STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465185	A. Building B. Wing	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millcreek Rehabilitation and Nursing LLC	3520 South Highland Drive Salt Lake City, UT 84106

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined for 1 of 43 sampled residents that the facility did not promote and facilitate the resident right to self-determination through support of the resident choice. Specifically, a resident who was assessed as not requiring supervision with smoking was not allowed access to the secured outside smoking patio after 9:00 PM unless it was at the supervised smoking times of 11:00 PM or 3:00 AM. Resident identifier 33. Findings included: Resident 33 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included type II diabetes mellitus, end stage renal disease, arteriovenous fistula, hypertension, encephalopathy, hidradenitis suppurativa, borderline personality disorder, major depressive disorder, anxiety disorder, and ascities. On 3/18/25 at 10:43 AM, an interview was conducted with resident 33. Resident 33 stated that he would like to sit outside on the smoking patio at night but he was told by staff that he had to be inside the facility by 9:00 PM. Resident 33 stated that he was treated like a child and could not leave when he wanted. On 1/10/25 and 3/24/25, resident 33's smoking evaluation documented that the resident was safe to smoke without supervision. On 3/27/25 at 11:01 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that the back interior door locked automatically at 9:00 PM and opened again at 6:00 AM daily. The ADON stated that the policy was that residents were supposed to go outside at the supervised smoking times at night even if they were independent with smoking. The ADON stated that was the policy at night because otherwise it would be too much for the staff to let residents in and out when they wanted. The ADON stated that the supervised smoking times at night were 11:00 PM and 3:00 AM. The ADON stated that resident 33 was a supervised smoker due to breaking the smoking policy. It should be noted that the resident assessment for smoking documented that the resident was safe to smoke without supervision. The ADON stated that the policy was after 9:00 PM residents needed to wait for the designated supervised smoking times to exit to the back smoking patio. The ADON stated that during the daytime residents were free to come and go as they wanted. The ADON stated that once the door locked at night if residents were outside alone the staff would not know when they wanted to be let back inside the building. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/25 at 11:34 AM, an interview was conducted with the Administrator (ADM). The ADM stated that the smoking patio doors locked at night after a certain time and then smoking times were at designated supervised times. The ADM stated that those residents who were assessed as safe to smoke independently could go out when they pleased. The ADM stated that his expectation was that staff unlock the door for those residents that were able to smoke independently. The ADM stated that there was no way for residents to alert staff other than knocking on the back door, and the back patio door did not have a doorbell.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that, for 1 of 43 sampled residents, that the facility did not provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Specifically, a resident had a brown substance on the wall next to the toilet for the entire length of the survey. Resident identifier: 50. Findings included: Resident 50 was admitted to the facility on [DATE] with diagnoses that included heart failure, type 2 diabetes, osteomyelitis, and diarrhea. On 3/17/25 at 10:07 AM, resident 50 stated there was fecal matter on the wall next to the toilet that had been there since he was admitted . The State Surveyor (SS) observed the area in the resident's bathroom and found there was a brown substance on the wall near the toilet next to the toilet paper dispenser and below the dispenser. On 3/27/25 at 11:15 AM, an observation was made in resident 50's bathroom. The brown substance that was observed on the wall previously was seen on the wall in the same place. On 3/31/25 at 10:10 AM, an observation was made in resident 50's bathroom. The brown substance that was observed on the wall previously was seen on the wall in the same place. On 3/31/25 at 10:12 AM, an interview was conducted with Housekeeper (HK) 1 who stated she cleaned the bathrooms every day which included the sink, the toilet, the toilet lid, the mirror, the floor, and the wall. On 3/31/25 at 10:19 AM, an interview was conducted with HK 2 who stated she cleaned the toilets, sinks, mirrors and floors. HK 2 stated if needed she would clean the walls. HK 2 was shown the area on resident 50's bathroom wall. HK 2 stated she did not notice it and would clean it right away. On 3/31/25 at 10:23 AM, an interview was conducted with the Maintenance and Housekeeping Supervisor (MHS) who stated he monitored the housekeeping staff every day. The MHS stated he did not receive consistent complaints and if he received a complaint he would get it addressed quickly. The MHS stated he had a maintenance log where staff or residents could let him know of a maintenance issue so he could have it repaired or addressed quickly. The MHS stated residents or staff were also able to catch him in the a hallway and let him know if they had a problem that needed to be fixed and he would make sure it was fixed. The MHS was taken in to resident 50's bathroom to show him where the brown substance had been on the wall. The brown substance had been partially cleaned off of the wall, but there was still some brown particles on the wall. The MHS stated he would have it cleaned right away.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 3 out of 43 sampled residents, that the facility did not ensure resident's were free from abuse. Specifically, a resident reported that another resident groped his genitals and attempted to penetrate his anus without his consent to the sexual activity. This deficient practice was found to have occurred at a Harm level. Additionally, a resident's capacity to consent to sexual activity assessment was not completed prior to the resident engaging in sexual activity. Resident identifiers 23, 49, and 112. Findings included: HARM 1. Resident 23 was admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease, type 2 diabetes mellitus, right below the knee amputation, phantom limb syndrome, congestive heart failure, hypertension, viral hepatitis C, schizoaffective disorder, insomnia, anxiety disorder, and post-traumatic stress disorder (PTSD). On 3/17/25 at 10:38 AM, an interview was conducted with resident 23. Resident 23 stated that he had an incident with resident 112 and the other resident tried to touch him improperly. Resident 23 said that was all he wanted to say about it. Resident 23 stated that he informed the Resident Advocate (RA) about the incident and the facility called the police. Resident 23 stated that resident 112 was not arrested. Resident 23 stated that after that incident the facility did nothing. Resident 23 stated that resident 112 was still in the facility for another 2 months after the incident. Resident 23 stated that it made him really angry that resident 112 was still there at the facility. Resident 23 stated he felt he was angry a lot because of the incident. Resident 23 stated that he spoke to the RA afterwards but felt as if nothing happened. Resident 23 stated that after the incident staff did not do anything to try and keep the residents separated. On 9/28/24 at 11:15 AM, the facility reported to the State Survey Agency (SSA) that on 9/28/24 at 3:00 AM, resident 23 reported that he woke up to resident 112 touching his private area and trying to put a finger in his rear end. Resident 23 yelled saying, don't touch me, I'm not a faggot!. Resident 23 stated that resident 112 did not respond back to him when he yelled this. Resident 23 reported he went to his girlfriends room and stayed with her until 6:00 AM. The facility's final investigation report documented on Form 359 that on 9/27/24 at 10:00 AM, the RA interviewed resident 23. The victim stated 'I was wearing sweatpants while sleeping. I woke up to his hands down my pants, fondling my manhood and trying to put a finger in my anus. I turned over and said 'get away from me, I know that's you [resident 112]'. He then crawled backwards on all fours and back into his bed. I took a minute to collect myself and then decided to go outside to have a cigarette.' RA asked why it took several hours to report to staff and the resident stated 'I was in shock'. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The summary of interviews documented, On 9/27/24 at 10:45 AM the RA spoke with the alleged perpetrator. He seemed disinterested but agreed. The RA started the conversation by asking, 'How are things? Did something happen to upset you this morning?' He then explained that he felt like others were talking about him, a frequent behavior with his diagnosis. I explained to him that an allegation was made against him and he responded with, 'I didn't do anything. That girl is making up rumors.' I let him know that it wasn't a female but it was a male that reported it. He was very taken aback and promptly stated 'That's crazy. I'm not attached to dudes'. He continued to tell me that he was in bed all night and slept like a rock. He became very upset and denying all claims. He asked to speak with his therapist, and we worked on his coping skills while waiting for his therapist to return our call. He stated multiple times, 'I'll stay away from other [sic] but I will not isolate myself because I did nothing wrong.' The conclusion of the facility investigation was documented as inconclusive. The allegation could not be verified based on evidence collected. After interviewing resident and staff, no conclusive evidence was found to implicate the alleged perpetrator. Resident 23's medical records were reviewed. On 9/13/24, the Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) score of 12/15, which would indicate a moderate cognitive impairment. Resident 23's Treatment Administration Record (TAR) documented verbalizations of anxiety with one episode documented on 9/28/24 and 9/29/24 during the morning shift and one episode documented on 9/28/24 and 9/29/24 during the evening shift. It should be noted that no other episodes of anxiety were documented for the month of September. Resident 23's progress notes documented the following: a. On 9/28/24 at 10:08 AM, the Health Status Note documented, Alert charting r/t [related to] resident to resident altercation. [Resident 23] told this nurse that early Saturday morning at 3 am his roommate [resident 112] came up to [resident 23] and touched him inappropriately a few times. As [resident 112] continued to touch [resident 23's] private parts, [resident 23] started yelling at [resident 112] and [resident 112] didn't say anything back to him but went back to his bed and pretended to be asleep. [Resident 23] left his room after the incident and stayed in his girlfriend's room until about 6 am and only then decided to tell staff about what happened at 3 am. The two residents were separated and DON [Director of Nursing], Administrator were contacted. [Resident 112] was moved to a different room and is being monitored. b. On 9/28/24 at 5:30 PM, the Health Status Note documented, Alert charting r/t resident to resident (R:R) altercation. This resident reported an incident to the NOC [night] shift nurse at 0551 [5:51 AM] and NOC shift nurse informed this nurse (oncoming RN [registered nurse]) at 0600 [6:00 AM] shift report. Facility administrator/abuse coordinator was notified immediately. The alleged perpetrator was moved to the front of the facility away from this resident (alleged victim.) The residents remained separated for this shift. No verbal or physical contact between the two residents was witnessed by this RN during this shift. This resident reported anxiety about the altercation at morning med pass and received emotional support from this RN. He did not report any physical changes r/t to the altercation to this RN. His safety and mental and physical health was continuously assessed during this shift and he received all medical care as usual. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	c. On 9/30/24 at 6:00 AM, the behavioral health Nurse Practitioner Psych Follow Up note documented, Staff report that the pt. [patient] experiences moments of increased agitations. Will continue to monitor this pt Psychiatric Exam: General Appearance: alert and dishevelled [sic]. Behavior: eye contact is good and guarded. Mood: depressed. Affect: appropriate and flat. Thought Processes: concentration intact. Thought Content: no delusions, hallucinations, suicidal ideation, or homicidal ideation and normal thought content. Judgment: is intact. Insight: limited. Neurological System: Orientation: oriented to person, place, and time. Memory: immediate recall is intact and remote memory is intact. Fund of Knowledge: shows at least average vocabulary. Speech: volume is normal; fluent. d. On 9/30/24 at 12:44 PM, the Alert Note documented, Resident had a visit with social worker, regarding an incident with another resident. He was visibly upset and asked to speak with someone. She was called in they visited for about an hour. He seems to be coping better after their session. e. On 10/1/24 at 12:48 PM, the Alert Note documented, [Resident 23] is still trying to effectively cope with the incident with another resident. He is doing better today. I have had to remind [Resident 23] and friends that the Administrator is handling it accordingly. This seems to elevate some stress about the situation. f. On 10/3/24 at 9:49 AM, the Health Status Note documented, Resident has been verbalising [sic] increased anxiety and acute insomnia d/t [due to] recent trauma. Per [behavioral health services Nurse Practitioner]: start resident on Hydroxyzine 25mg [milligrams] po [by mouth] q [every] 6hrs [hours] PRN [as needed] x [times] 14 days for anxiety. MD [Medical Doctor] notified. g. On 10/9/24 at 2:21 PM, the Health Status Note documented, Per [behavioral health services Nurse Practitioner]: [Resident 23] reports that his depression is getting better, but residual anxiety is still there, so he agreed; 1). Increase Escitalopram to 20 mg daily. 2). Reduce Abilify to 10 mg in AM. MD approved. Resident 23's care plans revealed the following: a. On 9/17/24, resident 23 had a care plan initiated for TRAUMA INFORMED CARE: Has a history of trauma that affects him negatively. The care plan did not identify any interventions that were specific to the sexual abuse incident that occurred on 9/28/24. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	b. On 11/8/24, resident 23 had a care plan initiated for Resident has expressed/demonstrated a desire to participate in sexual activity with others. The interventions identified for the care plan were If sexual abuse or other sex-related crimes are suspected, staff shall immediately intervene to protect the resident and notify the administrator and law enforcement.; If the resident does not demonstrate capacity for consent or loses the capacity to consent to sexual activity, staff shall intervene as indicated to protect the resident from the risk for sexual abuse.; Staff shall educate resident that sexual activity should occur in a private setting to honor the rights of other residents and provide a private setting for sexual activity as needed.; Staff shall notify the attending physician if a resident desires to participate in sexual activity to obtain orders for contraceptive products, prophylactic or active antibiotics/antivirals, labs, etc. as indicated.; and The sexual capacity for consent assessment will be performed upon initiation of sexual activity, and then quarterly thereafter or with significant changes. On 3/18/25, a Sexual Activity Capacity for Consent assessment was conducted. The assessment documented Residents providers endorse that he is mentally at his baseline and is stable. When he is in a heightened state of emotion he tends to spend long amounts of time sleeping. He states his relationship with [resident 112] helps to get him out of his 'funks'. The resident's stated choice documented, Interview regarding residents choice to engage in sexual activity reflects consistency. He endorses that him and resident [resident 112] have been in a mutual and voluntary relationship for a long time. He spoke about how they met through mutual friends and bonded over their history. He states he enjoys having someone to confide in. Understands STI's [sexually transmitted infections] can be transmitted through sex. Understands pregnancy can be a risk. Patient understands how to prevent these risks. Resident also expressed an understanding of emotional risks associated with a sexual relationship and how to cope with these feelings. c. On 1/28/25, resident 23 had a care plan initiated for MOOD AND BEHAVIOR: History for an alteration in mood or exhibition of behavioral symptoms r/t: Schizoaffective disorder depressive type, Anxiety disorder, PTSD. The care plan identified an actual resident to resident altercation on 9/27/24. The interventions identified for the altercation were to move the alleged perpetrator to the farthest room away, as possible, from resident 23, in-person meeting with therapist, and weekly phone calls with therapist. The interventions were initiated on 1/28/25. It should be noted that the interventions were initiated 4 months after the incident occurred. