STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525659	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grande Prairie Care and Rehab Ctr LLC	10330 Prairie Ridge Blvd Pleasant Prairie, WI 53158

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 - 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** 49845 Based on interviews and record review, the facility failed to protect the residents' right to be free from verbal and or physical abuse by Certified Nursing Assistant (CNA)-J. *R5 reported that R5 was attacked in the doorway of the kitchen, in the dining room, at the facility resulting in R5 to be fearful and cautious in the facility. R5 reported left shoulder, left rib and left knee pain following the incident. R5 sought evaluation and treatment for R5's left knee pain on 01/13/2025 resulting in R5 requiring an invasive injection into R5's left knee. Findings: Findings include: The facility's policy, titled Abuse, Neglect and Exploitation, dated as reviewed/revised on 10/2024, documents: Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others nut has not yet been investigated and if verified, could be indication of noncompliance with Federal requirements related to mistreatment, exploitation, neglect, or abuse . Mistreatment means inappropriate treatment or exploitation of a resident . Physical Abuse includes, but is not limited to hitting slapping punching biting and kicking. It also includes controlling behavior through corporal punishment. Serious bodily injury means an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization , or physical rehabilitation; or an injury resulting from criminal sexual abuse . Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; b. Establish policies and procedures to investigate any such allegations . (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 - Actual harm Residents Affected - Few	The components of the facility abuse prohibition plan are discussed herein: V. Investigation of alleged abuse, neglect and exploitation A. On immediate investigation is warranted when suspicion of abuse, neglect or expectation, or reports of abuse, neglect or exploitation occur VI. Protection of resident The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after an investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim in integrity of the investigation: . D. Room or staffing changes, if necessary, to protect the residents from the alleged perpetrator; E. Protection from retaliation by: . VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the administrator, state agency, Adult Protective Services and to all required agencies (e.g., law enforcement when applicable) within specified time frames: a. Immediately, but not later than 2 hours after the allegation is made, if the event that caused delegation involves abuse or result in serious bodily injury, or b. Not later than 24 hours of the event that caused the allegation do not involve abuse and do not result in serious bodily injury. 1.) R5 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, unspecified dementia without disturbance psychotic disturbance mood disturbance and anxiety, pain in right knee, pain in left knee, anxiety disorder, peripheral vascular disease, pain in right wrist, pain in left shoulder and rotator cuff tear or rupture of left shoulder. R5's Annual Minimum Data Set (MDS), dated [DATE], documents that R5 is able to understand and be understood and that a staff assessment for mental status was conducted that documented R5 has a memory problem and was able to recall current season, location of own room, staff names and faces, and that he/she is in a nursing home/hospital swing bed. The MDS documents that R5 has modified independence- some difficulty in new situations only, that R5 has no behaviors/rejection of care exhibited, uses a walker, and is not on antipsychotic drug therapy. R5's Quarterly MDS, dated [DATE], documents a staff assessment for mental status was conducted and that R5 has a memory problem and was able to recall current season, location of own room, staff names and faces, and that he/she is in a nursing home/hospital swing bed. The MDS documents that R5 has modified independence- some difficulty in new situations only, that R5 has no behaviors/rejection of care exhibited, uses a walker, and is not on antipsychotic drug therapy. (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 - Actual harm Residents Affected - Few	On 03/17/2025, at 08:50 AM, Surveyor interviewed R5. R5 informed Surveyor that R5 was attacked in the doorway to kitchen by a named staff member, later identified as Certified Nursing Assistant (CNA)-J. Surveyor asked R5 about what led up to the incident and R5 indicated being unsure and stated CNA-J is a belligerent and stupid person. R5 indicated that Adult Protective Services (APS) came to the Facility and spoke with R5. R5 unsure who notified APS and indicated there were many witnesses. R5 informed Surveyor that CNA-J told R5 that Director of Nursing (DON)-B said that R5 could not come in the kitchen. R5 indicated speaking with DON-B regarding the incident and was told it would be taken care of. R5 informed Surveyor that R5 was hurt during the incident and had pain to left rib cage, left shoulder, and left foot. R5 stated that R5 does not feel safe at the facility, that the incident is not taken care of and stated, I was abused!. R5 stated that R5 is fearful and is very careful with what R5 says and does now in the facility. Surveyor reviewed staff roster for the last name of the staff member R5 identified. Surveyor noted 2 staff with that last name, so Surveyor interviewed one of the two staff members with the same last name and was able to determine that the individual alleged to have been in altercation with R5 was CNA-J. On 03/17/2025, at 9:37 AM, Surveyor left a voice message with Adult Protective Services (APS)-K. On 03/17/2025, at 10:37 AM, Surveyor spoke with Dietary Aide (DA)-L. DA-L stated that DA-L heard about the incident involving R5, and indicated R5 will usually come to the kitchen door to get juice/milk/ice etc. at mealtimes. DA-L indicated DA-L was not working that day of incident. On 03/17/2025, at 10:42 AM, Surveyor spoke with Director of Dietary-N. Director of Dietary-N was not here the day of the incident but knows of incident involving R5. Director of Dietary-N was informed the following day by a DA-M who witnessed the incident between CNA-J and R5. Director of Dietary-N indicated DA-M is not working today but stated Director of Dietary-N could call DA-M via phone. Director of Dietary-N stated that DA-M and Director of Dietary-N spoke with DON-B together the following day. On 03/17/2025, at 10:45 AM, Director of Dietary-N called DA-M via telephone who witnessed the incident between CNA-J and R5. DA-M indicated on the day of the incident, dietary staff were getting ready to serve dinner, when R5 came to get ice. DA-M stated that DA-M heard CNA-J saying, get away from there. DA-M then saw that CNA-J had the resident by the forearm area, then pushed the cart away aggressively trying to get the drink from R5's hand. DA-M stated that CNA-J then pushed R5 and the cart, and R5 fell into the door. DA-M stepped in between resident and CNA-J. DA-M asked R5 if R5 was okay and DA-M stated R5 stated that R5 was rattled. DA-M observed milk and coffee on the floor, DA-M walked resident back to R5's room. CNA-J kept yelling. DA-M spoke to DON-B and stated DON-B wasn't interested, and DON-B rolled DON-B's eyes. CNA-J proceeded to cause problems in the kitchen slamming doors and talking crap. The next day Director of Dietary-N and DA-M went to talk to DON-B regarding CNA-J but again DON-B did not seem interested. On 03/17/2025, at 10:54 AM, Surveyor interviewed Lead Cook-P. Lead Cook-P indicated on the evening of the incident, Lead Cook-P heard commotion by the door to the dining room. Lead Cook-P indicated Lead Cook-P did not see what had occurred but indicated milk had fallen off the cart and onto the floor. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 03/17/2025, at 1:26 PM, Surveyor interviewed DON-B. Surveyor asked DON-B if an incident occurred in the dining room involving R5. DON-B indicated there was an incident possibly in December or January, involving two staff members yelling at each other and milk spilled on the floor. DON-B indicated R5 was there, that CNA-J was telling R5 that R5 cannot grab milk from the cart due to infection control concerns and told resident that DON-B said that. DON-B indicated that DON-B spoke with both staff, and they never mentioned R5 being grabbed or pushed. DON-B indicated DON-B spoke to R5 at the time but only talked about not going into the pushcart due to infection control. DON-B indicated the incident was not reported or investigated due to it being an incident between two staff members and DON-B had informed the staff members to separate. Surveyor reviewed R5's Electronic Medical Record (EMR) and noted an office visit with R5's Orthopedic Doctor on 01/13/2025 that documented, Seen for left knee pain, patient last seen for issue on 10.18.24 where he completed 3 injection series of Synvics injections. Patient was slammed into a door jam at Grand Prairie approximately 10 days ago which is when the pain began. Describes pain as sharp that radiates from the anterior of the left knee cap that radiates down the left leg. Patient rates the pain a 10/10, Patient states the pain does interfere with sleep. Patient states walking aggravates the pain. The patient does not endorse catching, popping, grinding, clicking. The patient does complain of leg buckling/giving way. Patient is not experiencing numbness/paresthesias, or gross motor weakness. The patient cannot walk for as long as they would like or exercise without pain. The symptoms aren't activity-related and don't improve with rest. The patient does have difficulty with Activities of Daily Living (ADLs) due to current symptoms. Patient denies any fever, chills, or issues with bowel/bladder functions .Assessment and Plan: Primary osteoarthritis of left knee Patient presents in office for an increase in left knee pain following an injury at his rehab facility. Corded the patient he was forcibly pressed into a wall in the left knee was twisted during the incident and his pain has been increased since. X-rays are negative for