STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175406	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Home	108 N Walnut Inman, KS 67546

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. The facility identified a census of 79 residents, with three residents reviewed for abuse. Based on record review, observation, and interview, the facility failed to ensure staff responded appropriately with adequate supervision to prevent potential abuse and/or mistreatment of Resident (R) 1, a cognitively impaired resident. This placed R1 at risk for potential abuse and/or mistreatment. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of dementia (progressive mental disorder characterized by failing memory, and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), weakness, and hypertension (high blood pressure). The Significant Change Minimum Data Set (MDS), dated 06/19/24, documented R1 had a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderately impaired cognitive function. The MDS documented R1 had no behaviors during the look back period. The MDS documented R1 required moderate staff assistance with dressing, personal hygiene, bed mobility, and transfer. The MDS documented R1 required substantial staff assistance with bathing and donning footwear. The MDS documented R1 had intact skin. The MDS documented R1 took antianxiety (class of medications that calm and relax people) medications and antidepressant (class of medications used to treat mood disorders) medications. The Quarterly MDS, dated 02/27/25, documented R1 had a BIMS score of 10, which indicated moderately impaired cognition. The MDS documented R1 had no behaviors during the look back period. The MDS documented R1 required moderate staff assistance with toileting hygiene, bathing, and dressing. The MDS documented R1 required supervision or touching assistance with all of her other activities of daily living. The MDS documented R1 had intact skin. The MDS documented R1 took antianxiety (class of medications that calm and relax people) medications and antidepressant (class of medications used to treat mood disorders) medications. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 06/19/24, documented R1 had orientation, memory, and recall deficits. The CAA documented R1 had dementia, a change in mental status, and short and long-term memory loss. The Communication CAA, dated 06/19/24, documented R1 had difficulty understanding others and being understood by others. The CAA documented R1 suffered from cognitive loss and aphasia (a condition with disordered or absent language function). (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Care Plan documented R1 had the potential for side effects related to the use of aspirin (a non-steroidal anti-inflammatory drug used to treat fever, pain, inflammation, and as an antithrombotic {medications used to prevent or treat blood clots}) and may be prone to bruising of unknown origin and directed staff to observe R1 for bruising (03/11/25). The care plan documented R1 had a bruise to her chest (07/18/24), a bruise to right lateral forearm (07/11/24), a bruise to her forehead (09/13/24), a bruise to her right wrist (10/08/24), a bruise to her forearm (12/13/24), a bruise to her right upper arm (01/29/25), two bruises to her right outer lower extremity (02/25/25). The care plan documented R1 had experienced traumatic events. R1 reported her husband had twisted her arm which led to bruising and this event happened over a month ago. The care plan directed staff not to discuss traumatic events with R1 as R1 was concerned about others knowing of her traumatic events (03/11/25). The Progress Note, dated 01/09/25, documented R1 often called her husband her brother. The Progress Note, dated 01/28/25, documented R1 continued to have multiple bruises from a fall on 12/30/24. The Progress Note, dated 01/29/25, documented nursing staff was helping R1 get dressed for the day and noted a new bruise on her right upper arm. The bruise measured 6.0 centimeters (cm) by 4.0 cm with a small, reddened area in the middle. When nursing staff assessed the area, R1 reached over and scratched the area. The bruise and small reddened area were consistent with R1 scratching her arm. The Progress Note, dated 02/04/25, documented the weekly skin assessment had been completed. R1 had multiple areas of bruising in various stages of healing. The Progress Note, dated 02/25/25, documented R1's skin assessment was completed that afternoon. Staff noted two small bruises next to one another on R1's right outer extremity. Bruises were reddish/purple and measured 2.5 cm by 2.0 cm and 1.5 cm by 1.0 cm. R1 communicated to staff she did not want staff to fuss over it. The administrator, director of nursing, R1's responsible party, and R1's primary care physician were notified of the bruising. The location of the bruising was consistent with wheelchair foot pedals or a walker during ambulation. The Progress Note, dated 04/01/25, documented bruising was noted to R1's right hand during her bath. The bruising measured 4.0 cm by 5.0 cm. R1 stated, Oh, that has been there a long time. When R1 was asked what happened, R1 stated, I probably swung my hand too fast and bumped it on something. R1's responsible party, administration, unit coordinator, and R1's primary care physician were notified of bruising. The edited Progress Note, dated 04/02/25 at 08:45 PM was documented as being a late entry (04/03/25 at 11:19 AM), edited on 04/03/25 at 11:23 AM, documented R1's husband visited R1 on 04/02/25 at approximately 08:45 PM. R1's husband reported he assisted R1 with getting ready for bed and while helping R1 get undressed, R1's arm got stuck in her sweater so he grabbed R1's arm to help pull her arm out of the sleeve. Evening staff reported a large bruise on R1's left forearm after R1's husband left her room. The bruising was dark blue/black in color with mild swelling noted to the area. R1's husband in to visit R1 again on 04/03/25, and LN H educated R1's husband to be cautious when assisting R1, as R1 bruised easily. LN H educated R1's husband staff would assist R1 to get ready for bed as R1 allowed. R1's primary care physician, administration, and R1's responsible party were notified of the new bruise. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The EMR lacked any further documentation regarding the large black/purple bruise on R1's left forearm. LN G's Notarized Witness Statement, dated 04/08/25, documented on 04/02/25 at approximately 08:45 PM, CNA M called LN G up to R1's living unit due to a bruise on R1's left forearm. LN G stated she went into R1's room and noted a bruise, dark in color, and edematous (swollen) on R1's left forearm. LN G stated she asked R1 what happened, and R1 replied, My brother got mad at me and twisted my arm! He gets mad a lot. CNA M told LN G R1 referred to her husband as her brother. LN G stated she reassured R1 she was okay. LN G stated she headed to the nurse's office to notify Administrative Staff A and told CNA M and CMA R to fill out witness statements when CMA R told LN G R1's husband had stopped by her medication cart when he was leaving and told CMA R he had lost his temper. LN G stated she called Administrative Staff A and informed her of the bruise and what the staff had reported. Administrative Staff A said, I don't believe that. Don't write up or chart anything, and I will have LN H (unit manager) follow up in the morning. LN G stated she told CNA M and CMA R what Administrative Staff A had said and told them to write a