STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676283	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Arcos Del Norte Care Center	11169 Sean Haggerty El Paso, TX 79934

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement their written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents for 1 of 7 (Resident #1) residents reviewed for abuse. The facility failed to follow their abuse policy when they did not perform a skin assessment following an incident. This failure placed Residents at risk for abuse and neglect. Findings included: Record review of Resident #1's face sheet dated 06/11/25, revealed admission on [DATE]. Record review of Resident #1's facility history and physical dated 05/21/25, revealed, an [AGE] year-old female diagnosed with chronic skin condition versus staphylococcal scalded skin syndrome (MSSA bacteremia - a bloodstream infection caused by the bacteria Staphylococcus aureus, which are susceptible to methicillin and other beta-lactam antibiotics). Record review of Resident #1's MDS dated [DATE] revealed BIMS score of 11, indicating her cognition was moderately impaired. Record review of Resident #1's care plan dated 6/6/25 revealed no focus area or interventions for Resident #1's refusal to shower. Record review of Resident #1's progress notes dated 5/28/25- 5/29/25 revealed there was no skin assessment documented following her behavior and/or allegation of mistreatment. Record review of Resident #1's skin assessment dated [DATE] did not specify reason for assessment and no abnormalities were found. (continued on next page)

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

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/25 at 11:15 am, CNA A stated that he was informed Resident #1 had alleged that he beat her up during a shower while she was on the gurney. CNA A stated that CNA B had asked him to assist with the shower. CNA A stated that he retrieved soap and began scrubbing the resident's back and hair due to visible dandruff. CNA A stated that midway through the shower, Resident #1 began saying that her cellphone had no battery and that she would call 911. CNA A stated that Resident #1 was not screaming and remained compliant until the water was applied, which he described as warm. CNA A stated after the shower, LVN D assisted him in transferring her back to bed after the shower and no cocnerns were voiced at that time, she had already been calm. CNA A described Resident #1 as having extremely dry skin and noticeable body odor, which he attributed to her refusal to shower. CNA A believed that Resident #1 became upset because she was given a shower. CNA A stated that this was the resident's first shower since admission and that she required a two-person assist. During an interview on 6/11/25 at 1:51 pm, CNA B stated that it was her first time working with Resident #1 and that she had not worked with her since, as she had not been scheduled to that hall. CNA B stated that CNA A assisted with turning on the water and waited for it to get warm, and once the water made contact with Resident #1, she began to scream, so they stopped. CNA B stated that she did not understand what Resident #1 was saying because she was speaking in Spanish. CNA B estimated they were in the shower room for approximately 8 to 10 minutes and attempted to complete the shower as quickly as possible. CNA B denied hitting Resident #1. During an interview and observation on 6/11/25 at 2:16 pm, Resident #1 was alert and oriented to person, place, and event. Resident #1 was observed with hair that appeared disheveled and uncombed, with strands scattered in multiple directions. Resident #1 had a strong body odor and visible white, flake-like substances on her skin. Resident #1 stated she only remembered receiving one shower approximately three or four weeks ago. Resident #1 stated she was taken into the shower on a gurney and that staff were putting water all over her in all directions. Resident #1 stated she felt scared because it was the first time someone had done this. Resident #1 stated she told staff she was going to call the police but ultimately did not. Resident #1 stated she could not recall the staff involved and was unable to describe them. Resident #1 stated that since then, she had been showered in different shower rooms and only required assistance with adjusting the water temperature. Resident #1 stated she was able to shower herself and now felt safe but still wanted to leave the facility. Resident #1 stated her most recent shower occurred three days ago. During an interview on 6/12/25 at 10:16 am, LVN D stated Resident #1's skin appeared very scaly and dry, and she had a strong body odor. LVN D stated that on the day of the incident (5/28/25), Resident #1 agreed to a shower. LVN D stated that once the shower was completed, he assisted with transferring Resident #1 back to bed. He stated that Resident #1 did not voice any concerns or make any statements upon returning from the shower. LVN D stated he was not made aware of any allegations until the following day when nursing administration brought it to his attention. He stated that no skin assessment was requested or conducted, and no staff reported any concerns to him at the time. