STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165794	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Gate	16 Valley View Drive Council Bluffs, IA 51503

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, policy review, family interview and staff interviews the facility failed to report an incident of possible physical abuse to the appropriate entity for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 34 residents.Finding include:The Minimum Data Set (MDS) dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS also documented a diagnosis of unspecified dementia without behavioral disturbances. Review of EHR dated 8/28/25 titled, Progress notes documented Resident #1 had a BIMS of 8 indicating moderate cognitive impairment at that time. Review of Resident #1's document titled, Clinical Summary dated 6/19/25 documented Resident #1 had a discharge diagnosis of right hip hematoma related to a ground level fall at home.Review of Resident #1's EHR titled, Progress notes revealed on 7/22/25 Resident #1 was sent to the Emergency Department (ED) via 911 ambulance and returned to the facility on 7/22/25 at 4:12 PM with a diagnosis of UTI.On 10/8/25 at 11:12 AM Staff C, RN Clinical Coordinator explained Resident #1 had passed away. Staff C stated she had no reports that staff were being rough with Resident #1. Staff C acknowledged it took longer to clean Resident #1 up at times because she had loose stools from C-diff. Staff C stated she had explained to Resident #1 that it took longer to clean her up and apply cream to the area because of this. Staff C stated if the resident reported staff being rough it would be reported as a grievance which then the Social Worker would have helped her with that. Staff C stated she had reported to the DON that Resident #1 had concerns when being cleaned up during the time she had a diagnosis of C-diff. Staff C stated she had spoke with Resident #1's daughter and a concern about staff being rough with the resident was never brought up. Staff C stated Staff D, the Previous DON left in July. On 10/8/25 at 11:28 AM Resident #1's daughter stated there was bruising noted on the legs related to a fall. Resident #1's daughter stated Resident #1 returned from the hospital and she spoke with Staff B, Licensed Practical Nurse (LPN) about the bruises that were on Resident #1's right hip. Resident #1's daughter stated Staff B said they were old bruises. Resident #1's daughter stated Resident #1 had complained about some female staff that would come in on overnight shifts and the female staff was pretty rough. Resident #1's daughter stated Resident #1 did not know who that staff was. Resident #1's daughter stated she and Resident #1 told the nurses about the incident. Resident #1's daughter stated she had spoken to Staff B about the bruising and how Resident #1 thought it was from the female staff turning her. Resident #1's daughter stated she had complained to her about it but did not believe that there was any mistreatment by staff at the facility when Resident #1 was at the facility after Staff B spoke to her. On 10/8/25 at 12:18 PM Staff A, Registered Nurse (RN) stated she had worked at the facility for 2 years and one month. Staff A acknowledged Resident #1 had several bruises on her body since admission. Staff A stated Resident #1 nor Resident #1's family never reported staff were rough with her during care. Staff A stated staff had never reported to her that any (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents were treated rough including Resident #1. Staff A stated none of the nurses had ever reported to her as the charge nurse that a staff member was being rough with a resident. Staff A stated Staff B had never reported to her that staff on any shift were being rough with a resident including Resident #1. Staff A stated she would inform the Clinical Coordinator about any report of staff being rough with a resident because that would be considered abuse. Staff A stated if there was no Clinical Coordinator then she would report the incident to the Director of Nursing (DON) and if the DON was unavailable she would report it to the Administrator. On 10/8/25 at 1:36 PM Staff B, LPN stated she had worked at the facility for about 6 months. Staff B acknowledged she worked with Resident #1. Staff B stated she worked at the facility when Resident #1 first arrived at the facility. Staff B stated she was present on the first day of admission. Staff B stated Resident #1 had a lot of bruising on her legs from a fall at home. Staff B stated Resident #1 had really bad bruising on her thighs and hips the day she entered the facility. Staff B stated she spoke to Resident #1's family and to Resident #1 frequently. Staff B stated Resident #1 had bruising on her legs and it had not healed yet when she returned from the hospital visit. Staff B stated Resident #1's daughter acted like she did not know about the bruising. Staff B stated it was not from when Resident #1 was at the facility. Staff B stated body audits that were completed every week