report and keep it with them. R1 was safe at that time, and her husband was gone. CMA R's Notified Witness Statement, dated 04/08/25, documented on 04/02/25 R1's husband came to visit R1 in her room. CMA R stated she checked on R1, and her husband was attempting to dress R1. CMA R stated she went back to her medication cart, and R1's husband stopped at her cart and asked if R1's condition was worsening. CMA R told R1's husband no R1 was about the same. CMA R stated that R1's husband said he lost his temper, and maybe he shouldn't have, and then left. About five to ten minutes later, CNA M came and told CMA R she had found a bruise on R1's left wrist, and R1 stated it came from her husband. CMA R stated she and CNA M called LN G to the unit to do an assessment. LN G called Administrative Staff A, and we were instructed not to report and not to do incident reports. CNA M's Notarized Witness Statement, dated 04/08/25, documented on 04/02/25 at around 08:30 PM, R1 called CNA M into her room and asked CNA M if she could cover her new bruise. CNA M asked R1 how it had happened, and R1 said her husband had done it because he got mad. R1 stated her husband had grabbed her arm and applied pressure. CNA M stated she and CMA R reported the bruise to LN G, and LN G measured the bruise and called Administrative Staff A. Administrative Staff A said not to report it or make witness statements and that she would talk to LN H, the unit coordinator, and R1's husband the next day. R1's husband said it happened when he was taking R1's sweater off for bed, so they made that report of that statement because Administrative Staff A said she did not believe the first story, and R1's husband wouldn't do that. LN H's Notarized Witness Statement, dated 04/08/25, documented LN H had received a phone call on 04/02/25 in the evening from CMA R at approximately 08:52 PM. CMA R reported an incident regarding R1 and her husband. CMA R reported to LN H that R1's husband had come up to her before leaving and stated he should not have lost his temper. Staff went in to assess R1 and located a large bruise developing on R1's left forearm. CMA R reported R1 stated her husband had grabbed her arm. CMA R reported to LN H she had reported the incident to LN G. CMA R told LN H, LN G had reported the incident to Administrative Staff A and was told Administrative Staff A did not believe that is what happened, and to not make a report until Administrative Staff A and LN H were back in the office in the morning to investigate. CMA R reported to LN H that Administrative Staff A had told them not to document anything at that time, including witness statements. On the morning of 04/03/25, Administrative Staff A told LN H to investigate the incident. LN H noticed a very large bruise to R1's left arm. LN H asked R1 what had happened, and R1 stated her brother was in her room and grabbed her arm. LN H questioned R1 further, and R1 stated it was her husband who grabbed her arm. R1's husband was visiting R1 later (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that morning, and LN questioned R1's husband about what had happened. R1's husband reported he was getting R1 ready for bed, and her arm got stuck in her sweater, so he grabbed R1's arm to help remove her arm from the sweater. LN H told R1's husband that staff reported he had made a comment when he left the room; he shouldn't have lost his temper with R1. R1's husband did not say anything to LN H's statement. LN H educated R1's husband that staff would assist R1 get ready for bed, and if he felt himself getting irritated or angry in R1's presence, he needed to leave immediately, as this would not be tolerated. LN H informed R1 and her husband that R1's door would remain open while R1's husband visited, and staff would peek in on them frequently. LN H called R1's responsible party, her son, to discuss the incident. R1's responsible party agreed that staff should assist R1 with her bedtime routine and not her husband. Following the interviews, LN H reported her findings to Administrative Staff A. LN H told Administrative Staff A this incident should be reported, and Administrative Staff A told LN H it was outside of the reporting window and LN H needed to drop it. LN H stated she was concerned this was physical abuse due to the bruising that was left, and the statements made by R1 and her husband on the evening it happened. LN H stated she told Administrative Staff A it indeed needed to be reported and asked Administrative Staff A to go and look at the bruise herself. LN H stated she was unaware if Administrative Staff A had gone to look at R1's bruise. LN H stated she did what she was told and made the event and documentation to reflect what her superior told her to. LN H stated she asked Administrative Staff A what she wanted LN H to do about the bruise documentation, and Administrative Staff A told LN H to document R1's husband grabbed R1's arm while removing her sweater, but not to document what staff had reported regarding R1's husband losing his temper with R1. LN H was told the intervention would be for staff to assist R1 with her bedtime routine, as she allowed. LN H asked Administrative Staff A if she should add to the care plan that R1's bedroom door would remain open while R1's husband was visiting, and frequent visual checks while he was visiting R1, and was told not to. LN H stated due to being told to drop the incident and to leave it alone, she did what she was told. On 04/08/25 at 10:30 AM, observation revealed R1 sat in her recliner watching television. R1 had her sweatshirt sleeve pulled up on her left arm. R1's left forearm had a large purple bruise in various stages of healing. On 04/08/25 at 10:30 AM, R1 was very suspicious of this surveyor. R1 wanted to know why I wanted to know what happened to her arm. This surveyor pointed out a bruise on her upper shoulder and shared that her dog had caused the bruise when he jumped up on her. R1 appeared to relax and stated she got the bruise a couple of weeks ago and thought someone had grabbed her and pushed her, but she could not remember who. R1 stated that her left forearm hurt her. On 04/08/25 at 10:45 AM, CNA O stated she had not witnessed the event but had heard in report that R1's husband had grabbed her left forearm and bruised her when he was frustrated with her, and R1 had told the nurse what he had done. CNA O stated the reason R1 was admitted to the facility was because this kind of thing was happening to her in the couple's apartment at the facility. CNA O stated she could understand R1's husband getting frustrated with R1's dementia. CNA O stated she was not concerned about R1's husband hurting her, and the facility had done nothing to protect R1 from her husband. On 04/08/25 at 11:30 AM, LN H, the nurse manager of the unit R1 lived on, stated LN G, who was on duty that night, had called Administrative Staff A to let her know R1's husband had come out of R1's room and stated he and R1 had gotten into an argument. He had put his hands on R1 and caused a bruise on her left forearm. LN H stated that Administrative Staff A told LN G she did not believe her. Administrative Staff A told LN H to investigate the bruise on 04/03/25. R1 told LN H that her brother (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	grabbed her arm and caused the bruise. R1's husband told LN H R1 had gotten her arm stuck in her sweater, and he had assisted her in getting her arm out of the sweater, which caused the bruise. LN H stated she was concerned for R1's safety with her