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/25 at 11:41 am, The DON stated she was first notified of the allegation involving Resident #1 on 5/28/25 in the afternoon, after the morning shift had ended that Resident #1 had said she had been hit during the shower the day before. The DON stated she did not recall who initially reported the concern but believed it may have been either the floor nurse or the wound care nurse. The DON stated she was told that Resident #1 voiced that someone had scrubbed her too hard during the shower and that both hot and cold water were used. The DON stated she reviewed the documentation and found no progress notes or skin assessments completed on the day of the allegation, 5/28/25. The DON stated the only available skin assessment was timestamped 5/30/25 and did not specify that it was related to the allegation. The DON stated that, per facility policy, a progress note should have been completed to document both the skin assessment and the incident. The DON stated that the failure to document the assessment following the allegation was a failure to provide adequate care, ensure continuity of care, and properly intervene. During an interview on 6/12/25 at 12:13 pm, the ADON stated she was notified of the incident by the morning nurse (LVN D) the day after the shower (5/29/25), which occurred on 5/28/25. The ADON stated she was aware that staff had been attempting to get Resident #1 to accept a shower for several days and that the resident had finally agreed. The ADON stated that Resident #1 expressed in Spanish to her that she had been scrubbed too hard during the shower, which was the only concern initially verbalized . The ADON stated that after the concern was brought to her attention, she went to speak with Resident #1, who was with her family member at the time. The ADON stated that Resident #1 did not disclose any additional information other than saying she did not like the shower. The ADON stated that a skin assessment was attempted, but the resident initially refused due to being upset. The ADON stated she had to wait until the next day, when the resident's family member was present, to follow up. The ADON stated that a skin observation was conducted on the day of the shower and that she later completed a follow-up assessment. The ADON stated that the initial attempt to complete the skin assessment was not documented in the clinical record because it was considered part of the internal investigation. The ADON stated she declined to answer specific questions regarding documentation, noting that showers were considered part of direct care and routine treatments. During an interview on 6/13/25 at 2:55 pm, The Administrator stated the DON notified him of Resident #1's incident but he could not recall the exact date. The Administrator stated the DON conducted an investigation. The Administrator stated that following the incident, body assessment should've been completed. The Administrator stated that the risk of not completing a skin assessment after the incident would be the inability to determine if any injuries occurred. The Administrator stated the ADON and DON should have been following up to ensure all required documentation was in place. The Administrator stated that education on documentation was provided on a case-by-case basis. Record review of the facility's Abuse, Neglect, Exploitation, or Mistreatment policy dated 11/1/2017 read in part on page #7 7. Guidelines for Investigation: A. Immediately assess the resident/patient at the time of discovery of alleged abuse. B. Document assessment in the medical record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident medical and nursing needs for 4 of 6 residents (Resident #1, Resident #6, Resident #10, Resident #12) reviewed for care plans. The facility failed to implement a comprehensive person-centered care plan that addressed Resident #1's refusal of showers. The facility failed to implement a comprehensive person-centered care plan that addressed Resident #6's wandering into other resident rooms. The facility failed to implement a comprehensive person-centered care plan that addressed Resident #10 ' s sexual inappropriateness. The facility failed to implement a comprehensive person-centered care plan that addressed Resident #12 ' s sexual inappropriateness. These failures could place residents in the facility at risk of not receiving the necessary care or services and having personalized plans developed to address their needs. Findings included: Resident #1 Record review of Resident #1's face sheet dated 06/11/25, revealed admission on [DATE] to the facility. Record review of Resident #1's facility history and physical dated 05/21/25, revealed, an [AGE] year-old female diagnosed with chronic skin condition versus staphylococcal scalded skin syndrome (MSSA bacteremia - a bloodstream infection caused by the bacteria Staphylococcus aureus, which are susceptible to methicillin and other beta-lactam antibiotics). Record review of Resident #1's MDS dated [DATE] revealed BIMS score of 11, indicating her cognition was moderately impaired ADLs for shower was marked 88 Not attempted due to medical condition or safety concerns. Record review of Resident #1's care plan dated 6/6/25 revealed no focus area or interventions for Resident #1's refusal to shower. Record review of Resident #1's progress note dated 6/6/25 revealed Resident was asking for lotion this morning; resident was asked if she wanted a shower and resident refused and even dismissed the idea of a shower. Resident had a shower over a week ago and has not received one since then. - (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Progress note dated 5/27/25 revealed refused shower despite multiple attempts this shift and previous shift. - Progress note dated 5/25/25 revealed Resident refused shower to take place multiple times on 5/24. Resident finally agreed 2-10 shift for shower.5/24. - Progress note dated 5/22/25 revealed family member reported patient had been without a shower for a year. During an interview on 06/10/25 at 1:27 PM, with the wound Care Nurse, she stated she asked Resident #1 if she would take a shower and afterwards, she would perform the wound care and that way she would be clean. The Wound Care Nurse stated Resident #1 had agreed to shower. The Wound Care Nurse went ahead and told the CNAs that she would be taking a shower. During an interview on 6/11/25 at 11:15 am, CNA A stated she often refused showers and had a history of declining hygiene care. CNA A stated that he was aware Resident #1 frequently refused showers and that staff had documented multiple refusals since her admission. CNA A described Resident #1 as having extremely dry skin and noticeable body odor, which he attributed to her ongoing refusal to shower. CNA A stated that this was Resident #1's first shower since admission and that it required a two-person assist due to her physical limitations. CNA A explained that morning staff would typically offer showers to Resident #1 because prior attempts during the evening shift had been unsuccessful due to her refusals. During an interview on 6/11/25 at 1:51 pm, CNA B stated that it was her first time working with Resident #1 and that she had been informed by staff that the resident had repeatedly refused showers since admission. CNA B stated that Resident #1 had a strong body odor and that she only agreed to the shower after speaking with the wound care nurse and a friend or family member, who helped encourage her to accept hygiene care. During an interview and observation on 6/11/25 at 2:16 pm, Resident #1 stated she only remembered receiving one shower approximately three or four weeks ago and recalled being taken in on a gurney. Resident #1 stated she felt scared because it was the first time someone had showered her in that manner and stated she told staff she would call the police. Resident #1 stated that since that time, she had been showered in different shower rooms and was now able to shower herself with minimal assistance. Resident #1 was observed with hair that appeared disheveled and uncombed, and had visible white, flake-like substances on her skin. A strong body odor was also noted during the observation. During an interview on 6/12/25 at 9:37 am, the Staff Coordinator stated that CNA A had approached him for assistance with showering Resident #1, noting that she had been refusing showers since admission and had developed a strong body odor as a result. The Staff Coordinator stated that he was aware family permission had been obtained to encourage hygiene care due to ongoing refusals and concerns about Resident #1's hygiene and skin condition . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/12/25 at 10:16 am, LVN D stated, Resident #1 had been at the facility for approximately ten days and had refused all showers during that time. LVN D stated that staff were aware Resident #1 had a history of going up to six months without accepting a shower, as reported by her family. LVN D stated Resident #1's skin appeared scaly and extremely dry, and she had a strong body odor, which staff attributed to her repeated refusal of hygiene care. LVN D stated that she agreed to a shower on 5/28/25 after persistent attempts by staff and encouragement from the wound care nurse and family. During an interview on 6/12/25 at 12:05 pm, The DON stated that she did not observe a care plan addressing Resident #1's refusal