would reflect the bruising. Staff B stated the interaction with the daughter was passed on in report that day as well. Staff B stated there was a couple times Resident #1 had said one of the staff members was rough when turning her on overnight shift. Staff B stated Resident #1 stated she did not know the staff member's name but that she worked the overnight shift and was rough with her during care. Staff B explained she had determined the staff was Staff E, Certified Nursing Assistant. Staff B stated she completed an assessment on Resident #1 at the time and there were so many bruises on the legs. Staff B stated it was difficult to determine if anything Staff E had done caused any more bruising. Staff B stated she let the charge nurse know. Staff B stated the charge nurse would have been Staff A or Staff F, Registered Nurse (RN). Staff B stated she did not know if Staff E worked with Resident #1 after that. Staff B stated she did not remember if she entered an assessment about the incident. Staff B stated she thought she just reported it to the charge nurse. Staff B stated when she spoke with Resident #1 she stated the overnight staff was rough with her that evening prior. Staff B stated when a resident reported any sort of rough treatment she would just report it to the charge nurse. Staff B stated the Program Coordinator was not working at the facility then. Staff B stated staff reported as being rough with a resident would be considered abuse and did report it as possible abuse to the charge nurse. On 10/9/25 at 8:06 AM Staff F, RN stated she worked at the facility for 2 years. Staff F acknowledged she worked as charge nurse frequently. Staff F stated she will work both halls. Staff F stated if the nurse working hall Wild Lupine had any concerns those concerns would be told to the charge nurse. Staff F stated she was familiar with Resident #1 and worked with her while she was at the facility. Staff F stated no nurse had reported that any staff was rough with residents on any shift. Staff F stated Resident #1 never had voiced any concerns with any staff on any shift being rough with her. Staff F stated Resident #1's family had never spoken to her about any concerns with bruising or staff being rough with care. Staff F stated if it was reported to her that staff were being rough with a resident she would report the incident to the Clinical Coordinator or the DON if there was no Clinical Coordinator. Staff F stated she would also notify the resident's physician and the resident's family member. Staff F stated if the resident claimed staff were rough she would complete a body audit and she would report the incident as suspected abuse. Staff F stated she would speak to the staff and ask if the incident happened and get an interview with the staff that was identified. Staff F stated if the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff was working she would call the DON / Clinical Coordinator and usually that staff would be sent home. Staff F stated the staff would be separated from the resident. Staff F stated this sort of incident was not reported to her about Resident #1 but had been reported about other residents in the past and she had reported that to the administration. Staff F explained that it was a long time ago. Staff F stated Resident #1 had bruises all over her body during admission. On 10/8/25 at 2:32 PM Staff D, Previous DON stated she did not remember Resident #1 complaining of any night shift staff being rough during care. Staff D stated she would have completed a self report for any concern of staff being rough with a resident to the state and investigated the report. Staff D stated she did not remember reporting any concerns to the state in regards to Resident #1. Staff D stated her last day at the facility was in August right after the facility's most recent state survey. Staff D stated she had frequent care conferences with the family and did not remember any complaints from the family or the resident. On 10/9/25 at 11:42 AM the DON stated he would have reported any incidents of suspected abuse to the State Agency. On 10/9/25 at 8:28 AM the Administrator stated if a resident reported a staff being rough during care he would separate the staff from the resident, report it to the state agency, complete an investigation, and then depending on the investigation address the findings. The Administrator stated there was no report of possible abuse or staff being rough to Resident #1 he was aware of. The Administrator acknowledged he was unaware therefore there was not a report to the State Agency.Review of policy modified 6/25 titled, Occurrence Reporting Policy documented the purpose was to obtain a record of the factual information regarding an occurrence. To initiate corrective and preventive measures for unexpected events involving residents. This may be in the form of an occurrence or incident report, referred to in this document as an occurrence report. Any employee discovering, observing or involved in the event will report the event as soon as possible