STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165420	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Traditions Memory Care of Newton	2130 West 18th Street South , Newton, Iowa, 50208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 ✓ OK/CP	INITIAL COMMENTS Correction date: 12/11/2025 The following deficiencies resulted from the investigation of facility reported incidents #2648877-I and #2649213-I conducted October 27, 2025 to October 28, 2025. Facility reported incidents #2648877-I and #2649213-I resulted in deficiencies. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000		
F0657 SS = E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as	F0657	1.Traditions Memory Care of Newton corrected the deficiency F0657 Care Plan Timing and Revision, by auditing resident #1, and all like residents to ensure that care plans are updated timely with effective interventions to protect the resident's right to be free from physical abuse on 10/28/25 by the DON, ADON, and MDS Coordinator. 2. To correct the deficiency and to ensure the problem does not recur, the DON, ADON, and MDS Coordinator were educated on 10/28/25 regarding the importance of ensuring that resident care plans contain effective interventions to manage behavioral issues to protect the resident's rights to be free from abuse by the Administrator. The DON and/or designee will audit 3x/week for 4 weeks, 2x/week for 4 weeks, and 1x/week for 4 weeks, and then PRN to ensure continued compliance. 3. As part of Traditions Memory Care of Newton's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns quarterly through the community's QA Process.	10/28/2025

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 reverse for further 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
Zulu Slin	Administrator	12-31-25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165420	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/28/2025

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F0657 SS = E	Continued from page 1 requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, clinical record review, policy review, and staff interviews, the facility failed to develop effective care plan interventions protect the resident's right to be free from physical abuse for 4 of 7 residents reviewed for resident to resident altercations(Residents #2, #5, #6, #7). The facility reported a census of 46 residents. Findings included: 1. The Minimum Data Set(MDS) assessment tool, dated 8/4/25, listed diagnoses for Resident #1 which included psychotic disorder(a mental health condition characterized by a loss of touch with reality, leading to significant disturbances in thoughts, perceptions, and behavior), schizophrenia(a chronic mental health condition characterized by a combination of symptoms that can significantly impact a person's thoughts, feelings, and behavior), and anxiety disorder. The MDS stated the resident was independent with walking and had physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) which occurred 4 to 6 days out of the 7 day review period. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 0 out of 0, indicating severely impaired cognition. The facility "Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy" updated 10/19/22, stated residents must not be subjected to abuse by anyone including other residents. The policy defined dependent adult abuse to include assault of a dependent adult, which meant the commission of any act which was generally intended to cause pain or injury to a dependent adult, or which was generally intended to result in physical contact which would be considered by a reasonable person to be insulting or offensive or any act which was intended to place another in fear of immediate physical contact which would be painful, injurious, insulting, or offensive, coupled with the apparent ability to execute the act.	F0657		

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F0657 SS = E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as	F0657	1.Traditions Memory Care of Newton corrected the deficiency F0657 Care Plan Timing and Revision, by auditing resident #1, and all like residents to ensure that care plans are updated timely with effective interventions to protect the resident's right to be free from physical abuse on 10/28/25 by the DON, ADON, and MDS Coordinator. 2. To correct the deficiency and to ensure the problem does not recur, the DON, ADON, and MDS Coordinator were educated on 10/28/25 regarding the importance of ensuring that resident care plans contain effective interventions to manage behavioral issues to protect the resident's rights to be free from abuse by the Administrator. The DON and/or designee will audit 3x/week for 4 weeks, 2x/week for 4 weeks, and 1x/week for 4 weeks, and then PRN to ensure continued compliance. 3. As part of Traditions Memory Care of Newton's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns quarterly through the community's QA Process.	10/28/2025

