STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynn Care Center	1000 Shenandoah Avenue Front Royal, VA 22630

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to protect the residents' right to be free from physical abuse by other residents for 11 of 52 residents in the survey sample, Residents #127, #94, #126, #128, #25, #13, #41, #68, and #58, resulting in the identification of immediate jeopardy; and for Residents #48 and #35. The findings include:1. For Resident #127 (R127), the facility staff failed to protect the resident's right to be free from physical abuse by Resident #99 on 2/1/25.A review of the facility's final synopsis of events dated 2/6/25 revealed, in part: On Saturday, February 1, 2025, it was alleged that [R99] became agitated, combative and struck [R127] in her left eye on the memory care unit. Throughout the investigation, it was reported by staff that frequently care for both residents, they wander throughout the unit and [R99] can become agitated and combative at times, especially when residents are in her personal space. When interviewing both residents involved, neither resident was able to recall the event.A review of R127's clinical record revealed the following progress notes: 2/1/25 Resident was part of an altercation with [R99]. [R99] was swinging both arms and hit [R127] in the face from behind with closed hands unprovoked. [R127] was sitting at dining room table waiting on lunch. CNAs (certified nursing assistants) separated the residents immediately and notified the nurse.2/3/25 Support visit held with resident. Resident was involved in an unprovoked altercation with [R99] where she was struck in the face. Resident denies any pain at the time. Resident denies recall of the altercation. When asked if resident felt safe, she stated yes.A review of R127's comprehensive care plan dated 1/28/25 failed to reveal any information related to this incident of abuse.2. For Resident #94 (R94), the facility staff failed to protect the resident's right to be free from physical abuse by Resident #99 on 2/15/25.A review of the facility's final synopsis of events dated 2/20/25 revealed, in part: On Saturday, February 15, 2025, it was alleged that [R99] became combative and struck [R94] on the right side of her face on the memory care unit. Throughout the investigation, it was reported by staff that frequently care for both residents, they wander throughout the unit and [R99] can become agitated and combative at times, especially when residents are in her personal space. When interviewing both residents involved, neither resident was able to recall the event.A review of R94's clinical record revealed the following progress note dated 2/17/25: Support visit held with resident r/t (related to) altercation with [R99]. Resident unable to recall the event. Resident stated she felt safe and happy.A review of R94's comprehensive care plan dated 1/16/25 revealed no information related to this incident of abuse.3. For Resident #126 (R126), the facility staff failed to protect the resident's right to be free from physical abuse by Resident #99 (R99) on 3/25/25.A review of the facility's final synopsis of events dated 3/27/25 revealed, in part: On Tuesday, March 25, 2025, it was alleged that [R99] became combative and struck [R126] on the right side of her face on the memory care unit. Throughout the investigation it was reported by staff that frequently care for both residents, they wander throughout the unit and [R99] can become aggressive, without provocation. When interviewing both residents involved, neither resident was able to recall the incident.A review of R126's clinical record revealed the following progress note dated 3/25/25: This nurse was coming out (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	of nurse station and saw [R99] struck (sic) [R126] with a fabric bed pad on the right side of her face. Separated [R99] immediately from situation. No injuries observed. No S/S (signs or symptoms) of distress or discomfort.A review of R126's comprehensive care plan dated 1/16/25 revealed no information related to this incident of abuse.4. For Resident #128 (R128), the facility staff failed to protect the resident's right to be from physical abuse from Resident #99 (R99) twice on 4/18/25 and on 4/20/25.A review of the final facility synopsis of events dated 4/24/25 revealed, in part: On Friday April 18, 2025, it was alleged that [R99] became combative and struck [R128] in the face on the memory care unit. Throughout the investigation, it was reported by staff that frequently care for both [R99] and [R128], they both wander throughout the unit; [R99] can become protective of the staff when other residents become agitated or aggressive towards them and [R128] is very anxious and can become easily agitated and aggressive with staff at times, especially when she feels as though others are in her personal space. When interviewing both residents involved, neither resident was able to recall the incident.A review of R128's clinical record revealed the following progress note dated 4/18/25 at 6:30 p.m.: Was told by another resident and CNA (certified nursing assistant) that this resident got in [R99's] face and was yelling and allegedly [R99] struck resident in the nose. There was a small red spot at time of incident on the [NAME] of [R128]'s nose. No other injuries observed.A review of the final facility synopsis of events dated 4/24/25 revealed, in part: On Friday April 18. 2025, it was alleged that [R99] became combative and struck [R128] in the face on the memory care unit. Throughout the investigation it was reported by staff that frequently care for both [R99] and [R128], they both wander throughout the unit. [R99] can become agitated and aggressive when someone is in her personal space and [R128] is very anxious and can be impulsive at times grabbing items that do not belong to her. When interviewing both residents involved, neither resident was able to recall the incident.A review of R128's clinical record revealed the following progress note dated 4/18/25 at 12:47 p.m.: Nursing observations, evaluation and recommendations are: Resident got in another resident's face and gets into their food. [R99] got upset and allegedly struck [R128]'s face. No injuries to the face.A review of the facility's final synopsis of events dated 4/25/25 revealed, in part: On Sunday April 20, 2025, it was alleged that [R99] became combative and struck [R128] in the mouth on the memory care unit. Throughout the investigation, it was reported by staff that frequently care for both [R99] and [R128], they both wander throughout the unit; [R99] can become protective of the staff when other residents become anxious, aggressive or physical towards them, and [R128] is very anxious and will grab on to staff at times for comfort, especially when she feels overwhelmed. When interviewing both residents involved, neither resident was able to recall the incident.A review of R128's clinical record revealed the following progress note dated 4/21/25 at 12:28 a.m.: Reported to this writer resident was punched by [R99] in the upper lip. CNA (certified nursing assistant) stated she was escorting [R128] from room [ROOM NUMBER]. [R128] grabbed CNA's upper arm. [R99] was outside room [ROOM NUMBER] when she grabbed CNA's other arm, told [R128] to let go of her. [R99] then punched [R128]in the upper lip. Both residents were separated.A review of R128's comprehensive care plan dated 2/17/25 revealed no information related to these incidents of abuse.5. For Resident #25 [R25], the facility staff failed to protect the resident's right to be free from physical abuse from Resident #99 (R99) on 5/17/25.A review of the facility's final synopsis of events dated 5/23/25 revealed, in part: On Saturday May 17, 2025, it was alleged that [R99] became combative and struck [R25] on the right side of her face on the memory care unit. Throughout the investigation it was reported by staff that frequently care for both residents, that [R99] wanders throughout the unit and can become aggressive immediately after care as she does not like anyone in her personal space. When interviewing both residents involved, neither resident was able to recall the incident.A review of R25's clinical record revealed the following progress notes: 5/17/25 [R99] was combative and swung her hand at glove dispenser that gave her a skin tear on left wrist. After resident was out of the bathroom she went to [R25] and hit the other resident on the right side of her face. The two were separated, assessed, and treated as per protocol. 5/19/25 This (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	writer provided follow up visit r/t (related to) negative encounter with another resident. She was unable to recall incident. She did not express any concern or fear of safety to this writer. She presented calm with no s/s (signs or symptoms) of distress.A review of R25 comprehensive care plan dated 3/5/25 revealed no information related to this incident of abuse.6. For Resident #13 (R13), the facility staff failed to protect the resident's right to be free from physical abuse from Resident #99 (R99) on 6/18/25 and 11/2/25.A review of the facility's final synopsis of events dated 6/24/25 revealed, in part: On Wednesday, June 18, 2025, it was alleged that [R99] became combative and aggressive and struct [R13] on the right side of her face with a comb in the memory care unit. Throughout the investigation, staff who frequently cared for [R99] and [R13] reported that they wander throughout the unit. Staff also reported that [R99] can become agitated at times, especially when residents are in her personal space. When interviewing both residents involved, neither resident was able to recall the incident.A review of R13's clinical record revealed the following progress notes: 6/18/25 8:16 a.m. The resident was sitting in her wheelchair by the nurse's computer table when another resident approached her and hit her on the face with a comb. Nurse assessed the face, no injuries noted. 6/18/25 12:17 p.m. Support visit held. Resident has no recall of negative encounter with another resident. Resident cont. (continued) to ask questions back to this writer and stated she did feel safe in facility.A review of the facility's final synopsis of events dated 11/7/25 revealed, in part: On Sunday, November 2, 2025, it was alleged that [R99] became combative and struck [R13] in the middle of her face on the memory care unit. Throughout the investigation it was reported by staff that frequently care for both residents that [R99] can become agitated when another resident touches her or is in her space. When interviewing both residents involved, neither was able to recall the incident.A review of R13's clinical record revealed the following progress notes: 11/2/25 8:00 p.m. This nurse was notified by CNA (certified nursing assistant) that resident was hit in the face with a padded box by [R99] after this resident gently touched [R99] on the arm. This nurse assessed resident. No injuries noted. 11/4/25 4:19 p.m. Bruising to upper lip noted after incident occurred. 11/5/25 1:58 p.m. Resident met with this writer but did not provide any remembrance to questions regarding her recall of a negative encounter with another resident or her comfort level among others in the facility.A review of R13's comprehensive care plan dated 12/17/24 revealed no information related to the incidents of abuse.7. For Resident #41 (R41), the facility staff failed to protect the resident's right to be free from physical abuse from Resident #99 (R99) on 8/20/25.A review of the facility's final synopsis of events dated 8/26/25 revealed, in part: On Wednesday, August 20, 2025, it was alleged that [R99] became combative and struck [R41] on the right shoulder.on the memory care unit. Throughout the investigation it was reported by staff that frequently care for both residents, that [R99] wanders throughout the unit and can become protective over staff when another resident is in their space. When interviewing both residents involved, neither resident was able to recall the incident.A review of R41's clinical record revealed the following progress notes: 8/20/25 9:35 p.m. Resident became verbally aggressive with [R99]. This writer went to intervene, resident went to swing at writer. [R99] hit resident on shoulder.Was able to redirect [R99] to their room. Resident remained agitated and aggressive toward staff. 8/21/25 2:06 p.m. Support visit held. Resident has no recall of negative encounter with another resident.A review of R41's comprehensive care plan dated 2/2/25 revealed no information related to the incident of abuse.8. For Resident #68 (R68), the facility staff failed to protect the resident's right to be free from physical abuse from Resident #99 (R99) on 10/24/25.A review of the facility's final synopsis of events dated 10/31/25 revealed, in part: On Friday, October 24, 2025, it was alleged that [R99] became combative and struck [R68]on the right side of her face on the memory care unit. Throughout the investigation it was reported by staff that frequently care for both residents that [R99] wanders throughout the unit and can become agitated when another resident is in her space. When interviewing both residents involved, [R68] was able to recall the incident.A review of R68's clinical record revealed the following progress notes: 10/24/25 9:45 p.m. Resident states [R99] was aggressive towards her. No injuries noted at this time and (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident denies pain or discomfort. 