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 3/25/25 at 9:02 AM, an interview was conducted with the RA. The RA stated that resident 23 reported that he woke up to his roommate [resident 112] having his finger near his butt. Resident 23 reported that resident 112 was on the floor on his knees and resident 23 yelled at him to get away from him. The RA stated that resident 23 reported that he went to his girlfriends room and they went to have a cigarette before reporting it to the nurse. The RA stated that she had no other documentation of the interview with resident 23 that was not already contained in the Form 359. The RA stated that resident 23 was agitated throughout the interview. The RA stated that they moved resident 112 to another room on 9/28/24. The RA stated that resident 23 had never made any allegations of sexual abuse prior to this incident. The RA stated that resident 112 had a history of sexual assault where he was the perpetrator and this information was contained within his Pre-admission Screening Resident Review (PASRR) Level II. The RA stated that resident 112 was not a registered sex offender. The RA stated that they asked the residents to stay apart and to have staff present during smoking breaks. The RA stated that she could not recall any new interventions that were implemented for resident 23 after the incident. The RA stated that she encouraged resident 23 to attend Mental Health Mondays where they reviewed coping skills, words of affirmations, wrote in a notebook for feelings, and identified 5 good things that happened that week. The RA stated she did not observe any prolonged change in resident 23's behavior. The RA stated that monitoring of resident 23 was alert charting for the nurses and she would meet with the resident several times a week. The RA stated she was not sure if those meetings were documented. The RA stated that during those short visits with resident 23 she would ask how his day was going. The RA stated that there was no reason for her not to believe resident 23's account of the incident and he had no history of making false allegations. The RA stated that she interviewed resident 112 and he was confused and shocked about the allegation and then he denied all claims. The RA stated that she asked him what happened this morning, and resident 112 replied he did not know. The RA stated that resident 112 was confused about the incident with his roommate. The RA stated she told resident 112 of the allegation and he denied all claims. The RA stated that resident 112 got loud and raised his voice. The RA stated that resident 112 stated no I would never. The RA stated that she informed resident 112 of a room change and the resident agreed. The RA stated that resident 112 remained in the facility for several more months after the incident. The RA stated that after the initial incident she was not aware of any additional conflicts between resident 23 and resident 112. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 3/25/25 at 10:33 AM, an interview was conducted with the contracted Certified Social Worker (CSW). The CSW stated she had been resident 23's therapist since October 2024. The CSW stated that she was not aware of any sexual abuse allegation that may have occurred in September 2024. The CSW stated that resident 23 was exhibiting signs and symptoms (s/sx) of depression and that was when she started seeing him. The CSW stated that when she took over she did not receive a report or hand off from resident 23's previous therapist. The CSW stated that she was able to see resident 23's notes by other behavioral health providers, but she did not review the resident's past therapy notes. The CSW was observed to review resident 23's history and notes. The CSW stated that resident 23 started individual therapy in November 2024. The CSW stated that she did a care plan in November and February for resident 23 and there were no mentions of sexual abuse allegations in resident 23's chart. The CSW stated that she started actual individual therapy with resident 23 on February 17, 2025. The CSW stated that the November visit was for the development of the care plan and annual assessment. The CSW stated at that time she conducted a PHQ-9 (Patient Health Questionnaire) depression test and the score was a 2 on 11/4/24, which would indicate a very low depression score. The CSW stated that she looked back in resident 23's notes from the previous provider and did not see any mention of a sexual abuse allegation. The CSW stated that if she had been informed she would have come in once a week to see resident 23. The CSW stated that she did see where a previous Nurse Practitioner had ordered Hydroxyzine for resident 23, but she was no longer his provider. The CSW stated that she viewed the note and recommendation to increase the Hydroxyzine medication but the note did not state why the medication increase was needed. The CSW stated that her experience with resident 23 focused on his depression related to feeling stuck and his adjustment with his amputation. The CSW stated that resident 23 did not have a history of delusions or hallucinations. The CSW stated that resident 23 had no grandiosity with making up stories. The CSW stated that resident 23 was pretty accurate with what his life was like in the drug world. The CSW stated that resident 23 had a tendency to perseverant on the same idea. Sometimes he did not think ahead, and he exhibited a lack of judgement and planning. The CSW stated an example of this was with resident 23's discharge planning and wanting to leave the facility, but through discussions he was able to identify his own limitations. The CSW stated that resident 23 exhibited good cognitive thinking. The CSW stated that resident 23 had never mentioned any female relationships in the facility, and she was not aware of any girlfriends. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 3/25/25 at 11:19 AM, an interview was conducted with the Administrator (ADM). The ADM stated that he was informed of the sexual abuse allegation by the staff nurses. The ADM stated that it was reported that resident 23 woke up to someone touching him and he went to his girlfriends room and she told him to report it and that was what he did. The ADM stated that he spoke with resident 23 and he reported what was documented in the facility investigation on Form 358 and Form 359. The ADM stated that he did not have any other documentation of the investigation. The ADM stated that he asked resident 23 why he waited so long to tell the staff and resident 23 replied that he was just freaked out by the whole thing. The ADM stated that resident 49 was resident 23's girlfriend. The ADM stated that resident 23 went into resident 49's room often. The ADM stated that resident 23 reported the incident to RN 2 and RN 3 during shift change and RN 3 informed him of the incident by email. The ADM stated that resident 112's room change was completed by the time he arrived at the facility and was done at the DON's direction. The ADM stated that RN 3 texted the DON immediately about the allegation. The ADM stated that resident 23 initially reported that resident 112 had come into his section of the room and attacked him. The ADM stated that resident 23 was upset when talking about the incident. The ADM stated that he reviewed the video footage and he did not see anything out of the ordinary, but that the cameras did not have resident room access. The ADM stated that the video footage showed resident 23 exit his room and go into his girlfriends room. The ADM stated that he was unable to recall the time that occurred and he did not have documentation of it. The ADM stated that after he spoke to resident 23 he went and spoke to resident 112. The ADM stated that resident 112 denied the allegation, and replied he was not into dudes. The ADM stated that resident 23 had not made any other allegations prior to or since this incident. The ADM stated that they informed resident 112 that if he went past the nurse's station or wanted to go on smoke break he had to have someone with him. The ADM stated that the conclusion of the investigation was inconclusive due to a he said/he said situation. The ADM stated that the allegation could not be verified based on the lack of evidence collected, and it was essentially one resident's word against another. The ADM stated that resident 23 had not made any prior allegations, and he did not have any reason to doubt his account of the situation. The ADM stated that resident 112 continued to reside at the facility after the incident for approximately another 5 months. The ADM stated that during that time resident 112 was agreeable to stay on the east side of the nurses's station, but there may have been times that they passed each other. 2. Resident 112 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which consisted of chronic obstructive pulmonary disease, type 2 diabetes mellitus, hypertension, atrial fibrillation, schizoaffective disorder, insomnia, anxiety disorder, post-traumatic stress disorder, borderline personality disorder, and borderline intellectual functioning. Resident 112 was discharged from the facility on 2/5/25. Resident 112's medical records were reviewed. On 9/17/24 resident 112's MDS assessment documented a BIMS score of 10, which would indicate a moderate cognitive impairment. Resident 112's September 2024 TAR documented the following: a. Monitoring for EPISODES OF AGITATION Q SHIFT documented 8 episodes on 9/24/24, 2 episodes on 9/29/24, and 4 episodes on 9/30/34. b. Monitoring for VERBALIZATIONS OF ANXIETY Q SHIFT documented 10 episodes on 9/24/24, 1 episode on 9/26/24, 1 episode on 9/28/24, 4 episodes on 9/29/24, and 4 episodes on 9/30/24. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	c. Monitoring for : # OF MANIC EPISODES (PRESSURED SPEECH, FLIGHT OF IDEAS) documented 4 episodes on 9/24/24. On 9/23/24 at 9:04 AM, resident 112's Resident Trauma Interview documented a history of physical, emotional, and sexual trauma. The resident reported experiencing nightmares, flashbacks, sleep disturbances, difficulty concentrating, irritation, anger, and anxiety. The resident reported episodes 1-2 times a month. The resident reported triggers of violent tv shows and conversations about past trauma. The resident identified coping mechanisms as medication, quiet environment, and talk therapy. Resident 112's progress notes documented the following: a. On 9/28/24 at 10:24 AM, the Health Status Note documented, Alert charting r/t resident to resident altercation. [Resident 112] roommate [resident 23] accused him of touching him inappropriately early Saturday morning at 3 am but shared this information with staff only at around 6 am. This nurse was unable to take a statement from [resident 112] because [resident 112] either pretended to be asleep or was asleep. Refused to talk. Residents were separated. DON, Administrator were called and [resident 112] was moved to a different room. He is being monitored. WCTM [will continue to monitor]. b. On 9/29/24 at 10:19 PM, the Health Status Note documented, Resident has been up in his wheelchair this shift. He was heard saying 'something is not right or not fair'. He would not express details, though repeated the same thing two to three times. Resident made no reference to others or any situation. Resident took his night-time medications and tolerated them well. No new negative behaviors have been observed or reported at this time. WCTM. c. On 10/1/24 at 6:26 PM, the Alert Note documented, Resident is on Alert charting r/t R:R altercation. Resident remained separated from two other residents that he has had R:R altercations with. Resident was sitting WC [wheelchair] in doorway of his room this afternoon with his pants down past buttox [sic]. Asked resident if would go back into his room and asked if he needed assistance fixing his pants. Resident was compliant with going back into his room to fix his pants. No other behaviors observed this shift. On 1/28/25, resident 112 had a care plan initiated for MOOD & BEHAVIOR: History for an alteration in mood or exhibition of behavioral symptoms r/t: Schizoaffective disorder bipolar type, GAD [generalized anxiety disorder], PTSD, BPD [borderline personality disorder], Borderline Intellectual functioning. The care plan identified an actual resident to resident altercation on 9/27/24. The interventions identified on the care plan included resident was moved to the farthest possible room away from alleged victim; resident met in person with therapist; administer medications as ordered; allow resident time to calm down and reapproach [sic] at a later time; evaluate for need and refer to psychological couseling [sic] as recommended by the physician; interact in an empathetic and supportive manner; monitor and document each behavioral event; 1:1 interaction as needed; offer psychosocial support as needed; and Psychotropic Review Committee to review medications. The interventions were initiated on 1/28/25. It should be noted that the interventions were inititiated 4 months after the incident occurred. On 1/13/25, resident 112 had a Montreal Cognitive Assessment (MOCA) conducted and the resident scored 11/30, which would indicate a moderate cognitive impairment. The resident had deficits in visuospatial/executive function, naming, memory, attention, language, abstraction, delayed recall, and orientation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 6/27/24, resident 112's PASRR Level II documented, Bipolar Disorder: A review of the record shows he has had the following symptoms of mania: grandiosity, pressured speech, racing thoughts, flight of ideas, distractibility, increased risk taking, including hypersexuality and general impulsivity. He has had auditory hallucinations during periods of mania. As best can be determined, symptoms of mania were not solely related to substance abuse. Posttraumatic Stress Disorder: [Resident 112] has a history of physical and emotional abuse by his father, as well as a history of rape as an adult, leading to a response of fear and helplessness. He has had flashbacks as often as once or twice a week, and experiences psychological distress as a result. Flashbacks are triggered by violent television shows, such as Law and Order: Special Victims Unit, and conversations about past trauma by others. These triggers are avoided. Hypervigilance, exaggerated startle response, and concentration problems are present, causing clinically significant distress and impairment, and have been problematic for years. He also reports having nightmares once or twice a month, and takes prazosin to help with this. Antisocial Personality Disorder: He has a history of 22 arrests in Florida, often for sexual assault, and was extremely aggressive, requiring frequent restraints and seclusion during the first three or more years of his [state hospital] stay. Failure to comply with social norms, impulsivity, irritability and aggressiveness, disregard for the safety of others, consistent irresponsibility, and lack of remorse. Many of these symptoms are not in evidence at this time, as he has greatly improved in his ability to manage his aggression. During the Level 2 evaluation in April 2024, Patient was significantly manic and hyperverbal with grandiose thought content, pressured speech and flight of ideas. Patient spoke with a very loud voice and was animated throughout the conversation. Patient showed his arms to evaluator that were covered in scars from cutting himself with a razor. Patient stated he has tried to kill himself 100-200 times. Patient stated he 'sometimes falls into the anger trap' and talked about what he does when he gets frustrated but using coping skills he has learned. Patient endorsed hearing ongoing almost constant voices. 