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F0657 SS = E	Continued from page 2 Care Plan entries, dated 7/31/25, directed staff to provide reassurance and consult psychiatric services as needed, change rooms if indicated, assess for contributing factors, and move to a quiet area to deescalate behavior. An 8/1/25 Care Plan entry directed staff to carry out non-pharmacological interventions such as offers of food, fluids, toileting, activities, family calls, pain assessments, repositioning, and one on one staff supervision. An 8/14/25 Care Plan entry directed staff to redirect the resident out of other resident rooms. An 8/29/25 Care Plan entry stated the resident relaxed and rested when she cuddled with staff. A 9/1/25 Care Plan entry stated the resident was one on one with staff as needed for safety while she ambulated. The Care Plan lacked interventions shown to be effective in preventing the resident from physical aggression with other residents. A 4/24/25 hospital Provider Progress Note stated the resident was involuntarily discharged from her nursing home and stated in the Emergency Department, she was very aggressive, hit staff, and required multiple security guards. A 7/28/25 Admission Summary stated the resident admitted to the facility. A 7/28/25 Health Status Note stated the resident wandered all shift and went in and out of other's rooms, crawled in bed with them, and sat in occupied chairs. A 7/30/25 Health Status Note stated the resident continuously wandered and entered peer rooms, upsetting them. An 8/2/25 Health Status Note stated the resident wandered, trespassed, and took peer belongings. She attempted to get into bed or sit in a chair with others which caused peer agitation. She was aggressive and combative and had two incidents of increased agitation with peers. She attempted to sit on a male peer's lap and attempted to kiss another male peer on the mouth. A 9/27/25 Health Status Note stated the resident told	F0657		

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F0657 SS = E	Continued from page 3 staff she would hit them and slapped a staff member on the back. A 10/5/25 Health Status Note stated the resident had an increase in her behaviors. She was mean and took her peer's meals away from them. She grabbed food off their plates and cursed at them. She hit, kicked, and bit when anyone tried to redirect her. Her morphine(a narcotic pain reliever) and Haldol(an antipsychotic medication) had "zero effectiveness". A 10/13/25 Health Status Note stated each day the resident became more aggressive with staff, peers, and even guests. She had no boundaries and called names, hit, kicked, and grabbed other's food. She was not redirectable and it required two staff to attempt to take care of her. A 10/14/25 Health Status Note stated the resident had multiple medication changes without benefit. The resident continued to wander into other's rooms, grabbed their belongings, and caused irritation to other residents. She swore at staff and called them crass and vulgar names. She told them to die and to go to hell. She hit a staff member which caused a bruise and skin tear to the staff member. Her medication regimen changes were completely ineffective regardless if they were scheduled or as needed(prn). A 10/21/25 Health Status Note stated the resident was agitated after dinner and repeatedly went in and out of resident rooms. Staff carried out 1:1 supervision with the resident to prevent further incidents. The administration of prn medication was ineffective. A 10/27/25 Orders-Administration Note stated the resident stuck staff hard with an open hand across the face when staff redirected her out of a male peer's room. The resident in one minute told staff she loved them but then a few seconds later was irritable and called staff names. On 10/27/25 at 10:23 a.m. Resident #1 walked out of the dining room. At 10:24 a.m., a staff member quickly got up and went down the hall and brought the resident back. The resident again stood up and went down the same hall and staff did not go after her until 10:26 a.m. The resident was in a room occupied by two other residents who were in bed at the time. While Resident #1 was still in the other resident's room, Staff A Hospice Social Worker stated to Resident #1 that she shouldn't hit people. Staff A stated that the Resident hit a staff member in the face. The resident then went into a different resident's room before staff assisted	F0657		

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F0657 SS = E	Continued from page 4 her out. Resident #1 then went down the opposite hall and went into Room 16 and closed the door before Staff A arrived and went in and got her. The room was unoccupied at this time. Observations on 10/27/25 from 10:41 a.m. to approximately 11:18 a.m. revealed the resident constantly pacing down different hallways. She sat down at the dining table at 11:16 a.m. but only stayed there for approximately two minutes before getting up again. a. Resident #1 and Resident #5 The MDS assessment tool, dated 6/23/25, listed diagnoses for Resident #5 which included diabetes(a disease which caused alterations in blood sugars), non-Alzheimer's dementia, and schizophrenia. The MDS listed the resident's BIMS score as 3 out of 15, indicating severely impaired cognition. Care Plan entries, dated 7/20/24, stated the resident had dementia with behavioral disturbances and stated the resident would remain safe over the next review period. An 8/25/25 Health Status Note stated staff heard Resident #5 yell "get out" and then heard Resident #1 scream. (Staff) entered the room and Resident #1 sat on Resident #5's bed on top of one of his legs and Resident #5 kicked her with the other leg. After staff assisted Resident #1 up to free Resident #5's legs, it freed his other leg and he began kicking her with both legs. b. Resident #1 and Resident # 6 The MDS assessment tool, dated 7/28/25, listed diagnoses for Resident #6 which included Alzheimer's disease, non-Alzheimer's dementia, and anxiety disorder. The MDS listed her BIMS score as 3 out of 15, indicating severely impaired cognition. Care Plan entries, dated 2/12/25, stated the resident had altered thought processes related to Alzheimer's disease, anxiety disorder, and severe cognitive impairment. The Care Plan directed staff to reassure the resident to decrease frustration. A 10/4/25 Physical Aggression Initiated form stated Resident #1 sat in Resident #6's chair in Resident #6's room and Resident #6 took Resident #1's hands to try to get her out of the chair. Resident #1 swung at Resident #6 and hit her in the left arm.	F0657		