husband visiting her and taking her out on excursions. LN H told Administrative Staff A that if this had happened outside the facility, it would have been domestic abuse, and the husband would have been arrested. LN H stated that Administrative Staff A told her to drop it and not report anything. LN H stated the facility had done nothing to protect R1 from her husband, and R1's husband visited two to three times a day. LN H stated she was scared of retribution from the facility and that she would lose her job. On 04/08/24 at 12:30 PM, CNA N stated she had heard about the incident in report the following morning, R1 had received a bruise on her forearm from her husband. CNA N stated she saw the bruise, and it was so black. CNA N stated CMA R from the evening shift was very upset about what had happened and was worried for R1's safety. On 04/08/25 at 01:30 PM, LN I stated she had been the nurse coming on the morning after the incident. LN I stated she went in to assess R1's bruise and asked R1 what had happened and R1 told LN I her brother had grabbed and twisted her arm. LN I stated R1 had dementia and it must have been traumatic to R1 for R1 to have the same story twelve hours later after the incident. On 04/08/25 at 02:00 PM, CMA R stated she had heard R1 and her husband arguing in the evening on 04/02/25, so she went into R1's room. R1 asked her to help her get changed for bed, but R1's husband told her no, he would do it and to just go. CMA R stated she went back to her medication cart to continue to pass medications and was standing at the cart when R1's husband left. CMA R stated that R1's husband stopped by her cart and asked her if R1's condition was getting worse, and CMA R stated no R1 was the same as she had been. CMA R stated that R1's husband then said, I lost my temper with her, and I shouldn't have lost my temper with her, and then left. CMA R stated CNA M had gone into R1's room, saw the bruise, and went and reported the bruise to her. CMA R said she and CNA M then called LN G and told LN G she needed to come up to assess R1's bruise. CMA R stated that LN G came out of R1's room and told CMA R and CNA M to fill out witness statements and that she was going to call Administrative Staff A to report the incident. CMA R stated LN G came back a short time later and told them she had been told by Administrative Staff A that she did not believe that happened, and to not report anything on the incident or have staff fill out any witness statements. CMA R stated she was fearful for R1's safety. CMA R stated she was scared she would lose her job at the facility for speaking out. On 04/08/25 at 02:15 PM, CNA M stated on 04/02/25 in the evening R1's husband had just left, and R1 put on her call light. CNA M went to R1's room and R1 pointed to her left forearm and said, Can you cover this up with something? I don't want to look at it. CNA M stated she asked R1 what had happened, and R1 stated her brother had gotten mad at her and grabbed her arm. CNA M stated she went right out to CMA R and told her about the bruise, and they then called LN G to come and assess R1. LN G assessed R1 and then told CNA M and CMA R to fill out witness statements. LN G then went to call Administrative Staff A and report the incident. LN G came back and told CNA M and CMA R she had been told not to document anything about the incident and not to have staff fill out witness statements. CNA M stated she was worried for R1's safety. CNA M asked if she was going to lose her job at the facility because she really liked it there. On 04/08/25 at 02:30 PM, when Administrative Staff A was asked about R1's bruise, Administrative Staff A signed into R1's chart on her computer and read the progress note about R1's bruise that occurred on 04/02/25. Administrative Staff A denied any reports of abuse related to R1's arm. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrative Staff A reported that R1's husband reported it had occurred when he was helping R1 get her arm out of her sweater. When Administrative Staff A was asked if she had received any phone calls from staff with concerns regarding R1 on 04/02/25. Administrative Staff A stated she had received a phone call from LN G, who stated staff had concerns about abuse related to R1 and her husband. Administrative Staff A stated she stopped LN G and told her before she threw out the big A word, was there any reason to suspect abuse. Administrative Staff A told LN G she would have LN H assess R1 the next morning. Administrative Staff A confirmed she had not taken the allegation of abuse seriously and had not come to the facility to assess the situation, assess R1, or talk to staff. Administrative Staff A confirmed she had not reported the incident as an allegation of abuse, had not protected R1 from any further potential abuse and denied telling staff not to document the incident. On 04/08/25 at 06:00 PM, LN G stated she had been the nurse on duty the evening of the bruising incident. LN G stated she had been called to the unit by CMA R to assess R1's bruising to her left forearm. LN G stated that R1's arm was dark black and swollen, and R1 complained it was really painful. LN G stated that R1 asked her to please cover the bruise because she did not want to look at it. LN G stated that R1 stated her brother had gotten mad at her and grabbed her arm, causing a bruise. LN G stated she left R1's room, told CMA R and CNA N to fill out witness statements, and went to the office to call Administrative Staff A. LN G stated Administrative Staff A stated she did not believe what LN G was saying was true and LN G should not document the incident or the bruise and she would have LN H assess R1 and the situation in the morning. LN G stated she was agency staff and was worried that if she did not do what Administrative Staff A said, she would not be asked to come back to the facility. The facility's Resident Abuse, Neglect, and Exploitation Policy, revised October 2024, documented it was the policy of this facility to prohibit and prevent abuse, neglect, and exploitation of residents by implementing specific procedures. It was the policy of this facility that each resident would be free from abuse, neglect, exploitation, and misappropriation of property. Abuse included verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Additionally, residents would be protected from abuse, neglect, and harm while residing in the facility. No abuse or harm of any type would be tolerated, and residents and staff would be monitored for protection. Any suspicion of abuse resulting in significant injury would be reported to the State Agency within two hours and local law enforcement per agreement with the agency. It was the policy of this facility to prohibit and prevent abuse, neglect, and exploitation. It was the policy of this facility to prevent abuse by providing residents, families, and staff information and education on how and to whom to report concerns, incidents, and grievances without fear of reprisal or retribution. The facility leadership would assess the needs of all residents residing in the facility to be able to identify concerns in order to prevent potential abuse. The facility failed to ensure staff responded appropriately with adequate supervision to prevent potential abuse and/or mistreatment of R1, a cognitively impaired resident. This placed R1 at risk for potential abuse and/or mistreatment. risk of abuse.

