STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465172	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
George E Wahlen Ogden Veterans Home	1102 North 1200 West Ogden, UT 84404

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on observation, interview and record review it was determined, for 1 of 9 sampled residents, that the facility did not ensure each resident was free from abuse. Specifically, a resident's husband tried to shove a spoon with medication into another resident's mouth. In another incident the same resident's husband shoved her and removed her clothing to change her clothes. There were no interventions to prevent the resident from further abuse. The findings for resident 1 were determined to have resulted in immediate jeopardy. Resident identifiers: 1 and 2. Findings included: NOTICE On 2/26/25 at 4:30 PM, an Immediate Jeopardy was identified when the facility failed to implement Centers for Medicare and Medicaid Services (CMS) recommended practices to prevent various forms of abuse. This notice was given verbally and in writing to the facility Administrator (ADM), and the Director of Nursing (DON) regarding resident 1. On 2/27/25, the facility ADM provided the following written abatement plan for the removal of the Immediate Jeopardy effective on 2/27/25 at 11:59 PM. Removal Plan for Immediate Jeopardy Substandard Quality of Care The Facility respectfully submits this Plan of Removal (POR) pursuant to Federal and State regulatory requirements. Submission of this Letter of Credible Allegation does not constitute an admission or agreement of the facts alleged or the conclusions set forth in the verbal and written notice of immediate jeopardy and/or any subsequent Statement of Deficiency. Health and Resident Safety 1. Immediate Action: (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Resident 1 was moved to the secure unit on 2/26/25. Visits in person will be scheduled in advance and supervised. Residents will have the opportunity to stay in contact with use of technology available in the facility. b. Resident 1 will be placed on q [every] shift monitoring to identify behaviors of distress indicating that she is not adjusting to room placement such as but not limited to searching for her husband, lack of appetite, anger/hostility towards others, refusals of care, or inability to be redirected. Resident 1's care plan will be updated with interventions to adjust to change in living condition. c. If Resident 1 does not adjust to her new room placement, she will be returned to her prior living situation with continued 1:1 supervision with staff who have been re-educated on abuse until the spouse receives caregiver burnout counseling and shows an ability to maintain a consistent kind and patient demeanor during care. d. Resident 2 will be placed on q shift monitoring to identify behaviors of distress indicating that he is not adjusting to room placement such as but not limited to, lack of appetite, anger/hostility towards others, refusals of care, or inability to be redirected. Resident 2's care plan will be updated with interventions to adjust to changes in living conditions. 2. Identification of Others At Risk: a. Current residents with a BIMs greater than or equal to 9 will be interviewed by Administrator/designee to screen for signs and symptoms of abuse. Residents with a BIMs less than 9 will have their POA interviewed to identify s/s of abuse. 3. Education: a. DON/Designee will provide Re-education: What is abuse, when to report abuse, and how to report abuse. i. Staff members in the facility on shift will be educated prior to end of day 02/26/2025 ii. Staff members not in the facility will be educated prior to their next shift b. Regional Nurse Consultant will provide re-education of abuse policies. 4. An ad hoc QAPI meeting was held on 2/27/25 to approve the above plan. 5. Alleged Date of Removal a. 2/27/2025 Quality Assurance and Monitoring (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. On 2/23/25 at 8:30 PM, a nursing note documented, [Resident 2] and [Resident 1] who goes by '[name redacted]' are married. The couple each have a private room with a shared bathroom between them. Every evening after dinner the couple enjoy sitting on a small sofa that is located in [resident 1's] room and spend the evening sitting next to each other watching TV and visiting. [Resident 1] has cognitive impairments r/t [related to] her diagnosis and needs prompting and cueing often to help encourage her to allow the staff at the facility to help her with many of her ADLs [activities of daily living]. At 2000 [8:00 PM] on 02/23/2025 the CNA [certified nurse aide] went to help [resident 1] get in her pajamas and get her ready for bed. [Resident 1] was telling the CNA that she was not ready to get ready for bed yet. The CNA waited for a couple for [sic] minutes and then [resident 1] got up with her walker and started to walk around the room. The CNA and [resident 1] were about halfway into the bathroom when [resident 2] got up from the couch and was raising his voice at [resident 1] telling her she needed to get her clothes changed. [Resident 2] shoved her into the bathroom while she did not have a hold of her walker, and she was stumbling. Next [resident 2] grabbed [resident 1's] dress forcing