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F0657 SS = E	Continued from page 5 c. Resident #1 and Resident #7 The MDS assessment tool, dated 9/8/25, listed diagnoses for Resident #7 which included Alzheimer's, non-Alzheimer's dementia, and bipolar disorder(a chronic mental health condition characterized by extreme mood swings). The MDS listed her BIMS score as 13 out of 15, indicating intact cognition. Care Plan entries, dated 10/11/23, stated the resident had altered thought processes/cognition related to Alzheimer's dementia and directed staff to reassure the resident to decrease frustration. A 10/17/25 Health Status Note stated on 10/16/25 at 1:15 p.m. Resident #1 entered Resident #7's room and Resident #7 reported that Resident #1 hit her on the head. Staff then witnessed Resident #7 hit Resident #1. d. Resident #1 and Resident #2 The MDS assessment tool, dated 9/22/25, listed diagnoses for Resident #2 which included Alzheimer's disease, non-Alzheimer's dementia, and psychotic disorder. The MDS listed the resident's BIMS score as 4 out of 15, indicating severely impaired cognition. A 1/27/25 Care Plan entry directed staff to reassure the resident to decrease frustration. A 6/16/25 Care Plan entry stated the resident had altered thought processes/cognition related to Alzheimer's Dementia with behavioral disturbances, generalized anxiety disorder, delusional disorders, and major depressive disorder. A 10/16/25 Health Status Note stated the resident sat in the dining room and Resident #1 came up to him and hit him on the right shoulder area. A 10/16/25 Physical Aggression Initiated form stated a nurse gently placed her hand on the resident(Resident #1) for her to come and the resident immediately stood up, jerked away from the nurse, turned to face the other resident(Resident #2), and took her right hand and hit the other resident's right shoulder. The nurse was unable to intervene in time as a dining room chair was between the resident and the nurse. A 10/19/25 Health Status Note stated Resident #1 hit Resident #2 on the right shoulder. On 10/27/25 at 10:44 a.m., Staff A Hospice Social Worker walked in the hall with Resident #1. Staff A	F0657		

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F0657 SS = E	Continued from page 6 stated she visited 1-2 times per week and was worried about other residents so kept an eye on Resident #1. On 10/27/25 at 3:52 p.m. via phone, Staff B Registered Nurse(RN) stated Resident #1 went in and out of other resident rooms and she observed Resident #1 hit Resident #2. She stated they tried to keep her one on one with staff when they had staff to do this. On 10/27/25 at 4:01 p.m. via phone, Staff C Certified Nursing Assistant(CMA) stated she observed Resident #1 slap the back of Resident #2's shoulder. She stated Resident #1 was all over all of the time and hard to redirect. She stated they kept an eye out for her when she was up and awake but thought it was impossible for them to care for her and her behaviors. She stated she did not think it was possible to prevent her from physically lashing out. On 10/28/25 at 8:22 a.m., Staff D Licensed Practical Nurse(LPN) stated Resident #1 was constantly moving and didn't rest. She stated none of her medications were effective. She stated when they went towards her, she started swinging and hitting people. She stated there was not enough staff to watch her and when asked if she thought the other residents were safe from Resident #1, she said no. On 10/28/25 at 8:47 a.m., Staff E LPN stated the resident was not on one on one supervision and she roamed all over and they tried to keep an eye on her. She stated it was not possible for them to prevent her from going in other rooms and stated she did not feel this was the facility for her. On 10/28/25 at 9:10 a.m., Staff F CNA stated Resident #1 was "very mean" to other residents and sometimes aggressive. She stated she slapped the other residents. She stated she was on 15 minute checks currently but she was able to get into other resident rooms without them knowing. On 10/28/25 at 9:20 a.m., Staff G CNA stated the facility did not have enough staff to keep an eye on Resident #1 at all times. On 10/28/25 at 9:27 a.m., the Director of Nursing(DON) stated Resident #1 had a "30 second switch" and could go from saying she loved her to calling her vulgar names. She went into other resident's rooms and if they became agitated, she became agitated and would hit. She stated they carried out numerous medication changes and stated one on one supervision may agitate her more. She stated if she was not on one on one supervision, there	F0657		