fracture; the knee is stable upon exam. Most likely this incident caused a flare in his arthritis for which a cortisone shot was given today .will follow up in our office as needed. On 03/17/2025, at 3:20 PM, DON-B informed Surveyor that CNA-J was suspended as of today, pending investigation. On 03/17/2025, at 3:22 PM, Surveyor left voice message for CNA-J requesting CNA-J call Surveyor. On 03/17/2025, at 3:04 PM, Surveyor asked DON-B and NHA-A about R5's Office visit note dated 01/13/2025. Surveyor asked if there was a separate incident or if this would be from the same incident in the kitchen area. DON-B indicated that she would guess it is the same incident and indicated no other incidents occurred. DON-B stated that the information from the visit was not brought to DON-B's attention. NHA-A stated that a good guess of when the incident occurred between CNA-J and R5 would be around the time of the last annual survey. NHA-A indicated police have now been notified. On 03/18/2025, at 07:36 AM, DON-B updated Surveyor regarding the investigation into the incident involving R5 and CNA-J. DON-B stated that DON-B thinks the incident occurred near the end of December and is trying to get in touch with CNA-J but has not got a call back. DON-B indicated she is attempting to pin point exact date the incident occurred. Surveyor noted, DON-B stated she found a note dated 01/08/2025 by another CNA indicating kitchen staff was following CNA-J around on unit but DON-B did not follow up because DON-B is not in charge of kitchen staff, per DON-B. DON-B informed Surveyor that CNA-J was upset because DON-B told CNA-J to stay out of the kitchen, but did not tell kitchen staff to stay off the unit where CNA-J was working. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 03/18/2025, at 08:37 AM, Surveyor interviewed Social Services Director (SS)-F. Social Services Director-F indicated R5's last care conference was 12/18/2025, R5 is his own person, R5 refuses Brief Interview for Mental Status (BIMS), declines psychiatric services and stated that no referrals to be seen for psych services have been made for R5. SS-F stated that R5 has no activated Power of Attorney (POA) and stated that SS-F is not aware of any situation involving allegations of abuse with R5 but would expect to be notified if there were any. Surveyor noted CNA-J worked 12/21/24, 12/23/24, 12/25/24 in the dining room per the schedule, but was not scheduled for dining room after those dates. Surveyor noted CNA-J worked a total of 46 shifts from 01/01/2025 through 03/16/2025 and noted CNA-J was scheduled to work on 03/17/2025. On 03/18/2025, at 2:30 PM, Surveyor spoke with Adult Protective Services (APS)-K. APS-K informed Surveyor that APS received a call through the elder abuse hotline from R5's doctor's office on 03/03/2025 regarding an abuse allegation. APS-K went to the facility on [DATE] and spoke with R5 whom indicated the incident happened near the kitchen door in the dining room. APS-K informed Surveyor that R5 stated that CNA-J pushed R5 against the wall causing R5 foot pain. APS-K informed R5 that APS-K would contact the Division of Quality Assurance (DQA). APS-K indicated APS-K did not speak to any staff at the facility because if a complaint is deemed credible, the complaint is sent to DQA. On 03/18/2025, at 02:38 PM, Surveyor spoke with Registered Nurse (RN)-O from R5's Orthopedics' office. RN-O indicated R5 was seen on 01/13/2025, and that per R5's statement, R5 was suffering from left kneed pain because of the incident involving CNA-J and R5. RN-O stated that R5 called the doctor's office on 03/03/2025 complaining of still having pain in the left knee following the incident. RN-O encouraged R5 to be seen in urgent care and then RN-O then called in the complaint to APS. RN-O informed Surveyor that R5 called the doctor's office again on 03/06/2025 with same complaints, and informed Surveyor that RN-O called the facility to follow up which led R5 to be sent to emergency roiagnom on [DATE] for shortness of breath and edema. On 03/18/2025, at 2:54 PM, DON-B sent an email to Surveyor documenting that R5 goes out for many appointments and does not give the facility the after-visit summaries for nursing to review. DON-B informed Surveyor that the medical records person must then call the doctor's office to have the after-visit summaries faxed over. DON-B informed Surveyor that the Facility received R5's doctor office visit record from the 01/13/2025 visit with orthopedics over a month later, on 02/17/2025. DON-B informed Surveyor that at the time, the document was uploaded but not given to a nurse to review. On 03/19/2025, at 09:43 AM, Surveyor received email from DON-B containing resident witness statements conducted on 03/19/2025, regarding the incident between CNA-J and R5. Surveyor noted the following questions lead the resident's statements, Did you witness an altercation in the dining room around Christmas time between a resident and staff member? If so, did you see the staff member push a resident into the wall? Did you see a staff member touch a resident in the dining room? If so, who was the resident and who was the staff. Describe. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted that a resident witness statement, dated 03/19/2025, documents yes CNA-J started yelling (talking) loudly toward R5, did not see CNA-J - hit or push R5, CNA-J backed R5 down by talking to R5. Another resident statement, dated 03/19/2025, documents yes I did CNA-J was in the right and was looking out for everyone, denies R5 was pushed into the wall and indicated if R5 said that then R5 is lying, CNA-J told R5 if R5 wanted something to ask for it and moved the cart away which upset R5 because R5 does not like to be told no and indicated the kitchen staff thought they could put their two cents in. Another resident statement, dated 03/19/2025, documents the resident heard about the incident but did not witness it. No additional information was provided.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49845 Based on interview and record review, the facility did not report 3 (R5, R1, R3 and R4) of 4 reportable incidents to the State survey agency and/or Law Enforcement within the required timeframe. The facility was made aware of an incident involving allegations of abuse that occurred involving R5 and two staff members. The facility did not report to law enforcement the allegation of potential abuse. R5 sought evaluation and treatment for R5's left knee pain following the incident. The staff member alleged to have abused R5 was allowed to work approximately 46 shifts following the incident, resulting in R5 and other residents to not be safeguarded from additional potential abuse. * On 3/3/2025, the facility investigated allegations of sexual abuse for R1 and did not update the police or state agency within the 2-hour time frame. Suspension of the accused CNA did not occur until 3/17/2025. * On 1/24/25, R3 and R4 had a resident-to-resident altercation. During the investigation, the facility did not call the police. Findings include: The facility's policy titled Abuse, Neglect and Exploitation, dated as reviewed/revised on 10/2024, documents: Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others that has not yet been investigated and if verified, could be indication of noncompliance with Federal requirements related to mistreatment, exploitation, neglect, or abuse . Mistreatment means inappropriate treatment or exploitation of a resident . Physical Abuse includes, but is not limited to hitting slapping punching biting and kicking. It also includes controlling behavior through corporal punishment. Serious bodily injury means an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization , or physical rehabilitation; or an injury resulting from criminal sexual abuse . Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; b. Establish policies and procedures to investigate any such allegations; . The components of the facility abuse prohibition plan are discussed herein: . VII. Reporting/Response (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	A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the administrator, state agency, Adult Protective Services and to all required agencies (e.g., law enforcement when applicable) within specified time frames: a. Immediately, but not later than 2 hours after the allegation is made, if the event that caused delegation involves abuse or results in serious bodily injury, or b. Not later than 24 hours of the event that caused the allegation do not involve abuse and do not result in serious bodily injury. 1.) R5 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, unspecified dementia without disturbance, psychotic disturbance mood disturbance and anxiety, pain in right knee, pain in left knee, anxiety disorder, peripheral vascular disease, pain in right wrist, pain in left shoulder, and rotator cuff tear or rupture of left shoulder. R5's Annual Minimum Data Set (MDS), dated [DATE], documents that R5 is able to understand and be understood and that a staff assessment for mental status was conducted that documented R5 has a memory problem but was able to recall current season, location of own room, staff names and faces, and that he/she is in a nursing home/hospital swing bed. The MDS documents R5 has modified independence-some difficulty in new situations only, R5 has no behaviors/rejection of care exhibited, uses a walker, and is not on antipsychotic drug therapy. R5's Quarterly MDS, dated [DATE], documents a staff assessment for mental status was conducted and R5 has a memory problem but was able to recall current season, location of own room, staff names and faces, and that he/she is in a nursing home/hospital swing bed. The MDS documents R5 has modified independence-some difficulty in new situations only, R5 has no behaviors/rejection of care exhibited, uses a walker, and is not on antipsychotic drug therapy. On 03/17/2025 at 08:50 AM, Surveyor interviewed R5. R5 informed Surveyor R5 was attacked in the doorway to kitchen by a named staff member, later identified as Certified Nursing Assistant (CNA)-J. Surveyor asked R5 what led up to the incident and R5 indicated being unsure and stated CNA-J is a, belligerent and stupid person. R5 indicated Adult Protective Services (APS) came to the facility and spoke with R5. R5 was unsure who notified APS and indicated there were many witnesses. R5 informed Surveyor CNA-J told R5 that Director of Nursing (DON)-B said R5 could not come in the kitchen. R5 indicated speaking with DON-B regarding the incident and was told it would be taken care of. R5 informed Surveyor R5 was hurt during the incident and had pain to left rib cage, left shoulder, and left foot. R5 stated R5 does not feel safe at the facility, the incident is not taken care of, and stated, I was abused! R5 stated R5 is fearful and is very careful with what R5 says and does now in the facility. Surveyor reviewed the staff roster for the last name of the staff member R5 identified. Surveyor noted 2 staff with that last name, so Surveyor interviewed one of the two staff members with the same last name and was able to determine that the individual alleged to have been in an altercation with R5 was CNA-J. On 03/17/2025 at 9:37 AM, Surveyor left a voice message with Adult Protective Services (APS)-K. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/17/2025 at 10:45 AM, Director of Dietary-N called DA-M via telephone. DA-M indicated on the day of the incident, dietary staff were getting ready to serve dinner, when R5 came to get ice. DA-M stated DA-M heard CNA-J saying, get away from there. DA-M then saw that CNA-J had the resident by the forearm area, then pushed the cart away aggressively trying to get the drink from R5's hand. DA-M stated CNA-J then pushed R5 and the cart, and R5 fell into the door. DA-M stepped in between resident and CNA-J. DA-M asked R5 if R5 was okay and DA-M stated R5 stated R5 was rattled. DA-M observed milk and coffee on the floor; DA-M walked resident back to R5's room. CNA-J kept yelling. DA-M spoke to DON-B and stated DON-B wasn't interested, and DON-B rolled DON-B's eyes. CNA-J proceeded to cause problems in the kitchen slamming doors and talking crap. The next day Director of Dietary-N and DA-M went to talk to DON-B regarding CNA-J but again DON-B did not seem interested. On 03/17/2025 at 10:54 AM, Surveyor interviewed Lead Cook-P. Lead Cook-P indicated on the evening of the incident, Lead Cook-P heard commotion by the door to the dining room. Lead Cook-P indicated Lead Cook-P did not see what had occurred but indicated milk had fallen off the cart and onto the floor. On 03/17/2025 at 1:26 PM, Surveyor interviewed DON-B. Surveyor asked DON-B if an incident occurred in the dining room involving R5. DON-B indicated there was an incident possibly in December or January, involving two staff members yelling at each other and milk spilled on the floor. DON-B indicated R5 was there, CNA-J was telling R5 that R5 cannot grab milk from the cart due to infection control concerns and told resident DON-B said that. DON-B indicated DON-B spoke with both staff, and they never mentioned R5 being grabbed or pushed. DON-B indicated DON-B spoke to R5 at the time but only talked about not going into the pushcart due to infection control. DON-B indicated the incident was not reported or investigated due to it being an incident between two staff members and DON-B had informed the staff members to separate. Surveyor reviewed R5's Electronic Medical Record (EMR) and noted an office visit with R5's Orthopedic Doctor on 01/13/2025 that documented, Seen for left knee pain, patient last seen for issue on 10.18.24 where he completed 3 injection series of Synvics injections. Patient was slammed into a door jam [sic] at Grand Prairie approximately 10 days ago which is when the pain began. Describes pain as sharp that radiates from the anterior of the left knee cap that radiates down the left leg. Patient rates the pain a 10/10, Patient states the pain does interfere with sleep. Patient states walking aggravates the pain. The patient does not endorse catching, popping, grinding, clicking. The patient does complain of leg buckling/giving way. Patient is not experiencing numbness/paresthesias, or gross motor weakness. The patient cannot walk for as long as they would like or exercise without pain. The symptoms aren't activity-related and don't improve with rest. The patient does have difficulty with Activities of Daily Living (ADLs) due to current symptoms. Patient denies any fever, chills, or issues with bowel/bladder functions .Assessment and Plan: Primary osteoarthritis of left knee Patient presents in office for an increase in left knee pain following an injury at his rehab facility. According to the patient he was forcibly pressed into a wall in the left knee was twisted during the incident and his pain has been increased since. X-rays are negative for fracture; the knee is stable upon exam. Most likely this incident caused a flare in his arthritis for which a cortisone shot was given today .will follow up in our office as needed. (continued on next page)

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	525659	A. Building B. Wing	03/27/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/17/2025 at 3:04 PM, Surveyor asked DON-B and NHA-A about R5's Office visit note dated 01/13/2025. Surveyor asked if there was a separate incident or if this would be from the same incident in the kitchen area. DON-B indicated she would guess it is the same incident and indicated no other incidents occurred. DON-B stated the information from the visit was not brought to DON-B's attention. NHA-A stated a good guess of when the incident occurred between CNA-J and R5 would be around the time of the last annual survey. NHA-A indicated police have now been notified. On 03/18/2025 at 07:36 AM, DON-B updated Surveyor regarding the investigation into the incident involving R5 and CNA-J. DON-B stated DON-B thinks the incident occurred near the end of December and is trying to get in touch with CNA-J but has not received a call back. DON-B indicated she is attempting to pinpoint the exact date the incident occurred. Surveyor noted, DON-B stated she found a note dated 01/08/2025 by another CNA indicating kitchen staff was following CNA-J around on unit but DON-B did not follow up because DON-B is not in charge of kitchen staff, per DON-B. DON-B informed Surveyor that CNA-J was upset because DON-B told CNA-J to stay out of the kitchen, but did not tell kitchen staff to stay off the unit where CNA-J was working. On 03/18/2025 at 08:37 AM, Surveyor interviewed Social Services Director (SS)-F. Social Services Director-F indicated R5's last care conference was 12/18/2024, R5 is his own person, R5 refuses Brief Interview for Mental Status (BIMS), declines psychiatric services and stated no referrals to be seen for psych services have been made for R5. SS-F stated R5 has no activated Power of Attorney (POA) and stated SS-F is not aware of any situation involving allegations of abuse with R5 but would expect to be notified if there were any. Surveyor noted CNA-J worked 12/21/24, 12/23/24, and 12/25/24 in the dining room per the schedule, but was not scheduled for dining room after those dates. Surveyor noted CNA-J worked a total of 46 shifts from 01/01/2025 through 03/16/2025 and noted CNA-J was scheduled to work on 03/17/2025. On 03/18/2025 at 2:30 PM, Surveyor spoke with Adult Protective Services (APS)-K. APS-K informed Surveyor APS received a call through the elder abuse hotline from R5's doctor's office on 03/03/2025 regarding an abuse allegation. APS-K went to the facility on [DATE] and spoke with R5 whom indicated the incident happened near the kitchen door in the dining room. APS-K informed Surveyor R5 stated that CNA-J pushed R5 against the wall causing R5 foot pain. APS-K informed R5 that APS-K would contact the Division of Quality Assurance (DQA). APS-K indicated APS-K did not speak to any staff at the facility because if a complaint is deemed credible, the complaint is sent to DQA. On 03/18/2025 at 02:38 PM, Surveyor spoke with Registered Nurse (RN)-O from R5's Orthopedics office. RN-O indicated R5 was seen on 01/13/2025, and per R5's statement, R5 was suffering from left knee pain because of the incident involving CNA-J and R5. RN-O stated R5 called the doctor's office on 03/03/2025 complaining of still having pain in the left knee following the incident. RN-O encouraged R5 to be seen in urgent care and RN-O then called in the complaint to APS. RN-O informed Surveyor R5 called the doctor's office again on 03/06/2025 with same complaints, and informed Surveyor RN-O called the facility to follow up which led R5 to be sent to emergency roiagnom on [DATE] for shortness of breath and edema. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/18/2025 at 2:54 PM, DON-B sent an email to Surveyor documenting that R5 goes out for many appointments and does not give the facility the after-visit summaries for nursing to review. DON-B informed Surveyor that the medical records person must then call the doctor's office to have the after-visit summaries faxed over. DON-B informed Surveyor the facility received R5's doctor office visit record from the 01/13/2025 visit with orthopedics over a month later, on 02/17/2025. DON-B informed Surveyor at the time, the document was uploaded but not given to a nurse to review. Surveyor noted that the facility did not follow up with R5's orthopedic office despite R5 being seen and reporting pain from the alleged incident on 1/13/25. Surveyor noted that the facility did not follow up or notify law enforcement, the administrator or the state agency of the above allegations on 1/13/25. On 03/19/2025 at 09:43 AM, Surveyor received email from DON-B containing resident witness statements conducted on 03/19/2025 regarding the incident between CNA-J and R5. Surveyor noted the following questions led the resident's statements, Did you witness an altercation in the dining room around Christmas time between a resident and staff member? If so, did you see the staff member push a resident into the wall? Did you see a staff member touch a resident in the dining room? If so, who was the resident and who was the staff. Describe. Surveyor noted that a resident witness statement, dated 03/19/2025, documents yes CNA-J started yelling (talking) loudly toward R5, did not see CNA-J hit or push R5, CNA-J backed R5 down by talking to R5. Another resident statement, dated 03/19/2025, documents yes I did CNA-J was in the right and was looking out for everyone, denies R5 was pushed into the wall and indicated if R5 said that then R5 is lying, CNA-J told R5 if R5 wanted something to ask for it and moved the cart away which upset R5 because R5 does not like to be told no and indicated the kitchen staff thought they could put their two cents in. Another resident statement, dated 03/19/2025, documents the resident heard about the incident but did not witness it. No additional information was provided. 