STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676186	A. Building B. Wing	05/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Castro County Nursing & Rehabilitation	1621 Butler Dimmitt, TX 79027

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure the reasonable accommodation of resident needs and preferences for 3 of 15 residents (Resident #17, Resident #19, and Resident #51) reviewed for call light placement. The facility failed to ensure that Resident #17, Resident #19 and Resident #51 had access to their call lights. This failure could place residents at risk of not receiving the necessary assistance they need to maintain their highest level of independence. Findings included: Review of Resident #19's clinical records dated 03/13/2025 revealed Resident #19 was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses of Dementia in other Diseases Classified Elsewhere, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety(dementia that is a result of a known physical condition), Chronic Viral Hepatitis C (long-term liver infection caused by the Hepatitis C Virus), Wernicke's Encephalopathy (a neurological disorder caused by a deficiency of vitamin B1, often due to chronic alcoholism), Rhabdomyolysis (a serious condition that occurs when muscle tissue breaks down, releasing harmful substances into the bloodstream), and Adult Failure to Thrive (a condition characterized by a decline in overall health and well-being, marked by weight loss, reduced appetite, and decreased physical activity). Review of Resident #19's quarterly MDS dated [DATE] revealed he had a BIMS score of 12 indicating he was moderately cognitively impaired, and a functional status of two-person physical assist for Bed Mobility, Transfers, and Toilet Use. He was not part of a urinary or bowel toileting program. Review of Resident #19's care plan dated 03/13/2025 revealed a Focus of Fall Risk related to gait and balance problems, weakness, and use of psychotropic drugs with a Goal of the Resident will remain free of complications related to falls through the review date of 06/11/2025, and Interventions of Anticipate and meet my needs and Ensure the resident's call light is within reach and encourage the resident to use it for assistance through the review date of 06/11/2025 An observation of Resident #19 on 05/12/2025 at 10:19AM revealed he was lying on his bed with his call light cord hanging in the middle of the south wall of his room, approximately 6 feet from his reach. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Resident #19 on 05/12/2025 at 10:24AM revealed he could not get out of bed on his own and could not transfer himself or use the bathroom without assistance. Resident #19 stated he had broken his left elbow sometime earlier in his life and his left arm would not fully extend. He stated if the call light was not clipped to his blanket, he would have to stand up to take hold of the cord. Resident #19 asked this investigator to hand him the call light cord because he needed to use the bathroom and was about to pee his pants. Resident #19 stated the call light cord had been out of his reach for at least 2 days and he would call to staff as they passed by his room if he needed help. He stated the staff who helped him had not placed the call light within his reach after providing assistance. Review of Resident #51's clinical records dated 05/08/2025 revealed Resident #51 was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of Type 2 Diabetes without Complications (a chronic condition that happens when you have persistently high blood sugar levels. Insulin resistance is the main cause), Shortness of Breath, Acute and Chronic Combined Congestive Heart Failure (a condition where a patient has a pre-existing chronic heart failure and experiences an acute exacerbation), Repeated Falls, and Hypothyroidism, Unspecified (a condition where the thyroid gland does not produce enough thyroid hormone, but the specific cause if unknown). Review of Resident #51's quarterly MDS dated [DATE] revealed she had a BIMS score of 13 indicating she was cognitively intact, and a functional status of one-person assist for Bed Mobility, Transfers, and Toilet Use. She was not part of a urinary or bowel toileting program. Review of Resident #51's care plan dated 05/08/2025 revealed a Focus of High Fall Risk with a Goal of Not sustaining a fall with major injury through the review date of 08/06/2025 and Interventions of Anticipate and meet my needs and Ensure the resident's call light is within reach and encourage the resident to use it for assistance through the review date of 08/06/2025. An observation of Resident #51 on 05/12/2025 at 10:53AM revealed her lying on her bed with her call light cord hanging behind her nightstand which had a mini refrigerator on its top that kept the cord out of her immediate reach. An interview with Resident #51 on 05/12/2025 at 10:57AM revealed she was not getting out of bed on her own currently, due to a large diabetic ulcer on her left calf which caused pain when she stood up. She stated the call light had been hanging in the same place for a few days. Resident #51 stated when staff came to round on her, they did not clip the call light cord to her blanket or pillow, even while she slept. Resident #51 stated she called to staff as they passed by her room if she needed assistance. Review of Resident #17's clinical records on 04/24/2025 revealed Resident #17 was a [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety (thought confusion and disorganization without behavioral disturbances), other Bacterial Infections of Unspecified Site (when a bacterial infection is present, but the specific type or location if unknown), Urinary Tract Infection, Site Not Specified (a UTI is present, but the exact location within the urinary tract is unknown), Difficulty in Walking, Not Elsewhere Classified and Overactive Bladder (a condition characterized by frequent, sudden and uncontrollable urges to urinate, often accompanied by urinary incontinence). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #17's quarterly MDS dated [DATE] revealed she had a BIMS score of 15, indicating she was cognitively intact, and a functional status of two-person physical assist for Bed Mobility, Transfers, and Toilet Use. She was not part of a urinary or bowel toileting program. Review of Resident #17's care plan dated 04/24/2025 revealed a Focus of High Fall Risk with a Goal of the Resident will not sustain a fall with major injury through the next review date of 07/14/2025, and Interventions of Anticipate and meet my needs and Ensure the resident's call light is within reach and encourage the resident to use it for assistance through the review date of 07/14/2025. An observation of Resident #17 on 05/12/2025 at 11:41AM revealed her lying in her bed with her call light cord hanging in the middle of the south wall of her room, approximately 6 feet from her reach. An interview with Resident #17 on 05/12/2025 at 11:44AM revealed she could not get out of bed on her own and could not transfer herself to her wheelchair or use the bathroom without assistance. Resident #17 stated was admitted to the facility with a UTI and a pressure ulcer to her coccyx and did not want to have either again, due to wearing a brief for too long. Resident #17 stated the CNAs usually clipped the call light cords to her blanket or pillow so she could easily reach it. Resident #17 was unable to say how long the call light cord had been out of reach. An interview with CNA W on 05/12/2025 at 2:01PM revealed she checked resident's call light placement every 15-30 minutes. She stated she clipped the call light cord to either the resident's blanket or pillow if they were in bed. An interview with CNA C on 05/12/2025 at 2:04PM revealed she checked resident's call light placement every 2-hours when she performed rounds. She stated she clipped the call light cord to either the resident's blanket or pillow if they were in bed. A second observation of Resident #17 on 05/12/2025 at 2:32PM revealed her call light cord continued to be out of her reach. A second observation of Resident #19 on 05/13/2025 at 11:32AM revealed his call light cord was hanging in the middle of the south wall of his room, approximately 6 feet from his bed. A third observation of Resident #17 on 05/13/2025 at 11:35AM revealed her call light cord was hanging in the middle of the south wall of her room, approximately 6 feet from her bed. A second observation of Resident #51 on 05/13/2025 at 11:41AM revealed her call light cord was hanging behind her bedside table which had a mini refrigerator on its top that kept the cord out of her immediate reach. An interview with the ADON on 05/13/2025 at 11:45AM revealed it was everyone's responsibility to ensure resident's call lights were within their reach and working. The ADON stated call light cords were to be clipped to the resident's pillow or blanket if they were in bed or sleeping in a recliner and within reach if they were watching TV from a chair or wheelchair in their room. Review of facility policy for Call Lights: Accessibility and Timely Response dated August 2024 revealed the following: (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Explanation and Compliance Guidelines: o All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light. o All residents will be educated on how to call for help by using the resident call system. o Each resident will be evaluated for unique needs and preferences to determine any special accommodations that may be needed in order for the resident to utilize the call system. o Special accommodations will be addressed on the resident's person-centered plan of care and provided accordingly. (Examples include touch pads, larger buttons, bright colors, etc.) o Staff will ensure the call light is within reach of resident and secured, as needed. o The call light system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure all residents had the right to formulate an advanced directive for 1 (Resident #7) of 15 residents reviewed for advanced directives. Resident #7 had a DNR in his record that was missing the date when Resident #7 initiated the form. The facility's failure could place residents a risk for not receiving healthcare as per their or their legal representatives wishes. Findings included: Record review of Resident #7's face sheet printed [DATE] revealed he was a [AGE] year-old male resident admitted to the facility originally on [DATE] and readmitted on [DATE] with diagnoses to include malignant neoplasm (a fast-growing cancer that spreads to other areas of the body) of unspecified part of the bronchus (any of the major air passages of the lungs which diverge from the windpipe) or lung and malignant neoplasm of the lobe (upper left bronchus or lung). Section for Advanced Directive revealed Resident #7 was listed as a DNR. Record review of Resident #7's last MDS was an annual assessment completed [DATE] listing him with a BIMS score of 15 indicating he was cognitively intact, and he had a functionality of being independent with most of his activities of daily living. Record review of Record review of Resident #7's care plan with admission date of [DATE] revealed the following: Focus: I have an order for Do Not Resuscitate. Goal: Residents decision for DNR will be honored through the next review date. -Target date [DATE]. Interventions: -in the absence of b/p, pulse, respiration, CPR will not be initiated. Record review of the clinical record for Resident #7 revealed an Order Summary with active orders as of [DATE] with the following order: -Advanced Directive: DNR Verbal Active [DATE]. Record review of the clinical record for Resident #7 revealed a DNR dated [DATE] (signed by the physician) with the following: (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Section A.-Declaration of the adult person. - Resident #7's signature and printed signature was present but there is no date of when Resident #7 signed the DNR form. During an interview on [DATE] at 03:19 PM LVN D (the nurse responsible for Resident #7 this shift) reported that the facility's current code status protocol was if a CNA reported that a resident was in trouble meaning not breathing or did not have a heart rate LVN D would immediately get the AED, have the CNA call 911, and then get help from other staff to start CPR. If the resident was a DNR then LVN D would not perform CPR but she would notify 911, then the Administrator, DON, ADON, and the Dr. LVN D then reviewed Resident #7's chart and reported that Resident #7 was a DNR which meant that LVN D would not start the CPR process. LVN D was asked to review Resident 7's DNR in his medical record in which LVN D noted that Resident #7 had not dated his signature and stated, that is not good. LVN D reported that Resident #7's DNR was invalid and that if something were to happen now, I would have to go against his wishes. LVN D reported that not having a valid DNR could cause a resident harm by not following their wishes. During an interview on [DATE] at 10:36 AM the DON reported that Resident #7 was missing the date of when Resident #7 signed his DNR form. The DON reported that all staff to include herself were responsible for checking the DNR's for accuracy and that they were supposed to be checked at each care plan meeting but this one was just missed. The DON reported that if the DNR process was not followed and the form was not correct then Resident #7 could have coded and the DNR would not have been valid, and they could not have honored his wishes. The DON reported that this would definitely affect the resident negatively. Record review of the facility provided policy titled Resident Rights Regarding Treatment and Advanced Directives date implemented 9-1-2023, revealed the following: Policy: It is the policy of this facility to support and facilitate a resident right to request, refuse, and/or discontinue medical or surgical treatment and to formulate an advanced directive. Definitions: Advance Directive-is a written instruction .recognized under State Law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. Record review of the OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER-TEXAS DEPARTMENT OF STATE HEALTH SERVICES, undated revealed the following: -The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professional

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to provide a comfortable environment for 3 (Room A2, A10, and F5) of 41 resident rooms reviewed for environment. -Room A2 had a large hole in the wall between the resident's bedside dressers. -Room A10 had two large holes and one small hole in the wall between the bathroom and closet doors. -Room F5 had a large area of peeling paint at the head of a resident's bed. These failures could place residents at risk for diminished quality of life due to the lack of a well-kept environment. Findings include: During an observation on 05/12/25 at 10:31 AM noted in room A10 (occupied by two male residents from the memory care unit that were not interviewable) were two large holes in the wall between the closet and bathroom door on the wall opposite the resident beds. The first hole was approximately 5 inches by 2 ½ inches and the second hole was approximately 2 ½ by 2 ½ inches. Also noted in the upper area of the wall was a small hole for the TV cable. During an observation on 05/12/25 at 10:46 AM noted in room A2 (occupied by one male resident from the memory care unit that was not interviewable) was a large hole in the wall between the resident bedside dresses at the head of each resident's bed that was approximately 2 ½ inches by 2 ½ inches. During an observation on 5/12/25 2:05 PM of room F5 an approximate 2-foot by 3-foot area of peeling paint was noted at the head of the bed for the resident located by the exterior wall. During an interview on 05/14/25 08:18 AM the MS viewed room A10 and noted the two large holes in the wall between the closet and bathroom door and the small whole in the upper wall between the closet and bathroom door. The MS reported that he was waiting on the patches to come in. That when the patches come in, they will have a plastic cover over the holes to prevent the residents from causing the holes again. The MS reported that a resident especially a resident from the memory care unit could get their fingers in the holes which could result in an issue or injury. The MS reported that he caught the damage to the wall on his rounds that he made on Monday. The MS reported that he makes rounds everyday as part of what they call Angel Rounds. The MS then reported that he had actually already received the patches for the wall and could get the walls fixed immediately. The MS viewed the wall in room F5 and noted that a large area had paint that had peeled. The MS reported that when staff raise and lower the bed for care they will often scrape the wall and the result will be damage to the paint and wall. The MS reported that he did not know how long this had been this way and he had missed this on his rounds. The MS reported that they would get the wall scraped and painted. The MS reported that he did not feel this was an issue for the residents because he did not feel they could see it. The resident occupying the bed in room F5 at the time of this observation was awake but did not respond to questions form the MS or this surveyor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 05/14/25 at 08:38 AM this surveyor with the MS present observed that the MS had fixed the large holes in room A10 and A2 with the patches. During an interview on 05/14/25 at 09:01 AM CNA B reported that she had worked in the memory care unit/A Hall for approximately 2 months. CNA B observed the hole (that had already been patched by the MS) in Room A2 and stated that that hole had been open and present for at least 2 weeks and the holes in room A10 have been open and present for at least 2 weeks too. CNA B reported that she did not feel any of the residents would mess with the holes and therefore would not hurt themselves due to the residents being unable to remember much and would not have any issues with the holes. CNA B reported that she did not report the holes because the MS was always in and out of the rooms. During an interview on 05/14/25 at 10:39 AM the DON reported that she expects the facility to be clean, in good condition, and well maintained. That there should be no holes in the walls or peeling paint in resident rooms. The DON reported that if there are holes in the walls rodents or bugs could get in or residents could put their fingers in the holes or something like that. The DON reported that the peeling paint should have been repaired. Record review of the facility provided policy titled, Safe and Homelike Environment date implemented 09/01/23, revealed the following: Policy: In accordance with residents' rights, the facility will provide a safe, clean, comfortable, and homelike environment . Record review of the facility provided policy titled, Safe and Homelike Environment date implemented 09/01/23, revealed the following: Policy: It is the policy of this facility to be designed, constructed, equipped, and maintained to provide a safe, functional, sanitary, and comfortable environment for residents .

