STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Rehabilitation and Healthcare Center	1776 Cambridge Drive Richmond, VA 23238

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to accommodate residents' physical limitations for one of 18 residents in the survey sample, Resident #8.The findings include:For Resident #8 (R8), the facility staff failed to provide an adaptive call bell that the resident could use. R8 was admitted to the facility with diagnoses that included but were not limited to quadriplegia (1), chronic respiratory failure (2) and pressure ulcer (3) of sacral region.On the most recent minimum data set (MDS), a quarterly assessment with an assessment reference date (ARD) of 1/17/2026, the resident was assessed as being severely impaired for making daily decisions. Section GG coded R8 being dependent on staff for all ADL (activities of daily living) care. It further documented R8 receiving oxygen, tracheostomy (4) care, tube feeding, pressure injury care and suctioning while at the facility. The comprehensive care plan for R8 documented in part, I have an ADL Self Care Performance Deficit r/t (related to) cerebral infarct (5), muscle wasting, metabolic encephalopathy, respiratory failure, quadriplegia. Date Initiated: 07/10/2025. Under Interventions/Tasks it documented in part, .Be sure Breathcall arm (6) is within reach, and provide reminders to use call for assistance as needed. Breathcall arm in place of traditional button call light due to patient's lack of mobility. Date Initiated: 07/10/2025 .On 4/6/2026 at approximately 2:10 PM, an observation was made of R8 lying in bed in their room. A handheld call bell with a finger press button on the end was observed clipped to the blanket near R8's chest. No Breath call was observed.Additional observations of R8 were made on 4/7/2026 at 9:01 AM and 4/7/2026 at 12:08 PM. The handheld call bell remained in place clipped to the bed linens. No Breath call was observed.On 4/7/2026 at 12:30 PM, an interview was conducted with licensed practical nurse (LPN) #2 who stated that when a resident was admitted the nurse used their judgement to determine what type of call bell the resident required based on their physical ability to activate it. He stated that they also followed any recommendations form therapy regarding specialized call bells as needed. On 4/7/2026 at 12:51 PM, an interview was conducted with the director of specialty care who stated that they assess the mobility of the residents arm, the range of motion, strength and coordination of the fingers when determining the type of call bell that the resident was given. She stated that they had a few options that they could use and they put in a work order for maintenance, and they changed the call bells out right away to an adaptive call bell when requested. The director stated that she was not sure what type of call bell R8 had used in their previous room but had recently switched rooms and she would have to investigate it further. On 4/7/2026 at 1:16 PM, an interview was conducted with certified nursing assistant (CNA) #1 who stated that if residents were contracted or had range of motion problems they gave them a flat call bell or ones they could blow in to call the staff. On 4/8/2026 at 12:38 PM, an interview was conducted with the director of nursing who stated that the interdisciplinary team decided what type of call bell was required for the resident and at times therapy made recommendations. She stated that if the resident changed rooms the adaptive call bell followed the resident to the new room. The facility policy Activities of Daily Living (ADL), Supporting revised April 2025 documented in part, .Interventions to improve a resident's functional abilities or minimize functional decline are in accordance with the resident's assessed (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needs, preferences, stated goals, and recognized standards of practice .On 4/8/2026 at approximately 3:58 PM, the administrator and director of nursing were made aware of the concern.No further information was provided prior to exit.Reference:(1) Paralysis of the arms and legs is quadriplegia . This information was obtained from the website: Paralysis | Hemiplegia | MedlinePlus(2) Respiratory failure is a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide. Sometimes you can have both problems . This information was obtained from the website: Respiratory Failure | Lung Disease | Lung Problems | MedlinePlus(3) Pressure sores are areas of damaged skin caused by staying in one position for too long . This information was obtained from the website: Pressure Sores | Bedsores | Pressure Ulcers | MedlinePlus(4) A tracheostomy is surgery to create a hole in your neck that goes into your windpipe . This information was obtained from the website: Tracheostomy care: MedlinePlus Medical Encyclopedia(5) A stroke occurs when blood flow to a part of the brain stops. A stroke is sometimes called a brain attack. This information was obtained from the website: Stroke: MedlinePlus Medical Encyclopedia(6) The Breath Call is a pneumatic (air-activated) nurse call cord that works with virtually any nurse call system. Breath Call is for patients with little to no motor skills and is activated by simply breathing into a disposable straw and filter assembly . This information was obtained from the website: Breath Call (BreathCall(R)) Nurse Call Cord - [NAME] Precision Products

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, clinical record review and facility document review, the facility staff failed to protect residents' right to be free from abuse by other residents for 4 of 18 residents in the survey sample, Residents #17, #16, #15, and #2, resulting in the identification of immediate jeopardy and substandard quality of care for Resident #2. The findings include:1.For Resident #17 (R17), the facility staff failed to protect the resident's right to be free from physical abuse by Resident #14 (R14) on 3/20/24.R17 was admitted to the facility 10/16/23 with diagnoses to include but not limited to Lewy body dementia with agitation, hereditary idiopathic neuropathy, frontotemporal neurocognitive disorder, type 2 diabetes mellitus, major depressive disorder, bipolar disorder, generalized anxiety disorder, muscle wasting, and tremors. R17's Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) 3/22/24 coded her a 03/15 in Section C. Cognitive Patterns, Brief Interview for Mental Status indicating severe cognitive impairment (suggesting significant difficulties with short-term memory and orientation). R14 was admitted to the facility 2/6/24 with diagnosis to include but not limited to vascular dementia with psychotic disturbance, anxiety, rheumatoid arthritis left hip, iron deficiency anemia, malignant neoplasm prostate, insomnia, restlessness and agitation, and major depressive disorder. R14's most recent MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 10/1/25 coded R14 as 03/15 on the BIMS (Brief Interview of Mental Status) indicating severe cognitive impairment with skills of memory, thinking and orientation to place and timeA review of the facility's final synopsis dated 3/20/24 involving R17 and R14 revealed, in part: On 3/20/24, staff reported R17 slapped R14 and R14 pushed R17 to the floor. Residents were immediately separated and assessed for any injuries. Skin and pain assessments were done on both parties following the incident.A review of witness statements from staff revealed the following:Certified Nursing Assistant #3 (C.N.A.#3) stated it was somewhere between 6:30-6:45 PM, she was assisting another resident heard screaming and a hard fall, stated she did not observe the altercation but that R17 told her R14 pushed her down.C.N.A. #2 stated she was in the dining room, heard a scream coming from the third hallway and rushed to the area, noting R17 on the floor next to the food cart, R14 standing up next to the food cart. She stated when the residents were asked what happened both responded saying R17 slapped R14 and then he pushed her to the floor.Per LPN#5, he was alerted to the altercation between R17 and R14 by the activity staff and immediately responded to investigate the situation, R17 had returned to her room and upon assessment R17 had a bump on the top/back of her head.C.N.A. #4 stated she heard a scream and responded noting R17 on the floor and notified the charge nurse.A review of R17's progress note dated 3/20/24 by LPN#5 revealed in part: Resident had an altercation with another resident. There was no witness. Skin check was conducted to assess the bump on the back of her head, two centimeters tall and one inch wide. Pain evaluation completed with R17 denying pain or headache. Resident vital signs are within normal limits with blood pressure 134/77, temperature 97.6 temporal, heart rate 86, respirations 19, oxygen at 94% on room air. The physician was notified of the incident and advised to initiate neuro checks. Every 15-minute monitoring was implemented.On 4/9/24, R17 was evaluated by Psychiatrist Nurse Practitioner, every 15-minute safety check was discontinued due to no behaviors noted since 3/20/24, adjustment was made to medication prescribed to treat her mood disorder.A review of R17's comprehensive care plan dated 3/21/24 revealed revision to include care plan focus psychosocial well-being problem r/t alleged physical altercation.On 4/9/24, the Unit Manager requested the Psychiatrist Nurse Practitioner to re-evaluate R14 for possible discontinuation of every 15-minute safety checks. According to the evaluation by the Psychiatrist Nurse Practitioner, R14 had not had any altercations with co-residents since 3/20/24, therefore every 15-minute safety check was discontinued, and adjustments were made to R14's medication to manage R14's mood and mood (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	fluctuations. 2. For Resident #16 (R16), the facility staff failed to protect the residents' right to be free from abuse by Resident #14 on 12/18/24.R16 was admitted [DATE] with diagnoses to include but not limited to dementia with agitation, major depressive disorder, psychotic disorder with delusions, hallucinations and adult failure to thrive. R16's Minimum Data Set assessment (MDS) with Assessment Reference Date (ARD) 1/9/24 coded her a 99 for Brief Interview for Mental Assessment as R16 not able to complete assessment on cognition.A review of the facility's final synopsis of incident dated 12/18/24 revealed, in part: R16 was noted to be in her bed with her entire body covered including her head with covers resting with R14 laying on top of the covers fully clothed in the same bed. Skin and pain evaluations were completed and no injuries were noted. Neither resident was able to recall the incident, and no evidence of abuse was substantiated. A review of witness statements from staff revealed the following:A review of C.N.A#5's witness statement revealed, CNA#2 informed her that R14 was in R16's room and she went to assist CNA#2 with re-directing R14 out of R16's room. According to CNA #5, she had laid R14 down in his room around 9:00 PM after already getting him from trying to go into R16's room and made sure he was laying down in his own bed. According to C.N.A#2, she overheard nurse tell R14 to exit R16's bed and stated as she was completing her rounds at approximately 10:15 PM, she observed R16's brief undone and her buttocks exposed. A review of R16's clinical record revealed the following progress note dated 12/18/24 at 11:03 PM: Male resident (R14) was observed in R16's bed. R14 was fully clothed and female resident (R16) was fully covered with blankets. The Certified Nursing Assistant (C.N.A #2) pulled the covers back and the female residents brief was deviated to the right side with the buttocks exposed.3. For Resident #15 (R15), the facility staff failed to protect the residents' right to be free from abuse by Resident #14 on 1/22/25.R15 was admitted [DATE] with diagnoses to include but not limited to abdominal aortic aneurysm, ruptured, iron deficiency anemia, Alzheimer's dementia with agitation, major depressive disorder, and anxiety. R15's Minimum Data Set assessment (MDS) with Assessment Reference Date (ARD) 1/2/25 coded him 06/15 on the Brief Interview for Mental Assessment, indicating severe cognitive impairment with skills such as memory, thinking and orientation to place and time.A review of the facility's final synopsis of event dated 1/22/25 revealed, in part: Upon investigation it was reported that R15 wandered into R14's room and called him a racial slur, then R14 hit R15. Neither resident sustained any injuries. Both residents tolerating meals and medications well. A review of witness statements from staff revealed the following:According to LPN#6, she observed R15 exiting R14's room holding a bloody rag on his mouth, saying that (n-word) hit me in my mouth.Per witness statement from C.N.A.#6, R15 was observed at the double doors with his mouth bleeding at approximately 12:30 AM and that R15 said that (n-word) hit me in my mouth.A review of clinical record revealed progress note dated 1/22/2025 at 1:00 AM, Resident was involved in an altercation with another resident. Small cut noted to lower lip right side.A review of the Interim Skin Check evaluation dated 1/22/25 revealed Head to Toe Skin Check and Evaluation, Skin Condition and Integrity Findings, 1a. Are there any skin impairments noted? YES. 1b. Is this a new skin impairment? YES. 1c. Type of Skin Impairment, Laceration.4. For Resident #2 (R2), the facility staff failed to protect the resident's right to be free from abuse by Resident #14 on 12/30/25, where a physical altercation occurred, when he entered her room, resulting in harm and hospitalization for R2.R2 was admitted to the facility on [DATE] with diagnoses to include but not limited to dementia without behavioral disturbance, post-traumatic stress disorder, scoliosis, anxiety, psychosis, depression, fibromyalgia, chronic pain syndrome, and long-term use of anticoagulants for treatment of deep vein thrombosis. R2's Minimum Data Set assessment (MDS) with Assessment Reference Date (ARD) 10/13/25 coded her a 07/15 on the Brief Interview for Mental Assessment, indicating severe cognitive impairment with skills of memory, thinking and orientation to place and time.A review of the facility's final synopsis of event dated 12/30/25 revealed, in part: Staff alleges R14 struck R2 in her left eye causing bruising, head to toe skin and pain assessments completed on both residents. Statements obtained from staff reported that another resident had informed them that R2 and R14 were fighting. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Upon entering R2's room they observed R14 standing in front of R2 and each resident struggling over R2's reacher/grabber tool, residents were immediately separated. R2 stated to staff that R14 hit her in her left eye. Skin assessment completed on R2 noting swelling and bruising to her left eye. She denied pain and discomfort. R14 was immediately escorted out of R2's room and placed on every 15-minute checks. Skin evaluation was negative for injury to R14.A review of nurse progress note dated 12/30/25 at 9:45 PM read in part, Writer was charting at the nurses' station, and a resident came to call me and said they are fighting. I rushed to the 3rd hall, and I saw R2 and R14 in front of her room pushing and pulling on a reacher/grabber stick. I separated them. R2 stated that he came to my room and I tried to ask him to leave and he hit me in my left eye. Swelling and bruising noted around R2's left eye. R2's responsible party, physician and the Director of Nursing were notified of the incident. Neuro checks were initiated.A review of Interim Skin Check evaluation dated 12/30/25 at 8:30 PM revealed Head to Toe Skin Check and Evaluation, Skin Condition and Integrity Findings, 1a. Are there any skin impairments noted? YES, 1b. Is this a new skin impairment? YES, 1c. Type of Skin Impairment, Bruise.A review of One-on-One Check Observation Log initiated 12/30/25 through 12/31/25 R2 revealed:10:00 PM Resident sitting in chair in her room11:00 PM Resident in wheelchair at nursing station12:00 AM Resident in wheelchair at nursing station1:00 AM through 7:00 AM Resident sleeping8:00 AM through 10:00 AM Resting in bed'A review of neurological checks completed by nurses initiated 12/30/25 through 12/31/25 assessed vital signs, pupil size and response, speech, response to name, pain, environment and seizure activity, headache and vomiting.A review of physician note dated 12/31/25 at 10:07 AM read in part, Patient (R2) recently was involved in an altercation where her orbit was injured. She became more lethargic and her vitals showed temperature 102 degrees Fahrenheit, heart rate 126, blood pressure 224/115, and oxygen saturation in the 50s before rising to 97% on 4L Venti mask (re-breathing mask). Due to risk of deterioration she (R2) was sent to the ED (local hospital emergency department).A review of nurse progress note dated 12/31/25 at 11:45 AM read in part, Writer (LPN#3) informed by charge nurse the resident breathing was abnormal and resident was unresponsive. Writer entered room and resident noted to be lying in bed heavily breathing but not responding to name or sternal rub. Vital signs taken and abnormal, blood pressure 244/119, heart rate 126, respirations 20, oxygen saturation 53% on room air. Physician notified. Oxygen was increased to 15 liters on a non-rebreather, with oxygen saturation up to 96%. R2 was still not responding. The physician was -notified again and with an order to send to the emergency room for further evaluation. Writer called and spoke to responsible party, R2's sister in-law. EMS (Emergency Medical Services) notified and R2 transferred to (name redacted) hospital. A review of R2's clinical record for physician orders revealed an order for Eliquis 5 milligrams by mouth two times a day for the prevention of recurring deep vein thrombosis. (Eliquis is a prescription blood thinner used to prevent and treat blood clots. Adverse Effects/Toxic Reactions may include but not limited to: increased risk for bleeding/hemorrhagic events. May cause serious, potentially fatal, bleeding of the following sites: intracranial (within the skull), intraocular (within the eye) (1).On 4/7/26 at 7:36 AM, an interview was conducted with C.N.A.#2 regarding the altercation between R2 and R14. According to C.N.A.