STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	08/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview, observation, and record review, it was determined for 7 of 17 sample residents, that the facility did not ensure that residents were free from abuse and neglect. Specifically, one nurse responded to a resident throwing water on him by approaching the resident, and pinning the resident against a wall by placing his fingers around the neck and clavicle area of the resident. This incident was found to have occurred at an Immediate Jeopardy level. Additionally, sexual and physical interactions occurred between residents with no interventions put into place. These incidents were found to have occurred at a harm level. Resident identifiers: 1, 2, 3, 7, 8, 9, and 10. On 8/23/22 at 11:45 AM, an Immediate Jeopardy was identified when the facility failed to implement Centers for Medicare and Medicaid Services (CMS) recommended practices to prevent various forms of abuse. Notice of the IJ was given verbally to the facility Administrator (ADM), Director of Nursing (DON), Clinical Resource Nurse (CRN) 1, the Director of Leadership Development (DLD), and the Regional [NAME] President of Operations (RVPO). On 8/25/22, CRN 2 provided the following written abatement plan for the removal of the Immediate Jeopardy effective on 8/25/22 at 5:00 PM. The facility seeks to ensure that each resident is free from abuse, neglect, misappropriation of resident property, and exploitation Immediate Interventions Resident physical abuse allegation with Nurse Allegation of abuse between resident 1 and nurse was reported to CMS on 8/9/2022 and investigation initiated. (See Exhibit 1) Resident was sent to ER, blue sheeted by MD on 8/9/2022 Nurse was suspended 8/23/22 pending completion of further investigation. Skin check completed on resident 8/23/2022 with no signs of latent injury. (See Exhibit 2) 8/10/2022 Returned from hospital, provided different room on other side of facility. Resident not happy with new room and was moved back to his old room per his request. (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[Resident 1] evaluated by Licensed Social worker on 8/24/25 (sic) for psychosocial status post incident (See Exhibit 3) Facility Plan to Abate Immediate Jeopardy Abuse Policy and Procedure reviewed by IDT on August 23, 2022, prior to initiating raining for nursing staff. Initial Education started 8/23/2022 Training was completed by Nursing Home Administrator (NHA)/ Designee and Regional [NAME] President (RVP) starting on August 23, 2022. (See Exhibit 4). Training was done using specific real-life examples of what type of situations constitute abuse and included the following topics: Types/Definitions of Abuse Abuse must be stopped before the staff leaves the resident Immediate interventions to put in place to prevent recurrence of the abuse When abuse is suspected to Notify Abuse Coordinator (NHA) immediately Notification guidelines (Police, APS, Utah State) This training will be ongoing until all facility staff are in-serviced Facility educated on their responsibility as mandatory reporters. This training was initiated on 8/24/2022 (See Exhibit 5) Additional Education to be provided to facility staff, initiated on 8/25/2022. Behavior De-escalation and abuse prevention. Training materials to be reviewed by Licensed Social Worker before training is initiated. Recognizing employee burnout and steps to do when burnout is identified (get out of the situation, step outside, etc). Training materials to be reviewed by Licensed Social Worker before training is initiated. Interventions staff can take if they do not feel comfortable reporting abuse/neglect to abuse coordinator. Training materials to be reviewed by Licensed Social Worker before training is initiated. Staff who were unable to complete the training on 8/25/2022 will have access to an audiovisual recording of the training and do a post training test to validate understanding of the material (See Exhibit 6). Training to be provided to Resident Population: Resident Council to be done on 8/25/2022 with education about how to contact the ombudsman and how to report grievances/concerns to facility staff (See Exhibit 7) (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Information Flyer to be posted in resident's rooms about who to contact in the facility to report concerns (facility social worker/resident advocate/Ombudsman). (See Exhibit 8) Additional Training: Administrator was educated on the abuse policy procedure on 8/23/2022 by Regional Nurse Consultant. (See Exhibit 9) Agency Staff to receive abuse training prior to the start of their shift starting 8/24/2022. Training to include the policy/protocol of identifying abuse and how to respond when abuse is suspected (See Exhibit 10) Facility Audit by Licensed Social Worker Licensed Social Worker Consultant(s) to perform evaluation of all facility residents to identify residents at increased risk for abuse, identify residents who are exhibiting signs or symptoms of abuse and make recommendations for addressing any concerns. (See Exhibit 11) The facility will take the recommendations and update the resident's plan of care to manage identified behaviors/deficits (See Exhibit 11). Any findings of abuse/neglect that are found doing rounds will be reported per facility protocol and investigated per federal guidelines. Facility Interventions to Maintain Abuse Program Going Forward NHA/Designee to Post signage in high visibility areas of facility that NHA/Designee is the abuse coordinator and is to be contacted if abuse is suspected at any time by 8/23/2022 (See Exhibit 12) Social Worker to maintain roster of residents at risk for abuse related to Altered Cognition or Behavioral Complex Status. Licensed Caregiver to do focused wellness rounds on these residents monthly and as needed. Frequency of audits will be adjusted by IDT (See Exhibit 13) Educational Huddles and focused rounding to be done with staff at least 3x/week to evaluate staff awareness of abuse and know what to do when abuse is identified until the QAPI team determines a lesser frequency is indicated. (See Exhibit 14) Facility Abuse Coordinator to reinforce at all times that there will be no retaliation or punitive action against staff for reporting abuse. Facility Resident Advocate signed up on 8/25/2022 to obtain Elder Abuse Certification that is Accredited by ASWB of Utah. This will be completed by 8/31/2022. QAPI committee to determine length and frequency of these huddles ongoing. Ad-Hoc QAPI on Abuse Prevention completed on 8/23/2022 (See Exhibit 15). Facility interventions were documented and will be discussed in the monthly QAPI meetings until a lesser frequency is deemed necessary. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Regional Nurse Consultant (RNC) and RVP to evaluate the facility abuse program at least monthly and as needed to ensure abuse prevention interventions are in place. On 8/26/22, while completing the partial extended survey and the abbreviated complaint survey, surveyors conducted an onsite revisit to verify that the Immediate Jeopardy had been removed. The surveyors determined that the Immediate Jeopardy was removed as alleged on 8/25/22 at 5:00 PM. Findings include: IMMEDIATE JEOPARDY 1. A Facility Reported Incident (FRI) report was reviewed after it was submitted to the State Survey Agency. The FRI indicated that on 8/9/22 resident 1 became agitated and started punching and hitting [Licensed Practical Nurse (LPN) 1]. While [LPN 1] was trying to defend himself CNA (Certified Nursing Assistant) [CNA 1] got hit as well while trying to break up the fight. The fight was broken up and [resident 1] was separated from [LPN 1]. The police were called and are taking [resident 1] to the hospital for psych (psychological) eval (evaluation). A review of the facility's recent abuse investigations was completed on 8/22/22. The facility's abuse investigation for the incident between resident 1 and LPN 1 on 8/9/22 was reviewed. The investigation included the following: a. A statement by LPN 1 that indicated that Patient came up to me at the nurse station while I was charting said nothing and threw a glass of water on me. I went to the patient to see why he did this; he came towards me and started throwing his raised fists at me. After throwing the water at me, he started a fist fight with me at the nurse station. I defended myself against the patient, other staff entered the action pulling us from each other. The patient was escorted to his room by staff. b. A nurses note by LPN 2 indicating