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	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** I. Investigation Visit: Based on interview and record review, the facility failed to ensure that residents were free from physical or sexual abuse for 19 (Resident #53, #56, #58, #47, #46, #49, #44, #4, #73, #32, #15, #72, #70, #71, #50, #1, #3, #41, and #14) of 19 residents reviewed for abuse/neglect. 1. The facility failed to protect Resident #41 from abuse when Resident #58 groped her on 03/27/2025. 2. The facility failed to protect an unidentified resident from abuse by Resident #58 when Resident #58 slapped the unidentified resident on 03/29/2025. 3. The facility failed to protect Resident #44 from physical abuse when Resident #44 was pushed to the floor by Resident #46 on 10/27/2024. Resident #44 fractured a hip as a result of the fall. 4. The facility failed to protect Resident #71 from physical abuse when Resident #53 smashed Resident #71's fingers with a metal cup on 01/23/2025. 5. The facility failed to protect Resident #3 from physical abuse when Resident #53 took his shoe and slapped this Resident #3 with it on 03/12/2025. 6. The facility failed to protect residents from physical abuse when Resident #56 hit Resident #32 and then Resident #32 hit Resident #56 back on 02/26/2025. 7. The facility failed to protect Resident #32 from physical abuse when Resident #47 punched Resident #32 on 12/16/2024. 8. The facility failed to protect Resident #32 from physical abuse when Resident #47 hit Resident #32 on 12/29/2024. 9. The facility failed to protect an unidentified resident from physical abuse when Resident #47 tried to stab UR with a fork on 02/12/2025. 10. The facility failed to protect Resident #1 from physical abuse when Resident #47 elbowed Resident #1 in the face on 03/05/2025. 11. The facility failed to protect Resident #49 from physical abuse when Resident #4 pushed Resident #49 to the floor on 02/20/2025. 12. The facility failed to protect Resident #44 from physical abuse when Resident #32 grabbed and spit on Resident #44 on 12/18/2024. 13. The facility failed to protect Resident #71 from physical abuse when Resident #72 kicked Resident #71 resulting in Resident #71 falling to the floor on 11/13/2024. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	14. The facility failed to protect Resident #50 from verbal abuse when Resident #15 screamed and cursed at Resident #50 on 01/15/2025. 15. The facility failed to protect Resident #41 from physical abuse when Resident #70 punched Resident #41 in the arm on 03/22/2025. 16. The facility failed to protect Resident #14 from verbal and physical abuse when Resident #70 yelled and tried to push Resident #14 off of her own bed. 17. The facility failed to protect multiple residents from Resident #72 when Resident #72 attempted multiple times to kiss other male residents. An Immediate Jeopardy situation was identified on 05/02/2025 at 7:55p.m. While the IJ was removed on 05/05/2025 at 11:25a.m., the facility remained out of compliance due to the facility's need to evaluate the effectiveness of their corrective systems. This deficient practice could place residents at risk of in a delay in care, continuous abuse or neglect, physical or psychosocial harm, including death. Findings include: During a record review of the facility's incident log, dated 04/16/2025, it revealed the following: 5395 Resident #1 had two incidents: 1. 01/23/2025 2. 03/12/2025 Resident #56 had 1 incident: 1. 02/26/2025 Resident #58 had 1 incident: 1. 03/27/2025 Resident #4 and Resident #49 both had 1 incident: (involving each other) (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	1. 02/20/2025 Resident #53 Record review of Resident #53's face sheet, dated 04/17/2025, revealed Resident #53 was a [AGE] year-old male resident who was admitted to the facility on [DATE] with the diagnoses of unspecified dementia (a decline in mental ability, specifically in memory, thinking, and reasoning, that significantly impacts daily life), severe, with other behavioral disturbance (a pattern of actions or reactions that deviates significantly from what is considered typical or appropriate behavior, often causing distress or difficulty for the individual or those around them), anxiety disorder (a mental health condition characterized by persistent and excessive worry, fear, and dread that significantly interfere with daily life), bipolar disorder, current episode mixed, severe with psychotic feature (occurs when someone with bipolar disorder experiences symptoms of psychosis, such as hallucinations or delusions, during a manic or depressive episode). Record review of Resident #53's MDS assessment, dated 01/21/2025, revealed that Resident #53 had a BIMS score of 06 which indicates that Resident #53 was severely cognitively impaired. Resident #53's required moderate assistance with bathing; all care areas are supervision or set-up assistance needed only. Record review of Resident #53's care plan, dated 12/31/2024 revealed the following: Focus o Behaviors: [Resident #53] has potential to demonstrate physical and verbal behaviors r/t Dementia. Has shown anger towards certain staff and will become hostile verbally and physically. Date Initiated: 12/31/2024 Revision on: 12/31/2024 Goal The resident will not harm self or others through the review date (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Date Initiated: 12/31/2024 Revision on: 12/31/2024 Target Date: 01/06/2025 Interventions/Tasks Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. Date Initiated: 12/31/2024 Assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc. Date Initiated: 12/31/2024 Give the resident as many choices as possible about care and activities Date Initiated: 12/31/2024 Revision on: 12/31/2024 When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Record review of Resident #53's progress notes revealed Resident #53 had multiple incidents with other residents. The progress notes revealed the following: 01/23/2025 at 04:54am CNA (CNA M) called this nurse (DON)to the unit and resident (Resident #53) smashed another resident's (Resident # 20) finger with metal cup. Resident (Resident #53) stated, He was touching and trying to grab my cup. Removed resident (Resident #71) from sight. PRN Vistaril given as ordered. Resident (Resident #53) calm after and CNA able to Resident room. DON notified. 01/23/2025 at 1:37pm Resident #53 was still being combative with staff and 'was attempting' to hit of another resident. Phone call was placed to [Psychiatric MD], Pending call back. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	01/30/2025 at 2:11pm Resident is readmit, returning from [psychiatric hospital] in [local city name]. 03/12/2025 at 7:30pm Resident (Resident #53) got his shoe and slapped another resident (Resident #3) when another resident was walking by and bumped into the bedside table that was next to Resident #53. Called on-call [Psychiatric services] and got an order to send resident to inpatient psychiatric hospital. 03/13/2025 at 12:36am return call from [staff] at [psychiatric hospital #1], resident was denied due to acuity. 03/13/2025 at 12:36am referral sent to [psychiatric hospital #2], pending call back. 03/17/2025 at 8:15am Depakote oral tablet delayed release 250mg-give 1 tablet by mouth two times a day related to bipolar disorder, current episode mixed, severe, with psychotic features (f31.64) from [psychiatric hospital], [psychiatric MD] notified med on order from pharmacy awaiting arrival. Resident #56 Record review of Resident #56's face sheet, dated 04/17/2025, revealed an [AGE] year-old male resident who was admitted to the facility on [DATE] with the diagnoses of unspecified dementia(a decline in mental ability, specifically in memory, thinking, and reasoning, that significantly impacts daily life), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a mental health condition characterized by persistent and excessive worry, fear, and dread that significantly interfere with daily life), schizophrenia (a chronic mental illness characterized by disruptions in thinking, perception, emotional expression, and behavior), unspecified, major depressive disorder (a mood disorder characterized by persistent sadness, loss of interest in activities, and other symptoms that significantly affect daily functioning), single episode, unspecified. Record Review of Resident #56's MDS assessment, dated 02/06/2025, revealed that Resident #56 had a BIMS score of 09, which indicates that Resident #56 had moderately impaired cognition. Functionality for ADLs was not determined at time of this assessment. Record review of Resident #56's care plan, dated 02/10/2025, revealed the following: Focus I have a mood problem Schizophrenia/Schizoaffective Medication: Risperidone Date Initiated: 01/22/2025 Revision on: 01/24/2025 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Goal I will have improved mood state such as: happier, calmer appearance, no s/sx of depression, anxiety or sadness through the review date. Date Initiated: 01/24/2025 Target Date: 02/12/2025 Interventions/Tasks Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 01/22/2025 Assist me with a program of activities that is meaningful and of interest. Encourage and provide opportunities for exercise and physical activity. Date Initiated: 01/22/2025 Behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.) Date Initiated: 01/22/2025 Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. Date Initiated: 01/22/2025 Monitor/record mood to determine if problems seem to be related to external (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	causes, i.e. medications, treatments, concern over diagnosis. Date Initiated: 01/22/2025 Monitor/record/report to MD prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/ eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills Date Initiated: 01/22/2025 Monitor/record/report to MD prn mood patterns s/sx of depression, anxiety, sad mood as per facility behavior monitoring protocols Date Initiated: 01/22/2025 Monitor/record/report to MD prn risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons Date Initiated: 01/22/2025 Observe for signs and symptoms of mania or hypomania racing thoughts or euphoria; increased irritability; frequent mood changes; pressured speech; flight of ideas; marked change in need for sleep; agitation or hyperactivity Date Initiated: 01/22/2025 Record review of Resident #56's progress notes revealed the following: 02/26/2025 at 6:51pm resident (Resident #56) in the unit got in a verbal altercation with another resident (Resident #32) and hit another resident (Resident #32), the other resident (Resident #32) reacted and hit him back, he has an open area to the left eyebrow. Notified [psychiatric NP], new order sent to [psychiatric hospital #1 and #2]. 02/26/2025 at 9:40pm resident exited facility enroute to [psychiatric hospital #2] via transport from [psychiatric hospital #2] at this time d/t initiating physical contact with another resident. 03/07/2025 3:20pm resident returned back to facility via facility transportation at 2:05pm, resident assisted via wheelchair to the unit in room [room number] discharge orders received and entered into EMAR. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Resident #58 Record review of Resident #58's face sheet, dated 04/16/2025, revealed that Resident #58 was a [AGE] year-old male resident admitted to the facility on [DATE] with the diagnoses of other psychoactive substance abuse (a disease that affects a person's brain and behavior and leads to an inability to control the use of a legal or illegal drug or medicine), uncomplicated, depression (a subtype of major depressive disorder (MDD) characterized by a milder form of the illness, typically lacking severe symptoms and functional impairment), anxiety disorder(a mental health condition characterized by persistent and excessive worry, fear, and dread that significantly interfere with daily life), unspecified, epilepsy(a diagnosis where a person is known to have epilepsy but the specific type (focal, generalized, etc.) is not known or can't be determined), unspecified, not intractable without status epilepticus(describes a type of epilepsy that is not considered difficult to control (intractable) and does not involve a continuous seizure (status epilepticus)), chronic diastolic (congestive) heart failure (occurs when the heart muscle becomes stiff, hindering its ability to relax and fill with blood during diastole). Record review of Resident #58's MDS assessment, dated 04/07/2025, revealed that Resident #58 had a BIMS score of 00, which indicated that Resident #58 had severely impaired cognition and was functionally independent. Record review of Resident #58's care plan, with no completion date, revealed no mention of inappropriate/aggressive behaviors towards other residents. Record review of Resident #58's progress notes revealed the following: 03/27/2025 at 9:30am this writer (LVN AA) was walking down F hall, this writer (LVN AA) noted resident (Resident #58) leaving wheelchair to stand up and walk; he went walking halfway down the hall and noted there was a female resident (Resident #41) there; he stood up against the side rail and was groping the female resident(Resident #41), he (Resident #58) was touching her (Resident #41) breast and her buttocks, squeezing them; this writer (LVN AA) could not get to female resident (Resident #41) fast enough to prevent this from happening; by the time this writer (LVN AA) reached resident (Resident #58) to sit him in his wheelchair and redirect him (Resident #58), he had already touched her (Resident #41) multiple times; this writer (LVN AA) informed the nurse in the hallway and notified DON; resident was assisted back to the memory care unit. 03/29/2025 at 4:53pm LVN A-Notified by CNA staff that resident was caught in another residents (UR) room. Resident was slapping the other resident (UR) back and forth with both hands. CNA staff assisted the resident out of the residents (UR) room. The resident (Resident #58) glared very manic at staff. Resident (Resident #58) caught holding a gait belt. Staff was able to retrieve gait belt from resident. Notified [DON name] DON and [FNP name] FNP. Obtained orders to start resident on risperidone 0.5 MG BID. Resident #47 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Record review of Resident #47's face sheet, dated 04/17/2025, revealed that Resident #47 was a [AGE] year-old male resident who was admitted to the facility on [DATE] with the diagnoses of unspecified dementia (a decline in mental ability, specifically in memory, thinking, and reasoning, that significantly impacts daily life), unspecified severity, without behavioral disturbance, psychotic disturbance mood disturbance, anxiety(a mental health condition characterized by persistent and excessive worry, fear, and dread that significantly interfere with daily life), bipolar disorder (a prolonged period of abnormally elevated, expansive, or irritable mood accompanied by increased activity or energy), current episode manic without psychotic features, moderate, mild cognitive impairment of uncertain or unknown etiology (a condition where individuals experience greater memory or thinking problems than expected for their age, but these issues are not severe enough to interfere with daily activities), restlessness and agitation, cognitive communication deficit (occurs when communication problems are caused by difficulties with cognitive processes like attention, memory, or executive function, rather than with language or speech production). Record review of Resident #47's MDS assessment, dated 03/12/2025, revealed Resident #47 had a BIMS score of 09, which indicated Resident #47 had moderately impaired cognition and a functionality of total dependency and maximal assistance was needed for most care areas with exception to partial assistance to oral hygiene and set-up assistance to eat. Record review of Resident #47's care plan, dated 02/10/2025, revealed no mention of inappropriate/aggressive behaviors towards other residents. Record review of Resident #47's progress notes revealed the following: 12/16/2024 at 10:49am (LVN A) Notified by staff (CNA M) that resident (Resident #47) went up to another resident (Resident #32) and punched him on the left side of face on cheek. Resident (Resident #47) stated he punched him because the other resident (Resident #32) told him to move. When told to move, [Resident #47] stated to the other resident (Resident #32) that he was watching tv and went up aggressively to him (Resident #32) and punched him (Resident #32) in the face. Residents were separated by two CNAs [CNA M] and [CNA I]. When trying to separate the residents, [Resident #47] scratched one of the CNAs on her right arm. Began one on one with [Resident #47] until further instruction. Notified [Psych MD] of residents behaviors. Obtained orders to send resident to [psychiatric hospital #2]. Notified by [psych hospital #2] that they do have beds available. Notified [DON name] DON and [previous ADM name] administrator. Notified guardian [guardian name]. 12/16/2024 at 3:41pm Notified by [staff] from [psych hospital #2] that resident is not accepted into [psych hospital #2] until EDO received from judge from [county name] county. Resident is not allowed to sign form himself due to have legal guardian. [Psych hospital #2] stated that we must go through [local hospital name] and then through the judge. [Local hospital] doctor [MD name] stated that the resident did not qualify to got to [psych hospital #2] and the judge was not going to sign due to going based of [MD name] decision. Notified [DON name] DON and [psych MD]. Obtained orders to try [psych hospital #1] in [local city name]. Notified that resident does not qualify due to the fact they don't accept Medicaid and he does not have Medicare yet. Obtained orders from [psych MD] to increased Depakote to 5 tabs of 125mg and obtain CBC and VA level in one week from today! 