STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525430	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Hills Rehab Ctr	14400 Cty Hwy B Sparta, WI 54656

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on the interview and record review, the facility failed to implement its policies and procedures and did not protect 2 of 3 residents from abuse. (R43, R35). R43 was not protected from verbal abuse when Certified Nursing Assistant (CNA) D threatened R43 by stating CNA D would throw R43 over shoulder and carry out of room if R43 didn't do what CNA D wanted R43 to do. R36 was not protected from physical abuse when R35 grabbed R36's walker and then swung at R36, hitting R36 and grabbing R36's wrist. Findings include: Example 1 On 2/17/25, Surveyor reviewed R43's medical record. R43 was admitted on [DATE] with Alzheimer's dementia with delusional thought process. R43's Minimum Data Set (MDS) assessment, dated 10/23/24, had a Brief Interview for Mental Status (BIMS) score of 03 out of 15 which indicated R43 had severe impaired cognition. Surveyor reviewed grievance logs from 08/20/24 to 02/18/25. -On 09/11/24, grievance was filed that R44 reported that CNA D was yelling at R43 to get dressed in R43's pajamas and CNA D would not stop telling R43 to get dressed on 09/10/24. R44 also stated that CNA D said she could throw R43 over CNA D's shoulders if she needed to make R43 put on pajamas. On 02/17/25, Surveyor reviewed R44's medical record. R44 was admitted on [DATE] with status post amputation, diabetes mellitus, and heart failure. R44's Minimum Data Set (MDS) assessment, dated 11/20/24, had a BIMS score of 15 out of 15, which indicated R44 has intact cognition. (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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	On 02/19/25 at 11:51 AM, Surveyor interviewed R44 and asked if R44 remembers the event on 09/10/24. R44 indicated that R44 does remember the incident. R44 overheard CNA D speak to R43 with a stern voice and threatened R43. Surveyor asked R44 how CNA D threatened R43. R44 indicated that CNA D was barking orders at R43 about putting boot on and making sure to use walker. R44 indicated that R43 refused to wear the boot and use walker. R44 heard CNA D tell R43 that R43 better do what CNA D is asking or CNA D will throw R43 over CNA D's shoulder and carry R43 out. R44 indicated that CNA D would not give R43 a chance to respond and explain what R43 needed instead. R44 indicated that R44 was scared for R43, so R44 told CNA C. R44 indicated that CNA C told R44 to let the nurse on duty know. R44 stated, I did not know which nurse was on that night, but I told who I could and then the next day a social worker talked to me. R44 clarified that CNA D continued with behavior by walking down the hallway antagonizing R43. Surveyor asked how CNA D antagonized R43. R44 indicated that CNA D would come up to R43, touch R43's shoulders, smile extra big and purposely talk to her. R43 would tell CNA D to get away from R43, but CNA D kept coming up and touching R43's shoulders while smiling big. On 02/19/25 at 11:59 AM, Surveyor was unable to interview R43, due to BIMS of 3. R43 was not protected from verbal abuse from CNA D. Example 2 On 02/17/25, Surveyor's review of R35's medical record discovered a nursing progress note which notes the following: Nurse progress note states: .On 01/28/2025 at 4:38 PM, Late Entry for: 01/27/2025. DATE OF INCIDENT: 01/27/2025, TIME OF INCIDENT: 17:12, INJURY: no apparent injury There was an altercation during supper time. Resident was grabbing at [R36's] walker during supper, [R36] tried to stop him by talking loudly. [R35] grabbed [R36]. [R36] stated if he grabs him again, he was going to, punch him. Staff had intervened. At 4:39PM, Today there was no further altercations between [R35] and [R36], they were kept apart from each other. At 10:13 PM, [R35] was aggressive and combative at the beginning of the shift. Resident was found in another resident's room and will not follow redirection from the CNA. Instead, he swung his hand on the CNA hitting the CNA on the chest . On 02/19/25 at 10:25 AM, Surveyor interviewed R36 and asked R36 if there have been any resident-to-resident altercations that have occurred on the unit. R36 stated, Yes, [R35]! Who has not had an altercation with [R35]. One time [R35] came at me in the dining room, but I put him in his place. I yelled to tell him not to ever touch me again or I'd punch him. Surveyor asked R36 to explain the incident in the dining room with R35. R36 indicated that R35 came at R36 and grabbed R36's walker and then swung at R36 hitting R36 and grabbing R36's wrist. Surveyor asked if R36 was injured. R36 indicated that he was not injured but, R35 is very strong, and it did frighten me. Staff intervened and R36 grabbed walker and went to room. R36 indicated that R36 tends to stay in room more now because R36 doesn't want those interactions with R35 again. R36 indicated that R35 has outbursts all the time in the dining room. R36 indicated that R36 dislikes that kind of aggressive behavior and mostly stays in room because of the outbursts. (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Few	On 02/20/25 at 8:02 AM, Surveyor interviewed Director of Nursing (DON) B and asked what the expectations are for resident to resident altercations and how residents are protected from abuse. DON B indicated that staff follow facility policy and staff should let DON B, NHA A, or Social Worker I know about any potential verbal or physical abuse. On 02/20/25 at 8:14 AM, Surveyor interviewed Nursing Home Administrator (NHA) A asking NHA A how residents are protected from abuse. Surveyor indicated to NHA A that the incident with R43 was verbal abuse. Surveyor indicated to NHA A that the incident with R36 did in fact happen, R36 was grabbed and hit by R35 which is physical abuse. Surveyor asked NHA A if NHA A thought abuse concerns from R35 had occurred. NHA A indicated that residents were not protected from abuse by not following through on the facility policy. NHA A indicated that everyone should be following the facility policy for abuse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - 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** 48793 Based on interview and record review, the facility did not report 2 of 3 (R43, R36) potential misconduct incidents to the State's Office of Caregiver Quality (OCQ) via the State's Misconduct Incident Reporting (MIR) system immediately upon learning of the incident. *CNA D threatened R43 by stating CNA D would throw R43 over shoulder and carry out of room if R43 didn't do what CNA D wanted R43 to do. *R35 grabbed R36's walker and then swung at R36, hitting R36 and grabbing R36's wrist. Findings include: Facility policy titled Misconduct Investigation and Reporting, last revised 08/20/24, stated in part, -#4. The staff member must immediately report the incident to the nurse on duty or other supervisory staff. -#5. The nurse/supervisor must notify the Administrator of the alleged incident/complaint immediately after ensuring the safety of the resident. If administrator can't be reached, notify the DON or social services manager. -#19. The Administrator or his designee will immediately notify the DQA of all alleged incidents involving mistreatment, exploitation, neglect, or abuse. CMS defines immediately to be as soon as possible but not to exceed 24 hours after discovery of the incident. If the allegation involves abuse or resulted in serious bodily injury the violation must be reported within 2 hours from when the issue if discovered . Example 1 Surveyor reviewed grievance logs from 08/20/24 to 02/18/25. On 09/11/24, grievance was filed that R44 reported that CNA D was yelling at R43 to get dressed in R43's pajamas and CNA D would not stop telling R43 to get dressed on 09/10/24. R44 also stated that CNA D said she could throw R43 over CNA D's shoulders if she needed to make R43 put on pajamas. Surveyor reviewed facility investigation on the grievance filed and when CNA D was asked about the incident, CNA D did confirm what was said to R43 but CNA D said CNA D was only joking and would never actually do it. On 2/17/25, Surveyor reviewed R43's medical record. R43 was admitted on [DATE] with Alzheimer's dementia with delusional thought process. R43's Minimum Data Set (MDS) assessment, dated 10/23/24, had a Brief Interview for Mental Status (BIMS) score of 03 which indicated R43 had severe impaired cognition. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/17/25, Surveyor reviewed R44's medical record. R44 was admitted on [DATE] with status post amputation, diabetes mellitus, and heart failure. R44's Minimum Data Set (MDS) assessment, dated 11/20/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicates R44 has intact cognition. On 02/19/25 at 11:51 AM, Surveyor interviewed R44 and asked if R44 remembers the event on 09/10/24. R44 indicated that R44 does remember the incident. R44 overheard CNA D speak to R43 with a stern voice and threatened R43. Surveyor asked R44 how CNA D threatened R43. R44 indicated that CNA D was barking orders at R43 about putting boot on and making sure to use walker. R44 indicated that R43 refused to wear the boot and use walker. R44 heard CNA D tell R43 that R43 better do what CNA D is asking or CNA D will throw R43 over CNA D's shoulder and carry R43 out. R44 indicated that CNA D would not give R43 a chance to respond and explain what R43 needed instead. R44 indicated that R44 was scared for R43, so R44 told CNA C. R44 indicated that CNA C told R44 to let the nurse on duty know. R44 stated, I did not know which nurse was on that night, but I told who I could and then the next day a social worker talked to me. Surveyor asked R44 if CNA D kept working with R43 with cares and activities throughout the next couple days. R44 indicated to Surveyor that CNA D continued to come into room to assist R43, and CNA D walked down the hallway antagonizing R43. Surveyor asked how CNA D antagonized R43. R44 indicated that CNA D would come up to R43, touch R43's shoulders, smile extra big and purposely talk to her. R43 would tell CNA D to get away from R43, but CNA D kept coming up and touching R43's shoulders while smiling big. Surveyor asked R44 if R44 let any staff members know of the continual approaches from CNA D to R43. R44 indicated that R44 did not let any staff know about the incidents because R44 didn't know if it was ok to after trying to report the verbal abuse and CNA D continually providing care for R43 and R44. On 02/19/25 at 11:59 AM, Surveyor interviewed R43 and asked if R43 can R43 remember any incidents that have caused R43 any mental anguish, or physical harm. R43 stared at Surveyor and had confused look on face. Surveyor was unable to interview R43. Surveyor asked R43 if R43 felt safe in the facility in R43's home. R43 chuckled and stated, Ahh the facility is fine, and my roommate takes care of me as needed. Surveyor could not find any facility documentation of this incident as being reported to the State Agency. Example 2 On 02/17/25, Surveyor's review of R35's medical record discovered a nursing progress note which notes the following: Nurse progress note indicated, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.On 01/10/2025 at 5:16 PM, PRN MED GIVEN: hydroxyzine HCl 25MG Tablet (1 tablet / 25mg) given for agitation tried to throw chair in dining room. 6:44PM PRN MED RESULT: at 6:44 PM, Improved but still present. At 9:00 PM BEHAVIOR: abusive behavior wandering behaviors Pushing /Grabbing Behavior occurred. Note: We were trying to direct [R35] over to his food at the table. [R35] did not want to come to the table but was trying to take plates from the dietetic worker instead. As we attempted to guide [R35] to the table, [R35] became agitated and attempted to pick up a chair as if [R35] was going to throw it. It was eased back to floor, and we directed [R35] back to tv area. There are three other residents at this table and two staff trying to feed residents and another resident that was not being too cooperative with eating. It seemed too much activity for [R35] at the time and [R35] got very agitated and angry. I then gave [R35] prn Atarax which had little effect tonight. About 7:30 [R35] grabbed another resident by the wrist and staff intervened before [R35] could hurt the resident. [R35] was angry because this resident grabbed [R35's] blanket [R35] was holding and so [R35] turned around quickly and grabbed her, and staff were standing there when [R35] grabbed her. I turned down lights early this evening to slow things down because residents seemed quite wound up tonight. Will continue to monitor [R35] closely around other residents . Surveyor did not find documentation to support that the facility reported the resident-to-resident altercation to DQA. Surveyor did not find documentation that staff notified a supervisor of the incident which occurred. Nurse progress note indicated, .On 01/28/2025 at 4:38 PM, Late Entry for: 01/27/2025. DATE OF INCIDENT: 01/27/2025, TIME OF INCIDENT: 17:12, INJURY: no apparent injury There was an altercation during supper time. Resident was grabbing at [R36's] walker during supper, [R36] tried to stop him by talking loudly. [R35] grabbed [R36]. [R36] stated if he grabs him again, he was going to, punch him. Staff had intervened. At 4:39PM, Today there was no further altercations between [R35] and [R36], they were kept apart from each other. At 10:13 PM, [R35] was aggressive and combative at the beginning of the shift. Resident was found in another resident's room and will not follow redirection from the CNA. Instead, he swung his hand on the CNA hitting the CNA on the chest . Surveyor did not find documentation to support that the facility reported the resident-to-resident altercation to DQA. Surveyor did not find documentation that staff notified a supervisor of the incident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/19/25 at 10:25 AM, Surveyor interviewed R36 and asked R36 if there have been any resident-to-resident altercations that have occurred on the unit. R36 stated, [R35]! Who has not had an altercation with [R35]?. One-time [R35] came at me in the dining room, but I put him in his place. I yelled to tell him not to ever touch me again or I'd punch him. Surveyor asked R36 to explain the incident in the dining room with R35. R36 indicated that R35 came at R36 and grabbed R36's walker and then swung at R36 hitting R36 and grabbing R36's wrist. Surveyor asked if R36 was injured. R36 indicated that he was not injured but, R35 is very strong, and it did frighten me. Staff intervened and R36 grabbed walker and went to room. R36 indicated that R36 tends to stay in room more now because R36 doesn't want those interactions with R35 again. R36 indicated that R35 has outbursts all the time in the dining room. R36 indicated that R36 dislikes that kind of aggressive behavior and mostly stays in room because of the outbursts. On 02/19/25 at 10:30 AM, Surveyor interviewed CNA F and asked about process to report resident-to-resident altercations to administration. CNA F indicated that CNA F would then report this to CNA F's nurse on duty. On 02/19/25 at 11:27 AM, Surveyor interviewed Licensed Practical Nurse (LPN) G and asked if LPN G reports to the supervisor if there is a resident-to resident altercation. LPN G indicated if it is severe enough and needed more attention than LPN G would report to supervisor. On 02/20/25 at 7:21 AM, Surveyor interviewed Registered Nurse (RN) H and asked RN H what is RN H's process when there is a resident to resident altercation or if there is an incident that happens with a resident. RN H indicated, Of course I intervene and separate the aggressor and the victim or the aggressor and the aggressor, then we document the events very thoroughly in the computer, and then there is follow up on both residents for the next 24 hours. Surveyor asked RN H if RN H reports to the supervisor. RN H indicated that RN H is the supervisor on nights but should be reporting to DON B the next day if it's in the middle of the night. Surveyor asked RN H what is the facility procedure for determining if an incident is verbal or physical abuse? RN H indicated intervening and letting supervisor know when supervisor is available is the appropriate measures. On 02/20/25 at 8:02 AM, Surveyor interviewed Director of Nursing (DON) B and asked what the expectations are for resident-to resident altercations and how are potential abuse concerns handled with staff to resident incidents. DON B indicated that staff follow facility policy and staff should let DON B, NHA A, or Social Worker I know about any incidents that are a concern for potential verbal or physical abuse. DON B said DON B was unaware of some of the incidents since nursing staff did not report these except for the more recent ones that occurred this year. On 02/20/25 at 8:14 AM, Surveyor interviewed Nursing Home Administrator (NHA) A and asked why facility did not report a few of the incidents of potential verbal and physical abuse concerns from staff to resident involving R43 and then R36 and then resident to resident altercations from R35 to the state. NHA A stated that usually staff report incidents and then between NHA A, DON B, and Social Worker I, us three decide the importance of the complaint and start a proper investigation if it's needed, and then report to state regulatory agency if needed. NHA A indicated that NHA A did not think the incidents with R43 or R36 were considered abuse concerns. Surveyor indicated to NHA A that the incident with R43 had concerns with verbal abuse, and CNA D even admitted to verbally saying the threat to R43 and that she continued to work with R43 and other residents before investigation was complete. NHA A indicated that CNA D was joking, but that NHA A didn't realize CNA D continued to work with R43. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor asked NHA A if NHA A thought that some of the physical abuse concerns from R35 unto another unknown resident on Birchwood was concerning. NHA A indicated that NHA A was unaware of some of the incidents and that staff did not report this to administration. NHA A indicated that everyone should be following the facility policy for misconduct.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based upon interview, policy review and record review, the facility did not ensure allegations of verbal and physical abuse were thoroughly investigated or prevent further potential abuse from occurring while the investigation was in progress for residents (R) (R43, R36) and other undocumented residents, which has the potential to affect all 19 residents on the Birchwood unit. Facility did not protect R43 when allowing Certified Nursing Assistant (CNA) D to continue to work with R43 when accused of verbal abuse. Facility allowed CNA D to continue to work with R43 during complaints of rough cares was being investigated. This is evidenced by: Facility policy titled Misconduct Investigation and Reporting, last revised 08/20/24, stated in part, .