her to change. The CNA stepped in and said that she has it from here. [Resident 2] said no she needs to change and continued to make her take her dress off. [Resident 1] got really flustered and started crying and then could no longer express herself and just kept crying more and more as and [sic] the CNA tried to finish getting her ready for the bed. Nurse came in to give [resident 1] her pills and saw [resident 1] sitting on the toilet just sobbing and trying to understand the CNA. CNA said she needed to talk to the nurse in private later. Nurse shut the door to bathroom and let the CNA console [resident 1]. Nurse gave pills to [resident 2] who was sitting on the sofa and then left the room and would come back later to give [resident 1] her medications. CNA said to [sic] come back in about 15 minutes. Nurse had no idea at the point what had happened. Nurse returned about 15 minutes later. [Resident 1] was sitting next to [resident 2] on the sofa watching TV. When the nurse went back to give [resident 1] her evening medications, she noticed that [resident 1] was still crying a little. Asked what was wrong and she does not have the ability to express herself. Nurse gave the Resident her pills which she held in her hands for a short time and then tried to put them into her mouth. [Resident 1] will not let the nurse help her put the medications into her mouth. [Resident 1] turned to [resident 2] and asked him to help in her own way. [Resident 2] took the pills and dumped them into [resident 1's] mouth and nurse helped her with her water mug that she likes to use. Before the nurse left theroom [sic], [resident 1] was holding [resident 2's] hand and was calming down. When we checked a few minutes later on them, all was well, and [resident 1] was no longer crying. [Resident 2] helped [resident 1] into bed about 2100 [9:00 PM] pm [sic] and then went to his room. [Resident 2] always tucks [resident 1] into bed every night. When CNA checked on [resident 1] later that evening, she was asleep in bed. Around 2015 [8:15 PM], the CNA was finally able to report to floor Nurse what happened, and it was immediately reported to RN Noc Supervisor. RN NOC Supervisor immediately reported it to [Administrator] who is the Administrator at [facility] . Resident relies a lot on her husband for help and support. Resident was comforted by the CNA for a while and then helped into her night clothes. Next, she was escorted back to the sofa where she spent the next hour watching TV with [resident 2] and she and him were holding hands. Resident is unable to explain what happened to the nurse r/t her diagnosis and cognitive impairment. Frequent checks done to make sure things were still okay . Police notified and an officer spoke with the CNA who reported the incident. [Resident 2] is the # [number] 1 Emergency contact for [resident 1]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. On 2/23/24 at 10:05 PM, a nursing note documented, Incident reported to this supervisor by floor nurse [name redacted] and CNA [name redacted]. It was reported that this resident has been refusing cares and her husband, [resident 2], has been getting frustrated. [Resident 2] got frustrated at her refusal of cares tonight and got pushy with [resident 1]. It was reported that [resident 1] stumbled but did not fall. [Resident 2] forced residents dress off so that she would change into clean pajamas. No physical injury noted. [Resident 1] was tearful after the incident. Resident was frequently checked on by CNA after the incident to ensure she is ok physically and emotionally. Administrator, [name redacted] notified of incident and is reporting to APS [adult protective services] and Dept [department] of Health. This nurse notified [local county dispatch]. Officer [name redacted] with [local police department] called the supervisor phone at 2150 [9:50 PM] for a verbal report. This supervisor answered all questions. Officer [name redacted] and this nurse discussed that residents are both safely in bed in their own rooms at this time. Officer [name redacted] also spoke to CNA [name redacted] for verbal report of incident. NOC staff aware of situation and will monitor residents close through the night and notify supervisor of any changes. Social work will follow up with residents. Officer satisfied to know that our internal social work department will follow up with the situation and happy to be notified that administrator will be in contact with APS and dept of health. Officer asked if we need anything else from him and stated we should call back if anything changes. c. On 2/24/24 at 8:00 AM, a nursing note documented, MD [medical doctor] was notified of resident to resident incident. No injuries were found upon assessment of [resident 1] per the floor nurse at the time of the incident. d. On 2/24/25 at 4:05 PM, a social services note documented, SS [social services] met with [resident 1] r/t the resident to resident altercation with her husband last night. She was able to answer my questions, but could not give more than just a few word answers. She could not recall what happened last night, but reports she feels safe at the facility and with [resident 2], she reports he treats her well and has no concerns. No physical or emotional harm noted. SS discussed with her husband