12/29/2024 at 10:22pm (LVN II) writer was called into locked unity by CNA. CNA reported that Resident (Resident #47) had struck male peer (Resident #32) in the face because peer (Resident #32) had entered his (Resident #47) room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	12/29/2024 at 10:49 pm (LVN GG) Writer talked to [staff] with [psych MD]'s office and received order to put resident on 1-on-1 monitoring until Resident is able to be sent out to behavioral hosp for eval. 02/12/2025 at 3:25pm (LVN GG) CNA K reported that resident hit residents (UR) with his elbow three times to patient. CNA K broke it up. Then patient went after another patient [Resident name] (Resident #1) with a knife and CNA C intercepted. Patient did not attack no further and has been monitored wctm. 02/12/2025 at 3:46pm [Guardian Name] spoke with and reported incident and she is away of his new ordered and noted wctm. 02/12/2025 at 4:08pm patient went and attack CNA and noted. Patient s attacking patients. Police was called and investigated the situation. Doctor ordered to send to [psych hospital #2] psychiatric facility. Patient guardian was notified, and management was notified a well as doctor wctm. Resident #46 Record review of Resident #46's face sheet, dated, 04/17/2025 revealed a [AGE] year-old male resident who was admitted to the facility on [DATE] with the diagnoses of major depressive disorder (a mood disorder characterized by persistent sadness, loss of interest in activities, and other symptoms that significantly affect daily functioning), recurrent severe without psychotic feature, generalized anxiety disorder (a mental health condition characterized by persistent and excessive worry, fear, and dread that significantly interfere with daily life), disorganized schizophrenia (a subtype of schizophrenia characterized by disorganized speech, behavior, and flat or inappropriate affect), cognitive communication deficit (occurs when communication problems are caused by difficulties with cognitive processes like attention, memory, or executive function, rather than with language or speech production). Record review of Resident #46's MDS assessment, dated 04/07/2025, revealed Resident #46 had a BIMS score of 10, which indicated that the Resident #46 was moderately impaired cognition, and required touch assistance in all care areas. Record review of Resident #46's care plan, dated 02/10/2025, revealed the following: Focus The resident has potential to Demonstrate physical behaviors mental Illness (schizophrenia) Date Initiated: 09/01/2024 Revision on: 10/08/2024 Goal (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	The resident will not harm self or Others through the review date Date Initiated: 09/01/2024 Revision on: 10/08/2024 Target Date: 02/09/2025 Interventions/Tasks Analyze of key times, places, circumstances, triggers, and what de-escalates Behavior and document Date Initiated: 09/01/2024 Give the resident as many choices as possible about care activities Date Initiated: 09/01/2024 Revision on: 10/08/2024 Modify environment: (Adjust room temperature to comfortable level, reduce noise, Dim lights, place familiar objects in room, keep door closed etc.) Date Initiated: 09/01/2024 Revision on: 10/08/2024 When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress' engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later Date Initiated: 09/01/2024 Revision on: 10/08/2024 Record review of Resident #46's progress notes revealed the following: 10/27/2024 at 10:26pm This nurse (LVN EE) witnessed resident (Resident #46) to resident (Resident #44) push and this resident going into residents' room and other resident said, Get out of my room' and pushed resident (Resident #44) down to the floor. Resident (Resident #46) stated, He doesn't belong in my room and that's why I pushed him out. Resident (Resident #46) sat back down on the bed and no other aggression noted. DON, MD, and [family member] notified. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	10/28/20245 at 1:01am New orders given from [psych MD] to send resident to impatient psych. [psych hospital #2] in [city name] accepted and will pick up at 9-10am on today. 11/11/2024 at 1:09pm resident returned via facility van from [psych hospital] . Resident #49 Record review of Resident #49's face sheet revealed that Resident #49 was a [AGE] year-old female who was admitted to the facility on [DATE]-24. Resident #49's diagnoses included, but were not limited to, unspecified dementia, moderate, with mood disturbance; muscle weakness; difficulty in walking; psychotic disturbance; mood disturbance and anxiety; depression; epilepsy. Record review of Resident #49's most recent MDS assessment completed on 3/14/25 revealed Resident #49 had a BIMS of 8 (indicating moderately impaired cognition) and a functionality of set-up assistance in all care areas. Record review of Resident #49's care plan notated that Resident #49 exhibited behaviors. Record review of Resident #49's nurses notes revealed that Resident #49 had an altercation with another female resident on 2/20/25. Resident #44 Record review of Resident #44's face sheet revealed that Resident #44 was an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, moderate, with other behavioral disturbance; intermittent explosive disorder; aftercare following joint replacement surgery; major depressive disorder; generalized anxiety disorder; diabetes. Record review of Resident #44's most recent MDS assessment dates 3/2/25 revealed a BIMS of 00 indicating severe cognitive impairment. This MDS assessment indicated that Resident #44 had a functionality of maximal assistance with dressing, personal hygiene, toileting, and putting on/taking off footwear. Touch assistance was needed for oral hygiene and set-up assistance with eating. Record review of Resident #44's care plan indicated it was completed on 4/3/25. Record review of Resident #44's nurse's notes indicated that on October 27, 2024, Resident #44 was pushed by another resident which resulted Resident #44 fracturing his hip and requiring surgery. Resident #4 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Record review of Resident #4's face sheet dated 04/17/2025 revealed that Resident #4 was a [AGE] year-old female resident who was admitted to the facility on [DATE] with the diagnoses of diffuse traumatic brain injury with loss of consciousness of unspecified duration (a traumatic brain injury where the damage is widespread and the person does not lose consciousness), sequela (a condition which is the consequence of a previous disease or injury), other symptoms of signs involving cognitive functions and awareness, major depressive disorder, recurrent severe without psychotic features (a serious condition where a person experiences both major depressive symptoms and psychotic symptoms like delusions or hallucinations, often related to themes of guilt or worthlessness), schizoaffective disorder (a mental illness characterized by a combination of psychotic symptoms, like hallucinations and delusions, and mood disorder symptoms, such as depression or mania), bipolar type (a mental health condition characterized by significant mood swings, fluctuating between periods of intense happiness and high energy (mania or hypomania) and periods of deep sadness and depression). Record review of Resident #4's MDS assessment, dated 03/18/2025, revealed that Resident #4 had a BIMS score of 13 which indicated that Resident #4 did not have any cognitive impairment and required set-up assistance in most care areas with a moderate assist with oral hygiene. Record review of Resident #4's care plan, dated 04/03/2025, revealed the following: Focus Behaviors: Aggression: [Resident #4] has potential to demonstrate physical and verbal behaviors r/t schizoaffective disorder Calling staff names and yelling Date Initiated: 11/20/2020 Revision on: 10/31/2023 Goal The resident will not harm self or others through the review date Date Initiated: 11/20/2020 Revision on: 12/05/2024 Target Date: 04/24/2025 The resident will verbalize (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	understanding of need to control physically aggressive behavior through the review date Date Initiated: 11/20/2020 Revision on: 12/05/2024 Target Date: 04/24/2025 Interventions/Tasks Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. Date Initiated: 11/20/2020 Give the resident as many choices as possible about care and activities Date Initiated: 11/20/2020 Revision on: 11/20/2020 When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later Date Initiated: 11/20/2020 Revision on: 11/20/2020 Record review of Resident #4's progress notes revealed the following: 02/20/2025 at 5:14pm Staff reported that resident [Resident #4's name] and her roommate (Resident #49) were arguing loudly, when staff arrived at the room [Resident #4] had pushed her (Resident #49) to the floor, [Resident #4] stated that her roommate (Resident #49) was yelling at her, and she (Resident #4)did not touch her roommate (Resident #49). Assessment completed Risk assessment, nursing notes and behavior note completed, FNP, DON, and family called moved to another room. Resident #32 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Record review of Resident #32's face sheet dated 005/04/2025 revealed that Resident #32 was a [AGE] year-old male resident who was admitted to the facility on [DATE] with the diagnoses of unspecified dementia, with severe agitation (a severe form of dementia where the specific cause is not identified, and the individual experiences significant agitation), psychotic disorder with delusions due to known physiological condition (a mental illness where the person experiences delusions (false, fixed beliefs) and other psychotic symptoms (like hallucinations, disorganized thinking, and speech) as a direct result of a physical illness or medical condition affecting the brain), major depressive disorder (a mental disorder characterized by persistent sadness, loss of interest in activities, and other symptoms that significantly affect daily functioning), recurrent severe without psychotic features (persistently low mood, loss of interest in activities, changes in appetite or weight, sleep disturbances, fatigue, feelings of worthlessness, difficulty concentrating, and recurrent thoughts of death or suicide), psychotic disorder with hallucinations due to known physiological condition (a mental health condition where hallucinations and/or delusions are directly caused by a known physiological or medical condition, rather than a primary psychiatric illness), anxiety disorder (mental health conditions characterized by excessive fear, anxiety, and worry that is disproportionate to the situation and interferes with daily life), extrapyramidal and movement disorder (Extrapyramidal symptoms are specifically drug-induced movement disorders, often caused by medications like antipsychotics. Movement disorders, on the other hand, are broader neurological conditions that can arise from various causes, including brain damage, genetics, or medication side effects), cerebellar ataxia (a neurological disorder characterized by impaired coordination and balance due to dysfunction of the cerebellum), and anoxic brain damage (brain injury resulting from a complete lack of oxygen supply to the brain). Record review of Resident #32's MDS assessment, dated 04/01/2025, revealed that Resident #32 had a BIMS score of 08 which indicated that Resident #32 had moderate cognitive impairment and required total assistance with putting on/taking off footwear. Maximal assistance was required with showering and toileting hygiene, Moderate assistance was required for dressing upper and lower body, touch assistance was required for oral hygiene, and setup assistance was required for care area of eating. Record review of Resident #32's care plan, dated 04/25/2025, with a revision date of 05/02/2025 revealed the following: Focus Behaviors: Physical & Verbal Aggression: [Resident #32] has potential to demonstrate physical behaviors r/t Poor impulse control. Resident has hx of Schizoaffective disorder, Major Depression with psychotic features, Anxiety and Psychotic disorder w/hallucinations. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Will threaten others, yell, and cuss, hit, kick, spit, grab and punch others. 12/9/24 Hit another resident in the face. 12/18/24

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** I. Investigation Visit Based on interview and record review, the facility failed to implement their policies and procedures that prohibited abuse for 19 (Resident #53, #56, #58, #47, #46, #49, #44, #4, #73, #32, #15, #72, #70, #71, #50, #1, #3, #41 and #14) of 19 residents reviewed for abuse/neglect. 1. The facility failed to protect Resident #41 from abuse when Resident #58 groped her on 03/27/2025. 2. The facility failed to protect an unidentified resident from abuse by Resident #58 when Resident #58 slapped the unidentified resident on 03/29/2025. 3. The facility failed to protect Resident #44 from physical abuse when Resident #44 was pushed to the floor by Resident #46 on 10/27/2024. Resident #44 fractured a hip as a result of the fall. 4. The facility failed to protect Resident #71 from physical abuse when Resident #53 smashed Resident #71's fingers with a metal cup on 01/23/2025. 5. The facility failed to protect Resident #3 from physical abuse when Resident #53 took his shoe and slapped this Resident #3 with it on 03/12/2025. 6. The facility failed to protect residents from physical abuse when Resident #56 hit Resident #32 and then Resident #32 hit Resident #56 back on 02/26/2025. 7. The facility failed to protect Resident #32 from physical abuse when Resident #47 punched Resident #32 on 12/16/2024. 8. The facility failed to protect Resident #32 from physical abuse when Resident #47 hit Resident #32 on 12/29/2024. 9. The facility failed to protect an unidentified resident from physical abuse when Resident #47 tried to stab the unidentified resident with a fork on 02/12/2025. 10. The facility failed to protect Resident #1 from physical abuse when Resident #47 elbowed Resident #1 in the face on 03/05/2025. 11. The facility failed to protect Resident #49 from physical abuse when Resident #4 pushed Resident #49 to the floor on 02/20/2025. 12. The facility failed to protect Resident #44 from physical abuse when Resident #32 grabbed and spit on Resident #44 on 12/18/2024. 13. The facility failed to protect Resident #71 from physical abuse when Resident #72 kicked Resident #71 resulting in Resident #71 falling to the floor on 11/13/2024. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	14. The facility failed to protect Resident #50 from verbal abuse when Resident #15 screamed and cursed at Resident #50 on 01/15/2025. 15. The facility failed to protect Resident #41 from physical abuse when Resident #70 punched Resident #41 in the arm on 03/22/2025. 16. The facility failed to protect Resident #14 from verbal and physical abuse when Resident #70 yelled and tried to push Resident #14 off of her own bed. 17. The facility failed to protect multiple residents from Resident #72 when Resident #72 attempted multiple times to kiss other male residents. An Immediate Jeopardy situation was identified on 05/24/2025 at 10:13am. While the IJ was removed on 05/25/2025 at 12:00pm, the facility remained out of compliance due to the facility's need to evaluate the effectiveness of their corrective systems. This deficient practice could place residents at risk of in a delay in care, continuous abuse, or neglect, physical or psychosocial harm, including death. Findings include: Record review of the facility's undated policy titled Abuse, Neglect and Exploitation revealed: Policy It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. 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. Abuse also included the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, physical abuse and mental abuse including abuse facilitated or enable through the use of technology. Policy Explanation and Compliance Guidelines The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, exploitation of residents and misappropriation of resident property. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	During a record review of the facility's incident log, dated 04/16/2025, it revealed the following: Resident #53 had two incidents: 1. 01/23/2025 2. 03/12/2025 Resident #56 had 1 incident: 1. 02/26/2025 Resident #58 had 1 incident: 1. 03/27/2025 Resident #4 and Resident #49 both had 1 incident: (involving each other) 1. 02/20/2025 Resident #53 Record review of Resident #53's face sheet, dated 04/17/2025, revealed Resident #53 was a [AGE] year-old male resident who was admitted to the facility on [DATE] with the diagnoses of unspecified dementia (a decline in mental ability, specifically in memory, thinking, and reasoning, that significantly impacts daily life), severe, with other behavioral disturbance (a pattern of actions or reactions that deviates significantly from what is considered typical or appropriate behavior, often causing distress or difficulty for the individual or those around them), anxiety disorder (a mental health condition characterized by persistent and excessive worry, fear, and dread that significantly interfere with daily life), bipolar disorder, current episode mixed, severe with psychotic feature (occurs when someone with bipolar disorder experiences symptoms of psychosis, such as hallucinations or delusions, during a manic or depressive episode). Record review of Resident #53's MDS assessment, dated 01/21/2025, revealed that Resident #53 had a BIMS score of 06 which indicates that Resident #53 was severely cognitively impaired. Resident #53's required moderate assistance with bathing; all care areas are supervision or set-up assistance needed only. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Record review of Resident #53's care plan, dated 12/31/2024 revealed the following: Focus Behaviors: [Resident #53] has potential to demonstrate physical and verbal behaviors r/t Dementia. Has shown anger towards certain staff and will become hostile verbally and physically. Date Initiated: 12/31/2024 Revision on: 12/31/2024 Goal The resident will not harm self or others through the review date Date Initiated: 12/31/2024 Revision on: 12/31/2024 Target Date: 01/06/2025 Interventions/Tasks Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. Date Initiated: 12/31/2024 Assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc. Date Initiated: 12/31/2024 Give the resident as many choices as possible about care and activities (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Date Initiated: 12/31/2024 Revision on: 12/31/2024 When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Record review of Resident #53's progress notes revealed Resident #53 had multiple incidents with other residents. The progress notes revealed the following: 01/23/2025 at 04:54am CNA (CNA M) called this nurse (DON)to the unit and resident (Resident #53) smashed another resident's (Resident # 20) finger with metal cup. Resident (Resident #53) stated, He was touching and trying to grab my cup. Removed resident (Resident #71) from sight. PRN Vistaril given as ordered. Resident (Resident #53) calm after and CNA able to Resident room. DON notified. 01/23/2025 at 1:37pm Resident #53 was still being combative with staff and 'was attempting' to hit of another resident. Phone call was placed to [Psychiatric MD], Pending call back. 01/30/2025 at 2:11pm Resident is readmit, returning from [psychiatric hospital] in [local city name]. 03/12/2025 at 7:30pm Resident (Resident #53) got his shoe and slapped another resident (Resident #3) when another resident was walking by and bumped into the bedside table that was next to Resident #53. Called on-call [Psychiatric services] and got an order to send resident to inpatient psychiatric hospital. 03/13/2025 at 12:36am return call from [staff] at [psychiatric hospital #53], resident was denied due to acuity. 