STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465092	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Uintah Health Care Special Service District	510 South 500 West Vernal, UT 84078

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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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 2 out of 22 sampled residents, that the facility failed to ensure that each resident received and the facility provided 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, the facility failed to provide behavioral health care and services to a resident who had expressed a desire to commit suicide and interventions and monitoring were not implemented prior to the resident successfully committing suicide. Additionally, another resident made statements of wanting to hang himself and behavioral health care and services were not provided and interventions and monitoring were not implemented. The deficient practice identified was cited at an Immediate Jeopardy level for both residents. Resident identifiers: 22 and 40. NOTICE On 9/24/25 at 5:31 PM, Immediate Jeopardy (IJ) was identified when the facility failed to implement Centers for Medicare and Medicaid Services recommended practices to ensure each resident had the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Specifically, resident 40 successfully committed suicide after expressing this desire to staff and behavioral health services, interventions, and monitoring were not implemented. Additionally, resident 22 made statements of wanting to hang himself and behavioral health services, interventions, and monitoring were not implemented. Notice of the Immediate Jeopardy was given verbally and in writing to the Administrator (ADM) and Director of Nursing (DON). On 9/25/25, the Administrator provided the abatement plan for the removal of the Immediate Jeopardy effective on 9/25/25 at 11:00 AM. The abatement plan for suicide prevention included the following:1. All residents will undergo a mental health screening by a qualified profession (sic) on September 27, 2025. Residents identified as being at risk for suicidal ideation and/or self-harm will receive intervention from the screening professional. Care plans will be updated to reflect these changs {sic} and interventions. In order to keep the residents safe, we will interview each resident today and ask the following questions. I'm here because we want to keep you safe. Have you had any thoughts of harming yourself or wanting to die? If yes: Do you have a plan - what, when, and how? (if yes ˆ escalate immediately). If the answer is yes, we will immediately implement our Suicide Prevention/Protocol. If the answer is no, there will be no further action. All documentation will be filed in the resident's chart.2. All current staff will receive suicide prevention training at the beginning of their next scheduled shift. New staff will receive this training during employee orientation. Additionally, all licensed nurses will be trained on the [NAME] Protocol and our suicide prevention policy who are working today and all other nurses will complete before their next shift.3. Charge nurses will monitor progress notes daily starting immediately, revieing the past 36 hours for resident safety risks to be communicated according to our suicide prevention policy/protocol. This monitoring will continue for 90 days. Charge nurses will sign a daily log confirming completion and the Director of Nursing (DON) will monitor this log weekly compliance, communicating any findings to the Administrator.4. [Registered Nurse (RN) 1] interviewed [Resident 22] on 9/25/2025 @ 10:45 using the [NAME] Protocol worksheet. RN 1 has had training from previous (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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	employment at the hospital and used this protocol during her employment there. [Resident 22] answered No to questions 1, 2 & 6. He will continue with his current care plan since he is not in immediate danger. On 9/25/25, 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 9/25/25. Findings included: 1. Resident 40 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, major depressive disorder, anxiety disorder and insomnia. Resident 40 passed away on 9/13/25 due to a successful suicide attempt. Resident 40's medical record was reviewed from 9/22/25 through 9/25/25. On 5/30/24, resident 40's admission Minimum Data Set (MDS) documented under the resident mood interview that the resident answered yes to “Little interest or pleasure in doing things”; “Feeling tired or having little energy”; “Trouble concentrating on things, such as reading the newspaper or watching television”; and “Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual.” Resident 40 had a severity score of 10, indicating a moderate level of depression. On 8/29/24, resident 40's Quarterly MDS documented under the resident mood interview that the resident answered yes to “Little interest or pleasure in doing things”; “Feeling down, depressed, or hopeless”; “Trouble falling or staying asleep, or sleeping too much”; “Feeling tired or having little energy”; “Poor appetite or overeating”; “Feeling bad about yourself - or that you are a failure or have let yourself or your family down”; “Trouble concentrating on