Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065278	A. Building B. Wing	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Pointe Health and Rehabilitation Center	710 3rd St Windsor, CO 80550

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to create an environment that protected residents from resident-to-resident abuse. This affected six (#2, #3, #5, #6, #8 and #10) of 10 residents out of 12 sample residents residing on three of five units (Mountain View South, Sunrise South, and Mountain View North) in the facility. 1. Resident-to-resident abuse on the Mountain View South UnitResident #4, with severe cognitive loss, exhibited physical aggression toward four residents (#2, #3, #5, and #10), all of whom were cognitively impaired and resided with Resident #4 in the Mountain View South unit. Resident #4 was known to wander aimlessly and in and out of other residents' rooms, and to significantly intrude on the privacy of others. Record review revealed Resident #4 began displaying physically aggressive behavior toward his new roommate, Resident #2, on 5/14/25, which the facility failed to investigate, despite Resident #4 never having shown behaviors of physical aggression before. This failure contributed to an escalation of aggression toward Resident #2, along with physical aggression toward Residents #3, #5, and #10. -On 5/31/25, staff observed Resident #4 standing over his sleeping roommate, Resident #2, and holding his oxygen tubing in a threatening manner. While the facility provided immediate intervention to ensure resident safety after the incident (15-minute checks for 72 hours), the immediate intervention was ineffective in preventing Resident #4 from attempting to put his walker on the shoulders of Resident #3 later the same day. The facility failed to investigate Resident #4's aggressive behavior and develop interventions to identify and address the risks Resident #4 posed to the safety of the cognitively impaired residents on the unit, including to his roommate, Resident #2, and additional physically aggressive incidents by Resident #4 followed on 6/1/25, 6/3/25, and 6/30/25. -On 6/1/25, one day after Resident #4 was involved in two aggressive incidents with Resident #2 and Resident #3, Resident #4 entered the room of Resident #5 and pushed him to the floor. Resident #4's psychoactive medications were adjusted, and 15-minute checks were continued. However, the 15-minute checks had not been effective in preventing the incident on 6/1/25. -On 6/3/25, three days after the incident with his roommate, Resident #2, Resident #4 placed a table on Resident #2's chest while he lay in bed, punching him, and attempting to drag him out of his bed. Resident #4 was then moved to another room and provided one-on-one staff supervision for 72 hours. However, there was no evidence that the facility conducted comprehensive clinical assessments of Resident #4 to rule out clinical contributing factors for his aggressive behavior. No updated interventions or triggers were added to his plan of care or the abbreviated care plan the staff were to utilize to prevent recurrences. Additionally, the resident's new behavior of physical aggression was not added to Resident #4's behavior monitoring orders for staff. -On 6/30/25, Resident #4 approached Resident #10 in a hallway and pushed Resident #10's walker with his walker, causing Resident #10 to almost lose his balance. Resident #4 did not have any enhanced supervision - either one-to-one monitoring or 15-minute checks - in place, even though his room was down a (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hallway with limited staff visibility. 2. Resident-to-resident abuse on the Sunrise South and Mountain View North Units Residents #6 and #7 resided in the Sunrise South Unit. Review of a facility abuse investigation, dated 6/18/25, documented Resident #7 physically abused Resident #6 on 6/18/25 at 9:25 p.m. The investigation read that Resident #7 entered his room, got into a verbal altercation with his roommate, Resident #6, and Resident #7 picked up a coffee cup and threw it at Resident #6, hitting him in the face and causing a one-inch laceration above his left eyebrow.Staff interviews revealed that Resident #6 and Resident #7 had personality clashes when they were roommates, which led to issues between the two that escalated over time. However, review of Resident #6 and #7's progress notes revealed no documentation indicating staff assessed, monitored, or addressed the escalating conflict between Resident #6 and Resident #7.Residents #8 and #9 resided in the Mountain View North Unit. Review of a facility abuse investigation documented that staff witnessed Resident #9 push Resident #8 with an open hand on the shoulder while they were in the dining room/sitting area. Resident #9 told Resident #8 to move out of his way and then pushed Resident #8. The residents were separated and started on frequent checks. However, neither resident's record contained documentation of frequent