03/13/2025 at 12:36am referral sent to [psychiatric hospital #2], pending call back. 03/17/2025 at 8:15am Depakote oral tablet delayed release 250mg-give 1 tablet by mouth two times a day related to Bipolar disorder, current episode mixed, severe, with psychotic features (f31.64) from [psychiatric hospital], [psychiatric MD] notified med on order from pharmacy awaiting arrival. Resident #56 (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Record review of Resident #56's face sheet, dated 04/17/2025, revealed an [AGE] year-old male resident who was admitted to the facility on [DATE] with the diagnoses of unspecified dementia(a decline in mental ability, specifically in memory, thinking, and reasoning, that significantly impacts daily life), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a mental health condition characterized by persistent and excessive worry, fear, and dread that significantly interfere with daily life), schizophrenia (a chronic mental illness characterized by disruptions in thinking, perception, emotional expression, and behavior), unspecified, major depressive disorder (a mood disorder characterized by persistent sadness, loss of interest in activities, and other symptoms that significantly affect daily functioning), single episode, unspecified. Record Review of Resident #56's MDS assessment, dated 02/06/2025, revealed that Resident #56 had a BIMS score of 09, which indicates that Resident #56 had moderately impaired cognition. Functionality for ADLs was not determined at time of this assessment. Record review of Resident #56's care plan, dated 02/10/2025, revealed the following: Focus o I have a mood problem Schizophrenia/Schizoaffective Medication: Risperidone Date Initiated: 01/22/2025 Revision on: 01/24/2025 Goal I will have improved mood state such as: happier, calmer appearance, no s/sx of depression, anxiety or sadness through the review date. Date Initiated: 01/24/2025 Target Date: 02/12/2025 Interventions/Tasks Administer medications as ordered. Monitor/document for side effects and (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	effectiveness. Date Initiated: 01/22/2025 Assist me with a program of activities that is meaningful and of interest. Encourage and provide opportunities for exercise and physical activity. Date Initiated: 01/22/2025 Behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.) Date Initiated: 01/22/2025 Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. Date Initiated: 01/22/2025 Monitor/record mood to determine if problems seem to be related to external causes, i.e. medications, treatments, concern over diagnosis. Date Initiated: 01/22/2025 Monitor/record/report to MD prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/ eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills Date Initiated: 01/22/2025 Monitor/record/report to MD prn mood patterns s/sx of depression, anxiety, sad mood as per facility behavior monitoring protocols Date Initiated: 01/22/2025 (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Monitor/record/report to MD prn risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons Date Initiated: 01/22/2025 Observe for signs and symptoms of mania or hypomania racing thoughts or euphoria; increased irritability; frequent mood changes; pressured speech; flight of ideas; marked change in need for sleep; agitation or hyperactivity Date Initiated: 01/22/2025 Record review of Resident #56's progress notes revealed the following: 02/26/2025 at 6:51pm resident (Resident #56) in the unit got in a verbal altercation with another resident (Resident #32) and hit another resident (Resident #32), the other resident (Resident #32) reacted and hit him back, he has an open area to the left eyebrow. Notified [psychiatric NP], new order sent to [psychiatric hospital #1 and #2]. 02/26/2025 at 9:40pm resident exited facility enroute to [psychiatric hospital #2] via transport from [psychiatric hospital #2] at this time d/t initiating physical contact with another resident. 03/07/2025 3:20pm resident returned back to facility via facility transportation at 2:05pm, resident assisted via wheelchair to the unit in room [room number] discharge orders received and entered into EMAR. Resident #58 Record review of Resident #58's face sheet, dated 04/16/2025, revealed that Resident #58 was a [AGE] year-old male resident admitted to the facility on [DATE] with the diagnoses of other psychoactive substance abuse (a disease that affects a person's brain and behavior and leads to an inability to control the use of a legal or illegal drug or medicine), uncomplicated, depression (a subtype of major depressive disorder (MDD) characterized by a milder form of the illness, typically lacking severe symptoms and functional impairment), anxiety disorder(a mental health condition characterized by persistent and excessive worry, fear, and dread that significantly interfere with daily life), unspecified, epilepsy(a diagnosis where a person is known to have epilepsy but the specific type (focal, generalized, etc.) is not known or can't be determined), unspecified, not intractable without status epilepticus(describes a type of epilepsy that is not considered difficult to control (intractable) and does not involve a continuous seizure (status epilepticus)), chronic diastolic (congestive) heart failure (occurs when the heart muscle becomes stiff, hindering its ability to relax and fill with blood during diastole). Record Review of Resident #58's MDS assessment, dated 04/07/2025, revealed that Resident #58 had a BIMS score of 00, which indicated that Resident #58 had severely impaired cognition and was functionally independent. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Record review of Resident #58's care plan, with no completion date, revealed no mention of inappropriate/aggressive behaviors towards other residents. Record review of Resident #58's progress notes revealed the following: 03/27/2025 at 9:30am this writer (LVN AA) was walking down F hall, this writer (LVN AA) noted resident (Resident #58) leaving wheelchair to stand up and walk; he went walking halfway down the hall and noted there was a female resident (Resident #41) there; he stood up against the side rail and was groping the female resident(Resident #41), he (Resident #58) was touching her (Resident #41) breast and her buttocks, squeezing them; this writer (LVN AA) could not get to female resident (Resident #41) fast enough to prevent this from happening; by the time this writer (LVN AA) reached resident (Resident #58) to sit him in his wheelchair and redirect him (Resident #58), he had already touched her (Resident #41) multiple times; this writer (LVN AA) informed the nurse in the hallway and notified DON; resident was assisted back to the memory care unit. 03/29/2025 at 4:53pm LVN A-Notified by CNA staff that resident was caught in another residents (UR) room. Resident was slapping the other resident (UR) back and forth with both hands. CNA staff assisted the resident out of the residents (UR) room. The resident (Resident #58) glared very manic at staff. Resident (Resident #58) caught holding a gait belt. Staff was able to retrieve gait belt from resident. Notified [DON name] DON and [FNP name] FNP. Obtained orders to start resident on risperidone 0.5 MG BID. Resident #47 Record review of Resident #47's face sheet, dated 04/17/2025, revealed that Resident #47 was a [AGE] year-old male resident who was admitted to the facility on [DATE] with the diagnoses of unspecified dementia (a decline in mental ability, specifically in memory, thinking, and reasoning, that significantly impacts daily life), unspecified severity, without behavioral disturbance, psychotic disturbance mood disturbance, anxiety(a mental health condition characterized by persistent and excessive worry, fear, and dread that significantly interfere with daily life), bipolar disorder (a prolonged period of abnormally elevated, expansive, or irritable mood accompanied by increased activity or energy), current episode manic without psychotic features, moderate, mild cognitive impairment of uncertain or unknown etiology (a condition where individuals experience greater memory or thinking problems than expected for their age, but these issues are not severe enough to interfere with daily activities), restlessness and agitation, cognitive communication deficit (occurs when communication problems are caused by difficulties with cognitive processes like attention, memory, or executive function, rather than with language or speech production). Record Review of Resident #47's MDS assessment, dated 03/12/2025, revealed Resident #47 had a BIMS score of 09, which indicated Resident #47 had moderately impaired cognition and a functionality of total dependency and maximal assistance was needed for most care areas with exception to partial assistance to oral hygiene and set-up assistance to eat. Record review of Resident #47's care plan, dated 02/10/2025, revealed no mention of inappropriate/aggressive behaviors towards other residents. Record review of Resident #47's progress notes revealed the following: (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	12/16/2024 at 10:49am (LVN A) Notified by staff (CNA M) that resident (Resident #47) went up to another resident (Resident #32) and punched him on the left side of face on cheek. Resident (Resident #47) stated he punched him because the other resident (Resident #32) told him to move. When told to move, [Resident #47] stated to the other resident (Resident #32) that he was watching tv and went up aggressively to him (Resident #32) and punched him (Resident #32) in the face. Resident was separated by two CNAs [CNA M] and [CNA I]. When trying to separate the residents, [Resident #47] scratched one of the CNAs on her right arm. Began one on one with [Resident #47] until further instruction. Notified [Psych MD] of residents behaviors. Obtained orders to send resident to [psychiatric hospital #2]. Notified by [psych hospital #2] that they do have beds available. Notified [DON name] DON and [previous ADM name] administrator. Notified guardian [guardian name]. 12/16/2024 at 3:41pm Notified by [staff] from [psych hospital #2] that resident is not accepted into [psych hospital #2] until EDO received from judge from [county name] county. Resident is not allowed to sign form himself due to have legal guardian. [Psych hospital #2] stated that we must go through [local hospital name] and then through the judge. [Local hospital] doctor [MD name] stated that the resident did not qualify to got to [psych hospital #2] and the judge was not going to sign due to going based of [MD name] decision. Notified [DON name] DON and [psych MD]. Obtained orders to try [psych hospital #1] in [local city name]. Notified that resident does not qualify due to the fact they don't accept Medicaid and he does not have Medicare yet. Obtained orders from [psych MD] to increased Depakote to 5 tabs of 125mg and obtain CBC and VA level in one week from today! 12/29/2024 at 10:22pm (LVN II) writer was called into locked unity by CNA. CNA reported that Resident (Resident #47) had struck male peer (Resident #32) in the face because peer (Resident #32) had entered his (Resident #47) room. 12/29/2024 at 10:49 pm (LVN GG) Writer talked to [staff] with [psych MD]'s office and received order to put resident on 1-on-1 monitoring until Resident is able to be sent out to behavioral hosp for eval. 02/12/2025 at 3:25pm (LVN GG) CNA K reported that resident hit residents (UR) with his elbow three times to patient. CNA K broke it up. Then patient went after another patient [Resident name] (Resident #1) with a knife and CNA C intercepted. Patient did not attack no further and has been monitored wctm. 02/12/2025 at 3:46pm [Guardian Name] spoke with and reported incident and she is aware of his new ordered and noted wctm. 02/12/2025 at 4:08pm patient went and attack CNA and noted. Patient s attacking patients. Police was called and investigated the situation. Doctor ordered to send to [psych hospital #2] psychiatric facility. Patient guardian was notified, and management was notified a well as doctor wctm. Resident #46 (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Record review of Resident #46's face sheet, dated, 04/17/2025 revealed a [AGE] year-old male resident who was admitted to the facility on [DATE] with the diagnoses of major depressive disorder (a mood disorder characterized by persistent sadness, loss of interest in activities, and other symptoms that significantly affect daily functioning), recurrent severe without psychotic feature, generalized anxiety disorder (a mental health condition characterized by persistent and excessive worry, fear, and dread that significantly interfere with daily life), disorganized schizophrenia (a subtype of schizophrenia characterized by disorganized speech, behavior, and flat or inappropriate affect), cognitive communication deficit (occurs when communication problems are caused by difficulties with cognitive processes like attention, memory, or executive function, rather than with language or speech production). Record review of Resident #46's MDS assessment, dated 04/07/2025, revealed Resident #46 had a BIMS score of 10, which indicated that the Resident #46 was moderately impaired cognition, and required touch assistance in all care areas. Record review of Resident #46's care plan, dated 02/10/2025, revealed the following: Focus The resident has potential to Demonstrate physical behaviors mental Illness (schizophrenia) Date Initiated: 09/01/2024 Revision on: 10/08/2024 Goal The resident will not harm self or Others through the review date Date Initiated: 09/01/2024 Revision on: 10/08/2024 Target Date: 02/09/2025 Interventions/Tasks Analyze of key times, places, circumstances, triggers, and what de-escalates Behavior and document Date Initiated: 09/01/2024 (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Give the resident as many choices as possible about care activities Date Initiated: 09/01/2024 Revision on: 10/08/2024 Modify environment: (Adjust room temperature to comfortable level, reduce noise, Dim lights, place familiar objects in room, keep door closed etc.) Date Initiated: 09/01/2024 Revision on: 10/08/2024 When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress' engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later Date Initiated: 09/01/2024 Revision on: 10/08/2024 Record review of Resident #46's progress notes revealed the following: 10/27/2024 at 10:26pm This nurse (LVN EE) witnessed resident (Resident #46) to resident (Resident #44) push and this resident going into residents' room and other resident said, Get out of my room' and pushed resident (Resident #44) down to the floor. Resident (Resident #46) stated, He doesn't belong in my room and that's why I pushed him out. Resident (Resident #46) sat back down on the bed and no other aggression noted. DON, MD, and [family member] notified. 10/28/20245 at 1:01am New orders given from [psych MD] to send resident to impatient psych. [psych hospital #2] in [city name] accepted and will pick up at 9-10am on today. 11/11/2024 at 1:09pm resident returned via facility van from [psych hospital] . Resident #49 Record review of Resident #49's face sheet revealed that Resident #49 was a [AGE] year-old female who was admitted to the facility on [DATE]-24. Resident #49's diagnoses included, but were not limited to, unspecified dementia, moderate, with mood disturbance; muscle weakness; difficulty in walking; psychotic disturbance; mood disturbance and anxiety; depression; epilepsy. Record review of Resident #49's most recent MDS assessment completed on 3/14/25 revealed Resident #49 had a BIMS of 8 (indicating moderately impaired cognition) and a functionality of set-up assistance in all care areas. Record review of Resident #49's care plan notated that Resident #49 exhibited behaviors. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Record review of Resident #49's nurses notes revealed that Resident #49 had an altercation with another female resident on 2/20/25. Resident #44 Record review of Resident #44's face sheet revealed that Resident #44 was an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, moderate, with other behavioral disturbance; intermittent explosive disorder; aftercare following joint replacement surgery; major depressive disorder; generalized anxiety disorder; diabetes. Record review of Resident #44's most recent MDS assessment dates 3/2/25 revealed a BIMS of 00 indicating severe cognitive impairment. This MDS assessment indicated that Resident #44 had a functionality of maximal assistance with dressing, personal hygiene, toileting, and putting on/taking off footwear. Touch assistance was needed for oral hygiene and set-up assistance with eating. Record review of Resident #44's care plan indicated it was completed on 4/3/25. Record review of Resident #44's nurse's notes indicated that on October 27, 2024, Resident #44 was pushed by another resident which resulted Resident #44 fracturing his hip and requiring surgery. Resident #4 Record review of Resident #4's face sheet dated 04/17/2025 revealed that Resident #4 was a [AGE] year-old female resident who was admitted to the facility on [DATE] with the diagnoses of diffuse traumatic brain injury with loss of consciousness of unspecified duration (a traumatic brain injury where the damage is widespread and the person does not lose consciousness), sequela (a condition which is the consequence of a previous disease or injury), other symptoms of signs involving cognitive functions and awareness, major depressive disorder, recurrent severe without psychotic features (a serious condition where a person experiences both major depressive symptoms and psychotic symptoms like delusions or hallucinations, often related to themes of guilt or worthlessness), schizoaffective disorder (a mental illness characterized by a combination of psychotic symptoms, like hallucinations and delusions, and mood disorder symptoms, such as depression or mania), bipolar type (a mental health condition characterized by significant mood swings, fluctuating between periods of intense happiness and high energy (mania or hypomania) and periods of deep sadness and depression). Record review of Resident #4's MDS assessment, dated 03/18/2025, revealed that Resident #4 had a BIMS score of 13 which indicated that Resident #4 did not have any cognitive impairment and required set-up assistance in most care areas with a moderate assist with oral hygiene. Record review of Resident #4's care plan, dated 04/03/2025, revealed the following: Focus Behaviors: Aggression: [Resident #4] has potential to demonstrate physical and verbal behaviors r/t (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	schizoaffective disorder Calling staff names and yelling Date Initiated: 11/20/2020 Revision on: 10/31/2023 Goal The resident will not harm self or others through the review date Date Initiated: 11/20/2020 Revision on: 12/05/2024 Target Date: 04/24/2025 The resident will verbalize understanding of need to control physically aggressive behavior through the review date Date Initiated: 11/20/2020 Revision on: 12/05/2024 Target Date: 04/24/2025 Interventions/Tasks Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. Date Initiated: 11/20/2020 Give the resident as many choices as possible about care and activities Date Initiated: 11/20/2020 (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Revision on: 11/20/2020 When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later Date Initiated: 11/20/2020 Revision on: 11/20/2020 Record review of Resident #4's progress notes revealed the following: 02/20/2025 at 5:14pm Staff reported that resident [Resident #4's name] and her roommate (Resident #49) were arguing loudly, when staff arrived at the room [Resident #4] had pushed her (Resident #49) to the floor, [Resident #4] stated that her roommate (Resident #49) was yelling at her, and she (Resident #4)did not touch her roommate (Resident #49). Assessment completed Risk assessment, nursing notes and behavior note completed, FNP, DON, and family called moved to another room. Resident #32 Record review of Resident #32's face sheet dated 005/04/2025 revealed that Resident #32 was a [AGE] year-old male resident who was admitted to the facility on [DATE] with the diagnoses of unspecified dementia, with severe agitation (a severe form of dementia where the specific cause is not identified, and the individual experiences significant agitation), psychotic disorder with delusions due to known physiological condition (a mental illness where the person experiences delusions (false, fixed beliefs) and other psychotic symptoms (like hallucinations, disorganized thinking, and speech) as a direct result of a physical illness or medical condition affecting the brain), major depressive disorder (a mental disorder characterized by persistent sadness, loss of interest in activities, and other symptoms that significantly affect daily functioning), recurrent severe without psychotic features (persistently low mood, loss of interest in activities, changes in appetite or weight, sleep disturbances, fatigue, feelings of worthlessness, difficulty concentrating, and recurrent thoughts of death or suicide), psychotic disorder with hallucinations due to known physiological condition (a mental health condition where hallucinations and/or delusions are directly caused by a known physiological or medical condition, rather than a primary psychiatric illness), anxiety disorder (mental health conditions characterized by excessive fear, anxiety, and worry that is disproportionate to the situation and interferes with daily life), extrapyramidal and movement disorder (Extrapyramidal symptoms are specifically drug-induced movement disorders, often caused by medications like antipsychotics. Movement disorders, on the other hand, are broader neurologi[TRUNCATED]

