STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065415	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pikes Peak Post Acute	2719 N Union Blvd Colorado Springs, CO 80909

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure three (#2, #3 and #5) of three residents were kept free from abuse out of nine sample residents. Specifically, the facility failed to:-Protect Resident #2 and Resident #3 from being physically abused by Resident #1; and,-Protect Resident #5 from being physically abused by Resident #4.Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigation policy and procedure, revised 11/17/25, was provided by the nursing home administrator (NHA) on 11/20/25 at 5:11 p.m. It read in pertinent part, Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse toward a resident can occur as resident-to-resident abuse, staff-to-resident abuse, or visitor-to-resident abuse. Physical abuse includes but is not limited to hitting, slapping, biting, punching or kicking. The Resident-to-Resident Altercations policy, dated 2001, was provided by the NHA on 11/20/25 at 5:11 p. m. It read in pertinent part, All altercations, including those that may represent resident-to-resident abuse, are investigated and reported to the nursing supervisor, director of nursing services and to the administrator. Facility staff to monitor residents for aggressive/inappropriate behaviors towards other residents, family members, visitors or staff. Behaviors that may provoke a reaction by residents or others include: verbally aggressive behavior, physically aggressive behavior, sexually aggressive behavior, taking, touching, rummaging through others' belongings, wandering into others' rooms or space. If two residents are involved in an altercation, staff should separate the residents and institute measures to calm the situation. Identify what happened, including what might have led to aggressive conduct, review the events with the nursing supervisor and director of nursing services and evaluate the effectiveness of the interventions. Make any necessary changes to the care plan approaches to any or all of the involved individuals. Document in the resident's clinical records all interventions and their effectiveness. II. Incident of physical abuse of Resident #2 by Resident #1 on 10/14/25 A. Facility investigation (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation documented that a certified nurse aide (CNA) witnessed Resident #1 slap Resident #2's right hand after a verbal escalation. The investigation documented the two residents were immediately separated and placed on increased rounding and line of sight. The investigation documented that neither resident recalled the incident and neither resident had any signs or symptoms of injury. The facility substantiated the incident as abuse because the incident was witnessed. B. Resident #1- assailant 1. Resident status Resident #1, age [AGE], was admitted on [DATE]. According to the November 2025 computerized physician orders (CPO), diagnoses included dementia with psychotic disturbance, major depressive disorder, anxiety disorder and post-traumatic stress disorder. According to the 8/22/25 minimum data set (MDS) assessment, Resident #1 had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. The assessment further revealed Resident #1 had verbal behavioral symptoms directed towards others. The assessment revealed Resident #1 needed partial assistance with most of her activities of daily living (ADL) and needed supervision or touching assistance with walking. The MDS assessment documented that Resident #1 did not have physical behavioral symptoms directed towards others. -However, interviews and record review revealed Resident #1 did have physical behavioral symptoms towards others (see record review and interviews below). 2. Observations During a continuous observation on 11/19/25, beginning at 10:28 a.m. and ending at 11:36 a.m., the following was observed: At 10:28 a.m. Resident #1 was standing in her doorway, there was an isolation bin outside of her room due to her recent diagnosis of COVID-19. At 10:40 a.m. Resident #1 wandered a few steps out of her room and then went back into her room. At 10:58 a.m. Resident #1 came out of her room and began touching everything sitting on top of the isolation bin. At 11:11 a.m. Resident #1 came out of her room and walked halfway to the common area and then was redirected by staff to go back to her room. At 11:20 a.m. a nurse went down to Resident #1's room to check on the resident. The nurse did not go into Resident #1's room but stood outside the doorway and spoke to Resident #1 from the hallway. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:27 a.m. Resident #1 pushed her bedside table out into the hallway and came out of her room and handed a staff member an N95 mask that she took from the isolation cart. She then went back to her room. At 11:36 a.m. Resident #1 was yelling in her room, however, staff did not go down to check on her. 3. Record review The behavior care plan, revised 10/22/25, documented Resident #1 had been observed with physical and verbal aggression towards staff and other residents due to lack of orientation, delusional thought processes. The care plan further documented Resident #1 had poor impulse control and was reactive to stimuli in her environment. The care plan documented Resident #1 had hit or pushed another resident as recently as 10/14/25. Interventions included 15-minute checks or a sitter as needed, analyzing key times, places, triggers and what de-escalated the behavior and documenting, providing physical and verbal cues to alleviate anxiety, assessing and anticipating the resident's needs, encouraging the resident to seek out a staff member when agitated, evaluating medication side effects, monitoring, documenting and reporting to the medical provider of danger to self or others and psychiatric evaluation consult as indicated. -The care plan failed to include the resident's 10/21/25 altercation with Resident #3 (see below). The trauma-informed care plan documented Resident #1 was at risk for decreased psychosocial well-being and adjustment issues, emotional distress, ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social, or spiritual well-being related to diagnosis of post-traumatic stress disorder and a history of domestic violence. The care plan documented Resident #1's trigger as unwelcomed guests going into her room. The interventions included a stop sign placed on Resident #1's door, allowing the resident time to make choices in her care, encouraging active decision making, approaching the resident in a calm, reassuring manner, encouraging family to visit and encouraging the resident to participate in activities of choice. A change in condition note, dated 10/14/25 at 9:06 p.m., documented Resident #1 initiated physical aggression with Resident #2 by slapping Resident #2 on her hand. The note documented that the residents were separated and no injuries were noted. The note further documented that the physician was notified and the physician recommended to monitor Resident #1 and gave no new orders. A social services note, dated 10/15/25 at 7:32 p.m., documented Resident #1 was being observed for psychosocial impact following an incident of aggression that she initiated. The note documented Resident #1 had increased aggression and agitation towards staff related to lack of orientation and delusional thought process. -However, the note did not mention aggression towards other residents. An interdisciplinary team (IDT) note, dated 10/16/25 at 9:52 a.m., documented the physical aggression that Resident #1 initiated and documented that Resident #1 did not recall the incident. The note further documented that staff was to monitor Resident #1 for overstimulation when she attended group activities. C. Resident #2- victim (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident status Resident #2, age [AGE], was admitted on [DATE]. According to the November 2025 CPO, diagnoses included dementia with other behavioral disturbance, mixed receptive-expressive language disorder (affects the ability to understand and produce language) and unspecified lack of coordination. The 10/13/25 MDS assessment revealed Resident #2 had severe cognitive impairment with a BIMS score of zero out of 15. The assessment revealed Resident #2 was dependent on staff for all of her ADLs and needed supervision or touching assistance when self-propelling in her wheelchair. The assessment further revealed Resident #2 did not have any verbal or physical behavioral symptoms towards others and did not wander. -However, interviews and further record review revealed Resident #2 did wander and have verbal aggression (see below). 2. Observations On 11/19/25 at 1:34 p.m. Resident #2 was in the common area in her wheelchair. On 11/19/25 at 1:52 p.m. Resident #2 was self-propelling down the hallway, away from the common area. On 11/19/25 at 2:16 p.m. Resident #2, along with an unknown male resident, was trying to get out of the gated area that led to another unit. No staff members redirected them. On 11/19/25 at 2:50 p.m. Resident #2 went into room [ROOM NUMBER], which was not her room. Staff did not redirect her out of the room. 3. Record review The psychosocial well-being care plan, revised 10/22/25, documented Resident #2 was the recipient of a resident-to-resident altercation. Interventions included a one-to-one sitter, 72-hour monitoring for psychosocial well-being, then one time a week for four weeks and keeping the residents separated. The mood care plan, revised 10/28/25, documented Resident #2 was at risk for decreased psychosocial well-being, adjustment issues, emotional distress, ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social, or spiritual well-being due to dementia with behaviors. The care plan further documented Resident #2 wandered throughout the unit and could become reactive to stimuli and the environment. The care plan revealed Resident #2 had been observed striking-out at others if startled or if others were confrontational. Interventions included activities staff were to evaluate and provide visits as needed, assessing clinical issues that may be causing or contributing to the resident's mood pattern, encouraging participation in activities, maintaining a calm, slow, understandable approach, observing for signs and symptoms of depression/emotional distress and notifying the physician and reviewing medications. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A change in condition note, dated 10/14/25 at 4:18 p.m., documented Resident #2 was slapped by another resident. The note documented there was no injury, pain or skin issues. The note documented the physician recommended monitoring Resident #2 and reporting any changes. A nurse progress note, dated 10/14/25 at 8:37 p.m., documented a CNA reported to the nurse that Resident #2's right hand was slapped by Resident #1. The note documented a registered nurse (RN) assessed Resident #2 and did not find any injuries and the resident's skin was intact. A social services note, dated 10/15/25 at 1:57 p.m., documented Resident #2 was being observed for psychosocial well-being following an incident of aggression. The note documented Resident #2 appeared to be at baseline. An IDT note, dated 10/16/25 at 8:53 a.m., documented the team reviewed the physical aggression event between Resident #2 and Resident #1. The note documented Resident #2 did not remember the event. The note documented that social services would follow up with Resident #2 in 72 hours, then weekly for four weeks. III. Incident of physical abuse of Resident #3 by Resident #1 on 10/21/25 A. Facility investigation The investigation documented Resident #1 was observed wheeling Resident #3 out of her room and hitting Resident #3 on the back while yelling, Help, she's stealing my things! Resident #1 reported that Resident #3 went into her room and was touching her and grabbing her things. The investigation reported the residents were immediately separated and placed on a line-of-sight with no further incident. No pain or injuries were observed or reported. The facility substantiated the incident as abuse. B. Resident #1 - assailant 1. Record review A behavior note, dated 10/21/25 at 3:01 p.m., documented Resident #1 reported another resident (Resident #3) went into her room and was touching and grabbing Resident #1 and her belongings. The note documented that the nurse witnessed Resident #1 wheeling the other resident out of her room while yelling, Help, she's stealing my things! The note documented the nurse saw Resident #1 hitting Resident #3 on the back. A behavior note, dated 10/21/25 at 3:11 p.m., documented Resident #1 was heard by a CNA yelling at a nonverbal resident for being too close and pointing at her. A social services note, dated 10/22/25 at 8:28 p.m., documented Resident #1 was provided with a one-to-one sitter following an incident of initiated aggression. The note documented Resident #1 presented with self-deprecating, persecutory thought processes and low affect and was not easily consoled. The note documented the physician and family were aware of the change. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A social services note, dated 10/22/25 at 8:32 p.m., documented an increase in Resident #1's antidepressant due to increased aggression, persecutory thought processes, self-deprecation and low mood. Staff was to monitor for medication effectiveness. C. Resident #3- victim 1. Resident status Resident #3, age [AGE], was admitted on [DATE]. According to the November 2025 CPO, diagnoses included dementia severe with other behavioral disturbances and cognitive communication deficit. The 11/5/25 MDS assessment revealed Resident #3 had severe cognitive impairment with a BIMS score of zero out of 15. The assessment further revealed Resident #3 needed substantial to maximal assistance with most of her ADLs but was able to move independently in her wheelchair. The assessment revealed Resident #3 did not have physical behavioral symptoms towards others and did not wander. -However, interviews, observations and further record review revealed Resident #3 did grab others and wander (see below). 2. Observations During a continuous observation on 11/19/25, beginning at 10:28 a.m. and ending at 12:02 p.m., the following was observed: At 11:14 a.m. Resident #3 was in her room with the door closed. At 11:25 a.m. Resident #3 was self-propelling in the hallway. At 11:48 a.m. Resident #3 was in another resident's room with a brush in her hand and pulling the hair out of the brush and throwing the hair on the floor. At 11:54 a.m. Resident #3 went into room [ROOM NUMBER]. She was touching another resident and digging through the trash. At 12:00 p.m. a nurse took Resident #3 from room [ROOM NUMBER] and put her in her room and closed the door. At 12:02 p.m. Resident #3 opened her room door and came out into the hallway. During a continuous observation on 11/19/25, beginning at 1:34 a.m. and ending at 2:50 p.m., the following was observed: At 1:34 p.m. Resident #3 was in her room with the door closed At 1:46 p.m. Resident #3 came out of her room and tried to open different doors (storage doors that were locked). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:50 p.m. Resident #3 went into room [ROOM NUMBER]. Staff brought her out of the room. Resident #3 then took a female resident's napkin off of her table and put it in her wheelchair. At 1:53 p.m. Resident #3 was alone in the dining room pushing around stools with wheels on them. At 2:00 p.m. the nurse took Resident #3 from the dining room area and took her back to her room and closed the door without saying anything to her. At 2:06 p.m. Resident #3 came out of her room and went and opened another resident's door but did not go into their room. At 2:10 p.m. Resident #3 was in the way of another resident in the dining room and the other resident yelled Move it! at Resident #3. Resident #3 moved and wheeled herself into room [ROOM NUMBER] and closed the door. At 2:17 p.m. Resident #3 was still in room [ROOM NUMBER]. She opened the door and then closed it. At 2:20 p.m. the activities assistant (AA) offered Resident #3 a snack and she came out of room [ROOM NUMBER]. At 2:22 p.m. Resident #3 went back into room [ROOM NUMBER]. Resident #3 was patting and touching the resident's legs in the recliner in room [ROOM NUMBER]. Resident #3 was pulling up the bedding on the bed and then was moving and pulling the fan on the bedside table. Resident #3 was opening and closing the bathroom door and she took the personal wipes out of the bathroom. The resident in the recliner began to yell at her in a different language. Resident #3 left the room. Staff did not intervene. At 2:35 p.m. Resident #3 went into room [ROOM NUMBER]. She picked up a red colored drink in a small plastic cup on the B side of the room and drank it. At 2:40 p.m. the nurse put Resident #3 in her room and closed the door without saying anything to her. At 2:45 p.m. a female resident yelled at Resident #3, asking her where she was going as she was going into room [ROOM NUMBER]. At 2:46 p.m. Resident #3 came out of room [ROOM NUMBER] and went back into room [ROOM NUMBER] where she bundled up the privacy curtain and put it on the bedside table and spilled a drink on side A of the room. -Staff failed to intervene and provide meaningful redirection for Resident #3. Cross reference F744 for failure to provide appropriate dementia care services. 3. Record review (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The behavior care plan, revised 10/2/23, documented Resident #3 would go into others' rooms and take other residents' items out of their room. Interventions included redirecting the resident from other residents' rooms as needed. Staff was to return items that were taken as needed. The physical aggression care plan, revised 7/16/25, documented Resident #3 had the potential to be perceived as being physically aggressive due to her grabbing others to try to get their attention. The care plan documented Resident #3 had a communication deficit due to her limited English. Interventions included using the communication board as needed, monitoring any signs or symptoms of Resident #3 posing danger to herself or others. A behavior note, dated 10/21/25 at 3:02 p.m., documented Resident #3 went into room [ROOM NUMBER] (Resident #1's room) and started to grab Resident #1's belongings. Resident #1 got frustrated and became verbal with Resident #3. A social services note, dated 10/22/25 at 4:54 p.m., documented Resident #3 appeared at baseline following the incident. A social services note, dated 10/23/25 at 10:38 p.m., documented Resident #3 appeared at baseline following the incident. -However, none of the notes documented that Resident #3 was hit or if she sustained any injuries. IV. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 11/20/25 at 12:26 p.m. LPN #1 said Resident #1 was fairly independent and very territorial. She said Resident #1 was not normally physically aggressive. She said she was not there when the incident happened between Resident #1 and Resident #2. She said she was not sure where it happened. She said Resident #2 was not as cognitively intact as Resident #1. She said Resident #2 may have hit Resident #1 when she was self-propelling in her wheelchair but she was not sure. LPN #1 said Resident #3 normally stayed in the area closest to the dining area. She said she was not sure when the incident happened between Resident #1 and Resident #3. She said the floor nurses did not update the care plan. She said the nurses would tell the director of nursing (DON) and the assistant director of nursing (ADON) about the incident and they would update the care plans. CNA #1 was interviewed 11/20/25 at 12:54 p.m. CNA #1 said that Resident #1 was half darling and half growly. She said Resident #1 could have dark moods, where she thought nobody cared about her. She said Resident #1 could be very territorial depending on who was going into her room. She said she could be very accusatory and most of her altercations had been verbal but she had become more physically aggressive. CNA #1 said Resident #2 was normally very sweet but there were times when she would get into moods where she would swear a lot. She said Resident #2 would sometimes wander. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #1 said Resident #3 wandered everywhere on the unit. She said Resident #3 would grab people to get their attention. She said she would take other residents' things which would be an issue for the other residents. She said all of the staff knew to redirect #3 from other residents' rooms. She said that Resident #3 would slap staff members but not other residents. The DON and the NHA were interviewed together on 11/20/25 at 3:10 p.m. The DON and the NHA said the facility substantiated the incident between Resident #1 and Resident #3. The DON and the NHA said the facility put a larger stop sign on Resident #1's door and implemented 15-minute checks until the facility was sure the stop sign was working. The DON and the NHA said they substantiated the incident between Resident #1 and Resident #2. The DON and the NHA said they implemented 15-minute checks and line-of-sight until the investigation was complete and that they were sure the interventions were working for the residents. The DON and the NHA said they were not sure where the incident happened but most likely it happened near or in Resident #1's room. The DON and the NHA said Resident #1's trigger for her behaviors was unwanted guests in her room. The DON and the NHA said that the IDT came up with and entered new interventions during the IDT meeting. V. Incident of physical abuse of Resident #5 by Resident #4 on 10/31/25 A. Facility investigation The 10/31/25 facility investigation documented Resident #5 went to the nurses' station and showed the nurse a skin tear to her right distal lateral forearm. She said Resident #4 pushed her, which caused her to fall onto the floor and scratch her arm. The incident was not witnessed and staff said they did not hear a commotion or altercation. Resident #5 denied pain, her skin tear was stable and she did not present with fear or psychosocial concerns. The investigation documented Resident #4 wandered the unit due to a diagnosis of advanced dementia and was non-interviewable. Resident #4 denied pushing anyone and staff said they did not witness the incident. The residents were immediately separated and a one-to-one supervision was put in place for Resident #4. The nurse assessed Resident #5 and documented a seven centimeter (cm) skin tear to the right forearm. The nurse cleaned the wound, reapproximated the skin and applied steri strips per physician's orders. The investigation documented there were no witnesses; however, the documentation showed a new skin tear consistent with the allegation. Resident #4 had no prior aggression toward residents, although she had previously been aggressive with staff and had thrown objects. One-to-one supervision remained in place to maintain resident safety. The investigation concluded the occurrence was unsubstantiated because there were no witnesses and both residents had a low BIMS score. -The facility failed to identify and implement effective interventions to prevent Resident #4 from entering other residents' rooms and demonstrating escalating physical and verbal behaviors toward others. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident #4 (assailant) 1. Resident status Resident #4, age [AGE], was admitted on [DATE] and discharged on 11/18/25. According to the November 2025 CPO, diagnoses included Alzheimer's disease and dementia. The 10/14/25 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of three out of 15. She required supervision or touching assistance for all ADLs. The MDS assessment documented the resident exhibited verbal and physical behavioral symptoms toward others during the assessment period. 2. Record review The 10/9/25 social services progress note revealed Resident #4 wandered the halls without purpose and became agitated and aggressive with redirection. The note documented she entered other residents' rooms, paced the halls, and attempted to exit. The resident was moved to the secured memory unit due to safety concerns. The 10/11/25 nursing progress note revealed Resident #4 paced the hallway repeatedly beginning at 3:30 a.m. and entered another resident's room multiple times. Staff redirected her four times before she stopped returning to the same room. The 10/19/25 nursing progress note revealed Resident #4 was found asleep in her roommate's bed, causing the roommate to become upset. The note documented Resident #4 attempted to dress in the roommate's clothing, wandered into additional rooms and became physically aggressive by hitting and kicking the nurse during redirection. The 10/21/25 nursing progress note revealed Resident #4 continued to enter other residents' rooms and lie in their beds, which caused distress to peers. Staff redirected her and documented she refused some care. The 10/22/25 nursing progress note revealed Resident #4 was found in another resident's bed. Resident #4 became combative when staff attempted to redirect her and she attempted to kick the nurse. The 10/24/25 nursing progress note revealed the nurse attempted to redirect Resident #4 out of another resident's room and the resident punched the nurse in the chest. Staff gave her space and later redirected her to another area. The 10/31/25 nursing progress note revealed one-to-one supervision was initiated for Resident #4 due to a physical altercation with another resident. The 11/3/25 nursing note revealed the one-to-one CNA said Resident #4 hit her on two occasions when she attempted to redirect her from entering another resident's room. The note documented the resident pushed the CNA while the CNA attempted to block the entry into another room. (continued on next page)

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	065415	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pikes Peak Post Acute	2719 N Union Blvd Colorado Springs, CO 80909