checks.Specifically, the facility failed to:-Protect Resident #2, Resident #3, Resident #5 and Resident #10 from physical abuse by Resident #4;-Protect Resident #6 from physical abuse by Resident #7; and,-Protect Resident #8 from physical abuse by Resident #9.The facility's failure to develop and implement effective interventions to prevent repeated incidents of resident-to-resident physical abuse created the potential for serious harm if the situation was not immediately corrected. Findings include: I. Immediate jeopardy A. Findings of immediate jeopardy Resident #4, with severe cognitive loss, exhibited physically aggressive behaviors toward four residents (#2, #3, #5, and #10), all of whom were cognitively impaired. Resident #4 attempted to physically harm Resident #2, his roommate, on 5 /31/25, standing over his sleeping roommate and holding his oxygen tubing in a threatening manner. And, attempted to harm him again on 6/3/25 by placing a bedside table on Resident #2's chest as he slept. Resident #4 attempted to harm Resident #3 on 5/31/25 by attempting to place his walker on Resident #3's shoulders. Resident #4 hit and pushed Resident #5 on 6/1/25, causing the resident to fall to the floor. And, Resident #4 pushed Resident #10 on 6/30/25 in the hallway, causing him to lose his balance Record review revealed additional incidents of resident-to-resident altercations on the Sunrise South and Mountain View North units. Resident #7 threw a cup at Resident #6, causing a facial laceration, and Resident #9 pushed Resident #8. There was no evidence that interventions to prevent repeat incidents of abuse were timely initiated. The facility's failure to develop and implement effective interventions to prevent cognitively impaired residents from being repeatedly subjected to Resident #4's physical abuse and attempts at physical abuse, as well as abusive incidents by Resident #7 and #9, created the potential for serious harm if the situation was not immediately corrected. On 7/14/25 at 7:05 p.m., the administrator in training (AIT), the regional clinical resource (RCR), and the director of nursing (DON) were notified that the facility's failure to develop and implement effective interventions to protect cognitively impaired residents from repeatedly being subjected to physical abuse and attempts at physical abuse created the potential for serious harm if the situation was not immediately corrected. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	B. Facility plan to remove immediate jeopardy On 7/15/25 at 10:25 a.m., the facility submitted a plan to abate the immediate jeopardy. The abatement plan read: Immediate Action: Upon notification of the immediate jeopardy, one-to-one staff supervision was immediately initiated on 7/14/25 for Resident #4. Resident #4 remained on one-to-one staff supervision until the survey exit at 6:00 p.m. on 7/15/25. During the period from 7/14/25 to 7/15/25, all staff were provided education on prevention and de-escalation of behaviors with Resident #4. Resident abuse education for staff was initiated on 7/15/25 by the DON. The education is to be completed at the beginning of each shift until all staff were 100% educated by 7/22/25 and ongoing education is to take place prior to the start of shift for all contracted staff. Abuse education included: types of abuse, reporting allegations and reporting to abuse coordinator and safety interventions. An additional binder was created and located in the nurses’ station to provide education to agency staff on abuse expectations and procedures. Education was initiated on 7/15/25 with staff on all residents’ plan of care updates. A binder for resident specific resident behaviors, identified triggers and interventions was initiated on 7/15/25 and placed at every nurses’ station. On 7/14/25, Resident # 4's comprehensive care plan and abbreviated care plan were reviewed and updated by social services and nursing, with up to date triggers and non-pharmacological interventions. A facility wide audit was completed on 7/15/25 for all residents with a history of verbal and/or physical aggression by social services and nursing. The care plans were updated with person centered care interventions including triggers and non-pharmacological interventions. Monitoring: The DON, or designee, to complete audits on three random residents three times a week for twelve consecutive weeks. The audits will include: Observation: Observe for any concerns with resident interactions and observe for any concerns with roommate living situations. Staff Interview: Ensure the staff are aware of resident behaviors, triggers and interventions. C. Removal of immediate jeopardy On 7/15/25 at 4:55 p.m., the AIT was notified that, based on review of the facility plan and evidence of its implementation, the immediate jeopardy situation had been abated. However, deficient practice remained at an E level, with the potential for more than minimal harm at a pattern. II. Facility abuse policy (continued on next page)

