STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185165	A. Building B. Wing	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lyndon Woods Care & Rehab, LLC	1101 Lyndon Lane Louisville, KY 40222

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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43694 Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure residents were treated with dignity and respect for two (2) of ninety-four (94) sampled residents (Residents #14 and #821). Resident #14's toilet was non-functional and had been non-functional frequently for the past year. Resident #821 was observed with a catheter bag hanging from a wheelchair without a dignity bag. The findings include: Review of the facility's policy titled, Resident Rights, dated 02/2021, revealed federal and state laws guaranteed certain basic rights to all residents of the facility. Those rights included a dignified existence, and to be treated with respect, kindness, and dignity. 1. Review of an untitled document revealed it was reported, on 03/08/2022, that the toilet adjacent to Resident #14's room was stopped up and backed up. Further review revealed a handwritten note that stated, Closed 03/12/2022. Interview with Resident #71, on 02/19/2023 at 2:25 PM, who shared the toilet with Resident #14, revealed he/she told staff not to flush the toilet because it would overflow. He/she stated a plumber had snaked it a while ago, but it had been broken for several weeks. Observation, on 02/19/2023 at 2:30 PM, revealed the toilet, between Resident #14's and Resident #71's room, was not flushed and was filled with urine and feces. After a plunger was located and brought to Resident #71's room, the Human Resources (HR) staff member repeatedly plunged and flushed the toilet, but it did not flush enough to allow the toilet bowl to fill with clear water. The HR staff member lifted the lid off the toilet to reveal the toilet tank was not filled with water completely after being flushed. Interview, with the HR staff member, on 02/19/2023 at 3:00 PM, revealed it seemed to her there was not enough water pressure to fill the toilet for it to flush. She stated the toilet was out of order and requested staff put an Out of Order sign on the door of the bathroom between Resident #14's and Resident #71's room. (continued on next page)

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

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F 0550 Level of Harm - Actual harm Residents Affected - Few	Interview, with Family Member #2, on 02/22/2023 at 2:01 PM, revealed her relative's toilet had recently been stopped up and was stopped up sometime last summer. Interview, with Maintenance Technician #1, on 02/20/2023 at 4:14 PM, revealed he began working on the toilet in room [ROOM NUMBER] on this date after he received notification the toilet was broken. He stated he snaked the toiled, then used the shop vacuum, and it was now in working order. Interview, with Resident #14, on 02/21/2023 at 10:10 AM, revealed he/she had lived in his/her current room for about two (2) years. The resident stated that he/she used the toilet, but it had been broken for several months. Resident #14 stated some of the aides had flushed wipes down the toilet, which caused it to get stopped up. He/she stated the only reason the toilet was fixed the previous day was because the State Survey Agency Surveyors were in the building. Resident #14 stated when the toilet was broken, he/she had to use the toilet in the shower room, which made him/her feel like they don't care. Interview, with the Executive Director (ED), on 03/16/2023 at 11:34 AM, revealed the risks for residents associated with a broken toilet could be incontinence and skin breakdown. 2. Review of Resident #821's clinical record face sheet revealed the facility admitted the resident on 12/21/2022 with diagnoses of Unspecified Dementia with Mood Disorders, Retention of Urine, and Malnutrition. Review of the hospital discharge papers, dated 12/21/2022, revealed the resident was sent to the facility with a catheter for long term use. Observation, on 03/04/2023 at 9:18 AM revealed Resident #821 wheeling himself/herself around. Observation revealed a catheter bag attached to the resident's wheelchair without a dignity bag. Interview, with Certified Nurse Aide (CNA) #34, on 03/04/2023 at 9:18 AM, revealed the night aide had put the dignity bags some place and she could not find them. She also stated the resident's catheter bag was broken at the clip and it could not hang like it was supposed to, so staff just hung it on the wheelchair between the resident's legs. Interview with the ED, on 03/16/2023 at 11:00 AM, revealed all people wanted to be treated with respect and dignity. She stated dignity was treating people kind, and it meant being compassionate and treating people the right way. She further stated maybe it was the way people talked to each other or how staff talked to the residents, and if one person thought it was disrespectful, that could impact their dignity. Continued interview revealed some things that show the residents dignity were knocking on the door, pulling their curtain closed, or making sure their catheter was covered with a dignity bag. The resident may not want everyone to know they had a catheter in. She further stated it was the responsibility of the aides to ensure the resident had a dignity cover over the catheter bag, and if a nurse noticed a resident did not have one, they would also be responsible to ensure the resident had one.

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32635 Based on interview, review of the medical records, and review of the facility's admission packet, it was determined the facility failed to assist residents to formulate an Advanced Directive upon admission for three (3) of ninety-four (94) sampled residents, (Residents #32, #90, and #91). The findings include: Review of the facility's admission packet titled, Resident Handbook and Admission Information not dated, revealed information under Health Care Advance Directives to make your wishes known. The Advance Directive was defined as a document written before a disabling illness. The Advance Directive stated it was a resident's choice about treatment and may name someone to make choices if the resident cannot. With Advance Directives, residents could legally decide about their future medical treatment. 1. Review of the medical record revealed the facility admitted Resident #32 on 10/28/2022 with diagnoses including Alcohol Dependence with Alcohol-Induced Persisting Dementia, Diabetes Mellitus Type 2, Anxiety and Major Depression. Review of the Admission Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15) which indicated Resident #32 was severely cognitively impaired. Review of the admission paperwork checklist not dated, revealed there was no check in the area that covered Advance Directive. Interview, with Resident of #32's son, on 02/20/2023 at 5:00 PM, revealed the facility did not speak to him about formulating an Advance Directive. He stated he signed a lot of papers and did not remember anything about formulating an Advanced Directive, or the facility informing him of formulating an Advanced Directive for Resident #32. 2. Record review revealed the facility admitted Resident #90, on 09/14/2022, with diagnoses that included Alzheimer's Disease, Cognitive Communication Deficit, and Anxiety. Review of the Admission MDS, dated [DATE], revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15) which indicated Resident #90 was severely cognitively impaired. Continued review of the medical record revealed no documented evidence of an Advance Directive for Resident #90. Interview, with Resident #90's son, on 02/20/2023 at 5:13 PM, revealed he did not remember the facility asking him about formulating an Advance Directive, upon admission. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Record review revealed the facility admitted Resident #91, on 05/04/2021 with diagnoses which included Dementia with Behavioral Disturbances, Anxiety, Alcohol Dependence, and Mood Disorder. Review of the Admission MDS, dated [DATE], revealed the facility assessed the resident as having a BIMS' score of six (6) of fifteen (15), which indicated Resident #91 was severely cognitively impaired. Review of the medical record revealed no documented evidence of an Advance Directive or Living Will. Interview, with Resident #91's sister/Power of Attorney (POA), on 02/20/2023 at 5:18 PM, revealed she thought Resident #91 had a Living Will prior to admission on 05/04/2021. She stated she was not aware the facility did not have a copy and she did not remember being asked by the facility about the Living Will or Advance Directive. Interview, with Business Officer Manager, on 02/21/2023 at 12:45 PM, revealed the admission personal liaison was responsible for the admission process to assess the residents for admission to the facility. She stated, she was responsible for the financial and questions concerning financial. Further interview revealed that usually, the POA or guardian supplied the paperwork for Advance Directives and Living Will. She stated she thought it was Social Services' responsibility to address code status and to assist residents and the residents' representatives with Living Wills and Advance Directives. Interview, with Social Services #2, on 02/21/2023 at 1:02 PM, revealed the Admissions Director was responsible for the Advance Directives. Interview, with the Admissions Concierge, on 02/23/2023 at 10:20 AM, revealed she was responsible for meeting with the Power of Attorney (POA) or Resident, (if own self) to go over admission paperwork, sign paperwork and provide them with the handbook. Interview, with Interim Director of Nursing (DON), on 02/21/2023 at 1:26 PM and on 02/23/2023 at 10:22 AM, revealed they followed up with the Advance Directive information. She stated the Admissions or Social Services was responsible for the recorded code status in the medical record. Interview, with the Executive Director, on 02/23/2023 at 10:23 AM, revealed they should follow up with the Advance Directive information and the information should be documented. The ED stated the Advance Directive was more than the code status and they should provide further information related to resident care.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14936 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure each resident had a right to a safe, clean, comfortable, and homelike environment for eight (8) of eight (8) residents' sampled rooms. Observation on 05/19/2023 at 9:41 AM, revealed room [ROOM NUMBER], Resident #23's room, revealed bleach wipes and incontinent supplies in the windowsill, drawers removed from the bedside nightstand, papers inside the nightstand frame laying on the floor, papers laying in the floor in front of nightstand, cap noted inside night stand, multiple holes noted in wall, overbed table top lying on floor against wall at end of bed, bed footboard off bed and lying on commode in bathroom, one night stand drawer facing noted laying on commode, large oval mirror in bathtub, call/alarm system in Jevity box in bathtub, bathroom light noted not to work, electrical plug-ins and vents partially pulled out from wall. Additionally, multiple resident rooms were observed to have broken or missing slats in the window blinds, and observations of furniture in residents' rooms were in disrepair (Rooms 110, 127, 140, 226, 239, 240 and 241). The findings include: Review of the facility's policy, Homelike Environment, revised February 2021, revealed staff would provide a safe, clean, and homelike environment that emphasized the residents' comfort, independence, and personal needs and preferences. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflects a personalized, homelike setting to include comfortable and safe temperatures. 1. Observation on 05/19/2023 at 9:41 AM revealed room [ROOM NUMBER] had a bedside nightstand without drawers with papers laying on the floor in front of the nightstand, and papers and a cap in the bottom of the nightstand. Further observation revealed the overbed rolling tabletop laying on the floor against the wall and the heater at the foot of the bed. Continued observation revealed vents and electrical plugs pulled partially out from the wall and a broken electric plug cover. Additional observation revealed incontinence supplies and bleach wipes on the windowsill with the curtain open. Observation revealed holes in the bedroom walls and the baseboard missing. Further observation revealed the bed was not in the locked position and the footboard was missing. Observation of the bathroom of room [ROOM NUMBER] revealed the bathroom light did not work, a call light/alarm system in a Jevity box, and a large oval mirror inside the bathtub with Advanced 350 Ultrasorb in a plastic package laying on the side of the bathtub. Further observation revealed toilet paper, a graduated cylinder, V05 shampoo, soothed cool cleanser, hand sanitizer, and a box of X-Large gloves laying on top of the toilet tank, and the bed footboard and nightstand drawer facing laying on top of the commode lid. Continued observation revealed an X-Large blue plastic gown in a plastic bag laying on the front part of the bathroom sink, and the garbage can under the edge of the sink partially in the bathroom doorway. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Certified Nursing Assistant (CNA) #89, on 05/19/2023 at 10:15 AM, she stated she thought the maintenance issues for room [ROOM NUMBER] had been reported a couple of weeks ago. She stated she was unsure how long the nightstand drawers had been missing. She further stated she had not been in the bathroom. In an interview with Registered Nurse (RN) #19, on 05/19/2023 at 10:20 AM, she stated she had not been in room [ROOM NUMBER] that day. She further stated she would expect staff to supervise the resident's room for unsafe objects as the resident was allowed to his/her belongings in his/her room and staff should maintain a safe environment for the resident. 2. Observation of room [ROOM NUMBER], on 06/01/2023 at 9:57 AM, revealed the wall casing and trim entering the bedroom from the closet entry area had paint and plaster that was scraped away. Additionally, a chest had four (4) drawers that were off-track and hanging out of the chest, and the window blind had one (1) broken slat. 3. Observation of room [ROOM NUMBER], on 06/01/2023 at 10:05 AM, revealed paint and plaster that was scraped away on the walls and window blinds that had five (5) missing or broken slats. 4. Observation of room [ROOM NUMBER], on 06/01/2023 at 10:06 AM, revealed paint and plaster that was scraped away on the walls and window blinds that had four (4) missing or broken slats. 5. Observation of room [ROOM NUMBER], on 06/01/2023 at 10:07 AM, revealed paint and plaster that was scraped away on the walls and window blinds that had four (4) missing or broken slats. 6. Observation of room [ROOM NUMBER], on 06/01/2023 at 10:13 AM, revealed paint and plaster that was scraped away on the walls and window blinds that had one (1) missing or broken slats. 7. Observation of room [ROOM NUMBER], on 06/01/2023 at 10:19 AM, revealed paint and plaster that was scraped away on the walls and window blinds that had eight (8) missing or broken slats. 8. Observation of room [ROOM NUMBER] on 06/02/2023 at 2:00 PM, revealed there was a floor mat next to the bed with about one foot covering the bottom of the nightstand. The mat was ripped in three (3) different places, one was about six (6) inches in length. The nightstand was missing the handle on the first and third drawer but there were studs sticking out in place of the handle. Also, the baseboard was pulled out around the sink. The window blind on the door window was missing four (4) slats. Interview with the Maintenance Director on 06/02/2023 at 3:00 PM, he stated the studs sticking out of the nightstand would be a concern if the resident fell and hit his/her head on them. He also stated the missing baseboard and blind slats did not represent a homelike environment. The Maintenance Director stated he had already disposed of he ripped fall mat. He said it was a trip hazard. In an additional interview, with the Maintenance Director, on 06/01/2023 at 3:45 PM, he stated he started on 05/01/2023 and there was a lot to do within the facility. He stated the Corporation had hired an assistant that started around the middle of May 2023. He said a checklist had been created to begin doing room inspections throughout the entire facility; however, this procedure of going room to room had not started yet. He further stated a lot of touch-up work was needed to make the rooms more homelike, adding, he worked for the residents and this is their home. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 05/19/2023 at 12:55 PM, the Director of Nursing (DON) stated it was her expectation that staff provided would expect the staff to make sure the environment was safe. She continued to state possible outcomes for bleach wipes in the room could have been gastritis, dermatitis, irritation to skin and tissue, nausea, vomiting, mouth pain, coughing, abdominal pain, irritation to the mucous membranes, eye irritation, hypersalivation, drooling, dizziness, and whatever is on the MSDS sheet. She additionally stated the situation could have been avoided by keeping the bleach wipes of the resident's reach and stored properly. During an interview with the Executive Director (ED) and the Senior [NAME] President of Clinical Services (SVPCS), on 06/01/2023 at 4:05 PM, both stated the residents' rooms were not homelike when things were not in good repair. Further, the ED further stated she had seen the missing or broken blinds from the parking lot. They further stated the Maintenance Director had developed a new checklist to help in auditing each of the resident rooms, to determine what might need to be fixed, but they have not started to complete observational rounds using the checklist. In an interview, on 05/19/2023 at 3:45 PM, the [NAME] President (VP) of Maintenance, stated he had not had a work order for room [ROOM NUMBER] since March 2023. He further stated he had a 04/12/2023 signed document that all plug-ins were in good working order at that time. He continued to state he had not had any notifications for maintenance issues in April or May 2023.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 47711 Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure residents were protected from physical abuse, including resident to resident abuse, for thirty (30) of ninety-four (94) sampled residents (Residents #17, #19, #35, #36, #47, #48, #49, #56, #57, #59, #67, #69, #74, #76, #80, #81, #86, #88, #89, #91, #92, #93, #102, #110, #112, #131, #132, #138, #140, and #144) Resident #80 suffered significant injury as a result of abuse. The facility failed to provide adequate supervision to ensure Resident #80 was protected from abuse by Resident #48 on [DATE]. Resident #48, who had a history of physical and verbal abuse towards other residents' Resident #48 punched Resident #80, in the face, on [DATE] at 6:43 PM, causing Resident #80 to fall. Resident #80 was tearful upon assessment stating his/her hip was hurting. There was no documented evidence the facility performed a thorough assessment of Resident #80. Even though the Nurse Practitioner gave an order for an x-ray on [DATE] at 7:42 PM, the facility failed to obtain an x-ray until over twelve (12) hours later. Resident #80 was admitted to the hospital on [DATE] for a fracture to the right femoral neck with lateral displacement requiring surgery. (a). On [DATE], at 6:43 PM, Resident #48 hit Resident #80 in the face causing him/her to fall to the floor. However, an x-ray was not obtained until [DATE] at 8:06 AM. The x-ray results revealed Resident #80 had sustained a fractured right hip, which required surgical intervention to repair the fractured hip. (b). On [DATE], Resident #81 made contact with Resident #80's area, resulting in Resident #80 reaching out and making contact with Resident #81's facial area. (c). On [DATE], Resident #47 and Resident #80 were found on a bed together. Resident #80 was lying on his/her back with his/her knees bent and did not have clothes on from the waist down. Resident #47 was observed fully clothed, on his/her knees at the foot of the bed, with his/her face in Resident #80's crotch area. (d). On [DATE], Resident #81 struck Resident #35 and Resident #47. (e). On [DATE], Resident #138 hit Resident #102 on the arm three (3) times. (f). On [DATE], Resident #131 pushed Resident #86 onto the bed and placed one hand on Resident #86's blouse and the other hand around Resident #86's throat. (g). On [DATE], Resident #80 slapped Resident #76 and Resident #132 in the face. (h). On [DATE], Resident #91 got up and brushed the back of Resident #92. Resident #92 grabbed Resident #91 by the shoulder and punched him/her in the chest. (i). On [DATE], Resident #144 slapped Resident #67 and Resident # 74 on the left side of the face. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	(j). On [DATE], Resident #92 hit Resident #88 in the mouth. (k). On [DATE], Resident #74 hit Resident #57 on the right forearm. (l). On [DATE], Resident #132 struck Resident #101 with a right open hand on the left side of the face. (m). On [DATE], Resident #89 made contact to the left side of Resident #59's cheek with an open hand. (n). On [DATE], Resident #89 made contact to Resident #59's face three (3) times with a closed fist (o). On [DATE], Resident #59 slapped Resident #140 with an open hand to prevent her/him from taking the water cup which resulted in an approximately two (2) inch scratch. (p). On [DATE], Resident #110 became upset because Resident #140 had his/her belongings and hit Resident #140 on the forehead. (q). On [DATE], Resident #35 attempted to take Resident #101's bag. Resident #35 hit Resident #101 with an open hand on the right side of his/her check. Resident #101 returned the hit making Resident #35 stumble and fall. Resident #35 suffered a small contusion to the bridge of the nose and was sent to the emergency room for evaluation and treatment. (r). On [DATE], Resident #144 walked up to Resident # 67 and made physical contact with the left side of Resident #67's face, and while staff were attending to and separating Resident #67 from Resident #144, Resident #144 then turned and made physical contact with Resident #74's left side of the face causing a mark. (s). On [DATE], Resident #74 bit Resident # 57 on the right forearm causing a discolored area (bruise). (t). On [DATE], Resident #36 started to yell at Resident #69 and the two (2) started a verbal altercation. Resident #69 left the room, with his/her fist clinched and approached Resident #36, at which time Resident #69 kicked Resident #36. (u). On [DATE], Resident #56 got in Resident #69's face and talked, pointed, and stepped on the resident's toes. Resident #69 pushed Resident #56 back, hard enough the resident fell to the ground and landed on his/her bottom. (v). On [DATE], Resident #112 ambulated through the common area with his/her walker and used the walker to hit Resident #17. Resident #112 then proceeded to hit Resident #17 in the shoulder. Resident #17 then hit #112 back. (w). On [DATE], Resident #17 and Resident #93 had a physical altercation. First Resident #17 attempted to enter #93's room and was stopped by the previous DON. Then Resident #17 walked up to Resident #93, who was standing in front of the common area television. Resident #17 was upset about that, so he/she grabbed Resident #93 by the back of the jacket and moved the resident out of the way. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	(x). On [DATE], Resident #19 leaned forward in the wheelchair and struck Resident #49 on the left side of his/her face with an open palm. Immediate Jeopardy (IJ) was identified on [DATE] at 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation at the highest S/S of a J, and 42 CFR 483.25 Quality of Care (F684) at the highest S/S of a J and was determined to exist on [DATE] and is ongoing. SQC was identified at 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F600). The facility was notified of the Immediate Jeopardy on [DATE]. The findings include: Review of the facility's policy titled, Freedom from Abuse and Neglect Policy, dated [DATE], revealed the facility defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. It included verbal abuse, sexual abuse, physical abuse, and mental abuse. The policy defined willful, as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The facility's staff would conduct an investigation of any alleged or suspected abuse, neglect, exploitation of residents or misappropriation of property, and would provide notification of information to the proper authorities according to state and federal regulations. Prevention of abuse included staffing levels assessed on a continuing basis. Adjustments to staffing levels were to be based on the census and the individual needs of the residents. 1). Review of Resident #48's Admission Record revealed the facility admitted the resident on [DATE], with diagnoses that included Dementia, Anxiety, Schizoaffective Disorder Bipolar type, and Muscle Weakness. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], revealed the facility assessed Resident #48 with a Brief Interview for Mental Status (BIMS) score of three (3) of fifteen (15), which indicated the resident was severely cognitively impaired. Further review revealed Resident #48 exhibited verbal and physical behaviors towards others including hitting, kicking, pushing, scratching, grabbing, screaming at others, or cursing and wandering. Review of Resident #48's Comprehensive Care Plan (CCP), initiated on [DATE], revealed the resident had been care planned for a Focus of Altered Psychosocial Needs related to schizoaffective disorder, dementia with behavior disturbance, anxiety, and adjustment disorder with depression and history of physical aggression toward staff. The goals included that the resident would be free from psychosocial instability. Interventions included arrange for psych consult as needed, and follow up as indicated, medications as ordered, provide non-pharmacological interventions such as redirect with activities, offer food, fluids, and reassurance and conversation; allow time to comprehend and accept task to be completed by staff initiated on [DATE]; one to one (1:1) staff observation initiated on [DATE]. Review of Resident #48's Nurse Practitioner note, dated [DATE], revealed 1:1 supervision was discontinued due to no further behaviors noted and was considered an isolated incident. Record review revealed Resident #48 had a history of physical and verbal altercations and the resident had been placed on 1:1 supervision, on [DATE] -[DATE]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #48's Progress Note, dated [DATE] at 6:49 PM, revealed Resident #48 had been placed on one on one (1:1) supervision, due to physical contact against another resident. Both residents were separated and 1:1 was initiated. Resident #48 had punched Resident #80 in the face. Review of the Facility Investigation/Initial Report, dated [DATE], revealed CNA #22 reported to LPN #3 that Resident #48 punched Resident #80 in the face and he/she fell to the right side and complained of pain. Review of the Social Service Progress Note, dated [DATE] at 4:15 PM, revealed Resident #48 showed signs of frustration and agitation. Resident #48 was difficult to redirect. Continued review revealed an order was received to send Resident #48 to a Behavioral Health facility for an evaluation and Resident #48 was admitted . Review of Resident #80's CCP, initiated on [DATE], revealed the resident had been care planned for Altered Psychosocial Needs related to Dementia and Anxiety, with a goal to maintain the highest level of independence with safety. Continued review revealed interventions included: administer medications as ordered; monitor for behaviors every shift and document; monitor for side effects of psychotropic medications as ordered; and arrange for psych consult, as needed. Interview, on [DATE] at 2:05 PM, with the Director of Nursing (DON), revealed Resident #48 had been placed on one on one (1:1) monitoring after the incident with Resident #80. She stated, generally residents were put on 1:1 supervision after aggressive incidents. The DON stated she expected residents to be watched and staff to follow the facility's policy related to abuse. Interview, on [DATE] at 1:14 PM with CNA #22, who witnessed the incident, revealed Resident #80 called Resident #48 a name and Resident #48 stood up and punched Resident #80 in the face. She stated Resident #80 fell to the floor on his/her right side. CNA #22 stated she separated Resident #80 and Resident #48 and notified LPN#3. Interview, on [DATE] at 3:45 PM with CNA #9, revealed Resident #80 was walking around the couch and talking in the common area. Resident #80 was overheard calling Resident #48 a bitch. Resident #48 stood up and punched Resident #80 in the face causing Resident #80 to fall. Continued interview with CNA #9 revealed, she and CNA#22 separated Resident #80 and Resident #48 immediately and notified the nurse. CNA #9 stated the incident happened so fast, they could not get there fast enough to separate the residents before Resident #48 hit Resident #80 causing him/her to fall and hit the floor. Interview, on [DATE] at 2:36 PM with LPN #3, revealed she did not witness the incident between Resident #80 and Resident #48, but had been notified by a CNA. LPN #3 stated she assessed Resident #80 after the incident occurred. LPN #3 stated Resident #80 was tearful and stated he/she was hurt. Resident #80 and Resident #48 were separated, and staff initiated enhanced supervision for Resident #48 after the incident occurred. 2. Review of Resident #80's Admission Record revealed the facility admitted the resident on [DATE], with diagnoses that included Dementia, Cognitive Communication Disorder, Insomnia, Muscle weakness, and Osteoarthritis. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #80's Quarterly MDS, dated [DATE], revealed the facility assessed Resident #80 with a BIMS' score of four (4) out of fifteen (15), which indicated the resident was severely cognitively impaired. Review of Resident #80's CCP, initiated on [DATE], revealed the resident had been care planned for Altered Psychosocial Needs related to Dementia and Anxiety, with a goal to maintain the highest level of independence with safety. Continued review revealed interventions that included: administer medications as ordered; monitor for behaviors every shift and document; monitor for side effects of psychotropic medications as ordered; arrange for psych consult, as needed. Further review revealed a Focus of Sexual Behaviors that included: self-pleasure; intimate touching; and expression of sexual interest in others, initiated on [DATE] with goals to include: the resident would not engage in inappropriate sexual behaviors, with an intervention to provide privacy to masturbate. Additional review revealed a Focus of has a history of seeking companionship with other residents, with a goal to include resident would refrain from seeking out companionship with other residents. Interventions included allow resident to express feelings of sexual desires as needed. Review of the facility's Investigation Report, dated [DATE], revealed Resident #80 and Resident #47 were found on a bed together. Resident #80 was lying on his/her back with his/her knees bent and he/she did not have clothes on from the waist down. Continued review revealed Resident #47 was observed fully clothed, on his/her knees, at the foot of the bed, with his/her face in Resident #80's crotch area. Further review revealed Certified Nurse Assistant (CNA) #37 reported Resident #80 was lying in bed with no pants on, with his/her knees bent, and Resident #47 was at the foot of the bed leaning up with his/her head between Resident #80's legs. CNA #37 separated Resident #80 and Resident #47 and notified the nurse. Additional review revealed CNA #37 stated she did not see any specific sexual activities. Review of Resident #80's Social Service Progress Note, dated [DATE] at 10:39 AM, entered by the former Social Service Director (SSD) revealed Resident #80 stated, (Resident #47) helps me out a lot. Last night (Resident #47) helped me change my pajamas. Review of Resident #47's Admission Record revealed the facility admitted the resident on [DATE], with diagnoses that included Alzheimer's Disease, Dementia, and Major Depressive Disorder. Review of Resident #47's Quarterly MDS Assessment, dated [DATE], revealed the facility assessed Resident #47 with a BIMS' score of three (3) out of fifteen (15), which indicated the resident was severely cognitively impaired. Continued review revealed Resident #47 had not exhibited verbal and physical behaviors towards others including hitting, kicking, pushing, scratching, grabbing, screaming at others, or cursing and wandering. Review of Resident #47's CCP, initiated on [DATE], revealed the facility care planned the resident for Sexual Behaviors that included self-pleasure, intimate touching, and sexual expressive behaviors with other residents, with a goal to include the resident would not engage in inappropriate sexual behaviors. Continued review revealed interventions that included provide privacy to masturbate, allow to vent feelings about sexual desires as needed, contact state guardian if resident exhibits any inappropriate sexual behaviors, refer to psych as needed, resident to sleep with a body pillow, staff will continue to redirect resident as needed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #47's Social Service Progress Note, dated [DATE] at 12:21 PM, revealed Resident #47 had been asked about his/her sexual preferences. Resident #47 stated I like men and women, always have. When asked about the resident (Resident #80) he/she was reported to have been expressing sexual behaviors towards, Resident #47 stated, I always help (him/her) out. I helped (him/her) last night. Whatever (he/she) needed help with. I love (him/her). Interview, on [DATE] at 10:07 PM with CNA #37, revealed Resident #80 had a habit of taking his/her clothes off. Per interview, Resident #80 and Resident #47 had been observed in the room together. CNA #37 stated Resident #47 appeared to be between Resident #80's legs. Resident #80 did not have on bottom clothes. Further interview revealed Resident #80 was removed from the situation, and taken to his/her bed, and the nurse was notified. Interview, on [DATE] at 2:38 PM, with the Former Director of Nursing (DON), revealed CNA #37 had notified her of an incident involving Resident #80 and Resident #47. The DON stated CNA #37 reported that Resident #80 and Resident #47 had been observed in bed together, but she could not confirm they were touching each other. Interview revealed Resident #80 and Resident #47 were separated and an investigation was conducted. The former DON stated Resident #80 and Resident #47 were always together and helped each other do things such as get the other one's clothes. 3). Review of the Facility Investigation/Initial Report, dated [DATE], revealed Resident #80 had been observed by staff to make contact to the right side of Resident #132's face with an open hand. Continued review revealed, as staff approached to intervene, Resident #80 made contact to the right side of Resident #76's face with an open hand. Review of Resident #76's Admission Record revealed the facility admitted the resident on [DATE], with diagnoses that included Alzheimer's Disease, Dementia with Behavior Disturbances, Major Depressive Disorder, and Muscle weakness. Review of Resident #76's Quarterly MDS, dated [DATE], revealed the facility assessed Resident #76 with a BIMS score of three (3) of fifteen (15), which indicated the resident was severely cognitively impaired. Review of Resident #76's SSD Note, dated [DATE] at 6:01 PM, revealed Resident #76 had been involved in a physically aggressive incident with Resident #80. Review of Resident #132's Admission Record revealed the facility admitted the resident, on [DATE], with diagnoses that included Dementia, Unknown Psychosis not due to a substance or known Physiological Condition, and Cognitive Communication Deficit. Review of Resident #132's MDS Assessment, dated [DATE], revealed the facility assessed Resident #132 with a BIMS score of ninety-nine (99) which indicated the resident was severely cognitively impaired. Review of Resident #132's SSD Note, dated [DATE] at 5:57 PM, entered by SSD, revealed Resident #132 had been involved in a physically aggressive incident received by Resident #80. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview, on [DATE] at 11:38 AM with CNA #9, revealed Resident #80 was beside Resident #132 and smacked him/her in the face. Continued interview revealed Resident #80 was moved away from Resident #132 and seated next to Resident #76. Resident #80 immediately smacked Resident #76 in the face. CNA #9 further stated, she had another staff member stay with the residents while she went to get the nurse. 4). Review of Resident #81's Admission Record revealed the facility admitted the resident on [DATE] with diagnoses that included Altered Mental Status and Bipolar Disorder, and Acute Kidney Failure. A diagnosis of Cognitive Communication Deficit was added on [DATE]. Review of Resident #81's Quarterly MDS, dated [DATE], revealed the facility assessed the resident as having a BIMS score of eleven (11) of fifteen (15), indicating moderate cognitive impairment. Continued review revealed Resident #81 was noted to have rejection of care one (1) to three (3) days during the seven-day look back period. Review of the Facility Investigation, dated [DATE], revealed Resident #81 made contact with Resident #80's area resulting in Resident #80 reaching out and making contact with Resident #81's face. Continued review revealed there were no witness statements to determine who was present or what occurred. The SSA requested additional information regarding the investigation from the Executive Director (ED) on [DATE], and again on [DATE], but the information was never received. Review of the Facility Investigation, dated [DATE], revealed Resident #81 was observed by a nurse striking Resident #35 on the back. LPN #11 intervened, separating the residents, and placing Resident #81 beside the med cart where LPN #11 was working. Continued review revealed Resident #47 walked towards the med cart, and before LPN #11 could intervene, Resident #81 stood up and struck Resident #47. Continued review revealed no injuries. Resident #81 was sent to the ER and treated for a Urinary Tract Infection (UTI). Interview with Resident #81, on [DATE] at 3:27 PM, revealed Resident #81 did not have any recollection of any altercations with other residents. Resident #81 stated another resident liked to swat at people, but stated that resident had died , and he/she had never been injured. Interview, on [DATE] at 9:23 AM, with the current Social Services Director (SSD), revealed since she had been at the facility ([DATE]) there had not been any resident-to-resident altercations involving Resident #81. She stated it was a surprise to her when she reviewed Resident #81's care plan regarding resident conflicts and behaviors as she had not observed those since she has been employed by the facility. Interview, on [DATE] at 1:48 PM, with the former SSD, revealed Resident #81 used to be located on a memory care unit. She stated her recollection of specific incidents from so long ago was limited, but she described Resident #81 as intrusive into other resident's personal space, describing Resident #81 as going up to others and patting them on the cheek as a way of showing love, which other residents did not always react well to. She further stated, other residents may have reacted to Resident #81's intrusiveness as a threat and just reacted. Continued interview revealed there were a lot of one-on-one (1:1)'s (supervision) on the unit, as a lot of residents had escalated behaviors, which she felt helped with residents requiring supervision. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview, on [DATE] at 1:24 PM, with (former) LPN #11, revealed limited recollection of incidents involving Resident #81. She stated she did recall Resident #81 hitting Resident #35 on [DATE]. The LPN stated Resident #35 was not injured, but was upset at that moment. LPN #11 further stated, Resident #81 would have behaviors, acting out and being bossy towards other residents at times, although physical aggression was rare. Interview with the ED, on [DATE] at 2:40 PM, revealed she was not working at the facility at the time of the reported incidents involving Resident #81, and there had been a lot of changeovers of staff. The ED expressed frustration at not being able to find investigations for incidents. The ED stated her expectation was that residents should be protected from abuse, and the facility should respond to any allegation quickly and investigate them thoroughly. She further stated, a thorough investigation included witness statements, and interviews with both residents and staff, so that anyone reviewing would know what happened, who was involved, and how the facility responded. 5). Review of Resident #92's Admission Record revealed the facility admitted the resident, on [DATE], with diagnoses that included Alzheimer's Disease, Cognitive Communication Deficit, Agitation and Anxiety Disorder. Review of Resident #92's Annual MDS Assessment, dated [DATE], revealed the facility assessed the resident as having a BIMS' score of six (6) out of fifteen (15), indicating severe cognitive impairment. Review of Resident #88's Admission Record revealed the facility admitted the resident, on [DATE], with diagnoses that included Cognitive Communication Deficit, Dementia and Anxiety. Review of Resident #88's Quarterly MDS Assessment, dated [DATE], revealed the facility assessed the resident as having a BIMS' score of three (3) out of fifteen indicating the resident was severely cognitively impaired. Review of the facility's investigation, for [DATE], revealed Resident #88 was sitting in the common area on the sofa and Resident #92 hit Resident #88 in the mouth. The two (2) residents were separated immediately, and the Director of Nursing (DON) was contacted. Resident #88 was assessed and had no injuries. Interview with CNA #6, on [DATE] at 4:49 PM, revealed Resident #92 hit Resident #88, who was sitting down, in the face for no reason. Per interview, she separated the residents and notified the Director of Nursing (DON) and Administrator, who both came to the unit. Interview with Social Services #2 on [DATE] at 8:50 AM, revealed Resident #92 had been hallucinating and thought someone had stolen his/her clothes. She stated Resident #92 thought (he/she) was in (his/her) twenty's and was in a bar fight. Social Services #2 stated she provided information for behavioral health referral for Resident #92 and notified the resident's Partner. Continued interview revealed Social Service #1 followed up with Resident #88 the next day and showed no apparent distress. 6). Review of Resident #91's Admission Record revealed the facility admitted the resident, on [DATE] with diagnoses to include Dementia with Behavioral Disturbance, and Mood Disorder. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #91's Quarterly MDS, dated [DATE], revealed the facility assessed the resident as having a BIMS' score of five (5) out of fifteen (15) indicating the resident was severely cognitively impaired. Review of the Progress Note, dated [DATE] at 3:33 PM, entered by LPN #12, revealed staff had witnessed a resident-to-resident altercation between Resident #91 and Resident #92. Resident #92 was identified as the aggressor. Continued review revealed the residents were separated and placed on 1:1 supervision. Resident #91 was assessed with no injuries noted at the time of the incident. Review of the Facility Investigation dated [DATE], revealed a Resident-to-Resident abuse had occurred between Resident #92 and Resident #91. Both residents were seated in the common area of the unit, when Resident #91 got up and brushed the back of Resident #92. Resident #92 grabbed Resident #91 by the shoulder and punch him/her in the chest. Staff separated the residents and placed Resident #92 on 1:1 supervision. Resident #92 was referred for psychiatric evaluation. Resident #91 was assessed with no injuries. Review of Resident #92's Admission Record revealed the facility admitted the resident, on [DATE], with diagnoses to include Alzheimer's Disease, Cognitive Communication Deficit, Agitation and Anxiety Disorder. Review of Resident #92's Annual MDS Assessment, dated [DATE], revealed the facility assessed the resident as having a BIMS' score of six (6) out of fifteen (15), indicating severe cognitive impairment. Review of Resident #92's Progress Note, dated [DATE] at 3:33 PM, entered by Licensed Practical Nurse #12, revealed staff witnessed resident to resident altercation with Resident #92. Resident #92 was separated from other residents and placed on 1:1 supervision. Resident #91 was assessed with no injuries noted at this time. Interview, with Social Services #2, on [DATE] at 02:49 PM, revealed Resident #92 had a history of combination of dementia and domestic violence. Social Services stated she tried to redirect Resident #92 with leaving the office door open to visit to give a sense of purpose as the resident thinks he/she was an employee. Interview, with Interim DON #2, on [DATE] at 1:37 PM, revealed Resident #92 has had agitation and behaviors. Per interview, the resident appeared to have different triggers with each event. Resident #92 had been placed on 1:1 supervision, and staff had been instructed to redirect the resident and make a referral to Psychiatric services for medication adjustment. Interview with ED, on [DATE] at 3:30 PM, revealed Resident #92 had behaviors and would get agitated. Social Services #2 had been working with the resident and offering to talk with his/her partner more often by phone. Per interview, staff were to try to redirect Resident #92. The ED stated, investigations should include the resident's cognitive status and referrals should be made to psychiatric behavioral services. Resident #92 was placed on 1:1 supervision after his/her behaviors and his/her medications had been changed. The ED further stated Resident #92's behaviors possibly were due to the need for medication adjustments periodically. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	7). Review of Resident #144's Admission Record, dated [DATE], revealed the facility admitted the resident with diagnoses to include dementia, anxiety disorder and urinary tract infection (UTI). Review of Resident #144's Quarterly MDS Assessment, dated [DATE], revealed the facility assessed the resident with the BIMS' score of two (2) out of fifteen (15) indicating the resident was severely cognitively impaired. Review of the CCP, dated [DATE], revealed Resident #144 had a focus for the safety of residing on a secured unit with dementia. The goal was to maintain safety while residing there. Interventions placed on [DATE] were to re-direct as needed. Review of the CCP revealed Resident #144 had a urinary tract infection (UTI) and interventions placed on [DATE], was to monitor for altered mental status and behavioral changes. Review of the Facility's Investigation Report, dated [DATE], revealed Resident #144 had walked up to Resident #67 and made physical contact with the left side of Resident #67's face, with no injury noted. Continued review revealed staff immediately intervened and separated Residents #144 and #67. While attending to and separating Resident #67 from Resident #144, he/she turned and made physical contact with Resident #74's left side of the face causing a mark. Resident #144 was immediately placed on one to one (1:1) supervision and transported to local Emergency Department (ED) for psychiatric evaluation. Review of the Facility Investigation revealed a witness statement given by CNA #10, dated [DATE], time not noted, stated Resident #144 slapped the left side of Resident #67's face. Review of the Facility Investigation revealed a witness statement given by CNA # 10, dated [DATE], no time given, stating Resident #144 threw a walker at Resident #74 and slammed the door shut. Review of a written interview, dated [DATE], for Resident #67 and Resident #74 completed by the Director of the Memory Care/Social Worker Assistant # 2 revealed neither resident was able to recall, and both had severe cognitive impairment. Review of the Hospital emergency room note, dated [DATE], revealed the lab and computerized tomography (CT) of the head was unremarkable. Continued review revealed the resident's behavior was consistent with chronic dementia and acting out was due to confusion. Record review revealed Resident #144 had become combative and uncooperative when attempting the CT scan and was treated with 2.5 milligrams of Haldol intramuscular (IM) to obtain the CT of the head. Review of the Discharge Note from the previous Long-Term Care (LTC) Facility, dated [DATE], revealed 1:1 supervision was being provided due to Resident #144's behaviors of wandering, poor safety awareness and not easily directed due to advanced dementia. 8. Review of Resident #74's Admission Record, dated [DATE], revealed the facility admitted the resident with diagnoses to include dementia with agitation and traumatic brain injury. Review of Resident #74's Annual MDS Assessment, dated [DATE], revealed the facility assessed the resident with a BIMS score of zero (0) out of fifteen (15), indicating the resident was s [TRUNCATED]