of showers. She stated that such a plan should have been developed to identify interventions that had been effective, evaluate their outcomes, and determine if alternative strategies were needed. She described this as initial care planning and stated that the failure to include refusals in the care plan represented a violation of Resident #1's rights, safety, and continuity of care. The DON stated that nursing and MDS staff were jointly responsible for completing and updating care plans. She further stated that a comprehensive care plan was required within seven days of admission, and based on the timeline, the facility should have already identified Resident #1's pattern of shower refusals and incorporated that information into her care plan. The DON stated she was not involved in the development of Resident #1's care plan. She reported that the most recent care conference on file occurred on 5/28/25. During an interview on 6/12/25 at 12:13 pm, the ADON stated that all members of the nursing department were expected to follow best practices, which involve breaking down the care plan into specific domains such as medical management, ADLs, medications, and therapies. She stated that a proper care plan would include clearly defined ADL goals and interventions, and that failure to do so poses a risk to continuity of care. During an interview on 6/13/25 at 2:55 pm, The Administrator stated he was made aware that Resident #1 had a history of refusing care, including showers. The Administrator stated that such behaviors should have been care planned to reflect the resident's specific needs. The Administrator stated there was a risk in not being fully informed of Resident #1's behavioral patterns, including how she responds to care interventions. The Administrator stated it was important to identify what strategies work for each resident and ensure appropriate interventions are in place. The Administrator stated that care approaches and planning are typically handled on a case-by-case basis . Resident #6 Record review of Resident #6's face sheet dated 06/12/25, revealed, admission on [DATE] and re-admission on [DATE] to the facility. Record review of Resident #6's hospital history and physical dated 12/09/24, revealed, a [AGE] year-old female diagnosed with Alzheimer's Disease (a progressive brain disorder that gradually destroys memory and thinking skills, eventually impacting the ability to carry out even the simplest tasks) and depression. Record review of Resident #6's care plan reviewed on 06/12/25, revealed wandering to be care planned for wandering regarding gait. Care plan did not address Resident #6 wandering into resident rooms . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #6's Facility self -report to state dated 05/01/25, revealed, Resident #7 hit call light and notified the RN E of incident which occurred. RN E notified RN F that Resident #6 entered room of another resident and attempted to remove Resident #7's graham crackers from her room. Resident #6 had the graham crackers slapped out of her hand. Head to toe assessment provided for both Residents. RN E and RN F at bedside with Resident #7 having no pain to left wrist/hand. Resident #6 was assessed left wrist/hand with no bruising, redness, or irritation . ROM present in all upper and lower extremities. Emotional, physical, and mental state, assessed, stable. Investigation was conducted confirmed. Other facility self-report dated 05/1/25, revealed, Resident #5 reported the incident. Resident #6 was noted rummaging through Resident #5's personal belongings. RN E notified RN F that Resident #6 entered room of another resident and attempted to remove Resident #5's belongings from her room. Resident #5 came out of the bathroom and noted Resident #6 touching her belongings. Resident #5 then pushed Resident #6 on the back and then Resident #6 turned around and scratched Resident #5 on the right hand. Pain medication was offered and head to toe assessments were conducted for both residents. Back noted with no bruises, redness, or irritation. ROM present in all upper and lower extremities for both residents. No emotional distress noted. Investigation was conducted and confirmed. Record review of Resident #6's Progress Notes generated by RN F dated 04/26/25, revealed, At 1:40 PM - Resident #7 had hit the call light and notified RN F of the incident which had occurred. Resident #6 entered room of another resident and attempted to remove Resident #7's crackers from her room. Crackers were slapped out of Resident #6's hand and wrist were grabbed. Resident #6 exited room. At 1:16 PM - Resident #6 entered room of another resident and attempted to remove Resident #5's belongings. Resident #5 then pushed resident on the back. Resident #6 turned around and scratched other resident on the right hand. Resident #6 exited room. During an interview on 06/10/25 at 2:05 PM, with the