20025 2.) Surveyor reviewed a facility investigation regarding a resident to resident physical altercation between R3 and R4. This incident was reported to the state agency. R3 was admitted to the facility on [DATE] with diagnoses of quadriplegia, type 2 diabetes, and anxiety. R3's annual MDS (minimum data set) dated 2/8/25 indicates R3 is cognitively intact and is dependent for ADLs (activities of daily living). R4 was admitted to the facility on [DATE] with diagnoses of ESRD (end stage renal disease), type 2 diabetes, and PTSD (post traumatic stress disorder). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's quarterly MDS dated [DATE] documents that R4 is cognitively intact and independent for ADLs. The facility investigation dated 1/24/25 documents that R3 was in bed and thought R4 was trying to climb in bed with him. R3 then threw water at R4 and R4 retaliated by throwing a fan at R3 hitting R3 in the shin. The investigation reveal R4 denied trying to get in bed with R3. R4's statement indicated the room was dark and he was walking and touched R3's bed on his way to his own bed. The facility investigation indicates both residents were separated and R4 slept in a different room. Interviews were conducted with R3 and R4 and staff involved. R3 and R4 are no longer are roommates and no further incidents have occurred. The investigation does not indicate whether the police were notified of this resident to resident altercation. On 3/17/25 at 3:10 p.m., Surveyor interviewed NHA (Nursing Home Administrator)-A. Surveyor asked NHA-A if the police were notified of R3 and R4's physical altercation. NHA-A stated he thought they were called but it's obvious they weren't called because it's not documented. No additional information was provided as to why R3 and R4's resident to resident physical altercation was not reported to law enforcement. 50700 3.) R1 was admitted to facility on 7/10/2023 with diagnoses that include hemiplegia and hemiparesis following an unspecified cerebrovascular disease affecting R1's left dominant side, repeated falls, bipolar disorder, depression, dysphasia, cognitive communication deficit, and need for assistance with personal cares. R1's Quarterly Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating that R1's cognition was intact. Section B documented that R1 is understood and understands. Section E documents that R1 did not exhibit any behavioral symptoms. R1's Behavioral care plan, dated 7/17/2023, with a target date of 3/20/2025, documents under the intervention section: Rude, uncooperative behavior, refusals, risks versus benefits completed, caregivers to provide opportunity for positive interaction/attention. Psych services, explain all procedures to resident before starting to allow the resident time to adjust to changes, if reasonable, discuss the resident's behavior explain/reinforce why behaviors inappropriate and/or unacceptable to the resident. Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation intake to alternate location as needed. Monitor behavior episodes and attempt to determine underlying cause. Praise any indication of the resident's progress/improvement in behavior. Provide a program of activities that is of interest and accommodates resident's status. Refuse shower in skin check: a resident because of holiday, Staff encouraged to: use the buddy system, at all times, when going into resident's room. Surveyor noted that the facility documented in R1's MDS that no behaviors were exhibited but had mentions of R1's behaviors thoughout R1's behavioral care plan. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/2025 at 9:06 AM, Surveyor interviewed R1 who stated that Certified Nursing Assistant (CNA)-H assisted with washing R1 up during cares. R1 stated that CNA-H washed R1's breast. R1 indicated that everyone at the facility knows R1 will do that independently. R1 stated that R1 told CNA-H, No, you don't wash me there. R1 stated, CNA-H stated: Oh (R1's name). R1 indicated that CNA-H continued to wash R1's breast. R1 stated that she told CNA-H, Don't Oh (R1's name) me. R1 indicated telling CNA-H that R1 knows resident rights and that R1 will call the state to report the incident. R1 indicated this occurred on 2/27/2025 and again on 3/3/2025. R1 stated that R1 left a voicemail with the Unit Manager (UM)-E and R1 indicated that the notification was left on UM-E's voicemail. R1 said, I will call the state. R1 indicated not hearing back from UM-E. On 3/17/2025 at 11:00 AM, Surveyor interviewed UM-E who indicated that UM-E will receive complaints via telephone or by voicemail. UM-E stated that R1 is one resident that will call her for complaints, but that UM-E did not get a complaint about someone inappropriately touching R1. UM-E indicated that if this was reported to UM-E, this would've been addressed right away. UM-E stated not writing down concerns, but that UM-E will address them verbally when received. UM-E stated not being part of an investigation with this matter but that Social Services (SS)-F indicated that R1 is now on the buddy system. On 3/17/2025 at 11:26 AM, Surveyor received a file from UM-E, which documented that an investigation relating to these allegations was started and that UM-E was unaware of this. Surveyor reviewed R1's electronic record, and reviewed progress notes from March 2025, but Surveyor could not locate any documentation relating to R1's behaviors and nursing staff. Surveyor reviewed behavioral charting from CNAs' task list for March 2025 and noted that no behaviors were documented for R1. Surveyor reviewed the facility's investigation file, dated 3/6/2025. Both CNA-H and CNA-I had statements in the file that were similar. Surveyor noted statements from both CNAs indicated that R1 was updated on getting a bed bath and that R1 agreed. Both CNA statements documented that R1 washed her face and neck area and that both CNAs grabbed washcloths and started to wash R1's arms and under R1's arms. Both CNA statements documented that before cleaning R1's breast, R1 stated nobody has permission to touch her breasts. It is documented on both CNA statements that R1 washed her own breasts. Surveyor reviewed statements from Social Service (SS)-F dated 3/6/2025. SS-F's statement documented that SS-F asked R1 if she had any concerns with staff, residents, or cares. The statement from SS-F documented that R1 stated she has no concerns. On 3/17/2025 at 11:46 AM, Surveyor was informed by the Nursing Home Administrator (NHA)-A that CNA-H is now suspended. NHA-A indicated that the allegation wasn't reported before because R1 didn't say that R1 was inappropriately touched until today (3/17/25). Surveyor reviewed the complaint file that was dated 3/6/2025 and CNA-H was an active employee, working at the facility from 3/6/2025 until 3/17/2025. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/2025, at 12:39 PM, Surveyor interviewed SS-F, who indicated that R1's allegation wasn't SS-F's investigation, and that SS-F believes it was Director of Nursing (DON)-B that was investigating it. SS-F indicated asking R1 if she had any concerns with cares or staff. SS-F indicated not asking R1 about being inappropriately touched; SS-F indicated only asking R1 about any care and staffing concerns. On 3/17/2025 at 12:49 PM, Surveyor interviewed Human Resources (HR)-G, who indicated CNA-H made concerned statements to HR-G. The above-mentioned statements were regarding CNA-H being worried about R1 reporting CNA-H to the state. HR-G indicated this occurred around 3/6/2025. HR-G indicated asking SS-F to go and speak with R1. HR-G stated that this was reported to Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. HR-G indicated that NHA-A asked HR-G to go retrieve some statements from staff, and HR-G collected statements and then was done with any more involvement with the investigation. On 3/17/2025 at 1:58 PM, Surveyor interviewed DON-B, who stated that all the investigation information was brought to NHA-A. DON-B indicated being informed there were conflicting statements; one CNA stated R1 washed herself and the other CNA stated something different. DON-B indicated not remembering what the other CNA stated and directed Surveyor to speak with NHA-A. DON-B stated that NHA-A would be the person to decide if the investigation needed to be reported. On 3/17/2025 at 2:09 PM, Surveyor interviewed NHA-A, who stated being the one that decides if something is to be reported to the state agency. NHA-A indicated that R1 denied the statements. Surveyor reviewed SS-F's statement collected from R1 on 3/6/2025 with NHA-A and there were no denied statements of allegation. Surveyor explained that SS-F was interviewed and stated SS-F did not ask R1 about being inappropriately touched. NHA-A indicated R1 wasn't directly asked about being inappropriately touched but R1 was asked about concerns with cares or staff. On 3/17/2025 at 3:09 PM, Surveyor informed NHA-A of having concerns that a thorough investigation into R1's allegation did not occur and the allegation was not reported to the state agency. NHA-A indicated NHA-A wouldn't lead someone into making a statement like that. NHA-A indicated the police are currently in the building for other residents and will also be seeing R1 for this reporting. On 3/18/2025 at 10:05 AM, Surveyor Interviewed R1, and asked R1 about feeling safe at the facility. R1 informed Surveyor that R1 is not currently scared and that R1 feels safe at the facility. R1 indicated that the only reason R1 is not scared is because CNA-H does not work with R1 anymore. R1 stated that the facility had police talk with R1 about R1's allegation yesterday. On 3/18/2025 at 10:22 AM, Surveyor informed DON-B of the concerns that the facility did not thoroughly investigate or report R1's allegation of potential abuse. Surveyor explained that reporting is for the allegation of abuse not that the abuse occurred. DON-B stated that NHA-A was out today, but that DON-B would pass on the information to NHA-A. No additional information was received regarding why a thorough investigation was not completed after a report from CNA-H and R1's allegation were received. No additional information received as to why CNA-H continued to work around residents and in care of residents at the facility from 3/6/2025 through 3/17/2025.