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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. The facility identified a census of 79 residents with three residents reviewed for abuse. Based on record review, observation, and interview, the facility failed to report an allegation of abuse for Resident (R) 1 immediately, but not more than two hours, to the required entities including Law Enforcement (LE) and the State Agency. This placed the resident at risk for unidentified and ongoing abuse or mistreatment. Findings included: - R1 ' s Electronic Medical Record (EMR) documented R1 had diagnoses of dementia (progressive mental disorder characterized by failing memory, and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), weakness, and hypertension (high blood pressure). The Significant Change Minimum Data Set (MDS), dated 06/19/24, documented R1 had a Brief Interview for Mental Status (BIMS) score of nine which indicated moderately impaired cognitive function. The MDS documented R1 had no behaviors during the lookback period. The MDS documented R1 required moderate staff assistance with dressing, personal hygiene, bed mobility, and transfer. The MDS documented R1 required substantial staff assistance with bathing and donning footwear. The MDS documented R1 had intact skin. The MDS documented R1 took antianxiety (class of medications that calm and relax people) medications and antidepressant (class of medications used to treat mood disorders) medications. The Quarterly MDS, dated 02/27/25, documented R1 had a BIMS score of 10 which indicated moderately impaired cognition. The MDS documented R1 had no behaviors during the lookback period. The MDS documented R1 required moderate staff assistance with toileting hygiene, bathing, and dressing. The MDS documented R1 required supervision or touching assistance with all of her other activities of daily living. The MDS documented R1 had intact skin. The MDS documented R1 took antianxiety (class of medications that calm and relax people) medications and antidepressant (class of medications used to treat mood disorders) medications. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 06/19/24, documented R1 had orientation, memory, and recall deficits. The CAA documented R1 had dementia, change in mental status, and short and long-term memory loss. The Communication CAA, dated 06/19/24, documented R1 had difficulty understanding others and being understood by others. The CAA documented R1 suffered from cognitive loss and aphasia (a condition with disordered or absent language function). R1 ' s Care Plan documented R1 had the potential for side effects related to the use of aspirin (a non-steroidal anti-inflammatory drug used to treat fever, pain, inflammation, and as an antithrombotic {medications used to prevent or treat blood clots}) and may be prone to bruising of unknown origin and directed staff to observe R1 for bruising (03/11/25). The care plan documented R1 had a bruise to her chest (07/18/24), a bruise to right lateral forearm (07/11/24), a bruise to her forehead (09/13/24), a bruise to her right wrist (10/08/24), a bruise to her forearm (12/13/24), a bruise to her right upper arm (01/29/25), two bruises to her right outer lower extremity (02/25/25). The care plan documented R1 had experienced traumatic events. R1 reported her husband had twisted her arm which (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	led to bruising and this event happened over a month ago. The care plan directed staff not to discuss traumatic events with R1 as R1 was concerned about others knowing of her traumatic events (03/11/25). The Progress Note, dated 01/09/25, documented R1 often called her husband her brother. The Progress Note, dated 01/28/25, documented R1 continued to have multiple bruises from a fall on 12/30/24. The Progress Note, dated 01/29/25, documented nursing staff was helping R1 get dressed for the day and noted a new bruise on her right upper arm. The bruise measured 6.0 centimeters (cm) by 4 cm with a small, reddened area in the middle. When nursing staff assessed the area, R1 reached over and scratched the area. The bruise and small reddened area were consistent with R1 scratching her arm. The Progress Note, dated 02/04/25, documented the weekly skin assessment had been completed. R1 had multiple areas of bruising in various stages of healing. The Progress Note, dated 02/25/25, documented R1 ' s skin assessment was completed that afternoon. Staff noted two small bruises next to one another on R1 ' s right outer extremity. Bruises were reddish/purple and measured 2.5 cm by 2.0 cm and 1.5 cm by 1.0 cm. R1 communicated to staff she did not want staff to fuss over it. The administrator, director of nursing, R1 ' s responsible party, and R1 ' s primary care physician were notified of the bruising. The location of the bruising was consistent with wheelchair foot pedals or a walker during ambulation. The Progress Note, dated 04/01/25, documented bruising was noted to R1 ' s right hand during her bath. The bruising measured 4.0 cm by 5.0 cm. R1 stated, Oh that has been there a long time. When R1 was asked what happened, R1 stated, I probably swung my hand too fast and bumped it on something. R1 ' s responsible party, administration, unit coordinator, and R1 ' s primary care physician were notified of bruising. The edited Progress Note, dated 04/02/25 at 08:45 PM was documented as being a late entry (04/03/25 at 11:19 AM), edited on 04/03/25 at 11:23 AM, documented R1 ' s husband visited R1 on 04/02/25 at approximately 08:45 PM. R1 ' s husband reported he assisted R1 with getting ready for bed and while helping R1 get undressed R1 ' s arm got stuck in her sweater so he grabbed R1 ' s arm to help pull her arm out of the sleeve. Evening staff reported a large bruise on R1 ' s left forearm after R1 ' s husband left her room. The bruising was dark blue/black in color with mild swelling noted in the area. R1 ' s husband in to visit R1 again on 04/03/25 and LN H educated R1 ' s husband to be cautious when assisting R1 as R1 bruised easily. LN H educated R1 ' s husband staff would assist R1 to get ready for bed as R1 allowed. R1 ' s primary care physician, administration, and R1 ' s responsible party were notified of the new bruise. The EMR lacked any further documentation regarding the large black/purple bruise on R1 ' s left forearm. LN G ' s Notarized Witness Statement, dated 04/08/25, documented on 04/02/25 at approximately 08:45 PM, CNA M called LN G up to R1 ' s living unit due to a bruise on R1 ' s left forearm. LN G stated she went into R1 ' s room and noted a bruise, dark in color, and edematous (swollen) to R1 ' s left forearm. LN G stated she asked R1 what happened and R1 replied, My brother got mad at me and twisted my arm! He gets mad a lot. CNA M told LN G R1 referred to her husband as her brother. LN G stated (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she reassured R1 she was okay. LN G stated she headed to the nurse ' s office to notify Administrative Staff A and told CNA M and CMA R to fill out witness statements when CMA R told LN G R1 ' s husband had stopped by her medication cart when he was leaving and told CMA R he had lost his temper. LN G stated she called Administrative Staff A and informed her of the bruise and what the staff had reported. Administrative Staff A said, I don ' t believe that. [NAME] ' t write up or chart anything and I will have LN H (unit manager) follow up in the morning. LN G stated she told CNA M and CMA R what Administrative Staff A had said and told them to write a report and keep it with them. R1 was safe at that time and her husband was