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	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 the resident environment remained as free of accident hazards as possible and failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 4 of 9 residents (Resident #7, #10, #15 and #41) reviewed for accidents and hazards. The facility staff failed to store hand sanitizer properly on 04/20/25 at 7:00 AM resulting in Resident #7 observing Resident #10 drinking an unknown amount of hand sanitizer which ended in him going to the hospital. The facility failed to provide adequate supervision for Resident #10 on an unknown date (after 4/20/25) in the dining room where he was able to drink the saliva of another resident (Resident #15) out of her (Resident #15) spit cup. The facility failed to provide adequate supervision for Resident #41 on 05/10/25 in the dining room where she was able to drink saliva of another resident (Resident #15) out of her (Resident #15) spit cup. An IJ was identified on 5/14/25 at 3:50 PM. The IJ template was provided to the facility on 5/14/25 at 4:10 PM. While the IJ was removed on 5/14/25 at 2:48 PM, the facility remained out of compliance at a severity of no actual harm and a scope of pattern because all staff had not been trained on 5/14/25. This failure could place residents at risk of injury/death due to unnecessary access to potentially harmful substances/chemicals. Findings included: Record review of Resident #7's face sheet, dated 5/14/25, revealed a [AGE] year-old-male was admitted to the facility on [DATE] with a diagnosis of schizoaffective disorder (mental health disorder). Record review of Resident #7's Comprehensive Minimum Data Set, dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 15, which indicated the resident's cognition was intact. Record review of Resident #7's progress notes, dated 3/13/25-5/14/25, did not reveal any notes regarding him witnessing Resident #10 ingest hand sanitizer on 4/20/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 05/12/25 at 2:12 PM, Resident #7 stated that he observed Resident #10 drinking hand sanitizer on an unknown date in the dining room. He stated he was unsure of the date and time, but other residents were in the dining room, but he does not remember if staff were present. He stated he observed the resident pick up the bottle of hand sanitizer screw and screw the top off. He stated he observed the resident put the pump straw in his (Resident #10) mouth. He stated he immediately rolled out of the dining room to find help. He stated that he yelled down the hall and saw a nurse. He stated he did not remember her name but could identify her face. He stated the nurse was not in the facility at the time of the interview. He stated that the nurse came immediately and went to the dining room. He stated he did not see anything after that. He stated that he had never observed Resident #10 drink hand sanitizer before but had observed him drink the saliva of another resident (Resident #15) out of her (Resident #15) spit cup about 3 months before the interview. He stated when Resident #10 drank Resident 15's saliva, he told staff but did not remember the staff's name. Record review of Resident #10's face sheet, dated 5/12/25, revealed an [AGE] year-old-male was admitted to the facility on [DATE] with a diagnosis of diabetes (elevated blood glucose/sugar), dementia (memory loss), psychiatric disorder with delusions(a false belief for judgment about external reality), intermittent explosive disorder(a behavioral disorder characterized by explosive outburst of anger and/or violence, often to the point of rage that are disproportionate to the situation at hand),, other amnesia (a partial or total loss of memory). Record review of Resident #10's Comprehensive Minimum Data Set, dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 2, which indicated the resident's cognition was severely impaired. Section E Behavior revealed Resident #10 had the presence of wandering that occurred 1 to 3 days. Record review of Resident #10's care plan, dated 5/12/25, revealed: Focus: Behavior: eating/Drinking inedible items: Resident #10 had a behavior problem r/t eating/drinking inedible items r/t cognitive impairments due to dementia. 4/20/25 Resident #10 drank hand sanitizer and was sent to ER for evaluation. (Date Initiated 4/20/25) Goal: Resident #10 safety will be maintained through the review date. (Date initiated 4/20/25) Interventions/Tasks: Anticipate and meet the resident's needs including hunger and thirst too help ensure he does not consume inedible items. Minimize potential for resident's behavior (eating inedible items) by increasing monitoring especially in the dining room. Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. (Date initiated 4/20/25) Record review of Resident #10's progress notes, dated 2/11/25-5/12/25, revealed: The DON documented on 04/07/25 at 12:54 PM: Resident #7 wanders, but his wandering was not goal directed, and did not affect the privacy of others. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	LVN AA documented on 04/20/25 at 7:07 AM: LVN AA was alerted by another resident (resident was not identified in the progress note) that Resident #10 was drinking hand sanitizer in the dining room, LVN AA ran to the dining room and observed Resident #10 with a small jug of hand sanitizer. Resident #10 had taken the hand pump off and she (LVN AA) observed Resident #10 with the jug tilted towards his mouth and was taking big gulps. LVN AA took the jug away from Resident #10 and immediately called 911 for ER transport. ER transport arrived in 4 minutes. LVN AA attempted to take Resident #10's vitals but he (Resident #10) was combative hindering her (LVN AA) from being able to take Resident #10's vitals. LVN AA notified the DON. LVN AA documented on 04/20/25 at 7:19 AM: Resident #10 was sent to the ER. LVN AA documented on 04/20/25 at 11:26 AM: Resident #10 returned to the facility. LVN AA reviewed hospital paperwork which revealed Resident #10's ethanol level was less than 5% mg. LVN AA documented that ER staff the alcohol consumption level was small, and the hospital staff monitored Resident #10 for the allotted time that poison control suggested (The allotted time not documented in the progress note). LVN AA documented that the ER doctor stated Resident #10 was fine. LVN AA documented on 04/20/25 at 11:33 AM: LVN AA notified the DON of Resident #10's return. Provider X documented on 04/22/25 at 12:00 AM: Provider X conducted a follow up visit after Resident #10 returned from the hospital after drinking hand sanitizer. Provider X documented staff created a care plan and are monitoring Resident #10 closely. Provider X documented that staff determined Resident #10 confused the hand sanitizer with a beverage. Provider X recommended that Resident #10 continue medication regimen and to monitor Resident #10's behavior. Provider X documented that Resident #10 was sleeping during this visit. Provider X documented on 05/06/25 at 9:23 PM: Provider X documented that they discussed with Resident #10 to refrain from drinking hand sanitizer or alcoholic beverages while taking prescribed medications. Provider X documented that Resident #10 verbalized understanding. Record review of the incident accident report, dated from 2/12/25-5/12/25, revealed Resident #10 had a self-inflicted injury/incident on 4/20/25 at 7:07 AM. Record review of Resident #10's hospital record dated 4/20/25 revealed that Resident #10 was seen on 4/20/25 for ingesting a substance, accidental poisoning and unintentional ingestion. The result details revealed ethanol level was less than 5 mg. The result details noted that results ranging from 0-10 mg would be interpreted as negative. During an interview on 05/12/25 at 12:29 PM, Resident #10 initially stated that he did drink hand sanitizer and that he liked the way it tasted. However, he did not remember the day he drank the hand sanitizer or where he got the bottle from. Resident #10 later confirmed that he did not know what hand sanitizer was. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #15's face sheet, dated 05/12/25, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with a diagnosis of end stage renal disease (kidney disease), metabolic encephalopathy(a chemical imbalance in the blood that causes problems in the brain), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and sequel of other cerebrovascular disease (conditions that arise after the acute phase of a cerebrovascular event that include various neurological deficits, cognitive impairments, and other complications). Record review of Resident #15's Comprehensive Minimum Data Set, dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 15, which indicated the resident's cognition was intact. Section E revealed Resident #15 did not have any other behaviors outside of verbal symptoms. Record review of Resident #15's care plan, dated 04/28/25, revealed: Focus: Behavior: Verbal & Physical Aggression: Resident #15 had potential to demonstrate verbal and physical abusive behavior r/t mental/emotional illness, poor impulse control. Resident will apologize after incidents when acting with aggression. Resident #15 yells, hits, grabs and pushes others. Resident recently fired psychiatric doctor. 1/15/25 Resident #15 grabbed a hoodie of another resident (resident unidentified) and yelled at him. Residents were separated. 4/27/25 Resident #15 pushed another resident causing fracture after a verbal altercation. 15-minute check and referrals will be sent to other facilities for alternative placement. (Initiated 4/28/25) Goal: Resident #15 will demonstrate effective coping skills. (Date initiated 04/28/25) Interventions/Tasks: Analyze key times, places, circumstances, triggers and what deescalates behaviors and document. Give Resident #15 as many choices as possible about care and activities. Check Resident #15 every 15 minutes for behavior and safety. When Resident #15 becomes agitated intervene before agitation escalates. Guide Resident #15 away from the source of distress. Engage Resident #15 calmly in conversation. If Resident #15 responds aggressively then the staff should walk away and approach later. (Date initiated 4/28/25). Record review of Resident #15's progress notes, dated 2/11/25-5/12/25, revealed: LVN Y documented on 04/26/25 at 9:39 PM: Resident #15 displayed aggression toward another resident (resident not identified in the progress note). Resident #15 and the other resident (unidentified) were verbally yelling at each other. The other resident (unidentified) stood up from wheelchair arguing with Resident #15 and the other resident (unidentified) was pushed down to the floor by Resident #15. Resident #15 was separated from the resident (unidentified) and escorted by staff to her (Resident #15) room. Record review of the incident accident report, dated from 2/12/25-5/12/25, revealed Resident #15 was involved in a physical aggression-initiated incident on 4/26/25 at 8:00 PM. During an interview on 05/13/25 at 11:25 AM, Resident #15 stated she spits in cups but disposes of them. She said she had never observed any residents drink her saliva. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #41's face sheet, dated 5/12/24, revealed a [AGE] year-old-female was admitted to the facility on [DATE] with a diagnosis of cerebral palsy (congenital disorder of movement, muscle tone, or posture), intermittent explosive disorder (a behavioral disorder characterized by explosive outburst of anger and/or violence, often to the point of rage that are disproportionate to the situation at hand), non-suicidal self-harm, major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and cognitive communication disorder (difficulty with thinking and how someone uses language). Record review of Resident #41's Comprehensive Minimum Data Set, dated [DATE], revealed: Section C Brief Interview for Mental Status score revealed a score of 00, which indicated the resident's cognition was unable to complete the interview. Section E revealed no documented behaviors. Record review of Resident #41's care plan, dated 5/02/25, revealed: Focus: Behaviors: Physical and Verbal Aggression: Resident #41 had potential to demonstrate physical and verbal behaviors r/t yelling out and attempting to kick, scratch and strike others especially during care. If Resident #41 sees someone with drinks (sodas) or snacks Resident #41 will follow them and take the items and becomes aggressive with the other person. Resident #41 will also rip off her (Resident #41's) clothing. 4/19/25 Resident #41 pinched another resident. 4/29/25 Resident #41 squeezed another resident's arm. 15-minute checks to check for behaviors and safety. (initiated on 1/24/25 and revised on 5/2/25) Goal: Resident #41 will not harm self or others. (Initiated 1/26/25 and revised 03/27/25) Interventions/Tasks: Analyze of key times, places, circumstances, triggers, and what deescalates Resident #41's behavior. (Initiated 1/26/24) Assess and address for contributing sensory deficits. (Initiated 1/26/24) Assess and anticipate Resident #41's needs: food, thirst, toilet needs comfort level, body positioning and pain. (Initiated 4/29/25) Give Resident #41 as many choices as possible about care and activities. (Initiated 1/26/24 and revised 1/26/24) Increase staff monitoring for aggressive behavior. (no initiation or revision date) Start 15-minute checks for behavior and safety. (Initiated 4/19/25 and revised 5/02/25) Monitor/document and report danger to self and others to the doctor. (Initiated 1/26/24) Consult psychiatric /psychogeriatric as indicated. (Initiated 4/29/25) When Resident #41 becomes agitated intervene before agitation escalates, guide away from source of distress, engage calmly in conversation. If resident #41 response is aggressive, staff were to walk away calmly and try to approach her again later. (Initiated 1/26/24 and revised 1/26/24) Record review of Resident #41's progress notes, dated 2/11/25-5/12/25, did not reveal any documentation of Resident #41 drinking Resident #15's saliva. Record review of the facility's incident accident report, dated 2/12/25-5/12/25 did not reveal that Resident #41 had an incident of drinking another resident's saliva on 05/10/25. Record review of Resident #41's facility documentation titled 15-minute checks, dated 4/19/25-5/2/25, revealed staff conducted 15-minute checks due to aggressive behaviors. (continued on next page)

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Castro County Nursing & Rehabilitation	1621 Butler Dimmitt, TX 79027

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 05/12/25 at 2:05 PM, Resident #41 was not cognitively able to engage in an interview regarding the incident between her and Resident #22 on 4/19/25. When asked any questions, she would stare and point out the window that was located in her (Resident #41's) room. During an interview on 5/12/25 at 10:48 AM CNA H stated she had not been trained on what to do if resident consumed inedible items or ingested harmful items. She stated she was an agency staff and only had worked at the facility a few times. She stated she had worked with Resident #10 but did not have any information regarding him drinking hand sanitizer on 04/20/25. During an interview on 5/12/25 at 11:00 AM LVN BB stated she does not remember if she had been trained at the facility regarding what to do if resident consumed inedible items or ingested harmful items. She stated because of her nursing experience she would call 911. She stated hand sanitizer should be in the dispenser or locked in the supply closet. She stated she did not have any additional information regarding Resident #10 drinking hand sanitizer on 04/20/25. During an interview on 5/12/25 at 11:23 AM LVN Z stated she had not been trained regarding what she should do if a resident consumes a harmful substance or ingest chemicals, but she would guess with her nursing experience she would call 911 and she believed there was a book that had a list of all the chemicals that were in the facility. She stated she worked the morning that Resident #10 consumed the hand sanitizer, but she was not in the dining room. She stated LVN AA was the other nurse, but she could not remember which aides were there. She stated Resident #10 was sent out to the ER. She stated she did not know how much he drank. She stated he had never drunk harmful substances before but that when he does drink, he drinks a whole lot. She stated she was unsure where hand sanitizer was kept but was sure that it was kept locked up by housekeeping. During an interview on 5/12/25 at 11:47 AM CNA C stated hand sanitizer should be kept locked up or they keep it in the shower rooms sometimes. She stated she worked the morning (4/20/25) that Resident #10 drank the hand sanitizer. She stated she was rounding and checking on other residents. She stated Resident #7 told the nurse (unidentified) about Resident #10 drinking hand sanitizer. She stated she was not responsible for Resident #10 that day. She stated she could not remember the other staff. She stated Resident #10 was sent out to the hospital. She stated she was not interviewed, nor did she receive additional training about Resident #10 drinking harmful substances. She stated she had been trained in the past on what to do if a resident drinks a harmful substance. She stated she had been trained to take the substance away and report it to the charge nurse. During an interview on 5/12/25 at 12:03 PM CNA CC stated she had not been trained regarding what to do if a resident ingests or consumed a harmful substance or chemicals. She stated she would go to the nurse, and she would know what to do. She stated she did not know where chemicals such as hand sanitizer were stored officially but believed it was stored in the supply rooms. She stated she had observed hand sanitizer in the dispensers on the walls. She stated she did not have any information regarding Resident #10 drinking hand sanitizer, but he had never done anything like that before. An observation was made on 05/12/25 at 12:25 PM Hall D and E of the SDS book (red and yellow located in a yellow tray mounted on the wall). A poster located to the right of the SDS book/sheets titled How to read a Safety Data Sheet. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 5/12/25 at 12:31 PM CNA DD stated she was responsible for Resident #10 at the time of the interview. She stated she was unaware that he had an incident where he drank hand sanitizer. She stated she was not notified that he had the behavior of drinking harmful substances or chemicals. She stated she had observed since she worked with him that he will remove the napkin from the utensils and attempt to put the napkin in his mouth. She stated she assumed Resident #10 was confused. She stated she did not report this to anyone. She stated she had not received training on what to do if a resident consumes a harmful substance or chemical. During an interview on 5/12/25 at 12:36 PM COTA J stated she was aware that Resident #10 had ingested hand sanitizer but was unsure of the date. She stated she was told by her supervisor (DOR). She said that he mentioned it to her, but no additional instructions were given. She stated she did not have the details of the incident. She stated that she had not received training regarding what the facility expected her to do if a resident consumed a harmful substance or chemical. She stated she was unaware of Resident #10 having the behavior of consuming inedible items, harmful substances, or chemicals. An observation was made on 05/12/25 at 1:54 PM of Hall E shower room (locked with a number keypad). Three bottles of hand sanitizer were observed in the shower room, 2 large bottles with hand pump on the floor and one small bottle of hand sanitizer with hand pump on the sink. During an interview on 5/13/25 at 8:22 AM the DON stated she had been trained and trained staff regarding what to do if a resident ingested a harmful substance or chemicals. She stated the Maintenance Supervisor was responsible for knowing where the chemicals and hand sanitizer was stored. She stated regarding Resident #10 drinking the hand sanitizer it was reported to her by staff (did not identify during the interview) that he had drank hand sanitizer. She stated he did not drink a lot. She stated Resident #10 was sent to the hospital. She stated she was unsure how he obtained the hand sanitizer. She stated the hand sanitizer should not have been accessible to the resident. She stated on 4/20/25 they (management staff) came to the facility and stayed at the facility for a while. She stated they were looking to make sure there was no more hand sanitizer accessible to the residents. During an interview on 5/13/25 at 8:54 AM the ADM stated she had been trained on what to do if a resident consumed harmful substances or chemicals. She stated she had also trained her staff. She stated the staff should refer to the SDS sheets/book, call poison control and call 911 immediately. She said the hand sanitizer should be stored in the supply closet (locked) and in the wall dispensers. She stated regarding Resident #10 she did not know where the hand sanitizer came from. She stated it was not a brand of hand sanitizer that they order for the facility. She stated when she came to the facility on [DATE] she and her management team went through the facility and ensured all hand sanitizer was not accessible to the residents. She stated they looked for anything else that could potentially be dangerous for the residents. She stated Resident #10 had never exhibited the behavior of drinking inedible items or consuming harmful substances before. She stated when he returned from the hospital Resident #10 was placed on 15-minute checks. She stated Resident #10 had become more confused. She stated she had observed him attempt to get his own juice from the juice dispenser after 4/20/25 and Resident #10 allowed the juice to overflow while he watched the juice flow from the dispenser. She stated Resident #10 was confused before 4/20/25. She stated the hand sanitizer in the gallon pump bottle should have been locked in the chemical supply closet inaccessible to Resident #10. She stated residents do have access to the shower rooms. Staff will let them in and out she believed. She stated if the resident were independent, they could shower in the shower room independently if they liked. They would have to let staff know. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 5/13/25 at 10:07 AM CNA DD stated she had not been trained on what to do regarding what to do if a resident ingested harmful substances or chemicals. She stated she would report it to her chain of command. She stated she believed chemicals such as hand sanitizer were stored in the supply room that was locked. She stated she had not observed any of the hand sanitizers that have the hand pumps around in a while. She stated if they did have them out it was ok for staff to use them. She stated she did not know anything about Resident #10 drinking hand sanitizer on 4/20/25 but only became aware when the investigator mentioned it to her on 04/12/25. She stated if she were unaware, she would not know to watch for the behavior. She stated since he was now on the locked unit, she would watch him closely, but it would be helpful to know if he had the behavior. During an interview on 5/13/25 at 9:58 HK R stated that she was responsible for filling the hand sanitizer dispensers located on the wall at the facility. She stated she had never set out any hand sanitizer jugs with the hand pumps. She stated she had not received any training regarding if a resident consumed harmful substance or chemicals or what they should do if they come across a jug of hand sanitizer that had been left out. She stated she did not have any information regarding Resident #10 drinking hand sanitizer on 4/20/25. During an interview on 5/13/25 at 10:00 AM HK L stated housekeeping was responsible for refilling the hand sanitizer in the dispensers on the walls in the facility. She stated the jugs of sanitizer with the hand pumps were not put out by them. She stated the Maintenance Supervisor was the only person who had access to the gallon jugs with the hand pumps. She stated she was not at the facility when the incident happened on 4/20/25 when Resident #10 drank hand sanitizer but was told by the Maintenance Supervisor if they see them turn them into him. During an interview on 5/13/25 at 10:17 AM HK V stated housekeeping was responsible for ensuring that the hand sanitizer on the walls were filled. HK V stated she had not observed any hand sanitizer jugs with the hand pump since the time of COVID. She stated she had not received training within the past 30 days regarding what to do if a resident consumes a harmful substance or chemical. She stated if she observed the hand sanitizer, she would take it to the Maintenance Supervisor but did not remember if she had been trained to do that. She stated she worked the morning of 4/20/25. She stated it was early around breakfast time. She stated it had to be near 7:00 AM. She stated she was preparing her housekeeping cart to start her day. She said she was asked by a nurse (she did not know her name) if the hand sanitizer was hers. She stated she told the nurse no. Before the nurse asked her about the hand sanitizer, she overheard Resident #10 and the staff arguing over the jug of hand sanitizer. She stated Resident #10 was saying the hand sanitizer was his. She stated she overheard the staff say the ambulance was coming and she (HK V) assumed it was for Resident #10. HK V stated that she did not physically see Resident #10 drink hand sanitizer. She said she had observed Resident #10 in the facility. She had never observed him eat inedible items or consume harmful substances. She stated Resident #10 was always hungry because he would say it all the time in Spanish. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 5/13/25 at 10:41 AM the Maintenance Supervisor stated he had not been trained on what to do if a resident consumes a harmful substance or chemical. He stated he had not been trained at the facility but had spoken with the vendor which he orders his supplies from. He said he had been trained to go to the SDS sheets/books and the book would tell the staff what steps to take. He stated the vendor encouraged him to read up on the contents of the book. He stated that the management team conducts what was known as angel rounds. He stated they go around daily and check areas and residents around the facility. He stated he was unsure who had the dining room and why the hand sanitizer in the dining room was missed. He stated he was assigned to Hall E and conducted his rounds daily. He stated the hand sanitizer was in his office locked in a closet. He stated on 04/20/25 he was notified by the ADM and DON that Resident #10 had consumed hand sanitizer. He stated he came to the facility immediately. Took a picture of the hand sanitizer gave it to the EMS and then retrieved it from the hospital and kept it locked in the closet for evidence. He stated him and other management staff started walking room to room looking for additional hand sanitizer. He stated they discussed the incident in a morning meeting. Stated he was responsible to ensure that the SDS sheets were up to date. He stated the SDS sheets were located on Hall C and D. He stated he was unsure if training was conducted the day (4/20/25) of the incident. The Maintenance Supervisor stated that he conducted a training with his housekeepers instructing them if they observed unapproved hand sanitizer, they were to bring it to him. He stated he did not have them sign an Inservice but verbally told them. He stated after conducting the sweep on 4/20/25 all hand sanitizer and any other risks were removed. The Maintenance Supervisor stated he did not know how the hand sanitizer was left out. He stated the hand sanitizer should not have been in the facility at all as it was a brand that they did not use. He stated he spoke with the vendor who said they did not bring the hand sanitizer to them. During an interview on 5/13/25 at 11:06 AM the DM stated she was not present the morning of 4/20/25 when Resident #10 when he drank the hand sanitizer. She stated she had never observed the hand sanitizer and could not describe to the investigator how the bottle of sanitizer looked like. She stated she participated in morning meetings and remembered discussing in a morning meeting on an unknown date after the date of 4/20/25 that they would increase management presence in the dining room during mealtimes. She stated Fridays were her day to be monitor mealtimes. She stated she had not seen any other management staff monitor mealtimes to help with supervision. She stated they conduct angel rounds and her hall assignment was Hall B. She stated they go to their assigned areas and see if there were any issues. She stated she was unsure who was assigned to the dining room. She said the angel rounds were not documented. She stated as a result of Resident #10 drinking hand sanitizer on 4/20/25 they did receive training over ANE and on storing hand sanitizer. She stated Resident #10 had never drank hand sanitizer before, but he had consumed the saliva in Resident #15's spit cups before. She stated she reported the saliva incident to the ADM, but it had been a while (at least a week). She stated the ADM did not say anything when she reported the incident. She stated the saliva incident with Resident #10 and #15 occurred after 4/20/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 5/13/25 at 11:10 AM DA Q stated he worked the morning of 4/20/25 when Resident #10 drank the hand sanitizer. He stated he was asked by LVN AA about the hand sanitizer, but he had never observed the hand sanitizer before. He stated he had never observed Resident #10 drink or eat any inedible items. He stated he heard from his DM that he had drank the saliva from Resident #15 and she (DM) allegedly reported the saliva drinking incident to the ADM. He stated he had not observed Resident #10 drink the saliva of Resident #15, but he had observed Resident #41 drink the saliva of Resident #15. He stated it happened on the 05/10/25. He stated he reported the incident to the nurse on duty (did not remember the nurses name), DA U and the DM. He stated he had not observed increased monitoring in the dining room during mealtimes. He stated he was not interviewed about the incident that occurred on 4/10/25 where Resident #10 drank hand sanitizer. He sated he was not interviewed about any resident drinking saliva. During an interview on 5/13/25 at 11:18 AM DA U stated she worked in the kitchen on the morning of 4/20/25 when Resident #10 drank hand sanitizer. She stated the Thursday (4/17/25) or Friday (4/18/25) before the incident she had observed a bottle of hand sanitizer with the hand pump on the table near kitchen door. DA U stated she thought a housekeeper left it there. She stated she asked a housekeeper (name unknown) was the hand sanitizer supposed to be on the table and she was told to leave it there by the housekeeper. She stated that the morning of 4/20/25 she was yelled at by the nurse (LVN AA) asking if she was the person who left the hand sanitizer on the table. She stated she explained that she was not the person who placed the hand sanitizer out. She stated she had not received any training regarding what to do if a resident ingested a harmful substance or chemical. She stated she had not observed increased monitoring in the dining room since 4/20/25. She stated she had not been interviewed regarding the incident on 4/20/25 involving Resident #10. She stated she had heard that Resident #10 had drank the saliva of Resident #15 before but did not observe it. She stated DA Q had told her that Residen

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure respiratory care, was provided consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 2 (Resident #9, #27) of 15 residents reviewed for respiratory care. The facility failed to ensure Resident #'9's and #27's oxygen setting was per physician orders. This failure could affect residents by placing them at risk for respiratory compromise and associated complications such as shortness of breath, confusion, respiratory failure, infection, and exacerbation of their condition. Findings Included: Record review of Resident #9's face sheet printed 4-8-2024 revealed she was a [AGE] year-old female resident admitted to the facility originally on 10/16/2008 and readmitted on [DATE] with diagnoses to include cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), weakness, lack of coordination, thrombocythemia (a condition in which the body produces to many platelets in the bone marrow), diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), sleep apnea (a common disorder that causes your breathing to stop or get very shallow), coronary artery disease (damage or disease in the hearts major blood vessels), asthma (a chronic disease in which the bronchial airways in the lungs become narrowed and swollen, making it difficult to breathe), and heart failure (a chronic condition in which the heart does not pump blood as well as it should). Record review of Resident #9's last MDS was a quarterly assessment completed 03/12/2025 listing her with a BIMS score of 14 indicating she was cognitively intact, and she had a functionality of being dependent on staff with most of her activities of daily living. Resident #9 was listed as having oxygen while a resident. Record review of Resident #9's care plan revealed the following: Focus: Resident has oxygen therapy r/t ineffective gas exchange. Interventions: -Oxygen Settings: O2 at 2-3L/min via nasal cannula for SOB while in bed. Record review of the clinical record for Resident #9 revealed an Medication Administration Record for the dates of 05/01/2025 - 05/31/2025 with the following order: Oxygen at 2 LPM per nasal cannula every shift. Record review of Resident #27's face sheet dated 05-13-2025 revealed a [AGE] year-old female was admitted to the facility on [DATE] with diagnoses that included but not limited to unspecified dementia, acute and chronic respiratory failure with hypoxia, chronic ischemic heart disease, unspecified atrial fibrillation, heart failure, chronic obstructive pulmonary disease and dependence on supplemental oxygen . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident#27's Quarterly MDS assessment dated [DATE] revealed her BIMS score was 11 out of 15 indicating moderately impaired cognition. Resident #27 was listed as receiving oxygen while resident. Record review of Resident #27's care plan last revised on 04/15/2025 revealed the following: Focus: I require oxygen therapy r/t shortness of breath 3-5 LPM to keep oxygen levels about 90%. Record review of Resident #27's active physician orders revealed the following: Oxygen at 3-5 LPM per nasal cannula continuous to keep oxygen saturations above 90% dated 4/15/2025. During an observation on 05/12/2025 at 10:00 AM, Resident #27 was in her bed, she was wearing O2 at 2.5 L/min via NC. During an observation and interview on 05/12/2025 at 10:07 AM Resident #9 was observed in her bed with the HOB elevated. Resident #9 was wearing O2 at 3L/min via NC. During an observation on 05/12/2025 at 11:59 AM Resident #9 was asleep in her room with her oxygen on via NC and the oxygen was set at 3L/min. During an observation on 05/12/2025 at 02:31 PM Resident #9 was sleeping under her covers with oxygen on at 3L/min via NC. During an observation and interview on 05/13/2025, Resident #27 was in her bed eating breakfast, her oxygen was on via NC at 2L/min. Resident #27 stated she was having problems when staff would transfer her from her bed to her w/c, it would always be a problem with moving the oxygen tubing from her tank to the portable tank, but other than that no issues. Resident #27 stated she was to wear oxygen continuous and was unsure what the oxygen levels were supposed to be on. During an observation on 05/13/2025 at 11:01 AM Resident #9 was in her room with her oxygen on via NC at 3L/min. She reported that she was doing alright at the time. During an observation on 05/13/2025 at 01:05 PM Resident #9 was wearing O2 at 3L/min via NC while in her room in bed. Resident #9 stated that staff had filled her water chamber for the oxygen but nothing else was done as far as she knew . During an interview on 05/14/2025 at 9:20 AM, LVN A stated she works on the hall with Resident #27 and stated her oxygen level she received should be 4lpm. LVN A stated staff should check oxygen each staff or anytime they move/transfer the resident to ensure her oxygen levels were correct. A negative outcome for not having correct oxygen levels would be the resident could have had shortness of breath, pass out and possibly death. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/14/2025 at 9:51 AM, the DON stated she was aware of what Resident #27's oxygen was to be at and stated that all staff were responsible to check oxygen levels on the tank and ensure they are complying with physician orders. The DON stated she was responsible to ensure her staff were following physician orders. A possible negative outcome for having oxygen therapy lower than ordered would cause the resident to have shortness of breath. During an observation and interview on 05/14/25 at 09:58 AM RN E (the nurse responsible for Resident #9 this shift) reviewed Resident #9's chart and verified that Resident #9 should be on 2L/min for her oxygen therapy. RN E then went to Resident #9's room and observed Resident #9's O2 and reported that Resident #9 was on 2.5L/min (per RN E's interpretation of the O2 setting) which RN E stated was higher than Resident #9's order. RN E immediately adjusted Resident #9's O2 to the ordered 2L/min. RN E reported that according to what she learned in school giving medications at a dose higher than what they were ordered (to include oxygen) can affect a resident especially if they have lung disease. RN E reported that they give Resident #9 oxygen for comfort and that even at 2.5L/min it could affect her condition or any resident's condition again especially depending on the residents' diagnoses. RN E reported this was her first shift on after time off and she had not been to Resident #9's room to assess her oxygen for that shift. During an interview on 05/14/25 at 10:38 AM the DON reported that she expects her staff to implement and follow physician orders and that her floor nurses are expected q- shift to check and implement physician orders as they are ordered. The DON reported that if a resident was not receiving his/her medications such as a resident receiving too much oxygen as per orders then that resident was not getting the appropriate dose which will affect the resident negatively depending on the diagnoses and treatment being administered. Record review of Oxygen Administration Policy dated 5/02/25 revealed the following: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Oxygen is administered under orders of a physician .