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49845 Based on interview and record review, the facility did not thoroughly investigate 2 of 4 allegations of abuse involving residents (R) (R5 and R1) and did not take steps to prevent further potential abuse while an investigation was in progress. The facility was made aware of an incident involving allegations of abuse that occurred involving R5 and two staff members. The facility did not investigate the incident causing R5 to be fearful and cautious. R5 sought evaluation and treatment for left knee pain following the incident. The staff member alleged to have abused R5 was allowed to work approximately 46 shifts following the incident, resulting in R5 and other residents to not be safeguarded from additional potential abuse. The facility's failure to thoroughly investigate allegations of abuse allowed accused staff to continue working with residents following the incident resulting in the failure to safeguard residents from potential further abuse. These failures created a finding of Immediate Jeopardy that began on 01/13/2025 . Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B were notified of the Immediate Jeopardy on 03/19/2025 at 12:16 PM. The Immediate Jeopardy was removed on 3/20/25, however the deficient practice continues at a scope/severity of D (potential for harm/isolated) due to the following example: *On 3/3/2025, the facility investigated allegations of sexual abuse for R1. The CNA was allowed to work 2 additional weeks at the facility while the investigation was in progress. These deficient practices has the potential to affect the residents on the unit which CNA-J was working on after the alleged incident. Findings include: The facility's policy titled Abuse, Neglect and Exploitation, dated as reviewed/revised on 10/2024, documents: Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others that has not yet been investigated and if verified, could be an indication of noncompliance with Federal requirements related to mistreatment, exploitation, neglect, or abuse . Mistreatment means inappropriate treatment or exploitation of a resident . Physical Abuse includes, but is not limited to hitting slapping punching biting and kicking. It also includes controlling behavior through corporal punishment. Serious bodily injury means an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization , or physical rehabilitation; or an injury resulting from criminal sexual abuse . (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; b. Establish policies and procedures to investigate any such allegations; . The components of the facility abuse prohibition plan are discussed herein: . V. Investigation of alleged abuse, neglect and exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur VI. Protection of resident The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after an investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim in integrity of the investigation: . D. Room or staffing changes, if necessary, to protect the residents from the alleged perpetrator; E. Protection from retaliation by perpetrator. 1.) R5 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, unspecified dementia without disturbance, psychotic disturbance, mood disturbance and anxiety, pain in right knee, pain in left knee, anxiety disorder, peripheral vascular disease, pain in right wrist, pain in left shoulder, and rotator cuff tear or rupture of left shoulder. R5's Annual Minimum Data Set (MDS), dated [DATE], documents R5 is able to understand and be understood and a staff assessment for mental status was conducted which documented R5 has a memory problem but was able to recall current season, location of own room, staff names and faces, and he/she is in a nursing home/hospital swing bed. The MDS documents R5 has modified independence-some difficulty in new situations only, R5 has no behaviors/rejection of care exhibited, uses a walker, and is not on antipsychotic drug therapy. R5's Quarterly MDS dated [DATE], documents a staff assessment for mental status was conducted and that R5 has a memory problem but was able to recall current season, location of own room, staff names and faces, and he/she is in a nursing home/hospital swing bed. The MDS documents R5 has modified independence-some difficulty in new situations only, R5 has no behaviors/rejection of care exhibited, uses a walker, and is not on antipsychotic drug therapy. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 03/17/2025 at 08:50 AM, Surveyor interviewed R5. R5 informed Surveyor R5 was attacked in the doorway to kitchen by a named staff member, later identified as Certified Nursing Assistant (CNA)-J. Surveyor asked R5 what led up to the incident and R5 indicated being unsure and stated CNA-J is a belligerent and stupid person. R5 indicated that Adult Protective Services (APS) came to the facility and spoke with R5. R5 was unsure who notified APS and indicated there were many witnesses. R5 informed Surveyor CNA-J told R5 that Director of Nursing (DON)-B said R5 could not come in the kitchen. R5 indicated speaking with DON-B regarding the incident and was told it would be taken care of. R5 informed Surveyor R5 was hurt during the incident and had pain to left rib cage, left shoulder, and left foot. R5 stated R5 does not feel safe at the facility, the incident is not taken care of and stated, I was abused! R5 stated R5 is fearful and is very careful with what R5 says and does now in the facility. Surveyor reviewed staff roster for the last name of the staff member R5 identified. Surveyor noted 2 staff with that last name, so Surveyor interviewed one of the two staff members with the same last name and was able to determine that the individual alleged to have been in altercation with R5 was CNA-J. On 03/17/2025 at 10:42 AM, Surveyor spoke with Director of Dietary-N. Director of Dietary-N was not here the day of the incident but knows of incident involving R5. Director of Dietary-N was informed the following day by a DA-M who witnessed the incident between CNA-J and R5. On 03/17/2025 at 10:45 AM, Director of Dietary-N called DA-M via telephone. DA-M indicated on the day of the incident, dietary staff were getting ready to serve dinner, when R5 came to get ice. DA-M stated DA-M heard CNA-J saying, get away from there. DA-M then saw that CNA-J had the resident by the forearm area, then pushed the cart away aggressively trying to get the drink from R5's hand. DA-M stated CNA-J then pushed R5 and the cart, and R5 fell into the door. DA-M stepped in between resident and CNA-J. DA-M asked R5 if R5 was okay and DA-M stated R5 stated R5 was rattled. DA-M observed milk and coffee on the floor, DA-M walked resident back to R5's room. CNA-J kept yelling. DA-M spoke to DON-B and stated DON-B wasn't interested, and DON-B rolled DON-B's eyes. CNA-J proceeded to cause problems in the kitchen slamming doors and talking crap. The next day, Director of Dietary-N and DA-M went to talk to DON-B regarding CNA-J but again DON-B did not seem interested. On 03/17/2025 at 10:54 AM, Surveyor interviewed Lead Cook-P. Lead Cook-P indicated on the evening of the incident, Lead Cook-P heard commotion by the door to the dining room. Lead Cook-P indicated Lead Cook-P did not see what had occurred but indicated milk had fallen off the cart and onto the floor. On 03/17/2025 at 1:26 PM, Surveyor interviewed DON-B. Surveyor asked DON-B if an incident occurred in the dining room involving R5. DON-B indicated there was an incident possibly in December or January, involving two staff members yelling at each other and milk spilled on the floor. DON-B indicated R5 was there, CNA-J was telling R5 that R5 cannot grab milk from the cart due to infection control concerns and told resident DON-B said that. DON-B indicated DON-B spoke with both staff, and they never mentioned R5 being grabbed or pushed. DON-B indicated DON-B spoke to R5 at the time but only talked about not going into the pushcart due to infection control. [Note: R5 told surveyor that DON-B had told him the problem would be taken care of.) DON-B indicated the incident was not reported or investigated due to it being an incident between two staff members and DON-B had informed the staff members to separate. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Surveyor reviewed R5's Electronic Medical Record (EMR) and noted an office visit with R5's Orthopedic Doctor on 01/13/2025 that documented, Seen for left knee pain, patient last seen for issue on 10.18.24 where he completed 3 injection series of Synvics injections. Patient was slammed into a door jam [sic] at Grande Prairie approximately 10 days ago which is when the pain began. Describes pain as sharp that radiates from the anterior of the left knee cap that radiates down the left leg. Patient rates the pain a 10/10, Patient states the pain does interfere with sleep. Patient states walking aggravates the pain. The patient does not endorse catching, popping, grinding, clicking. The patient does complain of leg buckling/giving way. Patient is not experiencing numbness/paresthesias, or gross motor weakness. The patient cannot walk for as long as they would like or exercise without pain. The symptoms aren't activity-related and don't improve with rest. The patient does have difficulty with Activities of Daily Living (ADLs) due to current symptoms. Patient denies any fever, chills, or issues with bowel/bladder functions .Assessment and Plan: Primary osteoarthritis of left knee Patient presents in office for an increase in left knee pain following an injury at his rehab facility. According the patient he was forcibly pressed into a wall in the left knee was twisted during the incident and his pain has been increased since. X-rays are negative for fracture; the knee is stable upon exam. Most likely this incident caused a flare in his arthritis for which a cortisone shot was given today .will follow up in our office as needed. On 03/18/2025 at 02:38 PM, Surveyor spoke with