#2, she usually works the day shift but had picked up an extra shift. She stated she and LPN#10 went to R2's room upon notification of the resident-to-resident fighting. She said she observed R2 and R14 pulling and pushing R2's reacher/grabber stick. R2's left eye was red and swollen. She said they removed R14 from R2's room and both residents were placed on every 15-minute safety checks and no further problems from either one of them that she was aware of the rest of the 3-11 PM shift. On 4/7/26 at 7:40 AM, an interview was conducted with LPN#4. According to LPN#4, the Unit Manager, LPN#3 was helping her out the morning of 12/31/26 as it was so busy. She said LPN#3 was taking care of R2 mostly. She stated she had made her rounds on the morning of 12/31/25 and noticed that R2's eye was swollen terrible, swollen shut, and had a purplish reddish bruising around the left eye. She wasn't responding as much as usual. Later the aide told us she wasn't eating her breakfast then we knew something wasn't right. LPN#3 called the doctor. R2 ?s (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	condition kept getting worse. Her blood pressure and pulse were getting higher and her breathing was labored. She was showing a drastic change, and the doctor told us to send her out.On 4/7/26 at 8:10 AM, an interview was conducted with LPN #3, the Unit Manager on the Memory Care Unit. According to LPN#3 she was notified of the altercation between R2 and R14 on 12/30/25 and came into facility. She stated she called the police and stayed at the facility until the police arrived. She stated R2 was at the nurse's station in her wheelchair watching TV when the police arrived and R14 was in his room. She stated the police did not stay long, they observed R2 and R14, left his card and then exited the facility stating not much he could do when it involved people who were cognitively impaired. She stated she cared for R2 on the morning of 12/31/25 and that R2 was noted not to be eating her breakfast which was out of the norm for her. Shortly after that nurse reported to her that R2's vital signs and mental status began to deteriorate. According to her, she contacted the Director of Respiratory for a non-rebreather mask and the Director of Respiratory and Director of the Dialysis Program arrived on-site to assist her in providing emergency care to R2 with applying the non-rebreather mask and communicating changes in resident condition to the physician via phone while she called 911 after physician gave order to transfer to out for evaluation and treatment. She stated R2 did not return to the facility but that her family had come in a few days later and retrieved her personal belongings. She stated she did not know why R2 did not come back to the facility.On 4/7/26 at 8:41 AM, a telephone interview was conducted with R2's responsible party, who stated that the physician at the hospital had told her R2 suffered a significant brain bleed from being hit in the eye and being on a blood thinner. She said she was told by the hospital doctor that R2 passed away at 2:00 AM on 1/1/26. On 4/7/26 at 9:05 AM, an interview was conducted with the Administrator regarding the altercation between R2 and R14. According to the Administrator, she was notified of the altercation and came into the facility on [DATE] and was present when the police arrived. When asked why the police were notified, she stated because it was a physical resident-to-resident altercation and R2 wanted the police to be notified. She stated she saw R2 in the wheelchair in the nurses' station and that she appeared to be okay and R14 was back in his room and staff had them both on every 15-minute safety checks. She stated she reported the incident to the appropriate authorities and then went home. When asked about the change in condition of R2 on 12/31/25 requiring transfer to the emergency room and why she had not returned to the facility she responded, I don't know why she did not come back. She stated the family came in a few days later and retrieved her belongings but when asked about R2's status they said she would not be returning to the facility and requested a copy of R2's medical records.On 4/7/26 at 9:40 AM an interview was conducted with the Director of Respiratory and Director of the Dialysis Program. According to the Director of Respiratory she had been notified by LPN# 3 for a non-rebreather mask. She said upon entering R2's room she noted resident was in crisis with labored breathing, unresponsive and critically high blood pressures and heart rate. According to the Director of the Dialysis Program, she noted R2's left eye was swollen shut with noticeable purplish black bruising and she and the Director of Respiratory stayed at the bedside and assisted nursing in communicating R2's condition with the physician via phone.On 4/7/26 at 9:45 AM, the Social Services Assistant (Other Staff Member #11) was interviewed. She stated she is responsible for following up with residents after any resident-to-resident altercation to evaluate their psychosocial needs. She stated that more times than not, when she follows up with the residents who reside in the Memory Care Unit, they are unable to recall the incident, but she attempts to ensure they are comfortable and feel safe. She stated she looks for nonverbal indicators or emotional distress/ anxiety as well as conducting follow-up interviews. When asked if resident-to-resident physical altercations or a male resident observed in bed with a female resident that is not consensual would constitute abuse, she responded, Absolutely, abuse can be physical, mental, sexual or financial, and it is our responsibility to protect them and they should be able to feel safe here, but the Memory Care Unit does present with lots of challenging behaviors.On 4/7/26 at 11:10 AM an interview was conducted with the Nurse Concierge (Other Staff (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Member #10). According to her it is her responsibility to follow up on residents who are sent out to emergency room the next day to see how they are doing and document her findings in the resident's chart and give an end-of-the-day report on all the calls to the Administrator.OSM#10 said she left a message for R2's sister-in-law but did not get a return call. When asked where the documentation for R2's follow-up call, she responded, In all honestly, it just didn't get into her chart. When asked why R2 did not return to the facility, she responded, I just don't know. On 4/7/26 at 1:05 PM, an interview was conducted with the physician regarding R2's change in condition on 12/31/25. According to the physician, he said he was notified on the evening of 12/30/25 after the altercation between R2 and R14 and the nurse informed him that R2 had slight bruising and swelling in her left eye. He stated he asked the nurse if R2 had any changes in level of consciousness, mentation, headaches and vision and he stated the nurse reported none. He said the nurse said R2 was fine. He said the nurse reported vital signs and neurological checks were within normal limits and R2 was drinking fluids with no nausea or vomiting. When asked about R2 being on a blood thinner and getting hit in the eye, immediately resulting in some bruising and swelling would that not have prompted sending R2 to the emergency room for evaluation due to the high risk of bleeding, he responded, The assessment from the nurse did not present with symptoms that would result in sending her out to the emergency room, her vital signs and neuro checks were okay.On 4/7/26 at 2:10 PM, interviews were conducted with several licensed practical nurses on what is the likelihood of injury if a person is hit on the head and is on a blood thinner. According to LPN#11, she said people who are on blood thinners are more vulnerable to excess bleeding and bruising than people who are not on blood thinners. She further stated the type and severity of injury would depend on how hard a blow the hit and where on the head the person was hit. I would expect to see bruising, maybe hematomas or excessive bleeding, perhaps a nosebleed, and maybe internal bleeding, this could be very dangerous and life-threatening.According to LPN#4, she said, They could bleed out.Per LPN#5, he responded I would expect to see increased bruising, a hematoma, aneurysm, heavier bleeding than someone who is not on a blood thinner.According to LPN#12, she said she would expect increase in bleeding, perhaps from the nose or cuts or maybe in the brain. They could bleed out.According to LPN#9, she responded by saying, they may experience a stroke from internal bleeding, more bruising, seizures, hematomas. Blood thinners can be very dangerous if a resident falls and hits their head or they can have some bleeding inside the body that we don't see. They can bleed profusely from small cuts. On 4/7/26 at 4:00 PM, an interview was conducted with the DON (Director of Nursing) on her expectation of what a nurse should be assessing when completing neurological checks, she stated, mentation, pupillary response, level of consciousness, and responding appropriately to questions. When a person is hit in the eye head and is on a blood thinner what is the likelihood of an injury? The DON responded, That would be patient specific and how hard they were hit. When asked about R2 being hit by R14, with immediate swelling and bruising to the eye resulting in a significant change in condition and a transfer to the emergency department she stated she did not necessarily think R2's change in condition was solely as a result from the altercation with R14 on 12/30/25. When asked about what constituted resident abuse, the DON stated, Abuse comes in different forms, it can be physical, emotional, verbal, financial or sexual. When asked is it the residents' right to be free from abuse, the DON responded, Of course, it is their right to be free from abuse and to feel safe in our care. All of these incidents of abuse occurred on the facility's Memory Care Unit and were perpetrated by the same resident, Resident #14 (R14)R14 remains a current resident of the facility and is permitted to ambulate throughout the unit and have direct access to other residents. Therefore. creating an imminent risk to other residents.A review of nurse progress note dated 1/3/2026 revealed R14 observed in a female's room attempting to get into bed with her, clothes on and brief was still on. Resident was given re-direction, to which R14 attempted to fight against and swing at staff. R14 made grabbing motions at staff and attempted to hit staff.A review of Psychiatrist Nurse Practitioner progress note dated 1/5/26 read in part, Facility staff requested consultation related to escalating behavioral disturbances. Facility staff (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	report increasing aggressive and inappropriate behaviors. According to the staff, R14 became verbally aggressive when staff attempted to obtain his weight, refused redirection, and became tense and competitive. Staff further report that the resident entered a female resident's room and attempted to get into bed with her while clothed and wearing a brief. When redirected, the R14 became physically aggressive, making grabbing motions, swinging at staff, and attempting to strike them. R14 poses risks to staff and peers due to aggressive and sexually inappropriate behaviors. Upon assessment, the R14 has significant behavioral disturbances characterized by aggression, poor impulse control, and sexually inappropriate behavior. Presentation is consistent with behavioral symptoms likely related to underlying neurocognitive disorder. Current behaviors place R14 and others at risk Treatment Plan/Recommendations: 1. Discontinue anti-depressant used to treat depression due to concern for activating effects contributing to agitation, aggression, and behavioral dysregulation. Discontinuation is part of behavioral symptom management to reduce stimulation and impulsivity. Monitor for improvement in agitation, aggression, and intrusive behaviors following discontinuation. Monitor for emergence or worsening of depressive symptoms. Continue non-pharmacological interventions including consistent redirection, calm approach, and environmental modifications. Ensure close supervision to reduce risk to staff and peers. Continue to assess risks to harm himself or others. Staff to utilize de-escalation techniques and document behavioral incidents.Review of nurse progress note dated 1/5/26 read in part, R14 no longer on 1:1 supervision per physician's order.On 4/6/2026 between 12:00 PM-1:00 PM, Resident #14 was observed ambulating independently on the Memory Care Unit in the hallways and in the common areas. He was observed in shorts and a long sleeve T-shirt constantly rubbing his arms as he wandered about unit.On 4/6/2026 at approximately 3:00 PM, Resident #14 was observed wandering the hallways and the common area of Memory Care Unit.A review of the facility's abuse policies: Resident Rights and Abuse Prevention Policy and Policy Manual 2001, MED-PASS, Inc; Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, reads in part: All reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Resident Rights and Abuse Prevention Policy and Policy Manual, 2001, MED-PASS, Inc; reads in part; Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervison and assistance to prevent accidents are facilty-wide priorities.Facilty-Oriented Approach to SafetyOur facility-oriented approach to safety addresses risks for groups of residents.Safety risk and environmental hazards are identified on an on-going basis through a combination of employee training, employee monitoring, and reporting processes; QAPI (Quality Assurance and Improvement Program) committee reviews of safety and incident/accident data; and a faclilty-wide commitment to safety at all levels of the organization.When accident hazards are identified, the QAPI/safety committee shalle evaluate and analyze the cause/s of the hazards and develop strategies to mitigate or remove the hazards to the extent possible.Employuees shall be trained on potential hazards and demonstrate competency on how to identify and report accidents hazards, and try to prevent avoidable accidents.The QAPI committee and staff shall monitor interventions to mitigate accident hazards in the facility and modify as necessary.The facility's deficient practice placed all residents on the Memory Care Unit at risk of being abused by R14. This resulted in a determination of immediate jeopardy (IJ), and cited at level four, pattern beginning 3/20/24. On 4/7/26 at 4:26 PM, the Administrator, Director of Nursing, Regional Director of Clinical Services and Regional [NAME] President of Operations were informed of these concerns and that the facility was in immediate jeopardy. On 4/7/26 at 9:31 PM, the facility's IJ Immediacy Removal Plan was accepted by the State Agency. Facility Removal Plan: Corrective actions which will be accomplished for those residents found to have been affected. Resident #14 has been placed on one-to-one supervision. This will continue until the medical director has evaluated and established that the risk for resident-to-resident (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	altercations is not present. The care plan will be updated to reflect the one-to-one support. Identification of other residents having the potential to be affected, and corrective actions that will be taken.The facility identified all residents residing on the secured memory care unit as potentially affected. A 100% audit was conducted to identify any residents exhibiting aggressive behavior and residents at risk for victimization due to cognitive impairment or vulnerability. All identified residents had their care plans reviewed and revised as needed. Skin evaluations completed for all current residents that reside on the Grove unit to identify any residents with injuries to ensure appropriate reporting and interventions are placed if indicated. Measures that will be put in place and systemic changes that will be made to ensure that the practices do not recur.Current employees will receive education regarding preventing, recognizing, and reporting abuse, specifically resident-to-resident altercations. No employee will work without receiving designated education. The Administrator/designee will conduct ten interviews with memory care resident family members and/or staff daily to determine concerns related to abuse, specifically resident-to-resident altercations.Any allegations of abuse or neglect identified as a result of the interviews will be immediately reported and investigated. Allegation of ComplianceThe facility alleges compliance with this plan on 11:59pm 04/07/2026. On 4/8/26 at 9:26 AM, the survey team began verification of the facility's removal plan. This verification process included observation of R14 for 1:1 supervision, interviews with multiple staff from various departments and units on education of abuse prevention and all elements of the removal plan, education on preventing, recognizing, and reporting abuse, specifically resident-to-resident altercations. and review of credible evidence binder order for 1:1 monitoring for increased supervision, care plan: I have behavior problems of becoming aggressive during care at times, audit of residents with behaviors and care plans updated to reflect behaviors, skin checks on all residents on the Memory Care Unit. The survey team was able to verify that the facility completed all elements of the removal plan as of 4/8/26 at 1:51 PM. Once the immediate jeopardy was removed, the scope and severity were reduced to a level two, pattern. No further information was provided. (1) This information was obtained from the following nurse drug reference book: [NAME] Nursing Drug Handbook 2016, Kizior, [NAME], J., [NAME], page 81.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to implement their abuse policies to prevent abuse by one resident, Resident #14, for four of eighteen residents in the survey sample. (Resident #17, # 16, #15, #2)Findings include:A review of the facility's policies: Resident Rights and Abuse Prevention Policy and Policy Manual 2001, MED-PASS, Inc; Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, reads in part: All reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Resident Rights and Abuse Prevention Policy and Policy Manual, 2001, MED-PASS, Inc; reads in part; Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.Facility-Oriented Approach to SafetyOur facility-oriented approach to safety addresses risks for groups of residents.Safety risk and environmental hazards are identified on an on-going basis through a combination of employee training, employee monitoring, and reporting processes; QAPI (Quality Assurance and Improvement Program) committee reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization.When accident hazards are identified, the QAPI/safety committee shall evaluate and analyze the cause/s of the hazards and develop strategies to mitigate or remove the hazards to the extent possible.Employees shall be trained on potential hazards and demonstrate competency on how to identify and report accidents hazards, and try to prevent avoidable accidents.The QAPI committee and staff shall monitor interventions to mitigate accident hazards in the facility and modify as necessary.Individualized, Resident-Centered Approach to SafetyOur individualized, resident-centered approach to safety addresses safety and accident hazards for individualized residents.The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents.The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision.Implementing interventions to reduce accident risks and hazards shall include the following: communication to all relevant staff, assigning responsibility for carrying out interventions, providing training, ensuring the interventions are implemented and documenting interventions.Monitoring the effectiveness of interventions shall include the following: ensuring that interventions are implemented correctly and consistently, evaluating the effectiveness of interventions, modifying or replacing interventions as needed, and evaluating the effectiveness of new and revised interventions.Systems Approach to SafetyThe facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly.Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards to the environment. The type and frequency of the resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as a change in the resident's condition).1.For Resident #17 (R17), the facility staff failed to prevent abuse from Resident #14 (R14) during a physical altercation on 3/20/24 where after R17 slapped R14, R14 pushed R17 to the floor.R17 was admitted to the facility 10/16/23 with diagnoses to include but not limited to Lewy body dementia with agitation, hereditary idiopathic neuropathy, frontotemporal neurocognitive disorder, type 2 diabetes mellitus, major depressive disorder, bipolar disorder, generalized anxiety disorder, muscle wasting, and tremors. R17's Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) 3/22/24 (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coded her a 03/15 in Section C. Cognitive Patterns, Brief Interview for Mental Status indicating severe cognitive impairment (suggesting significant difficulties with short-term memory and orientation). R14 was admitted to the facility 2/6/24 with diagnosis to include but not limited to vascular dementia with psychotic disturbance, anxiety, rheumatoid arthritis left hip, insomnia, restlessness and agitation, and major depressive disorder. R14's most recent MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 10/1/25 coded R14 as 03/15 on the BIMS (Brief Interview of Mental Status) indicating severe cognitive impairment with skills of memory, thinking and orientation to place and timeA review of the facility's final synopsis for event dated 3/20/24 involving R17 and R14 revealed, in part: On 3/20/24, staff reported R17 slapped R14 and R14 pushed R17 to the floor. Residents were immediately separated and assessed for any injuries. Skin and pain assessments were done on both parties following the incident.A review of witness statements from staff revealed the following:Certified Nursing Assistant #3 (C.N.A.