-2. If the issue could be considered verbal, sexual, or physical abuse the staff person is required to take action immediately to protect the resident and/or stop the occurrence. This includes incidents perpetrated by staff. The staff's primary responsibility is to always ensure the safety of the resident. Before all else protect the resident. -7. The building supervisor must take action to protect the resident or other residents who may be at risk while the incident is being investigated (I.e. staff person is sent home on administrative leave, is directly supervised to maintain all resident's safety, or is reassigned to non-resident duties). -#14. Investigation of the incident will proceed with interviews being conducted with residents and staff and information regarding the allegations being collected. The investigation may include documenting each step taken during the internal investigation and any conclusions made. Resident to resident altercation should look for causes or situations that may have contributed to the incident occurring. Misconduct Definitions dated, 07/2024 indicates: 'Abuse' is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, or mental anguish; Verbal abuse involves the use of speech, sound, writing, or gestures when communicating with residents or their families or when within their hearing or sight, regardless of their age ability to comprehend, or disability. Examples include but are not limited to threats of harm or frightening a resident; Physical harm includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment. Note the federal definition of abuse indicates that the act needs to be willful and that it needs to have resulted in physical or psychosocial harm to the resident or-if the resident cannot provide a response-would be expected to have caused harm to a reasonable person. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 1 Surveyor reviewed grievance logs from 08/20/24 to 02/18/25. On 09/11/24, grievance was filed that R44 reported that CNA D was yelling at R43 to get dressed in R43's pajamas and CNA D would not stop telling R43 to get dressed on 09/10/24. R44 also stated that CNA D said she could throw R43 over CNA D's shoulders if she needed to make R43 put on pajamas. Surveyor reviewed facility investigation on the grievance filed and when CNA D was asked about the incident, CNA D did confirm what was said to R43 but CNA D said CNA D was only joking and would never actually do it. On 02/17/25, Surveyor reviewed R43's medical record. R43 was admitted on [DATE] with Alzheimer's dementia with delusional thought process. R43's Minimum Data Set (MDS) assessment, dated 10/23/24, had a Brief Interview for Mental Status (BIMS) score of 03 out of 15, which indicates R43 has severe impaired cognition. On 02/17/25, Surveyor reviewed R44's medical record. R44 was admitted on [DATE] with status post amputation, Diabetes Mellitus, and heart failure. R44's Minimum Data Set (MDS) assessment, dated 11/20/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicates R44 has intact cognition. On 02/19/25 at 11:51 AM, Surveyor interviewed R44 and asked if R44 remembers the event on 09/10/24. R44 indicated that R44 does remember the incident. R44 overheard CNA D speak to R43 with a stern voice and threatened R43. Surveyor asked R44 how CNA D threatened R43. R44 indicated that CNA D was barking orders at R43 about putting boot on and making sure to use walker. R44 indicated that R43 refused to wear the boot and use walker. R44 heard CNA D tell R43 that R43 better do what CNA D is asking or CNA D will throw R43 over CNA D's shoulder and carry R43 out. R44 indicated that CNA D would not give R43 a chance to respond and explain what R43 needed instead. R44 indicated that R44 was scared for R43, so R44 told CNA C. R44 indicated that CNA C told R44 to let the nurse on duty know. R44 stated, I did not know which nurse was on that night, but I told who I could and then the next day a social worker talked to me. Surveyor asked R44 if CNA D kept working with R43 with cares and activities throughout the next couple days. R44 indicated to Surveyor that CNA D continued to come into room to assist R43, and CNA D walked down the hallway antagonizing R43. Surveyor asked how CNA D antagonized R43. R44 indicated that CNA D would come up to R43, touch R43's shoulders, smile extra big and purposely talk to her. R43 would tell CNA D to get away from R43, but CNA D kept coming up and touching R43's shoulders while smiling big. Surveyor asked R44 if R44 let any staff members know of the continual approaches from CNA D to R43. R44 indicated that R44 did not let any staff know about the incidents because R44 didn't know if it was ok to after trying to report the verbal abuse and CNA D continually providing care for R43 and R44. Surveyor reviewed investigation file dated 09/11/24 which indicates Social Worker I interviewed R44 about the events pertaining to CNA D and R43. On 09/12/24, Social Worker I interviewed staff that were on same shift when the incident occurred on 09/10/24. DON interviewed residents on 09/12/24. Surveyor reviewed CNA D's schedule and time punches from 09/01/24-09/14/24. CNA D worked on 09/10/24 on Pineview unit, then on 09/12/24 on Birchwood Unit, and again on 09/13/24 on [NAME] Lane unit. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor did not find in the investigation if facility had removed CNA D from the Pineview unit and supervised CNA D with other residents on other units until investigation was complete to prevent further potential abuse concerns. Surveyor did not find a clear investigation complete date of the incident with R43 and CNA D. Example 2 On 02/17/25, Surveyor reviewed R36's medical record. R36 was admitted on [DATE] with atrial fibrillation, hypertension, and chronic obstructive pulmonary disease. R36's Minimum Data Set (MDS) assessment, dated 01/08/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicates R36 has intact cognition. On 02/17/25, Surveyor reviewed R35's medical record. R35 was admitted on [DATE] with diagnoses including dementia unspecified with behavioral disturbances, cataracts, hypertensive heart disease, and insomnia. R35's Minimum Data Set (MDS) assessment, dated 11/06/24, had a Brief Interview for Mental Status (BIMS) score of 00 which indicated R35 had severe impaired cognition and could not complete the BIMS test. Surveyor reviewed R35's nursing progress notes that indicated, .-On 06/22/2024 at 4:09 PM, Note: [R35] was sitting at the dining table eating and suddenly he yelled at resident across the table who was eating his meal and then kicked the table and was swearing. We were going to remove him from the area but then he continued to eat, and we stayed nearby. When he appeared not to be eating, we offered that he could go watch tv if he wanted to. He got up and started pacing the hallway. After residents were done eating one resident stayed in his chair by the dining room table to watch tv and [R35] came up behind him and hit the back of the chair hard. This frightened the resident in the chair, and he got up with his walker and went to his room . Surveyor did not find documentation that staff notified a supervisor of the incident that occurred, and did not find a proper investigation into the incident. Surveyor did not find a thorough investigation that identified who the affected resident was on Birchwood unit. Nurse progress note indicated, . On 09/16/24 at 9:30 PM, Note: [R35] spent first part of our shift outside. He did not eat much of his supper this evening. Given cold fluids as it was warm outside. Brought him in to get ready for bed but he has been very resistive to cares again his shift. I only now was able to get him to take his medications. Will attempt to change him again when he has had his meds in him for 30 minutes or so. CNA informed me that, [R35] walked by another resident and apparently swung as to hit him but did not. It is very difficult to address his cares even with two staff. Will continue to monitor behaviors and chart . Surveyor did not find a thorough investiation into R35 swinging at another residen. Unable to determine who the affected resident was. Nurse progress note indicated, (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.On 01/10/2025 at 5:16 PM, PRN MED GIVEN: hydroxyzine HCl 25MG Tablet (1 tablet / 25mg) given for agitation tried to throw chair in dining room. 6:44PM PRN MED RESULT: at 6:44 PM, Improved but still present. At 9:00 PM BEHAVIOR: abusive behavior wandering behaviors Pushing /Grabbing Behavior occurred. Note: We were trying to direct [R35] over to his food at the table. He did not want to come to the table but was trying to take plates from the dietetic worker instead. As we attempted to guide him to his table, he became agitated and attempted to pick up a chair as if he was going to throw it. It was eased back to floor, and we directed [R35] back to tv area. There are three other residents at his table and two staff trying to feed residents and another resident that was not being too cooperative with eating. It seemed too much activity for [R35] at the time and he got very agitated and angry. I then gave him his prn Atarax which had little effect tonight. About 7:30 he grabbed another resident by the wrist and staff intervened before he could hurt the resident. He was angry because this resident grabbed his blanket he was holding and so he