things, such as reading the newspaper or watching television”; “Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual”; and “Thoughts that you would be better off dead, or of hurting yourself in some way.” Resident 40 had a severity score of 26, indicating a severe level of depression. Resident 40's progress notes revealed the following: a. On 5/24/25 at 1:35 PM, the admission Note documented, “Patient is having a hard time; states he wants to hurry and get things going. Friend has brought patient's own brown smooth cover electric chair. [Resident 40] states I want my own chair I don't want to sit in a chair that someone died in, I know how these places are. [Resident 40's] chair was set next to his bed. Medications taken from daughter and reviewed and counted. When going thru [sic] the check list of his room he states I'm not one of these people that are old I'm [AGE] years old and I can do things for myself. I just came in and lost my kids and everything I have to be here. I just want to go to sleep.” b. On 5/27/24 at 2:35 PM, the Behavioral Symptoms note documented, “Resident went into the dining room around 1300 (1:00 PM) and said, ‘I don't know what the hell that noise is, but somebody better get off their ass and fix it or I'm going to blow my fucking top.' Staff reported another resident's call light was going off and the noise upset him. When nurse went to residents room he appeared anxious, he kept rubbing his face with his hands, stating ‘that noise set me off' ‘I'm sorry, I'm too nice of a person for this, this isn't me' ”. c. On 5/27/24 at 4:04 PM, the Behavioral Symptoms note documented, “Resident states his (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	visit resident. Care plan and orders reviewed. POLST [Physician Order for Life Sustaining Treatment] signed. New orders are as follows: 1) start Sertraline 50mg PO AM.” l. On 6/30/24 at 4:19 PM, the Behavioral Symptoms note documented, “resident asked for 2 o'clock medications early stated he didn't feel right in the head and needed to be left alone. Resident placed a note on the door not to bother him until 1630 [4:30 PM]”. m. On 7/1/24 at 10:30 PM, the Behavioral Symptoms note documented, “At times the resident will be confused about the time of day it is, and express some agitation, with some queing [sic] and redirecting he calms down, ”. n. On 7/12/24 at 2:48 PM, the Physician Visit note documented, “New Order: 1. Increase Zoloft (Sertraline HCL [hydrochloride] 50mg to 100mg po AM 2. Decrease Zyprexa to 2.5mg daily.” o. On 7/12/24 at 3:00 PM, the Behavioral Symptoms note documented, “ “Patient is up to the Nursing Station. He states tell [physician name omitted] I think about Suicide daily. I ask if he had talk [sic] with [physician name omitted] about this, he states no, there where [sic] to many people in the room. Call was made to [physician name omitted] to inform him of patient's statement. [Physician name omitted] request to monitor patient closely and that he has increase his antidepression [sic] medication.” p. On 7/16/24 at 5:47 PM, the Behavioral Symptoms note documented, “resident isolated himself in his room for a majority of the day.” q. On 8/2/24 at 4:16 PM, the Physician Visit note documented, “[Physician name omitted] here to see resident and review plan of care. Discussed how he has been feeling since increasing the zoloft to 100mg and decreasing the zyprexa to 2.5mg. Resident voices he has felt better but feels like it could be adjusted just a little more, and also added he could use something to help him sleep. New order received to discontinue zyprexa and add trazodone 50mg one po QHS [every hour of sleep].” r. On 8/2/24 at 8:36 PM, the progress note documented that resident 40 stated, I am losing my memory fast. I wish I would lose it faster so that I don't have to remember I have kids or a family. s. On 8/7/24 at 8:04 PM, the Behavioral Symptoms note documented that resident 40 had increased confusion. t. On 8/8/24 at 11:18 AM, the Late entry note for 8/7/24 documented, “Resident reported ‘It takes about a half hour when I wake up to remember where I am' He also reports feeling overwhelmed and anxious when there are too many people or noises around him. Resident shows poor recall, he uses his phone alarm and printed schedules to remember meal and snack times.” u. On 8/16/24 at 1:57 PM, the Behavioral Symptoms, Mood State note documented, “While administering 1400 [2:00 PM] scheduled medication I asked resident if there was anything that I could get for him and he responded ‘a bullet ‘. I asked resident if he was having thoughts of self-harm. Resident responded ‘It was just a joke but yes I do think about it sometimes.' Resident declined want [sic] to talk but did thank me for being nice to him. I advised resident that I would be checking in frequently but that If he needed anything further or before I came to check in to call for assistance. Resident stated understanding”. It should be noted that no documentation (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	could be found that the physician was notified of the resident's statement or any interventions or monitoring that was implemented. v. On 8/20/24 at 1:39 PM, the Behavioral Symptoms note documented, “Resident brought sticky note to the nurses' station that read my irritated short fuse has