10/25/25 6:50 a.m. This writer spoke with [R68] in reference to her complaint of [R99] being aggressive on 10/24/25. Resident stated she was ?whacked' across the right side of her face. 10/27/25 Resident presented as anxious throughout [social services] visit; however, she attributed it to adjusting to new environment due to recent admission. She did not express feeling unsafe in her environment.A review of R68's comprehensive care plan dated 10/23/25 revealed no information related to the incident of abuse.9.a. For Resident #58 (R58), the facility staff failed to protect the resident's right to be free from physical abuse from Resident #99 (R99) on 8/16/25.A review of the facility's final synopsis of events dated 8/22/25 revealed, in part: On Saturday, August 16, 2025, it was alleged that [R99] became agitated and aggressively pulled [R58]'s hair in the dining area of the Memory Care Unit. Throughout the investigation, it was reported by staff that frequently care for both [R99] and [R58] that they both wander throughout the unit and [R99] can become agitated at times, especially when residents are in her personal space. When interviewing both residents involved, none was able to recall the event.A review of R58's progress notes revealed, in part: 8/16/25 Resident was at dining room table when [R99] grabbed her hair at back of head, shook her head. CNA (certified nursing assistant) intervened and redirected [R99]. Resident removed from dining room and vital signs taken. No apparent injuries noted.8/18/25 Support visit held. Resident has no recall of negative encounter with another resident.On 1/8/26 at 11:29 a.m., LPN (licensed practical nurse) #1, a unit manager, was interviewed. She stated usually there is a staff member in the memory care unit dining room. She explained that a hospitality aide sits among the residents and monitors them in the morning. She stated if residents become involved in a physical altercation, the staff separates, redirects them, and assesses them for injury. She stated that if a resident is hit in the face or head, the likelihood of a serious injury would depend on the situation. She explained that if a resident is punched with a fist, then there is a good likelihood of a serious injury. She stated there is also a likelihood of serious injury such as bleeding if the resident who is hit is on a blood thinning medication. She stated that any resident could experience bruising or a laceration if they are hit hard enough. She added that even residents with cognitive impairment like those who live on the memory care unit can be traumatized by a resident to resident altercation. She stated residents on the memory care unit are especially vulnerable to serious injury because of their cognitive status, and because they are sometimes not able to communicate their symptoms. On 1/12/26 at 2:36 p.m., OSM (other staff member) #9, the director of social services, was interviewed. She stated her [NAME] is to focus on the residents' needs after a resident to resident altercations. She stated she wants to make sure that the residents still feel comfortable and safe in their environment. She added that she always attempts to interview residents who are involved in an altercation with another resident even if those residents have limited cognitive capabilities due to dementia. She stated if one resident physically strikes another resident or pulls another resident's hair in a manner that is willful and not accidental, that constitutes physical abuse. She acknowledged that it can be tricky because the residents can't recall what they did.On 1/12/26 at 3:24 p.m., RN (registered nurse) #3 was interviewed. She stated that if one resident strikes another, it is abuse. She stated the residents have to be separated and assessed. She stated it is a resident's right to be free from abuse.On 1/12/26 at 3:43 p.m., LPN #7, a unit manager, was interviewed. She stated that physical abuse can be defined as smacking, hitting, and biting, and that physical abuse can occur between staff and residents, as well as between residents themselves as resident to resident altercations. She stated every resident has the right to be free from abuse of any kind.A review of the facility policy, Abuse, revealed, in part: This organization recognizes and respects that each resident has the right to be free from abuse, neglect, misappropriation of residents' property, and exploitation.The facility is committed to developing and operationalizing policies and procedures for.protection of residents.'Abuse' is the willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in physical harm, pain, or mental anguish.Instances of abuse of all residents, irrespective of any mental or physical condition, can cause physical pain or mental (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	anguish.Willful, as used in this definition of abuse, means the resident must have acted deliberately, not that the individual must have intended to inflict injury or harm.Identification.Staff are encouraged and protocols will be maintained to promote timely identification and reporting of events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse.The facility's deficient practice placed all residents on the memory care unit at risk of being abused by R99. This resulted in a determination of Immediate Jeopardy (IJ), cited at level four pattern beginning on 2/1/2025.On 1/8/26 at 1:44 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical Services, were informed of these concerns and that the facility was in immediate jeopardy.On 1/8/26 at 6:04 p.m., the facility's IJ Removal Plan was accepted by the SA (state agency) supervisor.Facility Removal Plan Plan of corrective action for those residents found to be affected by deficient practices.Resident #99 was placed on 1 on 1 supervision until the resident discharge or significant change in condition limits the resident's physical ability to come in contact with another resident. Residents #58, 94, 25, 13, 41, 68 have been seen previously by psychiatric services and will receive follow up psychosocial support from social services on 1/8/26. Resident #127, 126, 128 no longer reside in the facility no corrective actions can be made.Corrective Actions taken for residents with potential to be affected by deficient practiceAll residents of the facility have the potential to be affected by this deficient practice. All residents to be screened for evidence of abuse and neglect. Residents who are interviewable BIMS score of 8 or greater to have abuse questionnaire completed, non-verbal residents or residents with a BIMS score of 7 or below will have head to toe physical assessment completed. Any identified concerns will be addressed according to the HVHC Abuse and Neglect Policy. The facility will conduct an audit of all incident reports for the last 30 days to ensure that all events meeting the reporting requirements were reported to the appropriate parties.Systemic changes put into place to ensure the deficient practice does not reoccur:All staff of the facility/agency will be reeducated on the HVHC Abuse and Neglect Policy. This education will include abuse prevention, types of abuse, abuse reporting, and the Elder Justice Act specifically pertaining to Resident to resident altercations. All staff will have education starting on 1/8/26, any staff not present on 1/8/26 will be required to receive mandatory education prior to the start of their next shift. No staff member will be allowed to return to work after 1/8/26 until this mandatory education has been completed. New hire orientation will include this training as part of the new hire process and all agency staff will be required to complete this education prior to starting work in the facility. The facility leadership NHA, DON, Social services, activities, will be provided reeducation on Abuse Reporting and Investigating allegations of abuse and resident altercations by the Regional Director of Clinical Services and Regional Director of Operations on 1/8/26.The facility alleges removal of the Immediate Jeopardy on 1/8/26 at 8:00 p.m.On 1/9/26 at 9:00 a.m., the survey team began verification of the facility's removal plan. This verification process included observation of the resident on 1:1 supervision, staff interviews on all elements of the removal plan, and review of the facility's credible evidence. The survey team was able to verify that the facility completed the removal plan on 1/8/26 at 8:00 p.m. Once the immediate jeopardy was removed, the scope and severity was reduced to a level two, pattern.9.b. For Resident #58 (R58), the facility staff failed to protect the resident's right to be free from physical abuse from Resident #38 (R38) on 4/15/25 A review of the facility's final synopsis of events dated 4/22/25 revealed, in part: On Tuesday April 15, 2025, it was alleged that [R38] became combative and struck [R58] on her left upper arm on the memory care unit. Throughout the investigation, it was reported by staff that frequently care for both [R38] and [R58] that [R58] wanders throughout the unit, propelling herself in a wheelchair and bumps objects often. [R38] can become agitated at times, especially when residents are in her personal space. When interviewing both residents involved, neither resident was able to recall the incident.A review of R58's clinical record revealed the following progress notes: 4/15/25 9:58 a.m. Staff witnessed resident got hit by [R38] on the upper arm, and her wheelchair got kicked by the same resident. Affected area assessed, no injuries noted. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	No pain verbalized/noted. 4/15/25 12:15 p.m. Resident has no recall of negative encounter with another resident.A review of R58's comprehensive care plan dated 2/7/25 contains no information related to the incidents of abuse.On 1/12/26 at 4:08 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were notified of these concerns.10. For Resident #48 (R48), the facility staff failed to protect the resident's right to be from abuse from Resident #121 (R121) on 6/4/24.A review of the facility's final synopsis of events dated 6/6/25 revealed, in part: On Tuesday, June 4, 2025, it was alleged that R121 hit R48 on the right shoulder causing her to lost balance and fall to the floor. When interviewing the residents, neither was able to recall the incident. Throughout the investigation, it was reported by staff that frequently care for R48 and R121 that both residents are mobile and can become easily agitated. Staff also stated that R48 will often invade others' personal space.A review of R48's clinical record revealed the following progress note dated 6/5/25 at 2:09 a.m.: This nurse witnessed [R121] hit [R48] on the right shoulder in the dining room. [R48] fell on the ground and hit back on wheelchair behind them but did not hit their head. This nurse thoroughly assessed [R48] and assisted them off the floor into chair.A review of R48's comprehensive care plan dated 2/2/25 revealed no information related to the incident of abuse.On 1/12/26 at 4:08 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were notified of these concerns.11. For Resident #35 (R35), the facility staff failed to protect the resident's right to be free from abuse from Resident #38 (R38) on 4/15/25.A review of the facility's synopsis of events dated 4/22/25 revealed, in part: On Tuesday, April 15, 2025, it was alleged that R38 became combative and allegedly struck [R35] on her chest. Throughout the investigation it was reported by staff that frequently care for both [R35] and [R38] that [R35] wanders throughout the unit and [R38] can become agitated at times, especially when residents are in her personal space. When interviewing both residents involved, neither resident was able to recall the incident.A review of R35's progress notes revealed the following: 4/15/25 Staff witness resident got hit by [R38] on the right lower arm. Affected area assessed, no injuries noted. No pain verbalized/noted. ROM (range of motion) on the affected area at baseline. 4/16/25 Resident has no recall of negative encounter with another resident.A review of R35's comprehensive care plan dated 1/31/25 revealed no information related to the incident of abuse.On 1/12/26 at 4:08 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were notified of these concerns.No additional information was provided prior to exit.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide care, services, and adequate supervision for resident safety for two of 52 residents in the survey sample, Resident #99, resulting in the identification of immediate jeopardy and for Resident #40, resulting in harm. The findings include:1. For Resident #99 (R99), on twelve occasions in 2025, the resident physically assaulted other residents on the memory care unit, despite being known to have had previous aggressive behaviors. The lack of adequate supervision of R99 resulted in injury to two victims, Residents #127 and #128. On 2/1/2025, R99 struck Resident #127 in the left eye resulting in redness to the eye. On 4/18/2025, R99 struck Resident #128 in the face resulting in bruising on the bridge of the nose. On the significant change minimum data set (MDS) with an assessment reference date (ARD) of 12/8/2025, R99 was coded as being severely impaired for making daily decisions with diagnoses that included but were not limited to non-Alzheimer's dementia and depression. The assessment documented no functional limitation in range of motion for upper or lower extremities and the resident not using a wheelchair or walker. It further documented that R99 required substantial/maximal assistance for transfers and partial/moderate assistance for walking 10/50/150 feet. The MDS assessment documented behaviors of rejection of care occurring daily that had worsened since the previous assessment. On 1/6/2026 at 9:19 AM, R99 was observed sitting in a recliner in the common area of the memory care unit eating breakfast. On 1/7/2026 at 5:05 PM, R99 was observed sitting in a recliner in the common area of the memory care unit. R99 was observed to be drowsy but easily aroused when approached by staff. R99's dinner tray was delivered by staff and placed on a tray at the side of the recliner however R99 did not eat until a staff member sat with them and assisted them to eat. On 1/8/2026 at 7:49 AM, R99 was observed in bed. From 8:21a.m. to 8:25 a.m., R99 was observed standing and walking independently without support while straightening the sheet and blanket on the bed in their room. The resident was observed kneeling on the bed, crawling on the bed and sitting down on the bed. At 8:29 a.m. R99 left the room with a certified nursing assistant (CNA) arm-in-arm from the room to a recliner in the dining area. After arriving in the dining area, the activities assistant held resident's hand while the aide placed a changing pad in the recliner. Further observation revealed the resident initiated the hand holding while waiting to sit in the recliner. On 1/8/2026 at 11:45 AM, R99 was observed in a recliner in the common area of the memory care unit. R99 was observed getting out of the recliner and standing up beside the chair. At that time, licensed practical nurse (LPN) #1 came over to R99 and assisted them to ambulate down the hallway to their room into the bathroom. A review of R99's clinical record revealed facility documentation regarding aggressive behaviors dating back to 12/30/2024. Interventions for 1:1 supervision until back to baseline were documented on 12/31/2024, 2/1/2025, 2/15/2025 and 3/25/2025, as well as increased supervision as tolerated on 4/18/2025. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the facility synopsis of events documented R99 striking Resident #127 in the left eye resulting in redness to the eye on 2/1/2025 and R99 striking Resident #128 in the face on 4/18/2025 resulting in bruising on the bridge of the nose. Review of additional events documented R99 involved in the following resident to resident altercations with no injuries observed. On 12/30/2024, R99 struck Resident #58 on the left side of the face, on 2/15/2025, R99 struck Resident #94 on the right side of the face and on 3/25/2025, R99 struck Resident #126 with a cloth pad on the right side of the face. On 4/18/2025, R99 struck Resident #128 on the right side of the face, on 4/20/2025, R99 struck R128 in the mouth and on 5/17/2025, R99 struck Resident #25 in the face. On 6/18/2025, R99 struck Resident #13 on the right side of the face with a comb, and on 8/16/2025, R99 aggressively pulled Resident #58's hair. On 8/20/2025, R99 struck Resident #41 on the arm, on 10/25/2025, R99 struck Resident #68 on the right side of the face and on 11/3/2025, R99 struck Resident #13 in the face. The events documented them happening on the memory care unit with other cognitively impaired residents. Review of the final investigation summaries for the events documented statements that included, Throughout the investigation it was reported by staff that frequently care for both residents, that [R99] wanders throughout the unit and can become protective over staff when another resident is in their space . , [R99] can become protective of the staff when other residents become anxious, aggressive or physical towards . and [R99] can become aggressive, without provocation . The comprehensive care plan, initiated 12/23/2024 and updated 11/3/2025, documented in part, BEHAVIORS: [Name of R99] has behaviors of kicking, grabbing, being combative and scratching staff during care. Other behaviors include: refusing medications and throwing them on the floor, throwing objects at staff or onto the floor, wandering into other residents rooms and rummaging through their belongings. Striking other residents with a closed fist; combative/ physical with staff; kicking and spitting at staff; being confrontational with staff and other resident and not easily being redirected; throwing medication; shaking other residents; attempting to strike other residents, some being successful attempts; Throwing drinks at staff; Crying at times with no known cause; Becoming verbally abusive to other residents; Urinating in inappropriate areas; Striking other residents with objects 11/2/25. Change in Condition evaluations for R99 documented in part, - 2/1/2025 15:00 (3:00 PM) Behavioral symptoms, Resident hit another resident . Resident was fine just a few minutes before, and then out of nowhere she began sticking [sic] another resident. It was unprovoked . needs one on one watching when like this . - 4/18/2025 12:47 (12:47 PM) Behavioral symptoms . This resident allegedly struck resident [Room number of other resident] after her food was touched at lunch time. This resident was separated and redirected. No injuries observed at the time of this incident . - 4/18/2025 16:30 (4:30 PM) Behavioral symptoms . Dinner time this resident was approached by the resident in [Room number of other resident] in the dining room while aides were assisting other residents with their dinner. This resident allegedly struck resident in the nose. At the time it weas [sic] a little red . Separated and redirected until back to baseline . - 4/20/2025 19:43 (7:43 PM) Behavioral symptoms . This resident was observed striking the resident in [Room number of other resident] in the face in the hallway. No injuries observed . - 6/18/2025 07:45 (AM) Behavioral symptoms . Resident approached another resident that was sitting in her wheelchair and hit her on the face with a comb. Resident re-directed . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	and redirect patient as needed . - 7/11/2025 . presents with increasing aggression. She has always been exhibiting violent behavior, including hitting, smacking and throwing coffee. Last night, she threw hot coffee on a nurse and broke a CNA's necklace . The severity of her actions is significant, as evidenced by the hot coffee incident and the breaking of a CNA's necklace. These behaviors are impacting the safety of the healthcare staff and potentially other patients on the unit . Treatment Plan: Aggressive Behavior, Plan: Exercise caution for safety when interacting with the patient. Monitor patient closely for further aggressive outbursts . - 8/19/2025 . incidents of aggression towards another resident. The patient reportedly exhibited aggressive behavior over the weekend, which involved grabbing another resident's hair while the other resident was in a wheelchair . This nurse described her behavior as unpredictable, especially towards new people . - 9/23/2025 . Patient throw [sic] water at another resident, which appears to be related to her dislike of having her personal space invaded, though she herself tends to be touchy and likes to touch others . - 10/28/2025 . On Friday night, [R99] was observed going through a new resident [Name of other resident] drawers, and when [Name of other resident] asked her to stop, [R99] turned and punched her. [Name of other resident] was able to recall and recount this incident multiple times over several hours and again today, though no staff witnessed the actual event. [R99]'s aggressive behaviors toward staff have been worsening, including hitting, spitting, and kicking. While she has always exhibited these behaviors, they are becoming more frequent and severe. She is more easily triggered and angered, with episodes of including crying spells. Specifically, she becomes triggered when she sees other peers and the husband of one of the residents and attempts to go after him for no apparent reason. Treatment adherence has been problematic, as [R99] frequently refuses to take her medications . - 11/18/2025 .She has had two physical altercations with other people over the past couple of weeks with the most recent incident occurring the weekend before last (not this past weekend) . On 1/8/2026 at approximately 9:10 AM, an interview was conducted with other staff member (OSM) #1, activities assistant, regarding R99's ambulation status and behaviors. OSM #1 stated that she worked on the memory care unit every day, was familiar with R99 and frequently provided one-to-one interaction with them. She stated that R99 could walk independently but required someone to walk next to them due to the risk of falling. OSM #1 stated that R99 had attempted to hit another resident when their wheelchair came close to them, but they did not hit R99. OSM #1 stated she could not recall when the incident occurred, but she had intervened by grabbing R99's hand. On 1/8/2026 at approximately 9:20 AM, an interview was conducted with CNA #1 who stated that R99 could walk by herself but required supervision to prevent falls. She stated that the type of supervision R99 required when walking was for staff to walk with them. CNA #1 stated that R99 had behaviors of hitting in the past but not recently. On 1/8/2026 at approximately 9:25 AM, an interview was conducted with CNA #2 who stated that she had worked with R99 for approximately a month. She stated that R99 could walk by themselves but required someone to hold their hand to prevent falls and that she had not witnessed any aggressive (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	behaviors. On 1/8/2026 at approximately 9:33 AM, an interview was conducted with LPN #1 who stated that R99 required stand-by assistance when ambulating to prevent falls. She stated that R99 no longer wandered on the unit but would wander in their room around their bed by themselves. LPN #1 stated that since a recent fall, R99 had not been aggressive towards other residents. At 11:30 AM, LPN #1 stated that staff supervision of residents on the memory care unit was by staff who stayed in the common area and rounded on residents in their rooms a minimum of every two hours. She stated that they tried to prevent any altercations but if anything happened they immediately separated the residents. LPN #1 stated that if a resident was hit in the face or head there were risks because it was a more sensitive area. She stated that if a resident was on a blood thinner that increased the risk of bleeding, bruising, brain bleeding, or mental status changes. LPN #1 stated that the residents on the memory care unit were more vulnerable due to their cognitive status and they were less likely to report any altercations but more at risk due to behaviors. On 1/8/2026 at approximately 11:54 AM, an interview was conducted with LPN #6 who stated that on the memory care unit they supervised the residents by having staff in the common area to monitor the residents at the tables and in the recliners and she parked the medication cart facing them when passing medications to watch them. She stated that the CNAs rounded on the residents in the rooms every couple of hours or more as needed. LPN #6 stated that if they had residents with aggressive behaviors they tried not to escalate the behaviors to an altercation and tried to redirect them and watch a little more closely. She stated that if a resident received a hit to the head by a fist there could be a likelihood of injury, but it depended on the situation. LPN #1 stated that residents on blood thinners or with bleeding disorders would be at risk from being hit in the face or head because it could cause bruising, bleeding, a laceration or trauma. She stated that in her previous employment any resident hit in the head would be sent out for evaluation if they were on blood thinners due to the risk, but she was not sure of the practice at the facility. LPN #6 stated that they used activities and music and tried to create a calming space for the residents on the memory care unit because they were more vulnerable due to their cognitive status and they could not advocate for themselves. On 1/12/2026 at 3:24 PM, an interview was conducted with registered nurse (RN)#3 who stated that if one resident struck another, it was abuse. She stated that residents are not being adequately supervised if they are repeatedly abusing other residents and in these cases, the facility staff should be looking more closely at these residents and providing closer supervision. The facility's deficient practice placed all residents on the memory care unit at risk of being abused by R99. This resulted in a determination of Immediate Jeopardy (IJ), cited at level four pattern beginning on 2/1/2025. On 1/8/2025 at 1:44 PM, administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services, were informed of these concerns and that the facility was in immediate jeopardy (IJ). On 1/8/2025 at 6:04 PM, the facility's IJ Removal Plan was accepted by the SA (state agency) supervisor. Facility Removal Plan Plan of corrective action for those residents found to be affected by deficient practices:Resident #99 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	was placed on 1 on 1 supervision until the resident discharge or significant change in condition limits the resident's physical ability to come in contact with another resident. Corrective Actions taken for residents with potential to be affected by deficient practice: All residents of the facility have the potential to be affected by this deficient practice. An audit will be conducted on Point of Care behavior documentation for the current month to ensure that residents identified with aggressive behaviors have interventions and care plans in place to provide adequate supervision. Systemic changes put into place to ensure the deficient practice does not reoccur: All staff of the facility/agency will be reeducated on the HVHC Safety and Supervision of Residents Policy. All staff will have education starting on 1/8/26, any staff not present on 1/8/26 will be required to receive mandatory education prior to the start of their next shift. No staff member will be allowed to return to work after 1/8/26 until this mandatory education has been completed. New hire orientation will include this training as part of the new hire process and all agency staff will be required to complete this education prior to starting work in the facility. The facility alleges removal of the Immediate Jeopardy on 1/8/2026 at 8:00 p.m. On 1/9/2026 at 9:00 a.m., the survey team began verification of the facility's removal plan. This verification process included observation of the resident on 1:1 supervision, staff interviews on all elements of the removal plan, and review of the facility's credible evidence. The survey team was able to verify that the facility completed the removal plan on 1/8/2026 at 8:00 p.m. After immediate jeopardy was removed, the scope and severity was lowered to a level three isolated. A review of the facility policy, Safety and Supervision of Residents documented in part, 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 . Adequate supervision is determined by assessing the appropriate level and number of staff required, the competency and training of the staff, and the frequency of supervision needed. This determination is based on the individual resident's assessed needs and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident . The care team will target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices . Monitoring the effectiveness of interventions shall include the following: a. Ensuring that interventions are implemented correctly and consistently; b. Evaluating the effectiveness of interventions; c. Modifying or replacing interventions as needed; and d. Evaluating the effectiveness of new or revised interventions. 