Registered Nurse (RN)-O from R5's Orthopedics office. RN-O indicated R5 was seen on 01/13/2025, and per R5's statement, R5 was suffering from left knee pain because of the incident involving CNA-J and R5. RN-O stated R5 called the doctor's office on 03/03/2025 complaining of still having pain in the left knee following the incident. RN-O encouraged R5 to be seen in urgent care and then RN-O then called in the complaint to APS. RN-O informed Surveyor R5 called the doctor's office again on 03/06/2025 with same complaints, and informed Surveyor RN-O called the facility to follow up which led R5 to be sent to emergency roiagnom on [DATE] for shortness of breath and edema. On 03/17/2025 at 3:22 PM, Surveyor left voice message for CNA-J requesting CNA-J call Surveyor. No return call was made. On 03/17/2025 at 3:04 PM, Surveyor asked DON-B and NHA-A about R5's Office visit note dated 01/13/2025. Surveyor asked if there was a separate incident or if this would be from the same incident in the kitchen area. DON-B indicated she would guess it is the same incident and indicated no other incidents occurred. DON-B stated the information from the visit was not brought to DON-B's attention. NHA-A stated a good guess of when the incident occurred between CNA-J and R5 would be around the time of the last annual survey. NHA-A indicated police have now been notified. On 03/18/2025 at 07:36 AM, DON-B updated Surveyor regarding the investigation into the incident involving R5 and CNA-J. DON-B stated DON-B thinks the incident occurred near the end of December and is trying to get in touch with CNA-J but has not got a call back. DON-B indicated she is attempting to pinpoint the exact date the incident occurred. Surveyor noted, DON-B stated she found a note dated 01/08/2025 by another CNA indicating kitchen staff was following CNA-J around on unit but DON-B did not follow up because DON-B is not in charge of kitchen staff, per DON-B. DON-B informed Surveyor CNA-J was upset because DON-B told CNA-J to stay out of the kitchen, but did not tell kitchen staff to stay off the unit where CNA-J was working. Surveyor noted CNA-J worked 12/21/24, 12/23/24, 12/25/24 in the dining room per the schedule, but was not scheduled for dining room after those dates. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Surveyor noted CNA-J worked a total of 46 shifts from 01/01/2025 through 03/16/2025 and noted CNA-J was scheduled to work on 03/17/2025. On 03/17/2025 at 3:20 PM, DON-B informed Surveyor CNA-J was suspended as of today, pending investigation. On 03/18/2025 at 2:30 PM, Surveyor spoke with Adult Protective Services (APS)-K. APS-K informed Surveyor APS received a call through the elder abuse hotline from R5's doctor's office on 03/03/2025 regarding an abuse allegation. APS-K went to the facility on [DATE] and spoke with R5 whom indicated the incident happened near the kitchen door in the dining room. APS-K informed Surveyor R5 stated that CNA-J pushed R5 against the wall causing R5 foot pain. APS-K informed R5 APS-K would contact the Division of Quality Assurance (DQA). APS-K indicated APS-K did not speak to any staff at the facility because if a complaint is deemed credible, the complaint is sent to DQA. On 03/18/2025 at 2:54 PM, DON-B sent an email to Surveyor documenting R5 goes out for many appointments and does not give the facility the after-visit summaries for nursing to review. DON-B informed Surveyor the medical records person must then call the doctor's office to have the after-visit summaries faxed over. DON-B informed Surveyor the facility received R5's doctor office visit record from the 01/13/2025 visit with orthopedics over a month later, on 02/17/2025. DON-B informed Surveyor at the time, the document was uploaded but not given to a nurse to review. Surveyor noted that the facility did not follow up with R5's orthopedic office despite R5 being seen and reporting pain from the alleged incident on 1/13/25. The facility's failure to thoroughly investigate allegations of abuse allowed accused staff to continue working with residents following the incident resulting in the failure to safeguard residents from potential further abuse. These failures created a reasonable likelihood for serious harm thus leading to a finding of Immediate Jeopardy that began on 01/13/2025. Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B were notified of the Immediate Jeopardy on 03/19/2025 at 12:16 PM. The Immediate Jeopardy was removed on 3/20/25 when the facility completed the following: - R5 was interviewed by the Director of Social Services and Local Law Enforcement on 3/18/25 to verify any adverse outcomes were present. - The resident was interviewed and wants to remain at the facility and declines any referrals for other living arrangements. A thorough investigation was initiated by the Director of Nursing, Administrator, and Regional Nurse. All staff with knowledge of the incident were interviewed. - Residents that still reside at the facility who could have potentially witnessed the incident were interviewed by the Unit Manager. - An in-service education program on Investigations and Reporting will be conducted by the Regional Team Leaders. All Department Heads addressing circumstances that require reporting for timely investigations, and their responsibilities related to investigations. Abuse policies were reviewed to include all sources of abuse, investigations and reporting. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- A random audit of five (5) residents/staff weekly for four (4) consecutive weeks was initiated. These residents/staff will be interviewed to ensure that any incidents are identified, properly investigated, and reported to the appropriate people. - Grievances were reviewed at the Clinical Stand-up meeting for any potential investigations, - Compliance will be monitored at the QAPI meeting until such time consistent substantial compliance has been met. The deficient practice continues at a scope/severity level of D (potential for harm/isolated) related to the following example: 50700 2.) R1 was admitted to facility on 7/10/2023 with diagnoses that include hemiplegia and hemiparesis following an unspecified cerebrovascular disease affecting R1's left dominant side, repeated falls, bipolar disorder, depression, dysphasia, cognitive communication deficit, and need for assistance with personal cares. R1's Quarterly Minimum Data Set (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating that R1's cognition was intact. Section B documented that R1 is understood and understands. Section E documents that R1 did not exhibit any behavioral symptoms. R1's Behavioral care plan, dated 7/17/2023, with a target date of 3/20/2025, documents under the intervention section: Rude, uncooperative behavior, refusals, risks versus benefits completed, caregivers to provide opportunity for positive interaction/attention. Psych services, explain all procedures to resident before starting to allow the resident time to adjust to changes, if reasonable, discuss the resident's behavior explain/reinforce why behaviors inappropriate and/or unacceptable to the resident. Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation intake to alternate location as needed. Monitor behavior episodes and attempt to determine underlying cause. Praise any indication of the resident's progress/improvement in behavior. Provide a program of activities that is of interest and accommodates resident's status. Refuse shower in skin check: a resident because of holiday, Staff encouraged to: use the buddy system, at all times, when going into resident's room. Surveyor noted that the facility documented in R1's MDS that no behaviors were exhibited but had mentions of R1's behaviors though out R1's behavioral care plan. On 3/17/2025 at 9:06 AM, Surveyor interviewed R1, who stated that Certified Nursing Assistant (CNA)-H, assisted with washing R1 up for cares. R1 stated that CNA-H washed R1's breast. R1 indicated that everyone at the facility knows R1 will do that independently. R1 stated that R1 told CNA-H, No, you don't wash me there. R1 stated CNA-H stated: Oh (R1's name). R1 indicated that CNA-H continued to wash R1's breast. R1 stated that she told CNA-H, Don't Oh (R1's name) me. R1 indicated telling CNA-H that R1 knows resident rights and that R1 will call the state to report the incident. R1 indicated this occurred on 2/27/2025 and again on 3/3/2025. R1 stated that R1 left a voicemail with the unit manager (UM)-E, and R1 indicated that the notification was left on UM-E's voicemail. R1 said, I will call the state. R1 indicated not hearing back from UM-E. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/17/2025 at 11:00 AM, Surveyor interviewed UM-E who indicated that UM-E will receive complaints via telephone or by voicemail. UM-E stated that R1 is one resident that will call her for complaints, but that UM-E did not get a complaint about someone inappropriately touching R1. UM-E indicated that if this was reported to UM-E, this would've been addressed right away. UM-E stated not writing down concerns, but that UM-E will address them verbally when received. UM-E stated not being part of an investigation with this matter but that Social Services (SS)-F indicated that R1 is now on the buddy system. On 3/17/2025 at 11:26 AM, Surveyor received a file from UM-E, which documented that an investigation relating to these allegations was started and that UM-E was unaware of this. Surveyor reviewed R1's electronic record, and reviewed progress notes from March 2025, but Surveyor could not locate any documentation relating to R1's behaviors and nursing staff. Surveyor reviewed behavioral charting from CNA's task list for March 2025 and noted that no behaviors were documented for R1. Surveyor reviewed the facility's investigation file, dated 3/6/2025. Both CNA-H and CNA-I had statements in the file that were similar. Surveyor noted statements from both CNAs indicated that R1 was updated on getting a bed bath and that R1 agreed. Both CNA statements documented, that R1 washed her face and neck area and that both CNA's grabbed washcloths and started to wash R1's arms and under R1's arms. Both CNA statements documented that before cleaning R1's breast, R1 stated nobody has permission to touch her breasts. It is documented on both CNA statements that R1 washed