It further indicated his “Level of Eating Assistance” was “Independent,” “Set Up Only,” and “Cueing”. It further indicated, “Skin intact. monitoring surgical site to RUE [right upper extremity]. Abx [antibiotics] for recent infection will be completed 8/2. Mirtazepine started on 7/11. Receiving therapy for rehab following Left femur fracture & surgery…Increased activity outside of his room, walks to meals and occasionally walks the hallway”. A Skin and Weight Review dated 8/5/25 indicated his “Most Recent Weight” was 143 lbs. on 8/8/25 and 148.8 lbs. on 7/23/25 that his “Change in Weight” was “Stable” and “2% loss in 7 days”. It further indicated an “Average Percentage of Meal Intake” was 51-75%. It further indicated the “Average Percentage of Supplement Intake” was 0-25% and an “Average Percentage of Snack Intake” was 26-50%. It further indicated his “Level of Eating Assistance” was “Independent,” “Set Up Only,” and “Cueing”. It further indicated, “Restorative shakes were started on the 7/9. Mirtazapine started on 7/11 to promote appetite. New orders to start Med Pass 60ML BID to assist with weight gain. Pain appears to be well managed. Resident continues having confusion r/t [related to] progression of disease. Staff continues to encourage oral intake and monitor weekly.” A Meal Task document dated 7/22/25 through 8/20/25 indicated the percentage of intakes for breakfast, lunch, and dinner was 0-25% 21 times, 25-50% 13 times, 51-75% 11 times, 76-100% 9 times, and Resident Refused 10 times. The Care Plan indicated a Problem of “The resident has an ADL [Activities of Daily Living] self-care performance deficit r/t [related to] Alzheimer's disease, recent left hip replacement after fracture, right humerus fracture and repair. Date Initiated: 06/17/2025 Revision on: 07/15/2025”; with the Approaches, “EATING: The resident is usually able to eat with setup assitance/cueing [sic]. Date Initiated: 06/17/2025 Revision on: 07/15/2025.” (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan further indicated a Problem of “The resident has a potential nutritional problem r/t type 2 diabetes, HLD [hyperlipidemia], HTN [hypertension], CKD [chronic kidney disease] stage 3, Alzheimer's disease, MDD [major depressive disorder], atherosclerotic heart disease. Date Initiated: 06/17/2025 Revision on: 07/15/2025”; It further indicated a goal of, “Resident will not have significant weight loss, 5% in 30 days, 7.5% in 90 days, 10% in 180 days. Date Initiated: 06/17/2025 Revision on: 07/14/2025”; and the Approaches included: a. Monitor intake and provide alternative options if intake is low. Date Initiated: 06/18/2025 Revision on: 07/15/2025;b. Provide and serve diet as ordered. Date Initiated: 06/17/2025;c. Provide diet to maintain weight and strength. Date Initiated: 06/18/2025 Revision on: 07/15/2025;d. Provide resident with required level of assistance for eating/drinking while allowing as much independence as possible Date Initiated: 06/18/2025; ande. Restorative shake Date Initiated: 06/18/2025. The Care Plan further indicated a Problem of “The resident is at risk for impaired skin integrity r/t recent surgery, incontinence, altered mobility, impaired cognition. Date Initiated: 06/17/2025 Revision on: 07/15/2025”; with the Approaches, “Monitor nutritional status. Serve diet as ordered, monitor intake and record. Date Initiated: 07/15/2025”. On 8/20/25 at 11:36 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated there was a snack provided at 7:00 PM every day but he did not think the snacks were documented. On 8/19/25 at 1:29 PM, an interview was conducted with the DM. The DM stated the CNAs passed out the snacks. The DM stated if a resident missed the 7:00 PM snack, the resident could ask for snacks and that there were sandwiches in the fridge. The DM stated she could not answer what should be done about residents who missed the 7:00 PM snack and could not say if they were hungry or not. On 8/20/25 at 1:14 PM, a telephone interview was conducted with the Registered Dietician (RD). The RD stated there was a concern for resident 25’s weight loss. The RD stated she received reports that he was not eating well and that the DM kept a close eye on the residents. The RD stated she was unsure where snack intakes were documented but the nurses and CNAs paid attention to that.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined, for 1 out of 32 sampled residents, that the facility did not provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Specifically, a resident identified as having behavioral outbursts and was involved in a sexual abuse incident did not receive any behavioral health services nor was an evaluation provided after the incident. Resident identifier: 11.Findings included:Resident 11 was admitted to the facility on [DATE] with diagnoses which included traumatic brain injury, cerebral infarction, aphasia, anxiety disorder, unspecified intellectual disabilities, and depression.On 8/4/25 at 7:34 AM, an observation was made of resident 11 walking down the hallway. Resident 11 was asked how she was doing, and resident 11 responded with fuck you.On 8/4/25 at 8:06 AM, resident 11 approached the licensor in the dining room. Resident 11 mumbled micky mad and demonstrated slapping her hands together. Resident 11 was asked if she was okay and she replied yes.On 8/04/25 at 10:53 AM, an observation was made of resident 11 in the dining room seated on the ground. Resident 11 had spilled her goldfish crackers and got down on the floor to eat them. The Director of Nursing (DON) approached the resident, cleaned up the spilled food, and assisted the resident off the ground. The DON took the bag of crackers and threw it away.On 8/05/25 at 10:42 AM, an observation was made of resident 11 on the back patio. Resident 11 was seated on the ground and was digging in the dirt. Outside on the patio were two male residents, resident 33 and 21. Resident 33 was observed ambulating