that This evening had just given resident [1] his meds (medications) and resident was calm and compliant and then when done had his glass of water and walked around the corner. This nurse busy [with] other things and then witnessed resident and staff member pushing against each other. Ran and tried to separate and pulled resident away from staff member. Walked resident down to his room and police were called. Resident telling police that the staff member was asking girls for sexual favors and then not paying them for it. Resident sent to hospital for eval (evaluation). Hospital sending him back. No other statements by staff or residents were located in the abuse investigation documentation provided by ADM. The facility's final abuse investigation for the incident between resident 1 and LPN 1 was reviewed and documented the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Description of Incident: Resident [1] walked up to nurse [LPN 1] and threw a glass of water at [LPN 1]. As [LPN 1] asked [resident 1] why he did that he started attacking [LPN 1] and punching him repeatedly. [LPN 1] was trying to defend himself and [CNA 1] came into help pull [resident 1] off [LPN 1] and she was also hit. [Resident 1] was pulled off of [LPN 1] and calmed down and was escorted back to his room. The police were called, and they took [resident 1] to the hospital for a psych evaluation because of the way he was acting and because he was so agitated. Patient has since returned with no further incidents. Pertinent Patient History and chart review: [Resident 1] is a [AGE] year-old male who admitted to us with a diagnosis of Dementia with behaviors, type 2 diabetes, chronic pain, adjustment disorder, cognitive communication deficit, and insomnia. Description of Action Taken: [Resident 1] was escorted back to his room and the police were called and [resident 1] was taken to the hospital for a psychological evaluation. Interview with Resident: [Resident 1] said he attacked [LPN 1] because he thought [LPN 1] was asking women for sexual favors and not paying them. [Resident 1] also says many odd things and is often making up bizarre stories. Interview with Staff: Staff confirmed the incident and also confirmed that [LPN 1] just defended himself and did not hit [resident 1]. Staff also confirmed that [LPN 1] was not propositioning female staff for sexual favors. [LPN 1] is openly homosexual. Interventions at conclusion of investigation: [Resident 1] spent the night at the hospital and returned the next day without incident. Conclusion: Substantiated. Event was witnessed by several residents and staff members. [Note: The final abuse investigation did not indicate which staff the ADM had spoken with, did not include an interview with CNA 1 or other staff on duty who might have witnessed the incident, did not include an interview with other residents, did not indicate what measures had been taken to prevent further potential abuse to residents during the investigation, nor which staff he had spoken to.] On 8/22/22 at 10:10 AM, an interview was conducted with resident 1. Resident 1 was unable to recall any physical aggression or altercations between staff and residents, including himself. Resident 1 stated that there was an employee working at the facility that would tell female residents if I do this for you will you do this sexual thing to me? Resident 1 then stated that when the employee was in the exercise room, he would have one of the ladies lay down and then tell female residents he would take care of them if they had sex with him. I was a couple of feet away when I heard it. I will file a complaint. I know what I heard. I was standing right there when he said that. Then he told me he would make a deal with me not to talk. He claims to be a doctor. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/22 at 11:22 AM, an interview was conducted with the ADM. The ADM stated that he had not completed abuse investigations as an Administrator prior to being employed at the current facility. The ADM stated that he submitted all abuse reports to his corporate officers each evening, and that Clinical Resource Nurse (CRN) 1 reviewed all of his abuse investigations when she came to the facility. The ADM was asked about documentation regarding previous abuse investigations completed at the facility prior to 5/23/22. The ADM stated that he did not have those investigations because the previous administrator had taken those with him when he was transferred to another facility. On 8/22/22 at 2:00 PM, an interview was conducted with the facility ADM regarding the incident with resident 1 and LPN 1 on 8/9/22. The ADM stated that he had received a call that resident 1 had approached LPN 1 and threw a glass of water at him, and [LPN 1] asked why he did that, and then [resident 1] started punching [LPN 1] and going crazy, and there was a brawl in the hall. The ADM stated that there was a CNA who got hit during the incident, but that he couldn ' t remember the CNAs name. The ADM stated that facility staff called the police because resident 1 was freaking out . he was super belligerent and going crazy saying [LPN 1] was going around propositioning females for sex and not paying them, but [LPN 1] is openly gay so . We just think he (resident 1) doesn ' t like [LPN 1]. The ADM stated that when resident 1 returned from the hospital, the resident acted like it never happened. The ADM stated that resident 1 has done other things like that, such as claiming another resident took his shoes. The ADM stated that resident 1's stories were all fabricated. He will seem normal at first, and then he goes into random bizarre things. And then you realize he ' s not normal. When asked if there were any other witnesses to the incident besides resident 1 and LPN 1, the ADM stated that he was not sure, but he could ask LPN 1 who was there. The ADM stated that for the abuse investigation he had only interviewed LPN 1 and LPN 2 via telephone. The ADM stated that LPN 2 had reported being hit during the incident, and then stated maybe it was CNA 1 who was hit. The ADM then stated that he had not interviewed LPN 2. When asked what statement LPN 1 provided to the ADM, the ADM stated that LPN 1 ' s assertion was he just had his arms up protecting himself. He was super shaken up. The ADM then stated that he did not talk to resident 1 regarding the incident because when you talk to him it ' s pretty much nonsense. [Note: The ADM documented in the abuse investigation that he had spoken with resident 1]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/22/22 at 3:21 PM an interview was conducted with CNA 1. When asked about the incident between resident 1 and LPN 1 on 8/9/22, CNA 1 stated that at about 9:30 PM, she was charting at the nurses station in the rehabilitation hall. CNA 1 stated that she saw resident 1 approach LPN 2 so that LPN 2 could administer resident 1 ' s medications. CNA 1 stated that she returned to her charting, and then saw some scuffling. CNA 1 stated that she did not see the beginning of the incident between LPN 1 and resident 1, but when she looked up from her charting she saw [LPN 1] pin [resident 1] against the door to the shower room. CNA 1 also stated that it looked like he (LPN 1) had him (resident 1) by the throat and pinned against the door. CNA 1 stated that LPN 1 was pushing resident 1 with one of his forearms, while the other hand had resident 1 by the throat. CNA 1 stated resident 1 was pushing LPN 1 away with his hands on LPN 1 ' s upper arm/bicep area. CNA 1 stated that it also looked like they were slapping each other. CNA 1 further stated, I didn ' t see anyone hit, but they were pushing each other. [LPN 2] ran over and got between them. Then I got in between them, and grabbed [LPN 1] ' s arms from behind. CNA 1 stated that she had grabbed LPN 1 ' s arms in an attempt to stop LPN 1 from continuing to pin the resident to the wall, and get them away from [resident 1]. CNA 1 stated that when she grabbed LPN 1 ' s arms, he squeezed my arms and said ' get the fuck off me, ' and then hit me in the chest. He raised his arm again and was getting ready to hit me again so I moved away. CNA 1 stated that the incident last for a couple of minutes. CNA 1 stated that she was very upset and crying, so she went to the memory care area of the facility to speak with other staff. CNA 1 stated that she did not think there were other residents present at the nurses station at the time. CNA 1 stated that after the incident, resident 1 was taken to the hospital for an evaluation, but subsequently returned to the facility, at