turned around quickly and grabbed her, and staff were standing there when he grabbed her. I turned down lights early this evening to slow things down because residents seemed quite wound up tonight. Will continue to monitor him closely around other residents . Surveyor did not find a thorough investigation for R35's physical abuse towards others. The affected resident is not identified. Surveyor did not find documentation that staff notified a supervisor of the incident that occurred. Nurse progress note indicated, .On 01/28/2025 at 4:38 PM, Late Entry for: 01/27/2025. DATE OF INCIDENT: 01/27/2025, TIME OF INCIDENT: 17:12, INJURY: no apparent injury There was an altercation during supper time. Resident was grabbing at [R36's] walker during supper, [R36] tried to stop him by talking loudly. [R35] grabbed [R36]. [R36] stated if he grabs him again, he was going to, punch him. Staff had intervened. At 4:39PM, Today there was no further altercations between [R35] and [R36], they were kept apart from each other. At 10:13 PM, [R35] was aggressive and combative at the beginning of the shift. Resident was found in another resident's room and will not follow redirection from the CNA. Instead, he swung his hand on the CNA hitting the CNA on the chest . Surveyor did not find documentation of a thorough investigation into the incident, nor preventative measures put into place to prevent reoccurrence of incidents. On 02/19/25 at 10:25 AM, Surveyor interviewed R36 and asked R36 if there have been any resident-to-resident altercations that have occurred on the unit. R36 stated, [R35]! Who has not had an altercation with [R35]?. One time [R35] came at me in the dining room, but I put him in his place. I yelled to tell him not to ever touch me again or I'd punch him. Surveyor asked R36 to explain the incident in the dining room with R35. R36 indicated that R35 came at R36 and grabbed R36's walker and then swung at R36 hitting R36 and grabbing R36's wrist. Surveyor asked if R36 was injured. R36 indicated that he was not injured but, R35 is very strong, and it did frighten me. Staff intervened and R36 grabbed walker and went to room. R36 indicated that R36 tends to stay in room more now because R36 doesn't want those interactions with R35 again. R36 indicated that R35 has outbursts all the time in the dining room. R36 indicated that R36 dislikes that kind of aggressive behavior and mostly stays in room because of the outbursts. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/19/25 at 10:30 AM, Surveyor interviewed CNA F and asked about process to deal with R35 or any other residents that may have altercations of aggression or explosions. CNA F indicated that CNA F will intervene and separate residents or try to redirect residents. Surveyor asked what CNA F's next process is after intervening and making sure residents are safe. CNA F indicated that CNA F would then report this to CNA F's nurse on duty. CNA F indicated the nurse would do a formal assessment and then monitor going forward. On 02/19/25 at 11:27 AM, Surveyor interviewed Licensed Practical Nurse (LPN) G and asked LPN G what is LPN G's process when there is an altercation between a resident to resident or if there is an incident that happens with a resident. LPN G indicated LPN G will intervene if LPN G observes the resident-to-resident altercation. LPN G would try to redirect R35 or any other resident who is aggressive and acting out. LPN G will then assess both residents and manage the residents' care as appropriate. On 02/20/25 at 7:21 AM, Surveyor interviewed Registered Nurse (RN) H and asked RN H what is RN H's process when there is a resident to resident altercation or if there is an incident that happens with a resident. RN H indicated, Of course I intervene and separate the aggressor and the victim or the aggressor and the aggressor, then we document the events very thoroughly in the computer, and then there is follow up on both residents for the next 24 hours. On 02/20/25 at 8:02 AM, Surveyor interviewed Director of Nursing (DON) B and asked what the expectations are for resident-to resident altercations and how are potential abuse concerns handled with staff to resident incidents. DON B indicated that staff follow facility policy and staff should let DON B, NHA A, or Social Worker I know about any incidents that are a concern for potential verbal or physical abuse. Surveyor asked what the process is for properly investigating and preventing further abuse concerns from happening. DON B indicated that once a concern is reported DON B, NHA A, or Social Worker will open an investigation and interview all staff members involved and remove the staff member accused until investigation is complete. DON B indicated then staff will interview other residents for any concerns and complete a thorough investigation with a resolution plan. Surveyor asked DON B why the complaint of possible verbal abuse was not thoroughly investigated before allowing CNA D to continue to work with R43. DON B indicated that DON B was unaware of all the logistics of the incident and that Surveyor would need to speak with Social Worker I. Surveyor asked DON B about the resident-to-resident and staff altercations that involved R35 on 06/22/24, 09/16/24, 01/10/25, and 01/28/25. DON B indicated that DON B was unaware of some of the incidents since nursing staff did not report these except for the more recent ones that occurred this year. Surveyor asked DON B why proper investigations were not completed for 06/22/24, 09/16/24, 01/10/25 and 1/28/25, to prevent any further potential for physical abuse on the Birchwood unit. Surveyor indicated to DON B that on two different occasions on 06/22/24 and 01/10/25, R35 had resident to resident physical altercations and Surveyor could not find complete documentation of the event, the investigation for it, or who the other resident was that was affected. DON B indicated the investigation was not completed, and staff should have had more thorough documentation so that staff could process what had occurred. DON B indicated the affected residents that were not named in the incidents should have had better follow up as facility policy states to assess and document for the next 24-48 hours on both residents involved in altercation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/20/25 at 8:09 AM, Surveyor interviewed Social Worker I and asked why the complaint of possible verbal abuse was not thoroughly investigated before allowing CNA D to continue to work with R43. Social Worker I indicated that Social Worker I was unaware CNA D continued to work with R43 but that Social Worker I does not make those decisions for staff and DON B makes scheduling decisions. Surveyor asked Social Worker I about the resident-to-resident and staff altercations that involved R35 on 06/22/24, 09/16/24, 01/10/25, and 01/28/25. Social Worker I indicated that Social Worker I was unaware of some of the incidents since nursing staff did not report these except for the more recent ones that occurred this year. Social Worker I indicated that thorough investigations were not completed for R35's incidents. On 02/20/25 at 8:14 AM, Surveyor interviewed Nursing Home Administrator (NHA) A and asked why facility did not thoroughly investigate the incidents of potential verbal, physical abuse concerns from staff to resident involving R43 and the resident-to-resident altercations from R35. NHA A indicated that NHA A did not think the incidents with R43 or R36 were considered abuse concerns. Surveyor indicated to NHA A that the incident with R43 had concerns with verbal abuse, and CNA D admitted to verbally saying the threat to R43. CNA D continued to work with R43 and other residents before investigation was complete. NHA A indicated that CNA D was joking, but that NHA A didn't realize CNA D continued to work with R43.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46693 Based on record review and interview, the facility did not transmit the Minimum Data Set (MDS) assessments within 14 days of completion for 3 residents (R) (R40, R47, and R31) out of 12 sampled residents. R40 had a Quarterly (Q) MDS assessment completed on 10/02/24 and a Quarterly MDS assessment completed on 12/31/25. Both assessments had not been transmitted as of end of survey, 02/20/25. R47 had a Prospective Payment System (PPS) discharge assessment completed 11/08/24 and a Quarterly MDS completed 12/23/24. MDS assessments had not been transmitted. R31 had a Quarterly MDS assessment completed on 10/02/24 and another Quarterly MDS completed on 12/31/24 which were not submitted by the facility. This is evidenced by: The requirements for the RAI are found at 42 CFR 483.20 and are applicable to all residents in Medicare and/or Medicaid certified long-term care facilities. The requirements are applicable regardless of age, diagnosis, length of stay, payment source or payer source. Federal RAI requirements are not applicable to individuals residing in non-certified units of long-term care facilities or licensed-only facilities. S483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. Example 1 (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R40 was admitted to the facility on [DATE] with diagnoses including pneumonia, atrial fibrillation, coronary artery disease, hypertension, and diabetes. On 02/19/25 at 7:59 AM, Surveyor reviewed R40's MDS assessments. R40's facility records identified the following: Quarterly (Q)90 was completed on 07/03/24. Status accepted. Q180 was completed