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F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

On 7/14/25 at 7:14 a.m., the RCR provided the facility’s Abuse Policy, revised April 2025. It read in pertinent parts:

The facility will engage in training and orienting its new and existing staff on topics which relate to the delivery of care and service in the post-acute setting. Topics of such training will include, but not be limited to: reporting abuse, neglect, exploitation, and misappropriation of resident property.

Identifying, assessing, care planning for appropriate interventions, and monitoring residents with needs and behaviors that might lead to conflict or neglect, such as:

Physically aggressive behavior, wandering into other rooms/space, and touching or rummaging through other's property.

If the allegation of abuse, neglect, or exploitation involves another resident, the facility will continue to assess, monitor, and intervene as necessary to maximize resident health and safety.”

III. Incidents of resident-to-resident abuse on Mountain View South

A. Incident on 5/14/25 between Resident #4 and his roommate, Resident #2

1. A nursing progress note, dated 5/14/25, revealed that Resident #4 woke up from sleeping, went over to his roommate's side of the room (Resident #2), and pushed all of his belongings onto the floor. The two residents began to yell aggressively at each other, and the staff was able to intervene before it escalated to a physical altercation. Resident #2 was put into a different room for the night to resolve the situation.

2. Facility failure

There were no notes in Resident #4's electronic medical record (EMR) to show a review by the interdisciplinary team (IDT) regarding Resident #4's behavior, although staff interview (see below) revealed Resident #4 did not exhibit physically aggressive behavior before Resident #2 became his roommate.

B. Incidents on 5/31/25 between Residents #4 and #2, and Residents #4 and #3

1. Incident on 5/31/25 with an unidentified time between Residents #4 and #2

Facility investigation:

The facility investigation read that the incident between Resident #4 and Resident #2 occurred in the room the residents shared. Resident #4 was observed by staff in the room, standing over Resident #2, who was sleeping in his bed, with oxygen tubing in his hands, extending it towards Resident #2. When stopped by the certified nursing assistant (CNA), Resident #4 stated, I haven't done anything to him yet. Resident #4 was removed from the room and placed on 15-minute checks.