#3) stated it was somewhere between 6:30-6:45 PM, she was assisting another resident heard screaming and a hard fall, st5ated she did not observe the altercation but that R17 told her R14 pushed her down.C.N.A.#2 stated she was in the dining room, heard a scream coming from the third hallway and rushed to the area, noting R17 on the floor next to the food cart, R14 standing up next to the food cart. She stated when the residents were asked what happened both responded saying R17 slapped R14 and then he pushed her to the floor.Per LPN#5, he was alerted to the altercation between R17 and R14 by the activity staff and immediately responded to investigate the situation, R17 had returned to her room and upon assessment R17 had a bump on the top/back of her head.C.N.A. #4 stated she heard a scream and responded noting R17 on the floor and notified the charge nurse.A review of R17's progress note dated 3/20/24 by LPN#5 revealed in part: Resident had an altercation with another resident. There was no witness. Skin check was conducted to assess the bump on the back of her head, two centimeters tall and one inch wide. Pain evaluation completed with R17 denying pain or headache. Resident vital signs are within normal limits with blood pressure 134/77, temperature 97.6 temporal, heart rate 86, respirations 19, oxygen at 94% on room air. The physician was notified of the incident and advised to initiate neuro checks. Every 15-minute monitoring was implemented.2. For Resident #16 (R16), the facility staff failed to prevent abuse from Resident #14 on 12/18/24 when he was observed in R16's bed, R16 was cognitively unable to consent to the male in her bed.R16 was admitted [DATE] with diagnoses to include but not limited to dementia with agitation, major depressive disorder, psychotic disorder with delusions, hallucinations and adult failure to thrive. R16's Minimum Data Set assessment (MDS) with Assessment Reference Date (ARD) 1/9/24 coded her a 99 for Brief Interview for Mental Assessment as R16 not able to complete assessment on cognition.A review of the facility's final synopsis of incident dated 12/18/24 revealed, in part: R16 was noted to be in her bed with her entire body covered including her head with covers resting with R14 laying on top of the covers fully clothed in the same bed. Skin and pain evaluations were completed and no injuries were noted. Neither resident was able to recall the incident, and no evidence of abuse was substantiated. A review of witness statements from staff revealed the following:A review of C.N.A#5's witness statement revealed, CNA#2 informed her that R14 was in R16's room and she went to assist CNA#2 with re-directing R14 out of R16's room. According to CNA #5, she had laid R14 down in his room around 9:00 PM after already getting him from trying to go into R16's room and made sure he was laying down in his own bed. According to C.N.A#2, she overheard nurse tell R14 to exit R16's bed and stated as she was completing her rounds at approximately 10:15 PM, she observed R16's brief undone and her buttocks exposed. A review of R16's clinical record revealed the following progress note dated 12/18/24 at 11:03 PM: Male resident (R14) was observed in R16's bed. R14 was fully clothed and female resident (R16) was fully covered with blankets. The Certified Nursing Assistant (C.N.A #2) pulled the covers back and the female residents brief was deviated to the right side with the buttocks exposed.3. For Resident #15 (R15), the facility staff failed to prevent abuse from Resident #14 on 1/22/25 during a physical altercation between R15 and R14, (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resulting in a laceration to R15's lip.R15 was admitted [DATE] with diagnoses to include but not limited to abdominal aortic aneurysm, ruptured, Alzheimer's dementia with agitation, major depressive disorder, and anxiety. R15's Minimum Data Set assessment (MDS) with Assessment Reference Date (ARD) 1/2/25 coded him 06/15 on the Brief Interview for Mental Assessment, indicating severe cognitive impairment with skills such as memory, thinking and orientation to place and time.A review of the facility's final synopsis of incident dated 1/22/25 revealed, in part: Upon investigation it was reported that R15 wandered into R14's room and called him a racial slur, then R14 hit R15. Neither resident sustained any injuries. Both residents tolerating meals and medications well. A review of witness statements from staff revealed the following:According to LPN#6, she observed R15 exiting R14's room holding a bloody rag on his mouth, saying that (n-word) hit me in my mouth.Per witness statement from C.N.A.#6, R15 was observed at the double doors with his mouth bleeding at approximately 12:30 AM and that R15 said that (n-word) hit me in my mouth.A review of clinical record revealed progress note dated 1/22/2025 at 1:00 AM, Resident was involved in an altercation with another resident. Small cut noted to lower lip right side.A review of the Interim Skin Check evaluation dated 1/22/25 revealed Head to Toe Skin Check and Evaluation, Skin Condition and Integrity Findings, 1a. Are there any skin impairments noted? YES. 1b. Is this a new skin impairment? YES. 1c. Type of Skin Impairment, Laceration.4. For Resident #2 (R2), the facility staff failed to prevent physical abuse from Resident #14 on 12/30/25, which resulted in harm and hospitalization.R2 was admitted to the facility on [DATE] with diagnoses to include but not limited to dementia without behavioral disturbance, post-traumatic stress disorder, scoliosis, anxiety, psychosis, depression, fibromyalgia, chronic pain syndrome, and long-term use of anticoagulants for treatment of deep vein thrombosis. R2's Minimum Data Set assessment (MDS) with Assessment Reference Date (ARD) 10/13/25 coded her a 07/15 on the Brief Interview for Mental Assessment, indicating severe cognitive impairment with skills of memory, thinking and orientation to place and time.A review of the facility's final synopsis of event dated 12/30/25 revealed, in part: Staff alleges R14 struck R2 in her left eye causing bruising, head to toe skin and pain assessments completed on both residents. Statements obtained from staff reported that another resident had informed them that R2 and R14 were fighting. Upon entering R2's room they observed R14 standing in front of R2 and each resident struggling over R2's reacher/grabber tool, residents were immediately separated. R2 stated to staff that R14 hit her in her left eye. Skin assessment completed on R2 noting swelling and bruising to her left eye. She denied pain and discomfort. R14 was immediately escorted out of R2's room and placed on every 15-minute checks. Skin evaluation was negative for injury to R14.A review of nurse progress note dated 12/30/25 at 9:45 PM read in part, Writer was charting at the nurses' station, and a resident came to call me and said they are fighting. I rushed to the 3rd hall, and I saw R2 and R14 in front of her room pushing and pulling on a reacher/grabber stick. I separated them. R2 stated that he came to my room and I tried to ask him to leave and he hit me in my left eye. Swelling and bruising noted around R2's left eye. R2's responsible party, physician and the Director of Nursing were notified of the incident. Neuro checks were initiated.A review of Interim Skin Check evaluation dated 12/30/25 at 8:30 PM revealed Head to Toe Skin Check and Evaluation, Skin Condition and Integrity Findings, 1a. Are there any skin impairments noted? YES, 1b. Is this a new skin impairment? YES, 1c. Type of Skin Impairment, Bruise.A review of physician note dated 12/31/25 at 10:07 AM read in part, Patient (R2) recently was involved in an altercation where her orbit was injured. She became more lethargic and her vitals showed temperature 102 degrees Fahrenheit, heart rate 126, blood pressure 224/115, and oxygen saturation in the 50s before rising to 97% on 4L Venti mask (re-breathing mask). Due to risk of deterioration she (R2) was sent to the ED (local hospital emergency department).A review of nurse progress note dated 12/31/25 at 11:45 AM read in part, Writer (LPN#3) informed by charge nurse the resident breathing was abnormal and resident was unresponsive. Writer entered room and resident noted to be lying in bed heavily breathing but not responding to name or sternal rub. Vital signs taken and abnormal, blood pressure 244/119, heart rate 126, respirations 20, oxygen saturation 53% on room (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	air. Physician notified. Oxygen was increased to 15 liters on a non-rebreather, with oxygen saturation up to 96%. R2 was still not responding. The physician was -notified again and with an order to send to the emergency room for further evaluation. Writer called and spoke to responsible party, R2's sister in-law. EMS (Emergency Medical Services) notified and R2 transferred to (name redacted) hospital. A review of R2's clinical record for physician orders revealed an order for a blood thinner by mouth two times a day for the prevention of recurring deep vein thrombosis. According to [NAME] Drug Handbook 2016, blood thinners increases risk for bleeding and hemorrhagic events, and may cause serious, potentially fatal, bleeding of the following sites: intracranial [within the skull], intraocular [within the eye]). (1).On 4/7/26 at 7:36 AM, an interview was conducted with C.N.A.#2 regarding the altercation between R2 and R14. According to C.N.A.#2, she usually works the day shift but had picked up an extra shift. She stated she and LPN#10 went to R2's room upon notification of the resident-to-resident fighting. She said she observed R2 and R14 pulling and pushing R2's reacher/grabber stick. R2's left eye was red and swollen. She said they removed R14 from R2's room and both residents were placed on every 15-minute safety checks and no further problems from either one of them that she was aware of the rest of the 3-11 PM shift. On 4/7/26 at 7:40 AM, an interview was conducted with LPN#4. According to LPN#4, the Unit Manager, LPN#3 was helping her out the morning of 12/31/25 as it was so busy. She said LPN#3 was taking care of R2 mostly. She stated she had made her rounds on the morning of 12/30/25 and noticed that R2's eye was swollen terrible, swollen shut, and had a purplish reddish bruising around the left eye. She wasn't responding as much as usual. Later the certified nursing assistant told us she wasn't eating her breakfast then we knew something wasn't right. LPN#3 called the doctor. R2 ?s condition kept getting worse. Her blood pressure and pulse were getting higher and her breathing was labored. She was showing a drastic change, and the doctor told us to send her out.On 4/7/26 at 8:10 AM, an interview was conducted with LPN #3, the Unit Manager on the Memory Care Unit. According to LPN#3 she was notified of the altercation between R2 and R14 on 12/30/25 and came into facility. She stated she called the police and stayed at the facility until the police arrived. She stated R2 was at the nurse's station in her wheelchair watching TV when the police arrived and R14 was in his room. She stated the police did not stay long, they observed R2 and R14, left his card and then exited the facility stating not much he could do when it involved people who were cognitively impaired. She stated she cared for R2 on the morning of 12/31/25 and that R2 was noted not to be eating her breakfast which was out of the norm for her. Shortly after that nurse reported to her that R2's vital signs and mental status began to deteriorate. According to her, she contacted the Director of Respiratory for a non-rebreather mask and the Director of Respiratory and Director of the Dialysis Program arrived on-site to assist her in providing emergency care to R2 with applying the non-rebreather mask and communicating changes in resident condition to the physician via phone while she called 911 after physician gave order to transfer to out for evaluation and treatment. She stated R2 did not return to the facility but that her family had come in a few days later and retrieved her personal belongings. She stated she did not know why R2 did not come back to the facility.On 4/7/26 at 8:41 AM, a telephone interview was conducted with R2's responsible party, her sister-in-law who stated that the physician at the hospital had told her R2 suffered a significant brain bleed from being hit in the eye and being on a blood thinner. She said the hospital doctor told her R2 passed away at 2:00 AM on 1/1/26. On 4/7/26 at 9:45 AM, the Social Services Assistant was interviewed on what constituted abuse. When the Social Services Assistant was asked is resident-to-resident physical altercations or a male resident observed in bed with a female that is not consensual would constitute abuse, she replied, Absolutely, abuse can be physical, mental, sexual or financial, and it is our responsibility to protect them and they should be able to feel safe here, but the Memory Care Unit does present with lots of challenging behaviors.On 4/7/26 at 4:00 PM, an interview was conducted with the DON (Director of Nursing). When asked about what constituted resident abuse, the DON stated, Abuse comes in different forms, it can be physical, emotional, verbal, financial or sexual. When asked is it the residents' right to be (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	free from abuse, the DON responded, Of course, it is their right to be free from abuse and to feel safe in our care. All of these incidents of abuse occurred on the facility's Memory Care Unit and were perpetrated by the same resident, Resident #14 (R14)R14 remains a current resident of the facility and is permitted to ambulate throughout the unit and have direct access to other residents. Therefore. creating an imminent risk to other residents.On 4/6/2026 between 12:00 PM-1:00 PM, Resident #14 was observed ambulating independently on the Memory Care Unit in the hallways and in the common areas. He was observed in shorts and a long sleeve T-shirt constantly rubbing his arms as he wandered about unit.On 4/6/2026 at approximately 3:00 PM, Resident #14 was observed wandering the hallways and the common area of Memory Care Unit.On 4/7/26 a review of R14's clinical record post the 12/30/25 incident revealed the following: Nurse progress note dated 1/3/2026 revealed R14 observed in a female's room attempting to get into bed with her, clothes on and brief was still on. Resident was given re-direction, to which R14 attempted to fight against and swing at staff. R14 made grabbing motions at staff and attempted to hit staff.Psychiatrist Nurse Practitioner progress note dated 1/5/26 read in part, Facility staff requested consultation related to escalating behavioral disturbances. Facility staff report increasing aggressive and inappropriate behaviors. According to the staff, R14 became verbally aggressive when staff attempted to obtain his weight, refused redirection, and became tense and competitive. Staff further report that the resident entered a female resident's room and attempted to get into bed with her while clothed and wearing a brief. When redirected, the R14 became physically aggressive, making grabbing motions, swinging at staff, and attempting to strike them. R14 poses risks to staff and peers due to aggressive and sexually inappropriate behaviors. Upon assessment, the R14 has significant behavioral disturbances characterized by aggression, poor impulse control, and sexually inappropriate behavior. Presentation is consistent with behavioral symptoms likely related to underlying neurocognitive disorder. Current behaviors place R14 and others at risk Treatment Plan/Recommendations: 1. Discontinue anti-depressant used to treat depression due to concern for activating effects contributing to agitation, aggression, and behavioral dysregulation. Discontinuation is part of behavioral symptom management to reduce stimulation and impulsivity. Monitor for improvement in agitation, aggression, and intrusive behaviors following discontinuation. Monitor for emergence or worsening of depressive symptoms. Continue non-pharmacological interventions including consistent redirection, calm approach, and environmental modifications. Ensure close supervision to reduce risk to staff and peers. Continue to assess risks to harm himself or others. Staff to utilize de-escalation techniques and document behavioral incidents.Nurse progress note dated 1/5/26 read in part, R14 no longer on one-one supervision per physician's order.On 4/9/2026 at 11:13 AM, the Administrator, Director of Nursing, Assistant Director of Nursing, Regional [NAME] President of Operations, Clinical Consultant, Regional Director of Clinical Services and were made aware of the concern. No further information was provided prior to exit. No further information was provided.