to a supervisor or designee so immediate and necessary action steps can be taken. A nurse/designee would complete the occurrence report. Review of policy modified 1/23 titled, Vulnerable Adult Abuse Prevention Plan documented the plan established the policies, procedures and responsibilities for protecting all adults who are dependent upon this facility for health services and/or a safe environment in which to live. Each resident has the right to be free from abuse including but not limited to verbal, sexual, physical, and mental abuse, injuries of unknown origin, corporal punishment, misappropriation of resident property, mistreatment, neglect or involuntary seclusion. Any form of resident abuse will not be tolerated. With an objective To protect each resident from abuse by care givers (facility employees, volunteers, resident's family or representative, visitors, vendors or other health professionals). Once abuse is suspected or identified, the facility will take all appropriate steps to stop the abuse and protect residents from additional abuse immediately. These steps include but are not limited to reporting the alleged violation within required timeframes and taking appropriate corrective actions.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, policy review, family interview and staff interviews, the facility failed to investigate an allegation of abuse to the State Agency for 1 of 1 residents reviewed (Resident #1). The facility reported a census of 34 residents.Finding include:The Minimum Data Set (MDS) dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS also documented a diagnosis of unspecified dementia without behavioral disturbances. Review of EHR dated 8/28/25 titled, Progress notes documented Resident #1 had a BIMS of 8 indicating moderate cognitive impairment at that time. Review of Resident #1's document titled, Clinical Summary dated 6/19/25 documented Resident #1 had a discharge diagnosis of right hip hematoma related to a ground level fall at home.Review of Resident #1's EHR titled, Progress notes revealed on 7/22/25 Resident #1 was sent to the ED via 911 ambulance and returned to the facility on 7/22/25 at 4:12 PM with a diagnosis of UTI.On 10/8/25 at 11:12 AM Staff C, RN Clinical Coordinator explained Resident #1 had passed away. Staff C stated she had no reports that staff were being rough with Resident #1. Staff C acknowledged it took longer to clean Resident #1 up at times because she had loose stools from C-diff. Staff C stated she had explained to Resident #1 that it took longer to clean her up and apply cream to the area because of this. Staff C stated if the resident reported staff being rough it would be reported as a grievance which then the Social Worker would have helped her with that. Staff C stated she had reported to the DON that Resident #1 had concerns when being cleaned up during the time she had a diagnosis of C-diff. Staff C stated she had spoke with Resident #1's daughter and a concern about staff being rough with the resident was never brought up. Staff C stated Staff D, the Previous DON left in July. On 10/8/25 at 11:28 AM Resident #1's daughter stated there was bruising noted on the legs related to a fall. Resident #1's daughter stated Resident #1 returned from the hospital and she spoke with Staff B, Licensed Practical Nurse (LPN) about the bruises that were on Resident #1's right hip. Resident #1's daughter stated Staff B said they were old bruises. Resident #1's daughter stated Resident #1 had complained about some female staff that would come in on overnight shifts and the female staff was pretty rough. Resident #1's daughter stated Resident #1 did not know who that staff was. Resident #1's daughter stated she and Resident #1 told the nurses about the incident. Resident #1's daughter stated she had spoken to Staff B about the bruising and how Resident #1 thought it was from the female staff turning her. Resident #1's daughter stated she had complained to her about it but did not believe that there was any mistreatment by staff at the facility when Resident #1 was at the facility after Staff B spoke to her. On 10/8/25 at 12:18 PM Staff A, Registered Nurse (RN) stated she had worked at the facility for 2 years and one month. Staff A acknowledged Resident #1 had several bruises on her body since admission. Staff A stated Resident #1 nor Resident #1's family never reported staff were rough with her during care. Staff A stated staff had never reported to her that any residents were treated rough including Resident #1. Staff A stated none of the nurses had ever reported to her as the charge nurse that a staff member was being rough with a resident. Staff A stated Staff B had never reported to her that staff on any shift were being rough with a resident including Resident #1. Staff A stated she would inform the Clinical Coordinator about any report of staff being rough with a resident because that would be considered abuse. Staff A stated if there was no Clinical Coordinator then she would report the incident to the Director