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 in the environment . No additional information was provided prior to exit. 2. For Resident #40 (R40), the facility staff failed to provide adequate supervision for the prevention of a fall resulting in hospitalization for a right hip fracture and a brain bleed. R40 was admitted to the facility with a diagnosis that included but not limited to muscle weakness, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	difficulty walking and dementia (1). On the most recent comprehensive MDS (minimum data set), a 5 (five)-Day assessment with an ARD (assessment reference date) of 06/29/2025, R40 scored 2 (two) out of 15 on the BIMS (brief interview for mental status), indicating R40 was severely impaired of cognition for making daily decisions. GG0170 Mobility coded R40 as requiring Substantial/maximal assistance –)helper does more than half the effort. The helper lifts or holds trunk or limbs and provides more than half the effort) for Sit to stand: the ability to come to a standing position from sitting in a chair, wheelchair or on the side of the bed. Under Toilet transfer: The ability to get on and off a toilet or commode R40 was coded 88. Not attempted due to medical condition or safety concerns. The comprehensive care plan for R40 dated 04/24/2025 it documented in part, Focus. Risk For Falls: the resident is at risk for falls related to: functional impairments, impaired physical mobility. Date Initiated: 04/24/2025. Revision on 05/12/2025. Under Interventions it documented in part, Educate staff on importance of not leaving resident alone in room. Date Initiated: 06/06/2025. The Occupational Therapy (OT) Discharge Summary for R40 dated 07/09/2025 documented in part, STG (short term goal) #1.0 Discontinue on 07/03/2025. Patient will increase standing balance during ADLs (activities of daily living) to Fair spontaneously righting self when needed in order to reduce the risk for falls and in order to facilitate upright posture. Discharge (07/03/25) Fair-(Min(A) (minimal assistance) or UE (upper extremity) support to stand w/o (without) LOB (loss of balance) & (and) to reach ipsilaterally (2); unable to weight shift). The Physical Therapy (PT) Evaluation & Plan of Treatment for R40 dated 07/23/2025 documented in part, STG #2.0 – New Goal. Patient will safely perform functional transfers with MOD(A) (moderate assistance) and 50% (fifty percent) Verbal Cues and 50% Tactile (touch0 Cues for proper sequencing w/o LOB and with reduced risk for falls in order to facilitate increased participation with functional daily activities and facilitate increased (I) (independence) with functional mobility throughout facility. (Target 8/5/2025). Baseline (7/23/2025). Transfers Max(A) (maximum assistance). The facility's Fall Risk Assessment for R40 dated 05/27/2025 and 06/05/2025 documented in part, A score of 10 or above deems residents at risk. The fall risk assessment dated [DATE] documented AT RISK and a fall risk score of 19.0 and the fall risk assessment dated [DATE] documented AT RISK and a fall risk score of 11.0. The facility's nursing note for R40 dated 7/29/2025 documented, 23:38 (11:38 p.m.) Note Text: resident on bathroom floor laying on R (right) side. Nursing supervisor called to come and assist this writer. Resident c/o (complain of) R hip pain, R elbow pain. v/s (vital signs) obtained bp (blood pressure) -147/76 147 over 76), p (pulse)-74, temp (temperature)-96.8, r (respiration)-22, O2 (oxygen saturation)-84%. 3 rd (third-eye; physician on-call service) was contacted with no response, (Name of Physician) was contacted and left a detailed message of the incident. Per assessment of the resident [sic] was determined to call 911 to send resident to hospital for further evaluation. Skin assessment performed and has contusion (bruise) to R elbow, contusion to R side of head, healingbruise [sic] to L (left) hand. And bilateral (both sides) lower leg edema (swelling). Resident was transferred via (by) ambulance to ER (emergency room) with correct paperwork to include face sheet, med (medication) list, DNR (Do Not Resuscitate). Did contact ER to let them know of the incident and resident would be on the way. Rsident [sic] RP (responsible party) (Name of RP) was contacted. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's nursing note for R40 dated 7/29/2025 documented in part, 23:51 (11:51 p.m.) Situation: The Change In Condition/s reported on this CIC (change in condition) Evaluation are/were: Falls. Nursing observations, evaluation, and recommendations are: resident on bathroom floor c/o R hip pain and R elbow pain. vs obtained and documented. resident then stated to c/o needing to throw up and was determined to send resident to ER. The facility's nursing note for R40 dated 7/29/2025 documented, 02:23 (2:23 a.m.) Note Text: received phone call from ER and resident has a R hip fracture and a brain bleed. ER trying to get a hold of RP. Advised ER I would try to call as well. Left message with granddaughter (Name of Granddaughter) and son (Name of Son) to call ER as soon as possible. ER is wanting to transfer resident to (Name of Hospital). The ED (emergency department) report from (Name of Hospital) for R40 dated 07/30/2025 documented in part, Final Impression. 1. Fall, initial encounter. 2. Closed fracture of right hip, initial encounter. 3. Intercranial hemorrhage (brain bleed). On 01/06/2026 at approximately 1:10 p.m. an interview was conducted with OSM (other staff member) #3, occupational therapist, regarding R40's sitting and standing balance. She stated R40 received occupational therapy for ADLs (activities of daily living). She stated that R40 had poor standing balance and required supervision due to the fact that R40 was impulsive when she wanted to stand. On 01/06/2026 at approximately 1:36 p.m. an interview was conducted with OSM (other staff member) #4, physical therapist, regarding R40's sitting and standing balance. She stated R40 had poor standing balance and required maximum assistance (support when standing) and R40's transfers also required maximum assistance. On 01/07/2025 at approximately 10:02 a.m. a telephone interview was conducted with CNA #5 regarding the fall and injury R40 sustained on 07/29/2025. She stated that she was familiar with R40 and that R40 had difficulty with standing balance and required someone to be within reach of her. CNA #5 stated she was familiar with R40's fall precautions and the only time R40 could be alone was [NAME] she was in bed or in a wheelchair. She also stated R40 was at risk for falls when transferring and standing up. She stated she was working on the night shift on the Shenandoah Gardens unit on 07/29/2025 and assisted R40 to and on the toilet in R40's room when R40's roommate entered the room and tried to enter the bathroom while R40 was occupying the toilet. She stated that she physically redirected the roommate to another resident room to use the bathroom. When asked to elaborate her actions regarding R40 being on the toilet and redirecting R40's roommate she stated that she closed the bathroom door while R40 was sitting on the toilet so she could open the resident room entrance door and physically escorted R40's roommate out of the room to another resident room next to R40's room. CNA #5 stated that she left R40 for only a brief period of time and when she went back to R40 she found R40 on the bathroom floor. On 01/07/2025 at approximately 12:04 p.m. an interview was conducted with LPN (licensed practical nurse) #8. She stated that at the time of R40's fall, 07/29/2025, she was working during the night shift as the night shift supervisor and was on another unit when the incident occurred. She stated she received a call from LPN #2 who was on the Shenandoah Gardens unit informing her that a resident had fallen and was on the floor in their bathroom and was requesting assistance. She further stated that when she arrived on the Shenandoah Gardens unit she witnessed LPN #2 assessing R40 and assisted in cleaning R40 of feces and transferring the resident to her bed. She stated R40 complained (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	of right hip pain. She stated that the on-call physician service was called but did not get a response from the medical director, so the director of nursing (DON) was called and informed her of the incident and situation. She stated that the DON told them not to wait for a call back from the medical director and call 911 to R40 sent to the hospital. LPN #8 stated she spoke with CNA #5 to determine what had happened. She stated CNA #5 told her that she took R40 to the bathroom and assisted R40 onto the toilet, then R40's roommate tried to enter the bathroom while R40 was occupying the toilet. She stated that CNA #5 stated R40's roommate was being persistent to use the bathroom and CNA #5 physically redirected the roommate out of the room to another resident bathroom leaving R40 alone sitting on the toilet. During the days of the survey, a request was made to interview LPN #2. ASM (administrative staff member) #2, director of nursing, informed the surveyor that LPN #2 was no longer employed with the facility. The facility's policy Safety and Supervision of Residents documented in part, POLICY: 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 Safety. 4. Implementing interventions to reduce accident risks and hazards shall include the following: a. Communicating specific interventions to all relevant staff; b. Assigning responsibility for carrying out interventions; c. Providing training, as necessary; d. Ensuring that interventions are implemented; and e. Documenting interventions. 5. Monitoring the effectiveness of interventions shall include the following: a. Ensuring that interventions are impl

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to review and revise the comprehensive care plan for four of 52 residents in the survey sample, Residents #94, #128, #25, and #13.The findings include:1. For Resident #94 (R94), the facility staff failed to revise the resident's care plan after she was abused by Resident #99 (R99).A review of the facility's final synopsis of events dated 2/20/25 revealed, in part: On Saturday, February 15, 2025, it was alleged that [R99] became combative and struck [R94] on the right side of her face on the memory care unit. Throughout the investigation, it was reported by staff that frequently care for both residents, they wander throughout the unit and [R99] can become agitated and combative at times, especially when residents are in her personal space. When interviewing both residents involved, neither resident was able to recall the event.A review of R94's clinical record revealed the following progress note dated 2/17/25: Support visit held with resident r/t (related to) altercation with [R99]. Resident unable to recall the event. Resident stated she felt safe and happy.A review of R94's comprehensive care plan dated 1/16/25 revealed no information related to this incident of abuse.On 1/12/26 at 2:36 p.m., OSM (other staff member) #9, the director of social services, was interviewed. She stated she is responsible for following up on a resident's psychosocial needs following any resident to resident altercation. She stated the abused resident's care plan should be updated following any such incident.On 1/12/26 at 3:24 p.m., RN (registered nurse) #3 was interviewed. She stated that a resident's care plan is maintained to make sure all care team members are on the same page and are providing appropriate care to the resident. She stated the resident's care plan should be updated for any victim of abuse. She explained that unit managers ordinarily update the care plans.On 1/12/26 at 3:43 p.m., LPN (licensed practical nurse) #7, a unit manager, was interviewed. She stated a resident's care plan should be updated after an incident of abuse by another resident because such an event could trigger a trauma response. She stated floor nurses do not typically update care plans, and that this task is usually accomplished by unit managers.A review of the facility policy, Care Planning - Comprehensive Person-Centered, revealed, in part: The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans.When there has been a significant change in the resident's condition.When goals, needs, and preferences change.On 1/12/26 at 4:08 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were notified of these concerns.No additional information was provided prior to exit.2. For Resident #128 (R128), the facility staff failed to revise the resident's comprehensive care plan after she was abused by Resident #99 (R99).A review of the final facility synopsis of events dated 4/24/25 revealed, in part: On Friday April 18, 2025, it was alleged that [R99] became combative and struck [R128] in the face on the memory care unit. Throughout the investigation, it was reported by staff that frequently care for both [R99] and [R128], they both wander throughout the unit; [R99] can become protective of the staff when other residents become agitated or aggressive towards them and [R128] is very anxious and can become easily agitated and aggressive with staff at times, especially when she feels as though others are in her personal space. When interviewing both residents involved, neither resident was able to recall the incident.A review of R128's clinical record revealed the following progress note dated 4/18/25 at 6:30 p.m.: Was told by another resident and CNA (certified nursing assistant) that this resident got in [R99's] face and was yelling and allegedly [R99] struck resident in the nose. There was a small red spot at time of incident on the [NAME] of [R128]'s nose. No other injuries observed.A review of the final facility synopsis of events dated 4/24/25 revealed, in part: On Friday April 18. 