on 10/02/24. Status completed. Q270 was completed on 12/31/24. Status completed. The Q180 and Q270 MDS assessments were never transmitted to Centers for Medicare & Medicaid Services (CMS). The Q180 assessment should have been transmitted on or before 10/16/24. Q270 assessment should have been transmitted on or before 01/14/25. R40's quarterly MDS's were marked as completed, but not transmitted or accepted by CMS. Example 2 R47 was admitted to the facility on [DATE] with diagnoses including COVID, atrial fibrillation, heart failure, hypertension, dementia, and diabetes. Surveyor reviewed R47's MDS assessments. R47's facility records identified the following: Admission 5 day was completed on 09/23/24. Status accepted. PPS discharge was completed on 11/08/24. Status completed. Q90 was completed on 12/23/24. Status completed. The PPS discharge and the Q90 MDS assessments were never transmitted to Centers for Medicare & Medicaid Services (CMS). The PPS discharge MDS assessment should have been transmitted on or before 11/22/24. Q90 assessment should have been transmitted on or before 01/06/25. R40's PPS discharge and Q90 MDS's were marked as completed, but not transmitted or accepted by CMS. Example 3 R31 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, atrial fibrillation, coronary artery disease, hypertension, and kidney disease. Surveyor reviewed R31's MDS assessments. R31's facility records identified the following: Admission-Not PPS was completed on 06/24/24. Status accepted. Q90 was completed on 10/02/24. Status completed. Q180 was completed on 12/31/24. Status completed. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Q90 and Q180 MDS assessments were never transmitted to Centers for Medicare & Medicaid Services (CMS). The Q90 MDS assessment should have been transmitted on or before 10/16/24. Q180 MDS assessment should have been transmitted on or before 01/14/25. R31's Q90 and Q180 MDS's were marked as completed, but not transmitted or accepted by CMS. On 02/19/25 at 9:09 AM, Surveyor interviewed Medical Records (MR) M who stated that MR M helps with MDS transmissions. MR M was provided a list of the residents above and asked for proof of transmissions for the MDS's completed but not transmitted. At 10:38 AM, MR M stated that the MDS assessments were not completed because those residents were self-pay or on a Medicare Advantage Plan and to speak with Nursing Home Administrator (NHA) A if there are more questions. On 02/19/25 at 1:10 PM, Surveyor interviewed NHA A and asked why the MDS's were not transmitted. NHA A stated it was due to payor source. Surveyor encouraged NHA A to visit chapter 5 of the Resident Assessment Instrument manual and F640 regulation. NHA A stated they will transmit them all from now on.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44863 Based on observation, interview and record review, the facility did not ensure residents received appropriate treatment and services to maintain range of motion (ROM). This had the potential to affect four residents (R) reviewed for mobility (R25, R26, R30, and R31). -R25 was not provided restorative services at least three times per week as identified in her care plan. -R26's care plan did not identify the frequency and duration of restorative services needed. -R30 was not provided restorative services daily as identified in her care plan. -R31 was not provided restorative services five times per week as identified in her care plan. This is evidenced by: Per Appendix PP of the State Operations Manual (SOM), regulation F688 reads in part . The facility must develop resident care policies in collaboration with the medical director, director of nurses, and as appropriate, physical/occupational therapy consultant. This includes policies on restorative/rehabilitative treatments/services, based on professional standards of practice. The care plan must identify the type of treatments, frequency, and duration, as well as the measurable objectives and resident goals. Example 1 R25 admitted to facility on 05/13/24, with a diagnosis including arthritis. Minimum Data Set (MDS) assessment confirmed R25 scored 15/15 during Brief Interview for Mental Status (BIMS), indicating intact cognition. R25's MDS assessment completed on 01/24/25 indicated the following changes in functional abilities related to transfers, since admission: -Sit to stand, partial assistance increased to substantial assistance. -Chair to bed, partial assistance increased to substantial assistance. -Toilet transfer, partial assistance increased to substantial assistance. R25's Restorative Aide Program documentation indicated restorative goal to decrease joint pain, risk of falls, and decline in transfers and mobility. GOAL: Participate in restorative services at least three times per week to maintain strength and promote safe transfers and mobility. R25's Restorative Aide Program documentation indicated R25 participated in restorative program as follows: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-12/2024, 6 of 31 days. -01/2025, 5 of 31 days. -02/20/25, 5 of 20 days. During the survey period of 02/17/25-02/20/2025, Surveyor did not observe R25 participating in restorative services. On 02/19/25 at 1:46 PM, Surveyor interviewed R25. R25 stated she participates in a restorative program to help strengthen her muscles. R25 reported she is supposed to receive exercises with Restorative Aide (RA) L, three times per week, but sometimes she doesn't come at all. Example 2 R26 was admitted to the facility on [DATE] and diagnoses included muscular dystrophy. MDS assessment confirmed R26 scored 15/15 during BIMS, indicating intact cognition. R26's MDS assessment completed on 01/22/25 indicated R25 is dependent on staff for all transfers. R26's Restorative Aide Program documentation indicated restorative goal to prevent decline, contractures, and falls. GOAL: Participate in exercises and transfers to maintain ability to safely transfer and ambulate with staff assist. (Surveyor noted R26's restorative care plan did not include a frequency or duration). R26's Restorative Aide Program documentation indicated R26 participated in restorative program as follows: -10/2024, 13 of 31 days. -11/2024, 8 of 30 days. -12/2024, 4 of 31 days. -01/2025, 7 of 31 days. -02/2025, 3 of 20 days. During the survey period of 02/17/25-02/20/2025, Surveyor did not observe R26 participating in restorative services. On 02/17/25 at 10:40 AM, Surveyor interviewed R26. R26 stated he had not received his exercise program last week. R26 reported he usually receives exercise program once weekly, but stated twice weekly would be better for him to maintain his abilities. R26 stated he reported this to a nurse sometime this winter but had not received any updates related to frequency of his weekly exercises. Example 3 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R30 was admitted to the facility on [DATE]. Diagnoses included osteoarthritis, pain, and history of blood clot in limb. MDS assessment confirmed R30 scored 15/15 during BIMS, indicating intact cognition. R30's MDS assessment, completed on 11/06/2024, indicated R30 requires substantial assistance from staff with all transfers. R30's Restorative Aide Program documentation indicated restorative goal to reduce decline in functional transfers and contracture risk. GOAL: Participate in daily exercises to maintain safe transfer ability. R30's Restorative Aide Program documentation indicated the following: -10/2024, 5 of 31 days. -11/2024, 7 of 30 days. -12/2024, 9 of 31 days. -01/2025, 7 of 31 days. -02/2025, 3 of 20 days. During the survey period of 02/17/2025-02/20/2025, Surveyor did not observe R30 participating in restorative services. On 02/19/25 at 2:04 PM, Surveyor interviewed R30 regarding his restorative services. R30 responded, No, not too much. Not even once a week. I want to be able to transfer and stand. Example 4 R31 was admitted to the facility on [DATE]. Diagnoses included Parkinson's disease and pain caused by compression fractures in back. MDS assessment confirmed R31 scored 13/15 during BIMS, indicating intact cognition. MDS assessment completed on 12/18/24 indicated R31 is dependent on staff for all transfers. Review of previous MDS assessment, completed on 09/18/24, confirmed R31 declined in toileting transfers from substantial assistance to dependent on staff. R31's Restorative Aide Program documentation included goal to reduce decline in range of motion, strength, and mobility. GOAL: Participate in restorative services five times per week to maintain strength and mobility as evidenced by ability to ambulate 50 feet with walker and staff assistance. R31's Restorative Aide documentation included the following: -11/2024, 12 of 30 days. -12/2024, 10 of 31 days. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-01/2025, 5 of 31 days. -02/2025, 4 of 20 days. During the survey period of 02/17/2025-02/20/2025, Surveyor did not observe R31 participating in restorative services. On 02/18/25 at 1:00 PM, Surveyor interviewed Physical Therapy Assistant (PTA) O. PTA O reported Certified Nursing Assistant (CNA) tasks and restorative program exercises are separate. CNAs do not complete restorative program exercises; the facility has RA L complete restorative program exercises. The facility has a Restorative Aide Program binder, kept in the therapy department, to document how often services were provided to each resident. PTA O stated RA L's schedule recently changed to part-time schedule. PTA O reported if RA L cannot complete the restorative programs for all the residents, therapy staff try to complete what RA L could not. PTA O confirmed DON B is the 'head' of the restorative program. On 02/18/25 at 1:10 PM, Surveyor interviewed Director of Nursing (DON) B. DON B confirmed she oversees the facility's restorative program. DON B confirmed RA L's schedule was changed to part-time and not available full-time, and the facility was working on a plan to have more than one restorative aide to ensure a full-time schedule for restorative services. DON B confirmed if RA L is not able to complete the services, therapy staff assist with ensuring restorative services are completed. DON B stated the facility would like to offer residents restorative services daily, so the frequency is set as daily in the hopes the resident will participate in services 3-5 days per week. DON B stated the purpose of the restorative program is to maintain or prevent loss of a resident's current functioning. DON B stated each resident's restorative program is reviewed monthly when she changes out the documentation in the Restorative Aide Program binder, and the nurses document in the resident's record. Surveyor requested the facility's policy related to restorative services. Director of Nursing (DON) B reported the facility did not have a Restorative Services Policy. Surveyor reviewed records for R25, R26, R30, and R31. Surveyor was unable to find nursing documentation related to restorative services. On 02/20/25 at 7:04 AM, Surveyor interviewed RA L. RA L confirmed she works every Thursday and Friday and every other weekend. RA L reported there are approximately 13 residents participating in the restorative program, and she tries to get to all residents but sometimes it is difficult due to resident schedules, activities, mealtimes, or resident declination to participate. RA L stated it can be difficult to complete the restorative program as she gets pulled to work on the floor as a CNA a lot. RA L reported on average she works as a CNA about one day per week. RA L confirmed if she is unable to complete restorative exercises with a resident, therapy staff attempt to complete those services with the resident. RA L stated she reports to therapy staff which residents did not receive the services, by writing it on a whiteboard in the therapy department and documenting in the Restorative Aide Program binder. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/20/25 at 8:58 AM, Surveyor interviewed Certified Occupational Therapy Assistant (COTA) Q. COTA Q stated therapy staff are responsible for evaluating a resident's level of skill and the nursing department is responsible for putting the evaluations into place and into the plan of care. COTA Q explained CNAs are responsible for completing the functional restorative program tasks, to help residents benefit from participating in independence in daily tasks. The RA is responsible for the Functional Aide Program, which is the restorative exercises recommended by therapy staff. COTA Q stated, If a frequency is not identified, ideally residents would receive restorative services daily, so let's see if we can get to them at least 3 days per week.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49353 Based on observation, interview and record review, the facility did not ensure resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents for 2 of 15 residents (R13, R35) reviewed. R13 was left unattended while connected to mechanical lift equipment. R35 did not have increased supervision to prevent resident to resident altercations after incidents on 06/22/24, 09/16/24, 01/10/25, and 01/28/25. This is evidenced by: Example 1 The Food and Drug Administration (FDA) Safety Information guidance provided in Kwikpoints Patient Lifts Safety Guide, states in part: Do not leave patient unattended while in lift. Never keep patient suspended in sling for more than a few minutes. R13 was admitted to the facility on [DATE] with pertinent diagnoses of spastic quadriplegic cerebral palsy and muscle weakness of extremities. R13's most recent Minimum Data Set (MDS) assessment dated [DATE] indicated that R13 has moderate cognitive impairment that requires cues and supervision and is dependent with assist for chair to bed transfers. On 02/18/25 at 12:45 PM, Surveyor observed R13 in his room, seated in broda chair, with mechanical lift sling positioned under him and attached to mechanical lift. Surveyor looked inside room and did not see a staff member present. On 02/18/25 at 12:51 PM, Surveyor observed Certified Nursing Assistant (CNA) C walking from around the corner of dining area from another resident hallway and enter R13's room. Surveyor observed CNA C check R13's sling attachment to mechanical lift by tugging slightly on sling strap. CNA C then walked to doorway, looked in both directions in hallway, and then returned to resident still suspended in sling attached to mechanical lift. On 02/18/25 at 12:53 PM, Surveyor observed another CNA enter R13's room to assist CNA C with transfer of R13. On 02/18/25 at 1:00 PM, Surveyor interviewed CNA C regarding observation. Surveyor asked CNA C why R13 was left unattended in his room while attached to the mechanical lift. CNA C stated she was waiting for her partner to assist with R13's transfer because he is a two person assist. Surveyor asked CNA C if this was a common practice for residents to be left unattended while connected to lift equipment. CNA C stated no. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/19/25 at 12:41 PM, Surveyor interviewed Director of Nursing (DON) B regarding observation and mechanical lift safety. Surveyor asked DON B if it would be an acceptable practice for staff to leave residents unattended while connected to lift equipment. DON B stated that other than an emergent situation, staff would be expected to stay with a resident while lift equipment is being used. Surveyor informed DON B of observation of R13 being left unattended for 6 minutes while attached to the lift machine. DON B stated disappointment and concern that this action could have resulted in harm from entrapment. 48793 Example 2 On 02/17/25, Surveyor reviewed R35's medical record. R35 was admitted on [DATE], with dementia unspecified with behavioral disturbances, cataracts, hypertensive heart disease, and insomnia. R35's Minimum Data Set (MDS) assessment, dated 11/06/24, had a Brief Interview for Mental Status (BIMS) score of 00 which indicated R35 had severe impaired cognition and could not complete the BIMS test. Surveyor reviewed R35's care plan for Alzheimer's disease major neurocognitive disorder due to medical condition with behavior disturbance: -On 11/16/22: Nurse to report any behavioral issues. Has wander management bracelet. -On 02/15/23: After wife visits monitor more closely for wandering or behaviors. -On 02/15/23: If attempt to swing fist may need to leave alone and reapproach later or get alternate staff. -On 02/21/24: Report to nurse if noting any behavioral issues or hitting peers. -On 06/25/24: Night shift to look in on him on rounds x 3. Keep door alarm on so as to alert staff to exiting room. On 1:1 visits as needed. -On 11/16/24: If pacing or restless, trying to go into peer's room offer to take toilet in his room. Redirect away from peers' rooms. -On 01/04/25: Turn on chime on outside door when he goes to bed, to alert staff when R35 exit seeks. -On 01/28/25: If in peers' room or noting to be touching peers, redirect R35. Surveyor reviewed R35's nursing progress notes that indicated, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	. -On 06/22/2024 at 4:09 PM, Note: [R35] was sitting at the dining table eating and suddenly he yelled at resident across the table who was eating his meal and then kicked the table and was swearing. We were going to remove him from the area but then he continued to eat, and we stayed nearby. When he appeared not to be eating, we offered that he could go watch tv if he wanted to. He got up and started pacing the hallway. After residents were done eating one resident stayed in his chair by the dining room table to watch tv and [R35] came up behind him and hit the back of the chair hard. This frightened the resident in the chair, and he got up with his walker and went to his room . Surveyor did not find documentation that staff implemented any new interventions to increase supervision or provide 1:1 for R35 after the resident altercation on 6/22/24. Nurse progress note indicated, -On 07/26/24: R35 was grabbing, pushing, and swinging. Attempted to put hands around writers' neck while trying to provide cares. Surveyor did not find documentation that staff implemented any new interventions to increase supervision for the other residents on the unit, when R35 exhibited increased aggressive behaviours on 7/26/24. Nurse progress note indicated, . On 09/16/24 at 9:30 PM, Note: [R35] spent first part of our shift outside. He did not eat much of his supper this evening. Given cold fluids as it was warm outside. Brought him in to get ready for bed but he has been very resistive to cares again his shift. I only now was able to get him to take his medications. Will attempt to change him again when he has had his meds in him for 30 minutes or so. CNA informed me that, [R35] walked by another resident and apparently swung as to hit him but did not. It is very difficult to address his cares even with two staff. Will continue to monitor behaviors and chart . Surveyor did not find documentation