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to implement their abuse policy for timely reporting of the final five-day investigative summary to appropriate agencies for one of eighteen residents in the survey sample, Resident #2. Findings include:For Resident #2 (R2), the facility staff failed to implement their abuse policy regarding the timing of reporting the final 5-day investigative summary of abuse to the state survey agency. On 4/7/26 during a review of the facility's synopsis event dated 12/30/25 involving R2 and R14 , it was noted that the final 5-day investigation was not submitted successfully to the state agency until 1/14/26.A review of the facility's final synopsis of incident dated 12/30/25 revealed, in part: Staff alleges R14 struck R2 in her left eye causing bruising, head to toe skin and pain assessments completed on both residents. Statements obtained from staff reported that another resident had informed them that R2 and R14 were fighting. Upon entering R2's room they observed R14 standing in front of R2 and each resident struggling over R2's reacher/grabber tool, residents were immediately separated. R2 stated to staff that R14 hit her in her left eye. Skin assessment completed on R2 noting swelling and bruising to her left eye. She denied pain and discomfort. R14 was immediately escorted out of R2's room and placed on every 15-minute checks. Skin evaluation was negative for injury to R14.A review of the clinical record revealed:Nurse progress note dated 12/30/25 at 9:45 PM read in part, Writer was charting at the nurses' station, and a resident came to call me and said they are fighting. I rushed to the 3rd hall, and I saw R2 and R14 in front of her room pushing and pulling on a reacher/grabber stick. I separated them. R2 stated that he came to my room and I tried to ask him to leave and he hit me in my left eye. Swelling and bruising noted around R2's left eye. R2's responsible party, physician and the Director of Nursing were notified of the incident. Neuro checks were initiated.Physician note dated 12/31/25 at 10:07 AM read in part, Patient (R2) recently was involved in an altercation where her orbit was injured. She became more lethargic and her vitals showed temperature 102 degrees Fahrenheit, heart rate 126, blood pressure 224/115, and oxygen saturation in the 50s before rising to 97% on 4L Venti mask (re-breathing mask). Due to risk of deterioration she (R2) was sent to the ED (local hospital emergency department).Nurse progress note dated 12/31/25 at 11:45 AM read in part, Writer (LPN#3) informed by charge nurse the resident breathing was abnormal and resident was unresponsive. Writer entered room and resident noted to be lying in bed heavily breathing but not responding to name or sternal rub. Vital signs taken and abnormal, blood pressure 244/119, heart rate 126, respirations 20, oxygen saturation 53% on room air. Physician notified. Oxygen was increased to 15 liters on a non-rebreather, with oxygen saturation up to 96%. R2 was still not responding. The physician was -notified again with an order to send to the emergency room for further evaluation. Writer called and spoke to responsible party, R2's sister in-law. EMS (Emergency Medical Services) notified and R2 transferred to (name redacted) hospital. On 4/7/26 at 8:41 AM, a telephone interview was conducted with R2's responsible party, her sister-in-law who stated that the physician at the hospital had told her R2 suffered a significant brain bleed from being hit in the eye and being on a blood thinner. She stated R2 passed away at 2:00 AM on 1/1/26.R14 was admitted to the facility 2/6/24 with diagnosis to include but not limited to vascular dementia with psychotic disturbance, anxiety, insomnia, restlessness and agitation, and major depressive disorder. R14's most recent MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 10/1/25 coded R14 as 03/15 on the BIMS (Brief Interview of Mental Status) indicating severe cognitive impairment with skills of memory, thinking and orientation to place and timeAccording to the fax confirmation sheets for the incident summary, it showed the facility submitted the initial report of the incident to the state survey agency, adult protective services, and the ombudsman on 12/30/25 at 10:12 PM. Further review of fax confirmation sheets revealed the facility submitted the final 5-day investigative summary to the adult protective services 1/7/26 at 5:15 PM and the ombudsmen at 5:19 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM. The fax confirmation sheet showed the final 5-day investigative summary submittal dated 1/7/26 at 5:26 PM to the state survey agency failed.No evidence the facility attempted to re-submit the final investigative summary on business days 1/8/26 or 1/9/26.The fax confirmation sheet showed the final 5-day investigative summary submittal on 1/12/26 at 3:23 PM to the state survey agency failed. No evidence the facility attempted to re-submit the final investigative summary on business day 1/13/26. According to the Administrator, she called the state survey agency supervisor on 1/14/26 and spoke to her about not being able to successfully transmit the final investigative summary and received guidance on how to transmit. A review of an email from state agency IT services support dated 1/14/26 at 1:57 PM confirmed state survey agency's receipt of the final 5-day investigative summary for the event occurring on 12/30/25.A review of the facility policy, Resident Rights and abuse Prevention Policy and Policy Manual, titled, Abuse, Neglect, Exploitation or Misappropriation, 2001 - Reporting and Investigating read in part: All reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Reporting Allegations to the Administrator and Authorities - 3. Immediately is defined as: a, within two hours of an allegation involving abuse or result in serious bodily injury, or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Follow-Up Report - 1. Within five (5) business days of the incident, the Administrator will provide a follow-up investigation. 4. The resident and/or resident representative are notified of the outcome immediately upon conclusion of the investigation.According to the clinical record, R2 was transferred to the emergency department on 12/31/25 and did not return to the facility. No evidence in the clinical record or facility synopsis file of resident or the resident representative notification of the outcome of the investigation of the incident 12/30/25 involving R2 and R14.On 4/8/2026 at approximately 4:10 PM, the Administrator and Director of Nursing were made aware of the concern. No further information was provided prior to exit.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on clinical record review and staff interview, it was determined that the facility staff failed to maintain an accurate minimum data set (MDS) assessment for one of 18 residents in the survey sample, Resident #13. The findings include:For Resident #13 (R13), the facility staff failed to code the quarterly MDS assessment with an assessment reference date (ARD) of 2/12/2026 for pressure injuries (1) present during the assessment period. Review of the clinical record for R13 revealed the most recent MDS assessment to be a quarterly MDS with an ARD of 2/12/2026. Section M0100 of the assessment documented the resident having a pressure injury however Section M0210 and M0300 failed to document whether the resident had unhealed pressure injuries and the current number of unhealed pressure injuries at each stage. The physician orders for R13 documented in part, - SACRUM- Cleanse with wound cleanser apply Calcium Alginate with silver and cover with bordered dressing Qday (every day) and PRN (as needed) one time a day. Order Date: 01/29/2026.- LEFT EAR- Cleanse with wound cleanser apply Manuka HD and cover with bordered dressing Qday and PRN one time a day. Order Date: 01/29/2026. The electronic treatment administration record for R13 documented treatments completed to the sacrum and left ear from 2/1/2026-2/28/2026 as ordered. The comprehensive care plan for R13 documented in part, The resident has a pressure ulcer or has the potential for pressure ulcer development r/t (related to) impaired mobility, incontinence, diabetes. Date Initiated: 10/21/2025. On 4/7/2026 at 1:28 PM, an interview was conducted with licensed practical nurse (LPN) #1, MDS coordinator. LPN #1 stated that she used the RAI (resident assessment instrument) manual as a guide when completing the MDS assessments. She stated that the lookback period for Section M was 7 days and she used the wound care documentation, nursing notes, and evaluations to determine if a resident had a current pressure injury or wounds. LPN #1 stated that R13's quarterly MDS with the ARD of 2/12/2026 should have the pressure injuries documented on it and it should not be left incomplete. According to the RAI Manual, Version 1.20.1, dated October 2025, section M0210: Unhealed Pressure Ulcers/Injuries documented in the Coding Instructions, . Code 1, yes: if the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage . On 4/8/2026 at approximately 3:58 PM, the administrator and director of nursing were made aware of the concern. No further information was provided prior to exit. Reference: (1) Pressure sores are areas of damaged skin caused by staying in one position for too long . This information was obtained from the website: Pressure Sores | Bedsores | Pressure Ulcers | MedlinePlus

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for two of 18 residents in the survey sample, Resident #8 and Resident #14. The findings include:1. For Resident #8 (R8), the facility staff failed to implement the comprehensive care plan to A) provide a Breath Call (1) adaptive call bell and B) provide ADL (activities of daily living) care. R8 was admitted to the facility with diagnoses that included but were not limited to quadriplegia (2) and chronic respiratory failure (3). On the most recent minimum data set (MDS), a quarterly assessment with an assessment reference date (ARD) of 1/17/2026, the resident was assessed as being severely impaired for making daily decisions. Section GG coded R8 being dependent on staff for all ADL (activities of daily living) care. It further documented R8 receiving oxygen, tracheostomy (4) care, tube feeding, pressure injury (5) care and suctioning while at the facility. The comprehensive care plan for R8 documented in part, I have an ADL Self Care Performance Deficit r/t (related to) cerebral infarct (6), muscle wasting, metabolic encephalopathy, respiratory failure, quadriplegia. Date Initiated: 07/10/2025. Under Interventions/Tasks it documented in part, .Be sure Breathcall arm is within reach, and provide reminders to use call for assistance as needed. Breathcall arm in place of traditional button call light due to patient's lack of mobility. Date Initiated: 07/10/2025 . Provide skin inspection daily during care. Observe for redness, open areas, scratches, cuts, bruises, etc., Report abnormal findings to Physician and document in Nurse's Notes. Date Initiated: 07/10/2025 . BATHING: I am dependent on staff for bathing. Date Initiated: 07/10/2025 . A) On 4/6/2026 at approximately 2:10 PM, an observation was made of R8 lying in bed in their room. A handheld call bell with a finger press button on the end was observed clipped to the blanket near R8's chest. No Breath call was observed. Additional observations of R8 were made on 4/7/2026 at 9:01 AM and 4/7/2026 at 12:08 PM. The handheld call bell remained in place clipped to the bed linens. No Breath call was observed. On 4/7/2026 at 12:51 PM, an interview was conducted with the director of specialty care who stated that they assess the mobility of the residents arm, the range of motion, strength and coordination of the fingers when determining the type of call bell that the resident was given. She stated that they had a few options that they could use and they put in a work order for maintenance, and they changed the call bells out right away to an adaptive call bell when requested. The director stated that she was not sure what type of call bell R8 had used in their previous room but had recently switched rooms and she would have to investigate it further. She stated that the purpose of the care plan was to be a roadmap for staff to provide individualized care and it should be implemented because it guides the staff on how to properly care for the resident and to be aware of any issues and risks. On 4/8/2026 at 12:38 PM, an interview was conducted with the director of nursing (DON) who stated that the interdisciplinary team decided what type of call bell was required for the resident and at times therapy made recommendations. She stated that if the resident changed rooms the adaptive call bell followed the resident to the new room. The DON stated that the purpose of the care plan was to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	direct the care of the resident for the entire team and address the specific needs of the resident. She stated that the care plan should be implemented to ensure the entire team was on board for the residents' needs. Review of the census for R8 documented a room change on 3/27/2026. B) The ADL documentation for R8 dated 3/1-3/31/2026 documented baths completed by staff from 3/19/2026-3/22/2026 with scheduled shower/bath completed on 3/19/2026. It further documented upper body dressing completed on day and evening shift 3/19/2026-3/22/2026. Review of the electronic medication administration record (eMAR) dated 3/1/26-3/31/26 documented in part, Insert Midline (7) one time only until 03/16/2026. Start Date: 03/16/2026. Insert peripheral IV (intravenous) for ABT (antibiotic) one time only for IV ABT for 1 Day. Start Date: 03/18/2026. The eMAR further documented R8 receiving the first dose of intravenous antibiotics on 3/18/2026 at 9:00 AM. The progress notes for R8 documented in part, - 03/16/2026 11:50 (AM) Late entry . At approximately 2100 (9:00 PM), MD was notified of no improvement in BP (blood pressure). Writer received a new order for a STAT (now) ammonia level, and UA/ C&S (urinalysis with culture and sensitivity), Midline placement, one-time order of Cefepime 1 gm IM (intramuscular) and Solu-Medrol 125 mg IM. Medication administered as ordered. Pt continues to be closely monitored for new or worsening symptoms. - 03/18/2026 11:09 (AM) Date of Service: 3/18/2026. Visit Type : HP SKIN AND WOUND NOTE . Reason for visit: subsequent encounter for skin and wound care metronidazole Intravenous Solution 500 MG/100ML three times a day . - 03/19/2026 07:57 (AM) Note Text : Resident continues on IV/ABT (intravenous antibiotics) for elevated WBCs (white blood cells), no adverse reactions noted, IV site noted with no signs of infection or infiltration, resident noted with no signs or symptoms of distress noted, will continue plan of care, lab to be in today to obtain CBC/CMP (complete blood count/comprehensive metabolic panel). - 03/23/2026 12:13 (PM) Situation : The Change in Condition/s reported on this CIC Evaluation are/were: Skin wound or ulcer . - 03/23/2026 13:30 (1:30 PM) .Skin Issue: #002: New skin Issue. Location: Left antecubital space. Issue type: Pressure ulcer/injury. Progress: New: new wound. Wound acquired in-house. Length (cm): 20 Width (cm): 4 Depth (cm): 0.1. - 03/23/2026 18:36 (6:36 PM) Note Text: AT 1130 (AM) RN (registered nurse) WAS ALERTED TO A TOURNIQUET ON PTS LEFT BICEP/AC (antecubital) AREA BY THE CNA (certified nursing assistant) WHO WAS WASHING HIM. RN REMOVED THE TOURNIQUET AND SKIN UNDERNEATH WAS DAMAGED DISCOLORED AND BLISTERED. UNIT MANAGER MADE AWARE. MD MADE AWARE. WOUND NURSE MADE AWARE. LEFT HAND ELEVATED. WILL MONITOR LUE (left upper extremity). On 4/7/2026 at 12:51 PM, an interview was conducted with the director of specialty care (DSC). She stated that the nurse had received an order to insert a peripheral IV on 3/18/2026 and she had been (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	able to place the line successfully on the right side and the pharmacy had a team that came to the facility to place midline IVs but had placed another peripheral line in the left arm. The DSC stated that the CNA working on 3/23/2026 had reported to the nurse that there was a tourniquet left on R8's left upper arm that she found when bathing the resident. She stated that the nurse had immediately called her to assess and they had notified the director of nursing, wound nurse and the physician. The DSC stated that the expectation was for the CNA staff to bath residents daily and to change their gowns daily. She stated that when she spoke with the CNA she was told that they could not find a clean gown, and she would still expect bathing to occur and the CNA to leave the unit to find a clean gown. She stated that the purpose of the care plan was to be a roadmap for staff to provide individualized care and it should be implemented because it guides the staff on how to properly care for the resident and to be aware of any issues and risks. On 4/7/2026 at 1:16 PM, an interview was conducted with CNA #1 who stated that ADL was provided every morning which included a full bed bath or shower. She stated that the resident was either dressed in their personal clothing or a gown depending on their preference and medical needs. CNA #1 stated that there were times when she ran out of linens and they had to go get them from the laundry or another floor until they were delivered from the laundry. On 4/8/2026 at 11:40 AM, an interview was conducted with CNA #7 who stated that she worked with R8 on 3/21-3/22/2026 and she had heard about the wound found on 3/23/2026. She stated that she had only given R8 a washup over the weekend because they did not have any more gowns to put on the resident. CNA #7 stated that she did not take R8's gown off because it was not soiled and she did not have a replacement for it and she felt very guilty for not changing it. She stated that if she had taken the gown off she may have seen the tourniquet on the arm and caught it earlier. The facility policy Care Plans, Comprehensive Person-Centered revised March 2022 documented in part, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . On 4/8/2026 at approximately 3:58 PM, the administrator and director of nursing were made aware of the concern. No further information was provided prior to exit. Reference: (1) The Breath Call is a pneumatic (air-activated) nurse call cord that works with virtually any nurse call system. Breath Call is for patients with little to no motor skills and is activated by simply breathing into a disposable straw and filter assembly . This information was obtained from the website: Breath Call (BreathCall) Nurse Call Cord – [NAME] Precision Products (2) Paralysis of the arms and legs is quadriplegia . This information was obtained from the website: Paralysis | Hemiplegia | MedlinePlus (3) Respiratory failure is a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide. Sometimes you can have both problems . This information was obtained from the website: Respiratory Failure | Lung Disease | Lung Problems | MedlinePlus (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Rehabilitation and Healthcare Center	1776 Cambridge Drive Richmond, VA 23238

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(4) A tracheostomy is surgery to create a hole in your neck that goes into your windpipe . This information was obtained from the website: Tracheostomy care: MedlinePlus Medical Encyclopedia (5) Pressure sores are areas of damaged skin caused by staying in one position for too long . This information was obtained from the website: Pressure Sores | Bedsores | Pressure Ulcers | MedlinePlus (6) A stroke occurs when blood flow to a part of the brain stops. A stroke is sometimes called a brain attack. This information was obtained from the website: Stroke: MedlinePlus Medical Encyclopedia (7) A Midline Catheter is a thin, flexible tube placed into a vein in the arm. The catheter is 8-10 centimeters long and can stay in the arm for up to 29 days. This allows patients to get IV (intravenous) medicines and have blood samples drawn. The catheter is placed by a trained nurse . This information was obtained from the website: A Midline Intravascular Catheter | Patients & Families | UW Health 2. For Resident #14, the facility staff failed to implement the comprehensive care plan to ensure he was dressed in multiple layers of clothing due to his cold nature. R14 was admitted to the facility 2/6/24 with diagnosis to include but not limited to vascular dementia with psychotic disturbance, anxiety, rheumatoid arthritis left hip, iron deficiency anemia, insomnia, restlessness and agitation, and major depressive disorder. R14's most recent MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 10/1/25 coded R14 as 03/15 on the BIMS (Brief Interview of Mental Status) indicating severe cognitive impairment with skills of memory, thinking and orientation to place and time. Section GG coded R14 requiring substantial/maximal assistant on staff for all ADL (activities of daily living) care. R14's comprehensive care plan contained a care plan focus, I have a behavior problem related to sexual ideations. roaming in rooms and taking other peoples' belongings, misplacing own belongings around the units, wearing multiple layers of clothes that don't belong to me including women's apparel, defecating on the floor Date. Under Interventions/Tasks it documented in part, Make sure to layer resident in multiple layers of his clothes due to the resident's cold nature. Date Initiated: 12/19/20. On 4/6/26 from 12:00 PM to 1:00 PM, R14 was observed ambulating independently on the memory care unit down the hallways and in the common area dressed in shorts and a long sleeve shirt. He was rubbing his arms and making mumbling noises. On 4/6/26 at 2:58 PM, observed R14 again ambulating randomly around the memory care unit down the halls and in the common area. He was still rubbing his arms and making mumbling noises. On 4/7/26 at 5:20 PM, an interview was conducted with LPN#10 on why R14 had on shorts when his care plan indicated to make sure to layer resident in multiple layers of clothes due to his being cold natured, LPN#10 responded, I was not aware that was on his care plan, he usually tells us when he is cold. An interview was completed with the Unit Manager for the Memory Care Unit (LPN#3) on the purpose of the resident care plan. According to Unit Manager LPN#3, the purpose of the care plan is to provide staff with guidelines on the resident's needs and how to address them. We update them whenever the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident has a change in condition such as a fall, infection or behaviors. On 4/9/2026 at 11:13 AM, the Administrator, Director of Nursing, Assistant Director of Nursing, Regional [NAME] President of Operations, Clinical Consultant, Regional Director of Clinical Services and were made aware of the concern. No further information was provided prior to exit.