approximately 2:00 AM. CNA 1 stated that when resident 1 returned from the hospital later that evening, LPN 1 and LPN 2 took resident 1 and his belongings over to the memory care area of the facility. CNA 1 stated that resident 1 was upset and repeatedly asked, Why do I have to leave?, Can I please go back to my room?, and Can I sign a paper that says I won ' t touch him (LPN 1) again? CNA 1 stated that resident 1 was offered a room in which another resident was residing, but resident 1 refused, so resident 1 sat in the hallway of the common area of the memory care area of the facility. CNA 1 stated that after the incident, LPN 1 should have gone home. You don ' t put your hands on a resident. I ' ve never seen a nurse hit a resident, and then the nurse gets to stay and work? . I went over to (the nurses station) to get my stuff but I didn ' t want to be around [LPN 1]. [Resident 1] isn ' t safe in his home. Even if [the resident] is the aggressor, you can ' t hit him. When asked about the investigation into the incident, CNA 1 stated that on the night of the incident, the DON spoke with her and told her she could leave work if she needed to. CNA 1 stated that she reported to the DON that she had been struck by LPN 1. CNA 1 stated that the DON told her that LPN 1 had blacked out and said he didn ' t realize he had hit CNA 1. CNA 1 also stated that the DON told her that LPN 1 feels bad and he ' s crying. CNA 1 stated that no one else in administration had spoken with her regarding the incident, including the ADM. CNA 1 stated that she reported the details of the incident to the DON, the same way she explained them to the surveyors. On 8/23/22 at 9:00 AM, a follow up interview was conducted with CNA 1. When asked if she was injured during the incident between LPN 1 and resident 1, CNA 1 stated that she was not injured but it hurt a little. It was more traumatic for me than physical. CNA 1 stated that when resident 1 was in the memory care area of the facility, which was locked, his voice was never raised, and he repeatedly stated I don ' t understand why I can ' t go back in the room. CNA 1 stated that she was never asked for a written statement. CNA 1 stated that after the incident, she requested not to work with LPN 1. CNA 1 stated that other staff encouraged her to report the incident to management or other government agencies, but she did not know who to contact. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/23/22 at 1:49 PM, an interview was conducted with CNA 2 regarding the incident between LPN 1 and resident 1. CNA 2 stated that on 8/9/22 at approximately 10:00 PM, she was seated at the nurses station while completing her charting. CNA 2 stated that she saw LPN 1 stand up from where he was seated on one end of the nurses station, and walk to the other end of the nurses station. CNA 2 stated that she then looked up to see resident 1 and LPN 1 fist fighting. CNA 2 stated that she saw resident 1 hit LPN 1 in the temple area of the head, and LPN 1 hit resident 1 twice in the cheeks. CNA 2 stated that LPN 1 used both hands, which were curled into fists, to hit resident 1. CNA 2 stated that LPN 2 and CNA 1 intervened and were able to get between LPN 1 and resident 1. CNA 2 stated that at one point during the incident, LPN 1 turned and hit CNA 1 in the chest, while saying Get off me, get off me, stop to CNA 1. CNA 2 stated that resident 1 told LPN 2 he wanted to press charges against LPN 1. CNA 2 stated that LPN 1 repeatedly told resident 1 that he was going to press charges because this was assault. CNA 2 stated that LPN 1 and LPN 2 later walked with resident 1 down to the memory care area of the facility. CNA 2 stated that LPN 2 was walking between resident 1 and LPN 1, but that LPN 1 repeatedly stated to resident 1 You know the cops are going to come, at which point resident 1 tried to reach around LPN 2 and hit LPN 1. CNA 2 stated that after the incident, CNA 1 looked at me, and said ' I ' m going home. I can ' t take this. ' CNA 2 stated that CNA 1 then went over to the memory care area of the facility to finish her shift. CNA 2 stated that both herself and LPN 2 contacted the DON to tell her about the incident. CNA 2 stated that the DON subsequently came to the facility, and spoke with both LPN 1 and resident 1. CNA 2 stated that the DON tried to relieve LPN 1 of his shift, but that LPN 1 didn ' t feel the need to go home, so he ended up staying . and worked until 6:00 AM. CNA 2 stated that after the incident, resident 1 was sent out to the hospital, but returned to the facility at approximately 2:00 AM. CNA 2 stated that resident 1 was sent to sleep in another room because things were still hostile that night. I don ' t know if [LPN 1] was still upset but we wanted to be safe more than sorry. We moved [resident 1 ' s] recliner to the other side of the facility. When asked if work assignments had been changed, CNA 2 stated that there were no adjustments, and that from 10:00 PM to 6:00 AM on the nights that LPN 1 worked, LPN 1 was the only nurse on the side of the facility were resident 1 currently resided, so if resident 1 needed anything, he would have to ask LPN 1. When asked if she had been interviewed or asked to provide a statement of the incident, CNA 2 stated that on the night of the incident, the DON asked CNA 2 what happened, but that that was the only time she was interviewed regarding the incident, and had not provided a written statement. CNA 2 stated that the ADM never spoke with her regarding the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/22/22 at 6:52 PM, an interview was conducted with LPN 2. LPN 2 stated that she was assigned to work the 6:00 PM to midnight shift. LPN 2 stated that on 8/9/22, she was standing on the outside portion of the nurses station, in the center area of the station. [Note: This particular nursing station desk is large and situated at the intersection of four halls. It is shaped like a letter L. From the center of the desk, to exit the nursing station, on either end, is approximately 8-10 feet.] LPN 2 stated that resident 1 was walking in the hallway near the nurses station, and LPN 2 offered to give him his evening pills. LPN 2 stated that resident 1 agreed. LPN 2 stated that after resident 1 took his pills, he walked behind her and to the left side of the nurses station (from her point of view) and threw a glass of water on LPN 1, who was seated on the inside portion of the nurses station. LPN 2 stated that resident 1 then turned and walked behind her again and around to the other end of the nurses station, on her right, but stayed on the outside of the nurses station. LPN 2 stated that LPN 1 stood up from the inside portion of the nurses station where he had been seated, and she heard scuffling to her right. LPN 2 stated that at that time she observed that resident 1 had his hands on LPN 1 ' s arms, holding onto the bicep area. LPN 2 stated that LPN 1 had his left hand up to his (resident 1 ' s) neck. LPN 2 then demonstrated what she observed. LPN 2 demonstrated to surveyors that LPN 1 ' s right hand was on resident 1 in a manner that his thumb was on one side of the resident ' s neck and his fingers were pressed in the area of the resident ' s clavicle. LPN 2 stated that resident 1 was taller than LPN 1, and they were pushing against each other. LPN 2 stated that when the altercation was over, she told resident 1, Let ' s go to your room. LPN 2 stated that resident 1 did not resist or have any behaviors at that time and was fine once I intervened. LPN 2 stated that while she was walking the resident to his room, LPN 1 was telling the resident that he was going to press charges because he was assaulted. LPN 2 stated that she told LPN 1 to go away. When describing the incident, LPN 2 stated that something snapped with LPN 1 and that I don ' t think [resident 1] was going to do anything else. So the water may have been the end of it. there was a look like he (LPN 1) was just not right. He was so upset. It was like a seizure look in [LPN 1 ' s] eyes. I think he (LPN 1) overreacted. LPN 2 further stated that CNA 1 reported to her that she had tried to separate LPN 1 and resident 1, but that LPN 1 had snapped and said get the f away and hit her and she was quite upset. LPN 2 stated that both she and CNA 1 reported what happened to the DON. LPN 2 stated that she didn ' t feel safe leaving LPN 1 alone with resident 1 during the remainder of the shift, so they moved resident 1 ' s recliner over to the other side of the facility. LPN 2 stated that resident 1 agreed to move over to the other side, when she told him it