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F0657 SS = E	Continued from page 7 was no guarantee(she wouldn't physically lash out at staff again). She stated the sent out referrals to other smaller facilities which may suit her better. On 10/28/25 at 12:23 p.m., the MDS Coordinator, was queried as to if there were any interventions which kept the resident out of other resident rooms. She stated this would be staff watching her but stated one on one supervision was probably not an option staffing wise.	F0657		
F0689 SS = E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, clinical record review, policy review, and staff interview, the facility failed to provide adequate supervision to protect the resident's right to be free from physical abuse for 4 of 7 residents reviewed for resident -to-resident altercations (Residents #2, #5, #6, #7). The facility reported a census of 46 residents. Findings include: 1. The Minimum Data Set (MDS) assessment tool, dated 8/4/25, listed diagnoses for Resident #1 which included psychotic disorder (a mental health condition characterized by a loss of touch with reality, leading to significant disturbances in thoughts, perceptions, and behavior), schizophrenia (a chronic mental health condition characterized by a combination of symptoms that can significantly impact a person's thoughts, feelings, and behavior), and anxiety disorder. The MDS stated the resident was independent with walking and had physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) which occurred	F0689	1. Traditions Memory Care of Newton corrected the deficiency F0689 Free of Accident Hazards/Supervision/Devices, by auditing the care plan of resident #1, and all like residents to ensure care plans are updated with effective interventions provide adequate supervision to protect the resident's right to be free from physical abuse on 10/28/25 by the DON, ADON, and MDS Coordinator. 2. To correct the deficiency and to ensure the problem does not recur, resident #1 was discharged on 10/29/25. All clinical staff were also educated on 12/11/2025 on the importance of following established resident care plans by the DON. The DON and/or designee will audit for compliance with care plan interventions that provide adequate supervision to protect the resident's right to be free from physical abuse 3x/week for 4 weeks, 2x/week for 4 weeks, and 1x/week for 4 weeks, and the PRN to ensure continued compliance. 3. As part of Traditions Memory Care of Newton's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns quarterly through the community's QA Process.	12/11/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Traditions Memory Care of Newton	**2130 West 18th Street South , Newton, Iowa, 50208**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = E	Continued from page 8 4 to 6 days out of the 7-day review period. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 0 out of 0, indicating severely impaired cognition. The facility "Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy" updated 10/19/22, stated residents must not be subjected to abuse by anyone including other residents. The policy defined dependent adult abuse to include assault of a dependent adult, which meant the commission of any act which was generally intended to cause pain or injury to a dependent adult, or which was generally intended to result in physical contact which would be considered by a reasonable person to be insulting or offensive or any act which was intended to place another in fear of immediate physical contact which would be painful, injurious, insulting, or offensive, coupled with the apparent ability to execute the act. Care Plan entries, dated 7/31/25, directed staff to provide reassurance and consult psychiatric services as needed, change rooms if indicated, assess for contributing factors, and move to a quiet area to deescalate behavior. An 8/1/25 Care Plan entry directed staff to carry out non-pharmacological interventions such as offers of food, fluids, toileting, activities, family calls, pain assessments, repositioning, and one on one staff supervision. An 8/14/25 Care Plan entry directed staff to redirect the resident out of other resident rooms. An 8/29/25 Care Plan entry stated the resident relaxed and rested when she cuddled with staff. A 9/1/25 Care Plan entry stated the resident was one on one with staff as needed for safety while she ambulated. A 4/24/25 hospital Provider Progress Note stated the resident was involuntarily discharged from her nursing home and stated in the Emergency Department, she was very aggressive, hit staff, and required multiple security guards. A 7/28/25 Admission Summary stated the resident	F0689		