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46651 Based on interview, record review, and review of the facility's policy, it was determined the facility failed to protect the residents from misappropriation of property for one (1) of ninety-four (94) sampled residents, Resident #371. Resident #371 had missing belongings which included a family portrait. The findings include: Review of the Missing Item Policy, undated, revealed all reports of resident missing property shall be promptly and thoroughly investigated and documented. When a resident reported a missing item, the facility should report the matter up to the administrator. The administrator shall appoint a staff member to investigate the matter. The investigation shall consist of at least the following: a. A detailed description of missing item(s) and the last time the resident or his/her personal representative reports the item(s) in their possession; b. An interview with the resident who reported the missing item(s); c. An interview with the resident missing the item(s) if not duplicative of step a; d. A review of the resident's personal inventory record to determine if the missing item(s) were recorded on the inventory; e. A search of the general use areas for the missing item; f. A search of the resident's room for the missing item; g. A search of the resident's prior rooms if applicable; h. The staff member assigned to the investigation shall document all interviews and steps taken to find the missing item(s).When/if a resident's missing item(s) were found, they should be returned immediately to the resident if found item(s) match the initial description given by the resident or his/her personal representative. When/if a resident's missing item(s) were found after a resident was discharged , facility staff shall deliver the missing item(s) to the facility administrator. The administrator would place the found item(s) in a bag, if possible, with date, time, and location item was found. The facility would attempt to contact the resident to let them know that their missing item(s) was ready for pickup. Review of Resident #371's medical record revealed the facility admitted the resident on [DATE] with diagnoses of Parkinson's Disease, Neurocognitive disorder with Lewy Bodies, and Essential Hypertension. Review of Resident #371 Admission Minimum Data Assessment (MDS), dated [DATE], revealed he/she required extensive assistance with activities of daily living (ADL). Further review revealed a Brief Interview for Mental Status (BIMS) Assessment on the same date, with a score of 99, indicating his/her cognition was severely impaired. Interview with Family Member (FM) of Resident #371, on [DATE] at 9:02 PM, revealed the family went to the facility after his/her passing to collect Resident #371's belongings. He/she stated they were given clothes not belonging to Resident #371 and staff could find any of Resident #371's belongings. Further interview revealed the family spoke with the administrator and the social worker, regarding the missing items and both were rude and unhelpful. Continued interview with Resident #371's FM revealed they never received the residents belongings, after speaking with Administration. Continued interview revealed the belongings the family were most concerned about, and never received, included a sixteen-inch wide by twenty-inch-tall family portrait, a bag embroidered with the resident's spouse's name and an Air Force blanket. (continued on next page)

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	185165	A. Building B. Wing	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Registered Nurse (RN) #18, on [DATE] at 8:25 PM, revealed she had worked at the facility for a few years. Further interview revealed Resident #371 resided in the memory care unit and the normal process for belongings when brought into the faciltiy was they were tagged/labeled with an indelible marker. She further stated there was supposed to be an inventory of belongings for every resident who was admitted and it should be in the computer, in the admission documents. RN #1 revealed if a resident passed away and their belongings were left at the facility, Social Services would see to it that the resident's belongings were collected and stored. She also stated if the family did not collect belongings, they were usually donated to someone in the facility. Interview with Licensed Practical Nurse (LPN) #31, on [DATE] at 9:10 PM, revealed she no longer worked at the facility but did remember Resident #371. Record review revealed she was working at the time of his/her passing. Further interview revealed she did not remember details of the resident's belongings being collected. She stated the typical process was to call family to report passing, then family would came in to obtain their things. She stated she did not think he/she had a lot of stuff, just some clothes and such. Continued interview revealed the expectation was to complete an inventory of resident belongings, at admission using a paper form. If family brought more things in for the resident, such as clothes or personal items; ideally those would be added to the inventory form. On [DATE] at 11:40 AM, an interview Interim Director of Nursing, revealed they encourage families to label all belongings, and educated that the facility would not be responsible for unlabeled stuff. Additionally, families were educated not to bring valuable belongings into facility. She stated inventory should be done at admission or shortly after and the assumption was that if there was no inventory sheet, the resident came with nothing. Further interview revealed they tried to educate families to use judgement about what residents really needed, such as snacks rather than money for snacks. She stated they generally put belongings waiting for pick up in an office, and encouraged families to come pick up within a day or two. Further interview revealed she was not sure if the family was provided the resident's belongings at the time of passing. In addition, was not able to provide evidence of an inventory form. On [DATE] at 10:41 AM, an interview with Executive Director (ED), revealed her expectation was that Certified Nursing Assistants (CNAs) were to take inventory of resident's belongings during admission. She stated families were encouraged to let staff know if they brought things in after the initial inventory was taken, so the items could be added to the resident's list of belongings. The ED stated going forward when a resident was discharged or deceased , belongings would be packed up and an inventory sheet would go with the family. 44396

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F 0609 Level of Harm - Actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45914 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to report immediately, but no later than two (2) hours allegations of abuse for one (1) out of nineteen (19) sampled residents (Resident #66). Registered Nurse (RN) #11 reported to the Director of Nursing (DON) on 06/22/2023 that she overheard staff state Resident #66 was dragged to the shower, sprayed off, and thrown in his/her bed. Further, she noted the resident had a reddened area to his/her face. Additionally, observations by the State Survey Agency (SSA) surveyor revealed a light brownish discolored area approximately one (1) inch long, and 1/2 inch wide on the resident's left upper arm, which the resident stated occurred during the transfer to the shower. However, the allegations were not reported to the SSA until 06/24/2023, approximately two (2) days after the incident occurred. In an interview with the resident's roommate (Resident #1) he/she stated the resident was crying and kept him/her up all night. The findings include: Review of the facility's policy titled, Freedom from Abuse and Neglect, not dated, revealed abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Further review of the policy revealed willful, as used in this definition of abuse, meant the individual acted deliberately, not that the individual intended to inflict injury or harm. Further review revealed that all allegations of abuse would be 1.) reported to the Executive Director (ED) immediately. 2.) The facility was to report all alleged violations and substantiated incidents to the state agency and to all other agencies as required. Further review revealed the timing of reporting events that caused the suspicion of abuse that resulted in serious bodily injury was to be reported immediately, but not later than two (2) hours after forming the suspicion; and if the event did not result in serious bodily injury, the individual was to report the suspicion not later than twenty-four hours after forming the suspicion. Review of Resident #66's Admission Record revealed the facility admitted the resident on 12/06/2019 with diagnoses to include: Schizoaffective Disorder, Bipolar, Anxiety Disorder, Major Depressive Disorder, Dementia, and Bladder Disorder. Review of Resident #66's Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of thirteen (13), which indicated the resident was cognitively intact. Review of MDS section E titled Behaviors, revealed Resident #66 had no indicators of Psychosis, no exhibited behavioral symptoms directed toward others and no behaviors exhibited not directed toward others. Further review revealed the resident was assessed to reject his/her care one (1) to three (3) days in the past fourteen (14) days. (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's initial investigation dated 06/24/2023 completed by the [NAME] President of Operations (VPO), revealed an allegation of physical abuse was received on 06/24/2023, which alleged that upon providing incontinent care to Resident #66, the resident was transferred with a blanket cradle to the shower room versus traditional shower chair. Continued review of the investigation revealed Certified Nurse Aides (CNAs) #120, #104, #84, and Licensed Practical Nurse (LPN) #37 completed the transfer. A skin assessment had been completed with mild redness noted on the resident's right side of his/her face. Further review revealed that all staff who were involved in the transfer had been suspended pending investigation. Review of the Facility's 5-day investigation, that was incorrectly dated for 07/21/2023 (as this date had not yet occurred) revealed a shower sheet was completed post shower that showed red areas of irritation. In an interview with Certified Nurse Aide (CNA) #104, on 06/28/2023 at 2:35 PM, she stated she completed the shower sheet for Resident #66, the morning of 06/22/2023, and circled all the reddened areas on the resident's trunk which appeared to be scalded, bright red raised areas on his/her thighs, groin, stomach and shoulders. Review of the facility's witness statements attached with the facility's investigation were signed with completion dates of 06/23/2023. Review of the email confirmation provided by the facility revealed the state agency was notified, on 06/24/2023 at 2:38 PM, of alleged physical abuse. In an interview on 06/29/2023 at 10:15 AM, Resident #66 stated the other night two (2) people carried him/her in blankets to the shower room, sat him/her on the floor, then put him/her in the chair. Resident #66 stated his/her arm was hurt when the people did that. During the interview the State Survey Agency (SSA) Surveyor asked Resident #66, if he/she had been hurt when the CNAs transferred him/her to the shower room, and the resident nodded his/her head up and down indicating Yes. Resident #66 then proceeded to show the SSA Surveyor a light brownish discolored area approximately one (1) inch long, 1/2 inch wide on his/her left upper arm. Interview on 06/29/2023 at 10:05 AM with Resident #1, he/she stated the other night his/her roommate (Resident #66) had pissed and shit everywhere. Resident #1 further stated he/she did not want them to take him/her to the shower, so they slid him/her across the floor. Resident #1 stated, I couldn't sleep for them (staff) cleaning and him/her (Resident #66) crying. Interview on 06/28/2023 at 2:35 PM with Certified Nurse Aide (CNA) #104 revealed sometime after midnight on 06/21/2023 (which would have been the morning hours of 06/22/2023), she smelled a urine odor around the C-wing Hall. CNA #104 stated she had looked in on Resident #66 but had not checked to see if the resident needed incontinent care. CNA #104 further stated she did not receive a report from the off-going staff at shift change at 7:00 PM. According to the CNA, Resident #66 would get up around two (2) AM and come out of his/her room holding onto the top of his/her pants/brief. She stated she would assist with changing the resident at that time. Further, CNA #104 stated on the morning of 06/22/2023, Resident #66 did not get up so sometime between 1:00-2:00 AM, she went into Resident #66's room to check on him/her and when she turned on the lights, she immediately saw soaked sheets. She stated the resident was curled in the fetal position, had on a shirt, pants, and a brief, and his/her head was at the foot of his/her bed. (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	Certified Nurse Aide (CNA) #104 stated, on 06/28/2023 at 2:35 PM, Resident #66's brief was swelled up and she/he was wet from head to toe, and the floor was wet. CNA #104 further stated she tried to assist Resident #66 to get up so she could change him/her but Resident #66 kept saying things like I am dead, this isn't real. CNA #104 stated she went to Licensed Practical Nurse (LPN) #37, CNA #120, and CNA #84 and asked for assistance. She stated she and CNA #120 could not encourage Resident #66 to go to the shower. CNA#104 stated they wanted to get Resident #66 into a wheelchair, but the Resident stayed curled in a fetal position. CNA #104 further stated she, along with, CNA #120, and CNA #84 tried coaxing, tried promising him/her a soft drink and could not get him/her to get up. CNA #104 stated she tried to assist Resident #66 to get up and Resident #66 tried to kick at them, and the Resident kept saying things like If I put my feet on the floor I will die, I am dead, this isn't real. After numerous attempts to get Resident #66 cleaned up, she stated they decided to carry Resident #66 in his/her blankets to the shower room. During the interview, the CNA stated she and CNA #120 picked the resident up in the blankets and carried him/her to the shower room which was approximately forty (40) feet from Resident #66's room. CNA #104 stated they carried the resident to the shower room and sat the resident on the floor on his/her bottom. She stated staff got on each side of the resident and lifted him/her to the shower chair and completed the resident's shower. During an interview on 06/28/2023 at 1:21 PM with Certified Nurse Aide (CNA) #120, she stated she assisted CNA #104 with carrying Resident #66 into the shower in a blanket cradle, in the early morning hours of 06/22/2023. She stated Resident #66 refused to get out of bed to be cleaned. CNA #120 further stated she felt that was the safest way they could transport the resident due to him/her kicking at them and refusing to stand. CNA #120 stated that while she and CNA #104 transported Resident #66 to the shower, CNA #84 was mopping and cleaning the resident's room. CNA #120 stated there was urine on the floor, under the bed, in the bed, dripping from the mattress, and Resident #66 was completely saturated. She further stated the Resident was stating I can't touch the floor, I will die. The CNA #84 stated there was so much urine on the floor, they were afraid of being shocked as the bed was plugged into the electrical outlet. CNA #120 stated she did not see an extra wheelchair anywhere and the extra ones were locked in the Therapy Department at night. She stated she did not feel Resident #66 had been abused and transferring the resident by a blanket cradle was the only choice they had at the time. CNA #120 stated the [NAME] President of Operations (VPO) contacted her by phone on Thursday night, 06/22/2023, on the next shift she worked, and questioned her about the incident. She further stated the VPO contacted her again by phone on Friday, on 06/23/2023 at 8:56 PM, and she was notified that she had been suspended. (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	Interview on 06/29/2023 at 8:21 AM, with Certified Nurse Aide (CNA) #84, she stated when CNA #120, and CNA #104 went into Resident #66's room, he/she was curled in a fetal position and would not get out of bed. CNA #84 stated Resident #66 was saturated in urine, including his/her clothes and shoes. CNA #84 stated, I was shocked when I saw the room. CNA #84 stated she was instructed by CNA #104 to go get another CNA on the other hall to assist and by the time CNA #84 got back to Resident #66's room, CNA #120 and CNA #104 had already had Resident #66 in a blanket, and they were carrying him/her out of the resident's room to the shower room. CNA #84 stated Resident #66 was not resisting or fighting but was stating, I am not alive, I am dead. CNA #84 stated she went into the shower room with them and assisted with getting Resident #66 into the shower chair and added, it was difficult to maneuver the resident into the shower chair. CNA #84 stated that she then went to Resident #66's room and began cleaning the room. She stated there was urine everywhere, and that urine appeared to be coming from inside of the mattress. She stated the urine under the bed was brown in color and the odor reeked, and there were gnats in the room. CNA #84 further stated that when she took the mattress out of the room there was a wet trail down the hall, and she also had to mop that area. CNA #84 stated, no matter anyone's mental capacity, they should stay clean, and the resident needed out of that room. CNA #84 stated it would have been negligent if the staff had left Resident #66 in the condition, he/she was found in and therefore was not abuse. During an interview with Licensed Practical Nurse (LPN) #37, on 06/27/2023 at 5:12 PM, she stated she had assisted CNA #120, CNA #104, and CNA #84 with Resident #66. LPN #37 stated that Resident #66 was refusing to shower and was saying, I would rather die than shower. The LPN stated Resident #66 refused to shower and attempted to kick and fight with them. Per the interview, LPN #37 stated CNA #120 and CNA #104 carried Resident #66 in a blanket to the shower room, adding, they did not drag him/her. Further, LPN #37 stated she held the door open as CNA #104 and CNA #120 brought the resident to the shower room. In an interview on 06/29/2023 at 9:51 AM with Registered Nurse (RN) #11, she stated that on 06/22/2023 around 6:50 PM, she overheard CNAs (unknown) discussing Resident #66 being dragged to the shower room, sprayed off, then thrown into bed by staff. RN #11 stated she immediately contacted the Director of Nursing (DON) and made her aware. She stated she was instructed by the DON to complete a head-to-toe assessment of Resident #66 and to report her findings to the DON. RN #11 further stated that the only area she noted was a reddened area to the resident's face. Further, she stated Resident #66's roommate (Resident #1) and Resident #66 both corroborated the same scenario that Resident #66 was dragged. RN #11 further stated that Resident #1 stated that Resident #66 kept him/her up all night crying. Interview on 06/28/2023 at 4:00 PM, with the Director of Nursing (DON), she stated she was contacted by RN #11 on 06/22/2023 with the report of overhearing CNAs talking about a resident being dragged to the shower. The DON stated she instructed RN #11 to complete a skin assessment on Resident #66. She stated RN #11contacted her after the skin assessment and reported only a small, reddened area on the side of Resident #66's face. She further stated that although this was not the conventional way to transport residents, she felt this was the safest way staff could transfer the resident to the shower. The DON stated that the staff should have reached out to the nurse or thought the incident out further. She further stated that she did not feel this was deficient practice but taking everything into consideration she felt staff did the best they could at the time. The DON stated she was more bothered that the resident and his/her bed were wet. (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	In an interview with the Executive Director, on 06/28/2023 at 11:28 AM, she stated she was unaware of the alleged allegations of abuse until she was notified on 06/23/2023. Per the interview, the Executive Director stated she was on vacation at the time the incident occurred. In an interview on 06/29/2023 at 10:40 AM with the [NAME] President of Operations (VPO), he stated he had been contacted on the evening of 06/22/2023 around 7:00-7:30 PM by the [NAME] President of Clinical Services (VPCO), who had just been notified by the DON. Per the interview, he stated that at that time the incident was presented, it was communicated as one staff overhearing a conversation between two other staff. The VPO stated he interviewed Resident #66 on 06/23/2023 and the resident had no recollection of the shower incident. The VPO stated he emailed the State Survey Agency (SSA) on 06/24/2023, to report the allegations of alleged abuse. He further stated that his delay in reporting was because the allegation was reported to him as hearsay. However, review of the facility's policy revealed, the timing of reporting events that caused the suspicion of abuse was to be reported immediately, but no later than two (2) hours after forming the suspicion.