'I always hear voices. I consider it telepathy. I consider the good voices guardian angels and the bad voices Satan's dominions.' He also stated, 'I've had visions in my head of Satan, but it doesn't scare me.' 3. Resident 49 was admitted to the facility on [DATE] with diagnoses which consisted of schizoaffective disorder bipolar type, fetal alcohol syndrome, post-traumatic stress disorder, opioid dependence, anxiety disorder, attention-deficit hyperactivity disorder (ADHD), and insomnia. On 3/17/25 at 9:14 AM, an interview was attempted with resident 49. Resident 49 made eye contact but did not respond to greeting. Resident 49 turned away from surveyor and closed her eyes. On 3/18/25 at approximately 1:30 PM, an observation was made of resident 49 and resident 23 in the hallway. Resident 49 was heard inviting resident 23 to watch a movie. Resident 23 replied that he was not allowed to go into her room to watch the movie. Resident 49's medical records were reviewed. Resident 49's physician orders revealed the following for behavior monitoring: a. On 7/18/22, an order was initiated for BEHAVIOR MONITORING: # OF VERBALIZATIONS OF ANXIETY Q [every] SHIFT. The TAR documented 3 episodes in November 2024, 4 episodes in December 2024, 5 episodes in January 2025, 2 episodes in February 2025, and 6 episodes in March 2025. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	b. On 7/19/22, an order was initiated for BEHAVIOR MONITORING:# OF DELUSIONS Q SHIFT. The TAR documented 1 episode in November 2024, 2 episodes in January 2025, 8 episodes in February 2025, and 2 episodes in March 2025. c. On 7/19/22, an order was initiated for BEHAVIOR TRACKING:# HALLUCINATIONS Q SHIFT. The TAR documented 1 episode in December 2024. d. On 8/8/22, an order was initiated for BEHAVIOR MONITORING:# EPISODES OF CRYING/TEARFULNESS Q SHIFT. The TAR documented 1 episode in November 2024, 14 episodes in December 2024, 11 episodes of January 2025, and 1 episode in March 2025. e. On 6/7/23, an order was initiated for BEHAVIOR MONITORING: # EPISODES OF FLASHBACKS Q SHIFT. f. On 3/21/25, an order was initiated for BEHAVIOR MONITORING: # OF PSYCHOSIS Q SHIFT. Resident 49's progress notes revealed the following: a. On 7/19/24 at 6:45 AM, the Psych Evaluation note documented, Psychiatric Exam: General Appearance: body odor and appears fatigued. Behavior: uncooperative, disruptive, guarded, does not make eye contact, attitude is disinterested, and shows impulsivity. Mood:dysphoric, depressed, anxious, and irritable. Affect: agitated, hostile, and labile. Thought Processes: shows loosening of associations and poverty of thought and attention wandered throughout interview, concentration impaired, and is tangential. Thought Content: delusions, obsessions, and hallucinations: both. Judgment: is impaired. Insight: is impaired. Neurological System: Orientation: o[TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 5 of 43 sampled residents, that the facility did not ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, to the administrator, the State Survey Agency (SSA), Adult Protective Services (APS), and local law enforcement. Specifically, an allegation of sexual abuse was not reported to the SSA, APS, or local law enforcement within 2 hours after the facility became aware of the allegation, an allegation of sexual abuse was not reported to the APS within 2 hours after the facility became aware of the allegation, and an injury sustained in the transportation van was not reported to the SSA and APS within 2 hours of the incident. Resident identifiers 23, 50, 112, 113, and 114. Findings included: 1. a. Resident 23 was admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which consisted of chronic obstructive pulmonary disease, type 2 diabetes mellitus, right below the knee amputation, phantom limb syndrome, congestive heart failure, hypertension, viral hepatitis C, schizoaffective disorder, insomnia, anxiety disorder, and post-traumatic stress disorder (PTSD). 1. b. Resident 112 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which consisted of chronic obstructive pulmonary disease, type 2 diabetes mellitus, hypertension, atrial fibrillation, schizoaffective disorder, insomnia, anxiety disorder, post-traumatic stress disorder, borderline personality disorder, and borderline intellectual functioning. Resident 112 was discharged from the facility on 2/5/25. On 9/28/24 at 11:15 AM, the facility reported to the State Survey Agency (SSA) that on 9/28/24 at 3:00 am, resident 23 reported that he woke up to resident 112 touching his private area and trying to put a finger in his rear end. The facility investigation, Form 358, documented that staff became aware of the incident on 9/28/24 at 5:51 AM and the Administrator (ADM) was notified on 9/28/24 at 9:18 AM. It should be noted that this was approximately 3.5 hrs after the staff first became aware of the incident. The facility investigation, Form 358, documented that the SSA was notified on 9/28/24 at 11:16 AM. It should be noted that this was over 5 hours after staff first became aware of the incident. The facility investigation, Form 358, documented that the local law enforcement was notified on 9/28/24 at 10:13 AM. It should be noted that this was over 4 hours after staff first became aware of the incident. The facility investigation, Form 358, documented that APS was notified on 9/28/24 at 11:15 AM. It should be noted that this was over 5 hours after staff first became aware of the incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/25/25 at 11:19 AM, an interview was conducted with the ADM. The ADM stated that he informed APS on 9/28/25 at 11:04 AM and the SSA on 9/28/24 at 11:16 AM. The ADM confirmed that staff were informed of the incident on 9/28/24 at 5:51 AM. The ADM stated that the timeframe for reporting to the SSA was 2 hours and it was not reported to him until after 9:00 AM. The ADM stated that staff should have reported it to him immediately and staff had been educated that allegations of abuse should be reported to him immediately. 2. a. Resident 113 was admitted to the facility on [DATE] with diagnoses which consisted of chronic obstructive pulmonary disease, overactive bladder, hypertension, insomnia, repeated falls, and congestive heart failure. 2. b. Resident 114 was admitted to the facility on [DATE] with diagnoses which consisted of cerebral palsy, schizoaffective disorder bipolar type, anxiety disorder, attention-deficit hyperactivity disorder, post-traumatic stress disorder, catatonic disorder, suicidal ideations, and insomnia. The facility investigation, Form 358, documented on 07/14/23 at 7:33 PM, the facility reported to the SSA that on 07/14/23 at 6:30 pm, resident 113 and resident 114 had engaged in a sexual act in the bathroom with the door open. The facility investigation, Form 359, documented that APS was notified on 7/18/23, no time was documented. It should be noted that the notification was made 4 days after the facility staff became aware of the incident. The facility investigation, Form 359, documented that local law enforcement was notified on 7/18/23, no time was documented. It should be noted that the notification was made 4 days after the facility staff became aware of the incident. 3. Resident 50 was admitted to the facility on [DATE] with diagnoses that included heart failure, type 2 diabetes, osteomyelitis, and diarrhea. (38480) On 3/17/25 at 10:07 AM, an interview was conducted with resident 50 who stated that on 2/14/25 at approximately 9:30 AM, he was in his wheelchair in the facility van being transported to a medical appointment when he fell over backward and hit his head and neck on the floor of the van. Resident 50 stated he was upset because the incident report did not reflect the facts of what happened, he was not properly assessed until the day after the incident and did not receive an x-ray until the day after the incident. On 3/19/25, the State Survey Agency (SSA) received an entity 358 report for the incident that occurred on 2/14/25. On 3/20/25, an email confirmation correspondence was sent to the facility to confirm the date of the incident. On 3/19/25 at 2:26 PM, an interview was conducted with the Director of Nursing (DON) who stated they did not report the incident to the State Survey Agency (SSA). The DON stated he did not know why. The DON stated it did not seem like abuse or neglect. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/19/25 at 3:18 PM, an interview was conducted with the ADM who stated he did not think this would have been considered neglect. The ADM stated the state should be made aware so they know what was done to correct the situation, and how it could be prevented. The ADM stated they probably should have reported it. On 3/26/25 an exhibit 359 follow-up investigation report was received from the facility. The report stated other agencies were not notified at the time of the incident.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for 1 of 43 sampled residents, the facility, in response to an allegations of abuse, neglect, or mistreatment, failed to provide evidence that all alleged violations were thoroughly investigated and failed to report the results of all investigations to the State Survey Agency (SSA), within 5 working days of the incident. Specifically, a resident sustained a fall in a wheelchair while being transported in the facility van and the facility did not investigate the incident or report the incident to the SSA. This was determined to have occurred at an Immediate Jeopardy level. Resident identifier: 47 and 50. On 3/20/25 at 1:30 PM, an Immediate Jeopardy (IJ) was identified when the facility failed to implement Centers for Medicare and Medicaid Services (CMS) recommended practices to thoroughly investigate alleged violations, prevent further potential abuse, neglect exploitation or mistreatment while the investigation was in progress, and report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with state law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violations was verified appropriate corrective action must be taken. Specifically the facility failed to report and investigate a resident's fall during transportation in a facility vehicle. The facility had no documentation that an investigation had been conducted, no actions were taken to re-educate transportation staff on how to properly secure residents and their equipment safely to prevent falls or injury during transportation. There was no evidence that monitoring had taken place to ensure that policies were being followed and that safety practices were being adhered to. Notice of the IJ was given verbally and in writing to the Corporate President (CP) and the Regional Nurse Consultant (RNC) 1 who were present by phone, the Regional [NAME] President of Operations (RVPO), RNC 2, the Administrator (ADM), the Director of Nursing (DON), the Minimum Data Set (MDS) Coordinator, and they were informed of the findings of IJ pertaining to F 610 for resident 50. On 3/20/25 at 4:09 PM, the Administrator provided the following revised abatement plan for the removal of the Immediate Jeopardy effective 3/20/25 at 10:00 PM. Identification of Residents Affected or Likely to be Affected: The facility took the following actions to address the identified issue and prevent any additional residents from suffering an adverse outcome (Completion Date: 3/20/25 Completion Time: 10:00 PM) * Resident #50 was evaluated on 3/20/25 at 1440 (2:40 PM) by the Director of Nursing (DON) for pain and offered to be transferred to the hospital to address concerns and to be evaluated for latent injury from the fall on 2/14/25. The resident declined to go to the hospital. The resident was reminded of the treatment modalities available to him including pain medication, muscle relaxation and non-pharmacological interventions. * Resident #50's w/c [wheelchair] was evaluated for safety and to ensure proper functioning by the DON and Nursing Home Administrator (NHA) on 3/19/25. There were no concerns identified. * The NHA inititiated an initial report to the State for the van incident that occurred on 2/14/25 on 3/19/25. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* The incident report for resident #50 was reviewed and updated for the event that occurred on 2/14/25 on 3/20/25 to address inaccuracies identified during the investigation initiated on 3/19/25. * The Transpiration Driver (TD) was suspended on 3/19/25 pending the outcome of the investigation. * On 3/20/25 the DON and designee(s) assessed all residents that have been transported by the facility since 2/14/25 to ensure they did not sustain any injury or falls while being transported on the facility van. No additional residents were identified. * On 3/20/25 the Regional Nurse Consultant (RNC) completed a 100% audit of risk management reports and progress notes from 2/14/25 to present to ensure all incidents to have been appropriately reviewed and investigated for potential abuse or neglect. Actions to Prevent Occurrence/Recurrence: The facility took the following actions to prevent an adverse outcome from reoccurring (Completion Date: 3/20/25 Completion Time 10:00 PM) * On 3/20/25 the RNC conducted a Root Cause Analysis (RCA) on all transport incidents from the previous 90 days. Current residents impacted by the findings of the RCA had safety measures and resident specific interventions added to their care plans. * On 3/20/25 the RVPO educated the NHA and DON on the facility Trigger Call process, driver safety including proper securement technique of w/c dependent residents such as seatbelt placement through the arm rest and secured against post assuring seat belt is against the resident and does not have any slack as well as securing the wheelchair to the wheelchair van through the appropriate placement of the wheelchair restraints onto a fixed part of the frame of the wheelchair, how to conduct a RCA, review of incidents to ensure allegations of abuse and neglect are investigated timely, and how to ensure incident investigations are timely and complete including the Event Note Template. The Trigger Event process includes the NHA and DON notifying the RNC and RVPO of high risk events to ensure they are handled appropriately with targeted interventions and actions to investigate and prevent recurrence. Trigger Events include areas such as allegations or suspicions of abuse and neglect, fall with major injury and any incidents that occur on an outing or transport. The incident investigation process includes IDT (Interdisciplinary Team) review of an incident report daily at stand up meeting and the use of an investigation checklist to assure the investigation process is thorough and complete. The Event Note Template includes a list of the IDT members involved in the incident RCA and investigation the event date and time, a description of the event, risk factors and root cause identification, preventative measures in place prior to the event and new interventions implemented post incident. * On 3/20/25 the RVPO educated the NHA and IDT Leadership on identifying, reporting and investigating neglect. The education included the definition of neglect and how to identify when a situation needs to be reported and investigated as neglect. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* The NHA educated all staff involved in using the facility van for transportation on safety including proper securement technique for wheelchair dependent residents, placement of the seatbelt and what to do if an accident occurs. A documented return demonstration checklist was completed on 3/20/25 with transportation staff including the RA [Resident Advocate], DON, BOM [Business Office Manager], and AD [Activities Director] prior to their next transport. Instructions for what to do if an incident/accident occurs while performing a transport was placed in the facility van for staff to refer back to in the event of an incident/accident. * The NHA or designee will visually inspect residents being transported in the facility van prior to transport to ensure w/c is properly secured for the next 30 days. * The Corporate Nurse or RVPO will review all incident reports within one working day for three months to ensure an RCA has been conducted and the resident specific interventions are reflected in the care plan. * The NHA or designee will initiate a Trigger Call with the RVPO and RNC for all incidents that occur on the facility van to ensure appropriate action has been taken and a comprehensive plan for investigation and RCA has been developed. * The DON or designee will review all falls and transport related incidents at the daily stand-up meeting with the IDT for three months to ensure appropriate safety interventions are implemented, the resident's care plan has been reviewed and revised, and staff education has been completed as needed. * A QAPI [Quality Assessment Performance Improvement] PIP [Performance Improvement Plan] has been initiated to report on the above monitoring and auditing procedures. All findings from the PIP will be presented at the monthly QAA [Quality Assessment and Assurance] meeting. Monitoring/auditing and reporting will continue for a minimum of three months. On 3/21/25, 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 3/20/25. Findings included: Resident 50 was admitted to the facility on [DATE] with diagnoses that included heart failure, type 2 diabetes, osteomyelitis, and diarrhea. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/17/25 at 10: 07 AM, an interview was conducted with resident 50 who stated the Transportation Driver (TD) was taking him to a cardiology appointment when he fell backward in his wheelchair, hit his head and neck on the floor. Resident 50 stated his wheelchair was strapped into the van and he was not sure about the placement of a seatbelt. Resident 50 stated he reported the accident when he returned to the facility and was provided an x-ray the day after the incident. Resident 50 stated the incident happened on 2/14/25 at approximately 9:30 AM. Resident 50 also stated that his roommate was also riding in the van and was a witness to the accident. Resident 50 stated he requested a copy of the incident report and was provided one. Resident 50 also stated the incident report was not accurate. Resident 50 stated he requested to have a second opinion regarding his injuries and was provided an appointment 2-3 weeks later. Resident 50 stated he spoke with the Director of Nursing (DON) about the incident the day after it occurred and was told he knew nothing about it. Resident 50's medical records were reviewed between 3/17/25 and 3/31/25. A progress note dated 2/15/25 at 8:34 PM revealed, Note text: During cares today, resident reported that he had a witnessed fall yesterday during transportation to his appointment. Resident states that he fell backwards and hit his head and neck. Fall was reported to management and MD [Medical Doctor], neuros initiated, no visible injuries but due to pain MD ordered cervical spine xrays. VS [vital signs] WNL [within normal limits]. Awaiting results on xrays. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/15/25 an incident report revealed, Witnessed fall: Resident: [Resident 50] .Incident location: out of facility/during transport .Incident Description: Nursing Description: Resident reported to the nurse today (2/15/25), that yesterday (2/14/25) he had a witnessed fall during transportation to his appointment. States that he fell and hit his head. Was heading to appointment, and when getting inside of the van he fell backwards and hit his head. states that heck[sic] has been hurting .Immediate action taken: Description: The resident was assessed for injuries and no injuries found. He reports tenderness to the neck on palpation. Reported to management and MD, initiated neuros and MD ordered cervical spine xrays- xrays ordered. X-ray results were negative for a fracture. Resident requested a second opinion, was referred to ortho. Alert charting initiated. IDT intervention: DON and NHA retrained the transportation driver on proper and safe transportation techniques. Also, resident's appointments to be rescheduled if the resident is not medically stable .Resident taken to Hospital? N .Injuries Observed at Time of Incident .No injuries observed at time of incident .Level of Pain: 0 .Level of Consciousness: Alert, Mobility: Ambulatory with assistance Mental Status: Oriented to Person, Oriented to Situation, Oriented to Place, Oriented to Time .Injuries Report Post Incident: No injuries observed post incident .Level of Pain: 0 .Level of Consciousness: Alert, Mobility: Ambulatory with Assistance . Mental Status: Oriented to Person, Oriented to Situation, Oriented to Place, Oriented to Time . Predisposing Environmental Factors: None .Predisposing Physiological Factors: None .Predisposing Situational Factors: Using Assistive Device .Other Info: Resident had loose bowels and was in his w/c at the time it happened. The back of his wheelchair opens backward. When the driver was at the light, the resident had another episode of loose BM [bowel movement], he got agitated and started to scream and thrash around while in wheelchair. His erratic movements caused the back of his wheelchair to reclined backward, which caused him to lean backward. According to driver, resident didn't land on the floor and did not hit his head on the floor or anything .Statements: Staff on 2/17/25 On Friday the 14th of March, [Resident 50] was having a cardiology appointment at [facility]. [Resident 50] was secured appropriately in the van according to our regular safety standards. When I went to get him, he was having diarrhea and a bad day as well, as he was so sad. Before we left the building, I changed his brief twice, so while we are driving he kept on yelling in the van because he also had diarrhea twice on our way. While this is happening, I always encourage him, and promise him that I will help him do a brief change when we get to the [facility]. So we got to the light close to the [facility], the moment it was green, I moved the car, all I heard was shit I just had diarrhea again. The he said I'm falling down, so I quickly park the van by the side of the road, he was still strapped with the seat belt, but he was down with his wheelchair. I asked him if hit his head and he said no, so I helped him up, and we continued our trip . Agencies/People notified: DON on 2/15/25 at 8:34 PM, Physician 2/15/25 at 8:34 PM. On 3/19/25 at 9:33 AM, an interview was conducted with resident 47 who stated he was sitting in the back seat of the van when the accident occurred on 2/14/25. Resident 47 stated he was wearing a seat belt. Resident 47 stated the TD placed the hooks of the straps to the frame of the wheelchair. Resident 47 stated, something in the front came undone. [TD] pushed on the gas and the wheelchair fell backward. Resident 47 stated the TD had to put the hooks back on the front of the wheelchair and re-tighten it down again. Resident 47 stated he did not remember if resident 50 hit his head, but he fell backward really fast. Resident 47 stated the TD stopped the van and opened the door to check on resident 50. Resident 47 stated he did not remember if resident 50 was wearing a seatbelt. Resident 47 stated resident 50 told him when he turned his head he could hear his bones popping and his neck hurt. Resident 47 stated resident 50 told everyone about the accident and asked for an x-ray right away but did not get on until the next day. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/19/25 at 9:40 AM, a follow-up interview was conducted with resident 50. Resident 50 stated he was not assessed after he returned to the facility. Resident 50 stated he was seen at [facility] on 3/7/25 and obtained a note stating that he had whiplash. Resident 50 stated he had a follow-up appointment on 3/28/25 for an MRI (Magnetic Resonance Imaging). Review of the facility abuse investigations revealed no documentation or investigation of resident 50's fall in the transportation van on 2/14/25. On 3/19/25 at 2:26 PM, an interview was conducted with the DON. The DON stated the TD was transporting resident 50 to an appointment. The DON stated that while riding in the van, resident 50 had a bowel movement and was yelling at the TD. The DON stated the TD told him the light turned green and he started to move and resident 50 fell down in the van. The DON stated they did a risk management on the incident and did not report it to the State Survey Agency (SSA). The DON stated he did not know why. The DON stated it did not seem like it was abuse or neglect. On 3/19/25 at 3:18 PM, an interview was conducted with ADM who stated resident 50 was having diarrhea really bad on the day of the incident. The ADM stated the TD was taking resident 50 to an appointment and he had 2 bowel movements in the van. The ADM stated that the TD reported that resident 50 freaked out for lack of a better term. The ADM stated that he did not think that the TD was accelerating when resident 50 fell back, but that he was already in motion. The ADM stated that he did not go and investigate because the TD told him the chair opened up and the resident did not have any injuries. The ADM stated if there was an accident in the van the process that should have been followed was that 911 should have been called and the resident should have been assessed. The ADM stated the TD should have reported to incident to him immediately. The ADM stated the TD notified him of the incident after returning to the facility but does not remember what time it was. The ADM stated he did not have any documentation. The ADM stated if a resident had an accident in the van he should be notified immediately. The ADM stated once notified, he should conduct an investigation. The ADM stated he did not investigate this incident because the TD reported the resident did not hit his head or receive any harm and that the wheelchair was secured. The ADM did not ask about how the chair was secured. The ADM stated it could have made a difference. The ADM stated he did not think to do an investigation. The ADM stated he did talk to the resident about the incident that day or the day after, he did not remember which. The ADM stated resident 50 was apologetic to the TD about the diarrhea. The ADM stated he was not aware that the resident was having ongoing pain. The ADM stated he was told the following day that the resident hit his head by either the DON or the nurse over his section. The ADM stated he did not think it would be considered neglect. The ADM stated they probably should have reported it. [Cross-refer F689]

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident 33 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which consisted of end stage renal disease, arteriovenous fistula, hypertension, encephalopathy, and ascities. On 3/18/25 at 10:00 AM, an interview was conducted with resident 33. Resident 33 stated that he had a fistula in his left arm for dialysis access. Resident 33 stated that he went to dialysis 3 times a week on Monday, Wednesday and Friday. Resident 33 stated that staff did not use the arm with the fistula for blood pressure readings. Resident 33 stated that the nurse assessed the site. Resident 33 stated that he had no complications with the fistula, just bruising at the access site. Resident 33's medical records were reviewed. Resident 33's care plan revealed no focus areas specific to dialysis or interventions in the care, treatment, and monitoring of the arteriovenous fistula. On 3/25/25 at 8:36 AM, an interview was conducted with RN 4. RN 4 stated that she assessed resident 33's fistula every morning for a thrill. RN 4 stated that she obtained resident 33's vital signs in the morning and she documented them on the dialysis communication form that went with the resident to dialysis. RN 4 stated that the dialysis center filled out the form with the resident's weights and vital signs at the appointment. RN 4 stated that when resident 33 returned from dialysis she obtained another set of vital signs, assessed the fistula bandage for drainage, assessed the fistula for a bruit or thrill, reviewed the communication form and documented the assessment in a progress note and on the communication form. RN 4 stated that she would expect resident 33 to have a care plan for dialysis that had interventions specific to the care and monitoring of the fistula and monitoring of vital signs pre and post dialysis for any fluid overload or signs of too much fluid pulled off. On 3/25/25 at 8:47 AM, an interview was conducted with the DON and the MDS Coordinator. The DON stated that nursing managers were responsible for care plan development. The DON stated that resident 33 should have a care plan for dialysis. The MDS Coordinator confirmed that resident 33 did not have a care plan for dialysis. The MDS Coordinator stated that the care plan should have interventions for monitoring for signs and symptoms of complications with dialysis, monitoring lab work, assessing and monitoring of the fistula, and notification to the Medical Doctor of any abnormal assessments or lab values. The MDS Coordinator stated that the purpose of the care plan was for the licensed nursing staff to find the proper care and interventions for resident specific care. 3. Resident 58 was admitted to the facility on [DATE] with diagnoses that included traumatic brain injury, muscle weakness protein-calorie malnutrition, major depressive disorder, respiratory failure with hypoxia, olecranon bursitis, right elbow and cellulitis of right upper limb. Resident 58's records were reviewed between 3/17/25 and 3/31/25. A review of resident 58's progress notes revealed: a. On 2/24/25 at 11:26 AM, Health Status Note: Note Text: MD notified of urine tox [toxicology] screen. Now new orders. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 2/25/25 at 12:01 PM, Health Status Note: Note Text: MD was notified of and reviewed the final drug screen. No new orders. c. 2/25/25 at 4:25 PM, Health Status Note: Note Text: [NAME] and BOM asked the resident to search his room as there were complaints about him having a TSH [sic] vape in his room. Resident was ok with DON and BOM to search his room. DON found a brand new TSH [sic] vape in his room and confiscated it. No other TSH [sic] or other illicit drugs found in his room. DON and BOM went over the drug and alcohol policy with resident again. The resident signed a new policy and consented to follow it. d. 2/27/25 at 6:03 PM, Health Status Note: Note Text: Resident had an unknown visitor drop by for under a minute they went out front on the patio and resident came back alone. e. 3/2/25 at 4:40 AM, Health Status Note: Note Text: CNA reported to the DON that they smell marijuana coming from the resident's room. Resident was OK with DON to search his room. DON found a brand new TSH [sic] vape hidden in his socks and confiscated it. No other TSH [sic] or other illicit drugs found in his room. f. 3/3/25 at 8:42 AM, Social Service/Resident Advocate Note: Note Text: RA [Resident Advocate] offered resident supportive services for his marijuana dependency-such as MA {Marijuana Anonymous] meetings and/or addiction Treatment centers. Resident has continually refused. RA will continue to offer supportive services. Resident 58's care plan revealed there were no care focus area addressing use of a THC vape device or use of other illicit drugs. There were no goals or interventions related to the use of a THC vape device or other use of illicit drugs. On 3/31/25 at 8:59 AM, an interview was conducted with the ADON who stated he thought there was something in resident 58's care plan but he did not know for sure. The ADON stated the staff were aware of the resident's history of substance abuse and go talk with him frequently. The ADON stated the resident usually handed over whatever he had. The ADON stated the resident was on probation and had gone to court. The ADON stated the administrative staff had talked about putting something in the resident's care plan about his use of drugs. The ADON stated they also talked about having the resident show a staff member everything he brought back when he went to the store. On 3/31/25 at 11:03 AM, an interview was conducted with the DON who stated he had confiscated THC (Tetrahydrocannabinol) vapes from the resident 2 times. The DON stated the resident signed a Drug and Alcohol policy care plan agreement and immediately broke it. The DON stated the resident was drug tested and the test came back positive. The DON stated the resident's use of drugs had the possibility to have an effect on other residents. The DON stated they had spoken to the resident about discharging. The DON stated they were planning on discharging the resident if they could find a safe place to discharge him to. The DON stated he had told the nurses to let him know if they suspected anything in the resident's possession. The DON stated the medical director was aware of what was going on with resident 58. The DON stated it made sense for there to be something in his care plan about it. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review it was determined, for 3 of 43 sample residents, that the facility did not develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframe's to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment. Specifically, a resident that received dialysis did not have a care plan, a resident that vaped THC (Tetrahydrocannabinol) did not have a care plan, and a resident with frequent falls did not have care plan interventions implemented. Resident identifiers: 1, 33, and 58. Findings included: 1. Resident 1 was admitted to the facility on [DATE] with diagnoses which included displaced intertrochanteric fracture of left femur, mild intellectual disabilities, traumatic brain injury, subdural hemorrhage, dementia with agitation, presbyopia, and sensorineural hearing loss. On 3/19/25 at 1:14 PM, an observation was made of resident 1 laying in his bed with the pressure alarm mat under the resident's bed, in a location that it would not be activated if resident 1 were to get out of bed. On 3/24/25 at 3:28 PM, an observation was made of resident 1 sitting in his wheelchair, self-propelling down the hallway wearing socks on his feet. On 3/27/25 at 2:21 PM, an observation was made of resident 1 sitting in his wheelchair in the hallway wearing socks on his feet. At 2:25 PM, resident 1 was observed standing up, approximately 4 feet from his wheelchair, and trying to open the front doors. Resident 1's wander guard was alarming. Staff was observed to be with the resident and asked him to sit down and that they would take him outside and resident 1 stated, Let me alone. Resident 1's medical record was reviewed from 3/17/25 through 3/31/25. An admission Minimum Data Set (MDS) Assessment, dated 1/25/25, indicated a Brief Interview for Mental Status (BIMS) score of 1. A BIMS score between a 0-7 indicated a severe cognitive impairment. It further indicated resident 1 was dependent on staff to: a. Put on socks and shoes or other footwear that was appropriate for safe mobility; b. Come to a standing position from sitting in a chair, wheelchair, or on the side of the bed; and c. To walk 10 feet. A Health Status Note, dated 2/1/25 at 5:50 PM, indicated, Alert charting r/t [related to] unwitnessed fall. Resident has been passing all neuro checks, vitals WNL [within normal limits]. ROM [range of motion] WNL in upper extremities. ROM weak in both legs. No c/o [complaints of] of pain or discomfort since resident got back in bed after fall. Resident transferred to toilet with SBA [stand-by assist] appropriately and is back resting in bed with call light in reach, WCTM [will continue to monitor]. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Alert Note, dated 2/1/25 at 7:29 PM, indicated, Resident is on alert charting due to unwitnessed fall. Resident has difficulty making needs known, and is non-compliant with bearing weight, and walking to use the bathroom. Staff is checking on patient frequently, changing briefs and offering to be toileted, which appears to be effective with keeping resident safe. MD [Medical Doctor] ordered bilateral x-rays of hips to ensure no fractures occurred from fall. Neuro checks have been wnl to baseline. An Alert Note, dated 2/2/25 at 7:16 PM, indicated, Alert charting r/t an unwitnessed fall. Resident has pain, and a hip Xray was completed. Results state 'no evidence of acute fx [fracture]' Resident took pain pill to help with pain. Resident is currently resting in bed. An Event Note Template, dated 2/7/25 at 11:42 AM, indicated, IDT [Interdisciplinary Team] Members: DON [Director of Nursing], NHA [Nursing Home Administrator], ADON [Assistant Director of Nursing], MDS coordinator, RA [Resident Advocate], BOM [Business Office Manager], CNA [Certified Nursing Assistant] coordinator,. Event Date/Time: 2/1/2025 @ 12:45. Event Description: The nurse heard a door slam in room [ROOM NUMBER]. When the nurse arrived to the room, the nurse found the resident on the floor between his bed and bathroom door. The resident was barefoot and did not use the call light for help. The resident is s/p [status post] Left hip fracture from a previous fall at his previous facility with Left hip surgery. He is WBAT [weight bearing as tolerated]. Risk Factors and Root Cause Identification: Resident has a diagnosis of dementia He lacks insight into his own limits and tries to do things independently without asking for help. The resident is S/P hip fracture and surgery. He is unsteady on his feet. The resident was bare foot and did not call for help. Preventative Measures in Place Prior to Incident: Resident has a working and reachable call light. He has been educated on using his call light and performed a return demonstration indicating he is able to use the call light. Facility staff anticipate resident's needs. Staff have been educated and encouraged to keep frequently used items within resident's reach. He has been working with PT/OT [physical therapy/occupational therapy] for strength and ROM improvement. New Interventions: Resident was assessed for injuries and none were found. The CNA and nursing helped resident back into chair then back into bed. VSs [vital signs stable] and neuro checks initiated and WNL. BP [blood pressure] 125/62, HR [heart rate] 93, RR [respiratory rate] 18 and Temp [temperature] 99.8. The resident is being monitored closely. Alert charting initiated. MD, DON and the administrator were notified. IDT Intervention: Ensure resident is wearing a Gerihip hip protector. Ensure resident is wearing proper footwear. Educated the resident to call for assistance for any transfer, Printed a sign and posted it in the resident room to remind him to call for assistance. In a Skilled Charting note, dated 2/7/25 at 9:16 PM, indicated, .Resident is weight bearing as tolerated, can walk to the bathroom independently but fell last night d/t wet floor. No injuries. Staff will make sure that floors are dry. WCTM. A Health Status Note, dated 2/10/25 at 10:15 AM, indicated, Alert charting for unwitnessed fall at 730A [sic] . Resident has not been compliant with assistance with transferring this shift . A Skilled Charting note, dated 2/10/25 at 1:37 AM, indicated, .Resident is weight bearing as tolerated and requires assistance to transfer to the bathroom safely. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Event Note Template, dated 2/17/25 at 2:15 PM, indicated, IDT Members: DON, NHA, ADON, and MDS coordinator. Event Date/Time: 2/7/25 @ around 05:39. Event Description: The Resident was trying to use the restroom with CNA present in the room but then he slipped and fell landing on his knees. There was urine spilled on the floor from one of his roommates. The CNA tried to intervene but [resident 1] fell down too fast that the CNA couldn't intervene. Resident had proper footwear on. Risk Factors and Root Cause Identification: Resident has a diagnosis of dementia He lacks insight into his own limits and tries to do things independently without asking for help. The resident is S/P hip fracture and surgery. He is unsteady on his feet. Wet floor and resident slipped and fell landing on his knees. Preventative Measures in Place Prior to Incident: Resident has a working and reachable call light. He has been educated on using his call light and performed a return demonstration indicating he is able to use the call light. Facility staff anticipate resident's needs. Staff have been educated and encouraged to keep frequently used items within resident's reach. He has been working with PT/OT for strength and ROM improvement. Ensure resident is wearing a Gerihip hip protector. Ensure resident is wearing proper footwear. Educated the resident to call for assistance for any transfer, Printed a sign and posted it in the resident room to remind him to call for assistance. New Interventions: Resident was assessed for injuries and no injuries found, then placed on the toilet so he could use the bathroom. Resident has no injuries, didn't hit his head, and no marks on the knees. ROM is at resident's baseline. MD was notified. Alert charting initiated, v/s are WNL: B/P 115/64, P [pulse] 83, RR 18, T [temperature] 98.0, O2 [oxygen] 95% on RA [room air]. 2/7/25 FALL - IDT intervention: Staff shall assist to provide the resident with a safe environment to reduce the risk for falls: Floors free from spills and/or clutter; adequate, glare-free light. A Skilled Charting note, dated 2/21/25 at 8:44 PM, indicated, Resident is doing well. Walks to the bathroom on his own. Resident is resting in bed with eyes closed . An Event Note Template, dated 3/4/25 at 1:49 PM, indicated, IDT Members: DON, NHA, ADON, MDS coordinator, RA, BOM, CNA coordinator,. Event Date/Time: 2/23/2025 @ around 09:36. Event Description: Nurse found resident lying on his back on the bathroom floor between sink and toilet with no brief on and WC [wheelchair] to his left side. Floor was not wet. Resident did not have his non-skid socks on. Resident said he was trying to get to the toilet, lost his balance and fell hitting his head on the sink counter. Risk Factors and Root Cause Identification: Resident has a diagnosis of dementia He lacks insight into his own limits and tries to do things independently without asking for help. The resident is S/P hip fracture and surgery. He is unsteady on his feet. Resident mattress was flat on the edges and resident wasn't wearing proper footwear. Preventative Measures in Place Prior to Incident: Resident has a working and reachable call light. He has been educated on using his call light and performed a return demonstration indicating he is able to use the call light. Facility staff anticipate resident's needs. Staff have been educated and encouraged to keep frequently used items within resident's reach. He has been working with PT/OT for strength and ROM improvement. Ensure resident is wearing a Gerihip hip protector. Ensure resident is wearing proper footwear. Educated the resident to call for assistance for any transfer, Printed a sign and posted it in the resident room to remind him to call for assistance. New Interventions: Assessed resident for injuries. Small laceration to right top side of head. Abrasion to spine and right side of back. Resident is Responding at his baseline. No changes with ROMx4 [person, place, situation, and time] extremities. Initiated Neuro checks. PERRL [pupils equal, round, reactive to light], Vitals 98 T, 117/54 BP, 73 P, 18 R, O2 Sats 99% RA. Assisted resident onto the toilet, brief changed and assisted back to his bed. Alert charting initiated. MD, DON and NHA notified. Education provided verbally and in writing d/t [due to] HOH [hard of hearing] about using call light and keeping non-skid socks on. IDT intervention: Placed pressure alarm mat by his bedside. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan Focus indicated, The resident is at risk for falls r/t General weakness, Impaired mobility, left hip fracture. Date Initiated: 01/24/2025. The Goal indicated, The resident will be free of falls with injury through the review date. Date Initiated: 01/24/2025 Target Date: 05/14/2025. Interventions included: a. 2/1/2025 FALL - IDT Intervention: Ensure resident is wearing a Gerihip hip protector. Ensure resident is wearing proper footwear. Educated the resident to call for assistance for any transfer, Printed a sign and posted it in the resident room to remind him to call for assistance. Date Initiated: 02/03/2025 Revision on: 02/07/2025; b. 2/10/25: IDT Intervention: Ensure resident is wearing anti-skidding socks at all times and maintenance team will ensure mattress is functioning well. Date Initiated: 02/10/2025; c. 2/23/25 FALL - IDT intervention: Placed pressure alarm mat by his bedside. Date Initiated: 02/24/2025; d. 2/7/25 FALL - IDT intervention: Staff shall assist to provide the resident with a safe environment to reduce the risk for falls: Floors free from spills and/or clutter; adequate, glare-free light. Date Initiated: 02/07/2025; and e. Educate and encourage the resident to wear appropriate footwear, such as nonskid socks or shoes, when ambulating/mobilizing. Date Initiated: 01/24/2025. On 3/27/25 at 1:48 PM, an interview was conducted with CNA 1. CNA 1 stated the pressure alarm pad was there in case resident 1 got up by himself and it would alert staff so they could immediately help him because he had an injury. CNA 1 stated resident 1 could walk with therapy and that he needed a 1-person assist to transfer. CNA 1 stated that he used his call light, but sometimes he forgot. CNA 1 stated resident 1 did not wear any protector on his hip. On 3/27/25 at 2:00 PM, an interview was conducted with the Director of Rehabilitation (DOR). The DOR stated they had been working with resident 1 due to safety because of a fall and that he could not walk on his own and needed a contact guard, someone there just in case he fell. The DOR stated they communicated with him by using a whiteboard because he was so hard of hearing. The DOR stated resident 1 could understand instructions with routine. On 3/27/25 at 2:15 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated they were not sure if resident 1 wore a Gerihip hip protector, but he had a hip fracture. RN 1 stated they did not know what a Gerihip hip protector was or why one would be used. On 3/27/25 at 2:30 PM, an interview was conducted with CNA 2. CNA 2 stated that they helped resident 1 in the bathroom today and he was not wearing a hip protector. CNA 2 stated he was at a risk for falls and knew that he had a pad next to his bed that alarms when he tried to stand up but was not sure of any other interventions in place to prevent falls. On 3/27/25 at 2:30 PM, an interview was conducted with CNA 3. CNA 3 stated resident 1 had to wear nonskid socks and have his bed low to help prevent falls. CNA 3 stated they had to assist resident 1 with putting on nonskid socks or his cowboy boots. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/31/25 at 11:10 AM, an interview was conducted with the DON. The DON stated resident 1 was admitted to the facility because he got a hip fracture from a fall that happened at a different facility. The DON stated he implemented a Gerihip hip protector as an intervention after one of his recent falls. The DON stated that because resident 1 was noncompliant, the hip protector would provide extra support if he had another fall. The DON stated resident 1 sustained falls at the facility because he would not use the call light and get up on his own. The DON stated the resident could not remember to use the call light. The DON stated resident 1 was not wearing a Gerihip hip protector on 3/27/25 because it was in the laundry, so he ordered more and gave them to the staff to use. The DON stated the resident would also take the hip protector off and throw it on the floor and scratch and swear at staff.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined, for 2 of 43 sampled residents, that the facility did not ensure that each resident received adequate supervision and assistance devices to prevent accidents. Specifically, one resident fell backwards while being transported in a facility van due to not being secured properly and the resident sustained an injury to the head/neck. This was determined to have occurred at an Immediate Jeopardy level. Also, a resident with multiple falls did not have interventions in place to prevent additional falls. Resident identifiers: 1, 47, and 50. On 3/20/25 at 1:30 PM, an Immediate Jeopardy (IJ) was identified when the facility failed to implement Centers for Medicare and Medicaid Services (CMS) recommended practices to identify hazard(s) and risk(s); evaluate and analyze the hazard(s) and risk(s); implement interventions to reduce hazard(s) and risk(s); and monitor for effectiveness and modify the interventions when necessary. Specifically, the facility failed to ensure that staff transporting residents and their equipment were trained on how to secure residents properly to prevent falls or injury. Notice of the IJ was given verbally and in writing to the Corporate President (CP) and the Regional Nurse Consultant (RNC) 1 who were present by phone, the Regional [NAME] President of Operations (RVPO), RNC 2, the Administrator (ADM), the Director of Nursing (DON), the Minimum Data Set (MDS) Coordinator, and they were informed of the findings of IJ pertaining to F 689 for resident 50. On 3/20/25 at 4:09 PM, the Administrator provided the following revised abatement plan for the removal of the Immediate Jeopardy effective 3/20/25 at 10:00 PM. Identification of Residents Affected or Likely to be Affected: The facility took the following actions to address the identified issue and prevent any additional residents from suffering an adverse outcome (Completion Date: 3/20/25 Completion Time: 10:00 PM) * Resident #50 was evaluated on 3/20/25 at 1440 (2:40 PM) by the Director of Nursing (DON) for pain and offered to be transferred to the hospital to address concerns and to be evaluated for latent injury from the fall on 2/14/25. The resident declined to go to the hospital. The resident was reminded of the treatment modalities available to him including pain medication, muscle relaxation and non-pharmacological interventions. * Resident #50's w/c [wheelchair] was evaluated for safety and to ensure proper functioning by the DON and Nursing Home Administrator (NHA) on 3/19/25. There were no concerns identified. * The NHA inititiated an initial report to the State for the van incident that occurred on 2/14/25 on 3/19/25. * The incident report for resident #50 was reviewed and updated for the event that occurred on 2/14/25 on 3/20/25 to address inaccuracies identified during the investigation initiated on 3/19/25. * The Transpiration Driver (TD) was suspended on 3/19/25 pending the outcome of the investigation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* On 3/20/25 the DON and designee(s) assessed all residents that have been transported by the facility since 2/14/25 to ensure they did not sustain any injury or falls while being transported on the facility van. No additional residents were identified. * On 3/20/25 the Regional Nurse Consultant (RNC) completed a 100% audit of risk management reports and progress notes from 2/14/25 to present to ensure all incidents to have been appropriately reviewed and investigated for potential abuse or neglect. Actions to Prevent Occurrence/Recurrence: The facility took the following actions to prevent an adverse outcome from reoccurring (Completion Date: 3/20/25 Completion Time 10:00 PM) * On 3/20/25 the RNC conducted a Root Cause Analysis (RCA) on all