that staff updated any new interventions to increase supervision or provide 1:1 for R35 to protect other residents on the unit when R35 was observed swinging at another resident on 9/16/24. Nurse progress note indicated, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.On 01/10/2025 at 5:16 PM, PRN MED GIVEN: hydrOXYzine HCl 25MG Tablet (1 tablet / 25mg) given for agitation tried to throw chair in dining room. 6:44PM PRN MED RESULT: at 6:44 PM, Improved but still present. At 9:00 PM BEHAVIOR: abusive behavior wandering behaviors Pushing /Grabbing Behavior occurred. Note: We were trying to direct [R35] over to his food at the table. He did not want to come to the table but was trying to take plates from the dietetic worker instead. As we attempted to guide him to his table, he became agitated and attempted to pick up a chair as if he was going to throw it. It was eased back to floor, and we directed [R35] back to tv area. There are three other residents at his table and two staff trying to feed residents and another resident that was not being too cooperative with eating. It seemed too much activity for [R35] at the time and he got very agitated and angry. I then gave him his prn atarax which had little effect tonight. About 7:30 he grabbed another resident by the wrist and staff intervened before he could hurt the resident. He was angry because this resident grabbed his blanket he was holding and so he turned around quickly and grabbed her, and staff were standing there when he grabbed her. I turned down lights early this evening to slow things down because residents seemed quite wound up tonight. Will continue to monitor him closely around other residents . Surveyor did not find documentation that staff updated any new interventions or increased supervision for R35 when he was exhibiting increased unsafe behaviors towards staff and residents on 1/10/25. Nurse progress note indicated, .On 01/28/2025 at 4:38 PM, Late Entry for: 01/27/2025. DATE OF INCIDENT: 01/27/2025, TIME OF INCIDENT: 17:12, INJURY: no apparent injury There was an altercation during supper time. Resident was grabbing at [R36] walker during supper, [R36] tried to stop him by talking loudly. [R35] grabbed [R36]. [R36] stated if he grabs him again, he was going to, punch him. Staff had intervened. At 4:39PM, Today there was no further altercations between [R35] and [R36], they were kept apart from each other. At 10:13 PM, [R35] was aggressive and combative at the beginning of the shift. Resident was found in another resident's room and will not follow redirection from the CNA. Instead, he swung his hand on the CNA hitting the CNA on the chest . Surveyor did not find any new intervention or increased supervision for R35 or 1:1 after R35 grabbed R36's walker and grabbed R36. Interviews: On 02/19/25 at 10:25 AM, Surveyor interviewed R36 and asked R36 if there have been any resident-to-resident altercations that have occurred on the unit. R36 stated, Yes, with [R35]! Who has not had an altercation with [R35]. One time [R35] came at me in the dining room, but I put him in his place. I yelled to tell him not to ever touch me again or I'd punch him. Surveyor asked R36 to explain the incident in the dining room with R35. R36 indicated that R35 came at R36 and grabbed R36's walker and then swung at R36, hitting R36 and grabbing R36's wrist. On 02/19/25 at 10:30 AM, Surveyor interviewed CNA F and asked how CNA F supervises difficult residents that may wander into others' rooms or become aggressive. CNA F indicated that CNA F tries to monitor residents such as R35 from becoming angry and wandering but sometimes CNA F is in rooms taking care of other residents and can't always monitor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/19/25 at 11:27 AM, Surveyor interviewed Licensed Practical Nurse (LPN) G and asked LPN G what is LPN G's process when there is an altercation between a resident to resident or if there is an incident that happens with a resident that may need extra supervision. LPN G indicated LPN G will intervene if LPN G observes the resident-to-resident altercation. LPN G would try to redirect R35 or any other resident who is aggressive and acting out. Surveyor asked LPN G if LPN G does any kind of extra supervision for R35's outbursts. LPN G indicated that LPN G will try to observe from afar while in the common area. Surveyor asked LPN G how LPN G intervenes if R35 is from afar in the common area and R35 is about to swing at another resident. LPN G indicated that LPN G tries to make sure R35 is within close proximity but that is not always feasible when LPN G has to go into other rooms to pass medications. On 02/20/25 at 8:02 AM, Surveyor interviewed Director of Nursing (DON) B and asked what interventions for increased supervsion are in place for R35 due to his aggressive behaviors towards staff and residents. DON B indicated that sometimes staff will keep a close eye on R35 in the common area and kind of perform a 1:1. Surveyor asked DON B to explain what 1:1 means. DON B indicated that 1:1 means there is an actual staff member designated to 1:1 with R35 and staff do not let R35 out of sight. Surveyor asked DON B if 1:1 was utilized on 06/22/24, 09/16/24, 01/10/25, and 01/28/25. DON B indicated that DON B was unsure, but that DON B doubts it since some of these events occurred. Surveyor indicated to DON B that through review of documentation that Surveyor could not find that R35 was 1:1. DON B indicated that R35 was probably not 1:1 as we do not have enough staff to be 1:1 at this time. DON B acknowledged that increased supervision was not provided for R35 to prevent incidents with other residents.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51095 Based on observation, interview and record review, the facility did not ensure a medication error rate of 5% or less. During the medication administration task, Surveyors observed 4 errors out of 35 medication opportunities, resulting in an error rate of 11.4%. This affected 2 out of 4 residents (R) observed for medication administration sample. (R11 and R39) R11 received two insulin injections by using injectable pens that were not primed before administration. R39's insulin was not primed prior to administration of insulin. Findings include: Manufacturer's instructions for Basaglar Kwikpen (insulin glargine) states in part, .Priming your pen: Priming means removing the air from the Needle and Cartridge that may collect during normal use. It is important to prime your Pen before each injection so that it will work correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your Pen, turn the Dose Knob to select 2 units. Step 7: Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 8: Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and 0 is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat the priming steps, but not more than 4 times. If you still do not see insulin, change the Needle and repeat the priming steps . The facility procedure document entitled Insulin Injection, procedure reviewed date 2/25, states, in part, 9. If using an insulin pen, cleanse hub, apply needle, then prime pen with 2 units (dial 2 units\, hold pen upright, flick to bring air bubbles to top, push button all the way until dose returns to zero- you should see drop of insulin at needle tip\, if not change needle and repeat) Turn dial until desired dose. Example 1 R11 was admitted to the facility on [DATE] with a diagnosis including type 2 diabetes mellitus. R11 orders include, Insulin Aspart 100 unit/ML solution, Dose 12 units subcutaneously twice per day AM and noon and (Basaglar Kwik-pen) Insulin Glargine 100units/ml, Dose 18 units subcutaneously daily in the AM. R11 received two insulin injections via injectable pens that were not primed by Licensed Practical Nurse (LPN) J before administration of insulin dose. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/18/25 at 7:32 AM, Surveyor observed LPN J remove 2 insulin pens from the med drawer. LPN J dialed the Glargin pen (Basaglar 100units/ml) to 18units and the Aspart pen to 12 units without priming the pens first. Surveyor asked if the insulin pens needed to be primed. LPN J stated these insulin pens did not need to be primed. Surveyor observed LPN J administer the insulins subcutaneously into R11'S abdomen. On 2/18/25 at approximately 8:30 AM, Surveyor interviewed Director of Nursing (DON) B on the type of education and training that has been provided to nursing staff. DON B reported there had been a training on how to use an insulin pen in Dec. 2022. DON B reported her expectation would be that nursing staff prime the insulin pen prior to injecting a resident with insulin. DON B reported awareness of LPN J not understanding the need to prime insulin pens prior to injecting insulin. 48793 Example 2 On 02/18/25 at 8:00 AM, Surveyor observed LPN G administer a Humalog insulin pen into R39's abdomen. Surveyor did not observe an open date or expiration date label on the used Humalog pen. Surveyor did not observe LPN G prime the Humalog insulin pen with 2 units before prepping 6 units into the insulin pen. On 02/18/25 at 8:05 AM, Surveyor interviewed LPN G and asked what LPN G's process is for priming and administering insulin. LPN G indicated that LPN G forgot to prime and should have primed the Humalog insulin pen with 2 units and discard the 2 units first before prepping the 6 units for R39's Humalog insulin.