the potential of moving rooms to the memory care unit as the structure and activities may be beneficial to [resident 1]. [Resident 2], her husband, does not want to move rooms at this time, but is open to discussing it again. SS to f/u [follow up] as appropriate. Resident 2 was admitted to the facility on [DATE] with diagnoses of Post-Traumatic Stress Disorder and recurrent severe major depressive disorder. On 2/26/25 at 10:18 AM, an interview was conducted with Resident 2. Resident 2 stated staff were very helpful. Resident 2 stated, on Sunday night staff were getting resident 1 ready for bed and she did not want to take her dress off. Resident 2 stated they got impatient, spoke to resident 1 a little harshly and took her dress off. Resident 2 stated they had not realized they had done anything terribly wrong until staff came in and talked to him the next day. Resident 2 stated they now realized that what they had done to resident 1 was wrong. On 12/30/24, a quarterly MDS documented resident 2 had a BIMS of 15 which indicated resident 2 was cognitively intact. A review of resident 2's progress notes revealed the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. On 11/7/24 at 10:34 PM, a progress note documented, [Resident 2] became frustrated when [resident 1] would not willingly take her night medications. He took the spoon and tried to force her to take them. The nurse intervened, taking the spoon away from [resident 2] and stating that it was ok if she did not want to takethe [sic] medications at this time and that I could try again later. He slammed his feet down and told [resident 1] 'Fine, I will see you in a week' and started to stand up. [Resident 1] apologized and took the spoon from the nurse and took her medications. Nurse educated [resident 2] that [resident 1] has the right to refuse medications, and we should not be forcing her to take them if she does not want to. Prior to this, [resident 2] had asked about his antidepressant and if it could be evaluated. He stated he feels 'blank.' . b. On 2/24/25 at 3:56 PM, a social services note documented, SS met with [resident 2] r/t the resident to resident altercation with his wife last night. [Resident 2] reported that he did not intend to hurt his wife in anyway [sic]. He reports he 'flipped' and became frustrated and 'slipped her dress off' as she was resistive to let staff assist her. SS discussed the memory care unit and the potential benefits to his wife moving to that unit. [Resident 2] is hesitant to move her as he feels the change might be too hard on her. Their direct social worker discussed it with them earlier today as well. SS discussed what [resident 2] is doing for self-care and to take breaks. SS invited [resident 2] to Caregiver Support Group, [resident 2] was interested in attending. SS to f/u as appropriate. c. On 2/24/25 at 4:02 PM, a social services note documented, SS discussed with [resident 2] the option of moving [resident 1] to [memory care unit] to help with caregiver burnout, sundowning, increased behaviors from [resident 1] during cares, and incident from last night. [Resident 2] stated that he did not intend to become upset with [resident 1] last night, he was just trying to help her get ready for bed. SS informed [resident 2] of the process and different approaches that staff can make to help [resident 1] with cares and that if she is upset in the moment, they may leave and attempt to care at a later time in a different approach. [Resident 2] appreciated the education on the staff process/approach and stated that he will keep that mind [sic] next time. He stated that at this time, he would like to wait to move [resident 1] to [memory care unit] and does not think 'she is to that point yet.' SS to F/U [follow up] with [resident 2] as needed when a community move/room is recommended in the future. SS WCTM [will continue to monitor]. On 2/26/25 at 8:22 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated resident 1 and resident 2 were a married couple. RN 1 stated resident 1 had dementia, and resident 2 had served as her primary care giver. RN 1 stated that resident 1 depended on resident 2 heavily, experienced frequent mood swings, and refused to get up in the morning unless resident 2 was there. RN 1 stated resident 1 often cried and despite these challenges, resident 2 rarely requested help. RN 1 stated resident 1 and resident 2 spent most of their time together, often watching TV. RN 1 stated she did not know the details of any incidents involving the residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/26/25 at 8:40 AM, an interview was conducted with CNA 1. CNA 1 stated resident 1 needed help getting dressed and getting out of bed. CNA 1 stated that resident 1 required substantial assistance with all daily activities but could walk independently with her walker. CNA 1 stated resident 1 had dementia and frequently needed reminders, often asking if she needed to use the bathroom. CNA 1 stated that resident 2 stayed with resident 1 most of the time, but did not assist with her personal care. CNA 1 stated that when resident 2 was not around, resident 1 would look for him. CNA 1 stated resident 1 experienced occasional mood swings or behavioral issues but was generally cooperative unless it involved a shower or an