increased since the med change.” “Resident reported he has had a hard time falling asleep at night and when he is in his room during the day he is resting but not sleeping.” w. On 8/20/24 at 3:00 PM, the Behavioral Symptoms note documented, “Resident came to nurses' station and said, ‘I need you to get a hold of the doctor and tell him that my agitation is getting worse' ‘I am not sleeping and whatever adjustments he made to my medication is not working.' Physician notified per resident request.” x. On 8/20/24 at 4:59 PM, the Medication note documented, “New orders given per Physician regarding residents increased agitation and ^ [complaints of] trouble sleeping: 1) Increase Seroquel to 125 mg PO at bedtime”. y. On 8/22/24 at 1:13 PM, the Mood State note documented, “[Physician name omitted] notified that resident is voicing concerns that he is having increased agitation and irritability. Feels like he ‘wants to rip someone's head off'. Adds that he is no longer having issues sleeping since adding the trazodone. Order received to increase his sertraline from 100mg to 150mg daily.” z. On 8/22/24 at 9:13 PM, the Behavioral Symptoms note documented, “Resident states ‘no one understands what it is like for me. Everyone around me has lost their minds and I can still remember things, I just want to not feel anything. I am laying in this bed wasting away. I really wish the Dr. [doctor] would over medicate me so I don't have to deal with all of this.' “ aa. On 8/24/24 at 4:43 PM, the note documented, “Resident spent the vast majority of the day isolating himself. He went to bingo and meals but was the first to leave meals and spent the rest of his time alone.” bb. On 8/24/24 at 4:57 PM, the Mood State note documented, “Resident reported to activities aid that he was feeling suicidal.” It should be noted that no documentation could be found that the physician was notified of the resident's statement or any interventions or monitoring that was implemented. cc. On 8/25/24 at 5:44 PM, the Behavioral Symptoms note documented, “This am resident while in room administering medications resident appeared very upset over the events of the night. He stated to me I don't fucking like how they just come in at 4 am and turn every fucking light on. I can't sleep as it is and this is how I get when I don't sleep. resident was speaking in elevted [sic] tone of voice and appeared to be very upset making gestures like throwing or shaking his hands and arms. At dinner resident was seen by staff taking a knife to the walls and scraping away at the lines.” dd. On 8/26/24 at 4:30 PM, the Mood State note documented, “Resident noted to be pacing up and down the hall and seemed irritable with some staff members. Maintenance man who is also a long-time friend spoke to him and resident voiced that he has to sign over his rights to his children Friday and that has him pretty upset.” (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ee. On 8/30/24 at 2:33 PM, the Behavioral Symptoms, Mood State note documented, “Resident has spent most of day thus far in his room with the door shut, blinds closed and lights off. Also noted to wear his sunglasses while in the dark room. Has refused hydration mug. Does not want it in his room. Has been short tempered with staff. Resident does not want staff in his room.” ff. On 8/31/24 at 3:40 AM, the Behavioral Symptoms note documented, “Resident came up to nurse's station states that he was upset because CNA [Certified Nurse Assistant] woke him up when she delivered a water pitcher and checked on him…. After CNA delivered water cup and checked on resident, he became agitated and aggressive to CNA, he threw his water cup out in the hall. CNA cleaned up the water and replaced the water cup; it was then that resident came to nurse and complained that he is not happy with the way this facility is handling his care. He states I am here to die, why can't you people just let me die? I don't need anyone in my room hovering over me. Staff attempted to deescalate confrontation; Nurse explained that if he is unhappy with his care that he is welcome to address his concerns with [name omitted] the resident advocate. however, resident stormed to his bedroom and slammed his door.” gg. On 8/31/24 at 11:09 AM, the Mood State note documented, “Nurse went into residents room to speak to him about his recent behaviors and concerns. Stated to nurse that he doesn't want to be ‘the asshole but nobody listens'. Voiced that he doesn't recall conversations that he has with someone 5 minutes after they occur…. When asked resident if he was having thoughts of self harm stated ‘I told myself long ago that I would never take my life with my own hands, but if there was a way for me to just die I would welcome that'. Voices feelings of increased agitation that he contributes to sleep deprivation…. Told him that I would reach out to Dr [NAME] to express his agitation concerns.” It should be noted that no documentation could be found for any interventions or monitoring that was implemented. hh. On 8/31/24 at 2:57 PM, the Medication note documented, “Order received from [physician name omitted] to increase residents seroquel from 125 mg to 150 mg QHS”. ii. On 9/4/24 at 9:49 AM, the Behavioral Symptoms note documented, “Resident refused breakfast this am x2…. This am resident has been pacing