gone. CMA R ' s Notified Witness Statement, dated 04/08/25, documented on 04/02/25 R1 ' s husband came to visit R1 in her room. CMA R stated she checked on R1 and her husband was attempting to dress R1. CMA R stated she went back to her medication cart and R1 ' s husband stopped at her cart and asked if R1 ' s condition was worsening. CMA R told R1 ' s husband no R1 was about the same. CMA R stated R1 ' s husband said he lost his temper and maybe he shouldn ' t have and then left. About five to ten minutes later, CNA M came and told CMA R she had found a bruise on R1 ' s left wrist and R1 stated it came from her husband. CMA R stated she and CNA M called LN G to the unit to do an assessment. LN G called Administrative Staff A and we were instructed to not report and not to do incident reports. CNA M ' s Notarized Witness Statement, dated 04/08/25, documented on 04/02/25 at around 08:30 PM, R1 called CNA M into her room and asked CNA M if she could cover her new bruise. CNA M asked R1 how it had happened and R1 said her husband had done it because he got mad. R1 stated her husband had grabbed her arm and applied pressure. CNA M stated she and CMA R reported the bruise to LN G and LN G measured the bruise and called Administrative Staff A. Administrative Staff A said not to report it or make witness statements and she would talk to LN H, the unit coordinator, and R1 ' s husband the next day. R1 ' s husband said it happened when he was taking R1 ' s sweater off for bed so they made that report of that statement because Administrative Staff A said she did not believe the first story and R1 ' s husband wouldn ' t do that. LN H ' s Notarized Witness Statement, dated 04/08/25, documented LN H had received a phone call on 04/02/25 in the evening from CMA R at approximately 08:52 PM. CMA R reported an incident regarding R1 and her husband. CMA R reported to LN H R1 ' s husband had come up to her before leaving and stated he shouldn ' t have lost his temper. Staff went in to assess R1 and located a large bruise developing on R1 ' s left forearm. CMA R reported R1 stated her husband had grabbed her arm. CMA R reported to LN H she had reported the incident to LN G. CMA R told LN H, LN G had reported the incident to Administrative Staff A and was told Administrative Staff A did not believe that is what happened, and to not make a report until Administrative Staff A and LN H were back in the office in the morning to investigate. CMA R reported to LN H Administrative Staff A told them not to document anything at that time including witness statements. On the morning of 04/03/25, Administrative Staff A told LN H to investigate the incident. LN H noticed a very large bruise to R1 ' s left arm. LN H asked R1 what had happened and R1 stated her brother was in her room and grabbed her arm. LN H questioned R1 further and R1 stated it was her husband who grabbed her arm. R1 ' s husband was visiting R1 later that morning and LN questioned R1 ' s husband on what had happened. R1 ' s husband reported he was getting R1 ready for bed and her arm got stuck in her sweater, so he grabbed R1 ' s arm to help remove her arm from the sweater. LN H told R1 ' s husband staff reported he had made a comment when he left the room, he shouldn ' t have lost his temper with R1. R1 ' s husband did not say anything to LN H ' s statement. LN H educated R1 ' s husband that staff would assist R1 get ready for bed and if he felt himself getting irritated or angry in R1 ' s presence he needed to leave immediately as this would not be tolerated. LN H informed R1 and her husband R1 ' s door would remain open while R1 ' s husband (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	visited, and staff would peak in on them frequently. LN H called R1 ' s responsible party, her son, to discuss the incident. R1 ' s responsible party agreed staff should assist R1 with her bedtime routine and not her husband. Following the interviews, LN H reported her findings to Administrative Staff A. LN H told Administrative Staff A this incident should be reported, and Administrative Staff A told LN H it was outside of the reporting window and LN H needed to drop it. LN H stated she was concerned this was physical abuse due to the bruising that was left, and the statements made by R1 and her husband on the evening it happened. LN H stated she told Administrative Staff A it indeed needed to be reported and asked Administrative Staff A to go and look at the bruise herself. LN H stated she was unaware if Administrative Staff A had gone to look at R1 ' s bruise. LN H stated she did what she was told and made the event and documentation to reflect what her superior told her to. LN H stated she asked Administrative Staff A what she wanted LN H to do about the bruise documentation and Administrative Staff A told LN H to document R1 ' s husband grabbed R1 ' s arm while removing her sweater but to not document what staff had reported regarding R1 ' s husband losing his temper with R1. LN H was told the intervention would be for staff to assist R1 with her bedtime routine as she allowed. LN H asked Administrative Staff A if she should add to the care plan R1 ' s bedroom door would remain open while R1 ' s husband was visiting and frequent visual checks while he was visiting R1 and was told not to. LN H stated due to being told to drop the incident and to leave it alone, she did what she was told. On 04/08/25 at 10:30 AM, observation revealed R1 sat in her recliner watching television. R1 had her sweatshirt sleeve pulled up on her left arm. R1 ' s left forearm had a large purple bruise in various stages of healing. On 04/08/25 at 10:30 AM, R1 was very suspicious of this surveyor. R1 wanted to know why I wanted to know what happened to her arm. This surveyor pointed out a bruise on her upper shoulder and shared her dog had caused the bruise when he jumped up on her. R1 appeared to relax and stated she got the bruise a couple of weeks ago and thought someone had grabbed her and pushed her but she could not remember who. R1 stated her left forearm hurt her. On 04/08/25 at 10:45 AM, CNA O stated she had not witnessed the event but had heard in report that R1 ' s husband had grabbed her left forearm and bruised her when he was frustrated with her and R1 had told the nurse what he had done. CNA O stated the reason R1 was admitted to the facility was because this kind of thing was happening to her in the couple's apartment at the facility. CNA O stated she could understand R1 ' s husband getting frustrated with R1 ' s dementia. CNA O stated she was not concerned about R1 ' s husband hurting her and the facility had done nothing to protect R1 from her husband. On 04/08/25 at 11:30 AM, LN H the nurse manager of the unit R1 lived on stated LN G, who was on duty that night, had called Administrative Staff A to let her know R1 ' s husband had come out of R1 ' s room and stated he and R1 had gotten into an argument. He had put his hands on R1 and caused a bruise to her left forearm. LN H stated Administrative Staff A told LN G she did not believe her. Administrative Staff A told LN H to investigate the bruise on 04/03/25. R1 told LN H her brother grabbed her arm and caused the bruise. R1 ' s husband told LN H R1 had gotten her arm stuck in her sweater and he had assisted her in getting her arm out of the sweater which caused the bruise. LN H stated she was concerned for R1 ' s safety with her husband visiting her and taking her out on excursions and told Administrative Staff A that if this had happened out of the facility it