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide ADL (activities of daily living) care for dependent residents to one of 18 residents in the resident sample, Resident #8. The findings include:For Resident #8 (R8), the facility staff failed to provide adequate ADL care to include bathing and dressing between 3/19/2026-3/22/2026. R8 was admitted to the facility with diagnoses that included but were not limited to quadriplegia (1), chronic respiratory failure (2) and pressure ulcer (3) of sacral region. On the most recent minimum data set (MDS), a quarterly assessment with an assessment reference date (ARD) of 1/17/2026, the resident was assessed as being severely impaired for making daily decisions. Section GG coded R8 being dependent on staff for all ADL (activities of daily living) care. It further documented R8 receiving oxygen, tracheostomy (4) care, tube feeding, and suctioning while at the facility. R8 was assessed as having one Stage 3 pressure injury and one Stage 4 pressure injury. The ADL documentation for R8 dated 3/1-3/31/2026 documented baths completed by staff from 3/19/2026-3/22/2026 with scheduled shower/bath completed on 3/19/2026. It further documented upper body dressing completed on day and evening shift 3/19/2026-3/22/2026. Review of the electronic medication administration record (eMAR) dated 3/1/26-3/31/26 documented in part, Insert Midline (6) one time only until 03/16/2026. Start Date: 03/16/2026. Insert peripheral IV (intravenous) for ABT (antibiotic) one time only for IV ABT for 1 Day. Start Date: 03/18/2026. The eMAR further documented R8 receiving the first dose of intravenous antibiotics on 3/18/2026 at 9:00 AM. The progress notes for R8 documented in part,- 03/16/2026 11:50 (AM) Late entry . At approximately 2100 (9:00 PM), MD was notified of no improvement in BP (blood pressure). Writer received a new order for a STAT (now) ammonia level, and UA/ C&S (urinalysis with culture and sensitivity), Midline placement, one-time order of Cefepime 1 gm IM (intramuscular) and Solu-Medrol 125 mg IM. Medication administered as ordered. Pt continues to be closely monitored for new or worsening symptoms.- 03/18/2026 11:09 (AM) Date of Service: 3/18/2026. Visit Type : HP SKIN AND WOUND NOTE . Reason for visit: subsequent encounter for skin and wound care metronidazole Intravenous Solution 500 MG/100ML three times a day .- 03/19/2026 07:57 (AM) Note Text : Resident continues on IV/ABT (intravenous antibiotics) for elevated WBCs (white blood cells), no adverse reactions noted, IV site noted with no signs of infection or infiltration, resident noted with no signs or symptoms of distress noted, will continue plan of care, lab to be in today to obtain CBC/CMP (complete blood count/comprehensive metabolic panel).- 03/23/2026 12:13 (PM) Situation : The Change in Condition/s reported on this CIC Evaluation are/were: Skin wound or ulcer .- 03/23/2026 13:30 (1:30 PM) .Skin Issue: #002: New skin Issue. Location: Left antecubital space. Issue type: Pressure ulcer/injury. Progress: New: new wound. Wound acquired in-house. Length (cm): 20 Width (cm): 4 Depth (cm): 0.1.- 03/23/2026 18:36 (6:36 PM) Note Text: AT 1130 (AM) RN (registered nurse) WAS ALERTED TO A TOURNIQUET ON PTS LEFT BICEP/AC (antecubital) AREA BY THE CNA (certified nursing assistant) WHO WAS WASHING HIM. RN REMOVED THE TOURNIQUET AND SKIN UNDERNEATH WAS DAMAGED DISCOLORED AND BLISTERED. UNIT MANAGER MADE AWARE. MD MADE AWARE. WOUND NURSE MADE AWARE. LEFT HAND ELEVATED. WILL MONITOR LUE (left upper extremity). The comprehensive care plan for R8 documented in part, I have an ADL Self Care Performance Deficit r/t (related to) cerebral infarct (5), muscle wasting, metabolic encephalopathy, respiratory failure, quadriplegia. Date Initiated: 07/10/2025. Under Interventions/Tasks it documented in part, Provide skin inspection daily during care. Observe for redness, open areas, scratches, cuts, bruises, etc., Report abnormal findings to Physician and document in Nurse's Notes. Date Initiated: 07/10/2025 . BATHING: I am dependent on staff for bathing. Date Initiated: 07/10/2025 . On 4/7/2026 at 12:51 PM, an interview was conducted with the director of specialty care (DSC). She stated that the nurse had received an order to insert a peripheral IV on 3/18/2026 and she had been able to place the line successfully on the right side and the pharmacy had a team that came to the facility to place (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	midline IVs but had placed another peripheral line in the left arm. The DSC stated that the CNA working on 3/23/2026 had reported to the nurse that there was a tourniquet left on R8's left upper arm that she found when bathing the resident. She stated that the nurse had immediately called her to assess and they had notified the director of nursing, wound nurse and the physician. The DSC stated that the expectation was for the CNA staff to bath residents daily and to change their gowns daily. She stated that when she spoke with the CNA she was told that they could not find a clean gown, and she would still expect bathing to occur and the CNA to leave the unit to find a clean gown. On 4/7/2026 at 1:16 PM, an interview was conducted with CNA #1 who stated that ADL was provided every morning which included a full bed bath or shower. She stated that the resident was either dressed in their personal clothing or a gown depending on their preference and medical needs. CNA #1 stated that there were times when she ran out of linens and they had to go get them from the laundry or another floor until they were delivered from the laundry. On 4/8/2026 at 11:40 AM, an interview was conducted with CNA #7 who stated that she worked with R8 on 3/21-3/22/2026 and she had heard about the wound found on 3/23/2026. She stated that she had only given R8 a washup over the weekend because they did not have any more gowns to put on the resident. CNA #7 stated that she did not take R8's gown off because it was not soiled and she did not have a replacement for it and she felt very guilty for not changing it. She stated that if she had taken the gown off she may have seen the tourniquet on the arm and caught it earlier. On 4/8/2026 at 12:38 PM, an interview was conducted with the director of nursing who stated that she had been called to assess R8's left upper arm on 3/23/2026 when the CNA found the tourniquet in place. She stated that they had investigated and found that R8 had two IV's placed, one in the right arm by facility staff and one in the left arm by the pharmacy IV team on 3/18/2026. The DON stated that when she went into R8's room on 3/23/2026 the tourniquet had been removed and there was a wound to the left upper bicep with no drainage. She stated that they asked R8 if they were having any pain and they shook their head no and the wound nurse came and assessed the wound and got an order for a treatment, and the physician and responsible party were notified. She stated that this wound was preventable and if staff were bathing and changing R8's gown they should have seen the tourniquet in place. On 4/8/2026 at 2:54 PM, an interview was conducted with the account manager of housekeeping and laundry who stated that laundry was staffed from 7:00 AM through 8:00 PM each day. She stated that each unit received a cart with 50 gowns each shift. Observations conducted revealed gowns stocked on each unit and in laundry storage. The facility policy Activities of Daily Living (ADL), Supporting revised April 2025 documented in part, .Appropriate care and services are provided for residents who are unable to carry out ADLs independently with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with: a: hygiene (bathing, dressing, grooming, and oral care) . On 4/8/2026 at approximately 3:58 PM, the administrator and director of nursing were made aware of the concern. No further information was provided prior to exit. Reference:(1) Paralysis of the arms and legs is quadriplegia . This information was obtained from the website: Paralysis | Hemiplegia | MedlinePlus(2) Respiratory failure is a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide. Sometimes you can have both problems . This information was obtained from the website: Respiratory Failure | Lung Disease | Lung Problems | MedlinePlus(3) Pressure sores are areas of damaged skin caused by staying in one position for too long . This information was obtained from the website: Pressure Sores | Bedsores | Pressure Ulcers | MedlinePlus(4) A tracheostomy is surgery to create a hole in your neck that goes into your windpipe . This information was obtained from the website: Tracheostomy care: MedlinePlus Medical Encyclopedia(5) A stroke occurs when blood flow to a part of the brain stops. A stroke is sometimes called a brain attack. This information was obtained from the website: Stroke: MedlinePlus Medical Encyclopedia(6) A Midline Catheter is a thin, flexible tube placed into a vein in the arm. The catheter is 8-10 centimeters long and can stay in the arm for up to 29 days. This allows patients to get IV (intravenous) medicines and have blood samples drawn. The catheter is placed by a trained nurse . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This information was obtained from the website: A Midline Intravascular Catheter | Patients & Families | UW Health

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide the necessary care and services, consistent with professional standards of practice, to prevent a pressure injury for one of 18 residents in the survey sample, Resident #8. A tourniquet was left in place on Resident #8's left upper arm for an extended period causing an unstageable pressure injury, resulting in harm cited at past non-compliance. The findings include:Resident #8 (R8) was admitted to the facility with diagnoses that included but were not limited to quadriplegia (1), chronic respiratory failure (2) and pressure ulcer of sacral region. On the most recent minimum data set (MDS), a quarterly assessment with an assessment reference date (ARD) of 1/17/2026, the resident was assessed as being severely impaired for making daily decisions. Section GG coded R8 being dependent on staff for all ADL (activities of daily living) care. It further documented R8 receiving oxygen, tracheostomy (3) care, tube feeding, and suctioning while at the facility. R8 was assessed as having one Stage 3 pressure injury (4) and one Stage 4 pressure injury. On 4/7/2026 at 9:01 AM, an observation was made of licensed practical nurse (LPN) #2, wound nurse, performing wound care to R8's pressure injuries. LPN #2 was observed providing treatment per the physician orders to a sacral pressure injury and a pressure injury on the left upper arm. The pressure injury on the left upper arm was observed to encircle the circumference of the upper arm with a larger area on the posterior of the upper arm. When asked the origin of the wound, LPN #2 stated that they were told that it was from a tourniquet. Review of the electronic medication administration record (eMAR) dated 3/1/26-3/31/26 documented in part, - Insert Midline (5) one time only until 03/16/2026. Start Date: 03/16/2026. - Insert peripheral IV (intravenous) for ABT (antibiotic) one time only for IV ABT for 1 Day. Start Date: 03/18/2026. The eMAR further documented R8 receiving the first dose of intravenous antibiotics on 3/18/2026 at 9:00 AM. The progress notes for R8 documented in part,- 03/16/2026 11:50 (AM) Late entry . At approximately 2100 (9:00 PM), MD was notified of no improvement in BP (blood pressure). Writer received a new order for a STAT (now) ammonia level, and UA/ C&S (urinalysis with culture and sensitivity), Midline placement, one-time order of Cefepime 1 gm IM (intramuscular) and Solu-Medrol 125 mg IM. Medication administered as ordered. Pt continues to be closely monitored for new or worsening symptoms.- 03/18/2026 11:09 (AM) Date of Service: 3/18/2026. Visit Type: HP SKIN AND WOUND NOTE . Reason for visit: subsequent encounter for skin and wound care metronidazole Intravenous Solution 500 MG/100ML three times a day .- 03/19/2026 07:57 (AM) Note Text : Resident continues on IV/ABT (intravenous antibiotics) for elevated WBCs (white blood cells), no adverse reactions noted, IV site noted with no signs of infection or infiltration, resident noted with no signs or symptoms of distress noted, will continue plan of care, lab to be in today to obtain CBC/CMP (complete blood count/comprehensive metabolic panel).- 03/23/2026 12:13 (PM) Situation : The Change in Condition/s reported on this CIC Evaluation are/were: Skin wound or ulcer .- 03/23/2026 13:30 (1:30 PM) .Skin Issue: #002: New skin Issue. Location: Left antecubital space. Issue type: Pressure ulcer/injury. Progress: New: new wound. Wound acquired in-house. Length (cm): 20 Width (cm): 4 Depth (cm): 0.1.- 03/23/2026 18:36 (6:36 PM) Note Text: AT 1130 (AM) RN (registered nurse) WAS ALERTED TO A TOURNIQUET ON PTS LEFT BICEP/AC (antecubital) AREA BY THE CNA (certified nursing assistant) WHO WAS WASHING HIM. RN REMOVED THE TOURNIQUET AND SKIN UNDERNEATH WAS DAMAGED DISCOLORED AND BLISTERED. UNIT MANAGER MADE AWARE. MD MADE AWARE. WOUND NURSE MADE AWARE. LEFT HAND ELEVATED. WILL MONITOR LUE (left upper extremity). A change in condition evaluation for R8 dated 3/23/2026 documented in part, The change in condition, symptoms or signs I am calling about is/are: skin wound or ulcer . Describe skin changes: Blister, contusion . Left antecubital: medical device associated contusion with blistering . The evaluation documented notification of the physician and responsible party. The wound nurse practitioner assessment for R8 dated 3/25/2026 documented in part, . Location: Left upper arm; Etiology: Pressure ulcer/injury; Stage/Severity: Unstageable; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Acquired in House: Yes; Date Wound Acquired: 03/25/2026; Wound Status: New; 70% epithelial; 10% granulation; 20% slough; 0% eschar . The wound nurse practitioner assessment for R8 dated 4/1/2026 documented in part, . Location: Left upper arm; Etiology: Pressure ulcer/injury; Stage/Severity: Stage 3; Acquired in House: Yes; Date Wound Acquired: 03/25/2026; Wound Status: Improving without complications; 90% epithelial; 10% granulation; 0% slough; 0% eschar . The comprehensive care plan for R8 documented in part, I have an ADL (activities of daily living) Self Care Performance Deficit r/t (related to) cerebral infarct (5), muscle wasting, metabolic encephalopathy, respiratory failure, quadriplegia. Date Initiated: 07/10/2025. The care plan further documented, The resident has a pressure ulcer or has the potential for pressure ulcer development r/t history of pressure ulcers, immobility, Sacrum wound, Left arm AC wound. Date Initiated: 07/23/2025. On 4/7/2026 at 11:36 AM, an interview was conducted with the wound nurse practitioner (NP) who stated that they followed R8's wounds at the facility weekly. She stated that she was seeing R8 prior to the wound on the left upper arm and was alerted to assess the new wound on her rounds 3/25/2026. The NP stated that she was told that the wound on R8's left upper arm was from a tourniquet that was left in place. She stated that the pressure injury was first assessed as unstageable due to slough obscuring the wound bed on 3/25/2026 and then when she assessed it the second time on 4/1/2026 it was assessed as a Stage 3. The NP stated that the pressure injury has continued to improve and has gotten smaller. She stated that a tourniquet should be short term, and she could not say how long it would have to be in place to create a pressure injury as it would depend on the person. On 4/7/2026 at 12:30 PM, an interview was conducted with licensed practical nurse (LPN) #2, wound nurse, who stated that he was alerted when staff discovered the pressure injury on R8's left upper arm and he assessed the wound and obtained a treatment order from the physician. He stated that he was not sure of when the tourniquet was placed, and he was only told that it was a wound from when they were trying to start an IV for antibiotics. On 4/7/2026 at 12:51 PM, an interview was conducted with the director of specialty care (DSC). She stated that the nurse had received an order to insert a peripheral IV on 3/18/2026 which they had placed in the right arm. She stated that the pharmacy IV team had also come to the facility to a place a midline IV but were not able to and had placed a second peripheral IV in the left arm. The DSC stated that the CNA working on 3/23/2026 had reported to the nurse that there was a tourniquet left on R8's left upper arm that she found when bathing the resident. She stated that the nurse had immediately called her to assess and they had notified the director of nursing, wound nurse and the physician. The DSC stated that there was a little swelling, mild redness and a wound that went around the circumference of the arm. She described the wound as having red edges with a dark purple top and a mild blister on the backside of the arm. The DSC stated that R8 denied any pain, and she did not think that the resident was aware of it due to their diagnoses. She stated that the director of nursing had investigated and completed education for the staff. On 4/8/2026 at 11:40 AM, an interview was conducted with certified nursing assistant (CNA) #7 who stated that she worked with R8 on 3/21-3/22/2026 and she had heard about the wound found on 3/23/2026. She stated that she had only given R8 a washup over the weekend because they did not have any more gowns to put on the resident. CNA #7 stated that she did not take R8's gown off because it was not soiled and she did not have a replacement for it and she felt very guilty for not changing it. She stated that if she had taken the gown off she may have seen the tourniquet on the arm and caught it earlier. On 4/8/2026 at 11:55 AM, an interview was conducted with registered nurse (RN) #2 who stated that she was working on 3/23/2026 when the CNA came to get her to look at R8's left upper arm. She stated that when she went into the room the CNA had loosened the tourniquet from R8's arm but it was still around the arm and there was a #20gauge IV in the forearm dated 3/18. RN #2 described R8's left arm as more swollen that the right, reddened, denuded with blisters on the front and a large blister on the back of the arm. She stated that she apologized to R8 because they understood even if they were not verbal. RN #2 stated that she thanked the CNA for reporting it and got the unit manager who brought the director of nursing. She stated that they advised her on the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	documentation that needed to be done and reporting process. RN #2 stated that they elevated the arm on a pillow and the wound nurse came over to assess the wound, the physician and the responsible party were notified and a treatment was put into place. On 4/8/2026 at 12:38 PM, an interview was conducted with the director of nursing who stated that she had been called to assess R8's left upper arm on 3/23/2026 when the CNA found the tourniquet in place. She stated that they had investigated and found that R8 had two IV's placed, one in the right arm by facility staff and one in the left arm by the pharmacy IV team on 3/18/2026. She stated that R8 had blood work drawn on 3/19/2026 by the lab in the left hand and they had verified with the phlebotomist that they had placed their tourniquet below the IV in the left arm to draw the blood from the left hand. The DON stated that they had been trying to get the documentation from the pharmacy on the left arm IV placement but had not gotten anything at that time. The DON stated that when she went into R8's room on 3/23/2026 the tourniquet had been removed and there was a wound to the left upper bicep with no drainage. She stated that they asked R8 if they were having any pain and they shook their head no and the wound nurse came and assessed the wound and got an order for a treatment, and the physician and responsible party were notified. She stated that this wound was preventable and if staff were bathing and changing R8's gown they should have seen the tourniquet in place. The DON stated that she had completed a plan of correction and would bring in the credible evidence for review. On 4/8/26 at 12:55 PM, the director of nursing presented a five-point plan of correction (POC) titled Plan of Correction-F686 - Treatment/Services to Prevent and Heal Pressure Ulcers. The POC documented the following: 1. Corrective Action for Affected Resident. The resident identified as having an unstageable pressure ulcer to the arm related to a tourniquet being left in place following IV initiation received immediate intervention. The tourniquet was immediately removed upon discovery.The physician and responsible party were notified.A full wound assessment was completed, and treatment orders were initiated.Wound care services were consulted, and appropriate interventions were implemented.The resident's care plan was updated to reflect the pressure injury, including monitoring and treatment protocols.The resident continues to be monitored for healing and any complications. 