hallway end to end. When asked if resident needed anything or if he was feeling okay resident continued to ignore nurse. At this time resident is showing signs of agitation but shows no s/sx of distress. He prefers to wear darkened sunglasses in room and in hallway.” jj. On 9/5/24 at 7:28 AM, the note documented, “Talked to him about his mood score being high. He said I'm not depressed. Voiced he is just upset about his kids and the situation. Also said he does not want more medication for depression. Asked if he would like me to setup an appointment for a counselor to see him and he said my counselor comes here to see me and I talk to her.” It should be noted that the note was authored by the Director of Nursing. kk. On 9/6/24 at 9:30 PM, the note documented, “Nurse into resident bedroom to administer HS [hour of sleep] medication, resident was asked if pain medication that was administer [sic] by AM [morning] nurse was effective. He states that stuff works great I wish the doctor would let me have that medication every day. I don't like to use drugs but man that pill made me relax enough that I could get some much-needed rest.” ll. On 9/8/24 at 7:26 AM, the Behavioral Symptoms note documented, “Has been ambulating up and down the hall for 20-30 mins, is requesting something for general pain”. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	mm. On 9/8/24 at 2:05 PM, the note documented, “Patient is c/o back pain is requesting a Percocet. Patient states his low back is aching. I have no refills on this medication.” nn. On 9/8/24 at 4:52 PM, the Medication note documented, “New order Discontinue Percocet 325/5mg. Use prn [as needed] orders Ibuprofen 400mg for pain or discomfort. [Physician name omitted] will be making rounds this week.” oo. On 9/9/24 at 9:00 PM, the not documented, “Nurse and CNA into resident's bedroom to administer HS med and ask if he need anything before, he goes to bed. Resident sates ‘no just shut my door and stay out of my room.' “ pp. On 9/10/24 at 12:35 PM, the Dietary Concerns note documented, “Spoke about low meal intake and wt lose [sic]. Informed him that they had come in and adjusted the juice machines. Also informed him again about the alternative meals. He hinted that he did not want to be a bother. Told him we were all set up for it and would not be any extra for the staff. He said ‘I will just keep losing weight until I die and get to see heavy [sic] father.' “ It should be noted that no documentation could be found that the physician was notified of the resident's statement or any interventions or monitoring that was implemented. qq. On 9/11/24 at 4:20 PM, the note documented, “resident c/o back pain, prescribed prn medications were offered, Acetaminophen, ibuprofen, and cyclobenzaprine. Resident refused any medications. stated that he would like to talk to his physician face to face first. That he needs something stronger for pain. He states that he is unable to sleep because the pain is so bad…. Spends most of the day in his bed asking everyone to leave him alone.” rr. On 9/12/24 at 11:40 AM, the note documented, “Resident had appointment with LCSW [Licensed Clinical Social Worker] [name omitted]. No concerns expressed at this time.” ss. On 9/12/24 at 2:40 PM, the Behavioral Symptoms note documented, “at this time resident approached nurses station and says that he is going to bed and will be refusing to get up for dinner. Nurse explained the importance of getting up and eating meals. Resident stated, ‘I will not be going to dinner and I don't care.' “ tt. On 9/13/24 at 3:00 PM, the note documented, “[Name of physician omitted] into see resident. Plan of care reviewed. Resident is c/o [complaining of] pain. Would like pain medication scheduled. [Name of physician omitted] inquired about location of pain. Resident states he has back pain from ‘sitting too much, laying too much, walking too much.' Resident states he is sleeping okay. Resident also states that he spends ‘17 hours a day in bed., but they [sic] denies being in bed. Resident also states that he had a back injury in his L [lumbar] 4-L5 from a car accident 20 years ago. States he has been ‘pissing himself'. Dr. [NAME] asked if resident if he has lost control of his bowel or bladder. Resident states ‘no.' Denies numbness in legs or in the saddle area of his crotch. Resident again states ‘no.' [Name of physician omitted] suggested increased activity and also attending facility activities. Resident states, ‘Not gonna happen.' [Name of physician omitted] inquired reason why? Resident states, ‘They are 80 and I'm not. That activity today was a wheelchair activity. I'm not going.' Resident states he wished marijuana was legal. [Name of physician omitted] states he will not order marijuana. Resident talked in circles and states that ‘this hospital doesn't even know what goes on here.' States he has been seeing his psychiatrist. [Name of physician omitted] stated he didn't know that resident was seeing a psychiatrist. Resident became angry and states, ‘How is it that you don't know me??' [Name of (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	physician omitted] inquired who his psychiatrist is. Resident states, ‘[name omitted]' [Name of physician omitted] states he knows [name omitted] and that she is a counselor and not a psychiatrist. Resident then