SW, she stated Resident #6 entered Resident #5's room going through her belongings. The SW stated Resident #5 had reported this to the nurse. The SW stated Resident #6 did not remember the incident and Resident #5 did not want Resident #6 going into her room. During an interview on 06/12/25 at 9:06 AM, with RN F, she stated Resident #6 had a habit of going into resident rooms to get stuff. RN F stated later in the day Resident #6 entered another resident room. RN F stated Resident #6's care plan should have addressed wandering and or going into residents' room. RN F stated care planning was so that nursing staff knew what kind to provide care for the resident. During an interview on 06/12/25 at 10:14 AM, with RN E, she stated she was told by Resident #7 that Resident #6 had gone into her room to try to take her graham crackers. RN E stated Resident #6 had a lot of behaviors and goes into other resident rooms. RN E stated the staff were constantly having to re-direct her and take her to the activities room. RN E stated it was care planned to go into other resident rooms. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/13/25 at 11:07 AM, with the DON, that this was Resident #6's normal behavior of going into other residents' rooms. The DON stated Resident #6 was placed on q15s and referred to psych (a primary care physician or other healthcare provider has recommended that a patient see a psychiatrist or other mental health specialist for further evaluation and treatment of a mental health concern) . The DON stated Resident #6 then went into another resident room. The DON stated Resident #6 went into Resident #5's room and was going through her stuff. The DON stated Resident #6 did not have anything care planned for wandering, going into resident rooms, or any focus area for behaviors. The DON stated it should have been addressed in Resident #6's care plan. The DON stated not care planning it could negatively impact the safety of the resident, violation of resident rights, and injuries to the residents to include her. The DON stated it was everyone responsibility to ensure it was care planned. During an interview on 06/13/25 at 3:41 PM, with the Administrator stated he could not confirm if it was care planned for Resident #6 on wandering and going into resident rooms. The Administrator stated it should have been care planned if it was not there. Resident #10 Record review of Resident #10 ' s face sheet dated 06/12/25, revealed, admission on [DATE] to the facility. Record review of Resident #10 ' s hospital history and physical dated 10/30/24, revealed, a [AGE] year-old male diagnosed with Parkinson ' s Disease, parkinsonism (a group of neurological conditions characterized by similar movement symptoms) and depression. Resident #10 did not have any diagnoses of sexual behaviors and or inappropriate behaviors. Record review of Resident #10 ' s quarterly MDS dated [DATE], revealed, a moderate impairment of cognition BIMS score of 9 to be able to recall or make daily decisions. No coding was noted for Mood or behaviors. Record review of Resident #10 ' s care plan dated 04/30/25, revealed, mood and behavior need as evidence by periods of refusing medications related to moderately impaired cognition. If resident was hallucinating to not argue or try to reason, assure him of his safety. Notify nursing. There was not focus area, goal, or interventions in the Resident #10 ' s care plan for sexual inappropriate behavior. Record review of Resident #10 ' s Facility self-report to the state dated 04/23/25, revealed, Resident #9 claimed that Resident #10 had come into her room on Tuesday (05/20/25) and exposed himself. Room change was offered to Resident #9, q15s was placed on Resident #10, psychosocial assessment was conducted on Resident #9, and psych refer was ordered for both residents. Investigation was conducted and was inconclusive. Record review of Resident #10 ' s Progress Notes generated by the DON dated 05/23/25, revealed, NP in facility, to evaluated resident as per incident. NP gave orders Ativan - 1 mg/1 tablet Q8 hours as needed. Behavior monitoring for 5 days. If increased behaviors or aggression it was okay to send to hospital. NP to evaluate resident for inappropriate behavior. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/10/25 at 2:28 PM. The SW stated Resident #10 lowered his pants and showered Resident #9 his private parts. The SW stated Resident #9 was given a room change and Resident #10 was referred to psych. The SW stated that sexual inappropriate behavior was not in his care plan. The SW stated it should have been care planned. The SW stated the risk of not care planning was not knowing he was capable of these behaviors and could do it again. During an interview on 06/13/25 at 12:12 PM, with the DON, he stated Resident #10 exposing himself was a new behavior. The DON stated she was informed that Resident #10 un-zipped his pants and exposed himself to Resident #9. The DON stated labs were ordered, referred to psych, room change, and placed on q15s. The DON stated it should have been care planned for sexual inappropriate or a new behavior. The DON stated not care planning places Resident #10 at risk of his safety and injury. The DON stated the nurses were responsible for care planning it. During an interview on 06/13/25 at 3:11 PM, The Administrator stated Resident #10 should have been care planned so everyone would know his behaviors to better provide care for him. Resident #12 Record review of Resident #12 ' s face sheet dated 06/12/25, revealed, a [AGE] year-old male diagnosed with anxiety and major depressive disorder, who was admitted on [DATE]. Resident #12 did not have diagnoses of sexual behaviors and or inappropriate behaviors. Record review of Resident #12 ' s quarterly MDS dated [DATE], revealed, a BIMS score of 11 indicating moderate impaired cognition. Resident #12 was not coded for mood or behaviors. Record review of Resident #12 ' s care plan dated 01/19/25, revealed, Resident #12 has physical interaction with another resident. Resident was receiver. Resident #12 will be encouraged for communication to report all changes and deviations from mood of others and self. There was nothing care planned for sexual inappropriateness or a focus on behaviors related to sexual inappropriateness. Record review of Resident #12 ' s progress notes generated by SW late entry on 06/09/25 for dated 06/03/25, revealed, SW visited with Resident #12 after reported allegation. Resident #12 informed SW that he had been in a relationship with a woman for 3-4 months and now she was trying to turn everything. SW attempted to re-orient Resident #12 to know that the Relationship might not have been that long as Resident #11 had not been at the facility that long. SW asked Resident #12 if the Resident #11 had ever told him to stop doing what he was doing, to which he stated No. Resident #12 stated she never told him to stop. Record review of Resident #12 ' s Facility self-report to the state dated 06/10/25, revealed, Resident #12 was witnessed by staff touching the breast of Resident #11. Resident #11 was given a head-to-toe assessment with no injuries. Resident #11 was not in distress nor pain. Resident #12 was placed on q15s, psychosocial assessments conducted, and referred to psych. Investigation was conducted and was confirmed. (continued on next page)

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	676283	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Arcos Del Norte Care Center	11169 Sean Haggerty El Paso, TX 79934

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/10/25 at 3:13 PM, with the SW, she stated Resident #12 told her that they were in a relationship and did not know why Resident #11 had turned her back on him. The SW stated Central Supply had witnessed Resident #12 reach out and grab Resident #11 ' s breast. The SW stated they immediately separated both of them and assessed them with no injuries. SW stated that both residents were referred to psych. SW stated they had increased monitoring on Resident #12. The SW stated there was a care plan meeting for Resident #12 to discuss the situation, but it was not care planned in the care plan. The SW stated it should have been care planned to prevent this from happening again. The SW stated the risk was another incident happening again. During an interview on 06/13/25 at 2:19 PM, with the Administrator, stated he could not confirm if Resident #12 was care planned for inappropriate behavior. The Administrator stated it should have been care planned. Record review of the facility's Care Plan Process, Person- Centered Care dated 5/5/23 revealed 6- The Interdisciplinary Team (IDT) will review for effectiveness and revise the person-centered care plan after each assessment. This includes both the comprehensive and quarterly assessments. For the comprehensive assessment the review will be completed within seven (7) days of V0200B2 and no more than 21 days after admission. 11- The person-centered care plan includes: A. Date B. Problem C. Resident goals for admission and desired outcomes D. Time frames for achievement E. Interventions, discipline specific services, and frequency F. Refusal of services and/or treatments: 1) Evaluation of resident's decision-making capacity; 2) Educational attempts; 3) Attempts to find alternative means to address the identified risk/need G. Discharge plans: 1) Resident's preference and potential for future discharge; 2) Resident's desire to return to the community and any referrals to local contact agencies and/or other appropriate entities, for this purpose. H. Resolution/Goal Analysis.