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51095 Based on observation, interview and record review, the facility did not ensure drugs and biologics were stored in accordance with current accepted professional practice. This had the potential to affect 2 out of 2 residents (R) for proper labeling. (R29 and R39) This is evidenced by: According to the Food and Drug Administration (FDA), insulin pens should be discarded 28 days after opening the pen to ensure effectiveness of the medication. According to the American Diabetes Association, insulin products contained in vials or cartridges supplied by the manufacturers (opened or unopened) may be left unrefrigerated at a temperature between 59 and 86 degrees F for up to 28 days and continue to work. After 28 days the insulin should be discarded. On 3/29/21, R29 was admitted to the facility with a diagnosis including type 2 diabetes mellitus. R29's orders included Tresiba FlexTouch/ Insulin Deglu[DATE]u/ml Solution Pen-injector Dose 45 unit subcutaneous twice per day. On 2/19/25 at 10:25 AM, during a tour of medication storage, with Registered Nurse (RN) K, Surveyor observed R29's insulin pen, Tresiba FlexTouch 100u/ml exp 8/31/26, pharmacy label reads, 45 units SQ BID, opened, not refrigerated, and not labeled with an opened date, in the drawer of the medication cart. Surveyor interviewed RN K, who reports she forgot to date it when it was originally opened. RN verbalized understanding that insulin pens should be labeled with an opened-on date when they are taken out of the refrigerator and used within 28 days. 48793 Example 2 On 02/18/25 at 8:00 AM, Surveyor observed Licensed Practical Nurse (LPN) G administer a Humalog insulin pen into R39's abdomen. Surveyor did not observe an open date or expiration date label on the used Humalog pen. On 02/18/25 at 8:05 AM, Surveyor interviewed LPN G and asked what LPN G's process is for administering insulin without an open date. LPN G stated, That is a good question. I guess I would figure out when the pen was opened before giving to [R39]. Surveyor asked LPN G was it the correct process to still give the Humalog insulin without an open date to R39. LPN G indicated that LPN G probably should have discarded the Humalog insulin and got another one, but LPN G did not.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 46693 Based on observation, interview and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections that has the ability to affect all 50 residents (R). -Facility staff failed to transport linens in a manner to prevent the spread of infection. -Facility staff did not properly doff personal protective equipment (PPE) for a resident on enhanced barrier precautions (EBP). -Facility staff demonstrated poor hand hygiene during medication administration. -Facility staff did not prep skin prior to administering a subcutaneous injection of insulin. This is evidenced by: Example 1 Federal Regulation S483.80(e) Linens state, Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. On 02/17/25 at 10:02 AM, Surveyor observed Nursing Support Aide (NSA) N passing clean linens in the hallway without the clean linen cart being covered. Surveyor asked NSA N if it is normal practice to pass out personal clean linen without them being covered. NSA N stated, Yes. I have not seen the carts covered in a long time. On 02/18/25 at 11:00 AM, Surveyor observed NSA N again passing out clean personal linens on a cart in the hallway without a cover. On 02/18/25 at 1:19 PM, Surveyor interviewed Nursing Home Administrator (NHA) A who stated the towels and bedding linens are sent out and covered all the time. Personal linens are done on each wing on PM and night shifts. They are then put on the carts and in the morning, the aides deliver them to the residents' rooms. NHA agreed that all clean linens should be covered, and NHA A will ensure personal linens are covered as well. NHA added that it probably slipped by us when we changed from sending out all linens to be cleaned, to the facility doing the personal clothing in house. On 02/18/25 at 1:59 PM, Surveyor interviewed Infection Control (IC) P nurse. IC P brought Surveyor to the laundry area and stated the clean linen carts are supposed to be covered. IC P retrieved a cover and placed it on the cart. 49353 Example 2 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525430	A. Building B. Wing	02/20/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility policy titled, Enhanced Barrier Precautions (EBP), with a reviewed date of 10/23/24, stated in part: Policy statement: Rolling Hills Rehabilitation Center will utilize EBP to expand the use of PPE to resident care activities that have high potential for contaminating staff's hand and clothes with blood or bodily fluids . 3. Gown and gloves must be put on before entering room and taken off at room exit . 4. Position a trash can inside the resident room and near the exit for discarding PPE after removal (garbage and PPE removal bins in cupboard outside room), prior to exit of the room . The Centers for Disease Control and Prevention (CDC) guidelines for removal of PPE with EBP precautions states in part: Facilities should remember to have an appropriate disposal container available in the resident room to allow for removal of PPE inside the room. On 02/18/25 at 7:00 AM, Surveyor observed an Enhanced Barrier Precaution (EBP) sign on R2's door. The EBP sign indicated the use of personal protective equipment (PPE) of a gown and gloves be used when providing direct care for the resident. The PPE was stored just outside of R2's room behind closed doors. Underneath the PPE storage area was a separate compartment with a sign that stated 'Garbage.' On 02/18/25 at 9:02 AM, Surveyor observed Certified Nursing Assistant (CNA) C don a gown, gloves, and goggles and enter R2's room to assist R2 with toileting. On 02/18/25 at 9:10 AM, Surveyor observed CNA C exit R2's room wearing the gown, gloves and goggles. Surveyor observed CNA C open the garbage compartment outside of R2's room, remove and dispose of all the PPE she was wearing in garbage, and close garbage compartment door. Surveyor then observed CNA C complete hand hygiene. On 02/18/25 at 9:12 AM, Surveyor interviewed CNA C. Surveyor asked CNA C if it is common practice to remove PPE outside of resident room. CNA C stated yes because that is where the garbage is located. On 02/19/25 at 12:41 PM, Surveyor interviewed Director of Nursing (DON) B regarding EBP. Surveyor asked DON B what the expectation is for staff to don/doff PPE with EBP. DON B stated that staff are expected to don PPE before entering a resident's room and remove PPE just outside of resident's room. Surveyor asked DON B if this expectation met the facility's and current CDC guidelines. DON B stated that she felt this was acceptable as it is just outside of the room. Surveyor asked DON B if just outside the resident room was the same as the facility's policy of before exiting the resident's room. DON B then reluctantly stated that it did not. Surveyor asked DON B if this practice had the potential to transmit infection by staff touching equipment outside of room while wearing the contaminated PPE after providing direct care. DON B stated yes, she could see how that could be a potential concern. 51095 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525430	A. Building B. Wing	02/20/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Example 3 The facility policy document titled: Hand Hygiene and Gloving, reviewed on 10/23/24, states in part, .All staff are required to wash their hands promptly and thoroughly between resident contacts and after contact with blood, body fluid, mucous membranes, secretions, excretions and equipment or articles contaminated by them. Gloves are also used for the above resident contacts and handwashing must follow both application and removal of gloves. The facility procedure document titled Insulin Injection, procedure reviewed date 2/25, states, in part, C. Injection of Insulin . 1. Take insulin alcohol pad to resident. Wash hands, put on gloves. 2. Cleanse injection site with alcohol pad. Allow to dry before injecting. On 2/18/25 at 7:28 AM, during medication administration pass, Surveyor observed Licensed Practical Nurse (LPN) J apply gloves without using hand hygiene prior to gloving. LPN J obtained a finger stick blood sample for R27. After performing the test, LPN J removed her gloves, did not sanitize or wash her hands and proceeded to move medication cart to the next resident's door. On 2/18/25 at 7:32 AM, Surveyor observed LPN J put on gloves, without hand hygiene prior, and obtain a finger stick blood sample for R11. LPN J then removed her gloves, did not sanitize or wash her hands, removed 2 insulin pens from the medication drawer and administer the insulins subcutaneously into R11's abdomen. LPN J did not use an alcohol pad to cleanse injection site prior to injecting. On 2/18/25 at 7:34 AM, Surveyor interviewed LPN J about hand hygiene practices, and she reported hand hygiene should be performed before and after gloving. LPN J stated, I did not do it, you make me nervous. Surveyor also asked if she used an alcohol wipe on the injection site prior to injecting insulin. LPN stated she did not wipe R11's injection site with alcohol prior to administering insulin. I usually do, I just forgot. On 2/18/25 at approximately 8:30 AM, Surveyor interviewed DON B. DON B reported her expectation would be that staff follow infection control procedures. DON B reported she is aware that LPN J did not follow appropriate infection control practices.