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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. 28707 Based on interview and record review, it was determined the facility failed to have evidence of investigations to ensure they were thoroughly investigated for five (5) of ninety-four (94) sampled residents (Residents #67, #74, #81, #122, and #144) The findings include: Review of the facility policy Freedom From Abuse and Neglect Policy, dated 10/30/19, revealed the facility was responsible for conducting an investigation of any alleged or suspected abuse, and the Executive Director was responsible for oversight. The policy stated the facility was responsible for conducting a thorough investigation of all alleged violations and taking appropriate actions, which included interviews and/or written statements from individuals with first-hand knowledge of the incident. 1. Record review revealed the facility admitted Resident #81 on 01/22/2020, with diagnoses to include Altered Mental Status and Bipolar Disorder, and Acute Kidney Failure. A diagnoses of Cognitive Communication Deficit was added on 06/23/2021. Review of Resident #81's, Quarterly Minimum Data Assessment conducted on 09/10/2021, revealed the resident scored an eleven (11) of fifteen (15) on a Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. Review of facility Investigation report dated, 10/31/2021, revealed on 10/28/2021, Resident #81 was observed holding Resident #122's face for an unknown reason, prompting Resident #122 to lightly swat at Resident #81's face with his/her fingers. The Investigation report revealed neither resident could recall incident, and no residents were injured. Requests for facility documentation of this investigation were made to the Executive Director twice on 02/20/2023, and once again on 02/23/2023, but no information was provided. Review of Facility Investigation report, dated 11/16/2021, revealed minimal information regarding the specifics of what occurred on an 11/11/2021, only that Resident #81 made contact with Resident #80's area, resulting in Resident #80 reaching out and making contact with Resident #81's facial area. The report revealed there were no injuries. Continued review of investigation report revealed, although other residents were assessed or interviewed as appropriate, there were no witness statements to determine who was present or what actually occurred. This information was requested of the Executive Director (ED) on 02/21/2023, and again on 02/23/2023, but was never received. Interview with the Executive Director (ED), on 03/12/2023 at 2:40 PM, revealed she was not working at the facility at the time of facility reported incidents, involving Resident #81, and there had been a lot of changeover of staff. She expressed frustration at not being able to find investigations reports for the incidents. She stated her expectation was that residents would be protected from abuse, and the facility responded to any allegation quickly and investigated them thoroughly. She stated a thorough investigation included witness statements, and interviews with both residents and staff, so that anyone reviewing knew what happened, who was involved, and how the facility responded. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of the Facility Reportable Incident form, dated 12/10/2022, which involved Resident #67 having a bruise to right brow bone, indicated skin assessments and staff interviews were performed. however these documents were not provided to the surveyor upon request. 3. Record review of the Facility Reportable Incident form, dated 10/12/2022, regarding Resident #144 slapping Resident #67 and #74, revealed Resident #144 was placed on 1:1 supervision. Request for the facility's investigation information revealed the facility was unable to produce all documents pertaining to the investigation, which included evidence of 1:1 supervision. Interview with Executive Director (ED), on 03/14/2023 at 3:15 PM, revealed she was ultimately responsible for investigations of allegations and was unable to locate all of the documentation pertaining to some of the investigations, but would keep looking. She also revealed she had started a new process of placing allegations in binders for easy access since coming to facility. 47662 45990

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46651 Based on observation, interview, and record review, it was determined the facility failed to obtain physician's orders, at the time of admission, for the resident's immediate care for one (1) of ninety-four (94) sampled residents (Resident #70). Resident #70 was observed to be wearing oxygen (O2); however, there was no documented evidence of a Physician's Order for O2 in the resident's record. The findings include: Record review revealed the facility admitted Resident #70 on 03/22/2021, with diagnoses that included muscle weakness, unsteadiness on feet, cognitive communication deficit, unspecified symbolic dysfunctions, type 2 diabetes, essential primary hypertension, heart disease, chronic kidney disease, hypothyroidism, anemia, bradycardia and anxiety. Review of Resident #70's Quarterly Minimum Data Set Assessment (MDS), dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was thirteen (13) out of fifteen (15). This score indicated the resident was cognitively intact. Review of Resident #70's Comprehensive Care Plan (CCP), dated 11/18/2022, revealed the facility care planned the resident for oxygen use. Observation on, 02/14/2023 at 9:00 AM, revealed Resident #70 was wearing oxygen via nasal cannula. Further observation revealed Resident #70 oxygen was being delivered at two (2) liters. Observations from 02/14/2023 through 03/16/2023, revealed Resident #70 was wearing oxygen daily and at all times. Interview, on 02/15/2023 at 4:00 PM with Resident #70 revealed he/she used oxygen all the time for his/her Chronic Obstructive Pulmonary Disease (COPD). Record review revealed the facility discharged the resident to the hospital, on 01/13/2023, and readmitted the resident on 01/18/2023. However, the re-admission Physician's Orders revealed no order to continue O2 or monitoring. Review of Resident #70's Physician's Orders, dated 01/18/2023 to 03/16/2023, revealed no active order for Oxygen. Interview, on 03/16/2023 at 2:00 PM, with Registered Nurse (RN) #4, revealed the Unit Manager was responsible for transcribing admission/re-admission orders for a resident entering the facility. RN #4 stated sometimes she did her own because she liked to know first hand what was happening with her residents. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lyndon Woods Care & Rehab, LLC	1101 Lyndon Lane Louisville, KY 40222

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview, on 03/16/2023 at 2:15 PM, with Licensed Practical Nurse (LPN) #1, revealed the Unit Manager was responsible for transcribing admission/re-admission orders for a resident entering the facility, but if the UM was not there then the nurse receiving the resident should put the orders in. Interview, on 03/16/2023 at 2:28 PM, with Unit Manager #3 revealed it was the responsibility of the receiving floor nurse to make sure orders for a new admission or a returning resident were in the computer, but she tried to help when she could. She stated as the Unit manager, she did weekly audits to ensure residents that had entered or returned to the facility in the previous week, had orders that were correct in the computer. Interview, on 03/16/2023 at 4:00 PM, with the Interim director of Nursing (IDON), revealed admission or readmission orders should be entered into the computer by the Unit Manager or the receiving nurse for that resident. She stated it was her expectation residents receiving oxygen would have orders transcribed timely and accurately.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32635 Based on interview and record review, it was determined the facility failed to update the Minimum Data Set (MDS) for one (1) of ninety-four (94) sampled residents, Resident #106. Review of the Admission MDS, dated [DATE], the Quarterly MDS, dated [DATE], and the Quarterly MDS, dated [DATE], revealed no documented evidence Resident #106 utilized the assistance of a wheelchair. The findings include: Review of the medical record revealed the facility admitted Resident #106 on 08/26/2022 and readmitted on [DATE] with diagnoses of Alzheimer's Disease, Difficulty with walking, Unsteadiness of feet, and history of repeated falls. Review of the Admission MDS dated [DATE], the facility assessed the resident with a Brief Interview of Mental Status (BIMS) score of ninety-nine (99) as severely cognitively impaired. Continued review of the medical record revealed the Admission MDS dated [DATE], Quarterly MDS dated [DATE], and the Quarterly MDS dated [DATE], documented in Section G, Resident #106 was ambulatory and did not identify resident's use of a wheelchair. Interview with Licensed Practical Nurse (LPN) #3, on 03/04/2023 at 10:35 AM, revealed Resident #106 was admitted to East unit then moved to [NAME] memory care unit. Resident #106 used a wheelchair and ambulation was unsteady. Interview with Speech Therapist #2, on 03/07/2023 at 1:15 PM, revealed Resident #106 had cognitive and memory deficits and used a wheelchair for mobility. Interview with Occupational Therapist #1, on 03/07/2023 at 1:24 PM, revealed Resident #106 had cognitive deficits and needed maximum assistance for lower body and utilized a wheelchair for mobility. Interview with LPN #24 on 03/10/2023 at 2:40 PM, revealed she remembered Resident #106 and stated the resident utilized a wheelchair, not a walker for assistance with mobility. Interview with float Registered Nurse (RN) Minimum Data Set (MDS) Coordinator #2, on 03/14/23 at 9:21 AM, revealed information gathered for MDS Assessments, came from review of staff notes and therapy notes as well as observations of the resident. The MDS Coordinator stated the facility did not identify Resident #106, as using a wheelchair and only documented as ambulatory. Interview with Interim Director of Nursing (IDON), on 03/15/2023 at 1:45 PM, revealed the MDS Coordinator was responsible for updating and checking for accuracy of the MDS. Interview with Executive Director (ED), on 03/15/2023 at 3:30 PM, revealed the MDS should be accurate to the resident in order for the faciclity to develop a person-centered care plan for each resident.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44974 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to develop and implement a comprehensive person-centered care plan for each resident, which included measurable objectives and timeframe's to meet a resident's medical, nursing, and mental, and psychosocial needs that were identified in the comprehensive assessment for fourteen (14) of ninety-two (92) sampled residents. (Residents #5, #17, #32, #56, #61, #73, #74, #89, #93, #97, #112, #138, #271, and #821). The facility assessed Resident #138 as a fall risk, however, did not implement care plan interventions which resulted in Resident #138 sustaining multiple falls. The resident fell on [DATE], requiring sutures to his/her head. Resident #138 had two (2) more falls that resulted in trauma to the same sutured area. Resident #138 had additional falls and was hospitalized from [DATE] through [DATE], with bilateral subdural hematomas. In addition, the resident experienced two (2) additional falls after returning to the facility. Resident #138 expired on [DATE]. Review of Resident #93's Quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed the facility identified the resident had wandering behaviors. However, the facility failed to develop an elopement care plan, and on [DATE], the resident eloped (left the facility, unsupervised, and without staff awareness). Review of Resident #89's wound care notes revealed on [DATE], the resident developed a stage three (3) pressure wound on the sacrum while in the facility. On [DATE] the sacrum wound deteriorated to a stage four (4). From [DATE] to [DATE] recommendations from the Wound Care Physician were to the turn the resident from side to side and front to back in bed every one (1) to two (2) hours. However, review of the medical record revealed the resident was not turned for 17 days. In addition, surveyor observation revealed resident was not turned as ordered, and interview with the certified nursing assistant revealed she had only turned the resident two times during her twelve hour shift. The facility's failure to have an effective system in place for developing and implementing Comprehensive Care Plans (CCPs) that were person centered, and based on assessments for elopement risk and root cause analysis of falls, in order to prevent further falls with injury, has caused or is likely to cause serious harm, serious impairment, or death of other residents. The facility assessed forty-five (45) residents as at risk for falls. the census was 120 at the time of the survey. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Immediate Jeopardy (IJ) was identified on [DATE] at 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F656), at the highest scope and severity (S/S) of a J; and 42 CFR 483.25 Quality of Care (F689), at the highest S/S of a J, which was determined to exist on [DATE] and is ongoing. The facility was notified of the Immediate Jeopardy on [DATE]. Additionally, IJ was identified on [DATE] at 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F656), at the highest scope and severity (S/S) of an L; and 42 CFR 483.25 Quality of Care (F689), at the highest S/S of a K and was determined to exist on [DATE] and is ongoing. The facility was notified of the Immediate Jeopardy on [DATE]. Additionally, IJ was identified on [DATE] at 42 CFR 483.25 Quality of Care (F689), at the highest S/S of an L and was determined to exist on [DATE] and is ongoing. The facility was notified of the Immediate Jeopardy on [DATE]. In addition, IJ was identified on [DATE] at 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F600) at the highest S/S of a K, and 42 CFR 483.25 Quality of Care (F684) at the highest S/S of a J and was determined to exist on [DATE] and is ongoing. The facility was notified of the Immediate Jeopardy on [DATE]. Additionally, IJ was identified on [DATE] at 42 CFR 483.35 Nursing Services (F725) at the highest S/S of a L and was determined to exist on [DATE] and is ongoing. In addition, IJ was identified on [DATE] at 42 CFR 483.25 Quality of Care/Prevention of Pressure Sores (F686) at the highest S/S of a J and was determined to exist on [DATE] and is ongoing. The facility was notified of the Immediate Jeopardy on [DATE]. In addition, Substandard Quality of Care (SQC) was identified at 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F600); 42 CFR 483.25 Quality of Care (F684); 42 CFR 483.25 Quality of Care/Prevention of Pressure Sores (F686); and 42 CFR 483.25, Free of Accident Hazards/Supervision/Devices (F689). The findings include: Review of the facility's Comprehensive Care Plan (CCP) Policy, dated [DATE], revealed its purpose was to ensure that the resident or resident representative was included in all aspects of person-centered care planning and that planning included the provision of services that enabled the resident to live with dignity and supported the resident's goals, choices, and preferences including, but was not limited to, goals related to the their daily routines and goals to potentially return to a community setting. Continued review revealed the Care Planning/Interdisciplinary Team (IDT) reviewed and updated care plans when there was a significant change in the resident's condition; when the desired outcome was not met; when the resident had been readmitted to the facility from a hospital stay; and at least quarterly. 1. Record review revealed the facility admitted Resident #138's on [DATE], with diagnoses of Dementia without Behavioral Disturbance, Paranoid Schizophrenia, and Obsessive-Compulsive Behavior. Continued review of revealed Resident #138 sustained twelve (12) falls from [DATE]-[DATE] with a fall on [DATE] which resulted in bilateral Sub-[NAME] Hematomas. Review of Resident #138's Admission Minimum Data Set (MDS) Assessment, dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of nine (9) out of fifteen (15), which indicated moderate cognitive impairment. Continued review revealed the resident required extensive assistance with Activities of Daily Living (ADL's) and required two (2) person physical assist with transfers. Further review revealed the resident had verbal behaviors directed towards others and other behavior symptoms not directed towards others. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #138's fall risk evaluation dated [DATE] revealed a score of fourteen (14) which indicated the resident was a high risk for falls. Continued review revealed the resident's level of consciousness/mental state was disoriented at all times. The resident was chair bound, and had balance problems with standing and walking. Review of Resident #138's Comprehensive Care Plan (CCP), initiated on [DATE], revealed the resident was at risk for falls related to a history of falls, weakness, current medications/potential side effects, and diminished safety awareness. Interventions included offer assistance to the bathroom as needed, offer/assistance to common areas when resident appeared restless in his/her room, offer reassurance the supra- pubic catheter functioned properly, and keep frequently used items within reach. Review of Resident #138's Falls Comprehensive Care Plan (CCP), dated [DATE], revealed interventions such as educate the resident to lock the brakes on the wheelchair, encourage the resident to ask for help before transfers, and assist the resident with ambulation when he/she allowed. Review of Progress Notes revealed the nursing staff documented the interventions were not working as the resident did not understand them. Review of the facility's Fall Risk Investigation Reports, dated [DATE], [DATE], [DATE], [DATE] (2 falls), [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE], revealed Resident #138 had confusion, memory impairment, and poor safety awareness Review of Resident #138's Closed Medical Record, revealed the resident had sustained a fall, on [DATE], resulting in a laceration to forehead that required sutures. Review of the CCP updated on [DATE], revealed offer one to one conversation or diversions when restlessness was noted, offer snacks, offer tactile cat, and therapy to review positioning in wheelchair to determine if wheelchair modifications were needed. Review of the CCP, updated on [DATE], revealed psych services for medication review. Review of the CCP, updated on [DATE], revealed lay resident down after meals, and place a Dycem to wheelchair for positioning and safety. Record review revealed on [DATE], Resident #138 fell and hit his/her head in the already sutured area from the prior fall on [DATE]. The fall resulted in a hospital stay with diagnoses that included: Multi-focal Bilateral Subdural Hematoma's and Intraventricular hemorrhage. 2. Review of the face sheet in Resident #93's clinical record, revealed the facility admitted the resident on [DATE] with diagnoses of Paranoid Schizophrenia, Hallucinations and Dysphagia. Review of Resident #93's Quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed the facility assessed the resident as having a Brief Interview Mental Status (BIMS) score of twelve (12) out of fifteen (15) indicating he/she was cognitively intact. Further review revealed the resident had episodes of wandering one (1) to three (3) times that week. Resident #93 was also noted to be delusional, had physical and verbal behaviors to others for one (1) to three (3) days, and behaviors directed to self for one (1) to three (3) days. Review of the hospital discharge paperwork, dated [DATE], revealed the resident was found sleeping on the side of the interstate and was taken to the emergency room (ER). (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #93's Guardianship papers revealed the resident had a State Appointed Guardian and did not have the ability to make decisions on his/her own pertaining to leaving the hospital at will. Continued review revealed the facility scanned the discharge documents into their electronic records system on [DATE]. However, the facility failed to identify the resident was at risk for elopement, therefore an Elopement Risk Care Plan was not developed. Review, Resident of #93's Elopement Risk Assessments, dated [DATE], [DATE], [DATE], and [DATE], revealed the facility did not identify Resident #93 was at risk for elopement. Review of the facility's investigation into the elopement, dated [DATE] and signed by the Executive Director (ED), revealed Resident #93 had not asked permission to sign out; however the resident had a State Guardian and was unable to sign himself/herself out of a healthcare setting. Further, Resident 93's care plan did not indicate the resident could not sign himself/herself out of the facility. In addition, Resident #93 was care planned for the Medical Director (MD) to consult with the pharmacy to consider dosage reduction when clinically appropriate, at least quarterly. The facility did not provide the necessary documentation to show Resident #93's medications were reviewed monthly, for the months of , d+[DATE] and ,d+[DATE]. 3. Observation on [DATE] at 4:00 PM, of Resident #89's wound care by Wound Doctor of Osteopathic Medicine (DOM), revealed the resident had a stage three (3) pressure wound on the right lower medial shin, a left knee stage three (3) pressure wound, and a stage four (4) pressure wound on the sacrum. The DOM used a scalpel to remove a small piece of necrotic tissue, no pain behaviors were present. The State Survey Agency (SSA) Surveyor observed a scar on the right buttock. The DOM sprayed a numbing solution on the area and used a [NAME] to remove necrotic tissue from the wound. The resident did not exhibit any signs of pain. Observation on [DATE] from 9:10 AM to 10:55 AM, revealed the resident laid on his/her right side for two (2) hours and forty-five (45) minutes. Also, Resident #89 was observed on his/her back from 12:10 PM to 3:50 PM for an additional total of three (3) hours and forty (40) minutes. Observation on [DATE] from 9:00 AM to 3:00 PM, revealed Resident #89 remained on his/her back the entire time. Record review revealed the facility admitted Resident #89's on [DATE] with diagnoses of schizophrenia, personal history of traumatic brain injury, and dementia. The Resident was ambulatory on admission. The admission skin assessment revealed Resident #89 was free of skin lesions. Review of Resident #89's hospital discharge summary, dated [DATE], revealed Resident #89's condition declined, and she/he was admitted to the hospital from [DATE] to [DATE]. The resident's condition further declined and he/she was again admitted to the hospital from [DATE] to [DATE]. The resident returned with a Percutaneous Endoscopic Gastrostomy (PEG) tube inserted. Further, Resident #89 returned with two (2) pressure ulcers, a stage 2 pressure wound on the left medial thigh and a stage three (3) pressure wound on the right buttock. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #89's wound care notes revealed on [DATE] the resident developed a stage three (3) pressure wound on the sacrum while in the facility. The thigh and right buttock wounds were documented as healed on [DATE]. On [DATE] the sacrum wound deteriorated to a stage four (4). From [DATE] to [DATE] recommendations from the Wound Care Physician were to the turn the resident from side to side and front to back in bed every one (1) to two (2) hours, if able. Review of Resident #89's CCP revised on [DATE] did not include interventions to off-load the wound and turn every two (2) hours. Review of the resident's treatment record revealed there was no documentation that the resident was turned and repositioned at least every two (2) hours until [DATE]. Review of the Treatment Administration Record (TAR) revealed the resident was not turned every two (2) hours on seventeen (17) of the nineteen (19) days in November of 2022 to include [DATE]; [DATE]; [DATE]; [DATE]; [DATE]; [DATE];[DATE]; [DATE]; [DATE]; [DATE]; [DATE] ;[DATE]; [DATE]; [DATE]; [DATE]; [DATE]; and [DATE]. On [DATE] at 3:33 PM, during interview with CNA #42, reevaled she did not have time to look at the care plan and was not aware the resident required turning every two hours. She said she turned Resident #89 twice this twelve (12) hour shift. Interview with the MDS Coordinator, on [DATE] at 5:40 PM, revealed she did not think the care plans needed to be more specific about prevention of pressure ulcers. 4. Review of the admission record for Resident #73 revealed the facility admitted the resident on [DATE] with diagnoses Alzheimer's Disease late onset, Muscle Weakness, Difficulty walking, and Cognitive Communication Deficit. Review of the Admission MDS Assessment, dated [DATE], revealed the resident was a one (1) person physical assist for bed mobility, transfers, and locomotion on and off the unit. The resident required supervision and one-person physical assist for ambulation. The facility assessed the resident to have BIMS score of nine (9) out of a possible fifteen (15) indicating the resident was moderately cognitively impaired. Review a progress note in Resident #73's clinical record revealed the resident sustained two (2) falls from [DATE] to [DATE]. Resident #73 fell while walking with a walker which resulted in chipping both front teeth and a lip laceration. Review of Resident #73's Comprehensive Care Plan (CCP), dated [DATE], revealed the resident ambulated with a walker and needed the assistance of staff. Record review revealed the resident was using a walker without the assistance of staff when the fall occurred. Review of the facility's Fall Risk Evaluation, dated [DATE] and [DATE], revealed Resident #73 was assessed as at high risk for falls. Review of Resident #73's Comprehensive Care Plan (CCP) revealed a focus for falls initiated on [DATE], which included diminished safety awareness with a goal the resident would not experience significant injury from a fall. Interventions included keeping the call device within reach, keeping frequently used items within reach, and completing a fall risk assessment upon admission and at least quarterly, ensuring appropriate footwear when out of bed, referring resident to Physical Therapy (PT) as needed, and to educating and reminding the resident of safety awareness such as locking brakes on wheelchair, asking for assistance before transferring and using the call light. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] Resident #73's CCP was updated to include interventions for activities of interest, redirection provided as needed, and to be supervised while on the secure unit. On [DATE], Resident #73's CCP was updated to include interventions to assist with ambulation when he/she appeared restless. On [DATE] the facility updated Resident #73's CCP, so the resident would use the walker to ambulate, and for safety staff was to assist the resident. It was noted Resident #73 often ambulated without assistance related to cognitive impairment. Review of Progress Note, dated [DATE] at 9:03 PM, entered by Licensed Practical Nurse (LPN) #23, revealed the resident was found sitting on the floor in the dayroom eating a snack. No injuries were noted after being assessed, Vital Signs were stable, and respirations were even/unlabored. The Resident was assisted to a chair in the dayroom while he/she finished his/her snack. Review of a Progress Note, dated [DATE] at 6:23 PM, revealed Resident #73 ambulated with his/her walker down to the dining room when he/she tripped and fell . The resident chipped his/her two (2) front teeth and had a laceration to bottom lip. 5. Record review revealed the facility admitted Resident #5's on [DATE] with diagnoses of dementia, difficulty walking, and muscle weakness. Review of Resident #5's Quarterly Minimum Data Set Assessment, dated [DATE], revealed the facility was unable to obtain a Brief Interview for Mental Status (BIMS) assessment and scored the resident at zero, which indicated he/she suffered from severe cognitive impairment. Resident #5 was assessed on [DATE], [DATE] and [DATE] for a one person assist when walking. Review of facility provided document, titled Incidents by Incident Type, dated [DATE], revealed Resident #5 had eleven (11) falls from [DATE] through [DATE]. Observation of Resident #5, on [DATE] at 9:35 AM, and again on [DATE] at 5:40 PM, revealed the resident was in bed, but the facility failed to place padding to the left side of the resident's wall, and staff had not placed the fall mat next to the bed, as directed by the plan of care. Observations made from [DATE] through [DATE], revealed Resident #5 was observed self-propelling down the hallway in his/her wheelchair. The resident was not accompanied nor supervised by staff. Observation of Resident #5, on [DATE] at 10:00 AM, revealed the resident was in the common area without staff supervision. Review of Resident #5's care plan dated, [DATE], revealed the resident was at clinically unavoidable risk for falls related to confusion and balance issues. Fall interventions noted on the care plan included staff was to place a fall mat to the right side of the resident's bed ([DATE]), a thick mat was to be placed on the wall next to the resident's bed ([DATE]), and the resident required the safety of a secured unit related to the dementia diagnosis and poor safety awareness. Additionally, Resident #5 was to be supervised by staff while on the secured unit. Resident #5 was noted to be frequently incontinent of bladder related to impaired cognition; however, the resident's plan of care did not include toileting interventions. Review of the facility's self-reported allegation of an Injury of Unknown Origin investigation, dated [DATE], revealed Resident #5's wall was padded with a thick padded mat. However, observations throughout the survey revealed there was no such padding in the resident's room. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #5's progress note, dated [DATE] at 1:23 PM, completed by Registered Nurse (RN) #10 revealed thick padding was placed to the left side of bed to aide in safety when the resident was in bed. Interview with Registered Nurse (RN) #10, on [DATE] at 05:20 PM, revealed she had no memory of the incident or of Resident #5. Interview with Certified Nurse Aide (CNA) #30, on [DATE] at 07:25 PM, revealed there had never been padding placed to left side of the wall in Resident #5's room and she did not know why a fall mat had not been placed since she knew Resident #5 was a fall risk. 6. Observation, on [DATE] at 8:48 AM, revealed Resident #61 was seated in his/her wheelchair (w/c), and the resident attempted to stand up three (3) times in front of the w/c, it was not until the last time did staff in the nurses station came out into the common area to address. Observations of Resident #61, on [DATE] at 9:06 AM, on [DATE] at 2:04 PM, on [DATE] at 9:30 AM, on [DATE] at 1:30 PM, on [DATE] at 11:00 AM, on [DATE] at 3:30 PM, on [DATE] at 9:00 AM, on [DATE] at 2:00 PM, on [DATE] at 8:46 AM, on [DATE] at 12:25 PM, and on [DATE] at 8:50 AM, revealed no staff present in the area, providing supervision to resident. Record review revealed the facility admitted Resident #61's on [DATE] with diagnoses of Dementia, Insomnia, Abnormal Gait, Difficulty Walking, and Cognitive Deficit. Review of Resident #61's Quarterly MDS Assessment, dated [DATE], revealed the facility assessed the resident with a BIMS score of six (6) out of fifteen (15) indicating the resident had severe cognitive impairment. The resident required two (2) person physical assistance for bed mobility, transfers, toileting and one (1) person physical assistance for dressing, eating, and personal hygiene. The resident was noted with impairment to both lower extremities, and required the use of a wheelchair. Review of the Quarterly MDS assessment, dated [DATE], revealed the facility could not establish a BIMS score (99), and the resident required the physical assistance of two (2) staff for toileting and eating, and required the use of a wheelchair for mobility. Review of Resident #61's CCP, dated [DATE], revealed staff were to offer to move the resident to a recliner in the common area when he/she was restless. The resident was to be supervised while on the unit, and it was noted the resident enjoyed sitting with peers and should have been coupled with peers for activities ([DATE]). However, observations of the resident during survey did not reveal the care plan intervention was followed by staff. Interview with Certified Nursing Assistance (CNA) #2, on [DATE] at 10:10 AM, revealed the care plan was used to tell staff what care a resident required. She stated it was important for staff to follow the care plan to prevent the resident from getting hurt and to ensure he/she got the best care possible. She stated it was important for aides to let the nurses know if they discovered an intervention was not working so the care plan could be reviewed. She also said it was important to get the pass down information from the night before to ensure if the resident had special or new needs for that day, she would be able to meet those needs. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview with Licensed Practical Nurse (LPN) #19, on [DATE] at 10:20 AM, revealed she knew the residents well but she still needed to review the care plan each day to ensure the care for the resident had not changed. She stated the care plan was used to drive the care for the resident and interventions were developed and put in place by the Interdisciplinary Team (IDT). LPN #19 revealed it was important for all staff to follow the care plan, to ensure the residents received the best care possible and hopefully to decrease any chance of harm to the resident. She stated if the care plan was not followed, there could be negative results to the resident. For example, if a resident was care planned to be a two (2) staff physical assist and one (1) staff moved the resident, the resident could fall and get hurt. She said, the care plan had to be followed. 7. Observation of Resident #821 on [DATE] at 9:00 AM, revealed the resident was very thin, he/she was seated in a wheelchair on the Men's Memory Care Unit, dressed in pajama pant bottoms and a coat. The resident had a large bruise that covered the entire right side of his/her head, around the eye brow and ear. Record review revealed the facility admitted Resident #821, on [DATE] with diagnoses of Dementia with mood disturbance, history of anticoagulants and anxiety. Review of Resident #821's Quarterly MDS assessment, dated [DATE], revealed the facility assessed the resident as requiring extensive assistance for bed mobility and dressing, limited assistance for transfers, walking in the room and in the corridor and supervision only for eating. Review of the Admission MDS dated [DATE], revealed the facility assessed the resident to have a BIMS of six (6) out of fifteen (15) showing severe cognitive impairment. The facility also assessed the resident to require the physical assistance of two (2) staff for bed mobility and personal hygiene, one (1) person physical assistance for locomotion on the unit, dressing, eating and toileting. The resident was totally dependent on staff for bathing. Resident #821 was noted to be absent of upper/lower extremity impairments and was assessed to use a wheelchair only for mobility. Review of Resident #821's CCP, dated [DATE], revealed the facility care planned the resident as at risk for falls with care plan interventions that included: fall risk assessments on admission and at least quarterly; ensure the resident had on appropriate footwear while out of bed; refer the resident to PT/OT/ST as needed; educate and remind the resident of safety awareness such as locking breaks on the wheelchair; asking for assistance before transferring; and to use his/her call light. On [DATE], the care plan was revised to keep frequently used items close to the resident and keep his/her call light within reach; on [DATE], with a new intervention to assist the resident to the dayroom; on [DATE] to place a fall mat to side of his/her bed; on [DATE] to place Dycem to his/her wheelchair; on [DATE] to assist the resident to the dayroom before meals; on [DATE] to provide a room close to the nurse's station. Review of the facility's Risk Management Report, dated [DATE] at 12:14 AM, revealed the resident was found on the floor in the room and complainted of shoulder pain. The Root Cause Analysis (RCA) revealed the resident attempted a self-transfer, lost his/her balance and fell . LPN #7 noted the resident required the assistance of one (1) staff member for all transfers and the resident was wheelchair bound. LPN #7 noted on the RMR a fall mat was placed next to the resident's bed. LPN #7 also noted assessed for injuries, none found except a bump to the right side of the forehead, about a nickel size. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #821's Risk Management Report (RMR), dated [DATE], revealed the resident fell from the bed and had bruises from a previous fall. Review of additional RMRs dated [DATE] at 5:12 PM, [DATE] at 5:17 PM and [DATE] at 11:41 PM, revealed the resident sustained three (3) additional unwitnessed falls in a short period of time. The State Survey Agency (SSA) Surveyor attempted to reach LPN #7 who assessed Resident #821 when he/she fell [DATE]. Attempts were made on [DATE] at 3:00 PM, [DATE] at 5:00 PM and [DATE] at 1:00 PM, however, contact was not made. Interview with the Assistant Director of Nursing (ADON), on [DATE] at 5:54 PM, revealed the resident was found on the floor next to his/her bed and complained of shoulder pain to bilateral shoulders, on [DATE]. She said she meant to put in an order for an x-ray but did not do so because she was too busy through the shift. She put the order in at 6:00 PM on [DATE]. The ADON stated Resident #821 was confused, had recent illness, and had impaired memory. Interview with the MDS Coordinator #2, on [DATE] at 9:20 AM, revealed care plans were to be followed by all nursing staff. She said any falls or behaviors needed to be addressed on the care plan immediately. MDS Staff #2 revealed care plans were to be reviewed quarterly and when there was a significant change. She stated the MDS Nurse went through the progress notes, daily, looked at the twenty-four (24) hour report, and if she was not able to physically be in the meeting she tried to get on a conference call with the team. MDS Staff #2 stated if the care plan was not created with the appropriate interventions to match the resident assessment, the resident would not get the care he or she deserved, or could result in potential harm of the resident. Interview with the Executive Director (ED), on [DATE] at 11:00 AM, revealed it was important to keep the residents busy as that would help prevent wandering, and hopefully decrease falls and cut back on resident to resident incidents. She also stated the residents' care plans should be followed as well as the facility policies to ensure the residents got the best possible care. 8. Record review revealed the facility admitted Resident #97 on [DATE] with diagnoses of Dementia with moderate mood disturbance, Parkinson's Disease and Dysphagia. Review of Resident #97's Quarterly MDS, dated [DATE], revealed the resident had a BIMS of fifteen (15) and required the assistance of one (1) staff member for bed mobility, transfers, dressing, toilet use and personal hygiene. The resident was absent upper/lower extremities impairments and used a wheelchair to for mobility. Review of Resident #97's progress notes revealed the resident sustained falls on [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. Review of the resident's CCP dated [DATE] revealed the resident was at risk for and had a history of falls related to new environment, weakness, current medications/potential side effects, diminished safety awareness, and incontinence. The care plan revealed there were to be nonskid strips on the floor next to the resident's bed as a fall prevention intervention. Observation on [DATE] at 11:21 AM, [DATE] at 9:55 AM, [DATE] at 9:00 AM, [DATE] at 12:34 PM, [DATE] at 12:25 PM, [DATE] at 8:45 AM, [DATE] at 8:20 AM and [DATE] at 9:02 AM, revealed Resident #97 was in bed, with eyes close or eating. In addition, observations revealed the facility had not placed the nonskid strips next to the resident's bed to prevent falls per the plan of care. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview with the MDS Coordinator #2 on [DATE] at 9:20 AM, revealed if care plans were not created with the appropriate interventions to match the resident assessment, the resident would not get the care he or she deserved, or could result in potential harm of the resident. Interview with the ED on [DATE] at 11:00 AM, revealed Resident #97's care plan should have been followed to ensure they receive the best possible care. 9. Record review revealed the faciltiy admitted Resident #32's on [DATE] with diagnoses of Dementia, Diabetes, and Anxiety. Review of Resident #32's Admission MDS, dated [DATE], revealed the facility assessed the resident as having a BIMS score of three (3) out of fifteen (15) indicating the resident was severely cognitively impaired. Using the MDS, the facility assessed the resident as one who wandered daily, which placed the resident at significant risk of harm/danger from other residents and hazards throughout the facility. Additional review of the MDS assessment revealed the resident intruded on the p [TRUNCATED]