with the use of a walker. Resident 33 stated that he was lost. On 3/26/25 at 9:13 AM, a complaint was called into the State Survey Agency (SSA) by an Adult Protective Services (APS) investigator. The APS investigator stated that they received a report that resident 11 was sexually assaulted by a fellow resident [resident 49]. The APS investigator reported that on 3/14/25 a Certified Nurse Assistant (CNA) was checking on resident 49 and found him with his pants down on top of resident 11 and was attempting to initiate sexual contact. On 8/5/25, Resident #11's medical records were reviewed.On 3/9/25, resident 11's admission Minimum Data Set (MDS) assessment documented that a Brief Interview for Mental Status (BIMS) was not conducted due to the resident being rarely/never understood. The assessment documented that the resident 11 had short term memory (STM) and long term memory (LTM) deficits. The assessment documented that resident 11 was not able to recall the current season, the name and faces of staff, and if they were in a nursing home or hospital. The assessment documented that the cognition skills for daily decision making was moderately impaired. The assessment documented that resident 11 had behavioral symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming and disruptive sounds and the behavior that occurred 1-3 days. Resident 11's progress notes documented the following: a. On 3/31/25 at 1:01 PM, the Social Services Note documented, [Resident 11] is new to the facility. [Resident 11] transferred from another skilled nursing facility. [Resident 11] has adjusted well to facility. [Resident 11] does have the occasional behaviors such as screaming and crying. This usually occurs when she needs something fixed and moved in her room. Staff is able to quickly assess the situation and provide a solution and comfort to [Resident 11]. [Resident 11] does also have sexual behaviors that are monitored by staff. [Resident 11] enjoys spending time in her room and participating in activities. [Resident 11] does need assistance with ADLs [activities of daily living], staff will assist with ADLs and [Resident 11] is cooperative and does well by pointing to what she needs. [Resident 11] family participated in recent IDT [interdisciplinary team] and is grateful for care she receives and wishes for [Resident 11] to remain long term in facility. b. On 4/4/25 at 1:08 PM, the Nursing Progress Note documented, resident has been fine all morning up until about 20 minutes ago. I heard [Resident 11] yelling very loudly and out of control. As I walked up to try to console her she was very agitated yelling and screaming offensive language. I tried to offer her some meds, some snacks and even a change of scenery. I called the MD and got an order prn med and offered it to her and she took It. Within an hour later she was acting better and she was not yelling as much. Vital signs were within normal limits. c. On 4/6/25 7:53 PM, the Nursing Progress Note documented, Pt had another total meltdown swearing, screaming at everyone vulgar languge [sic] jumping at everyone in a threatening manner. Pt grabbed a pt [patient] box of playing cards [NAME] [sic] throgh [sic] it acrossed [sic] the room. Ativan given x2 some relief with second dose. Pt redirected by the nurse taken outside several times and

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on interview and record review, the facility did not provide training to their staff that at a minimum educated staff on activities that constituted abuse, neglect, exploitation, and misappropriation of resident property; procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property; and resident abuse and neglect prevention. Findings included: On 8/6/25 at 11:58 AM, an interview was conducted with Nursing Assistant (NA) 6. NA 6 stated they did education at the facility. NA 6 stated they just went over things that needed to be fixed. Usually the teaching was done during the in-service or the daily huddle that they had with everyone. NA 6 was not sure what the Quality Assurance and Performance Improvement (QAPI) meetings were about or if there was education that went over that stuff. On 8/19/25 at 1:33 PM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated they did get education at work but he was unsure what QAPI was. RN 2 stated they did education when there was something that needed to be corrected.During an interview on 8/19/25 at 9:15 AM, the Administrator stated there had been training done on abuse every month. The Administrator stated they discussed the types of abuse that could happen in a facility. The Administrator stated they did not have a way to determine if the information was understood by the staff but they just kept educating on it monthly. The Administrator stated the staff in-services did not provide education on a person's ability to give consent so the staff were not educated on that area. The Administrator stated that he had sent over the facility in-services to the survey team.It should be noted, none of the in-service staff trainings from 1/16/25 through 7/17/25 that were provided by the facility on 8/19/25 included agendas for abuse training. Agendas for dementia, assault, de-escalation and speech/space/grace trainings were provided but none of these trainings defined abuse, explained types of abuse, what to do when abuse occurred, who to report the abuse to and who had the ability to give consent.A follow up interview was conducted on 8/20/25 at 8:57 AM with the Administrator. The Administrator stated they have tried to ensure everyone understood the teaching when it was provided, but staff may not practice what was taught when they were working. The Administrator stated they were trying to make sure the education encompassed the entire problems addressed during QAPI. The Administrator stated that the abuse training needed to be updated and they were trying to make that better. [Cross refer to F600]