STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675756	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsburg Village Healthcare Campus	941 Scotland Dr Desoto, TX 75115

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 2 of 6 residents (Resident #6 and Resident #8) reviewed for abuse. 1. The facility failed to ensure Resident #8 had the right to be free from abuse on 03/01/25 when Resident #9 hit him with a ruler 2-3 times, as the argument escalated further, Resident #9 then stabbed Resident #8 with a pen which resulted in scratches on his abdomen and the back of his neck. Resident #8 was sent to the hospital for further evaluation. 2. The facility failed to ensure Resident #6 had the right to be free from abuse when Resident #7 pushed her on 03/09/25 while on the secure unit, causing Resident #6 to fall which resulted in a right hip fracture that required a hospital stay and surgery to repair the injury. The noncompliance was identified as PNC. The IJ began on 03/01/25 and ended on 03/09/25. The facility had corrected the noncompliance before the investigation visit began. This failure placed residents at risk for injury, hospitalization, and emotional distress. Findings included: 1. Record review of Resident #8's face sheet, dated 06/19/25, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #8's Quarterly MDS Assessment, dated 05/15/25, reflected his BIMS score was blank, indicating severe cognitive impairment. Her diagnoses included Seizure Disorder or Epilepsy, Bipolar Disorder and Schizophrenia. Record review of Resident #'8s care plan, updated 02/20/25, reflected Resident #8 was a fall risk related to fall [03/01/25]. Goals: Resident will be free from complications related to falling. Resident at risk for falls, resident safety will be maintained. Interventions included to Administer first aid as needed. Assess contributing factors related to fall history. Assess for potential fall-related injury prevention, looking at circumstances, location, new or worsening medical problems. Keep call light and most frequently used personal items withing reach. Record review of Resident #8's Nurses Notes dated 03/01/25 written by LVN AA reflected the following: (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Upon arrival to resident room, Resident witnessed to be positioned on the floor of his room perpendicular to the foot of his bed. Resident noted to have [varies] wounds on his body starting at the base of his neck an approximate 1.5-2 cm laceration, on his right proximate of spine there are 2 bright red scratched on his back. There were two superficial lacerations observed on upper abdomen. On the left shoulder the resident appears to possess a contusion. The neighboring end table appeared to have been flipped over laying on top of a broken bedside table. Various contents of food were on the floor of the room. The resident's G-tube was still connected at the item of the incident. When arriving to the room the G-tube was paused and disconnected. When assessing the resident, breathing was even but labored related to an emotional state of distress. Resident was redirected verbally to a state of ease. Resident was alert and oriented to person and place. Resident stated, I'm ok, but my neck hurts a little, resident was referred to hospital for further evaluation due to unwitnessed patent altercation. Family and Administrative staff has been notified of incident. Record review of Resident #8's Nurses Notes dated 03/01/25 written by LVN OO reflected the following: Resident was evaluated after altercation between roommate and self. Due to present injuries on body, Resident will be sent emergency room by Emergency Service to hospital. Resident is alert and orientated to person, place, and time. Resident sated to possess pain localized at the back of his head. Record review of Resident #8's Nurses Notes dated 03/01/25 written by LVN AA reflected the following: Resident returned from hospital with no change in condition. Resident was transferred to room [ROOM NUMBER]a. Vistal signs 119/96-83-17-98.5 New order for Bacitracin 500gm apply topically twice a day for 7 days. Nurse Practitioner made aware of new order. Skin assessment completed left voice message with his mother to contact the facility regarding update. Call light in reach. Plan of care ongoing. Record review of LVN OO's interview statement dated 03/01/25 at 12:30 PM reflected Did not hear commotion, was alerted resident was on the floor. When I arrived to the room, I witnessed [Resident #9]]sitting at the end of hall and [Resident #8] was on the floor. I asked [Resident #8] how he got on the floor he stated, he did it. First aide was provided for superficial scratches, transported to the emergency room for evaluation and treatment. Record review of Resident #8's Psychiatric Periodic Evaluation, dated 03/03/25, reflected the following: Patient lying in bed with multiple scratches/abrasions over body. Tube feeds infusing. Patient was involved in altercation with his roommate 2 days ago. Per nursing report roommate attacked the patient. Patient was sent out to the ER for evaluations of wounds and PEG tube positioning. Patient was sent back to facility with bacitracin ordered twice daily to wounds. Patient denies any complaints at this time. Observation and interview on 06/18/25 at 10:35 AM with Resident #8 revealed him stating he stabbed me, and I had to go to the hospital, he wanted to get his anger out on me. He had a weapon, stabbing me in the stomach and the neck area. (Surveyor observations did not reveal any skin tears or scratches) To be that angry and take it out on someone, it was methodically planned out. Resident #8 stated he stayed at the hospital for a day and returned to the facility to a new room. Resident #8 stated he felt nervous and upset about the incident at the time, however now felt safe to remain in the facility, that he did not see Resident #9, but if he did, he would avoid him. Resident #8 expressed he never got his map pencils and activity books back, he believed that Resident #9 stole them, he did not want to bring that up to staff, he would let it go. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/18/25 at 11:34 AM with Resident #9 revealed he was in his room, sitting in wheelchair soaking his feet looking at activity books. According to Resident #9, there was a lot going on between he and Resident #8, Resident #9 stated it escalated so fast that it got out of hand. We both said some racial things to each other, then it got physical between us. I was trying to defend myself, I hit him on the right shoulder with a wood staff, like a ruler 2-3 times. [Resident #8] kept talking and agitating me, so I picked up a pen and stabbed him in the left collar bone. One of the nurses came by and stopped the incident. When she asked what happened I told her that I was in the restroom and when I came out, I saw him on my side of the room trying to get something. [Resident #9] stated that he knew [Resident #8] was weak on one side of his body therefore he could have very well just fell out of the bed and landed on his side of the room, but it all escalated very fast. Interview on 06/18/25 at 1:32 PM with CNA I revealed Resident #8 was seen on the floor when she entered the room to pick up food trays. CNA I stated Resident #8 was laying flat on his back, Resident #9 was sitting on the side of his bed. CNA I stated Resident #8 was saying something like he did it, my roommate did this to me. CNA I stated Resident #8 was yelling and upset, when she entered the room she noticed Resident #8 with scratches with some bleeding, at this point she alerted the nurse. According to CNA I, Resident #9 was usually a loner and keeps to himself. Interview on 06/18/25 at 2:18 PM with LVN AA revealed she was working the opposite side of the hall, but due to the situation she came to help LVN OO. LVN AA stated Resident #9 was removed from the room to keep both residents safe. Resident #9 was sitting down the hall away from the room. LVN AA stated the room presented that violence had occurred, room was in shambles, furniture was flipped over, food was all over the floor, Resident #8 was on the floor. Resident #8 had abrasion to his abdomen and there was a laceration to the back of his neck. LVN AA explained Resident #9 was sitting down the hall, with a blank stare, rocking back and forth. According to LVN AA she did not see a weapon or device in Resident #9's hands, but she did not want to get too close. LVN AA stated she had never observed any aggressive behaviors with Resident #9 prior to this incident. LVN AA stated when speaking with the MDS Coordinator, Resident #9 reported he needed help, mediation was provided to him, and he was sent out to hospital for evaluation. LVN AA stated Resident #8 was transported to the hospital for further evaluation, returned to the facility, and relocated to a different room. LVN AA stated Resident #9 also transferred for medication evaluation. She stated upon his return, he was also relocated to a private room. Interview on 06/18/25 at 3:04 PM with MDS Coordinator PP revealed she was alerted to the altercation between Resident #8 and Resident #9, Resident #9 was on my angel rounds, we had a good rapport, so I went to speak with him. At the time, Resident #8 was sent out to hospital for further evaluation, Resident #9 was sitting on his bed. MDS Coordinator PP stated, the room was disheveled with stuff all over the floor from the altercation., She stated when asked if he was ok, Resident #9 responded he was ok, just injustice going on, I just need my medications. MDS Coordinator PP stated Resident #9 stated he had refused his medication that morning, so she went to consult with staff to his medication administered. MDS Coordinator PP stated, there had not been any concerns or behaviors expressed by Resident #9 prior to this incident, he is usually quiet and to himself. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/19/25 at 12:30 PM with the Assistant Administrator revealed she was notified about the altercation between Resident #8 and Resident #9. she was told that Resident #8 was found on the floor by staff, and that he was yelling he did it referring to Resident #9 whom was his roommate at the time. The Assistant Administrator stated Resident #8 was assessed and sent out the hospital for further evaluation, and Resident #9 remained in his room with one-on-one monitoring until he was sent out for psychiatric evaluations that day as well. According to the Assistant Administrator, in-services were completed with all staff on abuse, neglect, and resident to resident altercations; to also notify the Administrator, DON, family, and physician. The Assistant Administrator stated resident to resident altercations placed residents at risk of harm, all staff were responsible for resident safety and to separate immediately when there is a reported resident to resident altercation. 2. Record review of Resident #6's face sheet, dated 06/19/25, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Record review of Resident #6's Quarterly MDS Assessment, dated 12/15/24, reflected her BIMS score was blank, indicating severe cognitive impairment. Her diagnoses included hip fracture, Non-Alzheimer's Dementia, and anxiety disorder. The MDS indicated she utilized a walker and wheelchair for mobility. Record review of Resident #6's care plan, updated 03/14/25, reflected she was a fall risk evidenced by fall within the last month. Goal: Resident at risk for fall resident safety will be maintained. Interventions included to anticipate resident's needs check frequently. Assess contributing factors related to fall history. Assess medications for contributing factors. Assist resident with toileting as needed. Keep call light and most frequently used personal items within reach. Keep glasses clean and fit with adequate prescription. Remind resident to call when needing assistance. Impaired physical mobility evidenced by left side weakness. Goal: Resident will maintain or improve physical function in Bed Mobility, Transfer, Ambulation, Locomotion, and Range of Motion. Interventions included to provide appropriate level of assistance to promote safety of resident. Record review of Resident #6's Nurses Notes dated 03/09/25 written by LVN QQ reflected the following: 4:21 PM - Resident was standing in common area on the side of another resident's wheelchair, when the resident pushed her down causing her to fall to the floor landing on her back. While attempting to stand Resident up, she began to yell she is also noted to yell when left hand is touched. There is no discoloration noted to hand. Nurse Practitioner notified with new order given for x-rays. Xray notified. Responsible Party and DON notified with message left as there were no answers. 6:26 PM - Xray performed to bilateral hips, bilateral femurs, and left wrist at 5:00 PM. Awaiting results at this time. 8:41 PM - Spoke with DON regarding incident. Xray confirms fracture to left wrist and hip. Nurse Practitioner was called and new order to transport to hospital emergency department was received and processed. Transportation notified with an estimated time of arrival 1 hour and 15 minutes. Resident at this time remains lying in bed on back with eyes closed. Attempts X 3 made to call report to RN at the hospital emergency room, with no answer to call. Resident transferred by stretcher to emergency department accompanied by emergency medical transportation service X2 at 9:30 PM. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	03/14/25 8:06 PM - Resident readmitted to facility by stretcher accompanied by emergency medical transportation service X2. Alert to name, orders and advance directive verified by Nurse Practitioner on call for doctor. Resident admitted to hospice. Resident is noted with bruising to back of both hands, there are 24 staples noted to left hip. There is no cast or sling noted to fracture of left wrist. All activities of daily living are provided by 1-2 staff members, resident not able to make needs known due to not making complete sentences, needs are anticipated by staff. Record review of Resident #6's hospital records dated 03/18/25 with discharged date of 03/14/25 reflected the following: Reason for Admission- Chief complaint Patient presents with Fall. Discharge Diagnoses - Principal Problem: Hip Fracture. Active Problem: Wrist fracture. Operative Procedures: Hemi Arthroplasty Hip Anterior Approach Left. Hospital Course: Comminuted and displaced left femoral neck fracture s/p fall . Record review of LVN QQ's interview statement dated 03/09/25 at 7:00 PM reflected [Resident #6] approached Resident #7 while siting the in the wheelchair. Resident #7 began arguing with Resident #6 to move away from her wheelchair and pushed her away from her. Resident #6 fell on her left side and had difficulty bearing weight on her left leg. Physician was contacted and stat x-ray was ordered as a precaution, pain medication given and assisted to bed for comfort. Resident #7 was placed on 15-minute checks as a precaution. Interview on 06/18/25 at 4:07 PM with CNA JJ revealed she worked closely with both Resident #6 and Resident #7. CNA JJ stated Resident #6 used to walk really good around in the television room, had never had behaviors towards staff or other residents, however now upon her return from the hospital she is wheelchair bound. Resident #7 can be aggressive at times and will push others. According to CNA JJ staff often will educate Resident #7 on resident-to-resident altercations, redirect her and complete one on one monitoring when was having behaviors. Interview on 06/18/25 at 3:56 PM with LVN Y revealed during the 2:00 PM-10:00 PM shift, she was sitting at the nursing station when she heard Resident #7 get upset, she was loudly screaming at Resident #6. LVN Y stated by the time she got to both residents to separate them, Resident #7 had pushed Resident #6 down. LVN Y stated she asked what happened however she stated I knew quickly that [Resident #6] was in pain when she grabbed her hip, and I observed her foot was turned in. I called emergency services and she was transferred to the hospital. According to LVN Y the altercation was not provoked, Resident #7 had a temper and did not like to be touched. LVN Y stated, [Resident #7] was educated on sharing space in the television room and on altercations. She was placed on 15-minute checks for behaviors. Attempted interview by phone on 06/18/25 with LVN QQ was unsuccessful. Interview on 06/18/25 at 4:24 PM with the ADON revealed she was not present during the resident-to-resident altercation between Resident #6 and Resident #7. The ADON stated Resident #7 was someone staff had to keep an eye on with constant monitoring because she does not like others in her space. The ADON stated she expected staff to act quickly when there was an altercation between residents. The ADON stated staff were to separate, deescalate the situation, keep residents safe, document the incident and provide 15-minute checks on residents for further behaviors. The ADON stated the CNAs were to notify nursing staff with any allegations of abuse and incidents between residents. The Nurses were to investigate, contact family, physician, and management after assessing to ensure residents were safe. Not doing so placed residents at risk of unknown or delayed injuries. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/19/25 at 2:30 PM with the DON revealed Resident #6 had a fall in the memory care unit during an altercation with Resident #7. The DON stated Resident #6 was sent to the hospital in pain. The DON stated, upon findings from the hospital, [Resident #6] had a pathological fracture which led me to believe the fracture could have been there regardless of the fall, The DON stated she did not believe the fracture resulted from Resident #7 pushing Resident #6. The DON further stated upon her investigation with Resident #8, he reported to her that he slid out of his bed, there was not an actual altercation between he and Resident #9. The DON stated in both altercations residents were separated, Resident # 6 was sent to the hospital immediately after the incident due to complaint of pain, Resident #7 was placed on monitoring, Resident #8 was sent to hospital for further evaluation to ensure he was ok, and Resident #9 was sent out for psychiatric evaluation. The DON stated she expected all staff to report any allegations of abuse to the Abuse Coordinator which was the Administrator and herself immediately. The DON stated all staff was to intervene and separate residents to deescalate the situation. The DON stated residents are monitored every 15 minutes for safety for 72 hours, the family and physicians were notified of the incidents. The DON stated the inhouse psychiatrist was also notified to evaluate medications, and if he was not available, residents were sent to a psychiatric facility to be evaluated. The DON stated if these steps were not followed, residents are placed at risk for safety and feeling secure in their environment. The DON stated in-services were completed on both reported incidents to ensure resident safety. Interview on 06/19/25 at 2:59 PM with the Administrator revealed he was the abuse coordinator for the whole campus. The Administrator said all staff were responsible for monitoring residents and their behaviors to ensure they were not getting into an altercation with each other. The Administrator said several things could happen to residents if they were to get into an altercation with each other such as harm or injury. The Administrator said because of the residents' diagnoses, a lot of times they did not remember what they did or who they did something to. The Administrator stated all staff were in-serviced on signs and symptoms of abuse and neglect along with resident-to-resident altercations. Record review of the facility's Abuse, Neglect and Exploitation and Misappropriation of Resident Property policy, dated 02/12/20, reflected: Policy 1. Resident Rights. Each resident has the right to be free from abuse, neglect, exploitation, misappropriation of resident's property, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse, neglect, exploitation, misappropriation of resident's property by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, resident representative, friends, or other individuals. 2. Facility Duty to Protect Resident Rights. The facility must prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident's property. This was determined to be a Past Non-Compliance Immediate Jeopardy on 06/18/23 at 4:45 PM. The Administrator and the DON were notified. The Administrator was provided with the IJ template on 06/18/25 at 6:35 PM. The facility took the following actions to correct the non-compliance prior to the abbreviated survey: 1. Record review of an in-service, dated 03/01/25, reflected 34 staff including nurses, nurse aides, housekeeping, medication aide, Business Office Manager, and dietary aides were in-serviced regarding Abuse & Neglect, Abuse Coordinator, Resident Behaviors, Fall Prevention. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Safe surveys were completed on 03/01/25 with five residents with no issues noted. Record review of Resident #8's clinical records reflected Resident # 8was transported to the hospital on [DATE] for further evaluation. Upon return Resident #8 was relocated to another room on 03/01/25. Record review of Resident #8's psych services notes reflected Resident #8 was seen by psych on 03/03/25, and no medication adjustments were made. Record review of Resident #9's clinical records reflected Resident #9 was placed on one-on-one supervision until he was sent to the hospital for further evaluation and medications adjustment. Record review of Resident #9's clinical records reflected Resident #9 was relocated to a private room on 03/01/25. Record review of Resident #9's psych services notes reflected Resident #9 was seen by psych on 03/04/25, medications were adjusted. Resident #9 received an order for Seroquel 150MG, 1.5 TAB PO BID for schizoaffective disorder. Record review of Resident #9's clinical records reflected Resident #9 was being monitored for behaviors throughout each shift. 2. Record review of an in-service, dated 03/09/25, reflected 50 staff including nurses, nurse aides, housekeeping, medication aide, Business Office Manager, dietary aides, and transportation staff were in-serviced regarding Abuse, neglect and exploitation and misappropriation of resident property, Fall Precaution/Fall management, Behaviors (Altercations) of Residents. Record review of safe surveys completed by the facility on 03/10/25 reflected five residents reported no issues. Record review of Resident #6's clinical records reflected Resident #6 was at the hospital from [DATE] and discharged on 03/14/25. Resident #6 had surgery. Resident #6 was provided with pain medication every 4 hours as needed for pain. Record review of Resident #6's clinical records reflected Resident #6 was being monitored for pain. Record review of Resident #7's clinical records reflected she was placed on q15 check for 72 hours. Facility continued to monitor behaviors and document. Record review of Resident #7's progress notes reflected Resident #7's medications were reviewed by Hospice and no new orders were given. Observations completed on 06/18/25 from 11:00 AM through 06/19/25 4:00 PM in the South building and North building memory care unit revealed residents engaged in activities, staff were providing snacks. Observed staff monitoring and redirecting residents from wandering and unwanted behaviors. No observations of aggressive behaviors. Observed staff answering call lights and completing rounds every 2 hours. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews on 06/18/25 from 11:22 AM through 06/19/25 3:30 PM with MDS Coordinator PP, LVN OO, LVN LL, CNA JJ, CNA EE, ADON, CNA B, Wound Care Nurse F, CAN I, CNA L, CMA K, RN X, CNA V, LVN Y, LVN AA, CMA RR, CNA SS, CMA TT, LVN UU, Activity Director, [NAME] K, Housekeeping R, Floor Tech Q, CNA J, CNA W. The facility staff were able to verify education was provided to them. Facility staff were able to accurately summarize abuse and neglect, how to work with residents with behaviors, immediately separate residents in altercations and report and fall prevention. Facility staff stated they monitor residents throughout the shifts, if known behaviors they will redirect them, placed them on 1:1 or q15 minute checks depending on the behavior. Staff stated for residents who have had altercations or incidents they monitor closely, keep them separated to prevent any further incidents. Staff stated they provide activities to keep them engaged and provide snacks throughout the day. Staff stated upon shift change they will notify the incoming staff of any incidents or behaviors.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain good personal hygiene for 2 of 2 residents (Residents #3 and #4) reviewed for ADL care. The facility failed to provide incontinence care to Residents #3 and #4 every 2 hours and as needed. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life. Findings included: Record review of Resident #3's quarterly MDS assessment, dated 05/22/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #3 had a diagnosis of Malignant neoplasm of brain, unspecified (cancerous brain tumors where the specific location within the brain has not been determined). He had a BIMS score of 00, which indicated his cognition was severely impaired. The MDS reflected the resident was frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding). Record review of Resident #3's Care Plan dated 03/19 /25, reflected the following the resident was at risk for problems with bowel and bladder elimination. The care plan reflected: Goal: Resident will be assisted with incontinence to ensure social acceptance over the next 90 days . intervention: Assist to toilet as needed. Provide peri care after each incontinent episode . Observation and interview on 06/18/25 at 9:50 AM revealed Resident #3 was in his room on his bed. He stated his brief was changed this morning when he got a shower. He denied being wet. Observation on 06/18/25 at 3:00 PM revealed CNA JJ providing Resident #3 with incontinence care. She went to the room and explained the procedure to Resident #3. CNA JJ put supplies together and went to the resident's bedside. She did not perform hand hygiene before contact with Resident #3, she put on gloves, and she unfastened the resident's brief. Resident #3 had on two briefs and was heavily soaked in urine. Interview on 06/18/25 at 5:06 PM, CNA JJ revealed she was the one assigned to Resident #3. She stated she had not changed the resident since they changed shift at 2:00 PM, and she was not aware when he was last changed. She stated she was aware they were not supposed to double the briefs on residents. She stated the risk of doubling the briefs would be skin break down. She stated she had done training of not putting residents on two briefs and rounding every two hours. She had just started her shift at 2:00 PM. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/19/25 at 10:08 AM, CNA C revealed she was the one assigned to Resident #3 yesterday on 06/18/25 morning shift. She stated she had changed the resident but could not tell when she changed Resident #3's brief. She stated she did not put two briefs on the resident. She stated she was aware they was not supposed to double the briefs on residents. She stated the risk of doubling the briefs would be skin break down. She stated she had done training of not putting residents on two briefs and rounding every two hours. 2. Record review of Resident #4's Quarterly MDS Assessment, dated 05/02/25, reflected Resident #4 was an [AGE] year-old female. She was admitted to the facility on [DATE]. BIMS score was 00. Record review of her cognitive patterns revealed she was severely impaired. Her diagnoses included diabetes mellitus (a group of metabolic diseases characterized by high blood sugar levels) and Acute respiratory failure with hypoxia (Acute impairment in gas exchange between the lungs and the blood causing hypoxia) and Stage 4 pressure ulcers that were present upon admission (the most severe stage of a pressure ulcer, characterized by full-thickness tissue loss with exposed bone, tendon, or muscle) and always incontinent. Record review of Resident #4's Care Plan dated 02/05 /25, reflected the resident was at risk for problems with bowel and bladder elimination. The care plan reflected: Goal: Resident will be assisted with incontinence to ensure social acceptance over the next 90 days . intervention: Assist to toilet as needed. Check resident every 2 hours and assist with toileting as needed . Observation and interview on 06/18/25 at 12:08 PM, revealed Resident #4 was in her room on her bed. She was not a good historian she was not able to tell when she was last changed. The room had urine odor smell, and the mattress cover was observed wet and soaked with urine. Observation on 06/18/25 at 12:13 PM, revealed CNA KK and CNA I providing Resident #4 with incontinence care. They both entered the room and explained the procedure to Resident #4. CNA KK put supplies together and they both went to the bedside, and they did not perform hand hygiene before contact with Resident #4. They put on gown and gloves and unfastened the resident's brief. Resident #4 was observed soaked and wet, the brief the pad and the mattress cover was wet, and she had urine odor smell. Interview on 06/18/25 at 1:26 PM with CNA KK revealed he was the one assigned to Resident #4. He stated he last changed the resident at around 7:15 AM before she ate breakfast. He stated he was aware they were supposed to do rounds every two hours and as needed but he was busy with other residents. He stated failure to round and change resident every 2 hours could lead to skin break down. CNA KK stated they had been given training on rounding every two hours. Interview with on 06/18/25 at 1:15 PM with RN X, who was the day shift nurse, revealed he had been to Resident #4's room, and he had not noticed she was wet. He stated staff are supposed to perform the incontinent rounds every 2 hours and as needed. He stated the risk of leaving residents wet for a long time was that they would be predisposed to skin irritation and urinary tract infections. Interview on 06/18/25 at 6:05 PM, the ADON revealed her expectation was that the staff performed rounds every two hours and as needed. She stated the nurses was responsible for monitoring the CNAs during their shifts. She stated staff should not double the briefs on residents. She stated the risk of not performing every two hours rounds and doubling the briefs could lead to skin issues and infections. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/19/25 at 2:21 PM, the DON revealed her expectation was that the staff performed rounds every two hours and as needed. She stated the nurses were responsible for monitoring the CNAs during their shifts. She stated staff should not double the briefs on residents. She stated the risk of not performing every two hours rounds and doubling the briefs was that it could lead to skin issues and infections. The DON stated she had done training with staff on providing incontinence care every two hours and not putting 2 briefs on residents. On 06/19/25, the facility was asked to provide the training records; however, the records were not provided prior to the exit conference. Record review of the facility's Perineal Care policy, revised April 2024, reflected the following: .Staff will provide perineal care in accordance with the standard of practice to prevent skin breakdown and infection

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 3 residents (Resident #2) reviewed for pressure ulcer treatment. The facility failed to ensure Resident #2 received wound care according to physician orders. This failure could place the resident at risk of worsening wounds. Findings included: Record review of Resident #2's face sheet, dated 06/18/25, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE] and discharged on 04/02/25. Record review of Resident #2's admission MDS assessment, dated 02/23/25, reflected her diagnoses included metabolic encephalopathy (brain disorder), Pressure ulcer of sacral region, stage 4, Unspecified severe protein-calorie malnutrition, Osteomyelitis of vertebra, sacral and sacrococcygeal region (a bone infection affecting the sacrum). Resident #1's BIMS score was 01 which indicated severe cognitive impairment. The MDS further revealed Section M - Skin Conditions indicated Resident #2 had pressure ulcers upon admission/entry to the facility. Record review of Resident #2's care plan, 02/27/25, reflected: Care Area/Problem: Skin Breakdown: At risk for/actual Related to: Stage 3 Pressure Ulcer, Stage 4 Pressure Ulcer. Goal: Resident will maintain clean and intact skin over the next 90 days. Measures will be taken to prevent skin breakdown over the next 90 days. Open area will be healed over the next 90 days. Interventions: Assist resident to turn and reposition frequently. Inspect skin complete body head to toe every week and document results. Inspect skin daily with care and bathing and report any changes to charge nurse. Monitor nutritional intake, weight, lab values, report significant changes to MD. Off load heels. Position resident properly; use pressure-reducing or pressure-relieving devices (e.g. pillows, positioning wedges, and alternating pressure mattress) if indicated. Stage 3 Wound: Skin Prep area daily and leave open to air. Stage 4 Wound: Cleanse with NS, Pay Dry. Treatments and dressings. Record review of Resident #2's Initial Wound Evaluation & Management Summary, dated 02/20/25, reflected the following Treatment Plan/Orders: (Site 1) Stage 3 Pressure Wound of the right, medial knee: Collagen Powder, Sodium Hypochlorite Gel (Anasept), gauze island w/bdr. Frequency: Three times per week. (Site 2) Stage 3 Pressure Wound of the right, distal, medial foot: Collagen Powder, Sodium Hypochlorite Gel (Anasept), gauze island w/bdr. Frequency: Three times per week. (Site 3) Unstageable (Due to Necrosis) Wound of Left Hip: Collagen Powder, Sodium Hypochlorite Gel (Anasept), gauze island w/bdr. Frequency: Three times per week. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Site 4) Stage 4 Pressure Wound of the Sacrum: Sodium Hypochlorite Solution (Dakins) Gauze Island w/bdr 4 x 10 ABD Pad: Frequency Daily. Record review of Resident #2's eTAR for February 2025 indicated orders were not put in the system and wound care was not provided until 02/27/25. New orders were put in on 02/26/25, which reflected the following: Cleanse Wound every am shift (6am-2pm) Stage 4 Pressure Wound of the Sacrum: Cleanse with NS or WC, pat dry, apply Dakin's soaked gauze, then cover with a dry dressing daily. Dx: Pressure ulcer of sacral region, state 4. Start Date: 02/26/25. Cleanse Wound Tuesday, Thursday, Saturday every am shift (6am-2pm) Stage 3 Pressure Wound of the right, medial knee: Cleanse with NS or WC, pat dry, apply anasept and collagen, then cover with a dry dressing 3x/week. Dx: Other skin changes Start Date: 02/26/25. Cleanse Wound Tuesday, Thursday, Saturday every am shift (6am-2pm) Stage 4 Pressure Wound of the Right, Distal Medial foot: Cleanse with NS or WC, pat dry, apply anasept and collagen, then cover with a dry dressing 3x/week. Dx: other skin changes. Start Date: 02/26/25. Cleanse Wound Tuesday, Thursday, Saturday every am shift (6am-2pm) Unstageable (Due to Necrosis) Wound of Left Hip: Cleanse with NS or WC, pat dry apply skin prep 3X/week. Dx: Other skin changes. Start Date: 02/26/25. Interview on 06/19/25 at 11:27 AM, Wound Care Nurse F revealed Resident #2 admitted to the facility with multiple wounds. He stated his work schedule was from Monday-Thursday, and when Resident #2 admitted to the facility, he was not working. He stated the facility had a weekend wound care nurse, who would have provided wound care during the weekend to Resident #2. He stated Resident #2 was seen by the Wound Care Doctor on 02/25/25 and wound care was provided. Wound Care Nurse F reviewed Resident #2's TAR and stated Resident #2 had no treatment orders in the system until 02/26/25. He reviewed Resident #2's initial evaluation and stated the Wound Care NP provided orders on 02/20/25 but whoever the orders were provided to, they did not put the orders in the system. He stated the orders provided on 02/20/25 wound care should had been completed Tuesdays, Thursdays, and Saturdays. He stated based on documentation; Resident #2 only missed one wound care treatment which was 02/22/25. He stated he cannot say if treatment was not provided to Resident #2, it appeared it might had been a documentation issue. He stated when he completed rounds with the Wound Care Doctor on 02/26/25, Resident #2 had dressings on with the date of 02/22/25. Wound Care Nurse F stated the expectation for when they get treatment orders, either from the Wound Care Doctor or hospital, the nurses or the wound care nurses were responsible for putting the orders in the system. He stated the failure to follow the doctors' orders could result in the wounds worsening and failure of documenting could result in not knowing if treatment was provided. Attempts were made to contact weekend Wound Care Nurse DD, LVN MM and LVN NN who were assigned to Resident #2 during 02/20/25 through 02/25/25 on 06/19/25 from 12:09 PM-12:12 PM by phone; however, there was no answer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/19/25 at 1:39 PM, Wound Care NP revealed the expectations for when treatment orders were provided to the facility were for the nurses or wound care nurse to put them on the system and to follow them. Wound Care NP stated there was no potential risk for Resident #2 if one treatment was missed, because depending on the order, some dressings could last up to 7 days. Interview on 06/19/25 at 2:00 PM, the DON revealed based on the initial assessment completed by the Wound Care NP on 02/20/25, wound care was provided to Resident #2. She stated the expectation was when treatment orders were provided, it was the responsibility of the nurse or wound care nurse to put the orders in the system. She stated she expects her staff to follow the treatment orders. She stated she was not aware the orders were not put in the system until 02/26/25. She stated the potential risk could results in the wounds deteriorating. Interview on 06/20/25 at 9:33 AM, the Wound Care Doctor revealed when treatments orders were provided, the receiving nurse should put them in the system, and she expected the nursing staff to follow them. She stated Resident #2's wounds were healing when she was at the facility. She stated there was no potential risk to the resident if a treatment was missed. Review of the facility's current policy dated July 2018 titled, Treatment of Wounds: Dressing Changes-Performing reflected: . 1. Review orders and treatments and gather supplies. .4. Ensure all wound dressing products are completely removed with each dressing change if present Review of the facility's current policy dated January 10,2023 titled, Physician Orders - Manual/Paper reflected: . 2. Record the actual order received from the physician.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as is possible and each resident received adequate supervision and assistive devices to prevent accidents for 1 of 5 residents (Resident #1) reviewed for supervision. The facility failed to ensure Resident #1 who had a history of wandering and exit-seeking, was provided with adequate supervision to prevent her from eloping on 06/09/25. Resident #1 was found 5 minutes away from the facility by police and was transported to the hospital for evaluation due to the resident experiencing hallucinations and delusions. The noncompliance was identified as a past non-compliance. The Immediate Jeopardy (IJ) began on 06/09/25 and ended on 06/10/25. The facility had corrected the noncompliance before the survey began. This failure placed residents at risk of harm and/or serious injury. Findings included: Record review of Resident #1's face sheet, dated 06/18/25, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #1's quarterly MDS assessment, dated 06/05/25, reflected her diagnoses included unspecified dementia, severe, with other behavioral disturbance, schizophrenia, and delusional disorders. Resident #1's BIMS score was 00 which indicated severe cognitive impairment. The MDS further revealed Section E - Behaviors indicated Resident #1 exhibited wandering behaviors. Record review of Resident #1's care plan, dated 06/04/25, reflected: Care Area/Problem: Attempted to Elopement: Resident is Exit seeking, high elopement risk. Goal: Resident safety will be maintained over the next 90 days. Interventions: Assess for contributing sensory. Check resident location every 15 minutes. Maintain behavior log. Notify physician and family/responsible party. Remove resident from immediate situation to assure safety. Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Record review of Resident #1's Resident Visual Monitoring dated 06/04/25-06/05/25 reflected Resident #1 was on 1:1 supervision. Record review of Resident #1's Nurse Visual Check Individual Resident Monitoring dated 06/06/25 - 06/09/25 reflected Resident #1 was on 15 minutes checks. Record review of Resident #1's progress notes dated 06/09/25 at 6:54 PM by LVN A reflected the following entries: 7:30 AM - in room dressed for the day (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7:46 AM - CNA summoned resident to the dining room for breakfast and noted resident not in room and window broken. CNA notified nurse and I contacted DON and Administrator. Staff began searching unit and grounds. All other doors and courtyard exit found to be in locked position. 8:00 AM - unable to find resident in building or on grounds, contacted PD [Police Number] for missing resident. 8:15 AM [Police Department] police contacted nurse, [LVN A], LVN stating they have resident in custody. 8:20 AM - Administrator and nursing staff attempting to calm resident along with PD, but resident remained belligerent and psychotic. Currently, she is delusional and believes buzzards are raping her and nursing staff are putting a curse on her. 8:25 AM - Attempted to transport resident for further evaluation and care via facility van without success. 8:39 AM - [Police Department] PD unable to coax resident in car or ambulance and were forced to restrain resident with handcuffs for everyone's safety and then transported to [Hospital] for further evaluation and treatment. 8:39 AM - Nursing staff at ER bedside to give report on patient. ER nurse stated they would have to continue to restrain her and give her some medication in order to do a proper exam. At bedside, no outward sign of injury or c/o pain noticed. unable to contact family members on file as there is no working number. PCP notified of incident. Record review of the facility's Provider Investigation Report, completed by the Assistant Administrator on 06/16/25, reflected the following: Incident date: 06/09/2025, Time of Incident: 07:45 AM Resident noted by staff to not be in room and window broken. Perimeter search completed and [Police Department] police notified. Assessment Date 06/09/25; Time: 08:15 AM; Resident assessed and no apparent injuries noted. Perimeter search and [Police Department] police notified. Physician [name], notified. Family [name], notified. Safe surveys completed. Staff in-service on Elopement procedures. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Entire facility check to ensure all residents accounted for. Investigation Summary: Resident noted by nursing staff to not be in room or on south memory community. Resident room noted with broken window. Perimeter search completed and [Police Department] located resident after resident noted missing and transported resident to [hospital] ER for psychiatric evaluation. Staff interview state resident was currently on every 15 minute checks and when checked resident not in room and window broken. Staff state perimeter check completed and when not able to locate during perimeter check [police department] police were notified. Staff interview stat resident had no attempted to leave memory unit prior to this incident. Resident placed on q 15 minute checks due to pacing and wandering in and out of other resident rooms. Chat review reflects resident referred to psych service for behavioral and medication management. Provider Action Taken Post-Investigation: Resident care plan to be updated upon return from hospital. All staff in-service on Elopement procedures. Window alarms ordered for memory care windows. Resident elopement risk assessments updated. Care plans reviewed and updated for elopement risk residents. QAPI meeting conducted with Medical Director to review elopement protocols and action plan. Record review of CNA C statement, dated 06/09/25 at 9:00 AM, reflected: Summoned resident for breakfast and noticed she was missing from her room and window was broken notified charge nurse immediately and assisted in search for resident. Record review of LVN A statement, dated 06/09/25 at 9:00AM reflected: CNA notified nurse that resident was missing from room and window was broken. We immediately contacted DON/admin and began search on unit and grounds. Admin assisted with search effort and 911 called; last time seen: 7:30, summoned for breakfast 0745, called DON/ED 0746, began search 0746, called 911 0800, police located resident 0815, staff/admin 0820, 0839 [Police} police restrained resident and escorted to [hospital] for further evaluation and treatment. Interview on 06/18/25 at 11:27 AM, CNA B revealed she worked the day Resident #1 eloped from the facility. She stated she was not the CNA assigned to Resident #1. She stated she could not recall the exact time, but she observed Resident #1 standing by her room door and then she closed the door. She stated Resident #1 was on q15 minutes checks and LVN A was completing them. She stated from what she was told Resident #1 was last seen at 7:30 AM in her room, then at 7:45 AM CNA C went to inform Resident #1 it was time for breakfast and that is when they realize she was gone. She stated Resident #1 broke the window and jumped the fence. She stated they called Code Green and initiated a search inside and outside the facility and notified the police department. She stated Resident #1 was found by the police department, unknown where she found. She stated prior to Resident #1's elopement, the resident was placed on 1:1 supervision and then q15 minute checks because Resident #1 was having behaviors and pacing up and down. She stated they were in-serviced on abuse, neglect, and elopement. She stated the facility added alarms to all residents' windows. An attempt was made to contact LVN A on 06/18/25 at 11:55 AM by phone; however, there was no answer. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/18/25 at 2:05 PM, the DON revealed Resident #1 eloped from the facility on 06/09/25. She stated she received a call from LVN A at 7:46 AM and informed her Resident #1 had broken the window from her room. She stated they initiated a search inside and outside the facility. She stated the police was notified and they were able to locate Resident #1 about .5 miles from the facility. She stated Resident #1 was a fast walker, when she was found she had no injuries; however, resident was having behaviors and the police decided to take her to the hospital for further evaluation. She stated prior to Resident #1 elopement, resident was not exit-seeking; however, she was pacing the hall and wandering into residents' rooms. She stated Resident #1 had history of eloping at home. She stated since Resident #1 was wandering into residents' room and pacing the hall, as an intervention, they placed Resident #1 on 1:1 supervision and then she was doing better and placed Resident #1 on q15 minute checks. She stated staff were completing q15 minutes checks when Resident #1 eloped, the last time she was observed was at 7:30 AM and then noticed she was gone at 7:45 AM. She stated all staff were in-serviced on abuse and neglect, and elopement. She stated alarms were also added to both North and South memory care unit and they also implemented resident logs which have to be completed before a resident was taken off the unit either for a visit or therapy session. Interview on 06/18/25 at 3:26 PM, the Administrator revealed he had arrived at the facility when he was informed Resident #1 had broken her room window and eloped. He stated the staff had initiated a search inside and outside facility grounds. He stated the police were notified, and the police was able to locate Resident #1 about 5 minutes from the facility. He stated he went to the scene were Resident #1 was located, he stated resident was having behaviors and was transported to the hospital for further evaluation. He stated prior to Resident #1's elopement, they had interventions in place due to Resident #1 having behaviors and refusing medications. He stated Resident #1 was placed on 1:1 and then q15 minute checks due to the resident pacing the halls and wandering into residents' rooms. He stated when Resident #1 eloped, staff were still completing q15 minute checks on Resident #1. He stated they in-serviced all staff on abuse and neglect and elopement. He stated they added alarms to all windows in the memory care unit. The Administrator stated Resident #1 had not returned to the facility since incident. Interview on 06/19/25 at 10:16 AM, CNA C revealed she was the CNA assigned to Resident #1 when she eloped. She stated the last time she observed Resident #1 was around 6:15 AM in her room. She stated Resident #1 was on q15 minutes check and LVN A was completing them while she was assisting other residents with getting them up for the day. She stated when it was time for breakfast, she went to Resident #1's room and that was when she noticed Resident #1 was not in the room and the window was broken. She stated she notified LVN A and they began a search for Resident #1. She stated she was in-serviced on abuse and neglect, and elopement. Record review of facility Elopement Management policy, revised 05/02/25, reflected the following: An immediate investigation and search will be conducted if a resident is considered missing. The resident will be located and returned to a safe environment within standard practice guidelines. This was determined to be a Past Non-Compliance Immediate Jeopardy on 06/18/23 at 4:45 PM. The Administrator and the DON were notified. The Administrator was provided with the IJ template on 06/18/25 at 6:35 PM. The facility took the following actions to correct the non-compliance prior to the abbreviated survey: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review revealed an elopement assessment were reviewed and completed on residents on 06/09/25. Record review of safe surveys completed by the facility on 06/09/25 with five residents reflected there were no issues noted. Record review of the facility's South Memory Unit Elopement binder located at the nurses' station reflected the binder contained pictures of residents, who were elopement risk, and contained information regarding the residents. Record review of the facility's Resident Log on North and South Memory Unit reflected residents were being signed out when taken off unit for therapy sessions. Observation on 06/18/25 at 11:34 AM revealed all windows in the South Memory Unit had an alarm. Alarms were loud enough to be heard throughout the unit. Record review of the following in-services dated 06/09/2025 reflected all facility staff were in-serviced on abuse, neglect, elopement, missing person, and Code [NAME] for elopements/missing persons. The in-services were conducted and signed by all facility staff. Interviews on 06/18/25 from 11:22 AM through 06/19/25 at 3:30 PM with CNA B, CNA C, LVN D, CNA E, Wound Care Nurse F, MDS Coordinator G, MDS Coordinator H, CNA I, CNA J, CMA K, CNA L, CNA M, [NAME] K. Physical Therapy O, CNA P, Floor Tech Q, Housekeeping R, Housekeeping Supervisor S, LVN/Coordinator T, LVN U, CNA V, CNA W, RN X, LVN Y, LVN Z, LVN AA, LVN BB, LVN CC, CNA EE, CNA FF, CNA GG, CNA HH, Activity Assistant, and the Assistant Administrator revealed the facility staff were able to verify education was provided to them. Facility staff were able to accurately summarize missing person/elopement policy, missing/elopement code, abuse and neglect, completing head counts before and after shift change and alarms added to all windows in the memory care unit.