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43694 Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to review and revise care plans for nine (9) of ninety-four (94) sampled residents, (Resident #17, #19, #69, #80, #95, #96, #98, #106, and #371). 1. Resident #96 had history of a fall related to cerebral infarction with residual weakness and motor ability as well as cognitive impairment. On [DATE], Resident #96 attempted to ambulate unassisted and fell , resulting in a fractured hip and surgery. The care plan was not revised to address future fall prevention. 2. Resident #371 was admitted after experiencing frequent falls related to Parkinson's Disease and Lewy Body Dementia. He/she fell on at least seven (7) documented occasions during approximately fifty (50) days of residence in the facility. The resident sustained lacerations from three (3) falls requiring a hospital visit with laceration repair. The care plan was not revised to address one-to-one (1) supervision. 3. Resident #95 went to the hospital after sustaining a cerebral infarction and returned with a pressure wound to the right ischium. The wound was healed, but then recurred within eight (8) days. In addition, more wounds emerged to the resident's sacrum and bilateral heels. The care plan was not revised timely to address wound healing and prevention. 4. Resident #17 had increased psychotic behaviors noted on [DATE], and on [DATE], the resident grabbed Resident #93 by the back of his/her coat and moved him/her out of the way of a television set, with no injuries. The care plan was not revised to address these increased behavior after [DATE] or [DATE]. 5. Resident #69 was involved in two (2) physical altercations on [DATE] (kicked Resident #36) and [DATE] (had physical contact with Resident #56). However, the care plan was not revised with new interventions after the [DATE] incident. 6. Resident #19 sustained a fall with injury on [DATE] with no new interventions added to the care plan. 7. Resident #98 sustained a fall with injury on [DATE] with no new interventions added to the care plan. 8. Resident #80 was assessed to exhibit verbal and physical behaviors toward others, and the resident cursed at another resident on [DATE]. However, there was no documented evidence the resident's care plan had been updated or revised to reflect these behaviors. 9. Resident #106 sustained a fall on [DATE] and had a new intervention identified at that time to be added to the care plan: Dycem (a non-slip material) to the wheelchair. However, this intervention was not added to the care plan until after the resident's [DATE] fall from the wheelchair. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The findings include: Review of the facility's policy titled, Comprehensive Care Plan (CCP), dated [DATE], revealed the Minimum Data Set (MDS) Coordinators or designee were responsible to update the residents care plan. Policy review also revealed the CCP would describe the services to be furnished to attain or maintain highest practicable well being, and any services otherwise that would be required but not provided due to the resident's exercise of right to refuse treatment. Additional review revealed the Interdisciplinary Team (IDT) was responsible for review and updating of care plans when there had been a significant change in condition, when the desired outcome was not met, when the resident had been readmitted to the facility from a hospital stay and at least quarterly. Review of the facility's policy titled, Fall Management, updated [DATE], revealed a root cause analysis would be done to determine an intervention based on the root cause to prevent further falls. The intervention was to be implemented immediately after the fall, and the care plan updated with the new intervention. 1. Review of Resident #96's electronic medical record (EMR) revealed the facility initially admitted the resident on [DATE] with most recent readmission on [DATE]. The resident's diagnoses included Age-Related Physical Debility, Muscle Weakness, Cognitive Communication Deficit, and Dementia. The Minimum Data Set (MDS) Significant Change Assessment, dated [DATE], revealed he/she was totally dependent for Activities of Daily Living (ADL) including bed mobility, transfers, and locomotion, requiring assistance from two (2) staff. Further review of the MDS assessment revealed his/her Brief Interview for Mental Status (BIMS) score was ninety-nine (99), unable to be assessed due to severe cognitive impairment. Review of Resident #96's EMR notes revealed the resident had sustained a fall subsequent to an arteriovenous malformation rupture in the cerebellum on [DATE], was hospitalized , and returned to the facility on [DATE] with related changes in mobility. Further review of Resident #96's EMR fall evaluation note, dated [DATE] at 12:28 AM, revealed he/she attempted to get up and stand when he/she fell and landed on his/her side. Per the note, the resident then complained of severe pain in the left hip, but would not allow for a full evaluation of the leg. Further review of the note revealed Resident #96 was at risk for falls due to dementia and loss of balance. The resident was diagnosed with a fractured hip and sent to the hospital for repair of the fracture. Review of the IDT note revealed Resident #96's fall on [DATE] was discussed on [DATE], and the root cause analysis showed Resident #96 was restless and fell out of bed. Further review revealed upon his/her return from the hospital, staff would assist Resident #96 up to the wheelchair when restless and that the care plan was updated. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #96's care plan revealed a focus for risk of falls, initiated on [DATE]. Interventions included keep frequently used items within reach; conduct fall risk assessments on admission and at least quarterly; provide/monitor use of assistive devices; refer to therapies as needed; educate and remind resident of safety awareness such as locking brakes on wheelchair, asking for assistance before transferring, and call device use as the resident had history of attempts to self-transfer. Further review of the (CCP) revealed a revision on [DATE] to wear a soft helmet when out of bed, and on [DATE], to wear a soft helmet when out of bed as well as to keep call device within reach. After the [DATE] fall, the interventions added were a high back wheelchair and assist up to the wheelchair when restless. There was no intervention addressing the mobility rail on the bed, bed in low position, or the use of fall mats. Observation, on [DATE] at 2:27 PM, revealed Resident #96's room was at the end of the A hallway and not located close to the nurses' station. In addition, the mobility rail on his/her bed was at the lower end of the bed and flush against the wall. There were no fall mats in place. Resident #96 was resting in bed, and when asked, he/she could not recall or verbalize any recollection of his/her fall with injury. Interview with Certified Nursing Assistant (CNA) #18 on [DATE] at 8:28 PM, revealed she was not familiar with Resident #96's fall but stated the aides knew that for the residents with fall risks, the bed should be in low position with a mobility rail and fall mats. 2. Review of Resident #371's EMR revealed the facility admitted the resident on [DATE] with diagnoses including Parkinson's Disease, Lewy Body Disease with Dementia, Muscle Weakness, and Repeated Falls. Review of Resident # 371's Admission Minimum Data Set (MDS) Assessment, dated [DATE], (for falls) revealed he/she had history of Parkinson's and Dementia. Further review revealed Resident #371 had a history of frequent falls and was at risk for falls related to impaired cognition, unsteady gait, and poor safety awareness. Review also revealed he/she had sustained one non injury fall since readmission. Continued review of the admission MDS assessments revealed while Resident #371 was independent with bed mobility, he/she was totally dependent for transfers, toileting, and hygiene activities of daily living. The assessments also demonstrated unsteadiness with transitions and walking and used a wheelchair for locomotion. Additional review of the Admission MDS Assessment revealed a BIMS score of ninety-nine (99), indicating the resident was unable to participate with staff using the BIMS tool. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #371's progress notes in the EMR revealed he/she had sustained multiple falls during his/her admission to the facility. By the day after admission, notes revealed a habit of placing self on hands and knees and crawling about on the floor. Further review revealed, on [DATE], Resident #371 was found on the floor of the room after falling at about 8:25 AM, sustaining a 2.3 centimeter (cm) by 0.3 cm laceration with subcutaneous tissue noted. He/she was transported to the hospital at 9:45 AM, returning that night at 9:05 PM with sutures closing the laceration. Continued review of the progress notes revealed Resident #371 was found on the floor after a fall again, on [DATE] at 6:39 AM, with a bloody laceration measuring 2.0 cm long by 0.1 cm deep, located just above the previous one, and standing blood pressure measuring ,d+[DATE]. Resident #371 was transported to the hospital and admitted for further workup, returning on [DATE]. Additional review of the progress notes revealed Resident #371 was found prone in the floor on elbows and forearms with legs extended the following day, [DATE] at 1:23 AM. He/she was tangled in a gown, anxious and tearful with standing, and his/her blood pressure measured at ,d+[DATE]. Further review revealed progress notes reflected there was supervision on a one-to-one (1:1) basis during the night shift of [DATE] to [DATE] and while the resident was awake on [DATE]. Continued review of the progress notes revealed Resident #371 stood from the wheel chair on [DATE] at approximately 8:10 AM, and fell resulting in a laceration to the right eyebrow and a standing blood pressure of ,d+[DATE]. Resident #371 was transported to the hospital where the laceration was approximated with glue and steri strips, a type of narrow bandage; the resident returned the same afternoon at 4:42 PM. Additional review revealed Resident #371 was found on the floor at 5:00 PM on [DATE] without injury, then slid out of the wheelchair to the floor on [DATE], after having been moved to a room in view of the nurses' station the day before. Further review revealed Resident #371 placed self in floor the morning of [DATE] then rolled self out of bed that afternoon. Additional review revealed he/she slid out of the wheelchair during the dinner meal on [DATE]. There was a note stating one-to-one (1:1) supervision for safety was begun on [DATE]. No further falls were noted throughout the resident's stay in the facility. One-to-one (1:1) supervision was reflected in the progress notes on [DATE], [DATE], [DATE], [DATE], and [DATE]; but, on [DATE], a note revealed one-to-one (1:1) supervision was expected but not in place due to short staffing. The note stated nursing staff made checks every thirty (30) minutes for fall prevention on [DATE]. Final review of the progress notes revealed this was a total of seven (7) falls in thirty (30) days in the facility. Review of Resident #371's CCP, initiated on [DATE], revealed a care plan focus for falls initiated the same date and revised on [DATE], [DATE], and [DATE]. Initial interventions, dated [DATE], included to keep frequently used items within reach, keep the call light in reach, provide and monitor use of assistive devices, and educate/encourage use of the call light, ask for assistance before transfers, and conduct fall risk assessments on admission and at least quarterly. Review further showed added interventions on [DATE] of assisting to crawling position as desired by resident to reduce risk of injury. A low bed with fall mats was added on [DATE], with enhanced supervision added on [DATE] and a pressure alarm in the wheelchair on [DATE]. However, the one-to-one (1:1) supervision that the progress note stated was begun on [DATE] was not in the care plan. In addition, the note stated after the one-to-one (1:1) supervision was added, the resident had no further falls. Interview with the Director of Nursing (DON) on [DATE] at 3:37 PM, revealed enhanced precautions or increased supervision meant, if a staff member was not assisting another resident, then that staff member should be beside the resident and/or they should watch that resident closer. She stated enhanced precautions or supervision was different from every fifteen (15) minute checks or one-to-one (1:1) supervision. The DON stated she would expect the care plan to be updated to reflect the MDS assessment and with any change in condition. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Licensed Practical Nurse (LPN) #9 on [DATE] at 3:30 PM, revealed Resident #371 did fall a lot and hallucinated, which manifested itself when the resident was asleep, opened his/her eyes, got up, and started running, attempting to jump over the chairs. Further interview revealed if staff approached, the resident would swing fists at them. Continued interview revealed interventions were in place, but the LPN did not recall the specifics of when fall mats or one-to-one (1:1) supervision were put in place. Interview with Registered Nurse (RN) #18 on [DATE] at 8:25 PM, revealed Resident #371 had a lot of falls, and his/her condition declined pretty quickly. She stated she could not say for certain but there was a time he/she had one-to-one (1:1) supervision because he/she was always trying to get up and staff could not get to him/her quickly enough to keep him/her from falling. Interview with LPN #31 on [DATE] at 9:10 PM, revealed she only vaguely remembered Resident #371 and little of the resident's specific care but did report trying to keep somebody with him/her, either assigning an aide to sit with the resident, or placing the resident by the nurses' station to try to prevent falls. Continued interview revealed she did remember that Resident #371 had frequent falls, impulsive actions, and he/she became less able to communicate and declined rapidly. Interview with the Executive Director (ED) on [DATE] at 10:41 AM, revealed rounding was key to prevent falls and nurses were expected to update care plans in real time, especially with something like a fall. Further interview revealed for resident with frequent falls, if they fell multiple times in a short time, that would be a flag to add one-to-one (1:1) supervision. 3. Review of Resident #95's EMR revealed the facility admitted the resident, on [DATE], with diagnoses of Encephalopathy, Cerebral Infarction, Type II Diabetes Mellitus, and Dementia. Review of Resident #95's Electronic Medical Record (EMR) progress notes revealed the Stage III pressure wound to the right ischium was identified on [DATE] after readmission from a hospital stay. The resident was referred to a wound specialist care at that time and was seen by the physician on [DATE], who ordered Santyl and Calcium Alginate to treat it. Further review revealed the wound was evaluated as resolved by the wound care physician and he signed off on Resident #95's care on [DATE]. Continued review revealed a change in condition note on [DATE] at 5:03 PM, specifically the Nurse Practitioner (NP) diagnosed a Stage III pressure wound to the coccyx and referred for return to wound care, eight (8) days after prior wound resolution. Still further review revealed a dietary note on [DATE] demonstrating four open pressure areas in total, bilateral heels, sacrum and reopened area to ischium. Review of Resident #95's wound care notes confirmed recurrence of right ischium pressure wound diagnosed on [DATE], as well as new presence of deep tissue injury to bilateral heels, and a stage IV wound to the sacrum. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #95's Comprehensive Care Plan revealed Focus for Risk of Skin Impairment, initiated [DATE], with interventions added as of the same date of turn and reposition to maintain skin integrity, pressure reducing mattress, and skin checks weekly. Further review revealed the first interventions added or revised after those at admission, even after the resident returned with a Stage III pressure wound on [DATE], were not documented until [DATE] and included moon boots to bilateral heels, wound MD to evaluate and treat, and turn and reposition to promote healing of current areas, without a frequency specified Continued review revealed the addition of interventions on [DATE] to include turn side to side in bed every one (1) to two (2) hours if able and to offload wounds. Observation of Resident #95 on [DATE] from 1:16 PM to 3:37 PM, revealed, even though CNA #18 entered the resident's room at 3:04 PM, the resident had not gotten up nor was the resident changed during this two (2) hour and twenty-one (21) minute time frame. Interview with CNA #18 on [DATE] at 8:28 PM, revealed staff should be repositioning residents every two (2)hours with pillows to protect skin or prevent contractures, and she only went in the room to weigh the resident with a Hoyer (mechanical) lift, not to reposition. Interview with CNA #15 on [DATE] at 3:20 PM, revealed there were two (2) different ways to know a resident's care needs: walking shift change report or look at the resident's care plan/Kardex. Continued interview revealed repositioning was expected every two (2) hours. Additional interview revealed turning and repositioning was important to protect residents' skin. Interview with CNA #48 on [DATE] at 8:33 PM, revealed she learned care needs with shift report from off going aides and from the Kardex. Further interview revealed check and change was supposed to be every two (2) hours. She stated keeping residents dry was important for hygiene, to be comfortable, and for protecting residents' skin from breakdown. Additional interview revealed Resident #95 should be turned every two (2) hours. Interview with LPN #31 on [DATE] at 9:10 PM, stated wound prevention relied on turning, repositioning, and offloading wounds. Telephone interview with the Wound Care Physician on [DATE] at 4:50 PM, revealed residents needed to be moved every two (2) hours and staff should be changing briefs then, if they were soiled or wet. He stated not doing so would clearly cause skin problems. 4. Review of Resident #17's clinical record revealed the facility admitted the resident on [DATE] with diagnoses of Schizoaffective Disorder and Post Traumatic Seizures. Review of Resident #17's Quarterly MDS Assessment, dated [DATE] revealed the facility assessed the resident with a BIMS score of fourteen (14) of fifteen (15), indicating intact cognition. Further review revealed Resident #17 had an altercation with Resident #93, on [DATE]. Resident #17 pulled Resident #93 by the back of his/her coat and moved him/her from in front of the television in the common room. No injuries were identified. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #17's Psychiatric progress note dated [DATE], revealed the resident had increased psychotic symptoms, and he/she would be continued on the same medication, with no new orders recommended. The Psychiatric progress note for [DATE] revealed the resident had improved behaviors; however, on [DATE], after the resident was involved in an altercation with another resident, he/she was initially placed on one to one (1:1) supervision. The Psychiatric Nurse Practitioner (PNP) was informed by staff that the one to one (1:1) supervision only agitated the resident more, so she removed the extra supervision. Review of Resident #17's Comprehensive Care Plan (CCP) dated [DATE], revealed the resident was noted to have the potential for physical aggression towards peers related to anger and poor impulse control, and on [DATE] the care plan added for an intervention that staff was to help the resident to determine what worked to deescalate him/her when he/she became angry. On [DATE], interventions were added for staff to give the resident positive cues and feedback to alleviate anxiety and encourage the resident to seek out staff when he/she was agitated and discuss his/her feelings. However, no new interventions were put in place for the resident's increased psychotic symptoms or his/her [DATE] behaviors. Interview with Certified Nursing Assistant (CNA) #33 on [DATE] at 9:45 AM, revealed the incident on [DATE] might have been prevented if other interventions were tried in February because it was noted the resident had increased behaviors then. She said Resident #93 was very paranoid and talked to the television to his/her deceased nephew who the resident thought was going to come out of the TV. She stated Resident #17 thought Resident #93 was talking about him/her and that upset the resident. She said Resident #17 stood straight up, and he/she was very tall. She said before staff could intervene, Resident had grabbed Resident #93. She recalled Resident #17 stated, I am going to beat your ass. CNA #33 stated one-to-one (1:1) supervision was removed the same day because it increased the resident's agitation. Interview with the Executive Director (ED) on [DATE] at 11:00 AM, revealed care plans should be reviewed and revised in accordance with the facility policy. She stated it was important for them to be revised because interventions that worked before might not necessarily work anymore. However, she stated she was not sure if a new intervention would have made a difference in the incident between Resident #17 and Resident #93 on [DATE], based on the information provided. 5. Review of Resident #69's clinical record revealed the facility admitted the resident on [DATE] with diagnoses of Schizophrenia and Anxiety Disorder. Review of Resident #69's Quarterly MDS Assessment, dated [DATE], revealed the facility assessed the resident with a BIMS score of fourteen (14) of fifteen (15) indicating he/she was cognitively intact. Further review of the assessment, did not reveal the resident had behaviors. Review of Resident #69's Discharge MDS Assessment, dated [DATE], revealed the resident's BIMS was not assessed, and the resident was noted to have physical and verbal behaviors present toward others for one (1) to three (3) days during the review period. Review of the resident's Quarterly MDS Assessment, dated [DATE], revealed the facility assessed the resident with a BIMS score of fourteen (14) of fifteen (15) indicating he/she was cognitively intact. The resident was assessed as delusional and verbally aggressive towards other and had additional behaviors but were not directed towards others for one (1) to three (3) days during the review period. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #69's progress notes, revealed he/she was involved in two (2) physical altercations on [DATE] (kicked Resident #36) and [DATE] (had physical contact with Resident #56). However, no new interventions were developed by the facility after the [DATE] incident. Resident #69 was already care planned for staff to anticipate and meet his/her needs, also for staff redirection ([DATE]). Staff were also to remove the resident from the situation that might trigger the resident's behaviors ([DATE]). 6. Review of Resident #19's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses to include Displaced Intertrochanteric Fracture of the Left Femur, Closed Fracture and Abnormal Posture. Review of Resident #19's Quarterly Minimum Data Set Assessment (MDS), dated [DATE], revealed the resident's BIMS assessment was unable to be completed due to the fact that the resident was rarely/never understood and was severely cognitively impaired. Review of Resident #19 Change of Condition note, dated [DATE] at 12:23 AM, revealed the resident had an unwitnessed fall from a wheelchair, was found lying on his/her right side in the common area next to his/her wheelchair with a laceration to the right side of his/her head. The resident was sent to the Emergency Department (ED) for evaluation and treatment. Review of Resident #19's CCP for falls, last revised [DATE], revealed interventions of add Dycem to the wheelchair to promote safety; anticipate and meet resident's needs; be sure resident's call light was within reach and encourage the resident to use it for assistance as needed; the resident needed prompt response to all requests for assistance; bed in low position unless providing direct care as tolerated by the resident; bilateral enabler bars to the head of the bed to help with transfer and positioning; and resident used a standard wheelchair and cushion and scoop mattress. However, further review revealed no new interventions had been put in place for the resident's fall dated [DATE]. 7. Review of Resident #98's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses to include Alzheimer's Disease and Hypertension. Review of Resident #98's Quarterly MDS Assessment, dated [DATE], revealed the resident's BIMS score was zero (0) of fifteen (15) indicating the resident was severely cognitively impaired. Review of Resident #98's progress notes, dated [DATE] at 8:51 AM, revealed the resident was sitting in the common area in his/her wheelchair, fell asleep, leaned forward, and fell to the floor, receiving a laceration to his/her forehead. Review of Resident #98 CCP for falls, created on [DATE], revealed interventions included add Dycem to wheelchair and a fall mat to the left side of the bed to promote safety; keep the call light within reach; standard wheelchair with a roho cushion (used to decrease the amount of pressure on the sitting area); keep frequently used items within reach; fall risk assessment upon admission and at least quarterly; ensure appropriate footwear when out of bed; and refer to PT/OT/ST (physical therapy/occupational therapy/speech therapy) as needed. However, further review revealed, as of [DATE], no new interventions had been put in place to address the resident's fall on [DATE]. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. Review of Resident #80's Admission Record revealed the facility admitted the Resident on [DATE], with diagnoses to include Dementia with Behavioral Disturbance, Cognitive Communication Disorder, and Muscle Weakness. Review of Resident 80's Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], revealed the facility assessed Resident #80 with a BIMS score of five (5) of fifteen (15), indicating the resident was severely cognitively impaired. Continued review revealed Resident #80 exhibited verbal and physical behaviors toward others including hitting, kicking, pushing, scratching, grabbing, screaming at others or cursing and wandering. Review of Resident #80's CCP, initiated on [DATE], revealed a focus area of exhibiting adjustment issues as evidenced by yelling, attempting to hit, kick, bite, throw items, and be verbally aggressive toward staff with a goal to include that the resident would be successfully redirected with minimal cues from staff with no aggressive type behaviors. Interventions included encourage ongoing family involvement and give the opportunity for resident to communicate her/his feelings. Continued review revealed, on [DATE], an added intervention to assist the resident to promptly move away from the dining table after meals. On [DATE], an added intervention that staff could initiate was a one-to-one (1:1) observation as a proactive intervention when increased agitation was observed. Review of Resident #80's CCP, initiated on [DATE], revealed a focus area of altered psychosocial needs related to Dementia and Anxiety, with a goal to maintain highest level of independence with safety. Interventions included administer medications as ordered, monitor for behaviors every shift and document, monitor for side effects of psychotropic medications as ordered, arrange for psychiatric consult as needed. Continued review of the CCP revealed a new focus initiated on [DATE], for use of psychotropic medications (antipsychotic), related to Dementia and Anxiety with interventions which included administer medications as ordered, consult with Pharmacy, enhanced supervision as needed, monitor/document/report any adverse reactions of Psychotropic medications, and monitor/record occurrence of target behavior symptoms such as inappropriate response to verbal communication and violence/aggression toward staff and/or others. However, there was no documented evidence to support Resident #80's CCP had been updated or revised to reflect the behaviors assessed in the Quarterly MDS assessment dated [DATE] to include verbal and physical behaviors toward others. These behaviors included cursing at others, such as what occurred with the incident on [DATE] when Resident #80 cursed at another resident. Review of Resident #80 Behavior Progress Note dated [DATE], entered by the Social Worker, revealed Resident #80 displayed physical aggression toward others, and one-to-one (1:1) supervision was initiated. Review of Resident #80's Nursing Progress Note dated [DATE], entered by LPN #3 revealed she was informed Resident #48 hit Resident #80 in the face because Resident #80 called him/her a whore. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with CNA #9, on [DATE] at 8:50 AM, revealed she was sitting in the corner of the common area with several residents when Resident #80 got upset at another resident and started cursing. Resident #80 got up from the chair and was walking in front of the couch where Resident #48 was sitting, all the while cursing at no person in particular. CNA #9 reported she was trying to get Resident #80's attention to calm him/her, when Resident #48 got up from the couch and punched Resident #80, knocking him/her to the floor. CNA #9 stated, it happened so fast I couldn't get to them quick enough. CNA #9 revealed she immediately separated the residents. Per the interview, CNA #9 stated that Resident #80 was always cursing. Interview with the Director of Nursing (DON) on [DATE] at 3:37 PM, revealed enhanced precautions or increased supervision meant, if a staff member was not assisting another resident, then that staff member should be beside the resident and/or they should watch that resident closer. She stated enhanced precautions or supervision was different from every fifteen (15) minute checks or one-to-one (1:1) supervision. The DON stated she would expect the care plan to be updated to reflect the MDS assessment and with any change in condition. 9. Review of Resident #106's medical record revealed the facility admitted the resident on [DATE] and readmitted the resident on [DATE] with diagnoses of Alzheimer's Disease, Difficulty with Walking, Unsteadiness of Feet, and History of Repeated Falls. Review of the Admission Minimum Data Set Assessment, dated [DATE], revealed a BIMS score of ninety-nine (99), indicating the resident could not participate with using the tool because of severe cognitive impairment. Review of the facility's Fall investigation for Resident #106 on [DATE] at 12:37 PM, revealed the resident was witnessed scooting self out of the wheelchair onto the floor in the day area. The root cause analysis showed the resident slid out of the wheelchair, with no injury. An added intervention was to add Dycem to the wheelchair. Review of facility's Fall investigation for Resident #106 on [DATE] at 12:00 PM, revealed the resident was asleep in the wheelchair in the common area and fell from the wheelchair, with no injury. The root cause analysis showed the resident fell asleep in the wheelchair and fell forward. There was no Dycem in the wheelchair. Review of Resident #106's CCP, initiated on [DATE], revealed there was a focus for risk of falls b [TRUNCATED]