2025, it was alleged that [R99] became combative and struck [R128] in the face on the memory care unit. Throughout the investigation it was reported by staff that frequently care for both [R99] and [R128], they both wander throughout (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the unit. [R99] can become agitated and aggressive when someone is in her personal space and [R128] is very anxious and can be impulsive at times grabbing items that do not belong to her. When interviewing both residents involved, neither resident was able to recall the incident.A review of R128's clinical record revealed the following progress note dated 4/18/25 at 12:47 p.m.: Nursing observations, evaluation and recommendations are: Resident got in another resident's face and gets into their food. [R99] got upset and allegedly struck [R128]'s face. No injuries to the face.A review of the facility's final synopsis of events dated 4/25/25 revealed, in part: On Sunday April 20, 2025, it was alleged that [R99] became combative and struck [R128] in the mouth on the memory care unit. Throughout the investigation, it was reported by staff that frequently care for both [R99] and [R128], they both wander throughout the unit; [R99] can become protective of the staff when other residents become anxious, aggressive or physical towards them, and [R128] is very anxious and will grab on to staff at times for comfort, especially when she feels overwhelmed. When interviewing both residents involved, neither resident was able to recall the incident.A review of R128's clinical record revealed the following progress note dated 4/21/25 at 12:28 a.m.: Reported to this writer resident was punched by [R99] in the upper lip. CNA (certified nursing assistant) stated she was escorting [R128] from room [ROOM NUMBER]. [R128] grabbed CNA's upper arm. [R99] was outside room [ROOM NUMBER] when she grabbed CNA's other arm, told [R128] to let go of her. [R99] then punched [R128]in the upper lip. Both residents were separated.A review of R128's comprehensive care plan dated 2/17/25 revealed no information related to these incidents of abuse.On 1/12/26 at 2:36 p.m., OSM (other staff member) #9, the director of social services, was interviewed. She stated she is responsible for following up on a resident's psychosocial needs following any resident to resident altercation. She stated the abused resident's care plan should be updated following any such incident.On 1/12/26 at 3:24 p.m., RN (registered nurse) #3 was interviewed. She stated that a resident's care plan is maintained to make sure all care team members are on the same page and are providing appropriate care to the resident. She stated the resident's care plan should be updated for any victim of abuse. She explained that unit managers ordinarily update the care plans.On 1/12/26 at 3:43 p.m., LPN (licensed practical nurse) #7, a unit manager, was interviewed. She stated a resident's care plan should be updated after an incident of abuse by another resident because such an event could trigger a trauma response. She stated floor nurses do not typically update care plans, and that this task is usually accomplished by unit managers.On 1/12/26 at 4:08 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were notified of these concerns.No additional information was provided prior to exit.3. For Resident #25 [R25], the facility staff failed to revise the resident's comprehensive care plan after she was abused by Resident #99 (R99). A review of the facility's final synopsis of events dated 5/23/25 revealed, in part: On Saturday May 17, 2025, it was alleged that [R99] became combative and struck [R25] on the right side of her face on the memory care unit. Throughout the investigation it was reported by staff that frequently care for both residents, that [R99] wanders throughout the unit and can become aggressive immediately after care as she does not like anyone in her personal space. When interviewing both residents involved, neither resident was able to recall the incident.A review of R25's clinical record revealed the following progress notes: 5/17/25 [R99] was combative and swung her hand at glove dispenser that gave her a skin tear on left wrist. After resident was out of the bathroom she went to [R25] and hit the other resident on the right side of her face. The two were separated, assessed, and treated as per protocol. 5/19/25 This writer provided follow up visit r/t (related to) negative encounter with another resident. She was unable to recall incident. She did not express any concern or fear of safety to this writer. She presented calm with no s/s (signs or symptoms) of distress.A review of R25 comprehensive care plan dated 3/5/25 revealed no information related to this incident of abuse.On 1/12/26 at 2:36 p.m., OSM (other staff member) #9, the director of social services, was interviewed. She stated she is responsible for following up on a resident's psychosocial needs following any resident to resident altercation. She stated the abused (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's care plan should be updated following any such incident.On 1/12/26 at 3:24 p.m., RN (registered nurse) #3 was interviewed. She stated that a resident's care plan is maintained to make sure all care team members are on the same page and are providing appropriate care to the resident. She stated the resident's care plan should be updated for any victim of abuse. She explained that unit managers ordinarily update the care plans.On 1/12/26 at 3:43 p.m., LPN (licensed practical nurse) #7, a unit manager, was interviewed. She stated a resident's care plan should be updated after an incident of abuse by another resident because such an event could trigger a trauma response. She stated floor nurses do not typically update care plans, and that this task is usually accomplished by unit managers.On 1/12/26 at 4:08 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were notified of these concerns.No additional information was provided prior to exit.4. For Resident #13 (R13), the facility staff failed to revise the resident's comprehensive care plan after she was abused by Resident #99 (R99). A review of the facility's final synopsis of events dated 6/24/25 revealed, in part: On Wednesday, June 18, 2025, it was alleged that [R99] became combative and aggressive and struct [R13] on the right side of her face with a comb in the memory care unit. Throughout the investigation, staff who frequently cared for [R99] and [R13] reported that they wander throughout the unit. Staff also reported that [R99] can become agitated at times, especially when residents are in her personal space. When interviewing both residents involved, neither resident was able to recall the incident.A review of R13's clinical record revealed the following progress notes: 6/18/25 8:16 a.m. The resident was sitting in her wheelchair by the nurse's computer table when another resident approached her and hit her on the face with a comb. Nurse assessed the face, no injuries noted. 6/18/25 12:17 p.m. Support visit held. Resident has no recall of negative encounter with another resident. Resident cont. (continued) to ask questions back to this writer and stated she did feel safe in facility.A review of the facility's final synopsis of events dated 11/7/25 revealed, in part: On Sunday, November 2, 2025, it was alleged that [R99] became combative and struck [R13] in the middle of her face on the memory care unit. Throughout the investigation it was reported by staff that frequently care for both residents that [R99] can become agitated when another resident touches her or is in her space. When interviewing both residents involved, neither was able to recall the incident.A review of R13's clinical record revealed the following progress notes: 11/2/25 8:00 p.m. This nurse was notified by CNA (certified nursing assistant) that resident was hit in the face with a padded box by [R99] after this resident gently touched [R99] on the arm. This nurse assessed resident. No injuries noted. 11/4/25 4:19 p.m. Bruising to upper lip noted after incident occurred. 11/5/25 1:58 p.m. Resident met with this writer but did not provide any remembrance to questions regarding her recall of a negative encounter with another resident or her comfort level among others in the facility.A review of R13's comprehensive care plan dated 12/17/24 revealed no information related to the incidents of abuse.On 1/12/26 at 2:36 p.m., OSM (other staff member) #9, the director of social services, was interviewed. She stated she is responsible for following up on a resident's psychosocial needs following any resident to resident altercation. She stated the abused resident's care plan should be updated following any such incident.On 1/12/26 at 3:24 p.m., RN (registered nurse) #3 was interviewed. She stated that a resident's care plan is maintained to make sure all care team members are on the same page and are providing appropriate care to the resident. She stated the resident's care plan should be updated for any victim of abuse. She explained that unit managers ordinarily update the care plans.On 1/12/26 at 3:43 p.m., LPN (licensed practical nurse) #7, a unit manager, was interviewed. She stated a resident's care plan should be updated after an incident of abuse by another resident because such an event could trigger a trauma response. She stated floor nurses do not typically update care plans, and that this task is usually accomplished by unit managers.On 1/12/26 at 4:08 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were notified of these concerns.No additional information was provided prior to exit.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview and facility document review, the facility staff failed to prepare store and serve food in a sanitary manner in one of one facility kitchens. The findings include:On 01/05/2026 at approximately 11:45 a.m. an observation of the facility's kitchen revealed OSM (other staff member) #6, kitchen aide and OSM #7, kitchen aide, at the tray line placing resident's plated lunch meal on trays. Further observations of OSM #6 revealed she was not wearing a hair net and OSM #7 did not have his mustache covered. On 01/05/2026 at approximately 11:50 a.m. an observation of the inside of the reach-in refrigerator revealed two trays containing 78 cups of pasta salad. Further observation failed to evidence a date to indicate when the salads were prepared. On 01/05/2026 at approximately 11:55 a.m. an observation of the inside of the reach-in dairy refrigerator revealed a container with approximately six ounces of pureed turkey without a date and a container with approximately eight ounces of sliced ham without a date. On 01/05/2026 at approximately 2:25 p.m. an observation of a kitchen preparation table revealed a food processor with the lid sitting upside-down on top of the bowl. Observation of the food processor lid and the inside of the bowl revealed left-over food debris. At approximately 2:30 p.m. an observation of the food processor and interview was conducted with OSM #2, dietary manager. When asked how someone would determine whether the food processor was clean and ready for use, she stated the lid would be turned upside-down on the food processor bowl. After observing the food processor lid and inside of the bowl she stated it was not clean and instructed a kitchen aide to remove the bowl and lid for washing. On 01/06/2026 at approximately 3:05 p.m. an interview was conducted with OSM #2 regarding the observations stated above. She stated that hair nets and beard/mustache covering should be always worn in the kitchen to prevent hair from falling into the resident's food. She also stated that all prepared and leftover food should be dated. Regarding the food processor, she stated that it should have been checked after it was washed to make sure it was clean. The facility's policy, Prevention Of Infection - Dietary Department documented in part, 6. Food will be stored, prepared, and distributed in a clean environment and will be monitored for signs of spoilage or contamination. c. Food items will be labeled and dated for safe use. 7. Dietary staff will wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food. The facility's policy, Sanitization documented in part, 3. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitize using hot water and/or chemical sanitizing solutions. The facility's policy, Receiving and Storage of Food documented in part, 8. All food in the refrigerator or freezer will be covered, labeled and dated (use by date). On 01/07/2026 at approximately 5:33 p.m. ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, and ASM #4, regional director of operations, were made aware of the above findings. No further information was provided prior to exit.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and staff interview, facility staff failed to promote resident's dignity for one of 52 residents in the survey sample, Resident #45. The finding include:For Resident #45 (R45), facility staff stood next to the bed while providing feeding assistance. R45 was admitted to the facility with a diagnosis that included but not limited to swallowing difficulties. On the most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/07/2025, R45 scored 3 (three) out of 15 on the BIMS (brief interview for mental status), indicating R45 was severely impaired of cognition for making daily decisions. GG0130 Self-Care coded R45 as requiring moderate assistance for eating. On 01/06/2026 at approximately 9:15 a.m. an observation revealed CNA (certified nursing assistant) #3 standing next to R45's bed assisting him with his breakfast. On 01/06/2026 at approximately 9:38 a.m. an interview was conducted with CNA #3. When asked to describe the position she was in while feeding R45 she stated she was standing and that she should have been sitting while assisting R45 with his meal. CNA #3 further stated that it was not dignified for the resident to stand and feed them On 01/07/2026 at approximately 5:33 p.m. ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, and ASM #4, regional director of operations, were made aware of the above findings. No further information was provided prior to exit.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review and facility document review, it was determined that the facility staff failed to maintain a clean, homelike environment for two of 52 residents in the survey sample, Residents #48 and #131.The findings include:1. For Resident #48 (R48), the facility staff failed to maintain a clean and homelike environment. On the most recent minimum data set (MDS), a quarterly assessment with an assessment reference date of 12/16/2025, the resident was assessed as being severely impaired for making daily decisions. On 1/5/2026 at 2:13 PM, an observation was made of R48 in bed in their room. An approximately 20-inch floor fan was observed sitting on top of the wooden arms of a chair facing the end of R48's bed. The fan was observed to be on and blowing air towards the resident. Observation of the cage of the fan revealed dust fibers and dried brown/grey substance on the inside of the cage. Additional observations of the fan in use with R48 in bed were made on 1/5/2026 at 4:08 PM and 1/6/2026 at 8:48 AM. The cage of the fan remained as described above. On 1/12/2026 at 1:24 PM, an interview was conducted with licensed practical nurse (LPN) #1 who stated that nursing did not clean the fan in R48's room. She stated that housekeeping was responsible for the cleaning of the fan. At approximately 1:30 PM, LPN #1 observed the fan in R48's room and stated that there was dust and dirt inside that needed cleaning. The fan was observed as described above and was blowing on R48 who was asleep in bed. On 1/12/2026 at 2:09 PM, an interview was conducted with other staff member (OSM) #10, environmental services supervisor. OSM #10 stated that housekeeping staff wiped the outside of R48's fan but did not clean the inside cage or blades. She stated that when it was needed, they put in a work order for maintenance to take it apart and clean it. On 1/12/2026 at approximately 3:00 PM, a request was made to administrative staff member (ASM) #3, the regional director of clinical services, for any work orders to clean R48's fan or evidence of cleaning of the fan. On 1/12/2026 at approximately 3:15 PM, ASM #2, the director of nursing, provided a work order created on 1/12/2026 to clean the inside of R48's fan. No other work orders were received to evidence cleaning of the fan. The facility policy Homelike Environment documented in part, Residents will be provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible . The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment . f. pleasant, neutral scents . On 1/12/2026 at 4:07 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #131 (R131), the facility staff failed to create a clean, home like environment when the resident was admitted on Saturday, 9/21/24. A review of R131's clinical record revealed that he was admitted to the facility on [DATE]. A review of a facility grievance form dated 9/23/24 revealed, in part: Source of Information – [R131]'s son.Date of Issue: all weekend. Time/Shift of Issue: all weekend. Rm (room) smelled of urine. Staff kept solving issue by opening his father's windows and pt (patient) was cold.Housekeeping told son, 'We have to go to Walmart to get supplies,' and Housekeeping left. 'We can't clean it until Monday.Initial Action 9/23/2024.Spoke to maintenance director and environmental director re: (regarding) plan. Follow Up Action 9/23/24 Investigated area in room.Remove affected carpet. Bleach the floor and apply area rug. Carpet being pulled completely in 2-3 weeks. On 1/12/26 at 2:09 p.m., OSM (other staff member) #10, the environmental services supervisor, was interviewed. She stated that she was on call the weekend of R131's admission to the facility. She stated there are always three housekeepers who work every Saturday and Sunday from 6:30 a.m. until 2:30 p.m. She could not recall what time R131 arrived at the facility, but believed it was after 2:30 p.m. She stated she has a clear memory of the events of this situation. She remembered receiving a call from the administrator (no longer employed at the facility) because there had been an issue with a resident who was being admitted . She stated R131's roommate had continuously been urinating on the carpet in the room, and when R131 and his family arrived at the facility, they told the staff that the urine odor was offensive and unacceptable. She stated when she arrived at the room, It did smell like very strong urine, and that the carpet stain was not new. She stated, We tried everything. I personally scrubbed the carpet. It was bad. The scrubbing did not take the smell out. She explained she removed the curtains, scrubbed the walls, and briefly opened the window; nothing helped. She stated that eventually (later in the week), the maintenance staff cut out the carpet where the stain was and put down an area rug. She stated it was not a home like environment at all, and added, All I know is I did the best I could to get the pee out of that carpet, but I could not. On 1/12/26 at 4:08 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were notified of these concerns. No information was provided prior to exit.

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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 facility document review, clinical record review and staff interview, it was determined that the facility staff failed to implement their abuse policy for timely reporting of an abuse allegation for one of 52 residents in the survey sample, Resident #99. The findings include:For Resident #99 (R99), the facility staff failed to implement their abuse policy for reporting of an abuse allegation to the state agency within two hours for resident-to-resident altercations that occurred on 10/24/2025 and 11/2/2025. The facility policy Abuse documented in part, .The organization will maintain systems to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or results in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, and his or her designee, and to other officials (including the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures . Change in Condition evaluations for R99 documented in part,- 10/24/2025 21:30 (9:30 PM) Other change in condition: Another Resident states [R99] was going through her drawers and aggressive tour [sic] her when she asked her to stop .- 11/2/2025 20:56 (8:56 PM) Other change in condition: resident to resident altercation . resident hit another resident [Room number of other resident] in the face with a padded sewing box after [Room number of other resident] reached out and gently touched resident, both residents assessed, no injuries noted, all parties notified . The progress notes for R99 documented in part,- 10/24/2025 21:30 (9:30 PM) Nursing note. Note Text: Residents roommate states she was going tough [sic] her drawers and when she asked her to stop [R99] punched her in the face.- 11/02/2025 20:52 (8:52 PM) Nursing note. Note Text: resident hit another resident [Room number] in the face with a padded sewing box after resident [Room number] reached out and gently touched resident both residents assessed no injuries noted, all parties notified. Review of the facility synopsis of events documented an initial report date of 10/25/2025 for the incident date 10/24/2025 documenting in part, On the memory care unit, [R99] allegedly struck [Name of another resident] on the right side of her face . The included fax confirmation for notification of the state agency documented the fax sent on 10/25/2025 08:35 (8:35am). The initial report date of 11/3/2025 for the incident date 11/2/2025 documented in part, On the memory care unit, it was alleged that [R99] struck [Name of another resident] in the face . The included fax confirmation for notification of the state agency documented the fax sent on 11/3/2025 10:50 (10:50am). On 1/8/2026 at 11:54 AM, an interview was conducted with licensed practical nurse (LPN) #6 who stated that if there was a resident-to-resident altercation they immediately separated the residents and ensured that they were uninjured and safe. She stated that the incident was immediately reported to the supervisor or director of nursing because it had to be reported. On 1/9/2026 at 9:23 AM an interview was conducted with certified nursing assistant (CNA) #1 who stated that any resident-to-resident altercations were reported to the charge nurse. She stated that she knew that the incidents had to be reported within two hours, so it was important to let the charge nurse know immediately. On 1/12/2026 at 3:15 PM, an interview was conducted with administrative staff member (ASM) #2, the director of nursing who stated that if there was a resident-to-resident altercation the staff responsibility was to get the residents to safety, deescalate the situation and stay with the residents until help arrives. She stated that the help that arrives notifies the charge nurse who calls administration. ASM #2 stated that staff normally call her and she came in to start the initial reporting of the incident. She stated that they are supposed to report within two hours and the incidents on 10/24/2025 and 11/2/2025 she was probably not informed until the next day. On 1/12/2026 at 4:07 PM, ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regional director of clinical services were made aware of the findings. No further information was provided prior to exit.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility document review, clinical record review and staff interview, it was determined that the facility staff failed to report an abuse allegation in a timely manner for one of 52 residents in the survey sample, Resident #99. The findings include:For Resident #99 (R99), the facility staff failed report of an abuse allegation to the state agency within two hours for resident-to-resident altercations that occurred on 10/24/2025 and 11/2/2025. Change in Condition evaluations for R99 documented in part,- 10/24/2025 21:30 (9:30 PM) Other change in condition: Another Resident states [R99] was going through her drawers and aggressive tour [sic] her when she asked her to stop .- 11/2/2025 20:56 (8:56 PM) Other change in condition: resident to resident altercation . resident hit another resident [Room number of other resident] in the face with a padded sewing box after [Room number of other resident] reached out and gently touched resident, both residents assessed, no injuries noted, all parties notified . The progress notes for R99 documented in part,- 10/24/2025 21:30 (9:30 PM) Nursing note. Note Text: Residents roommate states she was going tough [sic] her drawers and when she asked her to stop [R99] punched her in the face.