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review the facility failed to ensure medical records, in accordance with accepted professional standards and practices, were maintained on each resident that were accurately documented for 2 of 3 residents (Resident #3, Resident #8) reviewed for medical records. The facility failed to ensure that the incident on 04/25/25, with Resident #3 who alleged ST had said something negative was documented in the resident's chart. The facility failed to ensure that the incident on 05/14/25, with Resident #8 who alleged that someone stole $40 out of his wallet was documented in the resident's chart. These failures could place residents at risk of records being inaccurate and not receiving potential needed services due to documentation errors. Finding included: Resident #3 Record review of Resident #3's face sheet dated 06/11/25, revealed, admission on [DATE] and re-admission on [DATE] to the facility. Resident #3 was a [AGE] year-old female diagnosed with depression and dementia. Record review of Resident #3's quarterly MDS dated [DATE], revealed, little to no impairment cognition BIMS of 15 to be able to recall and make daily decisions. Record review of Resident #3's care plan dated 04/03/25, revealed, Resident #3 was having mood and behavior needs as evidence by periods of refusing facility transportation to appointments. Care plan dated 01/31/24, revealed, has socially inappropriate/disruptive behavioral symptoms as evidenced by failure to adapt to other residents in room and in dining areas, yelling at staff and residents. Record review of Resident #3's Facility Self-Report to state dated 04/28/25, revealed, Resident #3 claimed that the ST said that she was an evil person during activities. Immediately suspended ST and notified the physician and NP. Investigation was conducted and was unconfirmed. Record review of Resident #3's Progress Notes were reviewed on 06/12/25 revealing, that the incident had not been documented and or recorded on the residents' chart. During an interview on 06/10/25 at 9:25 AM, with Resident #3, she stated she was in the activities room with other resident playing the loteria game (a traditional Mexican board game of chance, similar to bingo, but played with a deck of cards instead of numbered balls). Resident #3 stated the ST came into the activities room and did not know why she was there. Resident #3 stated she did not know anything about the ST telling her about her telling or calling her evil. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/10/25 at 10:18 AM, with Resident #3 stated she remembered now what the state was talking about and stated that the ST had told her she was evil. Resident #3 stated she had reported it and did not know why she was being called evil. During an interview on 06/10/25 at 11:03 AM, with DOR , he stated the ST had an incident with Resident #3 in which it was claimed by Resident #3 that the ST had called her evil. The DOR stated he received a statement from the ST. The DOR stated ST went into the activities room and was asked by the activities director to take over the Loteria Game that residents were playing. The DOR stated she was then suspended pending the conclusion of the investigation which was unconfirmed. During an interview on 06/10/25 at 11:24 AM, with the Activities Director, she stated she was working the day of the incident and did not hear ST say anything bad to Resident #3. The Activities Director stated that Resident #3 had claimed that the ST had told her she was evil. During an interview on 06/10/25 at 11:50 AM, with the ST, she stated she entered the activities room to help out a resident when the Activities Director was called out of the activities room. The ST stated she took over calling out the cards for the loteria game that the residents were playing. The ST stated Resident #3 was getting upset with her and not to be calling out the loteria. The ST stated she claimed she was not doing it right and not calling the cards from the bottom of the stack. The ST stated Resident #13 joined the game late and she was trying to catch him up when Resident # 3 got upset again and told her not to catch him up. The ST stated that Resident #13 won the game and Resident #3 got more upset. The ST stated she tried accommodating everything that Resident #3 wanted but it was not good enough. During an interview on 06/10/25 at 1:36 PM, with the SW, she stated the ST went into the activities room. The SW stated Resident #3 claimed ST had called her evil in which she took it personal. The SW stated that ST was not supposed to say that. The SW stated she reported it to the Administrator. The SW stated she interviewed Resident #14 and Resident #15 who both were present in the room sitting in front of Resident #3. The SW stated both resident (14 & 15) did not hear ST say anything of that sort or anything bad. During an interview on 06/11/25 at 8:53 AM, with Resident #14, she stated there was one resident who was getting upset with the ST. Resident #14 stated she did not know the name