states he is not depressed and argued about his medication. [Name of physician omitted] states he is happy to help, but will not do it with bad medicine. When resident asks about pain medication, [Name of physician omitted] states he will not prescribe narcotics. Resident becomes upset and states the other stuff doesn't work. Resident states that he can't remember to ask for medication and wants medication scheduled. [Name of physician omitted] states he is able to ask. New orders received: 1) Discontinue flexaril 2) Methocarbamol 750mg 2 tabs Q 8 hours at 0800 [8:00 AM], 1400 [2:00 PM], and 2200 [10:00 PM] x [times] 3 days. then 3) Methocarbamol 750mg 2 tabs PO TID PRN [as needed]- back pain.” uu. On 9/13/24 at 11:33 PM, the note documented, “Call from East side nurse telling nurse to come over for help around 2040 [8:40 PM]. This nurse and [name omitted], RN [Registered Nurse] came over to East side immediately. All nurses ran into resident's room at that time. Curtain was pulled. Resident was laying sideways on the bed, left foot out on the floor and right foot and leg tucked under bottom. Black trash bag was over head and knotted tightly around neck with string, appeared to be from a jacket. Feet, hands, neck were blue. Resident's legs were assisted onto bed, small hand towel was placed over face, bag was ripped and cord was unable to be unknotted, so scissors were obtained to cut off. Face was blue. No pulse found. Resident with DNR [Do Not Resuscitate] status. DON, Administrator, 911, physician notified. All staff out of room at that time until police arrived. DON and Administrator arrived right before police arrived. Police took over investigation at that time.” On 5/31/24, resident 40's signed POLST order documented Do not attempt or continue any resuscitation (DNR) (Allow Natural Death). Resident 40's physician orders revealed the following: a. On 5/24/24, an order was initiated for Klonopin 1mg two times a day (BID) for anxiety disorder. b. On 5/24/24, an order was initiated for Quetiapine 100mg QHS for major depressive disorder. c. On 5/29/24, the Klonopin was increased to 2mg three times a day (TID) at 8:00 AM, 2:00 PM, and 10:00 PM for anxiety disorder. d. On 6/8/24, an order was initiated for Zyprexa 5mg daily (QD) for major depressive disorder. It should be noted that this medication was initiated because Rexulti was not covered by insurance. e. On 6/14/24, an order was initiated for Sertraline 50mg QD for major depressive disorder. f. On 7/12/24, an order was initiated to increase the Sertraline to 100mg QD for major depressive disorder. g. On 7/29/24, an order was initiated to decrease Zyprexa to 2.5mg QD for major depressive disorder. h. On 8/2/24, an order was initiated to discontinue Zyprexa. i. On 8/5/24 an order was initiated for Trazodone 50mg QHS for insomnia. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	j. On 8/22/24, an order was initiated to increase Sertraline to 150mg QD for major depressive disorder. k. On 8/20/24, an order was initiated for Quetiapine 25mg QHS, give with 100mg tablet to equal 125 mg for major depressive disorder. l. On 8/31/24, an order was initiated for Quetiapine 50mg QHS, give with 100mg tablet to equal 150 mg for major depressive disorder. Resident 40's Antipsychotic Medication Monitor Form Documented the following: a. On 5/26/24 and 5/27/24 for day shift, the Seroquel form documented 4 events for throwing objects and striking out at others. The form documented behavior management interventions utilized were positive reinforcement, “Live the Moment” validation, food/fluids offered, and music activity offered. The form documented that the outcome after intervention was effective or improved. b. June 2024 monitoring for the Seroquel documented zero events. It should be noted that documentation was missing for 6/3/24 day shift, 6/6/24 night shift, 6/23/24 night shift, 6/24/24 night shift, and 6/25/25 night shift. c. July 2024 monitoring for the Seroquel documented 2 events on 7/25/24, 2 event on 7/27/24, and 2 events on 7/29/24 for behaviors of delusions. The form documented behavior management interventions utilized were positive reinforcement, redirection, and “Live the Moment” validation. The form documented that the interventions were effective on 7/25/24 and 7/29/24. The form did not have documentation for the interventions or outcome for the 7/27/24 events. It should be noted that documentation was missing for 7/6/24 day shift. d. July 2024 monitoring for Zyprexa documented a behavior for suicidal thoughts. The form documented 2 events on 7/12/24 and interventions utilized were documented that all of the following interventions were provided: taken to bathroom, positive reinforcement, redirection, “Live the Moment” validation, food/fluids offered, music/activity offered, medication offered. The outcome was documented as “N” for not observed/unchanged. On 7/13/24 one event was documented, interventions were documented as all and outcome was “N”. On 7/14/24, 7/15/24, and 7/16/24 two events were documented, interventions were documented as all and outcome was “N”. It should be noted that no documentation could be found that the physician was notified of the suicidal thoughts on 7/13/24, 7/14/24, 7/15/24, or 7/16/24. e. August 2024 monitoring for the Seroquel documented 6 events on 8/7/24, 2 events on 8/8/24, 3 events on 8/17/24, 1 event on 8/18/24, 2 events on 8/19/24, and 3 events on 8/20/24 for behaviors of delusions. The form documented the interventions utilized were positive reinforcement, redirection, and “Live the Moment” validation. On 8/7/24, 8/8/24 and 8/17/24 the outcome was documented as not observed or unchanged. On 8/30/24 two events were documented for throwing things and on 8/31/24 one event was documented for throwing things. The interventions documented as utilized for the behavior of throwing things were “all” for taken to bathroom, positive reinforcement, redirection, “Live the Moment” validation, food/fluids offered, music/activity offered, medication offered. f. September 2024 monitoring for the Seroquel documented 1 event on 9/3/24 and 9/4/24, 2 event