of Nursing (DON) and if the DON was unavailable she would report it to the Administrator. On 10/8/25 at 1:36 PM Staff B, LPN stated she had worked at the facility for about 6 months. Staff B acknowledged she worked with Resident #1. Staff B stated she worked at the facility when Resident #1 first arrived at the facility. Staff B stated she was (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	present on the first day of admission. Staff B stated Resident #1 had a lot of bruising on her legs from a fall at home. Staff B stated Resident #1 had really bad bruising on her thighs and hips the day she entered the facility. Staff B stated she spoke to Resident #1's family and to Resident #1 frequently. Staff B stated Resident #1 had bruising on her legs and it had not healed yet when she returned from the hospital visit. Staff B stated Resident #1's daughter acted like she did not know about the bruising. Staff B stated it was not from when Resident #1 was at the facility. Staff B stated body audits that were completed every week would reflect the bruising. Staff B stated the interaction with the daughter was passed on in report that day as well. Staff B stated there was a couple times Resident #1 had said one of the staff members was rough when turning her on overnight shift. Staff B stated Resident #1 stated she did not know the staff member's name but that she worked the overnight shift and was rough with her during care. Staff B explained she had determined the staff was Staff E, Certified Nursing Assistant. Staff B stated she completed an assessment on Resident #1 at the time and there were so many bruises on the legs. Staff B stated it was difficult to determine if anything Staff E had done caused any more bruising. Staff B stated she let the charge nurse know. Staff B stated the charge nurse would have been Staff A or Staff F, Registered Nurse (RN). Staff B stated she did not know if Staff E worked with Resident #1 after that. Staff B stated she did not remember if she entered an assessment about the incident. Staff B stated she thought she just reported it to the charge nurse. Staff B stated when she spoke with Resident #1 she stated the overnight staff was rough with her that evening prior. Staff B stated when a resident reported any sort of rough treatment she would just report it to the charge nurse. Staff B stated the Program Coordinator was not working at the facility then. Staff B stated staff reported as being rough with a resident would be considered abuse and did report it as possible abuse to the charge nurse. On 10/9/25 at 8:06 AM Staff F, RN stated she worked at the facility for 2 years. Staff F acknowledged she worked as charge nurse frequently. Staff F stated she will work both halls. Staff F stated if the nurse working hall Wild Lupine had any concerns those concerns would be told to the charge nurse. Staff F stated she was familiar with Resident #1 and worked with her while she was at the facility. Staff F stated no nurse had reported that any staff was rough with residents on any shift. Staff F stated Resident #1 never had voiced any concerns with any staff on any shift being rough with her. Staff F stated Resident #1's family had never spoken to her about any concerns with bruising or staff being rough with care. Staff F stated if it was reported to her that staff were being rough with a resident she would report the incident to the Clinical Coordinator or the DON if there was no Clinical Coordinator. Staff F stated she would also notify the resident's physician and the resident's family member. Staff F stated if the resident claimed staff were rough she would complete a body audit and she would report the incident as suspected abuse. Staff F stated she would speak to the staff and ask if the incident happened and get an interview with the staff that was identified. Staff F stated if the staff was working she would call the DON / Clinical Coordinator and usually that staff would be sent home. Staff F stated the staff would be separated from the resident. Staff F stated this sort of incident was not reported to her about Resident #1 but had been reported about other residents in the past and she had reported that to the administration. Staff F explained that it was a long time ago. Staff F stated Resident #1 had bruises all over her body during admission. On 10/8/25 at 2:32 PM Staff D, Previous DON stated she did not remember Resident #1 complaining of any night shift staff being rough during care. Staff D stated she would have completed a self report for any concern of staff being rough with a resident to the state and investigated the report. Staff D stated she did not remember reporting any concerns to the state in regards to Resident #1. Staff D stated her last day at the facility (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was in August right after the facility's most recent state survey. Staff D stated she had frequent care conferences with the family and did not remember any complaints from the family or the resident. On 10/9/25 at 11:42 