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents who were trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 of 15 residents (Resident # 38) reviewed for trauma-informed care. The facility did not ensure Resident #38 had a trauma screening that identified possible triggers when Resident #38 had a history of trauma. This failure could put residents at an increased risk for severe psychological distress due to re-traumatization. The findings included: Record review of the face sheet, dated 05/13/2025, indicated Resident #38 was a [AGE] year-old male, admitted to the facility on [DATE] had diagnoses that included but not limited to schizoaffective disorder, bipolar type, post-traumatic stress disorder (a mental health condition that can develop in people who experience or witness a traumatic event), cannabis dependence, in remission and cocaine dependence, in remission. Record review of the quarterly MDS Assessment, dated 03/21/2025, revealed Resident #38 had a BIMS of 11, which indicated moderately impaired cognition. In Section I Active Diagnoses revealed Resident had Post Traumatic Stress Disorder. Record review of the comprehensive care plan, revised on 04/08/2025, had no documentation of Resident #38's Post-Traumatic Stress Disorder and any interventions related to his PTSD. Record review of Assessments in Resident #38's clinical filed revealed no Trauma Informed Care Assessment. During an interview on 05/13/2025 at 3:14 PM, the ADM stated a Trauma Assessment should be documented in the resident's clinical file on admission and without this information in the file, staff would be unclear on appropriate treatment that was needed for the resident, and this could cause the resident to become withdrawn. The ADM stated the SW was responsible for ensuring this assessment was completed but ultimately, she was responsible because she was the Administrator. During an observation and interview on 05/14/2025 at 8:30 AM, Corp RN looked through Resident #38's clinical file and could not find the Trauma Informed Assessment and stated he should have had one on admission because of his diagnosis of PTSD. The Corp RN stated the SW, DON or ADON would be the staff responsible for ensuring the assessment was completed and if a referral was needed for psychotherapy and services were to be provided. She stated a possible negative outcome for not completing the assessment would be staff would not be aware of triggers to watch for and how to treat the resident. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 05/14/2025 at 9:02 AM, Resident #38 was sitting in his w/c in his room, he had a ball cap on that said Veteran. Resident #38 stated he had PTSD due to being in the Vietnam War and was a [NAME] for 6 years. Resident #38 stated the facility had not offered him any services related to his PTSD but would be interested in services. Resident #38 stated he did not feel he had any adverse triggers related to his diagnoses but thought services could help him cope with his diagnoses. During an interview on 05/14/2025 at 9:11 AM, the SW stated she had only worked for the facility for three days but voiced understanding of Trauma Informed Care. The SW stated she would be responsible for ensuring the resident would be assessed on admission and a possible negative outcome for failing to complete an assessment could result in staff being unclear about what triggers a resident. During an interview on 05/14/2025 at 10:01 AM, the DON stated the Trauma Informed Care Assessment should have been completed on Resident #38. The DON stated the assessment was a tool to help identify triggers and the needs of the residents. The DON stated the SW would be the one that would do the assessment, but also clinical staff would be also responsible if the SW was unavailable. A negative outcome for not being aware of a resident that had trauma could cause increased behaviors. During an interview on 05/14/2025 at 10:11 AM, the ADON stated the Trauma Informed Care Assessment should have been completed on Resident #38. The ADON stated clinical staff were responsible for ensuring this was completed on admission. A negative outcome for not doing a trauma informed assessment would be staff would not be aware of a resident that had trauma and their needs may not be met . Record review of the facility's policy titled Trauma-Informed Care revised on 05/02/2025, indicated: The facility will use a multi-prolong approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument, admission Assessment, the history and physical and social history/assessment and others. The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals(such as psychologists and mental health professionals) to develop and implement individualized care plan interventions. Trauma specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. The interventions will also recognize the survivors' need to be respected, informed, connected, and hopeful regarding their own recovery.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 1 of 1 facilities reviewed for RN coverage. The facility failed to ensure the presence of a register nurse to oversee the care for high acuity residents and the care provided by other staff such as Licensed Vocational Nurses (LVNs) and Certified Nurse's Aides (CNAs) for 30 of 31 days in January 2025, 19 of 28 days in February 2025, 20 of 31 days in March 2025, and 20 of 30 days in April 2025. This failure could place residents with unpredictable health concerns or requiring a higher level of care at risk of serious injury, harm, impairment, or death. Findings included: Review of RN coverage hours for the month of January 2025 revealed there was no RN coverage for 8 consecutive hours on the following dates: January 1-17, and January 19-31. Review of RN coverage hours for the month of February 2025 revealed there was no RN coverage for 8 consecutive hours on the following dates: February 3-13, February 16-18, February 21-23, and February 26-27. Review of RN coverage hours for the month of March 2025 revealed there was no RN coverage for 8 consecutive hours on the following dates: March 2-5, March 7-10, March 12-13, March 16-19, March 21, March 25-28, and March 30-31. Review of RN coverage hours for the month of April 2025 revealed there was no RN coverage for 8 consecutive hours on the following dates: April 1-7, April 9-10, April 13-15, April 18-20, April 23-24, and April 27-29. An interview with the ADON on 05/14/2025 at 11:47AM revealed she was aware there was not a registered nurse in the building on many of the days over the past few months. She stated no residents who were higher acuity than was within her scope of practice resided in the facility and she had not had any kind of emergency that required the presence of a RN. She was unable to say if resident assessments had been completed and/or updated during this timeframe. The ADON stated she was unaware of who had overseen the practice of CNAs during this timeframe. She stated the CNAs she worked with knew what to do for the residents they were assigned to, and had not given much thought to their oversight. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the DON on 05/14/2025 at 2:39PM revealed there was no way to tell if there was coverage on the days that she worked, since she was on salary. She stated she did not use the time punch system that the LVNs and CNAs used, so her hours were never recorded. She was unable to say how staffing hours were reported for the PBJ staffing reports to indicate the hours that she worked. She stated the negative outcome of not having a RN in the facility 8 consecutive hours a day, 7 days per week was resident assessments would not be completed and resident care would not be provided at the level of a RNs scope of practice, along with no one to give guidance to the LVNs and CNAs. She stated she was unaware of any emergencies or residents with a higher level of acuity, who resided in the facility during this timeframe. The DON stated she had overseen the practice of LVNs and CNAs during this timeframe but was unable to provide documentation of this evidence. An interview with the Corporate RN on 05/14/2024 at 2:46PM revealed she had tried to find additional RN coverage hours for January 2025-April 2025, but was unsuccessful. She stated no agency staff was called to fill the dates when core staff was unavailable and was unable to say if any emergencies or residents with a higher level of acuity had resided in the facility during this timeframe. She stated RNs were responsible for resident assessments and levels of care such as IV antibiotics. LVNs would have been practicing outside of their scope of practice if they had performed these duties. The Corporate RN stated she had not been made aware there was no RN coverage for the dates during this timeframe, or she would have engaged the use of agency staff to cover the RN hours. The Corporate RN stated LVNs and/or the DON had overseen the practice of LVNs and CNAs during this timeframe. She was unable to provide any documentation of this evidence. An interview with the Administrator on 05/14/2025 at 2:52PM revealed she was not aware there had not been RN coverage for the dates during this timeframe. She stated she was the third administrator since January 1, 2025, and had only been in her current position since April 1, 2025. The Administrator stated she had not taken note of the fact that there was not a RN in the building during the month of April, as she was getting accustomed to her new position. She stated it would have been tragic if something had happened to a resident in the facility that required the care of a RN. She was unable to say if any LVNs had practiced outside of their scope, or why the use of an agency RN was not utilized from January 2025-April 2025. The Administrator stated LVNs, and the DON had overseen the practice of CNAs during this timeframe. She was unable to provide any documentation of this evidence. Review of facility policy for Nursing Services dated 5/12/2025 revealed the following: Policy: It is the intent of the facility to comply with Registered Nurse staffing requirements as per Social Security Act § 1919 and §1819. Policy Explanation and Compliance Guidelines: 1. The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week. (The requirement of 8 consecutive hours of RN services can be met by any RN or multiples of RNs. The hours worked by the DON would be considered applicable towards the requirement). (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The RN takes responsibility and accepts accountability for practicing within the legal scope of practice, is prepared to work in all health care settings, and may engage in independent nursing practice without supervision by another health care provider. The RN, with a focus on patient safety, is required to function within the parameters of the legal scope of practice and in accordance with the federal, state, and local laws, rules, and regulations. In addition, the RN must comply with policies, procedures and guidelines of the employing health care institution or practice setting. The RN is responsible for providing safe, compassionate, and comprehensive nursing care to patients and their families with complex healthcare needs. The purpose of this position statement is to provide direction and recommendations for nurses and their employers regarding the safe and legal scope of practice for RNs and to promote an understanding of the differences in the RN programs of study and between the RN and LVN levels of licensure. The professional RN serves as an advocate for the patient and the patient's family and promotes safety by practicing within the NPA and the BON Rules and Regulations. The RN provides nursing services that require substantial specialized judgment and skill. The planning and delivery of professional nursing care is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course of study in an approved school of professional nursing. Unless licensed as an advanced practice registered nurse, the RN scope of practice does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures. RNs utilize the nursing process to establish the plan of care in which nursing services are delivered to patients. The level and impact of the nursing process differs between the RN and LVN as well as between the different levels of RN education. Assessment The comprehensive assessment is the first step and lays the foundation for the nursing process. The comprehensive assessment is the initial and ongoing, extensive collection, analysis, and interpretation of data. Nursing judgment is based on the assessment findings. The RN uses clinical reasoning and knowledge, evidence- based outcomes, and research as the basis for decision-making and comprehensive care. Based upon the comprehensive assessment the RN determines the physical and mental health status, needs, and preferences of culturally, ethnically, and socially diverse patients and their families using evidence-based health data and a synthesis of knowledge. Surveillance is an essential step in the comprehensive assessment process. The RN must anticipate and recognize changes in patient conditions and determines when reassessments are needed. Patient Diagnosis/Problem Identification/Planning The second step in the nursing process is analyzing data gathered during the assessment and problem identification. The role of the RN is to synthesize comprehensive assessment data to identify problems, formulate goals/outcomes, and develop plans of care for patients, families, populations, and communities using information from evidence-based practice and published research in collaboration with these groups and the interdisciplinary health care team, as appropriate for their educational background and scope. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The third step in the nursing process is planning. The RN synthesizes the data collected during the comprehensive assessment to identify problems, participate in the patient diagnoses, and to formulate goals, teaching plans and outcomes. A nursing plan of care for patients is developed by the RN, who has the overall responsibility to coordinate nursing care for patients. Teaching plans address health promotion, maintenance, restoration, and prevention of risk factors. The RN utilizes evidence-based practice, published research, and information from patients and the interdisciplinary health care team during the planning process. Implementation Implementing the plan of care is the fourth step in the nursing process. The RN may begin, deliver, assign, or delegate certain nursing tasks within the plan of care for patients within legal, ethical, and regulatory parameters and in consideration of health restoration, disease prevention, patient independence, wellness, and promotion of healthy lifestyles. The RN's duty to patient safety when making assignments to other nurses or when delegating tasks to unlicensed staff is to consider the education, training, skill, competence, and physical and emotional abilities of those to whom the assignments or delegation is made. The RN is responsible for reasonable and prudent decisions regarding assignments and delegation. The RN scope of practice may include the supervision of LVNs or other RNs. Supervision of LVN staff is defined as the process of directing, guiding, and influencing the outcome of an individual's performance and activity. The RN may have to directly observe and evaluate the nursing care provided depending on the LVN's skills and competence, patient conditions, and level of urgency in emergent situations. The RN may determine when it is appropriate to delegate tasks to unlicensed personnel and maintains accountability for how the unlicensed personnel perform the tasks. The RN is responsible for supervising the unlicensed personnel when tasks are delegated. The proximity of supervision is dependent upon patient conditions and skill level of the unlicensed personnel. In addition, teaching and counseling are interwoven throughout the implementation phase of the nursing process. Evaluation and Re-assessment A critical and final step in the nursing process is evaluation. The RN evaluates and reports patient outcomes and responses to therapeutic interventions in comparison to benchmarks from evidence-based practice and research findings and plans any follow-up care and referrals to appropriate resources that may be needed. The evaluation phase is one of the times when the RN reassesses patient conditions and determines if interventions were effective and if any modifications to the plan of care are necessary.