The residents were not interviewed until 6/2/25 (due to late reporting to the management by the unit staff), and neither resident could recall the incident due to cognitive impairment.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. Resident #3 (victim) Resident #3, age greater than 65, was admitted on [DATE]. According to the July 2025 CPO, diagnoses included dementia. The 6/4/25 MDS assessment revealed the resident had been unable to participate in the assessment due to cognitive impairments. A staff interview revealed Resident #3 had short-term and long-term memory deficits, he was only orientated to himself, and had severely impaired in decision-making. The resident's elopement care plan, revised 6/4/25, revealed that the resident had impaired decision-making and intruded on the privacy of others. Interventions, revised 6/5/25, included offering him his favorite candy and playing his favorite music. The July 2025 CPO revealed orders dated 11/26/24 for behavior monitoring for verbal and physical aggression. Interventions included to offer a back rub, redirect, approach in a calm manner, reposition, offer food/fluids, assess for pain, and provide a quiet environment. c. Resident #4 (assailant) Resident #4, age [AGE], was admitted on [DATE]. According to the July 2025 CPO, diagnoses included dementia and paranoid schizophrenia. The 4/29/25 MDS assessment revealed the resident had a severe cognitive impairment with a BIMS score of four out of 15. He had a behavior of wandering. The assessment’s behavior section failed to reveal that Resident #4 had behaviors of verbal or physical aggression. The resident's elopement care plan, revised 11/14/24, revealed the resident wandered aimlessly and significantly intruded on the privacy of others. He would wander in and out of other residents' rooms. Interventions, initiated 11/14/24, included to distract the resident from wandering with diversional activities. The July 2025 CPO revealed orders dated 11/26/24 for behavior monitoring for verbal threatening, agitation, and wandering. Interventions included to offer a back rub, redirect, approach in a calm manner, reposition, offer food/fluids, assess for pain, and provide a quiet environment. 4. Facility failures The facility failed to comprehensively evaluate either incident on 5/31/25; there were no notes in Resident #4's electronic medical record (EMR) to show a review by the interdisciplinary team (IDT) regarding this change in Resident #4's behavior, which posed a risk to cognitively impaired residents on the unit. Further, there was no evidence that the facility conducted comprehensive clinical assessments of Resident #4 to rule out clinical contributing factors for his aggressive behavior. And, there was no evidence that the facility considered separating Resident #2 and Resident #4, despite the earlier incident on 5/14/25, the nature of the incident on 5/31/25, and staff knowledge that the residents did not get along. CNA #7, interviewed on 7/15/25 at 1:41 p.m., said she had never seen Resident #4 display any behaviors of aggression until Resident #2 moved into his room (census records show that was on 5/5/25). CNA #7 said the residents did not like each other from the beginning, and both men had too many belongings for the space in the room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	No additional interventions were initiated on Resident #4's care plan until after several other aggressive actions by Resident #4 (see below). No updated interventions or triggers were added to his plan of care or the abbreviated care plan the staff were to utilize to prevent recurrences. Additionally, the resident's new behavior of physical aggression was not added to Resident #4's behavior monitoring orders for staff. C. Incident on 6/1/25 between Residents #4 and #5 Facility investigation: The facility investigation revealed the incident between Resident #4 and Resident #5 occurred in Resident #5's room. Staff heard yelling and found Resident #5 standing up and yelling at Resident #4 to leave the room. Resident #4 reached out and hit Resident #5 in the arms and then pushed him, causing Resident #5 to fall to the floor onto his buttocks. The registered nurse (RN) contacted the director of nursing (DON) to report the incident. The RN advised the DON that Resident #4 had been agitated more than usual the prior day and had to be redirected many times to prevent him from agitating other residents on the unit. Both residents were put on 15-minute checks for 72 hours. Resident #4's hospice team was notified, and an order for twice-daily Ativan (an antianxiety medication) was initiated for Resident #4. Both residents were assessed by the RN and found not to have injuries. Resident #4 was interviewed on 6/2/25 and was unable to articulate the events due to cognitive impairments, other than to make a punching gesture while being interviewed. Resident #5 was interviewed on 6/2/25 and was unable to recall the event due to cognitive impairment. The facility substantiated the abuse. 2. Residents a. Resident #5 (victim) Resident #5, age [AGE], was admitted on [DATE]. According to the July 2025 CPO, diagnoses included unspecified dementia. The 5/7/25 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of eight out of 15. (Resident #5 was approached on 7/14/25 at 2:15 p.m. and was unable to recall the events of the incident.) The resident's behavior care plan, revised 6/6/25, after the incident on 6/1/25, revealed the resident had the potential to display verbally aggressive behaviors regarding others entering his room. Interventions, revised 6/6/25, were for staff to document observed behaviors and attempted interventions and place a stop sign across his doorway to discourage other residents from entering. b. Resident #4 (assailant) (see resident information above) 3. Facility failures The care plan for Resident #5 (see above) did not reflect the incident on 6/1/25 with Resident #4, (continued on next page)

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Residents Affected - Few

and observations on 7/14/25 at 10:23 a.m. did not reveal a stop sign across Resident #5's doorway as care planned.