AM the DON stated should a resident have any change he would expect that an assessment would have been completed. The DON stated if a resident or resident family member had reported any allegations of abuse should have had an assessment. On 10/9/25 at 8:28 AM the Administrator stated if a resident reported a staff being rough during care he would separate the staff from the resident, report it to the state agency, complete an investigation, and then depending on the investigation address the findings. The Administrator stated there was no report of possible abuse or staff being rough to Resident #1 he was aware of. The Administrator acknowledged he was unaware therefore there was an investigation completed related to the incident. Review of policy modified 6/25 titled, Occurrence Reporting Policy documented the purpose was to obtain a record of the factual information regarding an occurrence. To initiate corrective and preventive measures for unexpected events involving residents. This may be in the form of an occurrence or incident report, referred to in this document as an occurrence report. Any employee discovering, observing or involved in the event will report the event as soon as possible to a supervisor or designee so immediate and necessary action steps can be taken. A nurse/designee would complete the occurrence report. Review of policy modified 1/23 titled, Vulnerable Adult Abuse Prevention Plan documented the plan established the policies, procedures and responsibilities for protecting all adults who are dependent upon this facility for health services and/or a safe environment in which to live. Each resident has the right to be free from abuse including but not limited to verbal, sexual, physical, and mental abuse, injuries of unknown origin, corporal punishment, misappropriation of resident property, mistreatment, neglect or involuntary seclusion. Any form of resident abuse will not be tolerated. With an objective To protect each resident from abuse by care givers (facility employees, volunteers, resident's family or representative, visitors, vendors or other health professionals). Once abuse is suspected or identified, the facility will take all appropriate steps to stop the abuse and protect residents from additional abuse immediately. These steps include but are not limited to investigating within required timeframes and conduct a thorough investigation of the alleged violation taking appropriate corrective actions.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, policy review, family interview and staff interviews the facility failed to complete an assessment when a resident reported bruising related to a staff being rough during care for 1 of 1 residents (Resident #1) reviewed. The facility reported a Census of 34 residents. Findings include:The Minimum Data Set (MDS) dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS also documented a diagnosis of unspecified dementia without behavioral disturbances. Review of EHR dated 8/28/25 titled, Progress notes documented Resident #1 had a BIMS of 8 indicating moderate cognitive impairment at that time. Review of Resident #1's EHR titled, Progress Notes documented no assessment related to resident reports to Staff B, Licensed Practical Nurse (LPN) of Staff E Certified Nursing Assistant (CNA) being rough during care.Review of Resident #1's EHR titled, Assessments documented no assessment related to resident report to Staff B, LPN of Staff E being rough during care.Review of Resident #1's document titled, Clinical Summary dated 6/19/25 documented Resident #1 had a discharge diagnosis of right hip hematoma related to a ground level fall at home.Review of Resident #1's EHR titled, Progress notes revealed on 7/22/25 Resident #1 was sent to the ED via 911 ambulance and returned to the facility on 7/22/25 at 4:12 PM with a diagnosis of UTI.Review of Resident #1's EHR dated 6/19/25 titled, Body Audit completed by Staff F documented a large purplish bruise from fall at home on the left lateral outer thigh. Review of Resident #1's EHR's titled, Body Audit documented no sizes for any skin alterations for audits completed on 6/19, 6/24, 7/8, 7/17, 7/29, 8/5, 8/8, 8/15, 8/28, 9/22 and 9/23.On 10/9/25 at 8:06 AM Staff F, RN stated she worked at the facility for 2 years. Staff F stated Resident #1 had bruises all over her body during admission. Staff F acknowledged she was the nurse that completed the skin assessment upon Resident #1's admission. Staff F stated she could not remember which side of the body the hematoma was on Resident #1 during admission. Staff F acknowledged she had documented a large purplish bruise from fall at home on the left lateral outer thigh. Staff F acknowledged a hospital discharge document titled, Clinical Summary from admission to the facility described the large bruise on the right hip. Staff F stated she could not remember which hip may have gotten left and right confused during the assessment. On 10/8/25 at 11:28 AM Resident #1's daughter stated there was bruising noted on the legs related