activity she did not want to do. CNA 1 stated regarding the incident the other night, the details were unclear. CNA 1 stated the previous shift reported a dispute in which resident 2 was trying to rip off resident 1's clothes, leading to a police intervention. CNA 1 stated despite this, care routines did not seem to have changed, though staff checked on resident 1 more frequently. CNA 1 stated she had not noticed any changes in resident 1's behavior. On 2/26/25 at 8:51 AM, an interview was conducted with RN 2. RN 2 stated that resident 1 had dementia, while resident 2 was cognitively intact. RN 2 stated resident 2 provided significant emotional support, especially when resident 1 exhibited behavioral changes. RN 2 stated resident 1 often became teary and cried in the morning without any apparent reason, sometimes experiencing similar episodes at night. RN 2 stated after breakfast resident 1 and resident 2 sat in resident 1's room watching TV, spending most of the day there before sleeping in separate rooms at night. RN 2 stated resident 1 was able to communicate her needs, though staff monitored her for behavioral issues, particularly angry outbursts when taking her medications. RN 2 stated she was unaware of the incident that occurred on Sunday and had not heard any details about it. RN 2 stated, starting on Tuesday, she was instructed to be more mindful of resident 2's feelings and to observe him to determine if he needed a break. On 2/26/25 at 9:03 AM, an interview was conducted with the Social Services Assistant (SSA). The SSA stated that staff attempted to provide care for resident 1 and get her ready for bed, but she resisted due to her worsening dementia. The SSA stated that resident 2 became upset and took resident 1 into the bathroom to help her change into her pajamas since she was not responding to staff. The SSA stated that she spoke with resident 2 and explained that nursing staff could not force resident 1 to comply with care. The SSA stated that resident 2 responded that he was not trying to harm her but was simply trying to get her ready for bed. Resident 2 admitted to removing her clothes but claimed not to know anything beyond that. The SSA stated she had heard reports of a push during the incident but could not verify it. The SSA stated she was unaware of any other incidents involving the couple but suspected that the situation was likely related to caregiver burnout. The SSA stated that resident 2 did not assist with resident 1's personal care, he spent all of his time with her, focusing on her needs rather than his own. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/26/25 at 11:13 AM, an interview was conducted with the Social Services Director (SSD). The SSD stated there was an incident that involved a married couple, resident 1 and resident 2. The SSD stated that resident 1 had dementia and resident 2 had been her caregiver for a long time. The SSD stated when resident 1 was first admitted , she stayed in the memory care unit, but visiting her on that floor became overwhelming for resident 2. The SSD stated resident 2 remained highly attentive to resident 1 as her dementia progressed. The SSD stated resident 1 often resisted care due to confusion and restlessness and became anxious when resident 2 was not nearby. The SSD stated resident 2 stayed with resident 1 unless family members visited to give him a break. The SSD stated resident 1 and resident 2 preferred to spend alone time in their room, where they had two recliners side by side, rather than participating in community activities. The SSD stated that resident 1 had major depression along with her dementia, and her baseline mood was typically tearful. The SSD stated resident 1 had become more emotional over time. The SSD stated resident 1 had also started exhibiting verbal aggression during care, frequently yelling at staff, though she was unsure if she had shown any physical aggression. The SSD stated resident 1 had adjusted well in memory care, and since resident 2 spent so much time there, the facility arranged for them to stay together when two adjoining rooms became available. The SSD stated on Sunday (2/23/25), CNA staff entered resident 1's room to assist resident 1 with changing into her nightclothes and use the restroom. The SSD stated resident 1 and staff were in the bathroom while resident 2 sat in his recliner. The SSD stated resident 1 began resisting care, and staff attempted to talk her through it. The SSD stated resident 2 heard the commotion and became frustrated and stern with resident 1. The SSD stated that staff reassured resident 2 that they had the situation under control and the CNA remained in the bathroom with resident 1 to comfort her while resident 2 returned to his recliner. The SSD stated that according to the nurse's report, the CNA reported that resident 2 bumped into resident 1. The SSD stated she was still in the process of getting interviews with staff. The SSD stated that resident 2 acknowledged that he typically did not react this way but recognized that resident 1's dementia was worsening and he often became frustrated when she resisted care. The SSD stated that she recommended moving resident 1 back to the memory care unit to give resident 2 a break and help prevent his frustration. The SSD stated