There were no notes in Resident #4's electronic medical record (EMR) to show a review by the IDT regarding this change in Resident #4's behavior, which posed a risk to cognitively impaired residents on the unit.

The behavior care plan and approaches for Resident #4, ordered on 11/26/24, were not updated to increase supervision of the resident, who was known to wander into residents' rooms.

The medication administration records (MARs) and treatment administration records (TARs) reviewed for June 2025 and July 2025 failed to reveal that the resident had behavior monitoring established for physical aggression toward other residents.

D. Incident on 6/3/25 at 8:46 a.m. between Residents #4 and #2

1. Facility investigation

The facility investigation revealed that a third incident between Resident #4 and Resident #2 occurred in the room the residents shared. Resident #4 was observed by staff in the room, standing over Resident #2, who was lying in his bed, and he was pushing a bedside table down onto Resident #2's chest. Resident #2 was attempting to push the table off himself when staff intervened. Resident #4 was assigned one-on-one staff supervision and was moved to a private room. Both residents were assessed by the RN and found not to have injuries.

Resident #4 was interviewed on 6/3/25 and was unable to articulate the events due to cognitive impairments. Resident #2 was interviewed on 6/3/25 and told staff he had woken up to a table on top of him, and Resident #4 wouldn't stop and leave him alone.

The facility substantiated the abuse.

Staff interview:

CNA #7 was interviewed on 7/15/25 at 3:11 p.m. She said she was present for the incident between Resident #4 and Resident #2 on 6/3//25.

CNA #7 said on 6/3/25, she heard noise coming from the room Resident #4 and Resident #2 shared, and she came in to see Resident #4 pushing a bedside table on Resident #2's chest. She said Resident #2 was lying in his bed and was trying to push the table off himself, but he was unable to until the CNA entered and distracted Resident #4. CNA #7 said that after Resident #2 was able to push off the bedside table, Resident #4 began punching him in the body, and Resident #2 began kicking Resident #4. She said Resident #2 was still lying in his bed, and Resident #4 grabbed his foot and tried to pull him out of his bed. CNA #7 said she had to put her body physically between the residents to stop them from fighting. She said she reported the incident to the nurse.

2. Residents

Resident #2 (victim) (see resident information above)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #4 (assailant) (see resident information above) Review of Resident #4's record revealed a physician visit note, dated 6/3/25, that the physician had visited Resident #4 and made no changes to his plan of care. The note indicated the resident had a few altercations in the past couple of weeks and had a history of hallucinations and underlying psychosis. 3. Facility failures On 6/4/25, interventions were initiated to analyze Resident #4's behavioral events for key times, circumstances, triggers, and what de-escalation was effective, to address contributing sensory deficits, and to document behaviors and interventions. -However, these interventions were not resident-centered and failed to address enhanced supervision when one-to-one supervision or 15-minute supervision was not in place. On 6/6/25, three days after the third incident with Resident #2, orders for alert charting in the treatment administration records (TARs), dated 6/1/25 to 6/30/25, was ordered, and documented Resident #4 was being monitored for chronic obstructive pulmonary disease (COPD) exacerbation with increased agitation, confusion, and wandering. -However, the medication administration records (MARs) and TARs reviewed for June 2025 and July 2025 failed to reveal that the resident had behavior monitoring established for physical aggression toward other residents. On 6/17/25, a psychoactive medication meeting note revealed Resident #4 had been reviewed due to agitation, verbal, and physical aggression towards others. However, no recommendations were made, and there was no mention of a root cause analysis to determine the cause of the resident's behavior. E. Incident on 6/30/25 at 4:10 p.m. between Residents #4 and #10 1. Facility investigation The facility investigation revealed that an incident between Resident #4 and Resident #10 occurred in the common area of the unit. Resident #4 was observed by staff pushing his walker against Resident #10's walker, almost causing him to lose his balance and fall before staff could intervene. The residents were separated and assessed by the RN and found not to have injuries. Resident #4 was placed on frequent checks. Resident #4 was interviewed on 6/30/25 and could not recall the specifics of the incident, but said he could recall feeling ticked off and if he had a problem with another resident, he said he would handle it. Resident #10 was interviewed on 6/3/25 and was unable to recall the incident due to cognitive impairments. The facility did not substantiate the incident, as no contact was made between the two residents. 2. Residents Resident #10 (victim) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Pelican Pointe Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 710 3rd St Windsor, CO 80550	