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 3 out of 22 sampled residents, that the facility did not ensure that each resident's drug regimen was free from unnecessary drugs. An unnecessary drug was any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued. Specifically, residents were prescribed psychotropic medications and monitoring was not conducted for episodes of behavior, adverse side effects, and non-pharmacological interventions. Resident identifiers: 3, 5, and 22. Findings included:1. Resident 3 was admitted to the facility on [DATE] with diagnoses which included neurocognitive disorder with Lewy Bodies, Schizophrenia, delusional disorder, and insomnia. Resident 3's medical records were reviewed from 9/22/25 through 9/25/25. On 10/12/23, resident 3 had an order initiated for Trazodone Hydrochloride 50 milligram (mg) by mouth at hour of sleep for insomnia. Resident 3's Medication Administration Record (MAR) and Treatment Administration Record (TAR) was reviewed for September 2025. No documentation could be found for monitoring of Adverse Side Effects (ASE), and non-pharmacological interventions for the Trazodone. On 9/23/25 at 2:07 PM, an interview was conducted with Certified Nurse Assistant (CNA) 2. CNA 2 stated that resident 3 had not been sleeping well and did not sleep great most of the time. CNA 2 did not report any non-pharmacological interventions that were provided for resident 3's insomnia. On 9/25/25 at 11:24 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that they recorded hours of sleep for hypnotics in the TAR. The DON stated that they did not monitor for ASE or non-pharmacological interventions for the hypnotics. 2. Resident 5 was admitted to the facility on [DATE] with diagnoses which consisted of anxiety disorder and dementia. Resident 5's medical records were reviewed on 9/22/25 through 9/25/25. On 4/7/25, resident 5 had an order initiated for Buspirone 10 mg by mouth two times a day for anxiety disorder. On 6/12/25, resident 5 had an order initiated for Seroquel 50 mg by mouth two times a day for striking out, resisting care, delusions, and unspecified dementia. On 6/17/25, resident 5 had an order initiated for Sertraline 50 mg by mouth daily for anxiety disorder. Resident 5's September 2025 MAR and TAR were reviewed. No documentation could be found for monitoring of episodes of behavior, ASE, and non-pharmacological interventions for Buspirone and Sertraline. On 9/23/25 at 1:50 PM, an interview was conducted with CNA 1. CNA 1 stated that resident 5 did not really have any behaviors. CNA 1 stated that resident 5 would refuse cares such as dressing and showering. On 9/23/25 at 2:00 PM, an interview was conducted with CNA 2. CNA 2 stated that resident 5 had behaviors of exit seeking on admission and there were times he would pull back his hand like he was wanting to hit you. CNA 2 stated that those behaviors were much less often, if at all, now. On 9/23/25 at 2:28 PM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that resident 5 had behaviors of verbal and physical aggression and struggles on shower days the most. RN 2 stated that the Seroquel was prescribed for the aggressive behaviors and striking out, resisting care, and delusions. RN 2 stated that resident 5 had days that he thought staff took his clothes and moved his stuff around. RN 2 stated that she was not sure if this was a delusion or just an opinion. RN 2 stated that they documented behaviors, ASE and non-pharmacological interventions on antipsychotics but not on the anti-depressants or anti-anxiety medications. RN 2 stated that they charted a change in condition in a progress note. RN 2 stated that typically the MAR had monitoring for behaviors and number of episodes for the anti-depressants and anti-anxiety medication. On 9/24/25 at 8:00 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that resident 5 initially upon admission had behaviors of aggression towards residents and staff, but that had decreased and was managed by Seroquel. LPN 1 stated that resident 5 did not have Bipolar or Schizophrenia. LPN 1 (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that the Seroquel was prescribed for severe anxiety and dementia and behaviors were striking out, resisting cares and delusions. LPN 1 stated that resident 5's delusions were paranoia that someone was in his room taking his things, and he would report seeing someone who was not there. On 9/24/25 at 9:17 AM, an interview was conducted with the DON. The DON stated that they did not document episodes of