would have been domestic abuse and the husband would have been arrested. LN H stated Administrative Staff A told her to drop it and not report anything. LN H stated the facility had done nothing to protect R1 from her husband and R1 ' s husband visited two to three times a day. LN H stated she was scared of retribution (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the facility and that she would lose her job. On 04/08/24 at 12:30 PM, CNA N stated she had heard about the incident in report the following morning R1 had received a bruise on her forearm from her husband. CNA N stated she saw the bruise and it was so black. CNA N stated CMA R from the evening shift was very upset about what had happened and was worried for R1 ' s safety. On 04/08/25 at 01:30 PM, LN I stated she had been the nurse coming on the morning after the incident. LN I stated she went in to assess R1 ' s bruise and asked R1 what had happened and R1 told LN I her brother had grabbed and twisted her arm. LN I stated R1 had dementia and it must have been traumatic to R1 for R1 to have the same story twelve hours later after the incident. On 04/08/25 at 02:00 PM, CMA R stated she had heard R1 and her husband arguing in the evening on 04/02/25 so she went into R1 ' s room. R1 asked her to help her get changed for bed, but R1 ' s husband told her no he would do it and to just go. CMA R stated she went back to her medication cart to continue to pass medications and was standing at the cart when R1 ' s husband left. CMA R stated R1 ' s husband stopped by her cart and asked her if R1 ' s condition was getting worse, and CMA R stated no R1 was the same as she had been. CMA R stated R1 ' s husband then said, I lost my temper with her and I shouldn ' t have lost my temper with her, and then left. CMA R stated CNA M had gone into R1 ' s room, saw the bruise, and came and reported the bruise to her. CMA R said she and CNA M then called LN G and told LN G she needed to come up to assess R1 ' s bruise. CMA R stated LN G came out of R1 ' s room and told CMA R and CNA M to fill out witness statements and that she was going to call Administrative Staff A to report the incident. CMA R stated LN G came back a short time later and told them she had been told by Administrative Staff A she did not believe that happened and to not report anything on the incident or have staff fill out any witness statements. CMA R stated she was fearful for R1 ' s safety. CMA R stated she was scared she would lose her job at the facility for speaking out. On 04/08/25 at 02:15 PM, CNA M stated on 04/02/25 in the evening R1 ' s husband had just left and R1 put on her call light. CNA M went to R1 ' s room and R1 pointed to her left forearm and said, Can you cover this up with something? I don ' t want to look at it. CNA M stated she asked R1 what had happened and R1 stated her brother had gotten mad at her and grabbed her arm. CNA M stated she went right out to CMA R and told her about the bruise, and they then called LN G to come and assess R1. LN G assessed R1 and then told CNA M and CMA R to fill out witness statements. LN G then went to call Administrative Staff A and report the incident. LN G came back and told CNA M and CMA R she had been told not to document anything about the incident and not to have staff fill out witness statements. CNA M stated she was worried for R1 ' s safety. CNA M asked if she was going to lose her job at the facility because she really liked it there. On 04/08/25 at 02:30 PM, when Administrative Staff A when asked about R1 ' s bruise, Administrative Staff A signed into R1 ' s chart on her computer and read the progress note about R1 ' s bruise that occurred on 04/02/25. Administrative Staff A denied any reports of abuse related to R1 ' s arm. Administrative Staff A reported that R1 ' s husband reported it occurred when he was helping R1 get her arm out of her sweater. When Administrative Staff A was asked if she had received any phone calls from staff with concerns regarding R1 on 04/02/25. Administrative Staff A stated she had received a phone call from LN G, who stated staff had concerns about abuse related to R1 and her husband. Administrative Staff A stated she stopped LN G and told her before she threw out the big A word, was there any reason to suspect abuse. Administrative Staff A told LN G she would have LN H assess R1 the next morning. Administrative Staff A confirmed she did not take the allegation of abuse seriously, did (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. The facility identified a census of 79 residents, with three residents reviewed for abuse, neglect, and exploitation. Based on record review, observation, and interview, the facility failed to immediately investigate an allegation of abuse for Resident (R) 1 and initiate protective measures to prevent further potential abuse until an investigation was completed. This deficient practice placed R1 at risk for ongoing abuse and/or mistreatment. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of dementia (progressive mental disorder characterized by failing memory, and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), weakness, and hypertension (high blood pressure). The Significant Change Minimum Data Set (MDS), dated 06/19/24, documented R1 had a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderately impaired cognitive function. The MDS documented R1 had no behaviors during the lookback period. The MDS documented R1 required moderate staff assistance with dressing, personal hygiene, bed mobility, and transfer. The MDS documented R1 required substantial staff assistance with bathing and donning footwear. The MDS documented R1 had intact skin. The MDS documented R1 took antianxiety (class of medications that calm and relax people) medications and antidepressant (class of medications used to treat mood disorders) medications. The Quarterly MDS, dated 02/27/25, documented R1 had a BIMS score of 10, which indicated moderately impaired cognition. The MDS documented R1 had no behaviors during the lookback period. The MDS documented R1 required moderate staff assistance with toileting hygiene, bathing, and dressing. The MDS documented R1 required supervision or touching assistance with all of her other activities of daily living. The MDS documented R1 had intact skin. The MDS documented R1 took antianxiety (class of medications that calm and relax people) medications and antidepressant (class of medications used to treat mood disorders) medications. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 6/19/24, documented R1 had orientation, memory, and recall deficits. The CAA documented R1 had dementia, a change in mental status, and short and long-term memory loss. The Communication CAA, dated 06/19/24, documented R1 had difficulty understanding others and being understood by others. The CAA documented R1 suffered from cognitive loss and aphasia (a condition with disordered or absent language function). R1's Care Plan documented R1 had the potential for side effects related to the use of aspirin (a non-steroidal anti-inflammatory drug used to treat fever, pain, inflammation, and as an antithrombotic {medications used to prevent or treat blood clots}) and may be prone to bruising of unknown origin and directed staff to observe R1 for bruising (03/11/25). The care plan documented R1 had a bruise to her chest (07/18/24), a bruise to right lateral forearm (07/11/24), a bruise to her forehead (09/13/24), a bruise to her right wrist (10/08/24), a bruise to her forearm (12/13/24), a bruise to her right upper arm (01/29/25), two bruises to her right outer lower extremity (02/25/25). The care plan documented R1 had experienced traumatic events. R1 reported her husband had twisted her arm, which led to bruising, and this event happened over a month ago. The care plan directed staff not to (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discuss traumatic events with R1, as R1 was concerned about others knowing of her traumatic events (03/11/25). The Progress Note, dated 01/09/25, documented R1 often called her husband her brother. The Progress Note, dated 01/28/25, documented R1 continued to have multiple bruises from a fall on 12/30/24. The Progress Note, dated 01/29/25, documented nursing staff was helping R1 get dressed for the day and noted a new bruise on her right upper arm. The bruise measured 6.0 centimeters (cm) by 4 cm with a small, reddened area in the middle. When the nursing staff assessed the area, R1 reached over and scratched the area. The bruise and small reddened area were consistent with R1 scratching her arm. The Progress Note, dated 02/04/25, documented the weekly skin assessment had been completed. R1 had multiple areas of bruising in various stages of healing. The Progress Note, dated 02/25/25, documented R1's skin assessment was completed that afternoon. Staff noted two small bruises next to one another on R1's right outer extremity. Bruises were reddish/purple and measured 2.5 cm by 2.0 cm and 1.5 cm by 1.0 cm. R1 communicated to staff that she did not want staff to fuss over it. The administrator, director of nursing, R1's responsible party, and R1's primary care physician were notified of the bruising. The location of the bruising was consistent with wheelchair foot pedals or a walker during ambulation. The Progress Note, dated 04/01/25, documented bruising was noted to R1's right hand during her bath. The bruising measured 4.0 cm by 5.0 cm. R1 stated, Oh, that has been there a long time. When R1 was asked what happened, R1 stated, I probably swung my hand too fast and bumped it on something. R1's responsible party, administration, unit coordinator, and R1's primary care physician were notified of bruising. The edited Progress Note dated 04/02/25 at 08:45 PM was documented as being a late entry (04/03/25 at 11:19 AM), edited on 04/03/25 at 11:23 AM, documented R1's husband visited R1 on 04/02/25 at approximately 08:45 PM. R1's husband reported he assisted R1 with getting ready for bed and while helping R1 get undressed R1's arm got stuck in her sweater so he grabbed R1's arm to help pull her arm out of the sleeve. Evening staff reported a large bruise on R1's left forearm after R1's husband left her room. The bruising was dark blue/black in color with mild swelling noted in the area. R1's husband in to visit R1 again on 04/03/25 and LN H educated R1's husband to be cautious when assisting R1 as R1 bruised easily. LN H educated R1's husband staff would assist R1 to get ready for bed as R1 allowed. R1's primary care physician, administration, and R1's responsible party were notified of the new bruise. The EMR lacked any further documentation regarding the large black/purple bruise on R1's left forearm. LN G's Notarized Witness Statement, dated 04/08/25, documented on 04/02/25 at approximately 08:45 PM, CNA M called LN G up to R1's living unit due to a bruise on R1's left forearm. LN G stated she went into R1's room and noted a bruise, dark in color, and edematous (swollen) on R1's left forearm. LN G stated she asked R1 what happened, and R1 replied, My brother got mad at me and twisted my arm! He gets mad a lot. CNA M told LN G R1 referred to her husband as her brother. LN G stated she reassured R1 she was okay. LN G stated she headed to the nurse's office to notify Administrative Staff A (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and told CNA M and CMA R to fill out witness statements when CMA R told LN G R1's husband had stopped by her medication cart when he was leaving and told CMA R he had lost his temper. LN G stated she called Administrative Staff A and informed her of the bruise and what the staff had reported. Administrative Staff A said, I don't believe that. Don't write up or chart anything, and I will have LN H (unit manager) follow up in the morning. LN G stated she told CNA M and CMA R what Administrative Staff A had said and told them to write a report and keep it with them. R1 was safe at that time, and her husband was gone. CMA R's Notified Witness Statement, dated 04/08/25, documented on 04/02/25 R1's husband came to visit R1 in her room. CMA R stated she checked on R1, and her husband was attempting to dress R1. CMA R stated she went back to her medication cart, and R1's husband stopped at her cart and asked if R1's condition was worsening. CMA R told R1's husband no R1 was about the same. CMA R stated R1's husband said he lost his temper, and maybe he shouldn't have, and then left. About five to ten minutes later, CNA M came and told CMA R she had found a bruise on R1's left wrist, and R1 stated it came from her husband. CMA R stated that she and CNA M called LN G to the unit to do an assessment. LN G called Administrative Staff A, and we were instructed not to report and not to do incident reports. CNA M's Notarized Witness Statement, dated 04/08/25, documented on 04/02/25 at around 08:30 PM, R1 called CNA M into her room and asked CNA M if she could cover her new bruise. CNA M asked R1 how it had happened, and R1 said her husband had done it because he got mad. R1 stated her husband had grabbed her arm and applied pressure. CNA M stated she and CMA R reported the bruise to LN G, and LN G measured the bruise and called Administrative Staff A. Administrative Staff A said not to report it or make witness statements and that she would talk to LN H, the unit coordinator, and R1's husband the next day. R1's husband said it happened when he was taking R1's sweater off for bed, so they made that report of that statement because Administrative Staff A said she did not believe the first story, and R1's husband wouldn't do that. LN H's Notarized Witness Statement, dated 04/08/25, documented LN H had received a phone call on 04/02/25 in the evening from CMA R at approximately 08:52 PM. CMA R reported an incident regarding R1 and her husband. CMA R reported to LN H R1's husband had come up to her before leaving and stated he shouldn't have lost his temper. Staff went in to assess R1 and located a large bruise developing on R1's left forearm. CMA R reported R1 stated her husband had grabbed her arm. CMA R reported to LN H she had reported the incident to LN G. CMA R told LN H, LN G had reported the incident to Administrative Staff A and was told Administrative Staff A did not believe that is what happened, and to not make a report until Administrative Staff A and LN H were back in the office in the morning to investigate. CMA R reported to LN H Administrative Staff A told them not to document anything at that time, including witness statements. On the morning of 04/03/25, Administrative Staff A told LN H to investigate the incident. LN H noticed a very large bruise to R1's left arm. LN H asked R1 what had happened, and R1 stated her brother was in her room and grabbed her arm. LN H questioned R1 further, and R1 stated it was her husband who grabbed her arm. R1's husband was visiting R1 later that morning, and LN questioned R1's husband about what had happened. R1's husband reported he was getting R1 ready for bed, and her arm got stuck in her sweater, so he grabbed R1's arm to help remove her arm from the sweater. LN H told R1's husband that staff reported he had made a comment when he left the room, he shouldn't have lost his temper with R1. R1's husband did not say anything to LN H's statement. LN H educated R1's husband staff would assist R1 get ready for bed, and if he felt himself getting irritated or angry in R1's presence, he needed to leave immediately, as this would not be tolerated. LN H informed R1 and her husband that R1's door would remain open while R1's husband visited, and staff would peek in on them frequently. LN H called R1's responsible party, her son, to discuss the incident. R1's responsible party (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175406	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Home	108 N Walnut Inman, KS 67546