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #10, age [AGE], was admitted on [DATE]. According to the July 2025 CPO, diagnoses included unspecified dementia. The 4/30/25 MDS assessment revealed the resident had a severe cognitive impairment with a BIMS score of three out of 15. Resident #10 was approached on 7/14/25 at 4:05 p.m. and was unable to recall the events of the incident on 6/30/25 due to cognitive impairments. The resident's behavior care plan, revised 4/30/25, revealed that the resident used antipsychotic medications related to dementia. The resident had behaviors of hallucinations, delusions, and aggression. Interventions, initiated 9/11/24, included documenting behaviors. The elopement care plan, revised 4/30/25, revealed the resident had wandering behaviors and poor impulse control. Interventions, initiated 9/11/24, included documenting wandering behaviors and offering structured activities. Resident #4 (assailant) (see resident information above) 3. Facility failures Resident #10 was observed on 7/14/25 at 10:23 a.m., engaged in behavior that placed him at risk for harm from Resident #4. He walked down the hallway to Resident #4's room, walking into the rooms across the hall from Resident #4's room. Resident #10 then walked in and out of Resident #4's room three times, each time slamming the door behind him when he left. While Resident #10 was going in and out of the room, CNA #10 was less than four feet away and did not intervene. CNA #10, interviewed on 7/14/25 at 2:00 p.m., said that when Resident #10 was going in and out of Resident #4's room, she was unaware of the two residents' history with each other or the risk to their safety that Resident #10's behavior posed. CNA #9, interviewed on 7/14/25 at 1:41 p.m., said the room that Resident #4 currently lived in could not be visualized unless the staff were in his hallway, and any residents who went into his room could not be observed. The administrator in training (AIT), interviewed on 7/14/25 at 4:56 p.m., said the potential outcome for Resident #10 wandering into Resident #4's room on 7/14/25 could have been an incident of resident-to-resident physical abuse. G. Staff interviews Staff interviews revealed the facility had expectations that aggressive behavioral events would be reviewed in a risk management meeting, and the resident's care plan updated immediately with the displayed behaviors and non-pharmacological interventions. However, record review (see above) and staff interviews (see below) revealed that these expectations were not all completed or completed timely, such that all staff would be aware of and know how to recognize and respond to Resident #4's physical aggression. 1. CNA #9 was interviewed on 7/14/25 at 1:41 p.m. She said if there were an incident between residents, the staff would put the residents on 15-minute checks, notify the nurses, and the social services director (SSD). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-CNA #9 said Resident #4 had behaviors of wandering into other residents' rooms, physical aggression towards other residents, and the interventions that staff used with him were to ensure he was wearing his oxygen and to redirect him. See below; an intervention to ensure the resident's oxygen remained full and to monitor for his removal of the oxygen tubing as needed was not added to the behavior care plan until 7/3/25. 2. CNA #10 was interviewed on 7/14/25 at 2:00 p.m. She said she had been working at the facility for three weeks as a contract employee, and the facility did not have a good process of communicating with contract staff about resident behaviors and interventions. CNA #10 said she was unaware of Resident #4's history of physical aggression, and she was not informed of his behaviors until earlier on 7/14/25, during the survey. She said she was only told by another CNA that Resident #4 did not work well with others. 3. Registered nurse (RN) #4 was interviewed on 7/14/25 at 2:10 p.m. She said she had worked as a contract employee at the facility for six shifts and had not received specific training about how to find resident-specific behaviors and individualized interventions in the electronic medical records (EMR). 4. CNA #11 was interviewed on 7/14/25 at 2:20 p.m. CNA # 11 said she had worked at the facility for 12 years. She said Resident #4 had behaviors of not keeping his oxygen on and becoming confused. CNA #11 said Resident #4 did not have behaviors of physical aggression and did not have any enhanced supervision, such as 15-minute checks, line of sight, or one-on-one supervision. 5. RN #3 was interviewed on 7/14/25 at 2:30 p.m. She said she had only worked at the facility for three months. RN #3 said she looked in the CPO behavior monitoring orders for behaviors and interventions. 6. The AIT, the regional clinical resource (RCR), and the DON were interviewed on 7/14/25 at 4:56 p.m. The AIT said if a resident showed aggressive behaviors, the facility would investigate, and if determined to be concerning, the residents would be separated. He said the interdisciplinary team (IDT) reviewed the incidents in a risk management meeting, and immediately updated the resident's care plan with the displayed behaviors and non-pharmacological interventions. The DON said the IDT conducted a root cause analysis to determine the circumstances of an incident, triggers, and prior interventions to develop new non-pharmacological interventions. She said new interventions were documented in the care plan, and staff were verbally educated on the interventions to use. The DON said the staff were trained to review the abbreviated care plan for behaviors and interventions. She said Resident #4 had behaviors of agitation related to exacerbations of his COPD when he failed to wear his oxygen, and this exacerbation c