however, due to an ongoing RSV outbreak in the memory care unit t, they were hesitant to transfer her at this time. The SSD stated resident 2 expressed an interest in attending the facility's monthly caregiver support group. The SSD stated a referral was placed for resident 1 to receive physical therapy services for strengthening, which would also provide resident 2 with some time apart from resident 1. The SSD stated staff were expected to continue their supervision, conducting regular two-hour rounding. The SSD stated when providing care, they were expected to observe resident 2 for signs of frustration or irritability and to ensure he and resident 1 had opportunities for space when needed. The SSD stated staff had been trained on recognizing signs of caregiver burnout in all staff meetings and completed a computer training module. The SSD stated education binders were available in all communities, allowing immediate access to training materials. The SSD stated staff were informed about the incident through verbal reports and through their messaging app. The SSD stated she was unsure of the specific details that were communicated to staff. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/26/25 at 11:33 AM, an interview was conducted with CNA 3. CNA 3 stated room [ROOM NUMBER] and 116 had a little situation happen the other day that staff were all aware of. CNA 3 stated resident 1 and resident 2 were married and got in an overheated argument but nothing too extreme. CNA 3 stated they were pretty sure it was just words that were said and maybe a little aggression. CNA 3 stated resident 2 had apparently pushed resident 1 just a little but not enough to cause harm. CNA 3 stated normally resident 2 and resident 1 were really good to each other but resident 1 gave resident 2 a little shove on Sunday. CNA 3 stated staff were checking on resident 1 to make sure they were okay and the checks were mainly occurring at night because that is when a dispute was more likely to occur. CNA 3 stated resident 1 had bad dementia and sometimes they were difficult to work with. CNA 3 stated they were informed of the incident between resident 2 and 1 during shift change on monday and since then, they had been checking on her during each round and doing visuals. CNA 3 stated resident 2 and 1 were good about voicing their needs. On 2/26/25 at 1:03 PM, an interview was conducted with CNA 4. CNA 4 stated she worked the Sunday night shift (2/23/25) from 2:00 PM-10:00 PM. CNA 4 stated while assisting resident 1 in getting ready for bed, she helped her change into pajamas and a new brief. CNA 4 stated resident 1 usually preferred to change in the bathroom and use the toilet. CNA 4 stated on Sunday night she gathered resident 1's pajamas, a new brief and asked resident 1 if she would like to get into her pajamas. CNA 4 stated resident 1 refused to get up and change. CNA 4 stated she reassured resident 1 that it would be quick, but resident 1 had become increasingly difficult to work with due to her dementia, only complying when resident 2 asked her to. CNA 4 stated that resident 1 eventually stood up, walked around the room, and insisted she did not want to get ready for bed. CNA 4 stated resident 1 began to walk into the bathroom and stopped about halfway through the door and repeated that she did not want to get changed. CNA 4 stated that resident 2 raised his voice and told resident 1 she needed to get changed and ready for bed. CNA 4 stated that resident 2 got up from the recliner and pushed resident 1 on her back, making her unsteady and nearly causing her to fall. CNA 4 stated she quickly grabbed onto resident 1 to prevent her from falling. CNA 4 stated that resident 2 then pulled up resident 1's dress to change her, acting aggressively, an unusual behavior from him, as he was not typically aggressive. CNA 4 stated that after resident 2 removed resident 1's dress, he went back to sit in his recliner. CNA 4 stated resident 1 began crying after she was pushed into the bathroom, but never said anything. CNA 4 stated she spent 10-15 minutes in the bathroom with resident 1 afterward, trying to help her calm down because resident 1 seemed extremely upset. CNA 4 stated once resident 1 felt ready they left the bathroom and at that time the nurse was coming into the room to give resident 1 her medications. CNA 4 stated that at that point, resident 1 had stopped crying and was not very expressive-just present but quiet. CNA 4 stated that resident 2 was still in the room, sitting in his recliner. CNA 4 stated resident 2 seemed fine and had calmed down. CNA 4 stated she informed the nurse that she needed to speak with her. CNA 4 stated following the incident she provided a verbal statement to a police officer and an incident report was filed with the nursing supervisor. CNA 4 stated she had recently noticed that resident 1's dementia had worsened, and resident 1 struggled to understand things and seemed more confused. CNA 4 stated over the past couple of weeks, she had observed resident 1's cognitive decline and noted that resident 2 had become increasingly frustrated, especially when resident 1 refused to take her medications. (continued on next page)

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	465172	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