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F0689 SS = E	Continued from page 9 admitted to the facility. A 7/28/25 Health Status Note stated the resident wandered all shift and went in and out of other's rooms, crawled in bed with them, and sat in occupied chairs. A 7/30/25 Health Status Note stated the resident continuously wandered and entered peer rooms, upsetting them. An 8/2/25 Health Status Note stated the resident wandered, trespassed, and took peer belongings. She attempted to get into bed or sit in a chair with others which caused peer agitation. She was aggressive and combative and had two incidents of increased agitation with peers. She attempted to sit on a male peer's lap and attempted to kiss another male peer on the mouth. A 9/27/25 Health Status Note stated the resident told staff she would hit them and slapped a staff member on the back. A 10/5/25 Health Status Note stated the resident had an increase in her behaviors. She was mean and took her peer's meals away from them. She grabbed food off their plates and cursed at them. She hit, kicked, and bit when anyone tried to redirect her. Her morphine (a narcotic pain reliever) and Haldol (an antipsychotic medication) had "zero effectiveness". A 10/13/25 Health Status Note stated each day the resident became more aggressive with staff, peers, and even guests. She had no boundaries and called names, hit, kicked, and grabbed other's food. She was not redirectable and it required two staff to attempt to take care of her. A 10/14/25 Health Status Note stated the resident had multiple medication changes without benefit. The resident continued to wander into other's rooms, grabbed their belongings, and caused irritation to other residents. She swore at staff and called them crass and vulgar names. She told them to die and to go to hell. She hit a staff member which caused a bruise and skin tear to the staff member. Her medication regimen changes were completely ineffective regardless	F0689		

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F0689 SS = E	Continued from page 10 if they were scheduled or as needed(prn). A 10/21/25 Health Status Note stated the resident was agitated after dinner and repeatedly went in and out of resident rooms. Staff carried out 1:1 supervision with the resident to prevent further incidents. The administration of prn medication was ineffective. A 10/27/25 Orders-Administration Note stated the resident stuck staff hard with an open hand across the face when staff redirected her out of a male peer's room. The resident in one minute told staff she loved them but then a few seconds later was irritable and called staff names. On 10/27/25 at 10:23 a.m. Resident #1 walked out of the dining room. At 10:24 a.m., a staff member quickly got up and went down the hall and brought the resident back. The resident again stood up and went down the same hall and staff did not go after her until 10:26 a.m. The resident was in a room occupied by two other residents who were in bed at the time. While Resident #1 was still in the other resident's room, Staff A Hospice Social Worker stated to Resident #1 that she shouldn't hit people. Staff A stated that the Resident hit a staff member in the face. The resident then went into a different resident's room before staff assisted her out. Resident #1 then went down the opposite hall and went into Room 16 and closed the door before Staff A arrived and went in and got her. The room was unoccupied at this time. Observations on 10/27/25 from 10:41 a.m. to approximately 11:18 a.m. revealed the resident constantly pacing down different hallways. She sat down at the dining table at 11:16 a.m. but only stayed there for approximately two minutes before getting up again. a. Resident #1 and Resident #5 The MDS assessment tool, dated 6/23/25, listed diagnoses for Resident #5 which included diabetes (a disease which caused alterations in blood sugars), non-Alzheimer's dementia, and schizophrenia. The MDS listed the resident's BIMS score as 3 out of 15, indicating severely impaired cognition.	F0689		

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F0689 SS = E	Continued from page 11 Care Plan entries, dated 7/20/24, stated the resident had dementia with behavioral disturbances and stated the resident would remain safe over the next review period. An 8/25/25 Health Status Note stated staff heard Resident #5 yell "get out" and then heard Resident #1 scream. (Staff) entered the room and Resident #1 sat on Resident #5's bed on top of one of his legs and Resident #5 kicked her with the other leg. After staff assisted Resident #1 up to free Resident #5's legs, it freed his other leg and he began kicking her with both legs. b. Resident #1 and Resident # 6 The MDS assessment tool, dated 7/28/25, listed diagnoses for Resident #6 which included Alzheimer's disease, non-Alzheimer's dementia, and anxiety disorder. The MDS listed her BIMS score as 3 out of 15, indicating severely impaired cognition. Care Plan entries, dated 2/12/25, stated the resident had altered thought processes related to Alzheimer's disease, anxiety disorder, and severe cognitive impairment. The Care Plan directed staff to reassure the resident to decrease frustration. A 10/4/25 Physical Aggression Initiated form stated Resident #1 sat in Resident #6's chair in Resident #6's room and Resident #6 took Resident #1's hands to try to get her out of the chair. Resident #1 swung at Resident #6 and hit her in the left arm. c. Resident #1 and Resident #7 The MDS assessment tool, dated 9/8/25, listed diagnoses for Resident #7 which included Alzheimer's, non-Alzheimer's dementia, and bipolar disorder (a chronic mental health condition characterized by extreme mood swings). The MDS listed her BIMS score as 13 out of 15, indicating intact cognition. Care Plan entries, dated 10/11/23, stated the resident had altered thought processes/cognition related to Alzheimer's dementia and directed staff to reassure the	F0689		