her own breasts. Surveyor reviewed statements from Social Service (SS) -F dated 3/6/2025. SS-F's statement documented that SS-F asked R1 if she had any concerns with staff, residents or cares. The statement from SS-F documented that R1 stated she has no concerns. On 3 /17/2025 at 11:46 AM, Surveyor was informed by the Nursing Home Administrator (NHA)-A, that CNA-H is now suspended. NHA-A indicated that the allegation wasn't reported before because R1 didn't say that R1 was inappropriately touched until today (3/17/25). Surveyor reviewed the complaint file that was dated 3/6/2025, and CNA-H was an active employee, working at the facility from 3/6/2025 until 3/17/2025. On 3/17/2025 at 12:39 PM, Surveyor interviewed SS-F, who indicated that R1's allegation wasn't SS-F's investigation, and that SS-F believes it was Director of nursing (DON)-B that was investigating it. SS-F indicated asking R1 if she had any concerns with cares or staff. SS-F indicated not asking R1 about being inappropriately touched, SS-F indicated only asking R1 about any care and staffing concerns. On 3/17/2025 at 12:49 PM, Surveyor interviewed Human Resources (HR)-G, who indicated CNA-H made concerned statements to HR-G. The above-mentioned statements were regarding CNA-H being worried about R1 reporting CNA-H to the state. HR-G indicated this occurred around 3/6/2025. HR-G indicated asking SS-F to go and speak with R1. HR-G stated that this was reported to Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. HR-G indicated that NHA-A asked HR-G to go retrieve some statements from staff, and HR-G collected statements and then was done with any more involvement with the investigation. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/17/2025, at 1:58 PM, Surveyor interviewed DON-B, who stated that all the investigation information was brought to NHA-A. DON-B indicated being informed there was conflicting statements, one CNA stated R1 washed herself and the other CNA something different. DON-B indicated not remembering what the other CNA stated and directed Surveyor to speak with NHA-A. DON-B stated that NHA-A would be the person to decide if the investigation needed to be reported. On 3/17/2025 at 2:09 PM, Surveyor interviewed NHA-A, who stated being the one that decides if something is to be reported to the state agency. NHA-A indicated that R1 denied the statements. Surveyor reviewed SS-F's statement collected from R1 on 3/6/2025 with NHA-A and there were no denied statements of allegation. Surveyor explained that SS-F was interviewed and stated SS-F did not ask R1 about being inappropriately touched. NHA-A indicated R1 wasn't directly asked about being inappropriately touched but R1 was asked about concerns with cares or staff. On 3/17/2025 at 3:09 PM, Surveyor informed NHA-A of having concerns that a thorough investigation into R1's allegation did not occur and was not reported to the state agency. NHA-A indicated NHA-A wouldn't lead someone into making a statement like that. NHA-A indicated the police are currently in the building for other residents and will also be seeing R1 for this reporting. On 3/18/2025 at 10:05 AM, Surveyor Interviewed R1, and asked R1 about feeling safe at the facility. R1 informed Surveyor that R1 is not currently scared and that R1 feels safe at the facility. R1 indicated, that the only reason R1 is not scared is because CNA-H does not work with R1 anymore. R1 stated that the facility had police talk with R1 about R1's allegation yesterday. On 3/18/2025 at 10:22 AM, Surveyor informed DON-B. of the concerns that the facility did not thoroughly investigate or report R1's allegation of potential abuse. Surveyor explained that reporting is for the allegation of abuse not that the abuse occurred. DON-B stated that NHA-A was out today, but that DON-B would pass on the information to NHA-A. No additional information was received regarding why a thorough investigation was not completed after a report from CNA-H and R1's allegation was received. No additional information received as to why CNA-H continued to work around residents and in care of residents at the facility from 3/6/2025 through 3/17/2025.

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F 0689 Level of Harm - 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** 38253 Based on observation, interview, and record review, the facility did not ensure residents received adequate supervision and assistive devices to prevent accidents for 1 (R6) of 2 residents reviewed for falls. R6 was assessed as needing bilateral enabler bars on the bed to assist with positioning and bed mobility. An enabler bar was placed on the left side of the bed. No enabler bar was placed on the right side of the bed. R6's care plan had the intervention of bilateral enabler bars until 1/7/2025 when the care plan was revised to reflect what was actually in place, the left enabler bar only. On 3/10/2025, Certified Nursing Assistant (CNA)-C was providing cares to R6 and rolled R6 away from CNA-C. R6 continued to roll to the right and fell out of bed sustaining a right hip fracture requiring surgical intervention. The post-fall intervention was to place an enabler bar to the right side of the bed, which should have been in place per the admission assessment for siderail use. Findings include: The facility's policy and procedure titled Incidents and Accidents dated 7/2024 documents: The propose of incident reporting can include: -Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care. -Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement (QAPI) to avoid further occurrences. -Alert risk management and/or administration of occurrences that could result in claims or further reporting requirements. The facility's policy and procedure titled Turing and Repositioning dated 10/2024 documents: 5. Use the appropriate number of staff to perform the tasks safely. The facility's policy and procedure titled Proper Use of Side Rails dated 10/2019 documents: General Guidelines: . 2. Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents. 3. An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: a. Bed mobility; b. Ability to change positions, transfer to and from bed or chair, and to stand and toilet; c. Risk of entrapment from the use of side rails; and d. That the bed's dimensions are appropriate for the resident's size and weight. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	4. The use of side rails as an assistive device will be addressed in the resident care plan. 5. Consent for using restrictive devices will be obtained from the resident or legal representative per facility protocol. 6. Less restrictive interventions that will be incorporated in care planning include: a. Providing restorative care to enhance abilities to stand safely and to walk; b. Providing a trapeze to increase bed mobility; c. Placing the bed lower to the floor and surrounding the bed with a soft mat; . 7. Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails. 8. The risks and benefits of side rails will be considered for each resident. 9. Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks. 1.) R6 was admitted to the facility on [DATE] with diagnoses of repeated falls, diabetes, cognitive communication deficit, schizophrenia, and depression. R6's Admission Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 12, indicating that R6 has moderate cognitive impairment. The MDS documented that R6 was always incontinent of bowel and bladder with total dependence for toileting hygiene and moderate assistance with bed mobility. R6's Falls Care Area Assessment (CAA) dated 10/29/2024 documented the CAA was triggered due to R6 requiring assistance for all transfers which placed R6 at an increased risk for further falls with a history of falling in the past. R6's Admit/Readmit Assessment form dated 10/23/2024 and completed by a Licensed Practical Nurse (LPN) documents under Section M: Mobility/Safety/Fall Risk/Recliner/Side rail, based on the evaluation, R6 needed a half side rail to the right and left side of the bed to promote independence with bed mobility and a consent was received for bilateral side rails. No alternatives were documented as being attempted before the side rails were installed. The LPN documented R6 could be at risk for falls due to weakness. On 10/23/2024, R6's POA signed the Informed Consent: Side Rail(s)/Mobility Bar(s) form. The form documented: An assessment was conducted to determine the appropriateness and need for side rail(s)/mobility bar(s). Side rails/mobility bars are metal or plastic bars that are attached to either on, or both sides of the bed frame, depending on the resident's needs. In some instances, side rails/mobility bars may present an inherent safety risk. In order to implement side rails/mobility bars, it must be determined that the benefits of the use of side rails/mobility bars outweighs the risk and therefore side rails/mobility bars are not a restraint for the resident. Potential benefits of side rails/mobility bars include: -The ability to aid in turning and positioning in bed. -Provides a hand hold for the resident to utilize when transferring in or out of bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Assist the resident to attain/maintain their highest practicable level. I understand that side rails/mobility bars are to be used only as mobility aids, and not as a physical restraint, or a way to prevent falls. I understand that the facility will continue to evaluate the need for the side rails/mobility bars in the future. If the side rails/mobility bars are no longer able to be used for their intended purpose of improving bed mobility, or as a supportive device during transfers to and from bed, then the side rails/mobility bars will be removed so they are not un unintended physical restraint. By signing below, I acknowledge that I have been provided with education regarding the risks and benefits of side rails/mobility bars. I understand the placement and use of side rails/mobility bars creates a potential for serious injury up to and including death. Despite being aware and understanding the risks, I consent to the placement of side rails/mobility bars. Surveyor noted the form did not indicate if the consent was for one or two side rails/mobility bars. R6's Activities of Daily Living (ADL) Care Plan was initiated on 10/23/2024 with