was just for tonight. On 8/23/22 at 9:11 AM, a follow up interview was conducted with LPN 2. LPN 2 stated that she didn ' t see if resident 1 or LPN 1 were hit. LPN 2 stated that during the incident she was facing the resident, and tried to distract him. LPN 2 stated that she had her back to LPN 1. LPN 2 stated that she kept telling him (LPN 1) to stop . [LPN 1] was shook up and upset and saying ' I ' m going to press charges ' but [resident 1] wasn ' t really saying anything. LPN 2 stated that after the incident, she walked resident 1 to his room, and LPN 1 came up to resident 1 during that time and repeatedly told resident 1 he was going to press charges. LPN 2 stated that she told LPN 1 to just go back to the desk. LPN 2 stated that resident 1 remained in his room until the police arrived at the facility. LPN 2 stated that when the DON arrived at the facility, she told the DON that LPN 1 and resident 1 were pushing against each other and that LPN 1 was freaked. I ' ve never seen him like that. LPN 2 stated that she heard CNA 1 tell the DON about the incident also, including that CNA 1 had been struck. LPN 2 stated that CNA 1 was pretty shook up by the incident. LPN 2 stated that after she told the DON about the incident, there was no other follow up by either the DON or the ADM. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/22/22 an interview was conducted with Staff Member (SM) 1. SM 1 stated that he/she wanted to remain anonymous due to fears of retribution. SM 1 stated that he/she was working at the facility on the night of 8/9/22 when the incident occurred between resident 1 and LPN 1. SM 1 stated that CNA 1 approached him/her and was crying, stating that LPN 1 had hit her. SM 1 stated that he/she was able to visualize a mark on CNA 1 ' s arm, where CNA 1 stated that LPN 1 had squeezed her arm. SM 1 stated that CNA 1 reported that the nurse (LPN 1) had [resident 1] up by his neck and holding him against the wall, and they were swinging at each other. SM 1 stated that CNA 1 told him/her that CNA 1 thought LPN 1 had purposely hit her because LPN 1 was looking at her when he hit her. SM 1 stated that CNA 1 reported that the DON had been contacted, was aware of the situation, but allowed LPN 1 to finish his shift. SM 1 stated that CNA 1 now refused to work with LPN 1, and had asked to exclusively work in the memory care area of the facility. SM 1 stated that CNA 1 reported that LPN 2 had also witnessed the incident. SM 1 stated You ' re not supposed to hit a resident. they sent [resident 1] out (to the hospital), and when he came back, [LPN 1] wouldn ' t let him (resident 1) stay in his room. SM 1 stated that when resident 1 returned from the hospital, he/she saw LPN 1 and LPN 2 take resident 1 down to the memory care area of the facility because LPN 1 took things into his own hands. SM 1 stated that LPN 2 stated that resident 1 has to stay over here because [LPN 1] won ' t have him there in his assigned area. SM 1 stated that LPN 1 was stating he refused to take care of resident 1. SM 1 stated that resident 1 sat in his recliner in the hallway of the locked memory care area for the rest of the night. On 8/22/22, resident 1 ' s medical records were reviewed. On 8/9/22, the physician attending to resident 1 in the emergency room documented that the patient is a [AGE] year-old male with history of dementia . Nursing staff were concerned because of his altercation and the patient was struck in the upper back. At this point time (sic) the patient complains of no significant anger or agitation. He does have some mild upper back pain. He is quite calm and was transported to the hospital and in route he was quite calm as well. at this point time (sic) this patient does not meet any criteria for involuntary hold and he should be able to be discharged home to the facility. He is not a risk of harm to himself or others. The patient has been calm and cooperative in the ER (emergency room). As discussed, please try to avoid any altercations at the facility. The physician documented that his/her clinical impression was that resident 1 was Agitated and had a Back contusion. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/22/22 at 6:07 PM, an interview was conducted with LPN 1. LPN 1 stated that prior to 8/9/22,he had only worked with resident 1 on two occasions. LPN 1 stated that on 8/9/22 he was told during shift change by another nurse that resident 1 was having delusions and was stating that a Mr. [NAME] was propositioning women at the facility and not paying them. LPN 1 stated that later that evening he was seated on one end of the nurses station completing some charting, when resident 1 walked up and chucks a glass of water at me. So I went around to the end of the nurses station to see what ' s happening. He (resident 1) had his fists up and is swinging. I attempted to block him . and hold him away. [Note: This particular nursing station desk is large and situated at the intersection of four halls. It is shaped like a letter L. From the center of the desk to exit the nursing station, on either end, is approximately 8-10 feet.] LPN 1 stated that he had bruises on his right upper chest and neck from where resident 1 had hit him. LPN 1 stated that we got pulled away from each other and that LPN 2 and LPN 1 got him (resident 1) down to his room, at which point LPN 1 called the police and told them that he had just been assaulted. When asked to describe the incident in more detail, LPN 1 stated that resident 1 walked to the area of the nurses station where LPN 1 was seated and threw a glass of water on him. LPN 1 stated that he did not say anything to the resident but that he did stand up, walked to the end of the nurses station and confronted resident 1 to determine why the resident had thrown water at him. LPN 1 stated that the resident started walking toward him and both fists were coming at me . I was trying to deflect and get him away, and he ' s deflecting. I ' m trying to get him off to the wall. There ' s three or four staff and I ' m trying to say ' what ' s your deal? ' and ' what ' s your problem? ' and ' what ' s going on? ' to the resident. LPN 1 stated that he was trying to get resident 1 against the wall because I don ' t know what he ' s capable of. LPN 1 stated that at that time all I want to do is control him and keep everyone else safe, and I don ' t know what he ' s capable of. LPN 1 stated that resident 1 was coming at me and LPN 2 was trying to pull him off of me . I attempted to grab his hands . I don ' t fight an [AGE] year old man. LPN 1 state [TRUNCATED]

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview, observation, and record review, it was determined for 4 of 17 sample residents, that the facility did not ensure that in response to allegations of abuse, neglect, exploitation or mistreatment that the allegations were thoroughly investigated, and that staff prevented further potential abuse while the investigation was in process. Specifically, one nurse responded to a resident throwing water on him by approaching the resident, and pinning the resident against a wall by placing his fingers around the neck and clavicle area of the resident. The allegation was not thoroughly investigated by administrative staff, and no actions were taken to prevent further incidents of potential abuse. This incident was found to have occurred at an Immediate Jeopardy level. Additionally, sexual and physical interactions occurred between residents with no thorough investigations completed, and no interventions put into place These incidents were found to have occurred at a harm level. Resident identifiers: 1, 7, 8, and 10. On 8/23/22 at 11:45 AM, an Immediate Jeopardy was identified when the facility failed to implement Centers for Medicare and Medicaid Services (CMS) recommended practices to investigation and prevent further abuse while the investigation was being conducted. Notice of the IJ was given verbally to the facility Administrator (ADM), Director of Nursing (DON), Clinical Resource Nurse (CRN) 1, the Director of Leadership Development (DLD), and the Regional [NAME] President of Operations (RVPO). On 8/25/22, CRN 2 provided the following written abatement plan for the removal of the Immediate Jeopardy effective on 8/25/22 at 5:00 PM. The facility seeks to ensure that each alleged violation of abuse, neglect, exploitation or mistreatment is thoroughly investigated, and the facility will prevent further abuse, neglect, exploitation and mistreatment from occurring while the investigation is in progress; and take appropriate corrective action, as a results of investigation findings. Immediate Interventions Resident physical abuse allegation with Nurse * 8/23/2022: Investigation reopened and all staff that were on shift at 2026 on 8/9/2022 were reinterviewed by corporate staff (See Exhibit 16). Nurse 1 was terminated on 8/24/2022. When investigation is completed, will be submitted to CMS per protocol. * Corrective action taken: Nurse 1 was suspended pending investigation. Other interventions described in F600: Allegation of abuse between resident 1 and nurse was reported to CMS on 8/9/2022 and investigation initiated. (See Exhibit 1) Resident was sent to ER, blue sheeted by MD on 8/9/2022 Nurse was suspended 8/23/22 pending completion of further investigation. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Skin check completed on resident 1 8/23/2022 with no signs of latent injury. (See Exhibit 2) 8/10/2022 Returned from hospital, provided different room on other side of facility. Resident not happy with new room and was moved back to his old room per his request. [Resident 1] to be evaluated by Licensed Social worker on 8/24/25 (sic) for psychosocial status post incident (See Exhibit 3) * Additional interventions put in place to prevent further abuse, neglect, exploitation and mistreatment from occurring: Facility Plan to Abate Immediate Jeopardy Facility Education Abuse Policy and Procedure reviewed by IDT on August 23, 2022, prior to initiating raining (sic) for nursing staff. Initial Training started 8/23/2022 Training was completed by Nursing Home Administrator (NHA)/ Designee and Regional [NAME] President (RVP) starting on August 23, 2022. (See Exhibit 4). Training was done using specific real-life examples of what type of situations constitute abuse and included the following topics: Types/Definitions of Abuse Abuse must be stopped before the staff leaves the resident Immediate interventions to put in place to prevent recurrence of the abuse When abuse is suspected to Notify Abuse Coordinator (NHA) immediately Notification guidelines (Police, APS, Utah State) This training will be ongoing until all facility staff are in-serviced Facility educated on their responsibility as mandatory reporters. This training was initiated on 8/24/2022 (See Exhibit 5) Additional Training to be provided to facility staff, initiated on 8/25/2022. Behavior De-escalation and abuse prevention. Training materials to be reviewed by Licensed Social Worker before training is completed. Recognizing employee burnout and steps to do when burnout is identified (get out of the situation, step outside, etc). Interventions staff can take if they do not feel comfortable reporting abuse/neglect to abuse coordinator. Training materials to be reviewed by Licensed Social Worker before training is completed. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff who were unable to attend the training on 8/25/2022 will have access to an audiovisual recording of the training and do a post training test to validate understanding of the material (See Exhibit 6) Training to be provided to Resident Population: Resident Council to be done on 8/25/2022 with education about how to contact the ombudsman and how to report grievances/concerns to facility staff (See Exhibit 7) Information Flyer to be posted in resident's rooms about who to contact in the facility to report concerns (facility social worker/resident advocate/Ombudsman). (See Exhibit 8) Additional Training: Administrator was educated on the abuse policy procedure on 8/23/2022 by Regional Nurse Consultant. (See Exhibit 9) Agency Staff to receive abuse training prior to the start of their shift starting 8/24/2022. Training to include the policy/protocol of identifying abuse and how to respond when abuse is suspected (See Exhibit 10) Facility Audit by Licensed Social Worker Licensed Social Worker Consultant(s) to perform evaluation of all facility residents to identify residents at increased risk for abuse, identify residents who are exhibiting signs or symptoms of abuse and make recommendations for addressing any concerns. (See Exhibit 11) The facility will take the recommendations and update the resident's plan of care to manage identified behaviors/deficits (See Exhibit 11). Any findings of abuse/neglect that are found doing rounds will be reported per facility protocol and investigated per federal guidelines. Facility Interventions to Monitor Abuse Program Going Forward NHA/Designee to Post signage in high visibility areas of facility that NHA/Designee is the abuse coordinator and is to be contacted if abuse is suspected at any time by 8/23/2022 (See Exhibit 12) Social Worker to maintain roster of residents at risk for abuse related to Altered Cognition or Behavioral Complex Status. Licensed Caregiver to do focused wellness rounds on these residents monthly and as needed. Frequency of audits will be adjusted by IDT (See Exhibit 13) Educational Huddles and focused rounding to be done with staff at least 3x/week to evaluate staff awareness of abuse and know what to do when abuse is identified until the QAPI team determines a lesser frequency is indicated. (See Exhibit 14) Facility Abuse Coordinator to reinforce at all times that there will be no retaliation or punitive action against staff for reporting abuse. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	QAPI committee to determine length and frequency of these huddles ongoing. Ad-Hoc QAPI on Abuse Prevention completed on 8/23/2022 (See Exhibit 15). Facility interventions were documented and will be discussed in the monthly QAPI meetings until a lesser frequency is deemed necessary. Regional Nurse Consultant (RNC) and RVP to evaluate the facility abuse program at least monthly and as needed to ensure abuse prevention interventions are in place. IMMEDIATE JEOPARDY 1. A Facility Reported Incident (FRI) report was reviewed after it was submitted to the State Survey Agency. The FRI indicated that on 8/9/22 resident 1 became agitated and started punching and hitting [Licensed Practical Nurse (LPN) 1]. While [LPN 1] was trying to defend himself CNA (Certified Nursing Assistant) [CNA 1] got hit as well while trying to break up the fight. The fight was broken up and [resident 1] was separated from [LPN 1]. The police were called and are taking [resident 1] to the hospital for psych (psychological) eval (evaluation). A review of the facility's recent abuse investigations was completed on 8/22/22. The facility ' s abuse investigation for the incident between resident 1 and LPN 1 on 8/9/22 was reviewed. The investigation included the following: a. A statement by LPN 1 that indicated that Patient came up to me at the nurse station while I was charting said nothing and threw a glass of water on me. I went to the patient to see why he did this; he came towards me and started throwing his raised fists at me. After throwing the water at me, he started a fist fight with me at the nurse station. I defended myself against the patient, other staff entered the action pulling us from each other. The patient was escorted to his room by staff. b. A nurses note by LPN 2 indicating that This evening had just given resident [1] his meds (medications) and resident was calm and compliant and then when done had his glass of water and walked around the corner. This nurse busy [with] other things and then witnessed resident and staff member pushing against each other. Ran and tried to separate and pulled resident away from staff member. Walked resident down to his room and police were called. Resident telling police that the staff member was asking girls for sexual favors and then not paying them for it. Resident sent to hospital for eval (evaluation). Hospital sending him back. No other statements by staff or residents were located in the abuse investigation documentation provided by ADM. The facility ' s final abuse investigation for the incident between resident 1 and LPN 1 was reviewed and documented the following: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Description of Incident: Resident [1] walked up to nurse [LPN 1] and threw a glass of water at [LPN 1]. As [LPN 1] asked [resident 1] why he did that he started attacking [LPN 1] and punching him repeatedly. [LPN 1] was trying to defend himself and [CNA 1] came into help pull [resident 1] off [LPN 1] and she was also hit. [Resident 1] was pulled off of [LPN 1] and calmed down and was escorted back to his room. The police were called, and they took [resident 1] to the hospital for a psych evaluation because of the way he was acting and because he was so agitated. Patient has since returned with no further