transport incidents from the previous 90 days. Current residents impacted by the findings of the RCA had safety measures and resident specific interventions added to their care plans. * On 3/20/25 the RVPO educated the NHA and DON on the facility Trigger Call process, driver safety including proper securement technique of w/c dependent residents such as seatbelt placement through the arm rest and secured against post assuring seat belt is against the resident and does not have any slack as well as securing the wheelchair to the wheelchair van through the appropriate placement of the wheelchair restraints onto a fixed part of the frame of the wheelchair, how to conduct a RCA, review of incidents to ensure allegations of abuse and neglect are investigated timely, and how to ensure incident investigations are timely and complete including the Event Note Template. The Trigger Event process includes the NHA and DON notifying the RNC and RVPO of high risk events to ensure they are handled appropriately with targeted interventions and actions to investigate and prevent recurrence. Trigger Events include areas such as allegations or suspicions of abuse and neglect, fall with major injury and any incidents that occur on an outing or transport. The incident investigation process includes IDT (Interdisciplinary Team) review of an incident report daily at stand up meeting and the use of an investigation checklist to assure the investigation process is thorough and complete. The Event Note Template includes a list of the IDT members involved in the incident RCA and investigation the event date and time, a description of the event, risk factors and root cause identification, preventative measures in place prior to the event and new interventions implemented post incident. * On 3/20/25 the RVPO educated the NHA and IDT Leadership on identifying, reporting and investigating neglect. The education included the definition of neglect and how to identify when a situation needs to be reported and investigated as neglect. * The NHA educated all staff involved in using the facility van for transportation on safety including proper securement technique for wheelchair dependent residents, placement of the seatbelt and what to do if an accident occurs. A documented return demonstration checklist was completed on 3/20/25 with transportation staff including the RA [Resident Advocate], DON, BOM [Business Office Manager], and AD [Activities Director] prior to their next transport. Instructions for what to do if an incident/accident occurs while performing a transport was placed in the facility van for staff to refer back to in the event of an incident/accident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* The NHA or designee will visually inspect residents being transported in the facility van prior to transport to ensure w/c is properly secured for the next 30 days. * The Corporate Nurse or RVPO will review all incident reports within one working day for three months to ensure an RCA has been conducted and the resident specific interventions are reflected in the care plan. * The NHA or designee will initiate a Trigger Call with the RVPO and RNC for all incidents that occur on the facility van to ensure appropriate action has been taken and a comprehensive plan for investigation and RCA has been developed. * The DON or designee will review all falls and transport related incidents at the daily stand-up meeting with the IDT for three months to ensure appropriate safety interventions are implemented, the resident's care plan has been reviewed and revised, and staff education has been completed as needed. * A QAPI [Quality Assessment Performance Improvement] PIP [Performance Improvement Plan] has been initiated to report on the above monitoring and auditing procedures. All findings from the PIP will be presented at the monthly QAA [Quality Assessment and Assurance] meeting. Monitoring/auditing and reporting will continue for a minimum of three months. On 3/21/25, 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 3/20/25. Findings included: 1. Resident 50 was admitted to the facility on [DATE] with diagnoses that included heart failure, type 2 diabetes, osteomyelitis, and diarrhea. On 3/17/25 at 10:07 AM, an interview was conducted with resident 50, who stated while being transported to a medical appointment on 2/14/25 at about 9:30 AM, in the facility van, he had fallen backward and hit his head. Resident 50 stated he was unhappy because the incident report he received from the administration was not accurate in the details of the accident. Resident 50 stated his wheelchair was strapped to the floor of the vehicle but he could not recall if he had a seatbelt on. Resident 50 stated he fell backward while the van was in motion and hit his head and neck on the floor of the van. Resident 50 stated his roommate, Resident 47, was also in the van and witnessed the accident. Resident 50 stated the incident report said the Transportation Driver (TD) had to sit the wheelchair back up but the resident did not fall. Resident 50 stated that after the fall he had pain to the base of his skull and when turning his neck he heard a cracking sound. Resident 50 stated he told staff about it upon returning from his appointment, but was not assessed. Resident 50 stated he received an x-ray the following day. Resident 50 also stated when he spoke with the Director of Nursing (DON), he was told he had not heard anything about it. Resident 50 stated that 2-3 weeks after his fall he went for a second opinion. Resident 50's medical record was reviewed between 3/17/25 and 3/31/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An admission Minimum Data Set, dated [DATE] revealed resident 50 had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. Resident 50's physician orders included: a. Referral for Orthopedic for Neck Pain Revision date; 2/26/25. b. Acetaminophen Oral tablet; Give 650 mg [milligram] every 4 hours as needed for pain. NOTE: 3 GM [grams] daily from all sources. Order date: 1/28/25. Resident 50's care plan included: a. The resident has limited physical mobility r/t [related to] Bilateral BKA [below knee amputation] and multiple wounds on BLE [bilateral lower extremities] and on coccyx. Date initiated: 1/29/25, Revision on 3/14/25. The goal was, The resident will remain free of complications related to immobility, including contracture's, thrombus formation, skin-breakdown, fall related injury through the next review date. Date initiated:1/29/25, Target date: 5/12/25. Interventions included, Monitor/document/report PRN [as needed] any s/sx [signs/symptoms] of immobility: contractures forming or worsening, thrombus formation, skin-breakdown, fall related injury. Date initiated: 1/29/25. b. The resident is at risk for falls r/t Hx [history] of BKA, bilateral multiple wounds and needs for assistance with ADL [activities of daily living] at times. Date initiated: 1/29/25, Revision on: 3/14/25. Interventions included, 2/15/25 FALL-IDT intervention: DON [Director of Nursing] and NHA [Nursing Home Administrator] retrained the transportation driver on proper and safe transportation techniques. Also, resident's appointments to be rescheduled if the resident is not medically stable. Date initiated: 2/17/25 .; Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Date initiated: 1/29/25; Follow facility fall protocol if a fall occurs. Date initiated: 1/29/25. Resident 50's progress notes documented: a. On 2/15/25 at 8:34 PM, a Health Status Note revealed, Note Text: During Cares today, resident reported that he had a witnessed fall yesterday during transportation to his appointment. Resident states that he fell backwards and hit his head and neck. Fall was reported to management and MD [Medical Doctor], neuros initiated, no visible injuries but due to pain, MD ordered cervical spine X-rays. VS [vital signs] WNL [within normal limits]. Awaiting results on X-rays. b. On 2/15/25 at 10:48 PM, a Health Status Note revealed, Note Text: Resident continues on neuro checks, no delayed injuries noted, no c/o [complaints of] pain or discomfort r/t the incident expressed during this shift. bed in the lowest position, call light within reach. c. On 2/17/25 at 5:40 AM, an Alert Note revealed, Note Text: Resident being monitored due to recent unwitnessed fall. residents neuros have been wnl. No changes to LOC [level of consciousness]. d. On 2/17/25 at 9:56 AM, a Health Status Note revealed, Note Text: MD was notified of and reviewed the cervical Spine x-ray results, NNO [no new orders]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	e. On 2/26/25 at 11:03 AM, a Health Status Note revealed Resident requested a second opinion regarding the pain he has in his neck following the fall in the van. A referral for Orthopedic for Neck Pain was made. f. On 3/7/25 at 2:07 PM, a Health Status Note revealed, Resident had an appointment today at [name omitted] Orthopedic Center. [Facility] transported to and from the appointment. Reason for Appointment: Neck Pain. Facility Comments/Questions: None. Findings at Appointment: Base of Skull pain; Cervical x-rays showing degenerative changes. New orders/Recommendation: External PT; Cervical MRI [magnetic resonance imaging]; Can try Tizanidine 2mg at night as needed; Tylenol, topical medications (Icy hot, lidocaine patches, etc). Next Appointment: PRN [as needed]. Transport coordinator was notified. MD notified. On 2/15/25 an incident report revealed, Witnessed fall: Resident: [Resident 50] .Incident location: out of facility/during transport .Incident Description: Nursing Description: Resident reported to the nurse today (2/15/25), that yesterday (2/14/25) he had a witnessed fall during transportation to his appointment. States that he fell and hit his head. Was heading to appointment, and when getting inside of the van he fell backwards and hit his head. states that heck[sic] has been hurting .Immediate action taken: Description: The resident was assessed for injuries and no injuries found. He reports tenderness to the neck on palpation. Reported to management and MD, initiated neuros and MD ordered cervical spine X-rays- X-rays ordered. X-ray results were negative for a fracture. Resident requested a second opinion, was referred to ortho. Alert charting initiated. IDT intervention: DON and NHA [Nursing Home Administrator] retrained the transportation driver on proper and safe transportation techniques. Also, resident's appointments to be rescheduled if the resident is not medically stable .Resident taken to Hospital? N[no] .Injuries Observed at Time of Incident .No injuries observed at time of incident .Level of Pain: 0 .Level of Consciousness: Alert, Mobility: Ambulatory with assistance Mental Status: Oriented to Person, Oriented to Situation, Oriented to Place, Oriented to Time .Injuries Report Post Incident: No injuries observed post incident .Level of Pain: 0 .Level of Consciousness: Alert, Mobility: Ambulatory with Assistance . Mental Status: Oriented to Person, Oriented to Situation, Oriented to Place, Oriented to Time .Predisposing Environmental Factors: None .Predisposing Physiological Factors: None .Predisposing Situational Factors: Using Assistive Device .Other Info: Resident had loose bowels and was in his w/c at the time it happened. The back of his wheelchair opens backward. When the driver was at the light, the resident had another episode of loose BM [bowel movement], he got agitated and started to scream and thrash around while in wheelchair. His erratic movements caused the back of his wheelchair to reclined backward, which caused him to lean backward. According to driver, resident didn't land on the floor and did not hit his head on the floor or anything .Statements: Staff on 2/17/25 On Friday the 14th of March, [Resident 50] was having a cardiology appointment at [facility]. [Resident 50] was secured appropriately in the van according to our regular safety standards. When I went to get him, he was having diarrhea and a bad day as well, as he was so sad. Before we left the building, I changed his brief twice, so while we are driving he kept on yelling in the van because he also had diarrhea twice on our way. While this is happening, I always encourage him, and promise him that I will help him do a brief change when we get to the [facility]. So we got to the light close to the [facility], the moment it was green, I moved the car, all I heard was shit I just had diarrhea again. Then he said I'm falling down, so I quickly park the van by the side of the road, he was still strapped with the seat belt, but he was down with his wheelchair. I asked him if hit his head and he said no, so I helped him up, and we continued our trip . Agencies/People notified: DON on 2/15/25 at 8:34 PM, Physician 2/15/25 at 8:34 PM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/15/25, a cervical spine x-ray was obtained for resident 50. The findings of the x-ray documented that the lower cervical spine and cervicothoracic junction was incompletely imaged given shoulder positioning. Patient in pain and could not reposition. The report documented no acute fracture was evident. The impression documented that the Patient may ultimately benefit from CT [computed tomography] or MRI [magnetic resonance imaging] if symptoms persist. On 3/7/25, a referral note to the Orthopedic clinic documented the reason for the referral was neck pain. The findings at the appointment documented Base of skull pain. The New Orders/Recommendations documented physical therapy, cervical MRI, Tizanidine at night as needed and Tylenol and topical medications for pain. The Orthopedic provider documented an associated diagnoses of cervical spondylosis and whiplash injury to the neck. On 3/19/25 at 8:22 AM, an interview was conducted with the Transportation Driver (TD), who stated that he made the medical appointments for residents and transported them to most of the appointments. The TD stated if a resident was in a wheelchair he would take the big van. The TD stated on the day of resident 50's appointment, resident 50 had diarrhea during the ride to his appointment and got upset. The TD stated that resident 50 said he was falling down. The TD stated that he did not know how the wheelchair fell, but it was while the van was in motion. The TD demonstrated that the back of the w/c was flat on the floor of the van. The TD stated that he pulled over and stopped immediately. The TD stated resident 50 was holding onto the seatbelt strap. The TD stated the wheelchair floor straps were tensioned on the floor. The TD also stated that he placed the seatbelt on resident 50. The TD stated the seatbelt went on top of the arms of the wheelchair, then the TD stated he could not remember if the seat belt went over or under the arm rests. The TD stated he sent a text to contact the facility about what happened and was told to make a progress note, which the TD said he did. The TD stated it might have been the next day. On 3/19/25 at 9:19 AM, an observation was made of the TD demonstrating how a wheelchair would be secured in the large facility van. The TD raised the wheelchair with the van lift and pulled the wheelchair into the van. The TD locked the brakes on the wheelchair. From the back, the TD placed the two hooks on the left and right sides of the frame of the wheelchair. Going to the front of the wheelchair, the TD showed that the front straps would not reach the wheelchair so he released the tension on the straps so he could apply the hooks. The TD applied the hooks to the outside of each of the wheels of the wheelchair. The TD then checked to ensure the wheelchair was secure. The TD demonstrated that he put the seatbelt over the arm of the wheelchair, but under the arm of the resident and across the resident's body, and secured it into the buckle on the floor. The State Surveyor [SS] asked how resident 50 fell back and the TD stated, honestly, I do not know. The SS asked what the TD saw when he looked in the rear view mirror and the TD stated that initially he did not look in the rear view mirror as he was trying to find a place to pull over. The TD stated after pulling over, he went to the back of the van and asked resident 50 if he was ok, and resident 50 stated that he was. The TD stated that he did not assess resident 50 but sat the chair up and continued to the appointment at the hospital. The TD stated after getting resident 50 cleaned up and to his appointment, he contacted the facility about what had happened. The TD stated he spoke with the Director of Nursing (DON). After returning to the facility the TD stated he spoke with the Administrator (ADM), and was asked several questions about what had happened. The TD stated resident 50's roommate, resident 47, was also in the van and was a witness to the incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/19/25 at 9:33 AM, an interview was conducted with resident 47 who stated he was present in the van when resident 50 fell backward in his wheelchair. Resident 47 stated he was sitting in the back seat of the van. Resident 