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	agreed that staff should assist R1 with her bedtime routine and not her husband. Following the interviews, LN H reported her findings to Administrative Staff A. LN H told Administrative Staff A this incident should be reported, and Administrative Staff A told LN H it was outside of the reporting window and LN H needed to drop it. LN H stated she was concerned this was physical abuse due to the bruising that was left, and the statements made by R1 and her husband on the evening it happened. LN H stated she told Administrative Staff A it indeed needed to be reported and asked Administrative Staff A to go and look at the bruise herself. LN H stated she was unaware if Administrative Staff A had gone to look at R1's bruise. LN H stated she did what she was told and made the event and documentation to reflect what her superior told her to. LN H stated she asked Administrative Staff A what she wanted LN H to do about the bruise documentation, and Administrative Staff A told LN H to document R1's husband grabbed R1's arm while removing her sweater, but to not document what staff had reported regarding R1's husband losing his temper with R1. LN H was told the intervention would be for staff to assist R1 with her bedtime routine, as she allowed. LN H asked Administrative Staff A if she should add to the care plan R1's bedroom door would remain open while R1's husband was visiting, and frequent visual checks while he was visiting R1, and was told not to. LN H stated due to being told to drop the incident and to leave it alone, she did what she was told. On 04/08/25 at 10:30 AM, observation revealed R1 sat in her recliner watching television. R1 had her sweatshirt sleeve pulled up on her left arm. R1's left forearm had a large purple bruise in various stages of healing. On 04/08/25 at 10:30 AM, R1 was very suspicious of this surveyor. R1 wanted to know why I wanted to know what happened to her arm. This surveyor pointed out a bruise on her upper shoulder and shared that her dog had caused the bruise when he jumped up on her. R1 appeared to relax and stated she got the bruise a couple of weeks ago and thought someone had grabbed her and pushed her, but she could not remember who. R1 stated that her left forearm hurt. On 04/08/25 at 10:45 AM, CNA O stated she had not witnessed the event but had heard in report that R1's husband had grabbed her left forearm and bruised her when he was frustrated with her, and R1 had told the nurse what he had done. CNA O stated the reason R1 was admitted to the facility was because this kind of thing was happening to her in the couple's apartment at the facility. CNA O stated she could understand R1's husband getting frustrated with R1's dementia. CNA O stated she was not concerned about R1's husband hurting her, and the facility had done nothing to protect R1 from her husband. On 04/08/25 at 11:30 AM, LN H, the nurse manager of the unit R1 lived on stated LN G, who was on duty that night, had called Administrative Staff A to let her know R1's husband had come out of R1's room and stated he and R1 had gotten into an argument. He had put his hands on R1 and caused a bruise on her left forearm. LN H stated Administrative Staff A told LN G she did not believe her. Administrative Staff A told LN H to investigate the bruise on 04/03/25. R1 told LN H her brother grabbed her arm and caused the bruise. R1's husband told LN H R1 had gotten her arm stuck in her sweater, and he had assisted her in getting her arm out of the sweater, which caused the bruise. LN H stated she was concerned for R1's safety with her husband visiting her and taking her out on excursions, and told Administrative Staff A that if this had happened out of the facility, it would have been domestic abuse, and the husband would have been arrested. LN H stated that Administrative Staff A told her to drop it and not report anything. LN H stated the facility had done nothing to protect R1 from her husband, and R1's husband visited two to three times a day. LN H stated she was scared of retribution from the facility and that she would lose her job. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/08/25 at 06:00 PM, LN G stated she had been the nurse on duty the evening of the bruising incident. LN G stated she had been called to the unit by CMA R to assess R1's bruising to her left forearm. LN G stated R1's arm was dark black and swollen, and R1 complained it was really painful. LN G stated R1 asked her to please cover the bruise because she did not want to look at it. LN G stated R1 stated her brother had gotten mad at her and grabbed her arm, causing the bruise. LN G stated she left R1's room, told CMA R and CNA N to fill out witness statements, and went to the office to call Administrative Staff A. LN G stated Administrative Staff A stated she did not believe what LN G was saying was true and LN G should not document the incident or the bruise and she would have LN H assess R1 and the situation in the morning. LN G stated she was agency staff and was worried that if she did not do what Administrative Staff A said, she would not be asked to come back to the facility. The facility's Resident Abuse, Neglect, and Exploitation Policy, revised October 2024, documented it was the policy of this facility to prohibit and prevent abuse, neglect, and exploitation of residents by implementing specific procedures. It was the policy of this facility that each resident would be free from abuse, neglect, exploitation, and misappropriation of property. Abuse may include verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Additionally, residents would be protected from abuse, neglect, and harm while residing in the facility. No abuse or harm of any type would be tolerated, and residents and staff would be monitored for protection. Any suspicion of abuse resulting in significant injury would be reported to the State Agency within two hours and local law enforcement, per agreement with the agency. It is the policy of this facility to prohibit and prevent abuse, neglect, and exploitation. It was the policy of this facility to prevent abuse by providing residents, families, and staff information and education on how and to whom to report concerns, incidents, and grievances without fear of reprisal or retribution. The facility leadership would assess the needs of all residents residing in the facility to be able to identify concerns in order to prevent potential abuse. The facility failed to immediately investigate an allegation of abuse for R1 and initiate protective measures to prevent further potential abuse until an investigation was completed. This deficient practice placed R1 at risk for ongoing abuse and/or mistreatment.