George E Wahlen Ogden Veterans Home	1102 North 1200 West Ogden, UT 84404

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/26/25 at 1:40 PM, a telephone interview was conducted with the RN 3. RN 3 stated they were informed that CNA 4 was encouraging resident 1 to get ready for bed. Resident 1 was refusing and resident 2 then got frustrated with resident 1 and got pushy. RN 3 stated resident 2 pushed resident 1 hard enough to make them stumble. RN 3 stated while resident 1 was sitting on the toilet, resident 2 forcefully took resident 1 ' s dress off which caused resident 1 to become visibly upset and start crying on the toilet. RN 3 stated afterwards resident 1 and resident 2 were observed to be sitting on their couch and holding hands prior to resident 1 going to bed. RN 3 stated thanks to resident 1 ' s diagnosis of dementia, resident 1 had forgotten about the incident pretty quickly. RN 3 stated they notified the police department about the incident. The police department did not arrive on scene because at that time, both residents were separated and in their own rooms sleeping. RN 3 stated the plan was for the CNAs to frequently monitor both residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/26/25 at 2:01 PM, an interview was conducted with the Administrator (ADMIN) and the Director of Nursing (DON). The ADMIN stated that she served as the abuse coordinator, overseeing all abuse allegations and incidents. The ADMIN stated that staff should report any concerns directly to her. The ADMIN stated she handled all the reporting when possible and that the social services director served as her backup. The ADMIN stated that she instructed the nursing supervisor to educate staff Sunday night to ensure resident 1's safety, and conduct frequent rounds to monitor resident 1's emotional state. The ADMIN stated that she typically preferred to have documentation written in the resident's chart but had been occupied with the ongoing complaint survey at the facility. The ADMIN stated that an immediate assessment of resident 1's emotional and physical state was conducted. The ADMIN stated that she decided not to separate resident 1 from resident 2 that night and instead implemented frequent rounding. The ADMIN stated that frequent rounding was not documented, though it should have occurred every 15 to 30 minutes. The ADMIN stated staff had only received verbal instructions to complete checks, and no formal documentation existed to confirm they had been done. The ADMIN stated on Monday morning, the SSD offered to move resident 1 to the memory care unit, but resident 2 requested a few days to reflect on his actions and learn from his mistakes. The ADMIN stated that resident 2 was informed that the recreation therapy team would need to take resident 1 on walks and resident 2 agreed to attend a caregiver support group. The ADMIN stated she classified this incident as a safety check but had used the term frequent rounding. The ADMIN stated that it was reported that resident 1 had been combative, attempting to hit staff, becoming verbally aggressive, and resisting getting dressed. The ADMIN stated that resident 2 overheard the commotion, intervened by pushing resident 1-though she did not fall-and then pulled her dress up off of her. The ADMIN explained that the process required reporting the incident first, followed by an investigation. The ADMIN stated that according to resident 2's account, he did not recall pushing resident 1 but remembered that her dress was pulled up over her head. The ADMIN stated resident 2 entered the bathroom and removed the dress. The ADMIN stated that staff should have documented the incident through occurrence charting, which tracks incidents requiring monitoring for adverse side effects, injuries, behavioral changes, or any new or ongoing concerns. The ADMIN stated staff failed to complete occurrence charting and it was missed. The ADMIN stated to address the situation, staff implemented new interventions such as recreation staff would begin to take resident 1 on walks throughout the day, therapy referrals were made for both residents, and social services conducted daily check-ins. The ADMIN stated that she had not been informed of any incident between the residents in November and only learned about it today from the SSD. The ADMIN stated that if she had known about the previous incident, she would have contacted the corporate office for guidance on handling the situation and determining the appropriate course of action. The ADMIN stated that the facility recently noticed that staff had not always notified management about incidents. The ADMIN stated that to address this issue, management began printing and reviewing notes to identify any necessary follow-ups. The ADMIN stated that knowing about the November incident could have influenced how she handled the recent situation on 2/23/25. The ADMIN stated that it might have changed her opinion and the direction she would have taken. The ADMIN stated that resident 2 was experiencing caregiver burnout and that resident 2 needed breaks and more education about dementia care. The ADMIN stated that the [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 - Few	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** 46232 Based on