47 stated the strap hooks were on the frame of resident 50's wheelchair. Resident 47 stated, something in the front came undone. Resident 47 stated that the TD pushed on the gas and the wheelchair fell backward. Resident 47 stated he did not remember if resident 50 hit his head, but stated he fell backwards really fast. Resident 47 stated that the TD stopped the van and opened the van door to see if resident 50 was ok. Resident 47 stated that the TD took the residents' to their appointments and then back to the facility. Resident 47 stated resident 50 told him after returning that his neck hurt and he could hear his bones popping. Resident 47 stated resident 50 told everyone about falling in the van. Resident 47 stated resident 50 asked to have an x-ray done right away, but did not get one until the next day. Resident 47 stated that after the chair fell, the TD had to put the hooks back on the chair and re-tighten the chair down again. On 3/19/25 at 9:40 AM, a follow-up interview was conducted with resident 50. Resident 50 stated his wheelchair was specialized for him. A crossbar was observed under the seat of the wheelchair near the back of the frame. The front of the wheelchair had small wheels attached to the frame by bars on either side of the chair and the bars were angled downward where the wheel was attached. Resident 50 stated that was where the front straps were attached. Resident 50 stated, again, that he was not assessed when he returned to the facility. Resident 50 stated he was seen at [facility] on 3/7/25 and obtained a note stating that he had whiplash. Resident 50 stated he had a follow-up appointment scheduled on 3/28/25 for an MRI (Magnetic Resonance Imaging). It should be noted that upon inspection of resident 50's wheelchair it was observed by the State Surveyor that the chair back did not recline backwards as previously reported in the facility incident report. On 3/19/25 at 1:28 PM, a follow-up interview was conducted with the TD who provided transportation schedules for the months of February and March of 2025. The TD stated 99.9% of the time, he was the staff member who transported residents to their appointments. The SS and the TD reviewed the schedules day by day and marked off residents day by day who ended up not going to their appointments. On 3/19/25 at 1:36 PM, an interview was conducted with the AD who stated she was approved to drive the facility vans. The AD stated the last time she drove the facility van was last week. The AD stated she took a resident to get a hot dog. The AD stated she took residents shopping every other Tuesday as well. The AD stated the TD had shown her how to secure resident wheelchairs into the big van. The AD stated the TD showed her to secure the floor strap hooks onto the back and front of the wheelchair frame. The AD stated that the seatbelt should go across the resident and over the armrests of the wheelchair. The AD stated she did not have anyone verify the resident's wheelchair was secured before leaving the facility grounds. The AD stated she had completed the computer based training for the company but none of the training was specific to transportation in the facility vehicle. The AD stated she had not been provided any guidance about what she should do should she have an accident, and she had not seen any transportation policies. The AD stated she had not had any accidents while driving residents in the van. The AD stated she was told about the accident the TD had while transporting resident 50 and resident 47. The AD stated that she overheard the TD talking about the accident and the TD stated that the wheelchair had tipped back. The AD stated that she had not been provided any additional training or instructions for driving residents in the facility van after the accident with resident 50. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/19/25 at 1: 54 PM, an interview was conducted with the BOM who stated she provided transportation occasionally for residents. The BOM stated the last time she provided transportation was about 2 months ago when she took a resident to the bank. The BOM stated when she first started working at the facility, the DON and the TD had trained her on how to secure a wheelchair in the facility van. The BOM stated that she was taught to lower the ramp, put the wheelchair on, lock the wheels, raise the ramp, and hook the belt on the bottom of the chair. The BOM stated she never had to do a return demonstration, she just had to repeat back what she saw them do. The BOM stated she thought there was a clip on the floor that the wheelchair was attached to. The BOM stated the seatbelt should be placed over the wheelchair armrest and secured. The BOM stated if a resident needed to be transported she would have the TD or the AD drive the van. The BOM stated she thought the DON did a demonstration and training recently. The BOM stated she had not heard of any resident related falls while being transported. On 3/19/25 at 2:03 PM, an interview was conducted with the RA who stated she had been authorized to transport residents in the van but had not done so since October 2024. The RA stated she had been trained how to secure a wheelchair into the van. The RA stated the ADM and the TD did the training. The training included using the lift, making sure the wheelchair brakes were on, and placing the floor straps on the front and the back of the wheelchair by the hooks. The RA stated the hooks were supposed to be put on the frame of the wheelchair. The RA stated the seatbelt should be brought across the resident and hooked into the buckle down near the floor. The RA stated the seatbelt would go over the arm rests, but as close to the body as possible. The RA stated she had a brief discussion at an all staff meeting about 3 months ago and about a year ago about safe transporting of residents. The RA stated they were all verbal trainings. The RA stated the training held one month ago was just for transportation about safety. The RA stated it was written documentation read to them about why safety was important, what to watch for, examples were reviewed, staff looked at pictures of buckles, and there was a wheelchair demonstration. The RA stated the ADM and the TD showed how to secure the buckles across the wheelchair. The RA stated one staff member did a return demonstration, but she did not do a return demonstration. The RA stated she had not had any residents fall while she transported them. The RA stated during the training they also talked about what supplies and tools should be in the van. The RA stated she had been instructed what to do if a resident fell during a transport, which would be pull over, assess for wounds, clear the surrounding areas, and report immediately to the facility. The RA stated staff who should be notified would be nurse management. The RA stated if there was no visible injury, the resident should be assisted. The RA stated there could be an injury even if it was not visible. The RA stated if the resident was in pain or there was a suspected injury, she would contact the facility administrator and take direction from him. The RA stated she was aware of the incident with resident 50. The RA stated resident 50 came to her after the incident and wanted to discuss the incident report as he felt it was inaccurate. The RA stated she did not know about the incident before resident 50 came to speak with her. The RA stated resident 50 was upset that the TD had stated that he had not fallen to the ground during the transport and that he was thrashing around, and that he did not hit his head. The RA stated resident 50 told her that resident 47 was a witness. The RA stated after resident 50 spoke to her he appeared to be more calm about the situation. The RA stated she was not the first person resident 50 had reported this to and it was several days after the event. The RA stated resident 50 told her he fell and hit his head and did not give any more details. The RA stated she did not have reason not to believe resident 50's account of what happened. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/19/25 at 2:26 PM, an interview was conducted with the DON who stated he did not recall the last time he transported a resident in the facility van. The DON stated that the corporation had a computer based training for transportation drivers on safe driving practices. The DON stated staff who were eligible to drive the van, did a background check, provided a copy of their driver's license, completed a driver's safety training, and the DON was unsure if a driving history was checked on the staff member. The DON stated he and the ADM trained the staff on how to transport a resident in the facility van. The DON stated demonstration was used on how to safely buckle up residents, how to strap the wheelchair in the van, and how to use the van lift. The DON stated he told staff to ensure the locks were engaged on the wheels of the wheelchair and the floor straps were secured to each corner of the wheelchair. The DON stated that he preferred the floor straps to be connected to the frame of the wheelchair, but if there was no other area the strap could be placed on the wheel. The DON stated the seatbelt should be placed over the hips of the resident and under the armrests if there was space. The DON stated a training was done after the most recent incident with resident 50. The DON stated prior to that incident staff were doing computer based training. The DON stated that they also provided verbal education along with a demonstration on how to secure a wheelchair in the facility van. The DON stated that demonstration was provided by himself and the ADM. The DON stated there was no documentation of the training. The DON stated that nobody used the big van except the TD, the ADON, and himself. The DON stated he did not know if the computer based

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 of 43 sampled residents, that the facility did not provide or obtain laboratory services to meet the needs of the residents. Specifically, resident had routine orders for a Complete Blood Count (CBC), a Comprehensive Metabolic Panel (CMP), and a hemoglobin A1c (HbA1c) every 6 months in February and August that were not completed. Resident identifier: 33. Findings included: Resident 33 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which consisted of type II diabetes mellitus, end stage renal disease, arteriovenous fistula, hypertension, encephalopathy, hidradenitis suppurativa, borderline personality disorder, major depressive disorder, anxiety disorder, and ascities. Resident 33's medical records were reviewed. On 8/15/23, resident 33's physician ordered routine labs for a CBC, a CMP, and a HbA1c every 6 months in February and August. The order was updated on 1/10/25. No documentation could be found in resident 33's medical records for the results of the routine labs for the CBC, CMP, and HbA1c that was ordered for August 2024 and February 2025. On 3/25/25 at 2:55 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that he just obtained the laboratory results from the dialysis center for the August 2024 ordered CBC and CMP. The DON stated that the order did not contain a HbA1c result. On 3/26/25 at 1:32 PM, a follow-up interview was conducted with the DON. The DON stated that resident 33 had a HbA1c test completed by the dialysis center every 3 months in January 2025, October 2024, July 2024 and April 2024. The DON stated that the dialysis center was obtaining lab orders from their Nurse Practitioner and were not following the facility's physician orders. The DON stated that he was not sure if the facility's physician was able to view the labs from the dialysis center and confirmed that the lab results were not located in resident 33's medical records.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident 33 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which consisted of type II diabetes mellitus, end stage renal disease, arteriovenous fistula, hypertension, encephalopathy, hidradenitis suppurativa, borderline personality disorder, major depressive disorder, anxiety disorder, and ascities. Resident 33's medical records were reviewed. On 8/15/23, resident 33's physician ordered routine labs for a Complete Blood Count (CBC), a Comprehensive Metabolic Panel (CMP), and a hemoglobin A1c (HbA1c) every 6 months in February and August. The order was updated on 1/10/25. On 1/7/25, resident 33's physician ordered a respiratory panel due to exposure and signs and symptoms of influenza A. No documentation could be found in resident 33's medical records for the results of the respiratory panel that was ordered on 1/7/25 or the routine labs for the CBC, CMP, and HbA1c that was ordered for August 2024. On 3/25/25 at 7:43 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that the lab results would be located with the dialysis communication form because resident 33 would not allow the facility to draw blood, and only allowed the dialysis center to obtain labs. On 3/25/25 at 9:35 AM, the ADON stated that he called the laboratory and they said they performed the respiratory panel on 1/7/25, but there was an error on the results. The ADON stated that he just received the respiratory panel today from the laboratory. On 3/25/25 at 2:55 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that he just obtained the laboratory results from the dialysis center for the August 2024 ordered CBC and CMP. 3. Resident 49 was admitted to the facility on [DATE] with diagnoses which consisted of schizoaffective disorder bipolar type, fetal alcohol syndrome, post-traumatic stress disorder, opioid dependence, anxiety disorder, attention-deficit hyperactivity disorder (ADHD), and insomnia. Resident 49's medical records were reviewed. On 1/7/25, resident 49's physician ordered a respiratory panel due to exposure and signs and symptoms of influenza A. No documentation could be found in resident 49's medical records for the results of the respiratory panel that was ordered on 1/7/25. (continued on next page)

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/18/25 at 2:46 PM, an interview was conducted with Registered Nurse (RN) 4. RN 4 stated that laboratory staff obtained the samples for the routine lab orders on Tuesday and Thursday. RN 4 stated that the nurse would enter the lab into the requisition book under the ordered date. RN 4 stated that the results came back within 12 to 24 hours. RN 4 stated that the results would be uploaded into the resident's medical records and would be viewable under the results review tab. RN 4 stated that the results were also sent to the physician by the ADON and were viewable to the nurses on the communication app. On 3/18/25 at 3:05 PM, an interview was conducted with the ADON. The ADON stated the the physician ordered routine labs every 6 months for most residents. The ADON stated that the lab would draw the routine specimens on Tuesdays and Thursdays. The ADON stated that for any stat lab order the staff would draw and call the laboratory for a pickup. The ADON stated that results were back within a couple of hours for stat orders and for routine orders usually by the end of the day. The ADON stated that the results were faxed to the facility, but that the lab sometimes needed a call to remind them to fax the results. The ADON stated that he then forwarded the results to the physician or Nurse Practitioner. The ADON stated that he sent the results to the providers on the Whatsapp, and then he would upload the results into the resident's medical records. The ADON stated that resident 49's respiratory panel that was ordered on 1/7/25 was still in the fax cue and had not been uploaded to the resident's medical records. The ADON stated that he tried to have the records uploaded into the resident's medical records within a week. Based on interview and record review it was determined, for 3 of 43 sampled residents, that 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, 3 residents did not have laboratory reports filed in their medical record. Resident identifiers: 33, 37, and 49. Findings included: 1. Resident 37 was admitted to the facility on [DATE] with diagnoses which included atrial fibrillation, congestive heart failure, thrombocytopenia, disorder of bilirubin metabolism, chronic kidney disease, hypertension, bipolar disorder, and generalized anxiety disorder. Resident 37's medical record was reviewed 3/17/25 through 3/31/25. A physician's order, dated 10/4/24 at 12:32 PM, indicated, Collect one time BMP [Basic Metabolic Panel] on 10/29/24 one time only . There were no laboratory results in resident 37's medical record. On 3/31/25 at 11:50 AM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 37's lab results from 10/29/24 were not in his medical chart and were accidentally uploaded to another resident's chart.