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure professional staff was licensed, certified, or registered in accordance with applicable State laws.Specifically, the facility failed to ensure the acting nursing home administrator's (NHA) license was valid. Findings include:I. Entrance interviewOn [DATE] at 9:00 a.m. the entrance conference was conducted with the director of nursing (DON). The DON said she was acting as the NHA at the time of the survey. The DON said there was a nursing home administrator in training who was preparing to become the permanent licensed NHA.II. Record reviewOn [DATE] at 9:15 a.m. a review was conducted on the State licensing website. The website showed the DON had applied for a temporary NHA license for emergency situations. The original issue and effective date was [DATE] and the expiration date was [DATE]. The NHA temporary permit for emergency situations was listed as expired.On [DATE] at 2:10 p.m. the corporate operations director provided the license invoice information. It was reviewed and revealed the application and payment for the temporary license submission was dated [DATE]. III. Staff interviewsThe DON was interviewed on [DATE] at 1:23 p.m. She said she had applied for the temporary NHA license [DATE] and it had expired on [DATE]. The DON said she was going to apply again and each time she applied it was good for 90 days. The corporate operations director was interviewed on [DATE] at 1:26 p.m. He said he was unable to provide evidence that the State Survey Agency was notified of the change in NHA position because he thought the licensing and regulatory agency would notify the State Survey Agency. IV. Facility follow up On [DATE] at 3:39 p.m. the DON provided documentation that the NHA temporary permit for emergency situations became effective on [DATE]. -There was a lapse in NHA licensing from [DATE] to [DATE].