2. Identification of Other Residents at Risk. All residents receiving IV therapy are at risk for device-related pressure injuries have potential to be affected. A facility-wide audit of all current residents with IV access was conducted to ensure no tourniquet or constrictive devices were in place.Skin assessments were completed for residents receiving IV therapy to identify any signs of pressure or injury.No additional residents were identified with similar concerns. 3. Systemic Changes to Prevent Recurrence. The facility has implemented the following systemic changes: Re-education of all licensed nursing staff on proper IV initiation procedures, including: Immediate removal of tourniquet after venipuncture.Post-procedure assessment of the extremity.Implementation of a standardized IV initiation checklist requiring:Verification that the tourniquet has been removed.Documentation of site condition and circulation.Increased supervisory oversight by nursing leadership during IV starts. 4. Monitoring Plan. To ensure ongoing compliance, the facility will implement the following monitoring: The Director of Nursing (DON), Unit Managers, or designee will conduct:Weekly audits of IV starts for 4 weeks.Monthly audits thereafter for 2 months.Audits will include:Verification that tourniquets are removed.Documentation compliance.Assessment of the IV site and surrounding skin.Any identified issues will be addressed immediately with corrective action, including re-education and counseling as needed.Audit results will be reviewed in the facility's QAPI (quality assurance, performance improvement) program for ongoing evaluation and performance improvement. 5. Date of Compliance. The facility alleges compliance with F686 on 3/30/2626 (sic) following completion of staff education, and implementation of monitoring systems. This issue has been incorporated into the facility's Quality Assurance and Performance Improvement (QAPI) program. Data from audits will be trended and analyzed to ensure sustained compliance. Additional interventions will be implemented as needed based on findings. Included in the POC binder was a QAPI summary dated 3/26/2026 documenting a review of the incident and the POC plan by the DON and QAPI committee, a timeline for R8 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	documenting the IV's placed on 3/18/2026, lab drawn on 3/19/2026, 3/20-3/23/2026 no further lab work drawn, 3/23/2026 the tourniquet found during Adl care with removal, notification of the physician, wound care nurse and treatment put into place. The binder further documented an in-service training record dated 3/25/2026 presented by the DON with the education title of IV Insertion/Lab Draws: All residents must have their skin inspected by the primary nurse after each attempt of drawing blood and after IV insertions to ensure that the tourniquet has been properly removed. The sign-in record documented 88 CNA's, LPN's, and RN's educated on the topic. Weekly audits of residents having labs drawn and IV's inserted were reviewed from 3/27/26, 3/31/26, 4/4/26, 4/6/26, lists of facility pressure injuries dated February 2026 and March 2026 with initial stage, onset date and location, current stage, status and status date and witness statements from the nurse who inserted the IV on 3/18/26, staff working with R8 on 3/20-3/22/26, and the CNA who discovered the tourniquet on 3/23/26. The education of staff on proper lab draw/IV initiation procedures including removal of the tourniquet, assessment of the extremity and use of the post procedure checklist was verified by direct interview with multiple licensed nursing staff members. The other points of the plan of correction as described in this writing were verified with facility document review, observation, clinical record review and staff interview. No concerns were identified. Verification was completed of implementation of the plan of correction and facility compliance date of 3/30/2026. On 4/8/2026 at approximately 3:58 PM, the administrator and director of nursing were made aware of the concern for harm cited at past non-compliance. No further information was provided prior to exit. PAST NONCOMPLIANCE Reference:(1) Paralysis of the arms and legs is quadriplegia . This information was obtained from the website: Paralysis | Hemiplegia | MedlinePlus(2) Respiratory failure is a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide. Sometimes you can have both problems . This information was obtained from the website: Respiratory Failure | Lung Disease | Lung Problems | MedlinePlus(3) A tracheostomy is surgery to create a hole in your neck that goes into your windpipe . This information was obtained from the website: Tracheostomy care: MedlinePlus Medical Encyclopedia(4) A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin . Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white (blanch) when pressed. This is a sign that a pressure ulcer may be forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater or ulcer. The tissue below the skin is damaged. You may be able to see body fat in the ulcer. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. There are two other types of pressure sores that don't fit into the stages. Sores covered in dead skin that is yellow, tan, green, or brown. The dead skin makes it hard to tell how deep the sore is. This type of sore is unstageable. Pressure sores that develop in the tissue deep below the skin. This is called a deep tissue injury. The area may be dark purple or maroon. There may be a blood-filled blister under the skin. This type of skin injury can quickly become a stage III or IV pressure sore . This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm(5) A Midline Catheter is a thin, flexible tube placed into a vein in the arm. The catheter is 8-10 centimeters long and can stay in the arm for up to 29 days. This allows patients to get IV (intravenous) medicines and have blood samples drawn. The catheter is placed by a trained nurse . This information was obtained from the website: A Midline Intravascular Catheter | Patients & Families | UW Health (6) A stroke occurs when blood flow to a part of the brain stops. A stroke is sometimes called a brain attack. This information was obtained from the website: Stroke: MedlinePlus Medical Encyclopedia

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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, staff interviews, clinical record review and facility document review, the facility staff failed to provide adequate supervision in an accident and hazard free environment to protect residents' safety and failed to provide adequate supervision of a resident with known aggressive behaviors (Resident #14) which resulted in altercations with four other residents in a survey sample of 18 residents. Residents #17, #16, #15, and #2, resulting in the identification of immediate jeopardy, substandard quality of care and harm for Resident #2. The findings include:1.For Resident #17 (R17), the facility staff failed to provide adequate supervision from Resident #14 (R14) on 3/20/24 from entering her room and resulting in physical altercation between the two residents. R17 was admitted to the facility 10/16/23 with diagnoses to include but not limited to Lewy body dementia with agitation, hereditary idiopathic neuropathy, frontotemporal neurocognitive disorder, type 2 diabetes mellitus, major depressive disorder, bipolar disorder, generalized anxiety disorder, muscle wasting, and tremors. R17's Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) 3/22/24 coded her a 03/15 in Section C. Cognitive Patterns, Brief Interview for Mental Status indicating severe cognitive impairment (suggesting significant difficulties with short-term memory and orientation). R14 was admitted to the facility 2/6/24 with diagnosis to include but not limited to vascular dementia with psychotic disturbance, anxiety, rheumatoid arthritis left hip, insomnia, restlessness and agitation, and major depressive disorder. R14's most recent MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 10/1/25 coded R14 as 03/15 on the BIMS (Brief Interview of Mental Status) indicating severe cognitive impairment with skills of memory, thinking and orientation to place and time.A review of the facility's final synopsis dated 3/20/24 involving R17 and R14 revealed, in part: On 3/20/24, staff reported R17 slapped R14 and R14 pushed R17 to the floor. Residents were immediately separated and assessed for any injuries. Skin and pain assessments were done on both parties following the incident.A review of witness statements from staff revealed the following:Certified Nursing Assistant #3 (C.N.A.#3) stated it was somewhere between 6:30-6:45 PM, she was assisting another resident heard screaming and a hard fall, stated she did not observe the altercation but that R17 told her R14 pushed her down.C.N.A. #2 stated she was in the dining room, heard a scream coming from the third hallway and rushed to the area, noting R17 on the floor next to the food cart, R14 standing up next to the food cart. She stated when the residents were asked what happened both responded saying R17 slapped R14 and then he pushed her to the floor.Per LPN#5, he was alerted to the altercation between R17 and R14 by the activity staff and immediately responded to investigate the situation, R17 had returned to her room and upon assessment R17 had a bump on the top/back of her head.C.N.A. #4 stated she heard a scream and responded noting R17 on the floor and notified the charge nurse.A review of R17's progress note dated 3/20/24 by LPN#5 revealed in part: Resident had an altercation with another resident. There was no witness. Skin check was conducted to assess the bump on the back of her head, two centimeters tall and one inch wide. Pain evaluation completed with R17 denying pain or headache. Resident vital signs are within normal limits with blood pressure 134/77, temperature 97.6 temporal, heart rate 86, respirations 19, oxygen at 94% on room air. The physician was notified of the incident and advised to initiate neuro checks. Every 15-minute monitoring was implemented.On 4/9/24, R17 was evaluated by Psychiatrist Nurse Practitioner, every 15-minute safety check was discontinued due to no behaviors noted since 3/20/24, adjustment was made to medication prescribed to treat her mood disorder.A review of R17's comprehensive care plan dated 3/21/24 revealed revision to include care plan focus psychosocial well-being problem r/t alleged physical altercation.On 4/9/24, the Unit Manager requested the Psychiatrist Nurse Practitioner to re-evaluate R14 for possible discontinuation of every 15-minute safety checks. According to the evaluation by the Psychiatrist Nurse Practitioner, R14 had (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	not had any altercations with co-residents since 3/20/24, therefore every 15-minute safety check was discontinued with adjustments were made to R14's medication to manage R14's mood and mood fluctuations. A review of R14's care plan revealed a care plan focus: I have a psychosocial well-being problem related to alleged physical abuse incident, Date Initiated: 03/21/2024 with intervention of Allow me time to answer questions and to verbalize feelings, perceptions, and fears. Date Initiated: 03/21/2024. The care plan revision does not reflect potential aggressive behaviors. R14 had an additional care plan focus I am at actual /potential risk of wandering related to cognitive impairment, dementia dated 8/1/24 which included interventions of Engage me in group activities to decrease wandering, Evaluate presence of pain, monitor behaviors, monitor side effects of medications, photograph in elopement book, psych consult and treat as indicated, date initiated 2/6/24. 2. For Resident #16 (R16), the facility staff failed to provide adequate supervision from Resident #14 climbing into her bed on 12/18/24.R16 was admitted [DATE] with diagnoses to include but not limited to dementia with agitation, major depressive disorder, psychotic disorder with delusions, hallucinations and adult failure to thrive. R16's Minimum Data Set assessment (MDS) with Assessment Reference Date (ARD) 1/9/24 coded her a 99 for Brief Interview for Mental Assessment as R16 not able to complete assessment on cognition.A review of the facility's final synopsis of incident dated 12/18/24 revealed, in part: R16 was noted to be in her bed with her entire body covered including her head with covers resting with R14 laying on top of the covers fully clothed in the same bed. Skin and pain evaluations were completed and no injuries were noted. Neither resident was able to recall the incident, and no evidence of abuse was substantiated. A review of witness statements from staff revealed the following:A review of C.N.A#5's witness statement revealed, CNA#2 informed her that R14 was in R16's room and she went to assist CNA#2 with re-directing R14 out of R16's room. According to CNA #5, she had laid R14 down in his room around 9:00 PM after already getting him from trying to go into R16's room and made sure he was laying down in his own bed. According to C.N.A#2, she overheard nurse tell R14 to exit R16's bed and stated as she was completing her rounds at approximately 10:15 PM, she observed R16's brief undone and her buttocks exposed. An interview was conducted with C.N.A. #2 on 4/8/26 and she stated she had not witnessed R14 in R16's bed, only heard the nurse tell R14 to get out of R16's room. C.N.A #2 stated shortly after that she completed her rounds and observed R16's brief undone and her buttocks exposed.A review of R16's clinical record revealed the following progress note dated 12/18/24 at 11:03 PM: Male resident (R14) was observed in R16's bed. R14 was fully clothed and female resident (R16) was fully covered with blankets. The Certified Nursing Assistant (C.N.A #2) pulled the covers back and the female residents brief was deviated to the right side with the buttocks exposed.A review of R14's care plan revealed a care plan focus dated 7/9/24, I have a behavior problem related to: -Sexual ideations, -Roaming in rooms and taking other people belongings -I misplace my own belongings around the units, -I wear multiple layers of clothes that don't belong to me including women's apparel, -Defecating on the floor with interventions to include: Administer medications as ordered. Monitor/document for side effects and effectiveness. Assist the resident to develop more appropriate methods of coping and interacting. Encourage the resident to express feelings appropriately. Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner, divert attention. Remove from situation and take to alternative location as needed. On 12/19/24 an additional intervention was added to the care plan: Make sure to layer resident in multiple layers of his clothes due to the resident's cold nature. R14 had additional care plan focus as noted previously for I am at actual /potential risk of wandering related to cognitive impairment, dementia dated 8/1/24 which included interventions of Engage me in group activities to decrease wandering, Evaluate presence of pain, monitor behaviors, monitor side effects of medications, photograph in elopement book, psych consult and treat as indicated, date initiated 2/6/24. Redirect during wandering episodes of confusion and prevent him from entering other resident's room when he cannot find his own room date initiated 8/1/24Per the Facility Reported Incident Final Summary, it revealed the facility was (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	aware of R14's history of wandering into other resident's rooms and was transitioned from every 15-miniute checks to 1:1 supervision thru 4/7/25 at which time the psych nurse practitioner assessed him and recommended Patient Q15min (every 15-minute) checks discontinued after assessment. Staff will continue to monitor. 3. For Resident #15 (R15), the facility staff failed to provide adequate supervision of resident entering R14's room resulting in a physical altercation between the two residents on 1/22/25.R15 was admitted [DATE] with diagnoses to include but not limited to abdominal aortic aneurysm, ruptured, Alzheimer's dementia with agitation, major depressive disorder, and anxiety. R15's Minimum Data Set assessment (MDS) with Assessment Reference Date (ARD) 1/2/25 coded him 06/15 on the Brief Interview for Mental Assessment, indicating severe cognitive impairment with skills such as memory, thinking and orientation to place and time.A review of the facility's final synopsis of incident dated 1/22/25 revealed, in part: Upon investigation it was reported that R15 wandered into R14's room and called him a racial slur, then R14 hit R15. Neither resident sustained any injuries. Both residents tolerating meals and medications well. A review of witness statements from staff revealed the following:According to LPN#6, she observed R15 exiting R14's room holding a bloody rag on his mouth, saying that (n-word) hit me in my mouth.Per witness statement from C.N.A.#6, R15 was observed at the double doors with his mouth bleeding at approximately 12:30 AM and that R15 said that (n-word) hit me in my mouth.A review of clinical record revealed progress note dated 1/22/2025 at 1:00 AM, Resident was involved in an altercation with another resident. Small cut noted to lower lip right side.A review of the Interim Skin Check evaluation dated 1/22/25 revealed Head to Toe Skin Check and Evaluation, Skin Condition and Integrity Findings, 1a. Are there any skin impairments noted? YES. 1b. Is this a new skin impairment? YES. 1c. Type of Skin Impairment, Laceration.According to R14 psych nurse practitioner progress notes dated 4/7/25, Q15-minute checks were discontinued. R14 had been on 1:1 then transitioned to Q15-minute checks from incident 12/18/24 through 4/7/25. R14 was on Q15-minute checks when this incident occurred.A review of R14's care plan revealed interventions to include Monitor behaviors, Assist resident to develop more appropriate methods of coping and interacting. Encourage the resident to express feelings appropriately. Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner, divert attention. Remove from situation and take to alternative location as needed. R14's care plan was reviewed/revised on 1/22/25 on the care plan focus of I have a psychosocial well-being problem r/t alleged physical abuse incident to include intervention of Administer medications as ordered, such as antidepressants, anti-anxiety, sedative/hypnotics, and antipsychotics. Monitor for side effects or adverse reactions. Report to physician or designee as indicated. Date Initiated: 01/22/2025. 