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review it was determined that, for 1 of 43 sampled residents, the facility failed to provide each resident with food prepared in a form designed to meet individual needs. Specifically, 1 resident received a modified diet that was not approved by the physician. Resident identifier: 5. Findings included: On 3/18/25 at 12:08 PM, an observation was made of resident 5 sitting in his wheelchair eating in the dining room. Resident 5's plate contained Lo Mein, chicken, and vegetables that were chopped into very small pieces. Resident 5 was observed to have no teeth and he stated that he could not remember the last time that he had teeth. Resident 5 was observed to finish his lunch and self-propel himself out of the dining room with a full fortune cookie in his lap. Resident 5 stated he would be fine eating the fortune cookie. On 3/18/25 at 1:44 PM, an observation was made of resident 5 in the dining room doing an activity that included French fries. Resident 5 was observed to eat whole French fries. Resident 5's medical record was reviewed 3/17/25 through 3/31/25. A Quarterly Minimum Data Set (MDS) Assessment, dated 1/3/25, indicated a Brief Interview for Mental Status (BIMS) score of 8. A BIMS score of 8-12 indicated moderate cognitive impairment. It further indicated resident 5 had a loss of liquids/solids from mouth when he ate or drank, held food in his mouth/cheeks or had residual food in his mouth after meals, and had complaints of difficulty or pain when he swallowed. A physician's order, dated 12/18/24 at 2:21 PM, indicated, Large portions diet Soft & Bite Sized SB6 texture, Regular consistency. A Nutrition/Dietary Note, dated 2/28/25 at 12:43 PM, indicated, Resident informed DM [Dietary Manager] he is having trouble chewing his food because the chunks are too large. SLP [Speech-Language Pathologist] notified. I will downgrade him on Nutrition Management to MM5 [Minced and Moist] until SLP can evaluate him. A meal ticket, dated 3/17/25, indicated, Diet Order: Minced & Moist MM5, Large Portions, Thin liquids Notes: Resident may have chips, crackers, and breads at regular texture, sandwich fillings minced and moist. On 3/18/25 at 2:33 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated resident 5's diet was chopped but she did not know why. CNA 1 stated resident 5 had no teeth or dentures. On 3/18/25 at 2:36 PM, an interview was conducted with CNA 4. CNA 4 stated he did not know what diet resident 5 was on but he could know by looking at the meal ticket or the care plan. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 2:47 PM, an interview was conducted with the Dietary Manager (DM). The DM stated that resident 5 was on a soft and bite-sized diet and he was saying that he was having trouble chewing these big chunks of food. The DM stated they had been serving resident 5 a minced and moist diet since 2/28/25 and that she also messaged the clinical team and the SLP that day. The DM stated she did not know if the SLP had seen resident 5 yet. The DM stated the Director of Nursing (DON) can change the diet order on the medical chart and she could update the tray card. In a follow-up interview at 3:14 PM, the DM stated a minced and moist diet was a lot more specific from the size and softening requirements than the soft and bite-sized diet. The DM pointed to an IDDSI (International Dysphagia Diet Standardization Initiative) document that was posted on the inside of the kitchen door and stated the minced and moist was smaller than the soft and bite-sized diet and had to be moistened. On 3/18/25 at 3:09 PM, an interview was conducted with the Director of Nursing (DON). The DON stated he was notified by the DM on 2/28/25 on the messaging application and that he should have followed up on it and that the SLP had not evaluated the resident yet. The text message was shown to said surveyor and it indicated, [Resident 5] just told me he's having trouble eating because he 'doesn't have no teeth' I'm going to downgrade him to MM5 [minced and moist] from SBS [soft and bite-sized] until Speech therapy can evaluate him. The DON stated that any downgrade had to be approved by the provider and the SLP would have to evaluate the resident. The DON stated the DM could change the meal card to match what the physician order was.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Resident 49 was admitted to the facility on [DATE] with diagnoses which consisted of schizoaffective disorder bipolar type, fetal alcohol syndrome, post-traumatic stress disorder, opioid dependence, anxiety disorder, attention-deficit hyperactivity disorder (ADHD), and insomnia. Resident 49's medical records were reviewed. Resident 49's progress notes contained the following: a. On 3/9/25 at 5:18 AM, the Health Status Note documented, Incomplete Documentation - Note Text: [Resident 9's name omitted] went into room [ROOM NUMBER] last night to ask [resident 59's name omitted] for a cigarette but [resident 49] wheeled [resident 9's name omitted] out of the room [ROOM NUMBER]. [Resident 9's name omitted] got upset and started calling [resident 49] names. Despite this, [resident 49] continued to be nice to [resident 9's name omitted] and gave [resident 9's name omitted] a can of soda. [Resident 9's name omitted] accepted soda but didn't stop insulting [resident 49]. Then [resident 9's name omitted] decided to go to her room and [resident 49] followed her because now she felt like [resident 9's name omitted] doesn't deserve a can of soda and [resident 49] wanted it back. They started arguing, [resident 49] took her soda back and as she was leaving [resident 9's name omitted] room, [resident 9's name omitted] threw a mug full of ice and water at [resident 49]. It hit [resident 49] in the lower back. On assessment, [resident 49] had no visible injuries to any areas of her body r/t [related to] this incident. CNA [Certified Nurse Assistant] was in the room and witnessed everything. [Resident 9's name omitted] called 911 and police came and handled this situation. b. On 3/9/25 at 4:48 AM, the Health Status Note documented, Note Text: Alert charting r/t [related to] R:R [resident to resident] altercation. Resident had an argument with [Resident 9's name omitted] last night and [Resident 9's name omitted] threw her water mug at [resident 49] hitting her in the lower back. Tylenol was given for pain. On assessment no visible injuries to the back or any other areas of the body. Residents were separated and had no further contact with each other. WCTM [will continue to monitor]. On 3/31/25 at 9:35 AM, an interview was conducted with the DON. The DON stated that staff should not document another resident name in a different resident record or chart. The DON stated that staff should be using a room number or resident identifier but not the resident name in other resident's medical records. The DON stated that staff had been provided education on the documentation policy. 4. Resident 164 was admitted to the facility on [DATE] with diagnoses that included hepatic encephalopathy, cirrhosis of the liver, nonalcoholic steatohepatitis, acute kidney failure, hepatorenal syndrome, and ascites. Resident 164's medical records were reviewed between 3/17/25 and 3/31/25. (continued on next page)

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	465185	A. Building B. Wing	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millcreek Rehabilitation and Nursing LLC	3520 South Highland Drive Salt Lake City, UT 84106

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Upon reviewing resident 164's discharge documentation for 3/18/25, documentation was found for another resident who had discharged to another facility on that day. Based on observation, interview, and record review it was determined that, for 4 of 43 sampled residents, the facility failed to maintain medical records on each resident that were complete, accurately documented, and readily accessible and failed to protect resident-identifiable information from being released to the public. Specifically, one resident did not have a physician's rationale for an on-going use of a PRN (as needed) psychotropic medication located in the medical record and 3 residents had another resident's name or documents located in their medical records. Resident identifiers: 49, 59, 164, and 214. Findings included: 1. Resident 59 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included post-traumatic stress disorder (PTSD), schizoaffective disorder bipolar type, generalized anxiety disorder (GAD), cognitive communication deficit, and frontal lobe and executive function deficit. Resident 59's medical record was reviewed 3/17/25 through 3/31/25. A physician's order, dated 2/24/25, indicated, clonazepam Oral Tablet 1 MG [milligram] (Clonazepam) *Controlled Drug* Give 1 mg by mouth every 24 hours as needed for GAD until 04/19/2025 23:59 [11:59 PM]. On 3/25/25 at 11:56 AM, an interview was conducted with the Director of Nursing (DON). The DON stated a PRN order of clonazepam should be ordered for 14 days initially and then could be extended to 90 days and that resident 59's PRN clonazepam order had been extended to 90 days. The DON stated that a rationale for the extension should be documented under documents in the medical record. No rationale for the extension was located in the medical record. On 3/25/25 at 3:38 PM, a follow-up interview was conducted with the DON. The DON provided the document, Physician Rationale for Clinically Contraindicated Gradual Dose Reduction, Duplicative Medication, or On-going use of PRN Psychotropic Medication, dated 1/9/25, and stated that it was not in the chart and that he had to dig through the shredder bin to find it. 2. Resident 214 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included paranoid schizophrenia and psychoactive substance abuse. Resident 214's medical record was reviewed 3/17/25 through 3/31/25. Health Status Notes included resident 34's first and last name on 8/25/23 at 2:00 PM, 8/26/23 at 4:01 AM, and 8/27/23 at 4:19 AM. An Event Note Template, dated 9/6/23 at 4:43 PM, included resident 34's first name.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. On 3/17/25 02:57 PM, an observation was made of Certified Nurse Assistant (CNA) 5 passing afternoon snack to residents in the hallway. CNA 5 was observed to hand residents cookies bare handed. On 3/31/25 at 8:36 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that staff should use tongs to plate the cookies and should hand sanitize between each resident. 2. Resident 58 was admitted to the facility on [DATE] with diagnoses that included sepsis, need for assistance with personal care, moderate protein-calorie malnutrition, personal history of traumatic brain injury, major depressive disorder, acute respiratory failure with hypoxia, tachycardia, cellulitis, and olecranon bursitis of the right elbow. On 3/17/25 at 10:42 AM, an interview was conducted with resident 58 who stated he had been on IV antibiotics for an extended period of time but was not taking oral antibiotics for his wound. Resident 58's medical record was reviewed between 3/17/25 and 3/31/26. A physician order, dated 3/17/25, indicated, Right elbow wound: WOUND VAC: Cleanse wound NS [normal saline] /wound cleanser, Apply skin prep to peri wound area, Apply 1 piece of wound vac sponge to wound bed. Apply wound vac drape to seal and secure dressing. Change dressing once weekly between visits and PRN [as needed] for accidental removal, saturation and/or soiling. Resident 58's Care Plan Focus, Potential for complications related to SEPSIS, CELLULITIS OF RIGHT UPPER LIMB. Interventions included, Administer antibiotics in accordance with physician orders. Monitor for and report any adverse side effects to MD. Date initiated: 10/18/24; Administer antipyretic medication as needed for fever > [Greater than]100.4 or per MD [Medical Doctor] orders. Date initiated: 10/18/24; Monitor for and report to MD s/s [signs and symptoms] of infection that are not resolving with current plan of care. In collaboration with MD, revise plan of care as indicated. Date initiated: 10/1/24; Monitor vital signs as indicated. Report abnormal vital signs to MD as needed. Date initiated: 10/1/24; Obtain labs as indicated. Report results to MD. Date initiated: 10/18/24; Offer and encourage fluids to maintain proper hydration status. Date initiated: 10/18/24; Staff shall utilize universal precautions before and after providing care. Date initiated: 10/18/24. On 3/25/25 at 1:30 PM, an observation was made of the doorway to resident 58's room. There was no posting for Enhanced Barrier Precautions related to resident 58's use of a wound vac. Based on observation, interview, and record review it was determined, for 2 of 43 sampled residents, that the facility failed to 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, there was direct food contact with bare hands and 2 residents who had indwelling medical devices or wounds and did not have Enhanced Barrier Precautions (EBP) in place. Resident identifiers: 22 and 58. Findings included: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident 22 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included respiratory failure with hypoxia, hypertension, pneumonia, paroxysmal atrial fibrillation, chronic viral hepatitis C, chronic kidney disease, bladder-neck obstruction, and retention of urine. On 3/17/25 at 9:45 AM, resident 22 was observed in his room in bed with a foley catheter drainage bag hanging from his bed. Resident 22 stated he had had a foley catheter in place. There was no signage outside of his room which indicated he was on EBP. Resident 22's medical record was reviewed 3/17/25 through 3/31/25. A physician's order, dated 2/11/25 at 3:43 PM, indicated, (18F [French]/10cc [cubic centimeters])(Foley) catheter to down drain for dx [diagnosis] of (obstructive uropathy) r/t [related to] (Urine retention and bladder neck obstruction). May change PRN [as needed] if dislodged or clogged. The Care Plan Report had a Focus, The resident has an ADL [Activities of Daily Living] self-care performance and mobility deficit r/t recent infections, debility, cognitive deficits r/t metabolic encephalopathy, multiple chronic health conditions, use of multiple medical devices/lines including indwelling catheter r/t bladder outlet obstruction, incontinence of bowel . Date Initiated: 06/23/2021Revision on: 11/14/2023. It included the Intervention, CATHETER CARE: Nursing staff should provide catheter care per physician order and standards of best practice, including ensuring drainage bag is below level of bladder and tubing is not touching floor, cleaning tubing, emptying catheter drainage bag as needed, ensuring privacy cover is in place over catheter drainage bag, flushing/changing catheter or catheter bag per physician order and as needed. Date Initiated: 06/23/2021 Revision on: 06/23/2021. On 3/27/25 at 1:48 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated resident 22 had a foley catheter since they started working at the facility. CNA 1 stated when they emptied the foley catheter bag or provided cleaning they would wear gloves and did not need to wear a gown. CNA 1 stated resident 22 was on precautions a month ago but not anymore. On 3/27/25 at 2:15 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated resident 22 was not on contact or enhanced barrier precautions and that when they emptied the catheter bag they would wear gloves and no gown. RN 1 stated they had not heard of enhanced barrier precautions. On 3/31/25 at 11:17 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that EBP should be implemented for anyone with an invasive device like a foley catheter.

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure that all corridors were equipped with firmly secured handrails. Specifically, 3 handrails throughout the facility were found to be loose which created a resident safety hazard. Findings included: On 3/17/25 at 2:09 PM, an observation was made in the resident corridor of a handrail outside of room [ROOM NUMBER]. The handrail was not secured to the wall. On 3/20/25 at 4:09 PM, an observation was made in the resident corridor of the handrail between rooms [ROOM NUMBERS]. The handrail was not secured to the wall. On 3/20/25 at 4:10 PM, an observation was made in the resident corridor of the handrail between rooms [ROOM NUMBERS]. The handrail was not secured to the wall. On 3/31/25 at 10:13 AM, an interview was conducted with the Maintenance and Housekeeping Supervisor (MHS) who stated audits were conducted with housekeeping staff everyday. The MHS stated audits included inspecting handrails at least everyday. The handrail between rooms [ROOM NUMBERS] was inspected with the State Surveyor (SS). The MHS stated, Maybe this one could be a little more tight. The handrail between rooms [ROOM NUMBERS] was inspected with the SS. The MHS stated it was loose and needed to be more tight. The handrail between rooms [ROOM NUMBERS] was inspected with the SS. The MHS stated it needed to be tightened maybe a little bit. The MHS stated if he was unable to tighten the handrails he would have to replace them. The MHS stated he had not noticed the loose handrails on his daily audits.