observation, interview and record review it was determined, for 1 of 9 sampled residents, that the facility did not ensure all alleged violations involving abuse were reported immediately to the State Survey Agency. Specifically, it was not reported to the State Survey Agency when a resident's husband tried to shove a spoon with medication into her mouth. The findings for resident 1 were determined to have resulted in immediate jeopardy. Resident identifiers: 1 and 2. Findings included: NOTICE On 2/26/25 at 4:30 PM, an Immediate Jeopardy was identified when the facility failed to implement Centers for Medicare and Medicaid Services (CMS) recommended practices to prevent various forms of abuse. This notice was given verbally and in writing to the facility Administrator (ADM), and the Director of Nursing (DON) regarding resident 1. The facility ADM provided the following written abatement plan for the removal of the Immediate Jeopardy effective on 2/27/25 at 11:59 PM. Removal Plan for Immediate Jeopardy Substandard Quality of Care The Facility respectfully submits this Plan of Removal (POR) pursuant to Federal and State regulatory requirements. Submission of this Letter of Credible Allegation does not constitute an admission or agreement of the facts alleged or the conclusions set forth in the verbal and written notice of immediate jeopardy and/or any subsequent Statement of Deficiency. Health and Resident Safety 1. Immediate Action: a. Resident 1 was moved to the secure unit on 2/26/25. Visits in person will be scheduled in advance and supervised. Residents will have the opportunity to stay in contact with use of technology available in the facility. b. Resident 1 will be placed on q [every] shift monitoring to identify behaviors of distress indicating that she is not adjusting to room placement such as but not limited to searching for her husband, lack of appetite, anger/hostility towards others, refusals of care, or inability to be redirected. Resident 1's care plan will be updated with interventions to adjust to change in living condition. c. If Resident 1 does not adjust to her new room placement, she will be returned to (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	her prior living situation with continued 1:1 supervision with staff who have been re-educated on abuse until the spouse receives caregiver burnout counseling and shows an ability to maintain a consistent kind and patient demeanor during care. d. Resident 2 will be placed on q shift monitoring to identify behaviors of distress indicating that he is not adjusting to room placement such as but not limited to, lack of appetite, anger/hostility towards others, refusals of care, or inability to be redirected. Resident 2's care plan will be updated with interventions to adjust to changes in living conditions. 2. Identification of Others At Risk: a. Current residents with a BIMs greater than or equal to 9 will be interviewed by Administrator/designee to screen for signs and symptoms of abuse. Residents with a BIMs less than 9 will have their POA interviewed to identify s/s of abuse. 3. Education: a. DON/Designee will provide Re-education: What is abuse, when to report abuse, and how to report abuse. i. Staff members in the facility on shift will be educated prior to end of day 02/26/2025 ii. Staff members not in the facility will be educated prior to their next shift b. Regional Nurse Consultant will provide re-education of abuse policies. 4. An ad hoc QAPI meeting was held on 2/27/25 to approve the above plan. 5. Alleged Date of Removal a. 2/27/2025 Quality Assurance and Monitoring The DON/Designee will bring the results of the audits to the QAPI committee for tracking, trending and further recommendations to ensure compliance with the plan. The ongoing audits will include random interviews of residents in the facility to identify indications of abuse. Audits will be brought to the QAPI committee by the DON/Designee for three months for tracking, trending, and additional recommendations based on the audit findings with oversight provided by the DON/Designee. On 2/28/25 at 11:00 AM, while completing the complaint survey, surveyors conducted an onsite revisit to verify that the Immediate Jeopardy removal. The surveyors determined that the Immediate Jeopardy was removed. Resident 2 was admitted to the facility on [DATE] with diagnoses of Post-Traumatic Stress Disorder and recurrent severe major depressive disorder. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/30/24, a quarterly Minimum Data Set (MDS) documented resident 2 had a brief interview for mental status (BIMS) of 15 which indicated resident 2 was cognitively intact. A review of resident 2's progress notes revealed the following: a. On 11/7/24 at 10:34 PM, a progress note documented, [Resident 2] became frustrated when [resident 1] would not willingly take her night medications. He took the spoon and tried to force her to take them. The nurse intervened, taking the spoon away from [resident 2] and stating that it was ok if she did not want to takethe [sic] medications at this time and that I could try again later. He slammed his feet down and told [resident 1] 'Fine, I will see you in a week' and started to stand up. [Resident 1] apologized and took the spoon from the nurse and took her medications. Nurse