behavior or monitor for ASE and non -pharmacological interventions for anti-depressants, anti-anxiety, and hypnotics. The DON stated that resident 5 had monitoring for his anti-psychotics but not for the other psychotropics. The DON stated that resident 5's monitoring was missed. On 9/25/25 at 11:30 AM, the DON stated that resident 5 was aggressive, struck out at staff, and refused cares. The DON stated that the pharmacy recommendation was to start a Selective Serotonin Reuptake Inhibitor (SSRI) and then start a gradual dose reduction of the Seroquel. The DON stated that the indication of use for Seroquel was a danger to self. The DON stated that the Seroquel was not prescribed for what it should be indicated for. The DON stated that indications of use for the Seroquel were Schizophrenia, Schizoaffective disorder, and Bipolar disorder. The DON responded no when asked if Seroquel was an appropriate use for dementia. On 9/25/25 at 1:12 PM, a follow-up interview was conducted with the DON. The DON stated that she spoke to the Medical Director and he knew that the resident did not have a diagnosis for the use of Seroquel. The DON stated that resident 5 was started on the Seroquel for anxiety and aggression. 3. Resident 22 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease, Down Syndrome, major depressive disorder, anxiety disorder and dementia. Resident 22's medical record was reviewed 9/23/25 through 9/25/25. A review of resident 22's physician orders revealed: a. A physician's order dated 5/23/23 documented, VENLAFAXINE HYDROCHLORIDE 75 MG [milligram] CAPSULE, EXTENDED RELEASE (Venlafaxine Hydrochloride) ORAL 1 CAP [capsule] 0800 [8:00 AM] for F32.9, F41.9 Major depressive disorder, single episode, unspecified, Anxiety disorder, unspecified. b. A physician's order dated 9/23/25 documented, CLONAZEPAM 0.5 MG TABLET (Clonazepam) Oral 0.5 mg BID [twice a day] with breakfast and dinner.for F41.9 Anxiety disorder, unspecified. c. A physician's order dated 7/15/25 documented, HALOPERIDOL 0.5 MG TABLET (Haloperidol) Oral 1 TAB Every 6 hours.**Target Behaviors; Paranoid statement, Delusions** For 02.B2 [sic] Dementia in other diseases classified elsewhere, moderate with psychotic disturbance. No documentation could be found of monitoring for adverse side effects, episodes of behaviors, and non-pharmacological interventions for the venlafaxine and clonazepam. On 9/25/25 at 10:22 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that resident 22 was monitored for delusions and paranoid statements with his antipsychotic use throughout the day and a log was kept in a binder at the nurse's station. LPN 1 stated there was not a binder that recorded any behaviors or monitored for any side effects from the use of venlafaxine and clonazepam.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined for 1 out of 22 sampled residents, that the facility failed to send a copy of the discharge notice to a representative of the Office of the State Long-Term Care Ombudsman. Specifically, the facility was only notifying the Ombudsman of residents who transferred to a hospital. Resident Identifier: 38. Findings Included: Resident 38 was admitted to the facility on [DATE] with diagnoses which included, unspecified fracture of left femur, unspecified fracture of right humerus, and unspecified fall.Resident 38's medical record was reviewed 9/23/35 through 9/25/25.A review of resident 38's progress notes revealed:a. On 8/11/25 at 6:08 PM, a progress note documented, Medication, follow up appointments and Home health PT [physical therapy] with [name redacted] discussed and answered any questions resident and husband had. Assisted resident to PMV [private motor vehicle] via W/C [wheelchair]. Resident expressed appreciation for care. b. On 8/12/25 at 4:33 PM, a late entry note documented, [Medical Doctor] into visit resident. Care plan and orders reviewed. Resident requesting to go home. New orders are as follows: 1) resident may d/c [discharge] to home; 2) P.T. orders; 3) Medications released to resident.On 09/25/25 at 8:31 AM, an interview was conducted with the Medical Record Coordinator (MRC). The MRC stated that she notified the Ombudsman of unexpected transfers and discharges of residents from the facility to the hospital. The MRC stated that she had not notified the Ombudsman regarding resident 38's discharge because resident 38 discharged home. The MRC stated that she did not report to the Ombudsman for any community discharges. On 9/25/25 at 11:09 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that she was only aware of having to notify the Ombudsman regarding residents that were discharged to a hospital.