of the resident. Resident #14 stated at no time did the ST say anything bad to Resident #3. During an interview on 06/12/25 at 10:21 AM, with Resident #15, he stated the ST was calling out the cards for the loteria game. Resident #15 stated at no time was the ST telling anybody anything bad. During an interview on 06/13/25 at 10:24 AM, with the DON, she stated the ST was in the activities room hovering over the residents. The DON stated that Resident #3 had told the ST why she was in Resident #3's space and that the ST told her she was an evil person. The DON stated the ST was participating in the activities with the residents. The DON stated this incident should have been documented in the Resident #3's chart. The DON stated it was not documented. The DON stated the nurses were responsible for documenting. The DON stated the reason for documenting was to show they were providing care to the resident and continuation of the care. The DON stated the impact of not documenting was omissions and lack of continuity of resident care. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/13/25 at 4:00 PM, with the Administrator, he stated the ST was in the activities room helping out. The Administrator stated that Resident #3 had claimed that the ST had called her evil. The Administrator stated anytime there were incidents with the residents it does need to be documented . The Administrator stated the negative outcome of not documenting would be the information not being passed and could affect resident care. Resident #8 Record review of Resident #8's face sheet dated 06/12/25, revealed admission on [DATE] and re-admission on [DATE] to the facility. Record review of Resident #8's facility history and physical dated 10/21/24, revealed, a [AGE] year-old male diagnosed with metabolic encephalopathy versus TIA (Encephalopathy is a broad term for brain dysfunction, often due to metabolic or systemic issues, while a TIA is a temporary interruption of blood flow to the brain, causing transient neurological deficits) Record review of Resident #8's quarterly MDS dated [DATE], revealed, a BIMS score of 8 indicating moderate impairment of cognition. Record review of Resident #8's care plan dated 12/01/23, revealed, impaired decision-making and impaired communication related to dementia. Monitor behaviors and assess for pain. Record review of Resident #8's Progress Notes were reviewed on 06/12/25 with no documentation of the incident of 05/14/25. Record review of Resident #8's Facility self-report to state dated 05/22/25, revealed, Resident #8 claimed that someone came into his room while he was napping and took his wallet out of his pants pocket that he was wearing and stole $40 from it and then put his wallet back into his pant pocket. Residents room and wallet were searched with residents' permission. Notified family and local police. Investigation was conducted and was unconfirmed. During an interview on 06/11/25 at 10:32 AM, with the ADON, she stated Resident #8 claimed that someone had taken his money. The ADON stated that he was very forgetful, had impaired judgment, and was always saying he was missing money. The ADON stated the facility offered to hold his money but refuses and was consistently re-direct when leaving his money laying on the meal tray. During an interview on 06/11/25 at 11:59 AM, with LVN G, she stated Resident #8 had gone to the nurse's station and told her someone had stolen money from him two days ago. LVN G stated this was reported to the Administrator. LVN G stated she went to look with Resident #8 in his room into his drawers and did not find the $40. During an interview on 06/13/25 at 11:33 AM, with the DON, she stated Resident #8 had voiced to LVN G that someone had taken his $40 two days ago. The DON stated the Administrator went to go assess Resident #8's wallet with the permission of Resident #8 to see if he might have misplaced it. The DON stated the incident should have been documented by the nurses who were responsible for documenting. The DON stated the impact would be the continuity of care to the resident if it was not documented. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/13/25 at 3:25 PM, with the Administrator, he stated Resident #8 was asleep in his bed with his wallet in his pocket. The Administrator stated he interviewed the family member who stated she had given him some money. The Administrator stated the facility would hold on to the money to keep it safe for him and he refused. The Administrator stated the incident should have been documented by the nursing staff. The Administrator stated not documenting could affect the resident care depending on the situation. Record review of the facility Documentation Guidelines dated 05/05/23, revealed, Policy - documentation guidelines pertinent to good clinical record practice will be followed by all individuals who document in the medical record.