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents fed by enteral means received the appropriate treatment and services to prevent complications of enteral feedings for 1 of 1 resident (Resident #100) reviewed for enteral nutrition. The facility failed to follow Resident #100's physician orders for enteral feeding. These failures could affect residents receiving enteral nutrition/hydration and place them at risk of health complications and decline in health. Findings included: Record review of Resident #100's face sheet dated 06/19/25 reflected the resident was [AGE] year-old male admitted on [DATE]. Record review of Resident #100's Quarterly MDS dated [DATE] reflected the resident had severe cognitive impairment with a BIMS score of 00. Resident #100 required supervision or touching assistance with eating. The assessment reflected Resident #100's diagnosis included Anemia (lack of healthy red blood cells), Diabetes Mellitus (high blood sugar), Alzheimer's Disease (gradual decline in memory, thinking, and behavior), Malnutrition (imbalance of nutrients the body needs and what it actually received). Resident #100 utilized a feeding tube, mechanically altered diet, and therapeutic diet while a resident at the facility. Record review of Resident #100's undated care plan reflected the following: Resident #100 had Altered Nutritional Status related to Dysphagia/Swallowing difficulty, limited mobility, and risk of malnutrition as evidenced by: Diet: Consistency - Puree - Level 4, Crushed medication, Diet: Liquids-Nectar/Mildly thick, Jevity 1.2 Cal 0.06 gram-1.2 kcal 65 ml/hr. X 9 hrs. GOAL: Resident will be comfortable with food and fluids provided. Snacks between meals as preference on a daily basis. Interventions included Dietitian referral as indicated. Monitor oral intake of food and fluid. Provide snacks between meals as preferred. Altered Nutritional Status: Enteral Feeding Monitor related to Jevity 1.2 Cal 0.06 gram-1.2 Kcal 65ml/hr. X 9 hrs. Evidenced by Peg-tub Dressing every noc shift (10PM-6AM). Peg-tub Flush 30 Cubic centimeter PEG Tube every shift. Peg-Tube Residual Cubic centimeter Feeding Tube every shift. Peg-tube Flush 200 Cubic centimeter G-tube every 4 hours. GOAL: Resident will have no signs or symptoms of aspiration over the next 90 days. Interventions included keep the head of the resident's bed at 30 degree and 45 degrees after bolus feeding. Monitor labs when available. Monitor tolerance of tube feeding. Monitor weight monthly/weekly. Provide family support/education regarding palliative nutrition and hydration care. Provide water flush as ordered. Provide water flush at med pass per nursing policy. Record review of Resident #100's physician orders included the following: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Glucerna 1.5 Cal 0.08 gram-1.5 Kcal/mL oral liquid (nutritional tx. Glucose intolerance, lactose-free, soy/fiber) 237 Milliliter PEG Tube every 4 hours once Osmolite 1.5 is available discontinue Glucerna 1.5 and restart previous Osmolite 1.5 orders. Diagnosis: unspecified severe protein-calorie malnutrition. Start date 04/23/25. Record review of Resident #100's April 2025, MAR reflected Resident #100 had not been administered Glucerna 1.5 on April 24, 2025, at 01:00 AM, 05:00 AM and April 25, 2025, at 01:00 AM. Observation on 06/18/24 at 12:38 PM of Resident #100 revealed him in the dining room assisted with puree diet. Interview by phone on 06/19/25 at 11:20 AM with LVN LL revealed she worked overnight shift with Resident #100. LVN LL stated Resident #100 was on 20 hours of continuous tube feedings with Osomilte, 200 flush of water every 4 hours. LVN LL stated she received a new order to substitute Jevity until Osomilte formula came in. LVN LL was asked to confirm if the alternative formula was for Jevity or Glucerna, she replied I do not recall the order being for Glucerna, I am really good about completing my feedings over night, I never miss. LVN LL stated she did not recall Resident #100 missing any feedings, there was only one resident that was on Glucerna and Resident #100 was not one of them. LVN LL was asked about Resident #100 MAR dated 04/24/25 with two missed feedings and 04/25/25 with one missed feeding on her shift, LVN LL stated she did not know why there would be any missed feedings. LVN LL stated when residents miss their feedings it placed them at risk of losing weight. LVN LL stated she was responsible for following physician orders to ensure resident's feedings were administered. Interview on 06/19/25 at 12:20 PM with RN X revealed he was working with Resident #100, RN X stated Resident #100 was on continuous feeding with puree diet pleasure foods. Upon review of Resident #100's April 2025 MAR he expressed there were two missed feedings on April 24, 2025 and one missed feeding on April 25, 2025 as indicated by the red X. RN X stated he was not able to review any progress notes on these days that indicated a reason for the missed feedings. According to RN X, the nurse that was on duty those days were responsible for ensuring Resident #100 completed his feedings. RN X stated not doing so placed him at risk of losing weight and malnutrition. Interview and record review on 06/19/25 at 2:30 PM with DON revealed Resident #100 is on continuous feeding by tube feeding 20 hours a day, 200 flushes with water every 4 hours. The DON stated Resident #100 is doing really well with no concerns of weight loss. Upon record review, the DON stated she confirmed the red x's indicated missed feedings for Resident #100 on 04/24/25 at 1:00 AM and 5:00 AM, and 04/25/25 at 1:00 AM. The DON stated she was able to review any notes on missed feedings in the clinical record. The DON stated nurses on duty with Resident #100 were expected to record the orders as they come in and follow them, if orders are placed on hold there should be documentation. The DON stated not following the orders or holding the orders without documentation placed Resident #100 at risk of weight loss. Record review of the facility's Physician Orders policy revised 01/10/23, reflected: The qualified nursing personnel will take and implement telephone orders according to the Practice Guidelines. Immediate electronic entry is recommended; however, manual orders may be required in instances . (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procedure: 1. Enter Resident's last name and first name, attending physician's name, date, resident number, and community's name. 2. Record the actual order received from the physician. 3. The nurse taking the order signs full signature (first initial, last name, and title) in the signature of Nurse Receiving Order box. Enter the time the order was received and check appropriate box (a.m. or p.m.). Telephone and verbal orders are immediately recorded on resident's medical record. 4. After initiating the steps to carry out the physician's written order (I.e., entering it on the medication sheet, placing order with pharmacy, etc.), the nurse countersigns and dates the order with full signature in the Signature of Nurse Noting Order box. 5. Telephone orders must be entered into the HER as soon as possible. 6. A licensed nurse will confirm manual/paper order has been entered into the HER. 7. Send copy of the Physician's Order(s) to the pharmacy. This provides backup to your verbal communication with the pharmacist.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 2 of 2 residents (Residents #3 and #4) observed for infection control. 1. CNA I, CNA JJ and CNA KK failed to perform hand hygiene while providing incontinence care to Resident #3 and #4. 2. The facility failed to ensure RN X performed hand hygiene and changed gloves during wound care for Resident #4. This failure could affect the residents by placing them at risk for worsening conditions and cross contamination. Findings included: Record review of Resident #3's quarterly MDS assessment, dated 05/22/25, reflected the resident was a [AGE] year-old male who was admitted to facility the on 02/18/25 and readmitted on [DATE]. Resident #3 had a diagnosis of Malignant neoplasm of brain, unspecified (cancerous brain tumors where the specific location within the brain has not been determined). He had a BIMS score of 00, which indicated his cognition was severely impaired. The MDS reflected the resident was frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding). Record review of Resident #3's Care Plan dated 03/19 /25, reflected the following: Resident at risk for problems with Elimination (B&B) (bowel and bladder) Goal: Resident will be assisted with incontinence to ensure social acceptance over the next 90 days . intervention: Assist to toilet as needed. Provide peri care after each incontinent episode . Observation on 06/18/25 at 03:00 PM, revealed CNA JJ providing incontinent care to Resident #3. CNA JJ was observed putting on gloves before washing hands. CNA JJ explained procedure to Resident #3, she positioned the resident and unfastened the brief and proceeded to cleanse Resident #3. She cleansed the abdominal folds and penis in a clockwise direction. She then removed gloves covered the resident and she left the room and went