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 11/4/25 nursing progress note revealed Resident #4 wandered in and out of rooms and beds throughout the shift with minimal effect from redirection. The 11/16/25 nursing progress note revealed Resident #4 hit the CNA in the face who provided the one-to-one supervision as the CNA attempted to redirect her from entering another resident's room. The note documented continued agitation, attempts to enter rooms and exit seeking. The behavioral care plan, initiated 10/22/25 and revised 11/2/25, documented Resident #4 had physical and verbal aggression, poor impulse control, and reactivity to environmental stimuli. Pertinent interventions included providing care in a calm and non-threatening manner, assisting with conflict resolution, attempting redirection when the resident exhibited agitation, observing for behavioral triggers and providing one-to-one supervision during waking hours to ensure the safety of other residents. The 11/4/25 IDT review documented Resident #4 continued to exhibit agitation, physical and verbal aggression, impulsivity, and negative verbalizations and required ongoing monitoring with non-pharmacological interventions to maintain safety. C. Resident #5 (victim) 1. Resident status Resident #5, age [AGE], was admitted on [DATE]. According to the November 2025 CPO, diagnoses included dementia and anxiety disorder. The 10/6/25 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of nine out of 15. She required supervision or touching assistance with bathing, oral hygiene, and dressing. The MDS assessment did not exhibit verbal or physical behaviors toward others during the assessment period. 2. Record review The trauma informed care plan, initiated 11/3/25, documented Resident #5 was at risk for decreased psychosocial well-being, emotional distress and ineffective coping skills related to physical contact made to her face by another resident on 9/10/25, and again on 10/31/25 and 11/3/25, which resulted in a skin tear. Pertinent interventions included monitoring for signs and symptoms of emotional distress, encouraging verbalization of feelings, providing calm reassurance, offering a quiet place to relax and reporting abnormal psychosocial findings to the physician. D. Staff interviews LPN #1 was interviewed on 11/20/25 at 11:58 a.m. LPN #1 said all allegations or incidents of abuse should be reported to the resident's responsible party, the physician, the DON and the ADON. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #1 said when a resident wandered into another resident's room, the resident should be redirected to an activity, another area, or back to their room if they wanted to lie down. She said she referred to the resident's care plan and the electronic medication administration record (eMAR) for each resident's individual interventions. She said during an active altercation, staff redirected residents and completed a change in condition for physical aggression and risk management. She said she would verbally redirect residents but would not get between two fighting residents for her own safety, especially when residents with dementia were sometimes unable to be redirected. LPN #1 said she had worked at the facility for four months, but she was not working on the day of the incident on 10/31/25 between Resident #4 and Resident #5. She said the night shift nurse informed her Resident #4 and Resident #5 had been involved in a physical altercation. She said Resident #4 pushed Resident #5 and Resident #5 sustained a skin tear on her arm. She said she had no doubt Resident #4 pushed Resident #5 due to Resident #4's ongoing pattern of aggression. LPN #1 said Resident #4 had a long history of wandering into other residents' rooms and was difficult to redirect. She said it often took three to four staff members to get Resident #4 out of a resident's room. She said Resident #4 had been physically aggressive with both staff and residents and had been placed under one-to-one supervision. She said a week ago, Resident #4 punched a CNA in the face; hard enough to bend the CNA's glasses. She said Resident #4's triggers usually occurred during care such as showering and changing. She said Resident #4 remained on one-to-one supervision from 10/31/25 until she was discharged to another facility. CNA #1 was interviewed on 11/20/25 at 1:10 p.m. CNA #1 said that when a resident wandered into another resident's room, she would provide redirection. She said she did not know where written interventions were documented for each resident. She said she had worked at the facility for two years and felt she knew each resident well enough to know what interventions worked. She said all allegations or incidents of abuse were reported to the abuse coordinator. CNA #1 said prior to one-to-one supervision, Resident #4 wandered freely throughout the unit, going in and out of other residents' rooms. She said that if a room door was open, Resident #4 would go inside. She said some days, Resident #4 was able to be redirected and other times she could not be redirected at all. She said the one-to-one supervision began after the incident on 10/31/25 with Resident #5 and continued for at least two weeks before she was discharged to another facility. She said she believed the lack of staffing directly contributed to the incident between Residents #4 and #5. CNA #1 said when she came on shift on 10/31/25, she was informed Resident #4 had entered Resident #5's room and hit her. She said Resid