4. For Resident #2 (R2), the facility staff failed to provide adequate supervision from Resident #14 on 12/30/25 which resulted in harm and hospitalization.R2 was admitted to the facility on [DATE] with diagnoses to include but not limited to dementia without behavioral disturbance, post-traumatic stress disorder, scoliosis, anxiety, psychosis, depression, fibromyalgia, chronic pain syndrome, and long-term use of anticoagulants for treatment of deep vein thrombosis. R2's Minimum Data Set assessment (MDS) with Assessment Reference Date (ARD) 10/13/25 coded her a 07/15 on the Brief Interview for Mental Assessment, indicating severe cognitive impairment with skills of memory, thinking and orientation to place and time.A review of the facility's final synopsis of event dated 12/30/25 revealed, in part: Staff alleges R14 struck R2 in her left eye causing bruising, head to toe skin and pain assessments completed on both residents. Statements obtained from staff reported that another resident had informed them that R2 and R14 were fighting. Upon entering R2's room they observed R14 standing in front of R2 and each resident struggling over R2's reacher/grabber tool, residents were immediately separated. R2 stated to staff that R14 hit her in her left eye. Skin assessment completed on R2 noting swelling and bruising to her left eye. She denied pain and discomfort. R14 was immediately escorted out of R2's room and placed on every 15-minute checks. Skin evaluation was negative for injury to R14.A review of nurse progress note dated 12/30/25 at 9:45 PM read in part, Writer was charting at the nurses' station, and a resident (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	came to call me and said they are fighting. I rushed to the 3rd hall, and I saw R2 and R14 in front of her room pushing and pulling on a reacher/grabber stick. I separated them. R2 stated that he came to my room and I tried to ask him to leave and he hit me in my left eye. Swelling and bruising noted around R2's left eye. R2's responsible party, physician and the Director of Nursing were notified of the incident. Neuro checks were initiated.A review of Interim Skin Check evaluation dated 12/30/25 at 8:30 PM revealed Head to Toe Skin Check and Evaluation, Skin Condition and Integrity Findings, 1a. Are there any skin impairments noted? YES, 1b. Is this a new skin impairment? YES, 1c. Type of Skin Impairment, Bruise.A review of One-on-One Check Observation Log initiated 12/30/25 through 12/31/25 for R2 revealed:10:00 PM Resident sitting in chair in her room11:00 PM Resident in wheelchair at nursing station12:00 AM Resident in wheelchair at nursing station1:00 AM through 7:00 AM Resident sleeping8:00 AM through 10:00 AM Resting in bed'A review of neurological checks completed by nurses initiated 12/30/25 through 12/31/25 assessed vital signs, pupil size and response, speech, response to name, pain, environment and seizure activity, headache and vomiting. A review of physician note dated 12/31/25 at 10:07 AM read in part, Patient (R2) recently was involved in an altercation where her orbit was injured. She became more lethargic and her vitals showed temperature 102 degrees Fahrenheit, heart rate 126, blood pressure 224/115, and oxygen saturation in the 50s before rising to 97% on 4L Venti mask (re-breathing mask). Due to risk of deterioration she (R2) was sent to the ED (local hospital emergency department).A review of nurse progress note dated 12/31/25 at 11:45 AM read in part, Writer (LPN#3) informed by charge nurse the resident breathing was abnormal and resident was unresponsive. Writer entered room and resident noted to be lying in bed heavily breathing but not responding to name or sternal rub. Vital signs taken and abnormal, blood pressure 244/119, heart rate 126, respirations 20, oxygen saturation 53% on room air. Physician notified. Oxygen was increased to 15 liters on a non-rebreather, with oxygen saturation up to 96%. R2 was still not responding. The physician was -notified again and with an order to send to the emergency room for further evaluation. Writer called and spoke to responsible party, R2's sister in-law. EMS (Emergency Medical Services) notified and R2 transferred to (name redacted) hospital. A review of R2's clinical record for physician orders revealed an order for Eliquis 5 milligrams by mouth two times a day for the prevention of recurring deep vein thrombosis. (Eliquis is a prescription blood thinner used to prevent and treat blood clots. Adverse Effects/Toxic Reactions may include but not limited to: increased risk for bleeding/hemorrhagic events. May cause serious, potentially fatal, bleeding of the following sites: intracranial (within the skull), intraocular (within the eye) (1).On 4/7/26 at 7:36 AM, an interview was conducted with C.N.A.#2 regarding the altercation between R2 and R14. According to C.N.A.#2, she usually works the day shift but had picked up an extra shift. She stated she and LPN#10 went to R2's room upon notification of the resident-to-resident fighting. She said she observed R2 and R14 pulling and pushing R2's reacher/grabber stick. R2's left eye was red and swollen. She said they removed R14 from R2's room and both residents were placed on every 15-minute safety checks and no further problems from either one of them that she was aware of the rest of the 3-11 PM shift. On 4/7/26 at 7:40 AM, an interview was conducted with LPN#4. According to LPN#4, the Unit Manager, LPN#3 was helping her out the morning of 12/31/26 as it was so busy. She said LPN#3 was taking care of R2 mostly. She stated she had made her rounds on the morning of 12/31/25 and noticed that R2's eye was swollen terrible, swollen shut, and had a purplish reddish bruising around the left eye. She wasn't responding as much as usual. Later the aide told us she wasn't eating her breakfast then we knew something wasn't right. LPN#3 called the doctor. R2 ?s condition kept getting worse. Her blood pressure and pulse were getting higher and her breathing was labored. She was showing a drastic change, and the doctor told us to send her out.On 4/7/26 at 8:10 AM, an interview was conducted with LPN #3, the Unit Manager on the Memory Care Unit. According to LPN#3 she was notified of the altercation between R2 and R14 on 12/30/25 and came into facility. She stated she called the police and stayed at the facility until the police arrived. She stated R2 was at the nurse's station in her wheelchair watching TV when the police arrived and R14 was in his room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	She stated the police did not stay long, they observed R2 and R14, left his card and then exited the facility stating not much he could do when it involved people who were cognitively impaired. She stated she cared for R2 on the morning of 12/31/25 and that R2 was noted not to be eating her breakfast which was out of the norm for her. Shortly after that nurse reported to her that R2's vital signs and mental status began to deteriorate. According to her, she contacted the Director of Respiratory for a non-rebreather mask and the Director of Respiratory and Director of the Dialysis Program arrived on-site to assist her in providing emergency care to R2 with applying the non-rebreather mask and communicating changes in resident condition to the physician via phone while she called 911 after physician gave order to transfer to out for evaluation and treatment. She stated R2 did not return to the facility but that her family had come in a few days later and retrieved her personal belongings. She stated she did not know why R2 did not come back to the facility.On 4/7/26 at 8:41 AM, a telephone interview was conducted with R2's responsible party, her sister-in-law who stated that the physician at the hospital had told her R2 suffered a significant brain bleed from being hit in the eye and being on a blood thinner. She said the hospital doctor told her R2 passed away at 2:00 AM on 1/1/26. On 4/7/26 at 9:05 AM, an interview was conducted with the Administrator regarding the altercation between R2 and R14. According to the Administrator, she was notified of the altercation and came into the facility on [DATE] and was present when the police arrived. When asked why the police were notified, she stated because it was a physical resident-to-resident altercation and R2 wanted the police to be notified. She stated she saw R2 in the wheelchair in the nurses' station and that she appeared to be okay and R14 was back in his room and staff had them both on every 15-minute safety checks. She stated she reported the incident to the appropriate authorities and then went home. When asked about the change in condition of R2 on 12/31/25 requiring transfer to the emergency room and why she had not returned to the facility she responded, I don't know why she did not come back. She stated the family came in a few days later and retrieved her belongings but when asked about R2's status they said she would not be returning to the facility and requested a copy of R2's medical records.On 4/7/26 at 9:40 AM an interview was conducted with the Director of Respiratory and Director of the Dialysis Program. According to the Director of Respiratory she had been notified by LPN# 3 for a non-rebreather mask. She said upon entering R2's room she noted resident was in crisis with labored breathing, unresponsive and critically high blood pressures and heart rate. According to the Director of the Dialysis Program, she noted R2's left eye was swollen shut with noticeable purplish black bruising and she and the Director of Respiratory stayed at the bedside and assisted nursing in communicating R2's condition with the physician via phone.On 4/7/26 at 9:45 AM, the Social Services Assistant (Other Staff Member #11) was interviewed. She stated she is responsible for following up with residents after any resident-to-resident altercation to evaluate their psychosocial needs. She stated that more times than not, when she follows up with the residents who reside in the Memory Care Unit, they are unable to recall the incident, but she attempts to ensure they are comfortable and feel safe. She stated she looks for nonverbal indicators or emotional distress/ anxiety as well as conducting follow-up interviews. When asked if resident-to-resident physical altercations or a male resident observed in bed with a female resident that is not consensual would constitute abuse, she responded, Absolutely, abuse can be physical, mental, sexual or financial, and it is our responsibility to protect them and they should be able to feel safe here, but the Memory Care Unit does present with lots of challenging behaviors.On 4/7/26 at 11:10 AM an interview was conducted with the Nurse Concierge (Other Staff Member #10). According to her it is her responsibility to follow up on residents who are sent out to emergency room the next day to see how they are doing and document her findings in the resident's chart and give an end-of-the-day report on all the calls to the Administrator.OSM#10 said she left a message for R2's sister-in-law but did not get a return call. When asked where the documentation for R2's follow-up call, she responded, In all honestly, it just didn't get into her chart. When asked why R2 did not return to the facility, she responded, I just don't know. On 4/7/26 at 1:05 PM, an interview was (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	conducted with the physician regarding R2's change in condition on 12/31/25. According to the physician, he said he was notified on the evening of 12/30/25 after the altercation between R2 and R14 and the nurse informed him that R2 had slight bruising and swelling in her left eye. He stated he asked the nurse if R2 had any changes in level of consciousness, mentation, headaches and vision and he stated the nurse reported none. He said the nurse said R2 was fine. He said the nurse reported vital signs and neurological checks were within normal limits and R2 was drinking fluids with no nausea or vomiting. When asked about R2 being on a blood thinner and getting hit in the eye, immediately resulting in some bruising and swelling would that not have prompted sending R2 to the emergency room for evaluation due to the high risk of bleeding, he responded, The assessment from the nurse did not present with symptoms that would result in sending her out to the emergency room, her vital signs and neuro checks were okay.On 4/7/26 at 2:10 PM, interviews were conducted with several licensed practical nurses on what is the likelihood of injury if a person is hit on the head and is on a blood thinner. According to LPN#11, she said people who are on blood thinners are more vulnerable to excess bleeding and bruising than people who are not on blood thinners. She further stated the type and severity of injury would depend on how hard a blow the hit and where on the head the person was hit. I would expect to see bruising, maybe hematomas or excessive bleeding, perhaps a nosebleed, and maybe internal bleeding, this could be very dangerous and life-threatening.According to LPN#4, she said, They could bleed out.Per LPN#5, he responded I would expect to see increased bruising, a hematoma, aneurysm, heavier bleeding than someone who is not on a blood thinner.According to LPN#12, she said she would expect increase in bleeding, perhaps from the nose or cuts or maybe in the brain. They could bleed out.According to LPN#9, she responded by saying, they may experience a stroke from internal bleeding, more bruising, seizures, hematomas. Blood thinners can be very dangerous if a resident falls and hits their head or they can have some bleeding inside the body that we don't see. They can bleed profusely from small cuts. On 4/7/26 at 4:00 PM, an interview was conducted with the DON (Director of Nursing) on her expectation of what a nurse should be assessing when completing neurological checks, she stated, mentation, pupillary response, level of consciousness, and responding appropriately to questions. When a person is hit in the eye head and is on a blood thinner what is the likelihood of an injury? The DON responded, That would be patient specific and how hard they were hit. When asked about R2 being hit by R14, with immediate swelling and bruising to the eye resulting in a significant change in condition and a transfer to the emergency department she stated she did not necessarily think R2's change in condition was solely as a result from the altercation with R14 on 12/30/25. When asked about what constituted resident abuse, the DON stated, Abuse comes in different forms, it can be physical, emotional, verbal, financial or sexual. When asked is it the residents' right to be free from abuse, the DON responded, Of course, it is their right to be free from abuse and to feel safe in our care. A review of the facility's policies on abuse read in part: Resident Rights and Abuse Prevention Policy and Policy Manual 2001, MED-PASS, Inc; Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, reads in part: All reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Resident Rights and Abuse Prevention Policy and Policy Manual, 2001, MED-PASS, Inc; Safety and Supervision of Residents, reads in part; Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.Individualized, Resident-Centered Approach to SafetyOur individualized, resident-centered approach to safety addresses safety and accident hazards for individualized residents.The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specifici accident hazards or risks for individual residents.The care team shall target interventions to reduce indivdual risks related to hazards in the envirnment, including adequate supervision.Implementing interventions to reduce (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	accident risks and hazards shall include the following: coomunication to all revelant staff, assigning responsibility for carrying out interventions, providing training, enxsuring the interventions are implemented and documenting interventions.Monitoring the effectiveness of interventions shall include the following: ensuring that interventions are implemented correctly and consistently, evaluating the effectiveness of interventions, modifying or replacing interventions as needed, and evaluating the effectiveness of new and revised interventions.Systems Approach to SafetyThe facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly.Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards to the environment. The type and frequency of the resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as a change in the resident's condition).All of these incidents of abuse occurred on the facility's Memory Care Unit and were perpetrated by the same resident, Resident #14 (R14)A review of nurse progress note dated 1/3/2026 revealed R14 observed in a female's room attempting to get into bed with her, clothes on and brief was still on. Resident was given re-direction, to which R14 attempted to fight against and swing at staff. R14 made grabbing motions at staff and attempted to hit staff.A review of Psychiatrist Nurse Practitioner progress note dated 1/5/26 read in part, Facility staff requested consultation related to escalating behavioral disturbances. Facility staff report increasing aggressive and inappropriate behaviors. According to the staff, R14 became verbally aggressive when staff attempted to obtain his weight, refused redirection, and became tense and competitive. Staff further report that the resident entered a female resident's room and attempted to get into bed with her while clothed and wearing a brief. When redirected, the R14 became physically aggressive, making grabbing motions, swinging at staff, and attempting to strike them. R14 poses risks to staff and peers due to aggressive and sexually inappropriate behaviors. Upon assessment, the R14 has significant behavioral disturbances characterized by aggression, poor impulse control, and sexually inappropriate behavior. Presentation is consistent with behavioral symptoms likely related to underlying neurocognitive disorder. Current behaviors place R14 and others at risk Treatment Plan/Recommendations: 1. Discontinue anti-depressant used to treat depression due to concern for activating effects contributing to agitation, aggression, and behavioral dysregulation. Discontinuation is part of behavioral symptom management to reduce stimulation and impulsivity. Monitor for improvement in agitation, aggression, and intrusive behaviors following discontinuation. Monitor for emergence or worsening of depressive symptoms. Continue non-pharmacological interventions including consistent redirection, calm approach, and environmental modifications. Ensure close supervision to reduce risk to staff and peers. Continue to assess risks to harm himself or others. Staff to utilize de-escalation techniques and document behavioral incidents.Review of nurse progress note dated 1/5/26 read in part, R14 no longer on 1:1 supervision per physician's order.R14 remains a current resident of the facility and is permitted to ambulate throughout the unit and have direct access to other residents, creating an imminent risk to other residents.On 4/6/2026 between 12:00 PM-1:00 PM, Resident #14 was observed ambulating independently on the Memory Care Unit in the hallways and in the common areas. He was observed in shorts [TRUNCATED]