the intervention right and left enabler bars to increase independent bed mobility added on 10/25/2024. This care plan and intervention was initiated by LPN Unit Manager (UM)-E. R6's At Risk for Falls Care Plan was initiated on 10/23/2025 with interventions: -Anticipate and meet R6's needs. -Be sure the call light is within reach and encourage R6 to use it for assistance as needed; R6 needs prompt response to all requests for assistance. -Ensure R6 is wearing appropriate footwear when ambulating or mobilizing in the wheelchair. -Follow facility fall protocol. -R6 needs a safe environment with even floors free from spills and/or clutter, adequate, glare-free light, a working and reachable call light, the bed in low position at night, slide fails as ordered, handrails on walls, and personal items within reach. R6's ADL Care Plan was revised on 1/7/2025 with the intervention left enabler bar to increase independent bed mobility. This intervention was revised by LPNUM-E. Surveyor noted the right enabler bar was removed from R6's care plan. On 3/10/2025 at 9:48 AM on the SBAR (Situation, Background, Assessment, Request) form, Registered Nurse (RN)-D documented R6 had a witnessed fall. R6 had rolled out of bed and had complaints of right hip pain. R6 was unable to extend the right leg and R6 was sent to the hospital for evaluation and treatment. RN-D documented things that make the conditions or symptoms better are assist of two for bed mobility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525659	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grande Prairie Care and Rehab Ctr LLC	10330 Prairie Ridge Blvd Pleasant Prairie, WI 53158

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R6's fall/incident investigation documents under the nursing description of the fall section: R6 was in bed with the bed elevated as the CNA was standing behind R6 providing incontinence cares. R6 was on the side already while cares were being performed when R6 attempted to grab the side of the bed and turn themselves more. R6 was already in an appropriate position for the CNA, but R6 attempted to roll further. R6 rolled over too far, causing R6 to fall. The interdisciplinary team (IDT) determined a long-term intervention to prevent future falls was to place a right side enabler bar as R6 was able to assist with rolling but had nothing to hold onto. R6's ADL Care Plan was revised on 3/10/2025 with the intervention left enabler bar to increase independent bed mobility - add right enabler bar. This intervention was revised by LPNUM-E. R6's At Risk for Falls Care Plan was revised on 3/10/2025 with the intervention place right side enabler bar. R6's hospital record dated 3/10/2025 documented R6 presented to the emergency department to be evaluated after a fall. R6 had a witnessed fall out of bed landing on the right side while staff was changing R6. The x-ray results showed an acute fracture of the right femoral neck. R6 underwent a right hip hemiarthroplasty to stabilize the bone and improve mobility. On 3/13/2025, R6 was readmitted to the facility. On 3/13/2025 on the Admit/Readmit Assessment form, an LPN documented in Section M: Mobility/Safety/Fall Risk/Recliner/Side rail, based on the evaluation, R6 did not need a full side rail, a half side rail, a quarter side rail, a bed bar, or an enabler on the bed. The LPN documented R6 was a low risk for falls. On 3/13/2025, R6's POA signed a second Informed Consent: Side Rail(s)/Mobility Bar(s) form. Surveyor noted the form did not indicate if the consent was for one or two side rails/mobility bars. On 3/17/2025 at 10:21 AM, Surveyor observed R6 in bed. Enabler bars were on both sides of the bed. Surveyor asked R6 how R6 was feeling. R6 stated R6 had pain in the right leg. Surveyor asked R6 if R6 was taking any pain medication and did it help. R6 stated, yes, R6 was getting medicine but it did not help very much. Surveyor asked R6 what happened that caused R6 to have pain. R6 stated the staff rolled R6 in bed and R6 fell on to the floor. Surveyor asked R6 how many staff were helping R6 when R6 fell . R6 stated one staff member was in the room. R6 stated the staff member was behind R6 cleaning R6 up. Surveyor asked R6 if the facility staff put an enabler bar on the right side of the bed. R6 said yes, they put it on the bed after R6 fell . In an interview on 3/17/2025 at 10:33 AM, Surveyor asked CNA-C if CNA-C knew who was caring for R6 on 3/10/2025 when R6 fell to the floor from bed. CNA-C stated CNA-C was doing cares with R6 when R6 fell . CNA-C stated the bed had been raised so CNA-C could do cares. CNA-C stated CNA-C rolled R6 away from CNA-C onto the side and was trying to wipe R6 when CNA-C could feel R6 rolling further away from CNA-C. CNA-C stated CNA-C told R6 to not move but R6 rolled off the bed. CNA-C thought R6 was trying to help CNA-C by turning over further. CNA-C stated CNA-C immediately got the nurse and R6 stayed on the floor until rescue personnel arrived. Surveyor clarified with CNA-C that CNA-C initially rolled R6 away from CNA-C. CNA-C stated yes. At 1:48 PM, Surveyor interviewed CNA-C regarding any education that had been provided to CNA-C after R6 fell from the bed. CNA-C stated CNA-C was educated on turning residents toward CNA-C and CNA-C stated CNA-C signed the education. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 3/17/2025 at 12:37 PM, Surveyor asked RN-D if RN-D was involved in the fall R6 had on 3/10/2025. RN-D stated RN-D was walking down the hall when CNA-C said CNA-C needed a nurse. RN-D stated CNA-C had been doing cares when CNA-C rolled R6 and R6 slid off the bed. RN-D stated R6 told RN-D R6 fell out of bed and had bumped the head. RN-D stated RN-D did a neurological check which was fine, but the hips did not feel symmetrical and R6 could not extend the right leg without grimacing. RN-D stated R6 stayed on the floor, and they called Emergency Medical Technicians (EMTs). Surveyor asked RN-D what the proper technique was for rolling a resident in bed. RN-D stated you should pull the resident towards you, and if you are on the other side of the bed, you move around the bed and pull towards you. In an interview on 3/17/2025 at 12:50 PM, Surveyor asked LPNUM-E if LPNUM-E had knowledge about R6's fall on 3/10/2025. LPNUM-E stated RN-D told LPNUM-E about the fall. LPNUM-E stated CNA-C was performing cares on R6 when R6 fell out of bed. Surveyor asked LPNUM-E how a CNA should roll a resident in bed. LPNUM-E stated CNA should pull the resident toward them. Surveyor asked LPNUM-E how the fall was reviewed. LPNUM-E stated the IDT meets and looks at the immediate intervention that was put in place and then determine a long-term intervention. LPNUM-E stated R6 only needed the enabler to the left side when R6 was admitted and they determined R6 would benefit from having an enabler on the right side as well. LPNUM-E stated an assessment for the enabler is usually done on admission. LPNUM-E stated R6's POA agreed to the second enabler. Surveyor asked LPNUM-E how often assessments are completed for enablers or side rails. LPNUM-E stated assessments are done quarterly by nursing staff. At 1:20 PM, LPNUM-E provided a Side Rail Consent form dated 3/10/2025 and a Half Side Rail/Bed Bar/Enabler Assessment form dated 3/13/2025 that had been printed from the computer charting system with hand-written answers completing the form. The assessment documented bilateral half siderail, bed bar, or enabler is not a restraint and will be utilized to enable R6 to attain to maintain their highest practicable level. The form was not in R6's medical record with no way to verify when it had been completed. In an interview on 3/17/2025 at 3:00 PM, Surveyor asked Director of Nursing (DON)-B about the hand-written assessment and consent forms LPNUM-E had provided. DON-B stated sometimes nurses handwrite the consent and wait for a signature before putting them in the record. Surveyor shared with DON-B R6 has a signed consent for the bed rails dated 3/13/2025 that was signed by R6's POA the day R6 readmitted to the facility in R6's medical record. DON-B did not know about the consent. DON-B stated R6 had only one enabler on the bed and now has two, so the second consent was needed. On 3/17/2025 at 4:35 PM, Surveyor shared with DON-B the concerns with R6's fall from bed. R6 fell from bed when CNA-C was performing cares behind R6 after rolling R6 away from CNA-C. R6's admission assessment for siderails documented bilateral enablers were needed and that was put in R6's ADL Care Plan. R6's ADL Care Plan was revised on 1/7/2025 to have a left enabler bar only with no assessment at that time to determine the need for enabler. The intervention after the fall was to put an enabler on the right side of the bed when that should have been in place with the initial admission assessment. When R6 was readmitted to the facility, the assessment for siderails documented no enablers were needed yet R6 had bilateral enablers placed on the bed. R6's fall resulted in a fractured right hip requiring surgical intervention. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 3/18/2025 at 8:56 AM, Surveyor shared with LPNUM-E the observation of LPNUM-E initiating R6's ADL Care Plan on admission with the intervention of bilateral enabler bars to R6's bed and then LPNUM-E revised R6's ADL Care Plan on 1/7/2025 to have only the left enabler bar to R6's bed. LPNUM-E stated the original assessment for siderails indicated bilateral enablers so that was why LPNUM-E put that in R6's care plan. LPNUM-E stated when LPNUM-E did a sweep of the unit to see what was actually in place on the bed, R6 only had an enabler bar on the left side so LPNUM-E revised R6's care plan to reflect what was in place. Surveyor clarified with LPNUM-E that R6 only had the left enabler bar in place since admission and LPNUM-E did not observe R6's bed until 1/7/2025, over two months after R6 was admitted . LPNUM-E stated LPNUM-E had observed R6's bed prior to that time but was not comparing the observations with R6's care plan. Surveyor noted the care plan revision was made to reflect what in place rather than the care plan driving what the assessment indicated should be in place. No additional information was provided as to why the facility did not ensure that R6 had assistive devices in place to prevent accidents for R6.