to a fall. Resident #1's daughter stated Resident #1 returned from the hospital and she spoke with Staff B, LPN about the bruises that were on Resident #1's right hip. Resident #1's daughter stated Staff B said they were old bruises. Resident #1's daughter stated Resident #1 had complained about some female staff that would come in on overnight shifts and the female staff was pretty rough. Resident #1's daughter stated Resident #1 did not know who that staff was. Resident #1's daughter stated she and Resident #1 told the nurses about the incident. Resident #1's daughter stated she had spoken to Staff B about the bruising and how Resident #1 thought it was from the female staff turning her. Resident #1's daughter stated she had complained to her about it but did not believe that there was any mistreatment by staff at the facility when Resident #1 was at the facility after Staff B spoke to her. On 10/8/25 at 1:36 PM Staff B, LPN stated she had worked at the facility for about 6 months. Staff B acknowledged she worked with Resident #1. Staff B stated she worked at the facility when Resident #1 first arrived at the facility. Staff B stated she was present on the first day of admission. Staff B stated Resident #1 had a lot of bruising on her legs from a fall at home. Staff B stated Resident #1 had really bad bruising on her thighs and hips the day she entered the facility. Staff B stated she spoke to Resident #1's family and to Resident #1 frequently. Staff B stated Resident #1 had bruising on her legs and it had not healed yet when she (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	returned from the hospital visit. Staff B stated Resident #1's daughter acted like she did not know about the bruising. Staff B stated it was not from when Resident #1 was at the facility. Staff B stated body audits that were completed every week would reflect the bruising. Staff B stated the interaction with the daughter was passed on in report that day as well. Staff B stated there was a couple times Resident #1 had said one of the staff members was rough when turning her on overnight shift. Staff B stated Resident #1 stated she did not know the staff member's name but that she worked the overnight shift and was rough with her during care. Staff B explained she had determined the staff was Staff E. Staff B stated she completed an assessment on Resident #1 at the time and there were so many bruises on the legs. Staff B stated it was difficult to determine if anything Staff E had done caused any more bruising. Staff B stated she let the charge nurse know. Staff B stated the charge nurse would have been Staff A or Staff F, Registered Nurse (RN). Staff B stated she did not know if Staff E worked with Resident #1 after that. Staff B stated she did not remember if she entered an assessment about the incident. Staff B stated she thought she just reported it to the charge nurse. Staff B stated when she spoke with Resident #1 she stated the overnight staff was rough with her that evening prior. Staff B stated when a resident reported any sort of rough treatment she would just report it to the charge nurse. Staff B stated the Program Coordinator was not working at the facility then. Staff B stated staff reported as being rough with a resident would be considered abuse and did report it as possible abuse to the charge nurse. On 10/8/25 at 2:32 PM Staff D, Previous DON stated she did not remember Resident #1 complaining of any night shift staff being rough during care. Staff D stated she would have completed a self report for any concern of staff being rough with a resident to the state and investigated the report. Staff D stated with any report of staff being rough during care an assessment should have been completed and documented. On 10/9/25 at 11:42 AM the DON stated should a resident have any change he would expect that an assessment would have been completed. The DON stated if a resident or resident family member had reported any allegations of abuse should have had an assessment. On 10/9/25 at 8:28 AM the Administrator stated a body audit would have only been completed when the resident was out of the facility for longer than 24 hours but an assessment should have been completed when Resident #1 reported the staff were being rough with her. The Administrator acknowledged he was unable to find that any assessment was completed related to the report of staff being rough with Resident #1 by any nurse. Review of policy modified 6/25 titled, Occurrence Reporting Policy documented the purpose was to obtain a record of the factual information regarding an occurrence. To initiate corrective and preventive measures for unexpected events involving residents. This may be in the form of an occurrence or incident report, referred to in this document as an occurrence report. Any employee discovering, observing or involved in the event will report the event as soon as possible to a supervisor or designee so immediate and necessary action steps can be taken. A nurse/designee would complete the occurrence report.