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure food was stored, prepared, and distributed in accordance with professional standards for 1 of 1 kitchen reviewed for food safety. The facility failed to ensure foods served to residents were not laying on the kitchen countertops, open to air. The facility failed to ensure refrigerated foods served to residents were covered, labeled, and dated. The facility failed to ensure dry pantry foods served to residents were properly sealed, labeled and dated. The facility failed to ensure frozen foods served to residents were properly sealed, labeled and dated. These failures could cause residents who consumed these foods to become sick due to food-borne illness, and/or a loss a of the food's nutritional value. Findings included: An observation of the kitchen countertops on 05/12/2025 at 9:35AM revealed the following: (1) partial 35oz. bag of frosted flake cereal, open to air, (1) partial 1lb. bag of corn chips, open to air, (4) thawed toaster waffles, laying on the countertop, and (1) partial 16oz. bag of potato chips, open to air. An observation of the refrigerator on 05/12/2025 at 9:39AM revealed the following: (3) 1/2c. servings of fruit cocktail, open to air, (8) individual vanilla protein drinks, with no date, (4) prepared snack sandwiches; one peanut butter and jelly and 3 ham and cheese with no date, (9) 1lb. packages of butter with no date, (5) fresh jalapenos, in a clear bag, with no date, (1) 1lb. package of lunch meat with no label and no date, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(1) 1lb. package of cheese slices with no label and no date, (2) 1gal. containers of iced tea, uncovered with no label and no date, 75 fresh eggs with no date received and broken shells in the box, 15lbs. of fresh bacon, with no date received and open to air, (2) 8oz. cans of dough sheets with no date, and (1) 16oz. bag of whipped topping with no date. An observation of the dry pantry on 05/12/2025 at 9:52AM revealed the following: 10lbs. of organic black-eyed peas with no date, (1) partial 30oz. bag of dry refried beans, with no label and no date, (1) partial 21oz. container of taco seasoning with no date, (1) partial 2lb. box of pancake mix with no date and open to air, (1) partial 10lb. bag of seasoned croutons, open to air, (1) partial 25lb. bag of food thickener, open to air, (1) 50lb. box of fresh white potatoes with no date, (1) partial 50lb. box of red potatoes with no date, (1) 16oz. bag of tri-colored rotini, with no date, (8) 18.6oz. boxes of cranberry orange muffin mix with no date and covered in a layer of dust. (150) 4oz. servings of vanilla fortified Mighty Shake with no date, (2) 14oz. cans of cranberry sauce with no date, (21) 12oz. cans of evaporated milk with no date, (2) 42oz. containers of oatmeal with no date, (20) 1lb. boxes of baking soda with no date, (1) 8lb. can of caramel fudge ice cream topping with an expiration date of 07/01/2024, (1) 7lb. can of cherry pie filling with no date, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(6) 6oz. bottles of hot sauce with no date, (1) 17oz. can of cooking spray with no date, (2) 10lb. bags of penne pasta with no date, (4) 28oz. bags of cream soup base with no date, (1) partial 200 serving box of mayonnaise packets with no date, (1) partial 200 serving box of mustard packets with no date, (1) partial 1000 serving box of ketchup packets with no date, (6) 112 serving boxes of ice cream cones with no date, and (2) 112 serving boxes of ice cream cones with no date and open to air. An observation of the freezer on 05/12/2025 at 10:42AM revealed the following: (1) partial food service box of [NAME] House rolls with no date and open to air, (1) 5lb. bag of frozen cinnamon rolls with no date, (1) 10lb. bag of frozen ham chunks, open to air, (1) partial 17lb. box of frozen dough sheets, open to air, (1) 29.7lb. box of frozen biscuits, open to air, (1) zip-style bag of frozen tater tots with no label and no date, (1) loaf of frozen white bread with no date, 16lbs. of frozen cookie dough with no date, (6) 20lb. bags of frozen chicken breasts with no date, (1) zip-style bag of frozen potato wedges with a date of 08/16/2024, (2) food service bags of meat pies with no label and no date, (2) food service bags of frozen crab cakes with no label and no date, (3) food service bags of frozen sausage with no label and no date, (1) 30lb. bag of frozen yellow squash, open to air, (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(12) individual frozen Philly steaks with no label and no date, (1) food service bag of frozen chicken wings with no label and no date, and (1) partial 14lb. box of frozen churros with no date and open to air. An interview with the DM on 05/13/2025 at 3:08PM revealed the negative outcome of serving foods to residents that were expired, not labeled and/or not dated was they could be served something that would make them sick if they were allergic to the food and it was not labeled, or they could become sick if they were served foods that were not dated or expired or had been left open to air. The DM stated the nutritional value of foods left open to air on countertops, in pantries, refrigerators, and freezers could be lost, leading to residents not getting the nutrition they needed. She stated she began in-servicing her on-site staff immediately on food safety and food storage and continued to in-service all staff on food safety and food storage, as they came in for their shifts on 05/12/2025. A copy of the in-service was provided, and all 8 dietary staff members attended. Review of facility policy for Food Storage dated 2012 revealed the following: Dry Storage Rooms: To ensue freshness, opened and bulk items are stored in tightly covered containers. All containers are labeled and dated. Where possible, items are left in the original cartons placed with the date visible. The first-in, first-out (FIFO) rotation method is used. Packages are dated and new items are placed behind existing supplies, so that the older items are used first. The Dry Goods Storage guidelines are used to determine the shelf-life of unopened items. Refrigerators: All refrigerated foods are stored per state and federal guidelines. All refrigerated foods are dated, labeled, and tightly sealed, including leftovers, using clean, non-absorbent covered containers that are approved for storage. Items that are over 48 hours old are discarded. The Refrigerated Foods Storage guidelines are used to determine the shelf-life of unopened items. Freezers: Frozen foods are stored in moisture-proof wrap or containers that are labeled and dated. The Frozen Foods Storage Guidelines are used to determine the shelf-life of unopened items. The Dry Goods Storage Guidelines dated 2012 revealed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dry Beans/Peas should be stored, unopened, for a maximum of 12-months. Dry Seasonings should be stored, unopened, for a maximum of 12-months. Condiments such as ketchup, mustard, and mayonnaise should be stored, unopened, for a maximum of 6-months. Cookies, crackers, pastas, croutons, etc. should be stored, unopened, for a maximum of 6-months. Grains and grain products such as pancake mix, muffin mix, cookie mix, food thickeners, oatmeal, etc. should be stored, unopened, for a maximum of 12-months. Prepared, canned dairy food products should be stored, unopened, for a maximum of 12-months. Canned fruit and fruit fillings should be stored, unopened, for a maximum of 6-months. Fresh potatoes should be used within 30-days if held at room temperature. The Refrigerated Foods Storage Guidelines dated 2012 revealed the following: Butter, cheeses, and prepared protein drinks should be stored, unopened, for a maximum of 3-months or used by the expiration date on the container. Frozen whipped topping, thawed, should be stored, unopened, for a maximum of 2-weeks. Yeast bread, rolls, etc. should be stored, unopened, for a maximum of 3-months. Sandwiches with meat fillings should be stored for a maximum of 2-days. Bacon, thawed, should be stored for a maximum of 1-week. Lunchmeat, thawed, should be stored for a maximum of 5-days. Eggs in the shell should be used by the expiration date. The Frozen Foods Storage Guidelines dated 2012 revealed the following: Frozen cookies, yeast breads, biscuits and bread-based novelty items should be stored, unopened, for a maximum of 3-months. Frozen potato products should be stored, unopened, for a maximum of 6-months. Frozen vegetables, regardless of kind, should be stored, unopened, for a maximum of 6-months. Frozen meats or frozen items containing meat should be stored, unopened, for a maximum of 4-months.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to maintain medical records in accordance with accepted professional standards and practices for each resident that are complete, accurately documented, readily accessible, and systemically organized for 2 (Resident #31, 42) of 15 residents reviewed for medical records. The facility failed to ensure Resident #31's and Resident #42's physician orders and care plans reflected their current status of no longer being in the secured unit. This failure could place residents at risk of having records that do not reflect their current status or needs. Findings Included: Record review of Resident #31's Face Sheet dated 05/13/2025 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia(impairment of memory), without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, major depressive disorder, Parkinson's disease with dyskinesia(neurological disorder with involuntary movement), neurocognitive disorder with Lewy bodies(abnormal deposit of protein in the brain). Record review of Resident #31's Quarterly MDS assessment dated [DATE] revealed a BIMS of 00 out of 15 which indicated cognition was severely impaired. Record review of Resident #31's care plan dated 04/03/2025 revealed Resident has a diagnosis of Dementia and resides in the secured unit due to poor safety awareness and low cognitive function with interventions of staff monitoring and report changes in exit seeking behaviors. Record review of Resident #31's active physician's orders revealed the following: Admit to Secured Unit due to poor safety awareness and or wandering due to low cognitive function dated 8/7/2024. Record review of Resident #42's Face Sheet dated 05/13/2025 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Unspecified dementia(memory loss) with other behavioral disturbance, major depressive disorder, anxiety disorder and unsteadiness on feet. Record review of Resident #42's Annual MDS assessment dated [DATE] revealed a BIMS of 01 out of 15 indicated cognition was severely impaired. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #42's care plan dated 04/14/2025 revealed Resident has a diagnosis of Dementia and resides in the secured unit due to poor safety awareness and low cognitive function with interventions of staff monitoring and report changes in exit seeking behaviors. Record review of Resident #42's active physician's orders revealed the following: Admit to Secured Unit due to poor safety awareness and or wandering due to low cognitive function dated 8/7/2024. During on observation on 05/12/2025 at 10:49 AM revealed Resident #31 was in his bed sleeping, his room was on Hall B in the general population, outside the secured unit. During an observation on 05/12/2025 at 2:08 PM revealed Resident #42 was in his bed, he was dressed for the day. Resident #42 would only provide yes answers and could not provide any other responses. Resident #42's room was on Hall B in the general population, outside the secured unit. During an interview on 05/13/2025 at 11:03 AM, Resident #31's family member stated she was happy with the care her husband was getting. She stated her husband was declining in health and had talked to a hospice provider and was deciding on what to do going forward. Resident #31's family member was aware her husband was no longer in the secured unit. During an observation and interview on 5/14/2025 at 8:28 AM, The Corp RN looked through Resident #31 and Resident #42's clinical file and stated the records were inaccurate due to the residents being in the general population and the orders stating they were to be in the secure unit. Corp RN stated both residents were moved out of the secured unit on 05/09/2025 and the orders should have been discontinued on that date. The Corp RN stated inaccurate documentation may lead to misrepresentation of the resident's actual status. During an interview with DON on 05/14/2025 at 9:56 AM, The DON state she was given verbal orders to move the residents out of the secured unit on 05/09/2025 by the Nurse Practitioner but it was not put in their record. The DON stated she was working on getting the written orders in their file as we spoke. The DON stated Resident #31 and Resident #42's behaviors of wandering had declined and therefore the rationale of moving them to a least restrictive area in the facility was decided, but it was not documented. The negative outcome for not having accurate documentation would be staff would not be aware of changed orders. The DON stated she was responsible for ensuring documentation was accurate. Record review of Documentation in Medical Record Policy dated 05/02/2025 revealed the following: Each resident's medical record shall contain an accurate representation of the actual experience of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #27)) of 4 residents observed for infection control. -CNA C did not wash her hands while performing incontinent care for Resident #27. This deficient practice has the potential to affect residents in the facility receiving incontinent care by exposing them to care that could lead to the spread of infections, tissue breakdown, and feelings of isolation related to poor hygiene. Findings include: Record review of Resident #27's face sheet revealed she was an [AGE] year-old female resident admitted to the facility originally on 11/14/23 and readmitted on [DATE] with diagnoses to include dementia (a group of thinking and social symptoms that interferes with daily functioning), schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms),, diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), delusions (a false belief for judgment about external reality), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), COPD (a group of lung diseases that block airflow and make it difficult to breath), and muscle weakness. Record review of Resident #27's last MDS revealed a quarterly assessment completed on 02/12/25 with a BIMS of 14 indicating she was cognitively intact, and she had a functional status of requiring substantial/maximal assistance with her toileting hygiene. Record review of the care plan with admission date of 01/19/24 for Resident #27 revealed the following: Focus: Resident has bladder incontinence related to dementia and impaired mobility. During an observation on 05/13/25 at 01:29 PM of incontinent care completed for Resident #27 CNA C did not wash her hands upon entering the room. CNA C was observed coughing into her left hand. CNA C then put on a pair of gloves she had in her right hand without washing her hands. CNA C then pulled Resident #27's bed out for access. CNA C then pulled 5 wipes, one at a time, from the wipe package to hand to the primary CNA to clean the resident's peri area. CNA C then assisted the primary CNA to roll the resident to her left side with her gloved hands coming into contact with Resident #27's skin. Keeping her left gloved hand on the resident hip/skin to keep Resident #27 in place, CNA C used her right gloved hand to pull 5 more wipes, one at a time, from the wipe package and hand to the primary CNA so the primary CNA could clean the resident rectal area. CNA C then assisted the resident to her back and the primary CNA finished the incontinent care. CNA C removed her gloves and used ABHR for the first time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/13/25 at 01:41 PM CNA C reported that she did not wash her hands before she entered the resident's room and coughed into her hands before she placed her gloves. When CNA C was asked, she reported that her hands and gloves were contaminated. CNA C reported that when she removed the new wipes for the primary CNA to use, each wipe became contaminated when her gloves touched the wipes. CNA C reported that not performing hand hygiene correctly was going to get germs on the resident. CNA C reported that she had been trained on hand hygiene recently but she could not remember exactly when. During an interview on 05/14/25 at 10:43 AM the DON reported that she expected her staff to completed hand hygiene upon entering the resident's room, when their hands are soiled/contaminated, and before they exit the room. The DON expects them to perform hand hygiene which is changing gloves and washing hands when they move from the dirty to the clean portion of the incontinent care. The DON reported that if a staff member does not use hand hygiene when they enter the room and during the resident care then their hands and gloves are considered contaminated so when they are performing such tasks as pulling clean wipes from the resident's package, they are putting the resident at risk for contamination and infection. The DON verified that she was the one, along with the ADON, who instructed the staff on handwashing and that the staff were due for their yearly training which was scheduled to be completed but State walked in, and training had to be delayed. During employee record review this surveyor noted that CNA C had been trained on Hand Hygiene on 2/12/25, for the following: 1. Hand hygiene should be completed before the following: a. contact with resident b. putting on gloves. c. inserting or manipulating a device. d. all of the above - CNA C answered d. 2. Hand hygiene should be completed after the following: a. Contact with residents' skin, bodily fluids, or excretion, or personal items. b. non-intact resident skin, wound dressing, or contaminated items. c. removing gloves. d. all of the above - CNA C answered d. -No listed trainer was provided. Record review of the facility provided policy titled Hand Hygiene date implemented 09/01/23, revealed the following: Policy: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, resident, and visitors. Policy: Explanation and Compliance Guidelines: 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. Hand Hygiene Table Conditions: -Before performing resident care procedures. -When, during resident care, moving from a contaminated body site to a clean body site. -After sneezing, coughing, and/or blowing or wiping nose.

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Put firmly secured handrails on each side of hallways. Based on observations and interviews, the facility failed to ensure corridors were equipped with firmly secured handrails on each side for 1 (A Hall) of 6 halls reviewed for handrails. The handrail between room A8 and A10 was loose. This deficient practice has the potential to place residents at risk for injuries related to falls that could result in bruising, skin tears, wounds, fractures, and decreased quality of life. Findings include: During an observation on 05/12/25 at 10:39 AM an approximate 10-foot section of handrail between room A8 and A10 was noted to have the middle section loose and this surveyor was able to move the handrail back and forth approximately ½ inch. The handrail was secured on each end and in the middle by brackets with two screws. Both screws in the middle bracket were loose. During an interview on 05/14/25 at 08:18 AM the MS noted that the handrail between room A8 and A10 was loose and that the screws had loosened. The MS reported that he makes rounds everyday as part of what the facility calls Angel Rounds and that he had missed the loose rail on his Angel Rounds. The MS did not know how long the handrail had been loose. The MS reported that residents have their good days and bad days but he did not believe they would get injured from this loose handrail. The MS reported that it was his responsibility to ensure the facility was well maintained. During an interview on 05/14/25 at 08:54 AM the MS reported that both screws holding the center bracket of the handrails on the wall between the A8 and A10 room were loose and required them to be tightened up. During an interview on 05/14/25 at 09:01 AM CNA B reported that she had worked in the memory unit/Hall A for approximately 2 months. CNA B was unaware of the loose handrail and reported that all the residents in the unit (on A Hall) were in wheelchairs and did not ambulate so she did not feel they could injure themselves on a loose rail. During an observation on 05/14/25 at 09:04 AM 12 residents were noted in the main area of the memory care unit (A Hall) for an activity. One resident was observed using the handrail to pull himself down the hallway in his wheelchair, one resident was present with his walker, and two residents were present with no assistive devises for ambulation. During an interview on 05/14/25 at 10:39 AM the DON reported that she expects the facility to be clean, in good condition, and well maintained. That there should be no loose handrails. The DON reported that she expects the handrails or any equipment to be up-to-date and secure. That if a handrail was loose then a resident could hurt themselves if they grabbed the rail and fell as a result of the rail being loose. The DON reported that it was maintenance's responsibility to make sure all the handrails were secure. Record review of the facility provided policy titled, Handrails date implemented 09/01/23, revealed the following: (continued on next page)

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Explanation and Compliance Guidelines: 1. All handrails will be firmly secured 2. Secured handrails means handrails that are firmly affixed to the fall. 3. Routine maintenance on handrails will be completed by the maintenance department.