to get briefs from the storage. She did not perform hand hygiene after removing the gloves. She came back to the room and put on gloves without performing hand hygiene. She positioned the resident on his side and cleansed his bottom area inside out. CNA JJ did not complete hand hygiene or change the gloves she applied the clean brief and left the resident comfortable bed low and call light within reach. CNA JJ was observed leaving the room after removing gloves without washing hands and walked down the hall with barrels. Interview on 06/18/25 at 05:06 PM with CNA JJ, revealed she forgot to perform hand hygiene before, during, and after perineal care. CNA JJ stated she was expected to wash hands before and in between the care if gloves was soiled and after care, but she forgot. CNA JJ stated she was supposed to complete hand hygiene and change gloves during incontinent care to prevent cross contamination. She stated failure to wash hands after or before contact with resident removing gloves could lead to cross contamination. She stated she has done training on Handwashing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #4's Quarterly MDS Assessment, dated 05/02/25, reflected Resident #4 was an [AGE] year-old female. She was admitted to the facility on [DATE]. BIMS score was 00 revealing her cognition was severely impaired. Her diagnoses included diabetes mellitus (a group of metabolic diseases characterized by high blood sugar levels) and Acute respiratory failure with hypoxia (Acute impairment in gas exchange between the lungs and the blood causing hypoxia) and Stage 4 pressure ulcers that were present upon admission (the most severe stage of a pressure ulcer, characterized by full-thickness tissue loss with exposed bone, tendon, or muscle) and always incontinent. Record review of Resident #4's physician orders dated 06/10/25 reflected the following order: Cleanse Wound every am shift (6am-2pm) stage 4 pressure wound to the sacrum: Cleanse with normal saline or wound cleanser, pat dry. Apply collagen sheet and calcium alginate, then cover with a dry dressing daily. Observation on 06/18/25 at 12:13 PM, revealed CNA KK and CNA I providing incontinent care to Resident #4. CNA KK and CNA I was observed entering the room and they put on gown and gloves without performing hand hygiene. CNA KK explained procedure to Resident #4. CNA I positioned the resident and unfastened the brief. He did not cleanse the abdominal folds and peri area they positioned the resident on her side and CNA KK was observed pat drying the area that had the wound and he did not cleanse the buttocks and thighs. The open area on the sacrum was observed with dressing having fallen off on the brief that was soaked with urine. Resident #4's brief, pad, and the sheets was soaked with urine. He removed the gloves and left the room to call the nurse for wound dressing and he failed to wash hands. He came back and put on gloves, he was observed folding the soiled brief and linen towards the CNA I and then with soiled gloves picked the clean brief and clean linen and started to spread on the bed. CNA I removed the soiled brief and the pad and the soiled sheet and put in a plastic bag. She did not change gloves and came to help CNA KK complete making the bed on her side and positioning the resident they did not provide resident with peri care CNA I was observed removing soiled gloves did not perform hand hygiene and left the room when the wound care nurse came to the room. Observation on 06/18/25 at 12:17 PM, revealed RN X got all supplies ready outside Resident #4's room. He put on gown and gloves without performing hand hygiene. He entered Resident #4's room and explained the procedure. He was observed placing the dressing supplies on the tv stand and the area was not disinfected. He cleansed Resident #4's, pressure ulcer on the sacrum with normal saline soaked gauzes. He was observed placing the dirty gauze on the clean bedsheet. He pat dried the wound. He then applied collagen, calcium alginate, and dry dressing dated 06/18/25 without changing the gloves and performing hand hygiene. He then picked the soiled gauze and put in a cup, help CNA KK pull and position Resident #4. They both removed the gown and gloves, and they left the room without washing hands. Interview with RN X on 06/18/25 at 01:15 PM, revealed he was supposed to perform hand hygiene before contact and during wound care, before applying a clean dressing and after removal of the gown and gloves. He stated he forgot to disinfect the table where he placed the wound care supplies. He stated he also forgot to have a biohazard paper to place the soiled gauze that he had used to cleanse the wound. He stated failure to perform hand hygiene and change of gloves would cause cross contamination and spread of infection. He stated he had done training on infection control and handwashing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/18/25 at 1:15 PM, CNA KK revealed he forgot to perform hand hygiene during perineal care. CNA KK stated he was expected to wash hands before contact, between the care if gloves was soiled and after care, but he forgot. CNA KK stated he was supposed to cleanse the abdominal walls and the peri area before he turned Resident #4 and changed the soiled brief, pad, and linen. He stated he thought when he left the room to call RN X, CNA I cleansed the resident. He said he was supposed to complete hand hygiene and change gloves during incontinent care to prevent cross contamination. He stated failure to washing hands before and between care and after removing gloves could lead to cross contamination. Failure to perform peri care on Resident #2 could lead to infection. He stated he has done training on handwashing. Interview on 06/18/25 at 1:49 PM, CNA I revealed he forgot to perform hand hygiene during perineal care. CNA I said she was aware she was supposed to wash hands before contact, between the care if gloves was removed and after care, but she forgot. CNA I stated CNA KK was supposed to cleanse the abdominal walls and the peri area before he turned Resident #4 and changed the soiled brief, pad, and linen but she thought he would later after making the bed. She stated failure to wash hands before and between care and after removing gloves could lead to cross contamination. Failure to perform peri care on Resident #2 could lead to infection. Interview on 06/18/25 at 06:05 PM, the ADON revealed her expectation during incontinent care was staff to complete hand hygiene before contact with residents, during care, and after care and also to perform peri care before applying a clean brief. The ADON stated CNA I, CNA JJ and CNA KK was supposed to complete hand hygiene and change gloves while performing incontinent care on Resident #3 and #4 to prevent cross contamination and infection. She stated RN X, was expected to complete hand hygiene during wound care to prevent cross contamination. The ADON stated the nursing staff had been offered the in-service on hand hygiene/infection control. Interview on 06/19/25 at 02:21 PM, the DON revealed her expectation was RN X was supposed to change gloves from dirty to clean and wash hands. She stated she expected RN X to disinfect the area before putting supplies together and have a place to discard the soiled gauze. She stated failure to change gloves and perform hand hygiene could risk infection and wound getting worse. She stated she had done training with staffs on infection control hand washing and wound care. The DON said her expectation during incontinent care was staff to complete hand hygiene before and after care. The DON also stated in between care CNA I, CNA JJ and CNA KK was supposed to complete hand hygiene and change gloves because their hands was considered dirty after cleaning the resident. The DON stated CNA KK was to complete peri care before applying a clean brief on Resident #4. She stated staff was expected to perform hand hygiene to prevent the spread on infection. The DON stated the nursing staff had been offered the in-service on hand hygiene/infection. Record review of the facility training records was requested on 06/19/25 and none was provided. Record review of the facility Hand Hygiene for Staff and Residents policy, dated July 2024, reflected, .The purpose of this procedure is to reduce the spread of infection with proper hand hygiene ' 1.Hand hygiene is done: Before (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A.resident contact After: A.contact with soiled or contaminated articles, such as articles that are contaminated with body fluids. B. Resident contact. D. Toileting or assisting others with toileting, or after personal grooming. Record review of the facility's Treatment of Wounds: Dressing Changes-Performing (General Information) policy, dated July 2018, reflected: .10. Perform Hand Hygiene .