educated [resident 2] that [resident 1] has the right to refuse medications, and we should not be forcing her to take them if she does not want to. Prior to this, [resident 2] had asked about his antidepressant and if it could be evaluated. He stated he feels 'blank.' . Resident 1 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, dementia, muscle weakness and cognitive communication deficit. A continuous observation was conducted on 2/26/25 from 10:44 AM through 11:50 AM for residents 1 and 2. It was observed that no staff entered room [ROOM NUMBER] where both of the residents were located. The residents were observed to be in the same room with both the door and blinds closed. On 1/28/25, a MDS documented resident 1 had a BIMS score of 0 which indicated severe cognitive impairment. The incident was not documented in resident 1's medical record. On 2/26/25 at 2:01 PM, an interview was conducted with the Administrator (ADMIN) and the Director of Nursing (DON). The ADMIN stated that she served as the abuse coordinator, overseeing all abuse allegations and incidents. The ADMIN stated that staff should report any concerns directly to her. The ADMIN stated she handled all the reporting when possible and that the social services director served as her backup. The ADMIN stated that she had not been informed of any incident between the residents in November and only learned about it today from the Social Service Director. The ADMIN stated that if she had known about the previous incident, she would have contacted the corporate office for guidance on handling the situation and determining the appropriate course of action. The ADMIN stated that the facility recently noticed that staff had not always notified management about incidents. The ADMIN stated that knowing about the November incident could have influenced how she handled the recent situation on 2/23/25.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46232 Based on observation, interview or record review it was determined, for 2 of 9 sampled residents, the facility did not ensure that a resident who needed respiratory care was provided such care consistent with professional standards of practice, the comprehensive person-centered plan, the residents' goals and preferences. Specifically, residents on oxygen were using empty oxygen tanks. Resident identifier: 7 and 8. Findings Included: 1. Resident 7 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, and chronic systolic congestive heart failure. On 2/25/25 at 1:32 PM, an observation was made of resident 7's portable oxygen tank while in use. The oxygen tank indicator was observed in the red refill area. Resident 7's medical records were reviewed on 2/25/25. A care plan focus area initiated 9/9/24 documented resident 7 had altered respiratory status and required supplemental oxygen to maintain oxygenation saturation. The facility grievances were reviewed from December to current. There were 5 documented grievances about residents having low or no oxygen in the portable oxygen tanks while in use. 2. Resident 8 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of acute respiratory failure with hypoxia, chronic respiratory failure with hypercapnia, and chronic obstructive pulmonary disease. On 2/25/25 at 12:45 PM, an observation was made of resident 8's portable oxygen tank. The indicator was observed to be on the number 0 in the red area. Resident 8 was immediately interviewed and stated they needed to be on oxygen due to shortness of breath. Resident 8's medical records were reviewed on 2/25/25. Resident 8's physician orders were reviewed and documented resident 8 had an order for oxygen due to acute respiratory failure. On 2/25/25 at 12:48 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON was observed to look at resident 8 ' s portable oxygen tank and stated they were going to get resident 8 a new portable oxygen tank because the indicator was getting close to the red area. On 2/25/25 at 12:50, an interview was conducted with Certified Nursing Assistant (CNA) 5. CNA 5 stated when the oxygen tank indicator was close to red, the portable oxygen tank needed to change. CNA 5 stated staff checked the portable oxygen tanks pretty frequently including prior to resident use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at 12:08 PM, an interview was conducted with the Licensed Practical Nurse (LPN). The LPN stated portable oxygen tanks were checked every shift by the CNAs. The LPN stated the portable oxygen tanks needed to be changed if the indicator was in the red which indicated the tank was low on oxygen. The LPN stated staff have been provided education on oxygen such as making sure residents were switched back from the portable oxygen tanks to the concentrators. On 2/28/25 at 10:44 AM, an interview was conducted with the Director of Nursing (DON). The DON stated portable oxygen tanks needed to be checked when they were initially put into use and checked at least every hour if they were in use. The DON staff needed to check and see how much oxygen was left in the tank and if the indicator was in the red then it needed to be changed because the oxygen would be running out soon. The DON stated they hoped staff would be proactive in switching out the portable oxygen tanks before they became empty.