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47852 Based on interview, observation, and record review it was determined the facility failed to ensure residents unable to carry out activities of daily living received the necessary services to maintain good oral hygiene for one (1) of nineteen (19) sampled residents (Resident #44). On 06/25/2023 at 1:52 PM, Resident #44 was observed with food particles/substance in his/her mouth and on his/her teeth. The findings include: Review of the facility's policy titled, Activities of Daily Living (ADLs), Supporting, not dated, revealed residents who were unable to carry out ADLs independently would receive the services necessary to maintain good grooming and personal and oral hygiene. Further review revealed appropriate care and services would be provided for residents who were unable to carry out ADLS independently, with the consent of the resident and in accordance with the plan of care, which included appropriate support and assistance with hygiene (bathing, dressing, grooming and oral care). Review of Resident #44's Admission Record revealed the facility admitted the resident on 03/29/2023. The resident's diagnoses included Malignant Neoplasm of the Brain, Osteoarthritis, Muscle Weakness, Difficulty in Walking, Need for Assistance with Personal Care, and Unsteadiness on Feet. Review of Resident #44's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 99. This score indicated the resident was severely cognitively impaired. Further review revealed the resident required extensive assistance of one (1) person for transfers and hygiene. Review of Resident #44's Comprehensive Care Plan initiated 04/11/2022, revealed the resident had an Activities of Daily Living (ADL) self-care performance deficit related to dementia, impulsive disorder, muscle weakness, and anxiety disorder. Further review revealed goals that included the resident would improve and maintain that level of function. Interventions included set up and assist with oral care daily and as needed. Observation of Resident #44, on 06/25/2023 at 1:52 PM, revealed the resident had food particles caked onto his/her teeth and crumbs were noted to be coming out of the resident's mouth while he/she was speaking. The resident did not have any food in his/her vicinity at the time of the observation. Interview on 06/25/2023 at 4:50 PM, with Certified Nurse Aide (CNA) #8, who was assigned to Resident #44, revealed the third (3rd) shift staff were responsible for getting residents up in the mornings, providing personal hygiene, including brushing residents' teeth. She further stated day shift staff assisted residents with oral care as needed. CNA #8 stated good hygiene was important for residents' dignity and to prolong how long residents could keep their teeth. Interview on 06/26/2023 at 10:36 AM, with Licensed Practical Nurse (LPN) #40, revealed she was not sure what the policy was at the facility regarding oral care. She further stated residents' dentures were soaked overnight. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON #4 stated during interview on 06/26/2023 at 11:05 AM, staff should assist residents with brushing their teeth before assisting them to the dining room in the mornings, after meals, and at bedtime. She stated staff should make sure food was not clinging to a resident's teeth and there was no build up on the teeth. The DON stated staff should follow the interventions on the Care Plan and brush the resident's teeth at the times listed above and as needed. During interview on 06/28/2023 at 5:32 PM, with Executive Director (ED) #2, revealed she expected the staff to follow the Care Plan interventions.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43694 Based on observation, interview and review of the facility's job descriptions, it was determined the facility failed to provide activities based on the comprehensive assessment and care plan and the preferences of each resident for four (4) of ninety-four (94) sampled residents (Resident #56, Resident #62, Resident #93 and Resident #271). The findings include: Review of the Activities Director's (AD) job description, as well as the Activities Assistant's (AA) job description, neither dated, revealed both were responsible for developing, organizing and ensuring implementation of a variety of activities for social, emotional, physical and other therapeutic needs of each resident. Under Essential Duties and Responsibilities, the policy revealed both positions were responsible for assessing residents and designing the activities program to meet the functional levels, needs, interests and choices of each resident. The roles would develop and implement the comprehensive activity program, including individual and group activities. Those in these positions would maintain dialogue with residents, family members, legal representatives and significant others to develop individualized activities programs, which promoted residents' needs, preferences and rights. Observation, on 02/14/2023 at 10:36 AM, revealed eight (3) residents seated in the common area of the [NAME] Hall who were watching television (TV), at 1:00 PM. Further observation revealed the AD was on the [NAME] Hall with ice cream and cake. It was noted there were no crafts being conducted with the Behavioral Unit. Crafts were being condcuted with the Memory Care Unit and at 3:54 PM, the smokers were gathered up and taken outside to smoke. Observation, on 02/15/2023 at 9:10 AM, revealed five (5) residents were gathered in the common area and watched TV. On 02/15/2023, at 2:21 PM, observation revealed the AD came through the [NAME] Hall and announced there would be live music in about twenty (20) minutes in the Men's Memory Care Unit. However, the residents from the Behavioral Unit were not allowed to go to the live music show to watch the performance. Observation, on 02/15/2023 at 2:55 PM, revealed Residents #56 and #62, who did not residen on the Men's Memeory Care Unit, were not allowed to go onto the Men's Memory Care Unit. Resident #56 looked through the window into the Men's Memory Care Unit. Observation, on 02/16/2023 at 12:45 PM, revealed Residents #271, #56 and Resident #15 seated in the common area and watched TV. Observation, on 02/17/2023 at 3:52 PM, revealed the live musical performance was back in the MMCU and again Resident #56, Resident 62 and Resident #271 were not allowed to go over and watch. Instead they sat in the [NAME] Hall common area and watched TV. Observation, on 02/20/2023 at 1:30 PM, revealed Residents, #56, #62, #93 and #271 were seated in the common area of the [NAME] Hall and watched TV. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation, on 02/24/2023 at 12:04 PM, revealed it was Fast Food Friday, but not all of the residents on the [NAME] Hall participated in it. Residents #56, #62, #93 and #271 had facility food for lunch Resident #69 made comments about the food coming and it was all his/her, he/she did not have to share and nobody was getting any of his/her food. Resident #93 and Resident #271 watched on as the other residents had fast food. Resident #56 and #62 did not seem to notice any difference in the food. Interview with the Activity Director revealed only resident with personal spending money could get fast food. Observations, on 02/15/2023, 02/16/2023, 02/17/2023, 02/18/2023, 02/19/2023, 02/26/2023 and 02/27/2023, from 8:30 AM to 4:00 PM, revealed no activities were done with the BU residents. Observation, on 02/26/2023 at 3:00 PM, revealed the calendar stated, Resident's Choice for the activity. At 3:30 PM, the Interim Director of Nursing I(DON) entered the [NAME] Unit with a beach ball and asked the residents if they wanted to play. Residents #56, #60, #62, #93, and #271 were present in the common area, some said, no and the others showed no interest. The DON left the unit. Observation on 03/13/2023 at 3:00 PM, of the BU Activity calendar revealed staff were to play cards with the residents, this activity did not take place. 1. Review of Resident #56's clinical record face sheet revealed the facility admitted the resident on 11/17/2022 with diagnoses of Schizophrenia, Dementia without behaviors and Dysphagia. Review of Resident #56's Admission MDS, dated [DATE], revealed the facility assessed the resident to have Hallucinations and paranoia, verbal and physical behaviors towards others and other behaviors not directed toward others. The facility assessed the resident with a BIMS score of three (3) out of fifteen (15) which indicated severe cognitive impairment. Review of Resident #56's Comprehensive Care Plan (CCP), dated 11/17/2020, revealed staff were to provide the activity of the resident's choice. The resident's CCP also revealed the resident wandered aimlessly and staff were to use distraction diversion such as structured activities, food, conversation, and books (11/22/2020). The facility was too encourage the resident to ambulate daily, walking inside and outside, to provide reorientation activities such as pictures, and memory box (11/22/2020). Resident #56 was a trauma survivor and it was noted in his/her care plan the resident enjoyed therapeutic activities such as coloring and journal (12/27/2022). 2. Review of Resident #62's face sheet, revealed the facility admitted the resident on 06/01/2020 with diagnoses of Schizophrenia, Dementia and Diabetes. Review of Resident #62's Quarterly MDS revealed the facility assessed the resident with a BIMS score of three (3) out of fifteen (15) signifying severe cognitive impairment. The facility assessed the resident to have behaviors of verbal and physical aggression for one (1) to three (3) days during the review period. The facility also assessed Resident #62 to reject care for one (1) to three (3) days. The resident required one person physical assistance for dressing eating, toilet use, walking in the room/corridor and for personal hygiene. For bed mobility and transfers the resident was identified as set up only. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #62's CCP, initiated 06/03/2020 and revised 02/12/2023, revealed the resident enjoyed sitting in the common area with his/her peers, socializing and watching TV. It was also noted the resident enjoyed coffee, outdoors, card games, bingo and horse shoes. The resident also liked to watch TV in the room alone, attending church service and listening to music. The resident was care planned to need assistance and escort to activities. 3. Review of Resident #93's clinical record revealed the facility admitted the resident on 06/28/2021 with diagnoses of Paranoid Schizophrenia, Paranoid Disorder, and Hallucinations. Review of Resident #93's Quarterly MDS, dated [DATE], revealed the resident had a BIMS' score of ten (10) out of fifteen (15) which indicated moderate cognitive impairment. The facility also assessed the resident to have delusions, verbally and physical behaviors towards others and other behaviors present for one (1) to three (3) days during look back period. On the Quarterly MDS, dated [DATE], revealed the facility assessed the resident to had a BIMS of fourteen (14) out of fifteen (15) which indicated the resident was cognitively intact. The facility assessed the resident to be absent of any behaviors at that time. On 07/19/2022, the resident was discharged to the hospital with delusions, inattention, disorganized thoughts, physical and verbal behaviors towards others. Review of Resident #93's CCP dated 01/12/2023, revealed the resident was care planned to enjoy watching TV, socializing, playing some games, going outside and coffee and snack socials. 4. Review of Resident #271's clinical record face sheet revealed the facility admitted the resident on 01/30/2023 with diagnoses of Dementia, Diabetes and Anemia. Review of Resident #271's Admission MDS dated [DATE] revealed the facility assessed a BIMS' score of six (6) out of fifteen (15) signifying the resident was severely cognitively impaired. In addition, the facility assessed the resident without behaviors, but rejected care one (1) to three (3) days through the evaluation period. The facility assessed the resident with daily wandering in the facility which was identified as intrusive to others. Review of Resident #271's Baseline Care Plan, dated 02/01/2023, revealed the facility would provide diversion to wandering through structured activities, food, conversation, books and television but it should have been the reference preference. Residents #56, #60, #62 and #271 were not interviewable. Interview, with Resident #93, on 02/14/2023 at 1:26 PM, revealed the resident stated he/she eloped from the facility because he/she wanted to go somewhere. The resident stated staff did not take residents for outings. The resident stated that the residents did not get to go out shopping, as staff did the shopping for residents. Interview, with Certified Nursing Assistant (CNA), on 03/03/2023 at 9:35 AM, revealed activities were not done with the men on the Behavioral Unit. She stated Patio time was the time smokers got to go out and smoke. She stated residents got to go out for about an hour when the weather was nicer. CNA #35 stated all residents were allowed to go out during Patio time but, the non smokers needed reminding. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview, with Licensed Practical Nurse (LPN) #2, on 02/14/2023 at 2:36 PM, revealed sometimes Activities came and played board games or cards with the residents on the [NAME] Hall. She stated she did not feel like she kept up with the activities listed on the calendar. She also stated Patio time was the time residents, who smoked, got to go outside and smoke. She stated all residents were allowed to go out, but it was usually just the smokers. LPN #2 stated activities were very important for the residents because it kept them engaged in something besides each other. The LPN stated Activities were likely to help decrease any resident to resident problems. Interview, and observation on 03/01/23 at 12:59 PM, revealed Activities Assistant #3 stated she was taking down the old activity calendars in each resident's room and putting up new ones. She stated she just started to work five (5) days per week but before, she worked Wednesday, Thursday and Friday. AA #3 stated she tried to do activities with the Behavioral Unit (BU) at least once a day. She stated on this day there were be Corn Hole' at 3:00 PM. She also stated the residents had Patio Time which was smoking time and the residents got to go out several times a day for that. AA #3 also stated all residents were welcome to go outside during Patio Time and enjoy the day. She stated the residents on the East Hall got to go out of the facility. However, the residents on the BU did not gte to go out because the facility did not have another bus driver. AA #3 stated she was trying to get licensed to drive the bus, so the residents on the BU would be able to go out too. Interview, with LPN #19 on 03/09/2023 at 10:30 AM, revealed she worked three (3) days a week on the Men's Memory Care Unit. She stated she tried to do an activity with the residents every day. Continued interview revealed on 03/09/2023, she had the residents in a circle and had them doing exercises. LPN #19 stated it was very important for residents to have daily activities, she stated this helped to keep them from wandering, prevented resident to resident altercations, and helped to keep the residents' mind working. She said nursing staff had to do their part to help the activities team because they were not always available to do it. LPN #19 said the activity should still happen because it was not the residents fault; whatever staff had going on. Interview with the AD on 03/15/2023 at 3:10 PM, revealed the problem with the lack of activities was one of the assistants were just fired right before state entered the building, making them short one (1) staff member. She stated she had to rely on CNAs to help do the activities. She stated the management team was well aware of the concerns and the Executive Director (ED) tried to get another Activity Director hired. The AD revealed she was the one who made the monthly calendar of activities. She said she had to have faith staff were doing the activities listed. She said she was not on site all of the time but would pop in to see what the team was up to. The AD said she had one (1) aide who had worked at the facility for three (3) years and she did a great job with keeping the residents busy. The AD said the importance of activities was to keep the residents intellect and social skills up. She also noted she did try to take the residents on outings, she said the Memory Care Unit got to go on two (2) outings. Continued interview with the AD on 03/15/2023 at 3:10 PM, revealed for Fast Food Friday, all resident got to be involved. She said she did not know of any residents on the [NAME] Hall who did not have money and she did not know why some of them would have been exploded in getting food. She said the Memory Care Director bought the residents food once a month too. She stated she would have to check with AA #3 to find out what happened as she was the one responsible for the Fast Food Friday on that day. The AD also said all of the residents were allowed to go outside for Patio time. She said she would make sure all residents were reminded they could go out, even if they did not smoke. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the ED on 03/16/2023 at 11:00 AM, revealed she looked at hiring another AD for the [NAME] Hall specifically and through she had that resolved. She said the residents in that unit liked to go outside. She said there was another bus to use for those residents and the aide worked to get her licenses so they could take the [NAME] Unit residents out of the facility. She wanted all of the facility's residents to be about to go out and shop. She said she was working to get the residents out and about. The ED stated it was important to keep the residents busy as that would help prevent wandering, and hopefully decrease falls and cut back on resident to resident incidents. She also stated the residents' care plans should be followed as well as the facility policies to ensure the residents got the best possible care.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 14936 Based on interview and review of the Activity Director's job description, it was determined the facility failed to ensure the Activity Program was directed by a qualified therapeutic recreation specialist or an activity professional who was licensed or registered by the State. The Executive Director (ED) stated in an interview on 05/23/2023, that the facility did not have an Activity Director in place who possessed the qualifications to serve in a Long-Term Care Facility. The findings include: Review of the Activity Director's job description, undated, revealed the required education and/or experience to fulfill the duties was an associates degree (A.A.) or equivalent from a two (2) year college or technical school, or two (2) to four (4) years related experience and/or training, or equivalent combination of education and experience, as well as meet state and federal requirements. During interview with Certified Nursing Assistant (CNA) #18/Activities Assistant #5, via telephone on 05/25/2023 at 7:18 PM, she stated she completed an Occupational Therapy Assistant degree. However, she had not taken the certification examination. She also stated she worked as an aide for fourteen (14) years, and had previously worked as an Activities Assistant at a different facility. She further stated she would be taking the Activity Director's position. Certified Nurse Aide (CNA) #18/Activities Assistant #5, stated she would apply for a temporary license and complete the post graduate field work while the board examination was pending. She stated she was not a certified Activity Director, but she was enrolled in a certification course that would begin in June 2023. During the interview, she stated the activities program was important because it helped the residents emotionally, and when residents were more engaged, they could become less agitated. During interview with the Human Resources Manager, on 06/02/2023 at 4:45 PM, she stated CNA #18/Activities Assistant #5 would no longer be taking the Activity Director position, as she she was no longer working at the facility. She stated the other new Activity Director had just started as of this date. The Executive Director (ED) stated during interview, on 05/23/2023 at 4:09 PM, that the previous Activity Director left about mid-March 2023. She stated she hired a replacement, but that person never started due to health issues. The ED stated two (2) new Activity Director hires were pending, one (1) for the upstairs unit and one (1) for the East side unit. She stated neither was currently certified as an Activity Director, but both were enrolled in the June 2023 class to receive that certification. During interview with ED, on 06/02/2023 at 1:23 PM, she stated one (1) of the new Activity Directors started today, but the other would not be filling that position after all. 44396