- 11/02/2025 20:52 (8:52 PM) Nursing note. Note Text: resident hit another resident [Room number] in the face with a padded sewing box after resident [Room number] reached out and gently touched resident both residents assessed no injuries noted, all parties notified. Review of the facility synopsis of events documented an initial report date of 10/25/2025 for the incident date 10/24/2025 documenting in part, On the memory care unit, [R99] allegedly struck [Name of another resident] on the right side of her face . The included fax confirmation for notification of the state agency documented the fax sent on 10/25/2025 08:35 (8:35am). The initial report date of 11/3/2025 for the incident date 11/2/2025 documented in part, On the memory care unit, it was alleged that [R99] struck [Name of another resident] in the face . The included fax confirmation for notification of the state agency documented the fax sent on 11/3/2025 10:50 (10:50am). On 1/8/2026 at 11:54 AM, an interview was conducted with licensed practical nurse (LPN) #6 who stated that if there was a resident-to-resident altercation they immediately separated the residents and ensured that they were uninjured and safe. She stated that the incident was immediately reported to the supervisor or director of nursing because it had to be reported. On 1/9/2026 at 9:23 AM an interview was conducted with certified nursing assistant (CNA) #1 who stated that any resident-to-resident altercations were reported to the charge nurse. She stated that she knew that the incidents had to be reported within two hours, so it was important to let the charge nurse know immediately. On 1/12/2026 at 3:15 PM, an interview was conducted with administrative staff member (ASM) #2, the director of nursing who stated that if there was a resident-to-resident altercation the staff responsibility was to get the residents to safety, deescalate the situation and stay with the residents until help arrives. She stated that the help that arrives notifies the charge nurse who calls administration. ASM #2 stated that staff normally call her and she came in to start the initial reporting of the incident. She stated that they are supposed to report within two hours and the incidents on 10/24/2025 and 11/2/2025 she was probably not informed until the next day. The facility policy Abuse documented in part, .The organization will maintain systems to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or results in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, and his or her designee, and to other officials (including the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures . On 1/12/2026 at 4:07 PM, ASM #1, the administrator, ASM #2, the director of (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing, and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to notify the ombudsman of a discharge for one of 52 residents in the survey sample, Resident #119.The findings include:For Resident #119 (R119), the facility staff failed to notify the ombudsman of discharge on [DATE].The progress notes for R119 documented in part, 11/21/2025 13:46 (1:46 PM) Note Text: Resident discharge to home via family's car. Alert and oriented at time of discharge. No acute distress noted. Left the facility accompanied by family. All belongings taken by resident.Review of the clinical record failed to evidence notification of the long-term care ombudsman of the discharge on [DATE].On 1/12/2026 at 3:24 PM, an interview was conducted with other staff member (OSM) #9, the director of social services who stated that she sent a monthly notification to the ombudsman of residents who were transferred or discharged to the hospital but did not send notifications of residents who were discharged or transferred to other facilities. She stated that she was not aware that it was required.On 1/12/2026 at 4:07 PM, administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the findings.No further information was provided prior to exit.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and facility document review, facility staff failed to obtain a Level I (one) PASARR (preadmission screening and resident review) for two of 52 residents in the survey sample, Resident #11 and #38. The findings include:1. For Resident #11 (R11), the facility failed to ensure a PASARR Level I screening was completed prior to admission. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 12/11/2025, R11 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. A review of R11's clinical record revealed they were admitted under Medicare. Further review of the clinical record failed to evidence a level 1 PASARR was completed prior to admission on [DATE]. On 01/12/2026 at approximately 1:20 p.m. a request for R11's PASARR was made to ASM (administrative staff member) #3, regional director of clinical services. ASM #3 stated the PASARR Level I was not completed for R11. On 01/12/2026 at approximately 2:35 p.m an interview was conducted with OSM (other staff member) #9, director of social services regarding a PASARR for a resident. She stated, the hospital should do the Level I PASARR and provide it to the facility and if the resident requires a level II the hospital should do that too. She further stated that the facility's admissions office has a checklist to see that it is done prior to coming to the facility. She also stated the if the PASARR is not done prior to the resident coming to the facility OSM #9 stated she can complete the PASARR. The facility's policy Long-Term Services and Supports (LTSS) Screening, Preadmission Screening and Resident Review (PASRR) Policy documented in part, POLICY: The organization observes preadmission screening requirements to ensure that: Medicaid-eligible individuals meet required level of care criteria for Long-Term Services and Supports People with known or suspected mental illness, intellectual disabilities, and/or related conditions are not inappropriately institutionalized or marginalized; to make sure that every individual receives the services and supports that will optimize their success in the least restrictive setting Residents with these specific types of disabilities are admitted or allowed to remain in the facility, only if the facility can provide them with the services they need.PASRR 1). Level 1 Screening. a. If a Level 1 Screening has not been completed prior to admission and the resident is already Medicaid member OR financially eligible by way of application as verified by the ePAS system, the Social Worker, Admissions Coordinator, or designee will request that the referral provider and/or Community Screening Team complete the screen prior to admission. b. If the resident is not Medicaid or Medicaid eligible by way of application, the nursing facility will be responsible for completion of the Level 1screening. i. May be completed by facility staff representative who has medical knowledge of the resident and knowledge of medical terminology using due diligence. On 01/12/2026 at approximately 4:06 p.m. ASM #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, and ASM #4, regional director of operations, were made aware of the above findings. No further information was provided prior to exit (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #38 (R38), the facility staff failed to complete a Level I PASRR (preadmission screening and resident review) prior to admission. R38 was admitted to the facility on [DATE] with diagnoses that included but were not limited to cerebral atherosclerosis and unspecified dementia. Review of R38's clinical record failed to evidence a completed Level I PASARR. On 1/6/2026 at approximately 10:30 AM, a request was made to administrative staff member (ASM) #3, the regional director of clinical services, for the Level I PASARR for R38. On 1/6/2026 at approximately 3:26 PM, ASM #3, stated that they did not have a Level I PASARR to provide for R38. On 1/12/2026 at 3:24 PM, an interview was conducted with other staff member (OSM) #9, the director of social services who stated that the hospital should complete the Level I PASARR prior to admission to the facility. She stated that admissions normally obtained the Level I PASARR from the hospital and kept a checklist to ensure it was done prior to the resident's admission. OSM #9 stated that if the assessment was not done prior to the admission, she would be able to complete it. On 1/7/2026 at 5:33 PM, ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were made aware of the findings. No further information was provided prior to exit.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide respiratory care and services in a sanitary manner for two of 52 residents in the survey sample, Residents #8 and #97.The findings include:1. For Resident #8 (R8), the facility staff failed to implement enhanced barrier precautions (1) and follow standard precautions (2) when providing tracheostomy (3) care on 1/6/26. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/12/25, R8 was coded as being in a persistent vegetative state. She was also coded as requiring an invasive mechanical ventilator for breathing and requiring tracheostomy care. On 1/6/25 at 1:10 p.m., OSM (other staff member) #13, a respiratory therapist, was observed providing tracheostomy care to R8. OSM #13 put on gloves before he entered R8's room and began the tracheostomy care; he did not put on a gown or mask. He used gloved hands to remove the soiled gauze around the resident's tracheostomy, and he did not remove those gloves or sanitize his hands before cleansing around the stoma or replacing clean gauze around the opening. A review of R8's provider's orders revealed an order dated 9/22/25 for enhanced barrier precautions. On 1/12/26 at 3:24 p.m., RN (registered nurse) #3 was interviewed. She stated if a resident is on enhanced barrier precautions, the staff member should wear gloves and gown. She stated the staff member should remove gloves, sanitize their hands, and put on clean gloves between handling soiled gauze and cleansing the area/placing clean gauze around a resident's tracheostomy. On 1/12/26 at 3:43 p.m., LPN (licensed practical nurse) #7, a unit manager, was interviewed. She stated that enhanced barrier precautions generally include gloves and a gown, and that tracheostomy care also requires a mask because there is a risk of a resident's bodily fluids to be sprayed into the air. She stated gloves should be changed and hands sanitized between handling dirty and clean gauze around a tracheostomy. On 1/12/26 at 4:08 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were notified of these concerns. A review of the facility policy, Tracheostomy Care, revealed, in part: A mask and eyewear will be worn if splashes, spattering or spraying of blood or body fluids is likely to occur when performing this procedure.Remove old dressings. Pull soiled glove over dressing and discard into appropriate receptacle.Apply clean gloves. Clean the stoma with two peroxide-soaked gauze pads.Wipe with dry gauze.Apply a fenestrated gauze pad around the insertion site. A review of the facility policy, Enhanced Barrier Precautions (EBP), revealed, in part: The purpose of this policy is to outline the guidelines for implementing Enhanced Barrier Precautions in order to reduce the transmission of multidrug-resistant organisms within our facility. EBP will be utilized in conjunction with standard precautions to provide targeted gown and glove use during high-contact resident care activities.Criteria for implementing EBP.Residents with wounds and/or indwelling medical devices. No additional information was provided prior to exit. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	References(1) Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). This information is taken from the website https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html. (2) Standard Precautions are the minimum infection prevention practices that apply to all patient care, regardless of suspected infection status, to protect both healthcare workers and patients from transmissible microorganisms found in blood, body fluids, non-intact skin, and mucous membranes. They include essential practices like hand hygiene, using Personal Protective Equipment (PPE) (gloves, gowns, masks, eye protection) as needed, respiratory hygiene/cough etiquette, safe injection practices, and proper handling/disposal of contaminated equipment or waste. This information is taken from the website https://www.cdc.gov/infection-control/hcp/basics/standard-precautions.html. (3) A tracheostomy is a surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube. This information is taken from the website https://medlineplus.gov/ency/article/002955.htm. 2. For Resident #97 (R97), facility staff failed to place a C-PAP (continuous positive airway pressure) (1) nasal mask is a plastic bag when not in use. R97 was admitted to the facility with diagnosis that included but not limited to sleep apnea (2). On the most recent comprehensive MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 12/18/2025, R97 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R97 was cognitively intact for making daily decisions. Section O Special Treatments, Procedures and Programs coded R97 as having a Non-Invasive Mechanical Ventilator. The physician's order for R97 documented, CPAP on at HS (hours of sleep) at bedtime related to obstructive sleep apnea. Order Date: 11/7/2024. On 01/05/2026 at approximately 1:24 p.m. an observation of R97's C-PAP nasal mask was observed lying in the bed uncovered. Further observations failed to evidence a storage bag for the mask. On 01/05/2026 at approximately 3:11 p.m. an observation of R97's C-PAP nasal mask was observed lying in the bed uncovered. Further observations failed to evidence a storage bag for the mask. On 01/06/2026 at approximately 8:40 a.m. an observation of R97's C-PAP nasal mask was observed lying in the bed uncovered. Further observations failed to evidence a storage bag for the mask. On 01/07/2026 at approximately 9:45 a.m. an observation of R97's C-PAP nasal mask was observed lying on the bedside table uncovered. Further observations failed to evidence a storage bag for the mask. On 01/07/2026 at approximately 9:50 a.m. an interview and observation of R97's C-PAP nasal mask was conducted with LPN (licensed practical nurse) #3. After observing R97's C-PAP nasal mask she (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that it was not covered and needed to be placed in a bag to prevent contamination. On 01/07/2026 at approximately 5:33 p.m. ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, and ASM #4, regional director of operations, were made aware of the above findings. No further information was provided prior to exit. References: (1) The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems. This information was obtained from the website: https://medlineplus.gov/ency/article/001916.htm. (2) Nasal CPAP masks cover only the nose and offer a lighter feel that works well for nose breathers and multiple sleeping positions. This information was obtained from the website: https://www.sleepfoundation.org/cpap/cpap-mask-types.