incidents. Pertinent Patient History and chart review: [Resident 1] is a [AGE] year-old male who admitted to us with a diagnosis of Dementia with behaviors, type 2 diabetes, chronic pain, adjustment disorder, cognitive communication deficit, and insomnia. Description of Action Taken: [Resident 1] was escorted back to his room and the police were called and [resident 1] was taken to the hospital for a psychological evaluation. Interview with Resident: [Resident 1] said he attacked [LPN 1] because he thought [LPN 1] was asking women for sexual favors and not paying them. [Resident 1] also says many odd things and is often making up bizarre stories. Interview with Staff: Staff confirmed the incident and also confirmed that [LPN 1] just defended himself and did not hit [resident 1]. Staff also confirmed that [LPN 1] was not propositioning female staff for sexual favors. [LPN 1] is openly homosexual. Interventions at conclusion of investigation: [Resident 1] spent the night at the hospital and returned the next day without incident. Conclusion: Substantiated. Event was witnessed by several residents and staff members. [Note: The final abuse investigation did not indicate which staff the ADM had spoken with, did not include an interview with CNA 1 or other staff on duty who might have witnessed the incident, did not include an interview with other residents, did not indicate what measures had been taken to prevent further potential abuse to residents during the investigation, nor which staff he had spoken to.] On 8/22/22 at 10:10 AM, an interview was conducted with resident 1. Resident 1 was unable to recall any physical aggression or altercations between staff and residents, including himself. Resident 1 stated that there was an employee working at the facility that would tell female residents if I do this for you will you do this sexual thing to me? Resident 1 then stated that when the employee was in the exercise room, he would have one of the ladies lay down and then tell female residents he would take care of them if they had sex with him. I was a couple of feet away when I heard it. I will file a complaint. I know what I heard. I was standing right there when he said that. Then he told me he would make a deal with me not to talk. He claims to be a doctor. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/22 at 11:22 AM, an interview was conducted with the ADM. The ADM stated that he had not completed abuse investigations as an Administrator prior to being employed at the current facility. The ADM stated that he submitted all abuse reports to his corporate officers each evening, and that Clinical Resource Nurse (CRN) 1 reviewed all of his abuse investigations when she came to the facility. The ADM was asked about documentation regarding previous abuse investigations completed at the facility prior to 5/23/22. The ADM stated that he did not have those investigations because the previous administrator had taken those with him when he was transferred to another facility. On 8/22/22 at 2:00 PM, an interview was conducted with the facility ADM regarding the incident with resident 1 and LPN 1 on 8/9/22. The ADM stated that he had received a call that resident 1 had approached LPN 1 and threw a glass of water at him, and [LPN 1] asked why he did that, and then [resident 1] started punching [LPN 1] and going crazy, and there was a brawl in the hall. The ADM stated that there was a CNA who got hit during the incident, but that he couldn ' t remember the CNAs name. The ADM stated that facility staff called the police because resident 1 was freaking out . he was super belligerent and going crazy saying [LPN 1] was going around propositioning females for sex and not paying them, but [LPN 1] is openly gay so . We just think he (resident 1) doesn ' t like [LPN 1]. The ADM stated that when resident 1 returned from the hospital, the resident acted like it never happened. The ADM stated that resident 1 has done other things like that, such as claiming another resident took his shoes. The ADM stated that resident 1's stories were all fabricated. He will seem normal at first, and then he goes into random bizarre things. And then you realize he ' s not normal. When asked if there were any other witnesses to the incident besides resident 1 and LPN 1, the ADM stated that he was not sure, but he could ask LPN 1 who was there. The ADM stated that for the abuse investigation he had only interviewed LPN 1 and LPN 2 via telephone. The ADM stated that LPN 2 had reported being hit during the incident, and then stated maybe it was CNA 1 who was hit. The ADM then stated that he had not interviewed LPN 2. When asked what statement LPN 1 provided to the ADM, the ADM stated that LPN 1 ' s assertion was he just had his arms up protecting himself. He was super shaken up. The ADM then stated that he did not talk to resident 1 regarding the incident because when you talk to him it ' s pretty much nonsense. [Note: The ADM documented in the abuse investigation that he had spoken with resident 1]. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/22/22 at 3:21 PM an interview was conducted with CNA 1. When asked about the incident between resident 1 and LPN 1 on 8/9/22, CNA 1 stated that at about 9:30 PM, she was charting at the nurses station in the rehabilitation hall. CNA 1 stated that she saw resident 1 approach LPN 2 so that LPN 2 could administer resident 1 ' s medications. CNA 1 stated that she returned to her charting, and then saw some scuffling. CNA 1 stated that she did not see the beginning of the incident between LPN 1 and resident 1, but when she looked up from her charting she saw [LPN 1] pin [resident 1] against the door to the shower room. CNA 1 also stated that it looked like he (LPN 1) had him (resident 1) by the throat and pinned against the door. CNA 1 stated that LPN 1 was pushing resident 1 with one of his forearms, while the other hand had resident 1 by the throat. CNA 1 stated resident 1 was pushing LPN 1 away with his hands on LPN 1 ' s upper arm/bicep area. CNA 1 stated that it also looked like they were slapping each other. CNA 1 further stated, I didn ' t see anyone hit, but they were pushing each other. [LPN 2] ran over and got between them. Then I got in between them, and grabbed [LPN 1] ' s arms from behind. CNA 1 stated that she had grabbed LPN 1 ' s arms in an attempt to stop LPN 1 from continuing to pin the resident to the wall, and get them away from [resident 1]. CNA 1 stated that when she grabbed LPN 1 ' s arms, he squeezed my arms and said ' get the fuck off me, ' and then hit me in the chest. He raised his arm again and was getting ready to hit me again so I moved away. CNA 1 stated that the incident last for a couple of minutes. CNA 1 stated that she was very upset and crying, so she went to the memory care area of the facility to speak with other staff. CNA 1 stated that she did not think there were other residents present at the nurses station at the time. CNA 1 stated that after the incident, resident 1 was taken to the hospital for an evaluation, but subsequently returned to the facility, at approximately 2:00 AM. CNA 1 stated that when resident 1 returned from the hospital later that evening, LPN 1 and LPN 2 took resident 1 and his belongings over to the memory care area of the facility. CNA 1 stated that resident 1 was upset and repeatedly asked, Why do I have to leave?, Can I please go back to my room?, and Can I sign a paper that says I won ' t touch him (LPN 1) again? CNA 1 stated that resident 1 was offered a room in which another resident was residing, but resident 1 refused, so resident 1 sat in the hallway of the common area of the memory care area of the facility. CNA 1 stated that after the incident, LPN 1 should have gone home. You don ' t put your hands on a resident. I ' ve never seen a nurse hit a resident, and then the nurse gets to stay and work? . I went over to (the nurses station) to get my stuff but I didn ' t want to be around [LPN 1]. [Resident 1] isn ' t safe in his home. Even if [the resident] is the aggressor, you can ' t hit him. When asked about the investigation into the incident, CNA 1 stated that on the night of the incident, the DON spoke with her and told her she could leave work if she needed to. CNA 1 stated that she reported to the DON that she had been struck by LPN 1. CNA 1 stated that the DON told her that LPN 1 had blacked out and said he didn ' t realize he had hit CNA 1. CNA 1 also stated that the DON told her that LPN 1 feels bad and he ' s crying. CNA 1 stated that no one else in administration had spoken with her regarding the incident, including the ADM. CNA 1 stated that she reported the details of the incident to the DON, the same way she explained them to the surveyors. On 8/23/22 at 9:00 AM, a follow up interview was conducted with CNA 1. When asked if she was injured during the incident between LPN 1 and resident 1, CNA 1 stated that she was not injured but it hurt a little. It was more traumatic for me than physical. CNA 1 stated that when resident 1 was in the memory care area of the facility, which was locked, his voice was never raised, and he repeatedly stated I don ' t understand why I can ' t go back in the room. CNA 1 stated that she was never asked for a written statement. CNA 1 stated that after the incident, she requested not to work with LPN 1. CNA 1 stated that other staff encouraged her to report the incident to management or other government agencies, but she did not know who to contact. (continued on next page)