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 44974 Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, that would meet the residents physical, mental and psychosocial needs for one (1) of ninety-four (94) sampled residents (Resident #80). On 12/16/2022, Resident #48 punched Resident #80 in the face, which resulted in Resident #80 falling to the ground. On 12/16/2022 at 6:43 PM and 7:42 PM, Licensed Practical Nurse (LPN) #3, noted the fall, the resident's complaint of hip pain and verbal order received for an X-Ray. However, the facility did not obtain the X-Ray for Resident #80 until the following morning, on 12/17/2022 at 8:00 AM. Resident #80 entered the emergency room , at 3:57 PM on 12/17/2022, and received a total hip replacement for a displaced right hip fracture. The facility's failure to ensure residents received treatment and care in accordance with professional standards of practice has caused or is likely to cause serious injury, serious harm, or death to residents in the facility. Immediate Jeopardy (IJ) was identified on 03/08/2023 at 42 CFR 483.25 Quality of Care (F684) at the highest S/S of a J and was determined to exist on 12/16/2022 and is ongoing. The facility was notified of the Immediate Jeopardy on 03/08/2023. In addition, Substandard Quality of Care (SQC) was identified at 42 CFR 483.25 Quality of Care (F684). The findings include: Review of the facility's policy titled, Fall Management- Response to a Resident's Fall, dated 09/01/2022, revealed the facility would evaluate and monitor the resident for 72 hours post fall; a neurological assessment would be completed on any unwitnessed fall or witnessed fall hitting the head; assess airway, breathing and circulation; summon help, as needed; assess level of consciousness, vital signs, and range of motion; look for lacerations, abrasions, and obvious deformities; initiate first aid if minor injury. Continued review revealed, if it was an emergency situation, initiate the Emergency Medical System (EMS) response, contact the provider and family, and remain with the resident until EMS arrives. Review of Resident #80's Admission Record revealed the facility admitted the resident, on 07/27/2021, with diagnoses that included Dementia, Cognitive Communication Disorder, Insomnia, Muscle weakness, and Osteoarthritis. Review of Resident #80's Quarterly Minimum Data Set (MDS) Assessment, dated 12/06/2022, revealed the facility assessed Resident #80 with a Brief Interview for Mental Status (BIMS) score of five (5) of fifteen (15), which indicated the resident was moderately cognitively impaired. Continued review revealed Resident #80 exhibited verbal and physical behaviors towards others which included: hitting, kicking, pushing, scratching, grabbing, screaming at others, or cursing and wandering. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #80's Nursing Progress Note, dated 12/16/2022 at 6:43 PM, entered by Licensed Practical Nurse (LPN) #3, revealed she had been informed by Certified Nursing Assistant (CNA) #22 that a resident had been punched in the face by another resident. Continued review revealed Resident #48 stated he/she hit Resident #80 in the face because he/she called him/her a whore. Further review revealed Resident #80 complained of pain in his/her right hip and had a small skin tear to the left side of his/her face. The Progress Note revealed LPN #3 continued to monitor Resident #80, and Resident #48 was placed on one on one (1:1) supervision immediately. Review of Resident #80's Nursing Progress Note, dated 12/16/2022 at 7:42 PM, revealed Nurse Practitioner (NP) #2 was contacted and gave a verbal order for an x-ray of the resident's right hip and pelvis. Review of a Triage Note, dated 12/16/2022 at 7:42 PM, entered by NP #2, revealed Resident #80 had been punched by another resident and fell on his/her right side, which resulted in right hip pain and a small skin tear to the left side of his/her face. Continued review revealed new orders were given to obtain an x-ray of the right hip/pelvis, and cleanse the skin tear, keep clean and dry, and to notify the provider of acute concerns. Review of Resident #80's Medication Administration Record (MAR), dated 12/16/2022, revealed Tylenol (pain medication) 500 milligram (mg) extended-release tablets, two (2) tabs had been administered by Certified Medication Technician (CMT) #13 at 9:00 PM. Review of the Radiology Report, dated 12/17/2022, at 8:06 AM revealed Resident #80 sustained a displaced fracture of the right femoral neck. Review of Resident #80's Hospital Discharge Summary, dated 12/23/2022, revealed the initial report from the facility had been called to the hospital on 12/17/2022 at 3:51 PM. Continued review revealed the resident had an acute displaced fracture through the sub-capital portion of the right femoral neck and an orthopedic surgical consultation was warranted. Interview on 02/23/2023 at 1:14 PM, with Certified Nursing Assistant (CNA) #22, who witnessed the incident, revealed Resident #80 called Resident #48 a name and Resident #48 stood up and punched Resident #80 in the face. Per interview, Resident #80 fell to the floor on his/her right side. CNA #22 stated she separated Resident #80 and Resident #48 and notified LPN #3. Interview on 02/23/2023 at 3:45 PM, with CNA #9, revealed Resident #80 was walking around the couch and talking in the common area. Resident #80 was overheard calling Resident #48 a bitch. Resident #48 stood up and punched Resident #80 in the face causing him/her to fall. Continued interview with CNA #9 revealed she and CNA #22 separated Resident #80 and Resident #48 immediately and notified the nurse. The CNA further stated the incident happened so fast, they could not get there fast enough to separate the residents before Resident #48 hit Resident #80, causing him/her to fall and hit the floor. Interview on 02/24/2023 at 2:36 PM, with Licensed Practical Nurse (LPN) #3, revealed Resident 80 was on the floor when she went to the resident. She stated Resident #80 was tearful and stated his/her hip hurt. LPN #3 stated she assessed Resident #80, and assisted the resident to a chair, and then assisted the resident to bed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 03/08/2023 at 1:56 PM, with NP #2, revealed she hardly recalled the call she received on 12/16/2022 regarding Resident #80. She stated she did give the order to get an x-ray due to the resident's complaints of hip pain. Per interview, it was her expectation that an order for an x-ray would be done the same day the order was given, and it would typically not be done the next day. Continued interview revealed a delay in treatment and services could cause continued pain and other complications with the hip due to the fracture. Interview, on 03/18/2023 at 11:34 AM, with the x-ray company's receptionist, revealed an order for a routine x-ray had been placed by phone on 12/16/2022 at 7:43 PM. Continued interview revealed a routine x-ray should be completed between eight to twenty-four (8-24) hours of receipt. However, a stat x-ray should be done within four to six (4-6) hours of receiving the order. Interview, on 03/08/2023 at 11:40 AM with the Medical Director (MD), revealed he did not specifically remember a call on 12/16/2022 regarding Resident #80. However, he did recall Resident #80 had altercations with other residents. The Medical Director stated the facility was to call him Monday through Friday 8:00 AM -5:00 PM, and to call the On-Call Physician Services Group after 5:00 PM, and on weekend for any concerns. Per interview, it was his expectation for staff to ensure safety of residents, assess the resident(s) involved, and he expected neurological tests to be initiated, assess for pain at specific area, and assess for any deformities. Further, he stated in specific situations, obtain a stat x-ray, if needed. The Medical Director stated it would concern him if x-rays were not completed timely for a suspected fracture, because of the pain level the resident might be experiencing. Interview on 02/22/2023 at 2:05 PM, with the Director of Nursing (DON), revealed she would expect residents to be watched and staff to follow the facility's policy. Interview on 03/16/2023 at 10:00 AM, with Executive Director (ED), revealed when a fall occurred, she expected the nursing to assess the resident, and if necessary, send the resident to the emergency room (ER). She stated if it was not emergent, she would expect an in-house x-ray to be obtained. The ED stated she expected the nurse to contact the DON immediately with any falls and hospital transfers.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14936 Based on interview, observations, record review, and the facility's policy it was determined the facility failed to ensure proper treatment and evaluation for assistive devices related to maintaining vision for one (1) of thirty-three (33) sampled residents (Resident #90). The facility admitted Resident #90 on 09/21/2022. However, the facility failed to arrange for the resident to be assessed for his/her vision impairment and need for eyeglasses. The findings include: Review of the facility's policy titled, Vision and Hearing Evaluations, Version #:1, dated 09/03/2017, revealed the purpose statement was to promote resident function at their highest practical level. Procedures included assess need for an evaluation, with resident or representative with Social Services or nursing staff arranging evaluation as soon as possible. Added review revealed Social Services or designee would update the resident's plan of care. Review of the facility's agreement with the contracted Optometry Service, with an effective date of 11/01/2019, revealed services available included Optometry Services. These services included vision examinations, medical eye evaluations, fall risk evaluations and fitting and ordering glasses. Review of Resident #90's Admission Record revealed the facility admitted Resident #90, on 04/05/2023 with diagnoses of Alzheimer's Disease, muscle weakness, difficulty walking, dementia, vision impairment, and repeated falls. Review of Resident #90's Quarterly Minimum Data Set (MDS) Assessment, dated 04/07/2023. revealed the facility assessed the resident with a Brief interview for Mental Status (BIMS) score of three (3) out of fifteen (15). This score indicated severe impairment. Further review revealed Resident #90 had moderately impaired-limited vision. Review of Resident #90's Fall Risk assessment dated [DATE] revealed a score of eighteen (18) indicating vision status as poor. Review of the facility's Fall Risk Assessment form revealed eight (8) areas of fall risks, which included, 1-level of consciousness/mental status, 2-history of falls(past three (3) months), 3- Ambulation/elimination status, 4- Vision status, 5- Gait/balance, 6- systolic blood pressure, 7- Medication, 7-1 resident has had a change in medication or change in dosage in the past five (5) days, and 8- predisposing disease. Continued review of FRA revealed number four (4) was indicated for vision status as poor (with or without glasses) for Resident #90. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #90's Comprehensive Care Plan (CCP), dated 09/15/2022, revealed the facility assessed the resident to reside on a secured unit related to diagnosis of dementia and impaired safety to surroundings. Interventions placed on the 01/20/2023 CCP, included the resident was to be supervised while on the secured unit. Continued review of the CCP revealed the facility assessed the resident to be at risk for falls related to impaired safety awareness and impaired vision increasing risk of injury. The date initiated was 09/15/2022 and was revised on 03/21/2023. Additional interventions included: individualized activities to reduce outside stimulation; resident had impaired vision causing hearing to be more sensitive to loud noises and outside distractions initiated on 10/21/2022 and revised on 03/09/2023. Continued review of Resident #90's CCP revealed the facility assessed the resident to have impaired visual function and uses walls as guides. Review of the CCP revealed interventions placed on 10/11/2022, which included to arrange consultation with eye care practitioner as required, assist with Activities of Daily Living (ADLs) as needed and consistently tell the resident where items were placed. Observation of Resident #90, on 05/25/2023 at 9:15 AM, revealed the resident was sitting in a chair with other residents in the common area and appeared to be dozing. Further observation revealed bruising noted to the resident's left eye orbital area. Review of Resident #90's Electronic Medical Record (EMR) revealed on 05/25/2023 at 4:15 AM the resident was found on the floor in his/her room with sheets wrapped around his/her feet. A skin assessment revealed a small area of blood from an old scab and two (2) small knots noted on the left side of his/her face. The facility did not transfer the resident to the hospital. Continued review of Resident #90's EMR revealed on 04/21/2023 at 6:45 AM, the resident attempted to sit in a chair located in the dayroom and missed the chair falling to the floor, no injuries were noted. Review of Resident #90's EMR revealed on 04/22/2023 ecchymosis (bruising) was noted to resident's buttock area. Review of the Interdisciplinary Team (IDT) meeting notes on 04/21/2023 revealed no injuries were noted after the fall, but ecchymosis was noted to the right buttock. Review of the IDT meeting notes revealed the root cause of the fall was determined to be the resident attempted to sit in chair and was not close enough to the chair, lost his/her balance and landed on his/her buttocks. Continued review of the meeting notes revealed no evidence the facility considered Resident #90's impaired vision as a root cause of the falls. Review of Resident #90 EMR revealed, on 04/15/2023 at 1:52 PM, the resident had two (2) falls within twenty (20) minutes, one in which the resident hit the back of his/her head which resulted in a small amount of blood noted. Further review revealed the facility transferred Resident #90 to the local emergency room . Review of the IDT Notes, dated 04/15/2023, revealed Resident #90 fell twice in twenty (20) minutes with no injuries noted with the first fall. However, the resident hit his/her head with the second fall with a small laceration and a small amount of blood noted to the back of the scalp. The root cause analysis concluded the resident attempted to transfer without assistance and was unable to do so. Continued review revealed no evidence the facility considered impaired vision as a possible root cause for the falls. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the results of the Computerized Tomography (CT) of Resident #90's head performed at a local emergency roiagnom on [DATE] were chronic subdural (membrane covering spinal cord and brain) hematomas (mass of blood) and or hygromas (sac of fluid) since study on 09/16/2022. Review of the CT of the spine revealed no fractures of the spine with final diagnosis of contusion of scalp per emergency room notes. Continued review of Resident #90 EMR revealed an active order as of 04/05/2023 which stated the resident was to see an ophthalmologist written on 09/15/2022 upon admission. Review of the EMR also revealed a Physical Therapy Evaluation and Plan of Treatment, dated 04/06/2023, which noted patient's (resident's) factors included poor scanning of environment and history of wandering around on unit. Continued review of the Physical Therapy Evaluation and Plan of Treatment, dated 05/29/2023, revealed a new goal was to provide verbal cues for use of compensatory strategies due to low/reduced vision. Review of the Physical Therapy Evaluation and Plan of Treatment revealed a functional mobility assessment for gait which included deviations of inconsistently scanning environment and difficulty with object negotiation below waist level. Review of Resident #90's EMR revealed appointments for an eye examination on 06/21/2023, with the resident listed as a new patient exam. Continued review revealed former the Medical Director, noted on 04/14/2023 for the eye doctor to evaluate Resident #90 on next visit due to vision declining. Observation on 05/30/22023 at 12:40 PM revealed another resident holding Resident #90 hand and guiding him/her as they walked down the hallway to the dining room. Additional observation revealed two (2) staff members who were already in the dining room, assisted Resident #90 to be seated in a chair at the table. Observation on 05/31/2023 at 9:25 AM revealed Resident # 90 sitting in chair with his/her head down. Resident #90 appeared to be dozing (falling asleep). Observation on 05/30/2023 at 12:40 PM revealed Speech Therapy #1 assisted the resident with his/her meal redirecting where the resident's food was located on the plate, placement of his/her drink and the amount of food to be placed in the spoon. During interview with Certified Nursing Assistant (CNA) #87 on 05/25/2023 at 9:30 AM, she stated Resident #90 was a little unsteady when walking and had sustained a fall on night shift. CNA #90 stated the resident now had bruising to the left eye. The CNA stated she had not noticed the resident wearing glasses since she has worked here. During interview with CNA #34, on 05/25/2023 at 9:20 AM, she stated she never saw the resident with glasses since he/she lived at the facility. In an additional interview with CNA #34, on 06/02/2023 at 5:05 PM, she stated Resident #90 needed assistance when trying to sit in a chair. In a interview with Licensed Practical Nurse (LPN) #9, on 05/30/2023 at 11:20 AM, she stated she never saw Resident #90 wearing glasses. She stated she recalled eye care had previously been to the facility but, she could not recall if Resident #90 had seen them. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with Social Service Director (SSD), on 05/31/2023 at 2:30 PM, she stated appointments were set up for routine visits for the residents, but the Optometry Service declined coming to facility since the State Survey Agency was in the building and appointments were moved to 06/21/2023. She stated that she did not know if the previous SSD made any appointments for Resident #90 to be seen by the eye doctors. Review of the CCP with the SSD, revealed the CCP was initiated on 09/15/2022 and revised on 03/21/2023 for Resident #90 to see an eye care doctor for impaired vision, which increased the risk for injury. In interview with Director of Nursing (DON), on 05/23/2023 at 2:00 PM, she stated the only time a resident was sent to outside provider for eye care was if the resident had an urgent condition.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44000 Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to have an effective system in place to ensure residents received adequate care and assistance to prevent pressure injury for residents at risk or to prevent new injury from developing for two (2) of ninety-four (94) sampled residents (Resident #89 and #95). The facility admitted Resident #89, on 04/22/2022 and assessed the resident to be ambulatory and a low risk for pressure ulcers (injury to the skin and underlying tissue due to prolonged pressure on the skin). However, the facility assessed the resident to have a Stage III pressure ulcer to the sacrum (full thickness tissue loss with subcutaneous fat likely visible), on 10/05/2022. The resident was seen by the wound care specialist. The specialist recommended for staff to turn and reposition the resident every one (1) to two (2) hours. However, there was no documentation to support the resident was turned and repositioned nor was the resident's care plan developed to include turning and repositioning the resident. On 10/26/2022, the facility assessed the resident's pressure ulcer had worsened to a Stage IV (the last stage and bone, muscles, and tendons could be visible). Resident #89 was admitted to the hospital on 11/02/2022 for sepsis and surgical wound debridement. Observations on 02/23/2023, revealed the resident was not turned or repositioned for two (2) hours and forty-five (45) minutes. Additional observation, later that day, revealed the resident was not turned for a total of three (3) hours and forty (40) minutes. Interview with Licensed Practical Nurse (LPN) #31 and Certified Nursing Assistant (CNA) #42 revealed they often were not able to turn and reposition the residents every two (2) hours. Immediate Jeopardy (IJ) was identified on 03/11/2023 at 42 CFR 483.25 Quality of Care/Prevention of Pressure Sores (F686) at the highest S/S of a J and was determined to exist on 10/05/2022 and is ongoing. The facility was notified of the Immediate Jeopardy on 03/11/2023. In addition, Substandard Quality of Care (SQC) was identified at 42 CFR 483.25 Quality of Care/Prevention of Pressure Sores (F686). In addition, Resident #95 had sustained multiple ischemic events and was no longer independent with bed mobility or transfers. He/she returned from a hospital admission on 01/30/2023 with a Stage III pressure injury to the ischium that was healed but recurred in eight (8) days. Then, Resident #95 developed a Stage IV pressure injury to the sacrum. The findings include: Review of the facility's policy, Pressure Prevention, revised April 2020, revealed residents' skin should be assessed upon admission for existing pressure injury risk factors, then repeat the risk assessment weekly and upon any changes in condition. Further review revealed the facility would use a standardized pressure injury screening tool to determine and document risk factors as well as supplemental use of a risk assessment tool with assessment of additional risk factors. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Prevention of Pressure Injuries Policy, dated 2001, revised April 2020, revealed the purpose was to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. The policy stated to review the resident's care plan and identify the risk factors as well as interventions designed to reduce or eliminate those considered modifiable. Per the policy, the skin was not to be rubbed or otherwise cause friction on skin that was at risk of pressure injuries. The policy also stated to reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team (IDT). The policy stated to choose a frequency for repositioning based on the resident's risk factors and current clinical practice guidelines. Per the policy, potential changes in the skin must be evaluated, reported, and documented. The policy directed to review the interventions and strategies for effectiveness on an ongoing basis. 1. Review of Resident #89's medical record revealed the facility admitted the resident, on 04/22/2022 with diagnoses that included Schizophrenia, Personal History of Traumatic Brain Injury, and Dementia. Per the record, Resident #89 was ambulatory on admission. In addition, the admission skin assessment revealed Resident #89 was free of skin lesions. Further review of Resident #89's medical record revealed his/her condition declined, and the resident was admitted to the hospital from 09/04/2022 to 09/09/2022. Resident #89's condition further declined, and he/she was again admitted to the hospital from 09/14/2022 to 09/22/2022. Per the record, Resident #89 returned with a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube inserted into the stomach to provide liquid nutritional support). Further review revealed Resident #89 returned with two (2) pressure ulcers: a Stage II pressure wound (partial thickness loss of the dermis presenting as a shallow open ulcer) on the left medial thigh and a Stage III pressure wound on the right buttock. Review of Resident #89's medical record revealed, on 10/05/2022, the resident developed a Stage III pressure wound on the sacrum while in the facility. Per the record, the thigh and right buttock wounds were documented as healed on 10/12/2022. Further review revealed, on 10/26/2022, the sacrum wound deteriorated to a Stage IV pressure ulcer. Per the record, from 10/19/2022 to 02/20/2023, recommendations from the Wound Physician were to turn the resident from side to side and front to back in bed every one (1) to two (2) hours if able. Review of Resident #89's Wound Physician's Note, dated 11/02/2022, revealed a recommendation to send the resident to the emergency department (ED) due to a change in behavior and pallor of the skin. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #89's hospital record revealed the resident was sent to the hospital ED on 11/02/2022. Per the record, in the ED the resident was found to have tachycardia (heart rate greater than 100 beats/minute) and tachypnea (breathing rate greater than 20 per minute). Further review revealed Resident #89 was administered intravenous (IV) Vancomycin and Zosyn (antibiotics to fight infection) in the ED. The hospital admitted the resident for further management. Per the record, upon admission, the resident was given IV fluids as the resident was diagnosed with Sepsis (a life threatening complication of an infection) and was dehydrated. Additional IV antibiotics were started as well. Continued record review revealed Resident #89 received an x-ray of the sacrum and coccyx on 11/03/2022 for possible osteomyelitis (an infection of the bone). The findings found decubitus ulceration in the region of the coccyx, and the distal coccygeal segments were eroded, compatible with osteomyelitis. The record stated Resident #89 underwent surgical wound debridement (removal of necrotic tissue) on the Stage IV pressure ulcer on the sacrum/coccyx on 11/04/2022 with no complications. Resident #89 was discharged back to the facility on [DATE]. Review of Resident #89's care plan, revised 10/25/2022, revealed it did not include interventions to off-load the sacral wound and turn every two (2) hours. Further review revealed the care plan did not have any documentation related to pressure ulcer care or prevention, even though the pressure ulcers were first identified when the resident returned to the facility, on 09/22/2022, from a hospital admission. Interview, with Minimum Data Set (MDS) Nurse #1, on 02/21/2023 at 5:40 PM, revealed she did not think the care plans needed to be more specific about prevention of pressure ulcers. Review of Resident #89's Treatment Administration Record (TAR) revealed there was no documentation that the resident was turned and repositioned at least every two (2) hours until 11/12/2022. Further review of the treatment record revealed Resident #89 was not turned every two (2) hours on eighteen (18) of the nineteen (19) days left in November 2022. Review of the Dietary Progress Note, dated 09/26/2022 at 1:14 PM, revealed Resident #89 returned from the hospital, on 09/22/2022, with enteral nutrition of Isosource 1.5 at 50 milliliters (ml)/hour continuous. Per the note, the enteral nutrition was changed to Osmolite 1.2 at 75 ml/hour continuous for twenty-two (22) hours, and off for Activities of Daily Living (ADLs) 8:00 AM to 10:00 AM. Interview with the Dietitian, on 02/26/2023 at 10:00 AM, revealed the tube (PEG) feeding was changed to the facility's formula. The Dietician stated this formula provided enough calories and protein to meet Resident #89's nutritional needs. Observation, on 02/15/2023 at 4:00 PM, of Resident #89's wound care by the Wound Doctor of Osteopathic Medicine (DOM) revealed the resident was found to have a Stage III pressure wound on the right lower medial shin; a left knee Stage III pressure wound; and a Stage IV pressure wound on the sacrum. Observation revealed the DOM used a scalpel to remove a small piece of necrotic tissue on the left knee Stage III pressure wound, and no pain behaviors were present. Further observation revealed a scar on the right buttock. The DOM sprayed a numbing solution on the area and used a [NAME] to remove necrotic tissue from the wound. Resident #89 did not exhibit any signs of pain. Observation, on 02/23/2023, revealed Resident #89 was lying on his/her right side for two (2) hours and forty-five (45) minutes, from 9:10 AM to 10:55 AM. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further observation, on the afternoon of 02/23/2023, revealed Resident #89 was lying on his/her back for three (3) hours and forty (40) minutes, from 12:10 PM to 3:50 PM. Observation, on 02/24/2023 every hour from 9:00 AM to 3:00 PM, revealed Resident #89 remained on her/his back the entire time. Interview, with Certified Nursing Assistant (CNA) #20, on 02/24/2023 at 3:10 PM, revealed, (Resident #89) has to be on the back, we have pillows where the wound is. When we turn her/him, (the resident) starts moaning. Observation, on 02/26/2023 at 2:45 PM, of Registered Nurse (RN) #7 changing the dressing on Resident #89s coccyx and lower extremities revealed CNA #32 assisted in turning Resident #89. Further, Resident #89 did not show any pain behaviors during dressing changes. Interview with CNA #42, on 03/09/2023 at 3:33 PM, revealed when specifically asked if she knew Resident #89 needed to be turned every two (2) hours, replied she did not know because she did not have time to look at the care plan. Interview, with the Associate Director of Nursing (ADON), on 02/23/2023 at 9:50 AM, revealed she had been doing rounds with the WP since 01/30/2023. She stated she thought the wounds on Resident #89 occurred due to the resident being contracted. The ADON stated she ensured staff followed the treatment listed in the chart by monitoring staff. She stated, if she found the treatment had not been followed, she educated the staff. Interview with the DOM, on 02/23/2023 at 10:19 AM, revealed he thought the wound on Resident #89's sacrum/coccyx was from pressure. Further he stated the resident was contracted, and the pressure wounds on the lower extremities could be caused by the contractures of the legs. He stated Resident #89's fairly young age should assist with the wound healing, and the wounds were less likely to occur. Interview with the Executive Director (ED), on 03/16/2023 at 10:36 AM, revealed she assured the Director of Nursing (DON) carried out the Physician's Orders by talking about them in the daily clinical meeting. She stated she could not say why the pressure ulcer was not documented or shown as worsening on the form used to show the resident's conditions. She stated it was also her understanding that the DON was knowledgeable about the worsening pressure ulcer. 44396 2. Review of Resident #95's electronic medical record (EMR) revealed the facility admitted the resident, on 10/14/2022, with diagnoses of Encephalopathy, Type II Diabetes Mellitus, and Dementia. Review of Resident #95's admission Skin Observation Tool, dated 10/17/2022, revealed no skin issues. Review of subsequent Skin Observation Tools revealed no skin disruption until 02/03/2023, when a Stage III pressure wound was identified to the right ischium after returning from a hospital stay following a cerebral infarction. Review of Resident #95's Braden Scale Evaluation, dated 01/30/2023, revealed he/she was at risk for pressure wounds with a score of sixteen (16). (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #95's MDS Significant Change Assessment, post cerebral infarction, dated 02/06/2023, revealed a Brief Interview of Mental Status (BIMS) score of ninety-nine (99), which indicated the resident could not participate, using this assessment tool. Review of Resident #95's EMR progress notes revealed the Stage III pressure wound to the right ischium was identified on 01/31/2023 after readmission from a hospital stay. The facility referred the resident for wound specialist care at that time. The resident was seen by the wound physician on 02/02/2023, who ordered Santyl (removed dead tissue from a wound to promote healing) and Calcium Alginate (created a dry wound by removing fluid to promote healing) to treat it. Further review revealed the wound was evaluated as resolved by the wound care physician, and he signed off on Resident #95's care on 02/15/2023. Continued record review revealed a change in condition note, dated 02/23/2023 at 5:03 PM. The note stated the Nurse Practitioner (NP) diagnosed a Stage III pressure wound to the coccyx and referred the resident back to wound care, eight (8) days after after the wound was noted to be resolved. Further review revealed a dietary note, dated 03/01/2023, which stated there were four (4) open pressure areas in total: bilateral heels, sacrum, and a reopened area to the ischium. Review of Resident #95's wound care note, dated 02/27/2023, confirmed the recurrence of the right ischium pressure wound, as well as the new presence of deep tissue injuries to the bilateral heels and a Stage IV wound to the sacrum. Review of Resident #95's Treatment Administration Record for February revealed treatments were documented as completed as ordered through 02/15/2023; and noted that the wound had healed. However, review of the point of care documentation for the month did not reflect consistent documentation for turning and repositioning or for offloading of the wounds. Review of Resident #95's Comprehensive Care Plan revealed a Focus for Risk of Skin Impairment, initiated 10/17/2022, with interventions added on the same date. The interventions were to turn and reposition to maintain skin integrity (it did not give the frequency), pressure reducing mattress, and skin checks weekly. Further review revealed the first interventions added or revised after those at admission were documented on 02/24/2023 and included moon boots (an orthotic device to offload weight) to bilateral heels, wound physician to evaluate and treat, and turn and reposition to promote healing of current areas (no frequency mentioned). Continued review revealed the addition of interventions on 03/15/2023 to include turn side to side in bed every one (1) to two (2) hours if able, to offload wound and wound care physician rounds at facility per schedule. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of Resident #95, on 03/07/2023 at 1:16 PM, revealed Resident #95 resting in bed on his/her back, his/her heels were not on an offload pillow, and his/her right hip was offloaded with a pillow. The resident was located in a corner room with the bed not visible to the hallway. Continued observation at 2:18 PM revealed Certified Occupational Therapy Assistant (COTA) #1 donned (put on) Personal Protective Equipment (PPE) and entered Resident #95's room then exited the room at 2:24 PM. Interview at that time revealed COTA #1 had removed the splint from Resident #95's right arm and placed a pillow under it. Observation at 2:29 PM revealed Resident #95's right hip was still offloaded with a pillow; his/her heels were not on offloaded on a pillow. The only change made was the resident's right arm was now offloaded with a pillow. Continued observation at 3:04 PM revealed CNA #18 entered Resident #95's room with a Hoyer (name brand mechanical) lift, then exited the room and returned down the hall. CNA #18 returned at 3:23 PM alone, obtained gloves from the cart and entered the room, closing the door. Additional observation at 3:37 PM revealed Physical Therapy Assistant (PTA) #1 entered the room to see Resident #95, and CNA #18 exited. Interview with CNA #18 revealed she was using the lift to weigh Resident #95, and she had not gotten him/her up nor had she changed him/her. Observation of Resident #95, after CNA #18's exit, revealed the resident was with the Speech Therapist (ST) and with the right hip still offloaded and his/her heels were not on an offload pillow. Observation with the Wound Care Physician and Resident #95, on 03/09/2023 at 4:15 PM, revealed the resident was diagnosed , on 02/27/2023, with a Stage III full thickness pressure wound to the right ischium, a Stage IV full thickness pressure wound to the sacrum, and bilateral Deep Tissue Injury (DTI) to his/her bilateral heels. This observation revealed the resident's right heel DTI had resolved, and the other three (3) wounds were healing. Interview, with the Wound Care Physician, on 03/09/2023 at 4:15 PM, revealed the key to wound care beyond the treatments was consistency. Further interview revealed that consistency with keeping residents dry and keeping the wounds offloaded was important to healing. He stated a wound was always multifactorial in causes and that a wound that had been treated consistently for three (3) weeks and was healing could be disrupted with a day of not providing that care. Telephone interview with the Wound Care Physician, on 02/27/2023 at 4:50 PM, revealed his expectation of staff to do dressing changes routinely as ordered was key and that the wound care nurse had to play a role through the week to spot check for compliance with orders being carried out. He stated, specifically when rounding, the nursing staff should always check to see what was being put on the wound. Continued interview revealed so much depended on the quality of aides on a particular floor because residents needed to be moved and wet or soiled briefs changed every two (2) hours. He stated not doing that would clearly cause problems. The wound care physician stated he enjoyed having aides come help them when they were rounding on the units because it was an opportunity for education on what poor hygiene caused as far as wound care. He also stated, in the end, the aides were the ones who had to respond to the lights and do the work. The physician stated central to wound healing was how well the resident was eating, and the aides were the ones with the best observance of that. He stated aides should clean, turn, and apply creams, lotions, and powders as ordered. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview, with CNA #15, on 03/01/2023 at 3:20 PM, revealed there were two (2) different ways to know a resident's care needs, walking shift change report or review the care plan/Kardex. Further interview revealed she usually had ten (10) to twelve (12) residents, maximum of fifteen (15). She stated she had worked on all units except one (1), so she knew a lot of residents already, but otherwise she would ask a full time staff member or the nurse for guidance. Continued interview revealed repositioning was expected every two (2) hours even when the resident was in a chair. She stated turning and repositioning was important to protect residents' skin. Interview, with CNA #48, on 03/01/2023 at 8:33 PM, revealed she learned care needs with shift report from off going aides and from the Kardex or asked the nurse for guidance. She stated check and change the residents was supposed to be every two (2) hours, but it depended if the resident had diarrhea or was a heavy wetter. She stated keeping residents dry was important for hygiene, for comfort, and to protect skin from breakdown. Continued interview revealed she knew it was also important for residents' skin to reposition with pillows on the side or put pillows under the back, under the arm, or between the knees. She stated Resident #95 should be turned every two (2) hours and also the head of his/her bed should be up because of tube feedings. Interview with CNA #18, on 03/02/2023 at 8:28 PM, revealed he/she thought the facility needed a paper report sheet because there was so much agency staff and new people in the building. She stated that way they would more easily know things like who needed to be turned every two (2) hours. Further interview revealed staff should be repositioning residents every two (2) hours with pillows to protect skin and prevent contractures. Interview with Registered Nurse (RN) #4, on 03/09/2023 at 3:50 PM, revealed she often did not have the treatment supplies she needed to complete wound care. However, she stated she used the supplies she had. Interview, with CNA #42, on 03/09/2023 at 3:33 PM, revealed she often did not have the time to turn residents every two (2) hours. Interview, with Licensed Practical Nurse (LPN) #31, on 03/15/2023 at 9:10 PM, revealed often times the facility was short staffed, and staff members did the best they could at the time to give the care to prevent wounds. LPN #31 stated wound prevention relied on turning and repositioning and offloading wounds. Interview, with the Assistant Director of Nursing (ADON), on 03/01/2023 at 3:43 PM, revealed her expectation for staff to provide turning and repositioning and offloading wounds, both to protect skin from developing wounds or to help existing wounds heal. She also stated she expected staff to conduct rounding every two (2) hours. Interview, with the Executive Director (ED), on 03/11/2023 at 11:01 AM, revealed she relied on the DON to ensure the Wound Care Physician's orders were carried out by the nursing staff. She stated there was a weekly clinical meeting that the DON attended where staff discussed the residents' wounds. She stated the DON would review the recommendations from the meeting and ensure these recommendations were put on the residents' care plans and implemented. (continued on next page)