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on staff interview and employee record review, it was determined that the facility staff failed to ensure that three of five certified nursing assistant (CNA) records reviewed received the required twelve hours of annual trainings.The findings include:On 4/9/2026 at 8:15 AM, a review of the facility's CNA annual training was conducted. Review of five CNA training transcripts revealed three of five CNAs selected for review did not meet the required 12-hours of annual training.1. Review of CNA #8's training transcript documented a hire date of 5/1/2023. Further review of the training transcript documented a total of 7.18 hours completed.2. Review of CNA #9's training transcript documented a hire date of 7/6/2022. Further review of the training transcript documented a total of 0.25 hours completed.3. Review of CNA #10's training transcript documented a hire date of 9/23/2022. Further review of the training transcript documented a total of 4.18 hours completed.On 4/9/2026 at 9:57 AM, an interview was conducted with the staff development coordinator who stated that they had been in the position since 12/15/2025 and had been working to coordinate the education schedules and competency calendars to catch them up. She stated that she had a performance improvement plan in place and it was on-going because she was still working on the audits and had not completed the plan at that time. She stated that the facility required the CNA stated to get 12 hours of annual training each year using the computerized education which tracked the hours and they had until December 31st of each year to complete their 12 hours. The facility assessment reviewed 2/26/2026 documented in Staff education and Competency, .Annual education requirements are in place for all staff to ensure robust ongoing education and competency . The facility policy In-Service Training, All Staff dated 2001 documented in part, .Completed training is documented by the staff development coordinator, or his or her designee and includes: .e. The hours of training completed.On 4/9/2026 at approximately 11:12 AM, the administrator, the director of nursing, the vice president of operations, the regional director of clinical services, the assistant director of nursing and the clinical consultant were made aware of the concern. No further information was provided prior to exit.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for two of 18 residents in the resident sample, Resident #8 and Resident #2. The findings include:1. For Resident #8 (R8), the facility staff failed to maintain a complete and accurate medical record documenting intravenous (IV) line placement procedures. Review of the electronic medication administration record (eMAR) dated 3/1/26-3/31/26 documented in part, Insert Midline (1) one time only until 03/16/2026. Start Date: 03/16/2026. Insert peripheral IV for ABT (antibiotic) one time only for IV ABT for 1 Day. Start Date: 03/18/2026. The eMAR further documented R8 receiving the first dose of intravenous antibiotics on 3/18/2026 at 9:00 AM. The progress notes for R8 documented in part, - 03/16/2026 11:50 (AM) Late entry . At approximately 2100 (9:00 PM), MD was notified of no improvement in BP (blood pressure). Writer received a new order for a STAT (now) ammonia level, and UA/ C&S (urinalysis with culture and sensitivity), Midline placement, one-time order of Cefepime 1 gm IM (intramuscular) and Solu-Medrol 125 mg IM. Medication administered as ordered. Pt continues to be closely monitored for new or worsening symptoms. - 03/18/2026 11:09 (AM) Date of Service: 3/18/2026. Visit Type : HP SKIN AND WOUND NOTE . Reason for visit: subsequent encounter for skin and wound care metronidazole Intravenous Solution 500 MG/100ML three times a day . - 03/19/2026 07:57 (AM) Note Text : Resident continues on IV/ABT (intravenous antibiotics) for elevated WBCs (white blood cells), no adverse reactions noted, IV site noted with no signs of infection or infiltration, resident noted with no signs or symptoms of distress noted, will continue plan of care, lab to be in today to obtain CBC/CMP. The clinical record for R8 failed to evidence documentation regarding the midline insertion procedure completion, site of the midline placement or resident tolerance of the procedure. It further failed to evidence documentation regarding the peripheral IV insertion, site of the peripheral line or resident tolerance of the procedure. On 4/7/2026 at 12:51 PM, an interview was conducted with the director of specialty care (DSC). She stated that the nurse had received an order to insert a peripheral IV on 3/18/2026 and she had been able to place the line successfully on the right side. She stated that there should be documentation in the progress notes regarding the IV insertion procedure. The DSC stated that the pharmacy had a team that came to the facility to place midline IV but had placed another peripheral line in the left arm. She stated that the pharmacy normally provided them with paperwork regarding the midline and it was put into the medical record, but they had not been able to get the information from the pharmacy. On 4/8/2026 at 11:45 AM, an interview was conducted with registered nurse (RN) #1 who stated that she had entered the initial order for the midline IV placement and had signed off the midline IV placement on the eMAR because it was already inserted when she came in on her shift that day. She stated that she had received report that day shift nurse had started a peripheral line in the right hand (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the pharmacy had sent someone in and they had placed the midline in the left arm. RN #1 stated that when the staff place IV lines they document where they place the line and the details of the procedure. On 4/8/2026 at 12:38 PM, an interview was conducted with the director of nursing (DON) who stated that R8 had an IV placed in the right arm by the facility nurse and one in the left arm by the pharmacy. She stated that both IVs were placed on 3/18/2026 and the pharmacy was supposed to give them documentation regarding the procedure. The DON stated that they were still trying to get verification for the placement from the pharmacy and the facility nurse should have documented the peripheral IV in the resident record also. No policy regarding a complete and accurate medical record was provided by the facility. According to Fundamentals of Nursing, 6th edition, [NAME] and [NAME]; page 480, documented in part regarding assessments and documentation, . The record needs to describe exactly what happened to a client. Nurses need to indicate all assessments, interventions, client responses, instructions, and referrals in the medical record. On 4/8/2026 at approximately 3:58 PM, the administrator and director of nursing were made aware of the concern. No further information was provided prior to exit. Reference: (1) A Midline Catheter is a thin, flexible tube placed into a vein in the arm. The catheter is 8-10 centimeters long and can stay in the arm for up to 29 days. This allows patients to get IV (intravenous) medicines and have blood samples drawn. The catheter is placed by a trained nurse . This information was obtained from the website: A Midline Intravascular Catheter | Patients & Families | UW Health 2. For Resident #2 (R2), the facility staff failed to maintain a complete and accurate medical record documenting medication administration, trauma informed care assessment and neurological assessments on 12/30/25 and 12/31/25. A review of the (MARs) Medication Administration Record for 12/31/25, revealed the nurse documented the administration of 9:00 AM medications at 11:09 AM and 1:00 PM medications at 14:14 PM. On 4/7/26 at 7:40 AM, an interview was conducted with LPN#4 regarding the care and services she provided to R2 on 12/31/25. According to LPN#4, the Unit Manager, LPN#3 was taking care of R2 mostly the morning of 12/31/25. She stated she had made her rounds on the morning of 12/30/25 and noticed that R2's eye was swollen terrible, swollen shut, and had a purplish reddish bruising around the left eye. She wasn't responding as much as usual. Later the aide told us she wasn't eating her breakfast then we knew something wasn't right. LPN#3 called the doctor. R2 's condition kept getting worse. Her blood pressure and pulse were getting higher and her breathing was labored. She was showing a drastic change, and the doctor told us to send her out. When LPN#4 was asked whether she had administered medications to R2 on the morning of 12/31/25 she stated, I don't think so, she was in bad shape and wasn't eating breakfast, so I don't think she would have been able to swallow (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her medications. A review of R2's eMAR (electronic Medication Administration Record) for 12/31/25 was conducted with LPN#4 to reveal she had signed off all 9:00 AM and 1:00 PM medications. She stated, Oh, I must have signed those off by mistake. Based on [NAME] and [NAME]'s Fundamentals of Nursing, 6th Edition, Chapter 15, read in part.medication administration documentation must be accurate, timely, and complete, occurring immediately after administration. Key documentation standards from [NAME] and [NAME]. Immediate Documentation: Never document medication administration until it has actually been given. On 4/7/26 at 9:45 AM, an interview was conducted with the Social Services Assistant (Other Staff Member #11) regarding her completion of the Trauma Informed Care assessment dated [DATE], completed in part, Information. A. Who assisted in completing this assessment? A. Resident and progress note 12/31/25 at 10:26 AM Resident is doing okay, no issues or behaviors observed. OSM #11 was interviewed on how R2 could assist in the completion of the Trauma Informed Care assessment and be doing okay, no issues or behaviors observed per her progress note as per nurse and physician progress notes and interviews R2 was unresponsive and presenting with abnormal vital signs, labored breathing and in the process of being transferred to the emergency department, OSM #11 states, Oh, I made a mistake in writing that. That is not an accurate note on Ms. (name redacted) R2. On 4/7/26 at 5:20 PM, an interview was conducted with LPN#10 on how to complete a neurological assessment. According to LPN#10, she checks the vital signs that included the blood pressure, heart rate, respirations and temperature, then she checks the residents pupils for size and reaction to light, checks their grip to see if it is strong or weak or if any change for them and she asks them questions such as their name and if they have any pain or headaches and determine if their speech is clear. The neurological assessment record for R2 dated 12/30 through 12/31/25 was reviewed with LPN#10 and when asked her to explain what the X marks indicated on the rows for pupils, extremities, speech and response to pain and environment, she explained the X mark meant she had completed that area of the assessment. When LPN#10 was asked about the legend/code at the top of the page, LPN#10 stated she had not had any training on the legend/code. According to the Director of Nursing, the facility does not have a policy regarding a complete and accurate medical record. She stated her expectation is for all disciplines to document accurate and timely information in the residents' medical record. According to Fundamentals of Nursing, 6th edition, [NAME] and [NAME]; page 480, documented in part regarding assessments and documentation, . The record needs to describe exactly what happened to a client. Nurses need to indicate all assessments, interventions, client responses, instructions, and referrals in the medical record. On 4/9/2026 at 11:13 AM, the Administrator, Director of Nursing, Assistant Director of Nursing, Regional [NAME] President of Operations, Clinical Consultant, Regional Director of Clinical Services and were made aware of the concern. No further information was provided prior to exit.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on staff interview, and facility document review, the facility staff failed to ensure communication training was completed for one of seven employee reviews.The findings include:For CNA #9, the facility staff failed to ensure communication training was completed.CNA #9 was hired on 7/6/2022. The facility staff failed to provide evidence that CNA #9 had completed communication training. On 4/9/2026 at 9:57 AM, an interview was conducted with the staff development coordinator who stated that since she had begun working at the facility in December 2025 and there was an annual competency calendar for staff which assigned education to staff throughout the year for them to complete and they had until December 31st each year to complete the assignments. She stated that she had an on-going performance improvement plan to catch up on missed education in progress, but it was not completed at that time. A request was made to the staff development coordinator for any evidence of CNA #9 completing communication training however none was provided.The facility assessment reviewed 2/26/2026 documented in Staff education and Competency, .All Staff Annual Education Course Topics: .Communicating Effectively . The facility policy In-Service Training, All Staff dated 2001 documented in part, .All staff are required to participate in regular in-service education . Required training topics include the following: a. Effective communication with residents and family (direct care staff) .On 4/9/2026 at approximately 11:12 AM, the administrator, the director of nursing, the vice president of operations, the regional director of clinical services, the assistant director of nursing and the clinical consultant were made aware of the concern. No further information was provided prior to exit.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on staff interview, and facility document review, the facility staff failed to ensure QAPI (quality assurance and performance improvement) training was completed for three of seven employee reviews.The findings include:1. For certified nursing assistant (CNA) #9, the facility staff failed to ensure QAPI training was completed.2. For other staff member (OSM) #8, dietary staff member, the facility staff failed to ensure QAPI training was completed.3. For OSM #9, housekeeping staff member, the facility staff failed to ensure QAPI training was completed.On 4/9/2026 at 9:57 AM, an interview was conducted with the staff development coordinator (SDC) who stated that since she had begun working at the facility in December 2025 and there was an annual competency calendar for staff which assigned education to staff throughout the year for them to complete and they had until December 31st each year to complete the assignments. She stated that she had an on-going performance improvement plan to catch up on missed education in progress, but it was not completed at that time. The SDC stated that she was working to obtain education for the contracted staff members including therapy staff and dietary staff. A request was made to the staff development coordinator for any evidence of CNA #9, OSM #8 and OSM #9 completing QAPI training however none was provided.The facility assessment reviewed 2/26/2026 documented in Staff education and Competency, .All Staff Annual Education Course Topics: .QAPI Basics . The facility policy In-Service Training, All Staff dated 2001 documented in part, .All staff are required to participate in regular in-service education .For the purposes of this policy, staff means all new and existing personnel, individuals providing services under contractual agreement, and volunteers . Required training topics include the following: . d. Elements and goals of the facility QAPI program .On 4/9/2026 at approximately 11:12 AM, the administrator, the director of nursing, the vice president of operations, the regional director of clinical services, the assistant director of nursing and the clinical consultant were made aware of the concern. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Rehabilitation and Healthcare Center	1776 Cambridge Drive Richmond, VA 23238

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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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on staff interview, and facility document review, the facility staff failed to ensure compliance and ethics training was completed for two of eight employee reviews.The findings include:1. For certified nursing assistant (CNA) #9, the facility staff failed to ensure compliance and ethics training was completed.2. For CNA #10, the facility staff failed to ensure compliance and ethics training was completed.On 4/9/2026 at 9:57 AM, an interview was conducted with the staff development coordinator who stated that since she had begun working at the facility in December 2025 and there was an annual competency calendar for staff which assigned education to staff throughout the year for them to complete and they had until December 31st each year to complete the assignments. She stated that she had an on-going performance improvement plan to catch up on missed education in progress, but it was not completed at that time. A request was made to the staff development coordinator for any evidence of CNA #9 and CNA #10 completing compliance and ethics training however none was provided.The facility assessment reviewed 2/26/2026 documented in Staff education and Competency, .All Staff Annual Education Course Topics: .Corporate Compliance . Ethics . The facility policy In-Service Training, All Staff dated 2001 documented in part, .All staff are required to participate in regular in-service education . Required training topics include the following: .The compliance and ethics program standards, policies and procedures. (Compliance and ethics training is conducted annually when this organization is operating five or more facilities) .On 4/9/2026 at approximately 11:12 AM, the administrator, the director of nursing, the vice president of operations, the regional director of clinical services, the assistant director of nursing and the clinical consultant were made aware of the concern. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Rehabilitation and Healthcare Center	1776 Cambridge Drive Richmond, VA 23238

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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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on staff interview, and facility document review, the facility staff failed to ensure behavioral health training was completed for two of eight employee reviews.The findings include:1. For certified nursing assistant (CNA) #9, the facility staff failed to ensure behavioral health training was completed.2. For other staff member (OSM) #8, dietary staff member, the facility staff failed to ensure behavioral health training was completed.On 4/9/2026 at 9:57 AM, an interview was conducted with the staff development coordinator (SDC) who stated that since she had begun working at the facility in December 2025 and there was an annual competency calendar for staff which assigned education to staff throughout the year for them to complete and they had until December 31st each year to complete the assignments. She stated that she had an on-going performance improvement plan to catch up on missed education in progress, but it was not completed at that time. The SDC stated that she was working to obtain education for the contracted staff members including therapy staff and dietary staff. A request was made to the staff development coordinator for any evidence of CNA #9 and OSM #8 completing behavioral health training however none was provided.The facility assessment reviewed 2/26/2026 documented in Staff education and Competency, .All Staff Annual Education Course Topics: .Tips on Managing Challenging Behaviors . Managing Aggressive Behaviors . Understanding Trauma-Informed Care . The facility policy In-Service Training, All Staff dated 2001 documented in part, .All staff are required to participate in regular in-service education .For the purposes of this policy, staff means all new and existing personnel, individuals providing services under contractual agreement, and volunteers . Required training topics include the following: . f. Behavioral health .On 4/9/2026 at approximately 11:12 AM, the administrator, the director of nursing, the vice president of operations, the regional director of clinical services, the assistant director of nursing and the clinical consultant were made aware of the concern. No further information was provided prior to exit.