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Lynn Care Center	1000 Shenandoah Avenue Front Royal, VA 22630

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on staff interview and facility document review, the facility staff failed to complete an annual performance evaluations for two of five CNA (certified nursing assistant) records reviewed, CNAs #5 and #6. The findings include:For CNA #5 and CNA #6, the facility staff failed to provide evidence of the required annual performance evaluation in the past 12 months. On 01/09/2026 at approximately 11:00 a.m., CNA #5's and CNA #6's most recent performance evaluation was requested. On 01/12/2026 at approximately 10:00 a.m., a review of CNA #5's and CNA #6's most recent performance evaluations were conducted by the surveyor. CNA #5's performance evaluation was dated 11/27/2024 and CNA #6's performance evaluation was dated 03/05/2024. On 01/12/2026 at approximately 11:13 a.m. an interview was conducted with OSM #11, human resources, and OSM #7, regional director of human resources, by telephone regarding employee performance reviews. OSM #11 stated that the employee performance evaluations should be completed annually. She further stated that she was trying to get all performance evaluations up to date. The facility's policy, Performance Evaluations documented in part, POLICY: The job performance of each employee shall be reviewed and evaluated at least annually. 1. A performance evaluation will be completed on each employee at the conclusion of his/her 90-day probationary period, and at least annually thereafter. The performance evaluation meeting will occur at the same time as the employee's compensation review. 4. Performance evaluations will be completed by the employees' department directors and supervisors and reviewed by the HR Director and Administrator. Each employee will be given the opportunity to review his/her evaluation with his/her department director and the HR Director. On 01/12/2026 at approximately 4:06 p.m. ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, and ASM #4, regional director of operations, were made aware of the above findings. No further information was provided prior to exit

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. Based on staff interview and facility document review, the facility staff failed to evidence agreements for contractual services for one of one facility. The findings include:The facility staff failed to maintain agreements for services with the contracted wound care company. On 01/09/2026 at approximately 11:00 a.m., a request was made for the facility's contracts for hospice, dialysis, mobile X-ray, mobile laboratory, dental, podiatry, ophthalmology/optometry wound care and psych (psychiatric/psychological) service. On 01/12/2026 at approximately 1:00 p.m. a review of the facility contracts failed to reveal agreements for services with the contracted wound care company. On 01/12/2026 at approximately 4:28 p.m. an interview was conducted with ASM # 4, regional director of operations. ASM #4 stated that when services are initiated with an outside company, the facility has the company sign an agreement and it is kept at the facility. He stated that he was unable to locate the contract for wound care. The facility's policy Consultants documented in part, SPECIFIC PROCEDURES / GUIDANCE. 1. Our facility may use as needed outside resources to furnish specific services to residents and to the facility. Such personnel are employed on a consultant basis. 3. Written, signed, and dated agreements are maintained for each consultant or consulting group. Each agreement may contain: a. The responsibilities of the consultant; b. The responsibilities of the facility; c. The qualifications of the consultant; d. The duration of the agreement; e. The financial terms of the agreement; and f. The minimum number of hours to be provided by the consultant. 4. Consultants will provide the Administrator and or designees with written, dated, and signed reports of each consultation visit. Such reports contain the consultant's: a. Recommendations; b. Plans for implementation of his/her recommendations; c. Findings; and d. Plans for continued assessments. On 01/12/2026 at approximately 4:06 p.m. ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, and ASM #4, regional director of operations, were made aware of the above findings. No further information was provided prior to exit

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow infection control procedures for one of 52 residents in the survey sample, Resident #8.The findings include:For Resident #8 (R8), the facility staff failed to implement enhanced barrier precautions (1) and follow standard precautions (2) when providing tracheostomy (3) care on 1/6/26.On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/12/25, R8 was coded as being in a persistent vegetative state. She was also coded as requiring an invasive mechanical ventilator for breathing and requiring tracheostomy care.On 1/6/25 at 1:10 p.m., OSM (other staff member) #13, a respiratory therapist, was observed providing tracheostomy care to R8. OSM #13 put on gloves before he entered R8's room and began the tracheostomy care; he did not put on a gown or mask. He used gloved hands to remove the soiled gauze around the resident's tracheostomy, and he did not remove those gloves or sanitize his hands before cleansing around the stoma or replacing clean gauze around the opening.A review of R8's provider's orders revealed an order dated 9/22/25 for enhanced barrier precautions.On 1/12/26 at 3:24 p.m., RN (registered nurse) #3 was interviewed. She stated if a resident is on enhanced barrier precautions, the staff member should wear gloves and gown. She stated the staff member should remove gloves, sanitize their hands, and put on clean gloves between handling soiled gauze and cleansing the area/placing clean gauze around a resident's tracheostomy.On 1/12/26 at 3:43 p.m., LPN (licensed practical nurse) #7, a unit manager, was interviewed. She stated that enhanced barrier precautions generally include gloves and a gown, and that tracheostomy care also requires a mask because there is a risk of a resident's bodily fluids to be sprayed into the air. She stated gloves should be changed and hands sanitized between handling dirty and clean gauze around a tracheostomy.On 1/12/26 at 4:08 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were notified of these concerns.A review of the facility policy, Tracheostomy Care, revealed, in part: A mask and eyewear will be worn if splashes, spattering or spraying of blood or body fluids is likely to occur when performing this procedure.Remove old dressings. Pull soiled glove over dressing and discard into appropriate receptacle.Apply clean gloves. Clean the stoma with two peroxide-soaked gauze pads.Wipe with dry gauze.Apply a fenestrated gauze pad around the insertion site.A review of the facility policy, Enhanced Barrier Precautions (EBP), revealed, in part: The purpose of this policy is to outline the guidelines for implementing Enhanced Barrier Precautions in order to reduce the transmission of multidrug-resistant organisms within our facility. EBP will be utilized in conjunction with standard precautions to provide targeted gown and glove use during high-contact resident care activities.Criteria for implementing EBP.Residents with wounds and/or indwelling medical devices.No additional information was provided prior to exit.Reference(1) Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). This information is taken from the website https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html.(2) Standard Precautions are the minimum infection prevention practices that apply to all patient care, regardless of suspected infection status, to protect both healthcare workers and patients from transmissible microorganisms found in blood, body fluids, non-intact skin, and mucous membranes. They include essential practices like hand hygiene, using Personal Protective Equipment (PPE) (gloves, gowns, masks, eye protection) as needed, respiratory hygiene/cough etiquette, safe injection practices, and proper handling/disposal of contaminated equipment or waste. This information is taken from the website https://www.cdc.gov/infection-control/hcp/basics/standard-precautions.html.(3) A (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tracheostomy is a surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube. This information is taken from the website https://medlineplus.gov/ency/article/002955.htm.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on employee record review and staff interview, the facility staff failed to provide required training on resident rights for one of five staff records reviewed, OSM (other staff member) #8, a member of the dietary staff. The findings include:For OSM #8, the facility staff failed to provide required resident rights training. On 01/09/2026 at approximately 11:00 a.m., OSM #8's education records were requested. On 01/12/2026 at approximately 10:00 a.m., a review of OSM #8's education record was conducted by the surveyor. The record failed to evidence the required training regarding resident rights. On 01/12/2026 at approximately 11:13 a.m. an interview was conducted with OSM #11, human resources, and OSM #7, regional director of human resources by telephone regarding OSM (other staff member) #8's annual training for resident rights. OSM #11 stated that OSM #8 was a contract employee and only received abuse training. OSM #7 stated that all contract employees receive an orientation packet from the facility's human resource (HR) department that contains the required trainings, and the training is completed by the HR department before the employee starts working. After reviewing OSM #8's training record, OSM #11 stated that OSM #8 had not received the required training on resident rights. On 01/12/2026 at approximately 4:06 p.m. ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, and ASM #4, regional director of operations, were made aware of the above findings. 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 employee record review and staff interview, the facility staff failed to provide required training on QAPI (quality assurance and performance improvement)for one of five staff records reviewed, OSM (other staff member) #8, a member of the dietary staff. The findings include:For OSM #8, the facility staff failed to provide required training on QAPI elements. On 01/09/2026 at approximately 11:00 a.m., OSM #8's education records were requested. On 01/12/2026 at approximately 10:00 a.m., a review of OSM #8's education record was conducted by the surveyor. The record failed to evidence the required training regarding QAPI elements. On 01/12/2026 at approximately 11:13 a.m. an interview was conducted with OSM #11, human resources, and OSM #7, regional director of human resources by telephone regarding OSM (other staff member) #8's, annual training for resident rights. OSM #11 stated that OSM #8 was a contract employee and only received abuse training. OSM #7 stated that all contract employees receive an orientation packet from the facility's human resource (HR) department that contains the required trainings, and the training is completed by the HR department before the employee starts working. After reviewing OSM #8's training record, OSM #11 stated that OSM #8 had not received the required training on QAPI. On 01/12/2026 at approximately 4:06 p.m. ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, and ASM #4, regional director of operations, were made aware of the above findings. No further information was provided prior to exit

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on employee record review and staff interview, the facility staff failed to provide required infection control training for one of five staff records reviewed, OSM (other staff member) #8, a member of the dietary staff. The findings include:For OSM #8, the facility staff failed to provide required infection control training. On 01/09/2026 at approximately 11:00 a.m., OSM #8's education records were requested. On 01/12/2026 at approximately 10:00 a.m., a review of OSM #8's education record was conducted by the surveyor. The record failed to evidence the required infection control training. On 01/12/2026 at approximately 11:13 a.m. an interview was conducted with OSM #11, human resources, and OSM #7, regional director of human resources by telephone regarding OSM (other staff member) #8's, annual training for resident rights. OSM #11 stated that OSM #8 was a contract employee and only received abuse training. OSM #7 stated that all contract employees receive an orientation packet from the facility's human resource (HR) department that contains the required trainings, and the training is completed by the HR department before the employee starts working. After reviewing OSM #8's training record, OSM #11 stated that OSM #8 had not received the required infection control training On 01/12/2026 at approximately 4:06 p.m. ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, and ASM #4, regional director of operations, were made aware of the above findings. No further information was provided prior to exit

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on employee record review and staff interview, the facility staff failed to provide required training on compliance and ethics for one of five staff records reviewed, OSM (other staff member) #8, a member of the dietary staff. The findings include:For OSM #8, the facility staff failed to provide required training on compliance and ethics. On 01/09/2026 at approximately 11:00 a.m., OSM #8's education records were requested. On 01/12/2026 at approximately 10:00 a.m., a review of OSM #8's education record was conducted by the surveyor. The record failed to evidence the required training on compliance and ethics. On 01/12/2026 at approximately 11:13 a.m. an interview was conducted with OSM #11, human resources, and OSM #7, regional director of human resources by telephone regarding OSM (other staff member) #8's, annual training for resident rights. OSM #11 stated that OSM #8 was a contract employee and only received abuse training. OSM #7 stated that all contract employees receive an orientation packet from the facility's human resource (HR) department that contains the required trainings, and the training is completed by the HR department before the employee starts working. After reviewing OSM #8's training record, OSM #11 stated that OSM #8 had not received the required training on compliance and ethics. On 01/12/2026 at approximately 4:06 p.m. ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, and ASM #4, regional director of operations, were made aware of the above findings. No further information was provided prior to exit

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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 employee record review and staff interview, the facility staff failed to provide required behavioral health training for one of five staff records reviewed, OSM (other staff member) #8, a member of the dietary staff. The findings include:For OSM #8, the facility staff failed to provide required behavioral health training. On 01/09/2026 at approximately 11:00 a.m., OSM #8's education records were requested. On 01/12/2026 at approximately 10:00 a.m., a review of OSM #8's education record was conducted by the surveyor. The record failed to evidence the required behavioral health training. On 01/12/2026 at approximately 11:13 a.m. an interview was conducted with OSM #11, human resources, and OSM #7, regional director of human resources by telephone regarding OSM (other staff member) #8's, annual training for resident rights. OSM #11 stated that OSM #8 was a contract employee and only received abuse training. OSM #7 stated that all contract employees receive an orientation packet from the facility's human resource (HR) department that contains the required trainings, and the training is completed by the HR department before the employee starts working. After reviewing OSM #8's training record, OSM #11 stated that OSM #8 had not received the required behavioral health training. On 01/12/2026 at approximately 4:06 p.m. ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, and ASM #4, regional director of operations, were made aware of the above findings. No further information was provided prior to exit.