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	185165	A. Building B. Wing	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the previous DON (Interim DON #3), on 03/08/2023 at 1:15 PM, revealed the floor staff were responsible to assure the residents were turned every two (2) hours. She further stated it was important to turn residents every two (2) hours to reduce pressure because if residents were not turned it could lead to skin impairment. Interview with the Immediate Past DON, on 03/16/2023 at 11:40 AM, revealed she had only vacated the DON position five (5) days earlier. Further interview revealed her expectation was for nurses to follow physician's orders for wound treatment. She stated the aides must follow standards of practice, such as offloading pressure areas, as even micro movement could make a difference. Continued interview revealed it was important that the staff took credit for what they did, by documenting it. She stated it was important to keep residents clean, dry, and to conduct perineal care during rounds. Interview, with RN #10 (former DON), on 03/11/2023 at 11:15 AM, revealed the process to assure care plans and the Kardex were followed was for nurses to report to the nurse aides each day after the morning huddle meetings. She stated the primary nurse or anyone in the morning huddle meeting was to physically go to the unit and verbally tell each nurse and nurse aide of any change in the care plan interventions. Further interview revealed the nurse aides would perform their rounds with the next shift and report any new changes. RN #10 added it was the primary nurse's responsibility to assure the residents were being repositioned as ordered. She stated the only time a turn should not take place would be if the resident refused or had pain. However, if pain was occurring, it should be reported to the nurse for pain medication prior to turning. She stated the Braden Scale was performed on new admits; skin assessments were performed upon admission; within the next twenty-four (24) hours, and then weekly. She added the Wound Care Physician performed treatments and measurements; but, if the measurements were not taken, it was ultimately the responsibility of the primary nurse to perform the task. She stated pressure relieving devices and offloading should be added to the care plan and performed. She stated monitoring of wounds was performed by either the Wound Care Physician or nurse weekly. Additional interview with the ED, on 03/16/2023 at 10:41 AM, revealed her expectation was that CNAs should keep residents turned, repositioned, clean, and dry to prevent pressure wounds. She stated immediate incontinence care and getting residents out of bed if tolerated would also help to prevent pressure wounds.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32635 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure residents' environment was as free of accident hazards as possible and failed to provide the necessary supervision to avert accidents for fifteen (15) of ninety-four (94) sampled residents. (Residents #5, #61, #73, #74, #80, #93, #96, #97, #106, #128, #131, #134, #138, #371 and #821). 1. The facility failed to ensure it had a system in place for adequate supervision and monitoring to prevent accidents/falls, to determine the root cause of falls, to evaluate falls and implement individualized interventions and to monitor the effectiveness of interventions to prevent additional falls for fourteen (14) of ninety-four (94) sampled residents (Residents #5, #61, #73, #74, #80, #96, #97, #128, #131, #134, #138, #371, #106, and #821). (a). On [DATE], Resident #138 sustained a fall, requiring sutures to his/her head. Resident #138 had two (2) more falls that resulted in trauma to the same sutured area. Resident #138 had multiple falls and was hospitalized from [DATE] through [DATE] at which time the resident was diagnosed with bilateral subdural hematoma. Resident #138 experienced two (2) additional falls after returning to the facility. Resident #138 expired on [DATE]. (b). Resident #131 fell multiple times from [DATE] through [DATE]. On [DATE], Resident #131 sustained a fall that resulted in a Sub-[NAME] Hematoma (collection of blood within the brain) with brain compression, and a midline shift (brain pushed off center). (c). Review of Resident #134's Progress Note, dated [DATE] at 7:21 AM, revealed the resident became combative with CNA (Certified Nurse Aide) #60. CNA #60 stated she let go of the resident and he/she fell and hit his/her face on the bedframe. The nurse assessed the resident, who had complaints of pain and swelling to the left cheekbone below his/her eye and a laceration. Emergency Medical Services (EMS) was called to transport the resident to the emergency room (ER). Resident #134 was diagnosed with a facial laceration that required sutures and a mild head injury. (d). Record review revealed Resident #5 sustained a witnessed fall, on [DATE] at 6:33 PM. The resident tripped and hit his/her head on the walker. Further review revealed he/she sustained a laceration to the left eyebrow, nosebleed, skin tear to the bridge of his/her nose, bruising to both hands, right arm, and darkened area on the left palm. (e). On [DATE] at 6:23 PM, Resident #73 was ambulating with a walker down to the dining room when he/she tripped and fell chipping his/her two (2) front teeth and causing a laceration to his/her bottom lip. (f). Resident #80 fell on [DATE] and sustained an approximate four (4) centimeter (cm) laceration to his/her lateral right eyebrow. The resident was sent to the ER and returned on [DATE] with sutures to the lacerated area. Resident #80 sustained a fall again on [DATE] at 2:00 AM, and an x-ray noted the resident had a fracture of his/her right femur. Resident #80 was sent to the hospital for hip repair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	(g). Resident #821 experienced falls and on [DATE] at 11:41 PM, the resident sustained another fall from the bed and complained of shoulder pain. The Assistant Director of Nursing (ADON) documented in the progress notes she placed an order for an x-ray. However, the ADON did not submit the order until 6:00 PM on [DATE], after the State Survey Agency (SSA) Surveyors brought it to her attention. (h). Review of the Progress Notes revealed on [DATE], Resident #97 was found lying on the floor and was observed to have an abrasion to his/her hip. Review of the Progress Note dated [DATE], revealed Resident #97 was found lying on the floor, and had attempted to self-transfer with regular socks on. Review of the Progress Note, dated [DATE], revealed Resident #97 was found lying on the floor next to the toilet and told staff he/she attempted to go to the bathroom. Continued review of the Progress Notes revealed on [DATE], Resident #97 was found lying on the floor. Further review revealed documentation that noted Resident #97 refused to use his/her call light to obtain assistance. Review of the Progress Notes revealed on [DATE], Resident #97 was again found lying on the floor, with documentation noting the resident fell out of his/her bed when he/she tried to reposition in the bed. (i). Review of Resident #106's Fall investigation, dated [DATE] revealed at 12:00 PM he/she was asleep in his/her wheelchair (W/C) in the common area and fell from the W/C. The fall was witness by a Certified Nurse Aide who was unable to stop the fall. (j). Observation revealed Resident #96 attempted to get up and stand on [DATE] at 12:28 AM and fell landing on his/her side and complained of severe pain in left hip area. The resident was diagnosed with a fractured hip and sent to the hospital for repair of the fracture. (k). Record review revealed Resident #371 was admitted for rehabilitation services after having frequent falls related to Lewy Body Dementia. Continued record review revealed the resident fell approximately seven (7) times, during his/her first (1st) fifty (50) days in the facility, resulting in head lacerations which required his/her wounds to be stapled. (l). Review of Resident #61's Facility Self-Reported incident revealed Resident #61 had fallen out of his/her bed on [DATE], and the nurse did not complete an assessment or report the incident. Review of Resident #61 clinical record revealed he/she had forty-three (43) documented falls from [DATE] to [DATE], and one (1) undocumented fall. The resident had a total of forty-four (44) falls, within a span of one and a half (1 and , d+[DATE]) years. (m). Record review revealed the facility admitted Resident #128 on [DATE]. Further review revealed the resident sustained five (5) falls between [DATE] and [DATE]. On [DATE] Resident #128 sustained a fall resulting in a laceration to the back left side of his/her head and was transported to the hospital. Subsequently, on [DATE] the resident sustained another fall which resulted in a laceration to the right side of the resident's head, a fracture to the frontal sinuses that went through the cranial vault (skull fracture) and the resident was sent to the hospital; however, did not return to the facility. Resident #128 passed away at the hospital on [DATE]. (n). Record review revealed Resident #74 sustained a total of eight (8) falls between [DATE] and [DATE]. On [DATE] the resident was noted to have a large hematoma on the right side of his/her forehead. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	2. The facility failed to ensure a safe environment and failed to ensure each resident received adequate supervision and monitoring to prevent elopement for one (1) of ninety-four (94) sampled residents. Resident #93 exited the facility, without staff's knowledge on [DATE] at approximately 4:20 PM. The facility did not locate Resident #93, until [DATE] at 1:10 AM, three (3) miles away. 3. The facility failed to ensure the residents' environment remained free of accident hazards related to water temperatures outside the acceptable range. Observation of water temperatures on [DATE] with checks initiated at 2:52 PM revealed water temperatures in rooms 102, 105, 106, 116, 118, 122, 125, 126, 130, 140, and 234, were not within the acceptable parameters for ensuring resident safety. The water temperatures ranged between 110.4 degrees to 121.1 degrees Fahrenheit (F). Immediate Jeopardy (IJ) was identified on [DATE] at 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F656), at the highest scope and severity (S/S) of a J; and 42 CFR 483.25 Quality of Care (F689), at the highest S/S of a J, which was determined to exist on [DATE] and is ongoing. The facility was notified of the Immediate Jeopardy on [DATE]. Additionally, IJ was identified on [DATE] at 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F656), at the highest scope and severity (S/S) of an L; and 42 CFR 483.25 Quality of Care (F689), at the highest S/S of a K and was determined to exist on [DATE] and is ongoing. The facility was notified of the Immediate Jeopardy on [DATE]. Additionally, IJ was identified on [DATE] at 42 CFR 483.25 Quality of Care (F689), at the highest S/S of an L and was determined to exist on [DATE] and is ongoing. The facility was notified of the Immediate Jeopardy on [DATE] and is ongoing. In addition, Substandard Quality of Care (SQC) was identified at 42 CFR 483.25, Free of Accident Hazards/Supervision/Devices (F689). The findings include: Review of the facility's policy titled, Fall and Fall Risk Managing - Investigating and Reporting, revised [DATE], revealed based on previous evaluations and current data, staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility's policy titled, Fall Management, dated [DATE], revealed a fall risk observation was used to identify individuals who were at high risk for falls, as well as those individuals who had any risk factors for falls. Per policy review, the observation (assessment) would be completed on a resident's admission to the facility, Quarterly, Annually, and with any Significant Change in Condition. Continued review revealed fall prevention would be achieved through an interdisciplinary approach of managing risk factors and implementing appropriate interventions to reduce risk for falls. Policy review revealed response to a resident's fall was to include: evaluating and monitoring the resident for seventy-two (72) hours post fall; assess the resident's level of consciousness, vital signs and range of motion; and look for lacerations, abrasions, and obvious deformities. Further review revealed additional responses to a resident's fall included: If an emergency situation existed, initiate the Emergency Medical System (EMS) response; contact the provider and resident's family; remain with the resident until EMS arrives; complete a root cause analysis (RCA) and determine an intervention based on the root cause determined; implement interventions (immediately) after the fall. Additionally, as the investigation of the fall continued the root cause analysis might trigger other interventions to the resident's plan of care; update the care plan; and Certified Nurse Aide (CNA) communication form with the new intervention. 1 (a). Review of Resident #138's closed record revealed the facility admitted the resident on [DATE], with diagnoses which included: Dementia without Behavioral Disturbance, Paranoid Schizophrenia, and Obsessive-Compulsive Behavior. Continued review of the closed record revealed Resident #138 sustained twelve (12) falls from [DATE] through [DATE], with a fall on [DATE] which resulted in the resident experiencing bilateral subdural hematoma (bleeding in the brain usually caused by a serious head injury). Review of Resident #138's Admission Minimum Data Set (MDS) Assessment, dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of nine (9) out of fifteen (15), which indicated moderate cognitive impairment. Continued review revealed the facility assessed Resident #138 as requiring extensive assistance with activities of daily living (ADL's), and to require two (2) persons assist with transfers. Further review revealed the facility assessed Resident #138 to have verbal behaviors directed towards others and other behavior symptoms not directed towards others. Review of the facility's Fall Risk Evaluation for Resident #138, dated [DATE], revealed the facility assessed the resident to have a score of fourteen (14) which indicated the resident was a high risk for falls. Continued review revealed Resident #138's level of consciousness/mental state was assessed as disoriented to person, time and place, at all times. Further review revealed the facility assessed Resident #138 as chair bound, to require restraints, and as needing assist with elimination. Review of the facility's Fall Risk Investigation Reports for Resident #138's falls, dated [DATE], [DATE], [DATE], [DATE] for two (2) falls, [DATE], [DATE], [DATE], [DATE] thru [DATE], revealed the facility noted Resident #138 to have confusion, memory impairment and poor safety awareness. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #138's Comprehensive Care Plan (CCP), initiated on [DATE], revealed the facility care planned the resident with a focus for risk for and history of falls, weakness, and diminished safety awareness status. Continued review revealed the care plan goal included the resident not to experience significant injury from a fall. Per the care plan review, the interventions included: offering Resident #138 assistance to the bathroom as needed; offer/assist the resident to common areas when he/she appeared restless in his/her room; offer reassurance that the supra-pubic catheter was functioning properly; and keep frequently used items within reach. Review of Resident #138's CCP updated on [DATE], revealed an intervention to encourage Resident #138 to ask for assistance prior to self-transfers and encourage him/her to lock his/her wheelchair brakes prior to transfers. Further review of CCP updated on [DATE] revealed an intervention to assist Resident #138 to ambulate when he/she attempted to stand up or was restless. Review of Resident #138's Progress Note, dated [DATE] at 1:23 AM, documented by Registered Nurse (RN) #23, revealed staff found the resident lying on the floor beside his/her bed, with the bed in the lowest position. Continued review of the Note revealed Resident #138 reported to the nurse that he/she had been trying to urinate. Further review revealed Resident #138 had a small abrasion to the top of his/her head, which the RN was unable to assess whether the scratch was a result of the fall or self- inflicted. In addition, review of the Note revealed RN #23 documented she would monitor Resident #138 closely throughout her shift. Review of the facility's Change in Condition (CIC) Note, dated [DATE] at 3:38 AM, revealed when Resident #138 fell out of his/her bed, the bed had been in the lowest position. Review of the CIC Note revealed documentation that noted, will monitor the resident frequently throughout shift for any distress. Review of the Progress Note dated [DATE] at 8:24 AM, documented by LPN #33, revealed staff had found Resident #138 lying on the floor on his/her back beside his/her bed. Continued review of the Note revealed documentation noting Resident #138 needed to be redirected not to stand up. Further review revealed Resident #138 was somewhat confused and believed he/she could do more than he/she was able to do. Review of the facility's Interdisciplinary Team (IDT) Note, dated [DATE] at 10:22 AM, entered by the former Director of Nursing (DON), revealed the IDT met and discussed Resident #138's recent falls. Per review, staff reported Resident #138 felt like he/she had to use the bathroom and attempted to self-transfer, and then sustained another fall when trying to self-transfer in his/her room. Further review revealed the IDT determined the root cause of Resident #138's falls was being in a new environment, having a new supra-pubic catheter, and attempting to self-transfer. In addition, review of the IDT Note revealed Resident #138's care plan was updated. Review of Progress Note, dated [DATE] at 4:05 PM, revealed Resident #138 had sustained a fall while trying to self-transfer from his/her wheelchair. Per review, Resident #138 fell on to his/her bottom when he/she self-transferred from the wheelchair unassisted. Further review revealed no injury was noted, Resident #138 had no complaints of pain. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the Nurse's Note, dated [DATE] at 9:57 AM, revealed the IDT met and discussed Resident #138's recent fall. Continued review revealed the IDT determined the root cause of Resident #138's fall as his/her new environment and self determination to transfer self with poor safety awareness. Further review revealed Resident #138's care plan was updated to include interventions for staff to encourage the resident to call for assistance and to encourage him/her to lock his/her wheelchair. Review of the Nurse's Note, dated [DATE] at 9:52 AM, revealed an order had been received to stop Resident #138's Haldol, as needed, in fourteen (14) days and for psychiatry to see the resident. Review of Resident #138's CCP, dated [DATE], revealed interventions were added to encourage the resident to lock his/her wheelchair brakes prior to transfers and to encourage him/her to ask for assistance prior to self- transfers. However, record review revealed the facility assessed the resident to be disoriented to person, time and place and was cognitively impaired. Review of the Progress Note, dated [DATE] at 4:08 PM, revealed Resident #138 had sustained two (2) falls while self-transferring, unassisted out of his/her wheelchair. Continued review of the Note revealed Resident #138 denied hitting his/her head, had no injuries and no complaints of pain. Further review revealed Resident #138 was placed closer to the nurse's station for closer observation and the Medical Director was notified of the fall. Review of the Progress Note, dated [DATE] at 10:07 AM, revealed the IDT met and discussed Resident #138's recent falls. Continued review of the Note revealed staff reported they were having a difficult time redirecting or distracting Resident #138 and became easily agitated. Per review, staff also reported Resident #138 would purposefully continue unsafe actions while they were attempting to redirect him/her. Further review revealed Resident #138 also often attempted to stand and ambulate by himself/herself and became resistive when redirected by staff. Review further revealed the IDT determined the root cause of Resident #138's falls as his/her determination to do things without assistance and resistance to redirection or cues for safety. In addition, record review revealed Resident #138's care plan was updated to include an intervention for staff to assist the resident to ambulate when he/she attempted to stand up or was restless. Review of CCP revealed on [DATE], the care plan was updated with the intervention to assist Resident #138 to ambulate when he/she attempted to stand up or was restless as he/she would allow. Review of Resident #138's Change in Condition (CIC) Note, dated [DATE] at 2:52 PM, revealed staff observed the resident lying on the floor face down in the hallway near the dining area. Continued review revealed Resident #138 reported he/she did not know how he/she had fallen. Review further revealed neurological checks were initiated, and the Medical Director was contacted. Review of Resident #138's Progress Note dated [DATE] at 10:13 AM, revealed the IDT met and discussed the resident's recent fall. Per review of the Note, staff observed Resident #138 lying face down on the floor and had a bruise observed to his/her face near the left eye. Continued review revealed Resident #138 had been participating in therapy using a rolling walker and contact guard assist. Further review revealed the IDT determined the root cause was Resident #138's poor safety awareness, UTI and attempts to self -ambulate. Additional review of the Note revealed Resident #138's care plan was updated to include dropping the back of the resident's wheelchair seat. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the Change in Condition (CIC) Note, dated [DATE] at 9:15 AM, revealed staff observed Resident #138 lying face down on the floor in front of his/her wheelchair in a puddle of blood. The resident was noted with a deep, jagged laceration observed to his/her forehead above his/her left eye. Further review revealed Resident #138 had no loss of consciousness, and the Medical Director was notified of the resident's fall at [DATE] at 8:20 AM. Continued review of Resident #138's closed medical record revealed documentation, dated [DATE], noted the resident sustained a fall on that date which resulted in a laceration to his/her forehead that required sutures. Review of the Progress Note, dated [DATE] at 9:30 AM, revealed the Emergency Medical Technicians (EMs) arrived and transported Resident #138 to the hospital Emergency Department (ED) for further evaluation at approximately 9:00 AM, due to the deep, jagged laceration on the resident's forehead above the left eye. Review of the Progress Note, dated [DATE] at 1:30 PM, revealed Resident #138 returned to the facility from the ED at approximately 1:00 PM by ambulance. Continued review revealed Resident #138's forehead laceration was closed with approximately eleven (11) sutures. Further review revealed the computerized tomography (CT) scan of Resident #138's cervical spine was normal. Review of the Progress Note, dated [DATE] at 9:30 AM, revealed Resident #138 sustained a fall, and was found by staff face down on the floor in a puddle of blood in front of his/her wheelchair in the same position as he/she had been found the day before. Per review of the Note, Resident #138 experienced no loss of consciousness, had no complaints of pain, and had good range of motion (ROM) in all extremities. Continued review revealed Resident #138 had a history of unassisted, self-transfers and impulsivity. Review further revealed the Medical Director was notified on [DATE], at 9:22 AM, and a new intervention to be implemented for enhanced supervision of the resident. Review of the Progress Note, dated [DATE] at 10:17 AM, revealed the IDT met and discussed Resident #138's recent falls. Per review of the Note, Resident #138 was observed laying on the floor in the common area and had a laceration to the left eye area. Continued review revealed Resident #138 was sent to the ED and returned with eleven (11) sutures to the lacerated left eye area. Further review revealed Resident #138 again sustained a fall and was observed lying on the floor with blood noted coming from the nostril and sutured laceration areas. Review of Resident #138's CCP revealed it was updated on [DATE], with interventions which included: offer one on one (1:1) conversation or diversions when restlessness was noted; offer snacks and tactile cat and therapy to review the resident's positioning in the wheelchair to determine if wheelchair modifications were needed. Review of the CCP revealed an update, dated [DATE], for psychiatric (psych) services to do a medication review for Resident #138. Review of the CCP updated on [DATE] revealed additional interventions: to lay the resident down after meals; and place Dycem (sticky, non-slip rubber used for stabilization) to his/her wheelchair for positioning and safety. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the Change in Condition (CIC) Note dated [DATE] at 3:45 PM, revealed Resident #138 was observed lying on floor on his/her side beside his/her wheelchair with no injuries or complaints of pain, and good ROM (range of motion) to all extremities. Continued review revealed Resident #138 had a history of unassisted, self-transfers, falls and he/she had an impulsive nature. Review of the IDT Clinical Note, dated [DATE] at 9:49 AM, revealed the IDT met and discussed Resident #138's fall when he/she was found by staff lying on the floor in his/her room. Further review revealed Resident #138's CCP was updated to have his/her anti-roll backs checked to ensure they were in functioning order. In addition, review of the CCP revealed an intervention to lay Resident #138 down after meals as the resident would allow and continue to monitor. Review of the Nurse's Note, dated [DATE] at 3:54 PM, revealed Resident #138 was noted as sliding down in his/her w/c multiple times during the shift and required staff to assist the resident back to a seated position each time. Review further revealed an order was received for Dycem to the resident's w/c to prevent sliding and possible injury. Review of the Nurse's Note, dated [DATE] at 9:30 PM, revealed Resident #138 slid out of the chair, falling forward on the floor and landing on the left side of his/her face where the existing stitches were. Further review revealed no new injuries were noted, neurological (neuro) checks were initiated. Review of the Nurse's Note, dated [DATE] at 10:45 AM, revealed Resident #138 again sustained a fall out of his/her chair while in the hallway. Continued review revealed Resident #138 had significant bleeding to the sutured left facial laceration area. Further review revealed Resident #138's vital signs were obtained and the resident was being sent out to the hospital ED (Emergency Department) for further evaluation. Review of Hospital Discharge Summary dated [DATE], revealed upon entering hospital ED, the CT scan showed bilateral subdural hematomas with diagnoses that included multi-focal traumatic subdural hematomas, intraventricular hemorrhage, and falls at nursing home. Review of the Hospital Admission Note, dated [DATE] at 7:26 PM, revealed Resident #138 returned to the facility from the hospital at approximately 5:00 PM. Per review, Resident #138 had multiple bruises all over his/her body in various stages of healing, scabbed areas on his/her knees, and greenish/purplish bruising to his/her left hip. Further review revealed Resident #138 had also been attempting to put himself/herself on to the floor and 1:1 supervision had to be provided to ensure the resident's safety. Record review revealed Resident #138's code status was changed to Do Not Resuscitate (DNR) and palliative care was consulted for the resident. Review of the Nurse's Note dated [DATE] at 10:31 PM, revealed Resident #138 had sustained a fall from his/her wheelchair landing on previous injuries to the resident's left forehead which was bleeding. Per review of the Note, pressure was applied to the bleeding area and that area was cleansed. Review further revealed the Medical Director was notified and orders received to increase the resident's Ativan and monitor the resident closely. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the CCP revealed a revision, dated [DATE], with interventions which included to transfer Resident #138 to a stationary recliner in the common area when the resident appeared restless. Further review revealed additional interventions to offer to take Resident #138 for a stroll off the unit or outside when he/she was restless as the resident would allow, offer diversional activities and provide 1:1 conversation with him/her when restless. Review of the Progress Note, dated [DATE] at 10:08 AM, revealed the facility's IDT met and discussed Resident #138's recent falls. Review of the Note revealed Resident #138 had returned from the hospital on [DATE] with new orders. Continued review revealed Resident #138 had recently experienced a general decline and was now a DNR. Record review revealed a Hospice consult was made for Resident #138. Review of the Change in Condition Note, dated [DATE] at 1:27 PM, revealed Resident #138 had vomited a large amount of coffee ground liquid. Continued review revealed Hospice was to come and assess Resident #138, and Phenergan (anti-nausea medication) 12.5 milligram (mg) was administered. Review of the Progress Note, dated [DATE] at 5:44 PM, entered by LPN #17, revealed she went to check on Resident #138 and found the resident to have no signs of life. Record review revealed Registered Nurse (RN) #9 arrived and pronounced Resident #138 as expired at 4:27 PM. In addition, review of the Note revealed Hospice, the DON, and the Medical Director were notified of Resident #138's death. (b). Review of Resident #131's closed record revealed the facility admitted the resident on [DATE], with diagnoses that included Unspecified Dementia, difficulty walking, and Bipolar Disorder. Review of Resident #131's Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status' (BIMS) score of ninety-nine (99), which indicated the resident was severely cognitively impaired and unable to be interviewed. Review of Resident #131's Progress Note, dated [DATE] at 1:18 PM, revealed Resident #131 nodded off to sleep while sitting up and slid out of the chair onto the floor. Continued review revealed Resident #131 had no apparent injuries. Review of the IDT Note, dated [DATE] at 10:18 AM, revealed the IDT met and discussed Resident #131's recent fall. Per review, staff witnessed Resident #131 slide off the edge of the chair when he/she started to fall asleep. Further review revealed a root cause analysis determined the resident's tiredness and sitting in the chair when sleepy was the cause. Review of the care plan revealed it was updated to include assist the resident to bed when he/she appeared sleepy. Review of Resident #131's Progress Note, dated [DATE] at 8:58 AM, revealed the resident sustained a fall in the hallway when walking to breakfast. Per review of the Note, Resident #131 had on another resident's shoes at the time of the fall, and he/she was not very responsive right after the fall. Continued interview revealed Resident #131 slowly began to respond more; however, he/she was not able to move his/her extremities very well. Review further revealed the facility transferred Resident #131 to the emergency room (ER). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #131's Progress Note, dated [DATE] at 1:03 PM, revealed the ER Nurse stated the resident would be returning to the facility with no significant injuries noted. Further review of the Note revealed Resident #131's care plan was updated for staff to ensure the resident wore proper fitting footwear. Review of Resident #131's Progress Note, dated [DATE] at 6:30 PM, revealed the resident sustained an unwitnessed fall in his/her room which resulted in a scalp contusion with moderate bleeding. Review further revealed Resident #131 was sent back to the ER. Review of Resident #131's Progress Noted, dated [DATE] at 12:22 AM, entered by LPN #33, revealed the resident arrived back at the facility with no new orders. Continued review revealed Resident #131 had no verbal or facial expressions of pain, neurological (neuro) checks and range of motion (ROM) were within normal limits (WNL. Review of the Note revealed staff were to continue to monitor the resident for: any changes in neuro checks; ROM; complaints of pain; and signs and symptoms (s/s) of distress. Review of the IDT Note, dated [DATE] at 10:25 AM, revealed the IDT met and discussed Resident #131's recent falls. Review of the Note revealed the IDT determined the root cause for the first fall was the resident was not wearing inappropriate shoes, and the root cause for the second fall was the resident's general weakness from the first fall. Review of the Note revealed Resident #131's Care Plan was updated with interventions to ensure the resident had proper shoes on and for staff to pad the furniture in the resident's room. Review of the Change in Condition Note, dated [DATE] at 11:45 AM revealed staff had found Resident #131 lying on his/her back on the floor beside his/her bed. Continued review revealed Resident #131 stated he/she hit his/her head; however, he/she did not know how he/she came to be lying on the floor. Further review revealed Resident #131 was wearing gripper socks at the time of the fall, was assessed and sent out to the ER. Review of the IDT Note, dated [DATE] at 4:07 PM, revealed the IDT met and discussed Resident #131's fall. Continued review revealed staff reported entering Resident #131's room they observed the resident lying on the floor in front of his/her bed, with gripper socks on, which [TRUNCATED]