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F0689 SS = E	Continued from page 12 resident to decrease frustration. A 10/17/25 Health Status Note stated on 10/16/25 at 1:15 p.m. Resident #1 entered Resident #7's room and Resident #7 reported that Resident #1 hit her on the head. Staff then witnessed Resident #7 hit Resident #1. d. Resident #1 and Resident #2 The MDS assessment tool, dated 9/22/25, listed diagnoses for Resident #2 which included Alzheimer's disease, non-Alzheimer's dementia, and psychotic disorder. The MDS listed the resident's BIMS score as 4 out of 15, indicating severely impaired cognition. A 1/27/25 Care Plan entry directed staff to reassure the resident to decrease frustration. A 6/16/25 Care Plan entry stated the resident had altered thought processes/cognition related to Alzheimer's Dementia with behavioral disturbances, generalized anxiety disorder, delusional disorders, and major depressive disorder. A 10/16/25 Health Status Note stated the resident sat in the dining room and Resident #1 came up to him and hit him on the right shoulder area. A 10/16/25 Physical Aggression Initiated form stated a nurse gently placed her hand on the resident (Resident #1) for her to come and the resident immediately stood up, jerked away from the nurse, turned to face the other resident (Resident #2), and took her right hand and hit the other resident's right shoulder. The nurse was unable to intervene in time as a dining room chair was between the resident and the nurse. A 10/19/25 Health Status Note stated Resident #1 hit Resident #2 on the right shoulder. On 10/27/25 at 10:44 a.m., Staff A Hospice Social Worker walked in the hall with Resident #1. Staff A stated she visited 1-2 times per week and was worried about other residents so kept an eye on Resident #1.	F0689		

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F0689 SS = E	Continued from page 13 On 10/27/25 at 3:52 p.m. via phone, Staff B Registered Nurse (RN) stated Resident #1 went in and out of other resident rooms and she observed Resident #1 hit Resident #2. She stated they tried to keep her one on one with staff when they had staff to do this. On 10/27/25 at 4:01 p.m. via phone, Staff C Certified Nursing Assistant (CMA) stated she observed Resident #1 slap the back of Resident #2's shoulder. She stated Resident #1 was all over all of the time and hard to redirect. She stated they kept an eye out for her when she was up and awake but thought it was impossible for them to care for her and her behaviors. She stated she did not think it was possible to prevent her from physically lashing out. On 10/28/25 at 8:22 a.m., Staff D Licensed Practical Nurse (LPN) stated Resident #1 was constantly moving and didn't rest. She stated none of her medications were effective. She stated when they went towards her, she started swinging and hitting people. She stated there was not enough staff to watch her and when asked if she thought the other residents were safe from Resident #1, she said no. On 10/28/25 at 8:47 a.m., Staff E LPN stated the resident was not on one-on-one supervision and she roamed all over and they tried to keep an eye on her. She stated it was not possible for them to prevent her from going in other rooms and stated she did not feel this was the facility for her. On 10/28/25 at 9:10 a.m., Staff F CNA stated Resident #1 was "very mean" to other residents and sometimes aggressive. She stated she slapped the other residents. She stated she was on 15-minute checks currently but she was able to get into other resident rooms without them knowing. On 10/28/25 at 9:20 a.m., Staff G CNA stated the facility did not have enough staff to keep an eye on Resident #1 at all times. On 10/28/25 at 9:27 a.m., the Director of Nursing (DON) stated Resident #1 had a "30 second switch" and could go from saying she loved her to calling her vulgar names. She went into other resident's rooms and if they	F0689		

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F0689 SS = E	Continued from page 14 became agitated, she became agitated and would hit. She stated they carried out numerous medication changes and stated one on one supervision may agitate her more. She stated if she was not on one-on-one supervision, there was no guarantee (she wouldn't physically lash out at staff again). She stated the sent-out referrals to other smaller facilities which may suit her better.	F0689		