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined for 1 out of 22 sampled residents, the facility did not file in the resident's clinical record laboratory reports that were dated and contained the name and address of the testing laboratory. Specifically, the resident's laboratory results were not located in the electronic medical record. Resident identifier: 21Findings included: Resident 21 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included other amnesia, borderline intellectual functioning, bipolar disorder, obsessive-compulsive disorder, and drug induced movement disorder.Review of resident 21's medical record was completed on 9/22/25 through 9/25/25.On 8/28/25 at 4:20 PM, a progress note revealed the following, physician was into see resident and new orders received to check complete blood count (CBC), comprehensive metabolic panel (CMP), thyroid stimulating hormone (TSH), and lipid panel on 9/2/25.On 8/28/25, a Physician's Order was entered for the following labs to be completed: CBC, CMP, TSH, and lipid panel to be drawn on 9/2/25.A review of resident 21's medical record revealed:There were no CBC, CMP, TSH, or lipid panel laboratory results located in resident 21's medical record. On 9/25/25 at 11:08 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that laboratory results are faxed over from the local hospital. RN2 stated the nurse will inform the physician and enter the results as a progress note in the electronic medical record. RN 2 stated the paper fax copy of the laboratory results are filed into the resident's hard chart located at the Nursing Station.On 9/25/25 at 1:59 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the facility draws all the laboratory requests per the physician's orders, a laboratory requisition form which has multiple copies is filled out. The drawn labs are taken to the local hospital by facility staff for processing. The hospital faxes over the laboratory results, the nurse will contact the physician, enter the results in the electronic medical record as a progress note and place faxed results into the resident's hard medical chart. The Minimum Data Set coordinator gets a copy of the laboratory requisition form, and it is their responsibility to track any laboratory request and to ensure the labs have been completed and the result gets placed into the resident's chart, both the electronic and hard medical chart. On 9/25/25 at 2:52 PM, The DON stated that the floor nurse had called the physician's main office to get laboratory results for CBC, CMP, TSH, or lipid panel that were completed on 9/2/25. The DON stated that the laboratory sent the results were sent to the physician's office and not the facility due to the orders coming from the physician's main office.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that for 1 out of 22 sampled residents, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, enhanced barrier precautions (EBP) were not implemented for a resident with a chronic abdominal abscess wound. Resident identifier: 5.Findings Included: Resident 5 was admitted to the facility on [DATE] with diagnoses which included, cutaneous abscess of abdominal wall, weakness, and unspecified severe protein-calorie malnutrition. Resident 5's medical record was reviewed 9/22/25 through 9/25/25. On 9/23/25 at 9:09 AM, an observation was made of resident 5's room. There was no signage that indicated that resident 5 required EBP. A review of resident 5's physician orders revealed the following: a. On 8/8/25 an order documented, Monitor chronic abdominal opening. Clean area with NS [normal saline], cover with ABD [abdominal] and 2 large tegaderm bandages Q [every] shift. b. On 9/9/25 an order documented, Cavilon Advanced Skin protectant Q shift Apply to area surrounding abdominal abscess every Tuesday. A review of resident 5's progress notes revealed the following: a. On 3/19/25 at 4: 51 PM, a note documented, .Abscess present on abdomen with scant yellow discharge and pungent smell. An ostomy waver [sic] and bag has been placed on abdominal abscess. b. On 3/27/25 at 5:24 AM, a note documented, .cnas [Certified Nursing Assistant] took to bathroom changed all clothes due to drainage from abd wound, when back in bed nurse cleaned abd and put new bag and wafer over wound to collect drainage. c. On 4/5/25 at 4:51 AM, a note documented, .Given warm blanket, nurse came in and changed wafer and appliance for wound to abdomen. Leakage noted to bottom side of new appliance. d. On 8/23/25 at 2:10 PM, a note documented, During drsg [dressing] change on abdomen, skin noted to have red-speckled areas. Noted change from yesterday. Area washed with soap and water during shower. New drsg applied. e. On 9/9/25 at 3:26 PM, a note documented, Abdominal dressing removed, area cleaned with hibiclens and NS, Cavilon advanced skin protectant applied to abdomen to prevent breakdown from draining chronic abdominal abscess. On 9/25/25 at 9:44 AM, an interview was conducted with CNA 1. CNA 1 stated that there were no signs placed on resident's doors to alert staff about residents that required EBP. CNA 1 stated that signs were placed for residents if they required isolation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/25 at 9:52 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that she had not heard of EBP. LPN 1 stated that resident 8 had a chronic abscess on his abdomen that required dressing changes because it weeped. LPN 1 stated that she only wore gloves when she changed resident 8's abdominal dressings. On 9/25/25 at 11:04 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that staff should be wearing gloves and gowns for residents who required EBP. The DON stated that the facility did not put up signage for EBP and expected staff to pass what residents required EBP in the shift report. The DON stated that resident 8 had a chronic abdominal abscess that was open and draining and she would classify that as a wound. The DON stated that resident 8 did require EBP.