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interviews and record review, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented, in order to facilitate improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life and resident safety.Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to freedom from abuse that rose to the level of immediate jeopardy and created a situation where a serious adverse outcome was likely to occur. Findings include:I. Facility policy and procedureThe Quality Assurance Performance Improvement (QAPI) policy and procedure, revised December 2024, was provided by the director of nursing (DON) on 7/15/25 at 1:00 p.m. It read in pertinent part, It is the policy of this facility to develop, implement, and maintain an ongoing program designed to monitor and evaluate the quality of resident care, and to resolve identified problems. The primary purposes of the Quality Assessment and Assurance Plan are: To have an ongoing Quality Assessment and Assurance Committee that includes designated key members Director of Nursing Services, a physician, and at least three other members of the facility's staff); to meet at least quarterly; to identify quality deficiencies and develop and implement plans of action to correct these quality deficiencies, including monitoring the effect of implemented changes and making needed revisions to the action plans. The committee should maintain a record of the dates of all meetings and the names/titles of those attending each meeting. The primary goals of the QAPI Committee is the identification of quality deficiencies. Include information such as: open and closed record audits; facility logs and tracking forms; incident reports; and, consultant's reports. The committee responds to quality deficiencies and serves a preventative function by reviewing and improving systems. The facility's QAPI Committee, having identified the root causes which led to their confirmed quality deficiencies, must develop appropriate corrective plans of action. Action plans may include: revision of policy and procedures; training for staff concerning changes; plans to purchase or repair equipment; improve the physical plant; standards for evaluating staff performance; implementation of facility's action plans; staff training; deployment of changes to procedures; monitoring and feedback mechanisms; and, process to revise plans that are not achieving or sustaining desired outcomes.II. Cross-reference citationCross-reference F600: The facility failed to ensure all residents were free from abuse. The facility's failure to protect residents from resident-to-resident physical abuse put residents in a situation where a serious outcome was likely to occur and created an immediate jeopardy situation. III. Staff interviewsThe medical director (MD) was interviewed on 7/15/25 at 11:19 a.m. He said he was in the building about twice per week. The MD said some of the roles he provided included rounding as an attending physician, attending QAPI meetings, psychopharmacology meetings and getting reports from the departments. The MD said he provided education to the staff when needed especially when he noticed something related to the clinical practice such as when monitoring weights or medications. The MD said he received and reviewed many reports such as from the registered dietitian (RD), QAPI reports from different departments and the emergency preparedness manual. The MD said he provided oversight and follow-up to any suggestions by communicating with the DON, who was currently serving as the temporary nursing home administrator (NHA). The MD said he would communicate with the DON and social worker via email regarding resident placements and discharges. The MD said he had not reviewed and made policy changes but was available for that if needed. The MD said he had been the medical director at the facility for approximately one and a half years. The MD said he was not informed by the facility yet that the survey team had called for immediate jeopardy for failure to prevent abuse. The MD said his (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	thoughts regarding the nature of the immediate jeopardy situation was that the facility needed to better communicate with the staff and thought that was something the facility could fix and improve upon. The MD said he was not sure of his further recommendations for the facility's next steps since he was just finding out about this and would give it some thought. The MD said he would review the charts and cases and said he was aware that there were some resident altercations but did not realize it rose to this level and was not aware that things were this serious. The DON was interviewed on 7/15/25 at 12:30 p.m. The DON said she had a temporary emergency license as the NHA since April 2025. The DON said she had notified the MD of the potential immediate jeopardy yesterday via email but did not necessarily say it was related to abuse but said it was related to reportable occurrences.The DON said the facility QAPI committee met monthly on the third Tuesday of each month. The DON said the last meeting was 6/17/25.The DON said the QAPI committee included all the required members and they completed a sign in sheet. The DON said for every issue identified the committee would review that. The DON said they had standard items that they reviewed and also obtained information from their tracking and trending, resident council meetings and grievances. The DON said they had worked on one performance improvement plan (PIP) since she started employment at the facility 10/24/24. The DON said the PIP was in regards to falls and there had been some improvements but they were still monitoring it.The DON said standard items were reviewed during QAPI such as admissions, discharges, dietary, weight loss, falls, hospitalizations, infection control, recruitment/hiring and online continuing education. The DON said there was a standard section they reviewed monthly for reportable occurrences and incidents. The DON said they had not implemented a PIP related to the recent occurrences because the interventions that they had in place seemed to be effective. The DON said they had reviewed the medications for Resident #4 and completed the investigations and it appeared it was going to be effective since there were no abuse incidents since the last three, but then another incident happened. The DON said it did not come to their attention to audit the facility since the occurrences were with the same resident. The DON said that abuse had not been identified by the facility as a concern, just the normal and usual review of any reportable occurrences which was looked at monthly.