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#3) of seven residents who were diagnosed with dementia, received the appropriate treatment and services to attain or maintain the highest practicable physical, mental and psychosocial well-being out of nine sample residents.Specifically, the facility failed to effectively identify person-centered approaches for dementia care for Resident #3.Findings include:I. Facility policy and procedureThe Dementia-Clinical protocol, dated 2001, was provided by the nursing home administrator (NHA) on 11/20/25 at 5:53 p.m. it read in pertinent part, As part of the initial assessment, the physician will help identify individuals who have been diagnosed as having dementia and those with impaired cognition. The staff and physician will evaluate individuals with new or worsening cognitive impairment and behavior and differentiate dementia from other causes. Progressive or persistent worsening of symptoms and increased need of staff support will be reported to the interdisciplinary team. The staff will monitor the individual with dementia for changes in condition and decline in function and will report these findings to the physician. The interdisciplinary team (IDT) will adjust interventions and the overall plan depending on the individual's response to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes, and other relevant factors. The physician and staff will review the effectiveness of and complications of medications used to try to enhance cognition and manage behavioral and psychiatric symptoms and will adjust, stop, or change such medications as indicated.II. Resident #3A. Resident statusResident #3, age [AGE], was admitted on [DATE]. According to the November 2025 computerized physician orders (CPO), diagnoses included dementia, severe with other behavioral disturbances and cognitive communication deficit. The 11/5/25 minimum data set (MDS) assessment revealed Resident #3 had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. The assessment further revealed Resident #3 needed substantial to maximal assistance with most of her activities of daily living (ADL) but was able to move independently in her wheelchair. The assessment revealed Resident #3 did not have physical behavioral symptoms towards others and did not wander. -However, interviews, observations and further record review revealed Resident #3 did grab others and wander.Cross reference F600 for failure to protect Resident #3 from abuse. B. ObservationsDuring a continuous observation on 11/19/25, beginning at 10:28 a.m. and ending at 12:02 p.m. , the following was observed:At 11:14 a.m. Resident #3 was in her room with the door closed.At 11:25 a.m. Resident #3 was self-propelling in the hallway.At 11:48 a.m. Resident #3 was in another resident's room with a brush in her hand and pulling the hair out of the brush and throwing the hair on the floor.-Staff did not intervene to redirect the resident out of the other resident's room.At 11:54 a.m. Resident #3 went into room [ROOM NUMBER] she was touching another resident and digging through the trash.At 12:00 p.m. a nurse took Resident #3 from room [ROOM NUMBER] and put her in her room and closed the door. At 12:02 p.m. Resident #3 opened her room door and came out into the hallway. During a continuous observation on 11/19/25, beginning at 1:34 p,m, and ending at 2:50 p.m., the following was observed:At 1:34 p.m. Resident #3 was in her room with the door closed.At 1:46 p.m. Resident #3 came out of her room and tried to open different doors (storage doors that were locked).-Staff did not attempt to redirect the resident. At 1:50 p.m. Resident #3 went into room [ROOM NUMBER] and staff brought her out of the room. Resident #3 then took a female resident's napkin off of her table and put it in her wheelchair. At 1:53 p.m. Resident #3 was alone in the dining room pushing around stools with wheels on them.-Staff did not attempt to redirect the resident. At 2:00 p.m. the nurse took Resident #3 from the dining room area and took her back to her room and closed the door without saying anything to her. At 2:06 p.m. Resident #3 came out of her room and went and opened another resident's door but did not go into their room. At 2:10 p.m. Resident #3 was in the way of another resident in the dining room and the other resident yelled Move it!at Resident #3. Resident #3 moved and wheeled herself into room [ROOM NUMBER] and closed the door. At 2:17 p.m. Resident #3 was still in room [ROOM NUMBER]. She opened the door and then closed it. At 2:20 p.m. the activities assistant (AA) offered Resident #3 a snack and she came out of room [ROOM NUMBER]. At 2:22 p.m. Resident #3 went back into room [ROOM NUMBER]. Resident #3 was patting and touching the resident's legs in the recliner in room [ROOM NUMBER]. Resident #3 was pulling up the bedding on the bed and then was moving and pulling the fan on the bedside table. Resident #3 was opening and closing the bathroom door and she took the personal wipes out of the bathroom. The resident in the recliner began to yell at her in a different