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	465117	A. Building B. Wing	08/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/23/22 at 1:49 PM, an interview was conducted with CNA 2 regarding the incident between LPN 1 and resident 1. CNA 2 stated that on 8/9/22 at approximately 10:00 PM, she was seated at the nurses station while completing her charting. CNA 2 stated that she saw LPN 1 stand up from where he was seated on one end of the nurses station, and walk to the other end of the nurses station. CNA 2 stated that she then looked up to see resident 1 and LPN 1 fist fighting. CNA 2 stated that she saw resident 1 hit LPN 1 in the temple area of the head, and LPN 1 hit resident 1 twice in the cheeks. CNA 2 stated that LPN 1 used both hands, which were curled into fists, to hit resident 1. CNA 2 stated that LPN 2 and CNA 1 intervened and were able to get between LPN 1 and resident 1. CNA 2 stated that at one point during the incident, LPN 1 turned and hit CNA 1 in the chest, while saying Get off me, get off me, stop to CNA 1. CNA 2 stated that resident 1 told LPN 2 he wanted to press charges against LPN 1. CNA 2 stated that LPN 1 repeatedly told resident 1 that he was going to press charges because this was assault. CNA 2 stated that LPN 1 and LPN 2 later walked with resident 1 down to the memory care area of the facility. CNA 2 stated that LPN 2 was walking between resident 1 and LPN 1, but that LPN 1 repeatedly stated to resident 1 You know the cops are going to come, at which point resident 1 tried to reach around LPN 2 and hit LPN 1. CNA 2 stated that after the incident, CNA 1 looked at me, and said ' I ' m going home. I can ' t take this. ' CNA 2 stated that CNA 1 then went over to the memory care area of the facility to finish her shift. CNA 2 stated that both herself and LPN 2 contacted the DON to tell her about the incident. CNA 2 stated that the DON subsequently came to the facility, and spoke with both LPN 1 and resident 1. CNA 2 stated that the DON tried to relieve LPN 1 of his shift, but that LPN 1 didn ' t feel the need to go home, so he ended up staying . and worked until 6:00 AM. CNA 2 stated that after the incident, resident 1 was sent out to the hospital, but returned to the facility at approximately 2:00 AM. CNA 2 stated that resident 1 was sent to sleep in another room because things were still hostile that night. I don ' t know if [LPN 1] was still upset but we wanted to be safe more than sorry. We moved [resident 1 ' s] recliner to the other side of the facility. When asked if work assignments had been changed, CNA 2 stated that there were no adjustments, and that from 10:00 PM to 6:00 AM on the nights that LPN 1 worked, LPN 1 was the only nurse on the side of the facility were resident 1 currently resided, so if resident 1 needed anything, he would have to ask LPN 1. When asked if she had been interviewed or asked to provide a statement of the incident, CNA 2 stated that on the night of the incident, the DON asked CNA 2 what happened, but that that was the only time she was interviewed regarding the incident, and had not provided a written statement. CNA 2 stated that the ADM never spoke with her regarding the incident. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/22/22 at 6:52 PM, an interview was conducted with LPN 2. LPN 2 stated that she was assigned to work the 6:00 PM to midnight shift. LPN 2 stated that on 8/9/22, she was standing on the outside portion of the nurses station, in the center area of the station. [Note: This particular nursing station desk is large and situated at the intersection of four halls. It is shaped like a letter L. From the center of the desk, to exit the nursing station, on either end, is approximately 8-10 feet.] LPN 2 stated that resident 1 was walking in the hallway near the nurses station, and LPN 2 offered to give him his evening pills. LPN 2 stated that resident 1 agreed. LPN 2 stated that after resident 1 took his pills, he walked behind her and to the left side of the nurses station (from her point of view) and threw a glass of water on LPN 1, who was seated on the inside portion of the nurses station. LPN 2 stated that resident 1 then turned and walked behind her again and around to the other end of the nurses station, on her right, but stayed on the outside of the nurses station. LPN 2 stated that LPN 1 stood up from the inside portion of the nurses station where he had been seated, and she heard scuffling to her right. LPN 2 stated that at that time she observed that resident 1 had his hands on LPN 1 ' s arms, holding onto the bicep area. LPN 2 stated that LPN 1 had his left hand up to his (resident 1 ' s) neck. LPN 2 then demonstrated what she observed. LPN 2 demonstrated to surveyors that LPN 1 ' s right hand was on resident 1 in a manner that his thumb was on one side of the resident ' s neck and his fingers were pressed in the area of the resident ' s clavicle. LPN 2 stated that resident 1 was taller than LPN 1, and they were pushing against each other. LPN 2 stated that when the altercation was over, she told resident 1, Let ' s go to your room. LPN 2 stated that resident 1 did not resist or have any behaviors at that time and was fine once I intervened. LPN 2 stated that while she was walking the resident to his room, LPN 1 was telling the resident that he was going to press charges because he was assaulted. LPN 2 stated that she told LPN 1 to go away. When describing the incident, LPN 2 stated that something snapped with LPN 1 and that I don ' t think [resident 1] was going to do anything else. So the water may have been the end of it. there was a look like he (LPN 1) was just not right. He was so upset. It was like a seizure look in [LPN 1 ' s] eyes. I think he (LPN 1) overreacted. LPN 2 further stated that CNA 1 reported to her that she had tried to separate LPN 1 and resident 1, but that LPN 1 had snapped and said get the f away and hit her and she was quite upset. LPN 2 stated that both she and CNA 1 reported what happened to the DON. LPN 2 stated that she didn ' t feel safe leaving LPN 1 alone with resident 1 during the remainder of the shift, so they moved resident 1 ' s recliner over to the other side of the facility. LPN 2 stated that resident 1 agreed to move over to the other side, when she told him it was just for tonight. On 8/23/22 at 9:11 AM, a follow up interview was conducted with LPN 2. LPN 2 stated that she didn ' t see if resident 1 or LPN 1 were hit. LPN 2 stated that during the incident she was facing the resident, and tried to distract him. LPN 2 stated that she had her back to LPN 1. LPN 2 stated that she kept telling him (LPN 1) to stop . [LPN 1] was shook up and upset and saying ' I ' m going to press charges ' but [resident 1] wasn ' t really saying anything. LPN 2 stated that after the incident, she walked resident 1 to his room, and LPN 1 came up to resident 1 during that time and repeatedly told resident 1 he was going to press charges. LPN 2 stated that she told LPN 1 to just go back to the desk. LPN 2 stated that resident 1 remained in his room until the police arrived at the facility. LPN 2 stated that when the DON arrived at the facility, she told the DON that LPN 1 and resident 1 were pushing against each other and that LPN 1 was freaked. I ' ve never seen him like that. LPN 2 stated that she heard CNA 1 tell the DON about the incident also, including that CNA 1 had been struck. LPN 2 stated that CNA 1 was pretty shook up by the incident. LPN 2 stated that after she told the DON about the incident, there was no other follow up by either the DON or the ADM. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/22/22 an interview was conducted with Staff Member (SM) 1. SM 1 stated that he/she wanted to remain anonymous due to fears of retribution. SM 1 stated that he/she was working at the facility on the night of 8/9/22 when the incident occurred between resident 1 and LPN 1. SM 1 stated that CNA 1 approached him/her and was crying, stating that LPN 1 had hit her. SM 1 stated that he/she was able to visualize a mark on CNA 1 ' s arm, where CNA 1 stated that LPN 1 had squeezed her arm. SM 1 stated that CNA 1 reported that the nurse (LPN 1) had [resident 1] up by his neck and holding him against the wall, and they were swinging at each other. SM 1 stated that CNA 1 told him/her that CNA 1 thought LPN 1 had purposely hit her because LPN 1 was looking at her when he hit her. SM 1 stated that CNA 1 reported that the DON had been contacted, was aware of the situation, but allowed LPN 1 to finish his shift. SM 1 stated that CNA 1 now refused to work with LPN 1, and had asked to exclusively work in the memory care area of the facility. SM 1 stated that CNA 1 reported that LPN 2 had also witnessed the incident. SM 1 stated You ' re not supposed to hit a resident. they sent [resident 1] out (to the hospital), and when he came back, [LPN 1] wouldn ' t let him (resident 1) stay in his room. SM 1 stated that when resident 1 returned from the hospital, he/she saw LPN 1 and LPN 2 take resident 1 down to the memory care area of the facility because LPN 1 took things into his own hands. SM 1 stated that LPN 2 stated that resident 1 has to stay over here because [LPN 1] won ' t have him there in his assigned area. SM 1 stated that LPN 1 was stating he refused to take care of resident 1. SM 1 stated that resident 1 sat in his recliner in the hallway of the locked memory care area for the rest of the night. On 8/22/22, resident 1 ' s medical records were reviewed. On 8/9/22, the physician attending to resident 1 in the emergency room documented that the patient is a [AGE] year-old male with history of dementia . Nursing staff were concerned because of his altercation and the patient was struck in the upper back. At this point time (sic) the patient complains of no significant anger or agitation. He does have some mild upper back pain. He is quite calm and was transported to the hospital and in route he was quite calm as well. at this point time (sic) this patient does not meet any criteria for involuntary hold and he should be able to be discharged home to the facility. He is not a risk of harm to himself or others. The patient has been calm and cooperative in the ER (emergency room). As discussed, please try to avoid any altercations at the facility. The physician documented that his/her clinical impression was that resident 1 was Agitated and had a Back contusion. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/22/22 at 6:07 PM, an interview was conducted with LPN 1. LPN 1 stated that prior to 8/9/22,he had only worked with resident 1 on two occasions. LPN 1 stated that on 8/9/22 he was told during shift change by another nurse that resident 1 was having delusions and was stating that a Mr. [NAME] was propositioning women at the facility and not paying them. LPN 1 stated that later that evening he was seated on one end of the nurses station completing some charting, when resident 1 walked up and chucks a glass of water at me. So I went around to the end of the nurses station to see what ' s happening. He (resident 1) had his fists up and is swinging. I attempted to block him . and hold him away. [Note: This particular nursing station desk is large and situated at the intersection of four halls. It is shaped like a letter L. From the center of the desk to exit the nursing station, on either end, is approximately 8-10 feet.] LPN 1 stated that he had bruises on his right upper chest and neck from where resident 1 had hit him. LPN 1 stated that we got pulled away from each other and that LPN 2 and LPN 1 got him (resident 1) down to his room, at which point LPN 1 called the police and told them that he had just been assaulted. When asked to describe the incident in more detail, LPN 1 stated that resident 1 walked to the area of the nurses station where LPN 1 was seated and threw a glass of water on him. LPN 1 stated that he did not say anything to the resident but that he did stand up, walked to the end of the nurses station and confronted resident 1 to determine why the resident had thrown water at him. LPN 1 stated that the resident started walking toward him and both fists were coming at me . I was trying to deflect and get him away, and he ' s deflecting. I ' m trying to get him off to the wall. There ' s thr [TRUNCATED]

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 40334 Based on observation, interview and record review it was determined that the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, laundry was delivered to the laundry room with solid chunks of feces, causing potential contamination and spread of disease. Additionally, clean laundry was stored in the soiled linen area. Lastly, infection control tracking was not completed for surveillance purposes. Findings include: 1. On 8/22/22 at 8:20 AM, a tour of the facility's laundry room was conducted with Staff Member (SM) 2. SM 2 donned gloves and retrieved soiled sheets out of a dirty laundry bin. Two sheets contained pieces of feces larger than 1 inch square each. Additional dried feces streaks and smears were observed on a bed pad, and on a towel. The sheets were observed to smell strongly of urine and feces. SM 2 was immediately interviewed. SM 2 stated that the strong urine and feces smell was nauseating. SM 2 stated that CNAs (Certified Nursing Assistants) should have washed out the linens that were soiled before taking them to the laundry room. On 8/22/22 at approximately 9:00 AM, an interview was conducted with the Housekeeping Manager (HM). The HM stated that laundry was visibly soiled with fecal matter daily, which included the pink bed pads, sheets, and wash cloths. The HM stated that housekeeping staff did not want to work with loose feces in the laundry because it was a health hazard and was nauseating. The HM stated that Certified Nursing Assistants (CNAs) were supposed to wash out the feces in the hopper in the soiled utility rooms on the floors. The HM stated that some CNAs blamed the agency staff for not cleaning out the laundry. The HM stated that the CNAs should have been trained to clean the solid matter out of the laundry before bagging it and taking it to the laundry personnel. The HM stated that some stains and smells were not able to be removed by the staff, creating a shortage of linens. 22992 2. On 8/24/22, the facility's infection control surveillance documentation was requested. On 8/24/22 at 2:25 PM, Clinical Resource Nurse (CRN) 1 stated that she had been working at the facility as the acting Director of Nursing (DON) a few months prior. CRN 1 stated that she had completed the infection control surveillance through May 2022, but that after the new DON took over, the new DON did not complete any infection control surveillance documentation. CRN 1 stated that there was no infection control surveillance currently occurring at the facility.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 22992 Based on observation and record review, the facility did not provide training to staff that educated staff with regard to activities that that constitute abuse, neglect, exploitation, and misappropriation of resident property; procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property; and dementia management and resident abuse prevention. Findings include: On 8/24/22, facility staff was asked to provide documentation of staff training with regard to abuse, neglect, exploitation, misappropriation of property, procedures for reporting incidents of abuse, and resident abuse prevention. On 8/24/22 at 1:50 PM, an interview was conducted with Clinical Resource Nurse (CRN) 1 and CRN 2. CRN 1 stated that after Immediate Jeopardy in abuse was identified at another facility the company owned, the company wanted abuse trainings to be completed at each facility each month. CRN 1 then stated that the last training she had conducted at this facility regarding abuse was in April 2021. CRN 1 confirmed that Licensed Practical Nurse (LPN) 1 was not present during that training. CRN 1 stated that abuse training was supposed to be provided to staff at least yearly per federal guidelines, but could not find any documentation for abuse or dementia training provided at the facility in the last 12 months. [Cross refer to F600 and F610]