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 14936 Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice for one (1) of thirty-three (33) sampled residents, Resident #22. Resident #22 had a Bilevel Positive Airway Pressure (BiPAP) machine that helped the resident get more air into the lungs. There was no evidence the Licensed Nursing staff were conducting assessments of pre/post lung sounds for administration of nebulizer medications. Also there was no evidence nursing staff was conducting more frequent rounds to ensure Resident #22 wore the Bi-PAP mask while napping and at bedtime, as per Physician's Orders. Review of Resident #22's Care Plan revealed he/she was care-planned for refusal to wear the Bi-PAP when napping or sleeping. However, there were no resident centered interventions to ensure Resident #22 was wearing the Bi-PAP mask as ordered. The findings include: Review of the facility's policy titled, Administering Medications through a Small Volume (Handheld) Nebulizer, revised 2010, revealed the process would include documentation of the pre/post lung sounds for administration of nebulizer medications. Review of the facility's policy titled, Care of Residents with Respiratory Diseases, revised 01/24/2012, revealed staff would assess lung sounds including auscultation (listening to lung sounds with a stethoscope). Review of the facility's policy titled, Chronic Obstructive Pulmonary Disease (COPD)-Clinical Protocol, revised 11/2018, revealed the clinical protocol included assessment and documentation of vital signs to include a detailed description of respirations. Additional review revealed full lung sounds were to be assessed and documented. During an interview with the Director of Nursing (DON), on 05/18/2023 at 10:55 AM, she stated there was not a facility policy, procedure, or process to ensure residents that were care-planned for refusals of care were monitored more frequently to ensure compliance. The Executive Director (ED), on 05/18/2023 at 11:38 AM, reiterated what the DON had said by stating there was not a facility policy, procedure, or process to ensure residents that were care-planned for refusals of care were monitored more frequently to ensure compliance. Review of Resident #22's clinical record revealed the facility admitted him/her on 02/10/2020, with diagnoses that included Acute/Chronic Respiratory Failure with Hypercapnia (build-up of carbon dioxide (CO2) in the blood) and Chronic Obstructive Pulmonary Disease (COPD). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #22's Quarterly Minimum Data Set (MDS) Assessment, dated 04/05/2023, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of twelve (12) of fifteen (15), indicating moderate cognitive impairment. Review of Resident #22's Care Plan, dated 03/28/2023, revealed a Focus that included at risk for decline related to his/her refusal for care as ordered, that included wearing the Bi-PAP mask; he/she understood the risk of refusing to wear the mask but did not like wearing the Bi-PAP mask. Further review revealed there were no resident centered interventions on the care plan to encourage use of the BiPAP. Observations on 05/16/2023 at 3:38 AM, revealed Resident #22 to be in bed with his/her eyes closed. Resident #22's Bi-PAP mask and Oxygen (O2) nasal cannula were both off. During an interview with Registered Nurse (RN) #15, on 05/16/2023 at 3:47 AM, she stated that she did not routinely check breath sounds unless a resident was exhibiting sounds and symptoms of respiratory distress. She stated she did assess lung sounds pre/post administration of nebulizer medications; however, there was no area to document the results on the medication administration record (MAR) or treatment administration record (TAR). She stated she would occasionally document lung sounds in the Nursing Progress Notes. RN #15 stated she would make resident rounds with medication administration and every two (2) hours; but to her knowledge, there was not a process to ensure Resident #22 received more frequent rounding to ensure compliance with wearing the Bi-PAP mask. Review of Resident #22's MAR/TAR, dated April 2023 and May 2023, revealed there was not an area to document pre/post nebulizer treatment lung sounds as per the facility's policy. Review of Nursing Progress Notes and General Notes for April 2023 and May 2023, revealed there was no documentation of Resident #22's lung sounds pre/post nebulizer treatments; nor was there documented evidence of more frequent monitoring for compliance or refusals to wear the Bi-PAP mask. During an interview with the Assistant Director of Nursing (ADON), on 05/16/2023 at 7:15 AM, she stated she was unaware if the facility had policies concerning care of residents with respiratory diseases. She also stated she was not aware if pre/post nebulizer lungs sounds should be obtained and where to document the results. In an interview with the facility's Advance Practice Registered Nurse (APRN), on 05/17/2023 at 11:39 AM, she stated it would be her expectation for staff to obtain and document pre/post nebulizer medication administration lung sounds. She also stated it would be her expectation for staff to monitor and document Resident #22's usage or refusal of the Bi-PAP mask. She stated Resident #22 needed to use the Bi-PAP machine to assist in managing his/her disease processes of Acute/Chronic Respiratory Failure with Hypercapnia and Chronic Obstructive Pulmonary Disease (COPD). RN #6, during an interview on 05/17/2023 at 1:55 PM, stated she was aware that pre/post lungs sounds with nebulizer medication administration should be assessed and documented; however, there was not a place on the MAR/TAR to document results. During the interview, RN #6 stated she was unaware if increased monitoring for Resident #22 was ordered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Agency RN #28 stated during an interview, on 05/17/2023 at 2:17 PM, that lung sounds should be assessed pre/post nebulizer medication administration, but there was nowhere to document the results. RN #28 also stated she was unaware of any increased monitoring related to Resident #22's refusal to wear the Bi-PAP mask. In an interview with the East Unit Manager, on 05/17/2023 at 2:36 PM, she stated there was a binder at the Nurses' Station that was used as a staff reminder for residents with additional needs such as nebulizer treatments, assistive devices for breathing such as Bi-PAP machines, and wounds. She stated that items in the binder would be discussed in daily clinical meetings. The East Unit Manager stated, to her knowledge, there was no increased monitoring for Resident #22. During an interview with the Director of Nursing (DON), on 05/18/2023 at 10:55 AM, she stated it was her expectation that nurses would assess a resident's lung sounds pre/post nebulizer medication administration and document the results per the policy to show the effectiveness of the treatment. She stated she was unaware there was not a place to document the results. The DON stated that ideally the results would be documented on the MAR, but nurses could also document them in the Nursing/General Notes. She stated lung sounds also should be assessed if there was a status change. The DON stated it was her expectation that baseline lungs sounds would be assessed on admission, re-admission, and with a change in condition. She stated currently there was not a process in place to monitor if lung sounds were being assessed and documented. The DON stated she was unaware if increased monitoring for compliance to wear the Bi-PAP mask was being completed for Resident #22. In an interview with the Executive Director (ED), on 05/18/2023 at 11:38 AM, she stated it was her experience that pre/post nebulizer medication administration lung sounds would be documented on the MAR. However, she stated she was unaware there was not a place on the MAR to document the lung assessment results. She stated it was her expectation for baseline lung sound assessments to be assessed on admission, re-admission, or a change in condition and for staff to follow the policy.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44486 Based on observation, interview, record review, and review of the facility's assessment and policies, it was determined the facility failed to have an effective system in place to ensure sufficient nursing staff were available at all times Based on observation, interview, record review, and review of the facility's assessment and policies, it was determined the facility failed to have an effective system in place to ensure sufficient nursing staff were available at all times to ensure resident care needs were met for forty-two (42) of ninety-three (93) sampled residents. (Residents #5, #17, #19, #35, #36, #47, #48, #49, #56, #57, #59, #61, #67, #69, #73, #74, #76, #80, #81, #86, #88, #89, #91, #92, #93, #95, #96, #97, #101, #102, #106, #110, #112, #128, #131, #132, #134, #138, #144, #146, #371 and #821) The facility failed to ensure residents' environment was as free of accident hazards as possible and failed to provide the necessary supervision to avert accidents for fourteen (14) residents. (Residents #5, #61, #73, #74, #80, #96, #97, #106, #128, #131, #134, #138, #371 and #821). Resident #93 exited the facility, without staff's knowledge on 01/17/2023 at approximately 4:20 PM. The facility did not locate Resident #93, until 01/18/2023 at 1:10 AM, three (3) miles away. The facility failed to ensure residents were protected from physical abuse, including resident to resident abuse, for thirty-one (31) residents (Residents #17, #19, #35, #36, #47, #48, #49, #56, #57, #59, #67, #69, #74, #76, #80, #81, #86, #88, #89, #91, #92, #93, #101, #102, #110, #112, #131, #132, #138, #140, and #144) Resident #80 suffered significant injury as a result of abuse. Interviews with residents and residents' family members revealed the facility was short staffed and residents had long wait times, for staff to respond to their care needs. Interviews with staff revealed due to lack of staffing they were not able to meet all resident care needs related to fall and pressure prevention, wandering or elopement supervision. Staff stated due to not enough staff it was difficult to toilet residents routinely or change incontinent residents frequently, nor could staff provide supervision to prevent residents with a history of physical aggression, from injuring other residents. The facility's failure to have sufficient staffing to provide the residents with their assessed care and service needs has caused or was likely to cause serious injury, harm, impairment, or death to residents. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Immediate Jeopardy (IJ) was identified on 02/21/2023 at 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F656), at the highest scope and severity (S/S) of a J; and 42 CFR 483.25 Quality of Care (F689), at the highest S/S of a J, which was determined to exist on 01/17/2023 and is ongoing. The facility was notified of the Immediate Jeopardy on 02/21/2023. Additionally, IJ was identified on 03/05/2023 at 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F656), at the highest scope and severity (S/S) of a L; and 42 CFR 483.25 Quality of Care (F689), at the highest S/S of a K and was determined to exist on 04/30/2022 and is ongoing. The facility was notified of the Immediate Jeopardy on 03/05/2023. Additionally, IJ was identified on 03/07/2023 at 42 CFR 483.25 Quality of Care (F689), at the highest S/S of a L and was determined to exist on 02/14/2023 and is ongoing. The facility was notified of the Immediate Jeopardy on 03/07/2023. In addition, IJ was identified on 03/08/2023 at 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F600) at the highest S/S of a K, and 42 CFR 483.25 Quality of Care (F684) at the highest S/S of a J and was determined to exist on 12/16/2022 and is ongoing. The facility was notified of the Immediate Jeopardy on 03/08/2023. Additionally, IJ was identified on 03/09/2023 at 42 CFR 483.35 Nursing Services (F725) at the highest S/S of a L and was determined to exist on 04/30/2022 and is ongoing. In addition, IJ was identified on 03/11/2023 at 42 CFR 483.25 Quality of Care/Prevention of Pressure Sores (F686) at the highest S/S of a J and was determined to exist on 10/05/2022 and is ongoing. The facility was notified of the Immediate Jeopardy on 03/11/2023. In addition, Substandard Quality of Care (SQC) was identified at 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F600); 42 CFR 483.25 Quality of Care (F684); 42 CFR 483.25 Quality of Care/Prevention of Pressure Sores (F686); and 42 CFR 483.25, Free of Accident Hazards/Supervision/Devices (F689). (Refer to F-600, F-656, F-684, F-686, and F-689) The findings include: Review of the facility's policy Staffing, Sufficient and Competent Nursing, dated August 2022, revealed staffing numbers and the skill requirements of direct care staff was determined by the needs of the residents based on each resident's plan of care, the resident assessments, and the facility assessment. Further review of the policy revealed factors considered in determining appropriate staffing ratios and skills included an evaluation of the diseases, conditions, physical or cognitive limitations of the resident population, and acuity. Review of the Census and Condition form (Form completed by the facility and represented the current condition of resident needs) received from facility, on 02/14/2023, indicated the facility had a census of one hundred and twenty-two (122). The form indicated sixty-two (62) residents needed one (1) to two (2) direct care staff to assist them with bathing, and sixty (60) residents were totally dependent on staff for bathing. One-hundred six (106) residents needed assistance of one (1) to two (2) staff for dressing and ten (10) residents were totally dependent upon direct care staff for dressing. Forty-four (44) residents needed one (1) to two (2) staff to assist with transfers and twenty-one (21) residents depended totally upon staff to transfer them between surfaces, such as the resident's bed and his/her wheelchair. Thirty-four (34) residents needed the assistance of one (1) to two (2) staff to toilet and fifty-five (55) residents depended totally upon the facility's direct care staff for all their toileting needs. Sixty-four (64) residents were on a scheduled program for urinary toileting, and sixty-three (63) residents were on a scheduled program for bowel toileting. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lyndon Woods Care & Rehab, LLC	1101 Lyndon Lane Louisville, KY 40222

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the Facility Assessment (FA), dated 02/09/2023, revealed the purpose of the assessment was to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies. The FA was used, to make decisions about resident's direct care staff needs, as well the facility's capabilities to provide services to the residents in the facility. The FA stated the facility was to use a competency-based approach, that focused on ensuring each resident was provided care that allowed the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being. The intent of the facility assessment was for the facility to evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services the residents require. Continued review revealed the facility's average daily census was one-hundred and twelve (112) and the maximum was one-hundred and twenty-two (122). The FA stated twenty-one (21) Certified Nursing Assistants (CNAs), and twelve (12) licensed nursing staff were needed to provide direct care to residents. Review of the Staffing Daily Staffing Schedules, dated 02/01/2023 through 02/15/2023, revealed the facility had an Acute Care Unit (ACU) that was secured. In addition, had an East Unit, which included a B hall, C hall, and a D hall. The schedule also indicated the facility had a [NAME] Unit. Observations made during survey revealed the ACU was a unit where male and female residents resided. The female residents on the ACU were separated by a locked door from the male resident side of the ACU. Record review of the Facility Matrix, printed 02/14/2023, revealed the ACU male secured unit had a census of fifteen residents and the ACU female secure unit had nineteen residents, for a total of thirty-four (34) residents. The East Unit had seventy-five (75) residents and thirteen (13) residents resided on the [NAME] Unit. Further review of the staffing schedules revealed one nurse was scheduled to care for the thirty-four (34) residents on the ACU each day, from 7:00 AM to 7:00 PM and from 7:00 PM to 7:00 AM. In addition, the ACU had one certified medication technician (CMT) scheduled from 7:00 AM to 11:00 AM. The staffing schedule revealed, three certified nursing assistants, were assigned to care for the thirty-four (34) residents on the ACU, each day from 7:00 AM to 7:00PM and 7:00 PM to 7:00 AM. Continued review of the staffing schedules revealed the East Unit had three (3) nurses scheduled to care for the seventy-five (75) residents. One nurse for B Hall, one nurse for C Hall, and one nurse for the D Hall, for both the day and night shifts. The schedule revealed four (4) to five (5) aides were assigned to the East Unit for both day and night shifts. In addition, during night shift, the [NAME] Hall did not have a night nurse assigned. The form indicated the only staff assigned to the [NAME] Hall from 7:00 PM until 7:00 AM, was CMT. Interview with Resident #30, on 02/15/2023 at 3:35 PM, revealed he/she could only get showered late at night, due to short staffing. The resident reported he/she had laid in stool for as much as eight (8) hours, and some days there was only one aide for his/her unit. Interview with CNA #17, on 03/06/2023 at 3:30 PM, revealed there were usually two (2) nurse aides on the male and female secured units. She said memory care staffing was concerned because residents could get hurt without enough staff. She said only four (4) of the nineteen (19) residents on the women's side, could toilet themselves and the others required staff to assist with incontinence care. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview with CNA #43, on 02/23/2023 at 8:52 PM, revealed the facility did not have enough staff to get everybody up every day. She stated they would have two (2) aides for sixty (60) residents on any given day. Further interview revealed the facility did not have enough staff to shower all the residents, and it was all staff could do to get residents fed, medicated, and some briefs changed. CNA #43 stated a resident got pressure sores on his/her bottom, and while she was not sure if the resident had the pressure sores when he/she was admitted , those pressure sores did not get better from that resident sitting in wetness. She stated staff could not change all the residents frequently, especially if two (2) staff were required for resident transfer. Interview with Registered Nurse (RN) #4, on 02/28/2023 at 2:22 PM, revealed there was never enough staff to answer call lights timely. She stated residents would get so upset when no staff came to assist them. She stated there were times when she was the only nurse on the whole unit and the Director of Nursing (DON) nor the Executive Director (ED), who was a nurse, would help. Continued interview revealed night shift had inadequate staffing numbers and one of the resident's complained to her every morning that he/she had to wait for help. Observation, on 02/19/2023 at 3:20 PM, revealed no staff were present on the [NAME] Wing, however five (5) residents were present in the common area. At 3:32 PM, twelve (12) minutes later, LPN #4 returned to the [NAME] Wing after having left the residents unsupervised. Observation on 03/07/2023 at 9:58 AM, revealed the call light was audible from the entrance of the East Wing. CNA #41, RN #19, the Interim Director of Nursing and housekeeping staff all walked past the room where the call light was activated, but the ringing did not cease. After the call light rang for twelve (12) minutes, the State Survey Agency (SSA) Surveyor approached the East Wing nurses' station where CNA #1 and RN #19 were seated. Interview at time of observation with RN #19 revealed she heard the call light ringing and it was part of her job to answer call lights. RN #19 then stood up and went to assist the resident in the room where the call light was ringing. 1. Record review revealed on 01/17/2023, Resident #93, with a history of elopement, and four (4) other residents were left in the smoking courtyard, without direct supervision by staff. The gate to exit the courtyard was unlocked. Resident #93 walked off grounds at approximately 4:20 PM and staff did not determine the resident was missing until approximately 5:20 PM. Resident #93 was not located until 01/18/2023 1:10 AM, approximately three (3) miles from the facility. (Refer to F689) Interview with Resident #40, on 02/14/2023 at 12:00 PM, revealed he/she was present out in the smoking area on 01/17/2023, when Resident #93 eloped from the facility. Resident #40 stated the gate was open to the courtyard, and it had been left open for a couple of days. Resident #40 also, stated it was not Resident #93's fault, if the facility staff could not keep the facility secured, it was their fault the resident left. Interview with Resident #38 on 02/14/2023 at 12:15 PM, revealed he/she was out in the smoking area on 01/17/2023 when Resident #93 eloped from the facility. Resident #38 stated the staff member who allowed them out to smoke, did not enter the courtyard with them, only lit their cigarettes and watched them from behind the closed door/window. Resident #38 stated the residents knew the gate in the courtyard was not secured, as they had witnessed it open for a few days in a row. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	2. Review of the facility's Falls Report revealed from 02/18/2022 through 02/15/2023 there had been thirty-five (35) witnessed falls with injury, and twenty-four (24) unwitnessed falls with injury The facility failed to ensure a system was in place to ensure adequate supervision and monitoring to prevent accidents/falls for multiple residents. a) Record review revealed the facility admitted Resident #138, on 04/08/2022. The facility assessed the resident to require the assistance for ambulation and the resident used a wheelchair and a walker. The facility assessed the resident as a high-risk falls risk. Resident #138 had eleven (11) falls from 04/09/2022 to 05/14/2022. On 04/30/2022, staff found Resident #138 face down on the floor. The resident had a large, jagged laceration on his/her forehead above the left eye. Resident #138 received eleven (11) sutures. On 05/01/2022, Resident #138 was found face down on the floor in a puddle of blood in front of his/her wheelchair. From 04/30/2022 to 05/07/2022, Resident #138 had four (4) more falls. On 05/07/2022, Resident #138 was hospitalized due to a fall with injury and diagnosed with bilateral Subdural Hematomas. Review of Hospital records dated 05/07/2022-05/13/2022 revealed diagnoses that included: Multi-focal Bilateral Subdural hematomas and Intraventricular hemorrhage. Resident #138 was placed on Hospice upon discharge. On 05/14/2022, Resident #138 fell from the wheelchair to the floor, with bleeding noted to the previous laceration/sutured area to the left forehead. On 05/22/2022 at 5:44 PM, Resident #138 was found in bed, by facility staff, with no signs of life. b) Record review revealed the facility admitted Resident #96, on 08/06/2021, with diagnoses that included muscle weakness, dementia, and cognitive communication deficit. Further record review revealed Resident #96 sustained two (2) falls between 11/08/2022 and 02/11/2023. Review of the Risk Management Note, dated 02/11/2023, revealed at approximately 10:48 PM, the resident was found lying on the floor. Review of the radiology report, dated 02/12/2023, revealed the resident had a left trochanter hip fracture. c) Record review revealed the facility admitted Resident #5 on 05/10/2021 with diagnoses of Unspecified Dementia, Psychotic Disturbance, and Anxiety. Record review revealed Resident #5 had sixteen (16) falls in the past twelve (12) months. Resident #5 had a fall on 01/11/2023. Review of the Computerized Tomography dated 01/11/2023 at 10:44 PM revealed the resident had a nasal fracture and scalp laceration of the forehead. d) The facility admitted Resident #73, on 01/16/2023 with diagnoses Alzheimer's Disease late onset, Muscle Weakness, Dysphagia, difficulty walking and Cognitive Communication Deficit. Record review revealed Resident #73 had experienced two falls from 01/16/2023 to 02/24/2023. Resident #73 fell while walking with walker which resulted in chipping both front teeth and a lip laceration. e) The facility admitted Resident #821, on 12/21/2022, with diagnoses of Dementia with mood disturbance, Urinary Retention with a catheter and history of anticoagulants and anxiety. Record review revealed the facility assessed the resident with a BIMS' score of six (6) out of fifteen (15), which indicated severe cognitive impairment. Review of the Risk Management report for Resident #821, dated 03/03/2023, revealed a fall from the bed. The nurse noted bruises from the previous falls. The resident complained of shoulder pain, with no evidence of any testing ordered. Record review revealed Resident #821 experienced six (6) falls in one (1) month. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	(f). Resident #131 sustained multiple falls from 04/21/2022 through 05/30/2022. On 05/30/2022, Resident #131 sustained a fall that resulted in a Sub-[NAME] Hematoma (collection of blood within the brain) with brain compression, and a midline shift (brain is pushed off center). (g). Review of Resident #134's Progress Note, dated 05/05/2022 at 7:21 AM, revealed the resident became combative with staff and he/she fell and hit his/her face on the bedframe. The nurse assessed the resident, who had complaints of pain and swelling to the left cheekbone below his/her eye and a laceration. Emergency Medical Services (EMS) was called to transport the resident to the emergency room (ER). (h). Resident #80 fell on [DATE] and sustained a laceration approximately four (4) centimeter (cm) to his/her lateral right eyebrow. The resident was sent to the ER and returned on 01/07/2023 with sutures to the lacerated area. Resident #80 sustained a fall again on 02/02/2023 at 2:00 AM, and per x-ray was noted to have a fracture of his/her right femur and was sent to the hospital for hip repair. (i). Review of Resident #97's Progress Notes revealed the resident sustained a fall on 07/20/2022 and was found lying on the floor. Further review revealed Resident #97 forgot to lock the brakes on his/her wheelchair. Review of the Progress Notes revealed on 07/25/2022, Resident #97 was found lying on the floor and was observed to have an abrasion to his/her hip. Review of the Progress Note dated 10/21/2022, revealed Resident #97 was found lying on the floor, and had attempted to self-transfer with regular socks on. Review of the Progress Note, dated 11/04/2022, revealed Resident #97 was found lying on the floor next to the toilet and reported to staff he/she attempted to go to the bathroom. Further review of the Progress Notes revealed on 01/17/2023, Resident #97 was found lying on the floor. Continued review of the Progress Notes revealed on 01/26/2023, Resident #97 was found lying on the floor. (j). Review of Resident #106's Fall investigation, dated 01/14/2023 revealed at he/she was asleep in his/her wheelchair (W/C) in the common area and fell from the W/C. The fall was witnessed by staff who was unable to stop the fall. (k). Resident #371 was admitted for rehabilitation services after frequent falls related to Lewy Body dementia. During the fifty (50) days Resident #371 was in the facility, he/she fell at least seven (7) times, with three (3) of those resulting in head lacerations requiring staples, sutures or surgical glue. (l). Review of the Facility's Self-Reported incident revealed Resident #61 had fallen out of bed on 11/07/2021, and the nurse did not complete an assessment or report the incident. Continued review of the clinical record revealed he/she had forty-three (43) documented falls from 06/12/2021 to 02/03/2023, and one fall on 11/07/2021, that was not documented, for a total of forty-four (44) falls. (m). Record review revealed Resident #128 sustained five (5) falls between 02/06/2022 and 07/18/2022. On 07/17/2022 Resident #128 sustained a fall resulting in a laceration to the back left side of the head and was sent to the hospital and returned. Then on 07/18/2022 the resident sustained another fall resulting in a laceration to the right side of the head, a fracture to the frontal sinuses that went through the cranial vault (skull fracture), was sent to the hospital and did not return to the facility. Resident #128 passed away at the hospital on 07/25/2022. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	(n). Record review revealed Resident #74 sustained a total of eight (8) falls between 12/29/2022 and 02/21/2023. On 12/29/2022 the resident was noted to have a large hematoma on the right side of the forehead. Interview, on 02/15/2023 at 2:36 PM, with Family Member (FM) #1, revealed Resident #114 had called on a Saturday night at about 11:45 PM and said his/her roommate, Resident #96, had fallen. FM #1 could hear Resident #96 yelling in pain. The facility had given residents a teeny tiny bell to ring. Continued interview revealed the call light response time was extremely slow. FM #1 stated that showed the facility was overwhelmed with understaffing. She further stated Resident #114 called another night to ask her to call the facility and ask them to come change Resident #114 since he/she had been ringing the bell for one (1) hour and five (5) minutes. FM #1 was not sure which day it was or who was working. Additional interview revealed FM #1 had visited four (4) days a week for the past six (6) weeks, and it looked to her like the facility did not have enough staff. Interview with CNA #51, on 03/09/2023 at 10:40 AM, revealed the facility was very short staffed, stating there was not enough staff to care for the residents, that they started the shift short. Sometimes people would leave in the middle of a shift so the facility would become even more short. She stated they could not keep up with all the residents' needs to prevent them from getting up and falling or from pressure wounds worsening, and/or from wandering into other residents' rooms. She stated there were just not enough staff to get appropriate care completed in a shift. Interview with RN #1, on 02/27/2023 at 1:35 PM, revealed she was the Unit Manager (UM) for both facility's memory care units. She did not think there was enough staff for both memory care units because residents on that unit were high fall risks and there were frequent falls 3. The facility failed to provide adequate supervision to ensure Resident #80 was protected from abuse by Resident #48, on 12/16/2022. Resident #48, who had a history of physical and verbal abuse towards other residents, punched Resident #80 in the face, causing the resident to fall. Review of Resident #80's hospital record, dated 12/17/2023, revealed the resident was admitted and required a surgical procedure for a right hip replacement. Additionally, thrity-one (31) other resident to resident abuse deficiencies were cited related to decreased supervision for residents assessed to exhibit behaviors causing an unsafe enviorment for residents. (Refer to F600) (a). Record review revealed on 12/16/2022, at 6:43 PM Resident #48, hit Resident #80 in the face causing him/her to fall to the floor. X-ray results revealed Resident #80 had sustained a fractured right hip, which required Resident #80 to have a surgical intervention to repair the fractured hip. (b). Record review revealed on 11/16/2021, Resident #81 touched Resident #80 resulting in Resident #80 reaching out and making contact with Resident #81's facial area. (c). Per the record on 11/22/2021, Resident #47 and Resident #80 were found on a bed together. Resident #80 was lying on his/her back with his/her knees bent and did not have clothes on from the waist down. Resident #47 was observed fully clothed, on his/her knees at the foot of the bed, with his/her face in Resident #80's crotch area. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	(d). Record review revealed on 12/02/2021, Resident #81 struck Resident #35 and then struck Resident #47. (e). Review of the record revealed on 04/24/2022, Resident #138 hit Resident #102 on the arm three (3) times. (f). Record review revealed on 04/27/2022, Resident #131 pushed resident #86 onto the bed and placed one (1) hand on Resident #86's blouse and the other hand around Resident #86's throat. (g). Review of the Incident Report revealed on 07/02/2022, Resident #80 slapped Resident #76 and then slapped Resident #132 in the face. (h). Record review revealed on 07/04/2022, Resident #91 got up and brushed the back of Resident #92. Resident #92 grabbed Resident #91 by the shoulder and punched him/her in the chest. (i). Record review revealed on 10/12/2022, Resident #144 slapped Resident #67 and then later slapped Resident #74 on the left side the face. (j). Review of the Incident Report, revealed on 12/27/2022, Resident #92 hit Resident #88 in the mouth. (k). Record review revealed on 02/25/2023, Resident #74 hit Resident #57 on the right forearm. (l). Review of the Incident Report dated 04/06/2022, revealed Resident #132 struck Resident #101 with a right open hand on the left side of the face. (m). Review of the Incident Report dated, 05/05/2022, revealed Resident #89 made contact to the left side of Resident #59's cheek with an open hand. (n). Review of the Incident Report, revealed on 05/08/2022, Resident #89 made contact to Resident #59's face three times with a closed fist. (o). Review of the record revealed, on 08/08/2022, Resident #59 slapped Resident #140 with an open hand to prevent her/him from taking the water cup which resulted in a scratch approximately two (2) inches long. (p). Per the Incident Report dated, 12/23/2022, Resident #110 became upset because Resident #140 had his/her belongings and hit Resident #140 on the forehead. (q). Review of the Incident Report and facility investigation revealed on 06/19/2022, Resident #35 attempted to take Resident #101's bag. Resident #35 hit Resident #101 with an open hand on the right side of her/his check. Resident #101 returned the hit making Resident #35 stumble and fall. Resident #35 suffered a small contusion to the bridge of the nose and was sent to the ER for evaluation and treatment. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	(r). Review of the Incident Report dated, 10/16/2022, revealed Resident #144 walked up to Resident #67 and made physical contact with the left side of Resident #67's face, and while staff was separating Resident #67 from Resident #144, Resident #144 then turned and made physical contact with Resident #74's left side of the face causing a mark. (s). Record review revealed on 02/25/2023 Resident #74 bit Resident #57 on the right forearm causing a discolored area (bruise). (t). Review of the Incident Report dated 10/11/2022, revealed Resident #36 started to yell at Resident #69 which initiated a verbal altercation. Resident #69, with his/her fist clinched, approached Resident #36 and kicked him/her. (u). Review of the incident Report revealed on 10/10/2022 Resident #56 talked to and pointed a finger in the face of Resident #69's then stepped on the resident's toes. Resident #69 pushed Resident #56 back hard enough for the resident to fall to the ground. (v). Record review revealed, on 11/30/2022 Resident #112 used his/her walker to hit Resident #17. Resident #112 then proceeded to hit Resident #17 in the shoulder. Resident #17 then hit #112 back. (w). Record review revealed on 03/08/2022 Resident #17 attempted to enter Resident #93's room and was stopped by the previous DON. Then Resident #17 walked up to Resident #93, who was standing in front of the common area television and grabbed Resident #93 by the back of the jacket and moved the resident out of the way. (x). Record review revealed, on 03/12/2022, Resident #19 leaned forward in the wheelchair and struck Resident #49 on the left side of his/her face with an open palm. Interview with CNA #21, on 03/06/2023 at 3:45 PM, revealed when she worked on the [NAME] Unit, she was the only aide for fifteen (15) residents. She stated she had to stop her medication pass to separate residents when they were arguing. She stated that situation was not safe for the residents or her. She stated she was all alone on the [NAME] Unit and nowhere in the facility should one (1) staff be assigned to fifteen (15) residents by themselves. Interview with CNA #7, on 03/13/2023 at 2:00 PM, revealed there was usually only one (1) aide on each of the Memory Care Units (MCUs) and a Certified Medication Technician (CMT). The other CMTs did not help in any way, with aide work, and she was often not able to take breaks, because they did not have any relief. CNA #7 stated not having enough aides scheduled to work was very dangerous for the residents and did not provide them with the care they needed and deserved. Interview with CNA #33, on 03/13/2023 at 9:45 AM, revealed the facility had staffing issues for some time. She stated it would be her and one other aide working to care for the residents. She stated she worked when there was critical staffing shortages in the building and management staff would just sit in their office and not come and help. Interview with Licensed Practical Nurse (LPN) #19, on 03/09/2023 at 10:30 AM, revealed she worked two (2) days a week and there was not sufficient staff to provide resident care during her shifts. (continued on next page)

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	185165	A. Building B. Wing	03/16/2023

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview with the Human Resources (HR) person responsible for staff scheduling, on 03/02/2023 at 2:52 PM, revealed she made out the schedule based on the number of residents on the units. Interview with the Interim Director of Nursing (IDON), on 03/08/2023 at 1:15 PM, revealed the interdisciplinary team met daily to review resident care needs. The IDON stated there was also weekly meetings to discuss resident care issues, in addition to monthly quality assurance meetings. She stated the team had not identified issues with staffing. The IDON stated the facility used a tool to determine staffing needs. She stated the number of residents in the facility was used in the tool and that number provided them with how many hours they needed to dedicate care to each resident. The DON stated if staffing needed to be increased management could assist. Interview with the Executive Director (ED), on 03/08/2023 at 1:15 PM, revealed the facility had reviewed the facility assessment in January and did not determine revision was needed. She stated they had a staffing tool they used, in which the number of residents in the building could be put into determine how many staff were needed to provide care. Also, many of the facility's leadership staff had CNA certification and could come into work if there were call-ins or could work on the unit providing resident care even though they had other jobs to do. Interview with [NAME] President of Operations (VPO), on 03/16/2023 at 11:48 AM, revealed the facility assessment was a tool that had the facility staffing numbers and the facility's leadership was responsible for determining resident needs. The VPO stated leadership looked at the condition of the residents and the changes that could occur to determine acuity. The facility assessment which indicated twelve (12) licensed nurses, twenty-one (21) CNAs, and seven (7) nurse managers were needed per day, was a guideline. Typically nurse managers and nursing administration would assist if needed. He stated the facility had budgets and guidelines and leadership should have adjusted staffing according to needs. He stated he was not aware of any signification resident issues but was aware of problems with resident falls and abuse. He stated he would have adjusted staffing if there were significant issues. He stated it was a challenge to resolve the staffing challenge, and the facility was doing their best to staff to meet residents' needs. <b [TRUNCATED]

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 14936 Based on interview, record review, review of the facility's investigation reports, review of the Pharmacy Services Agreement, review of Pharmacy invoices, and review of the facility's policies, it was determined the facility failed to have safeguards and systems in place to control, account for, and reconcile controlled medications to ensure all controlled medications were maintained for three (3) of ninety-nine (99) sampled residents (Residents #21, #71, and #521). Review of Resident #71's Medication Administration Record (MAR) revealed he/she was prescribed Norco (Hydrocodone-Acetaminophen, an opioid pain reliever) 7.5-325 milligram (mg). There was a discrepancy of thirty-five (35) tablets between the narcotic control sheet and the resident's MAR, from 04/20/2022 to 05/12/2022. Review of Resident #21's MAR revealed he/she was prescribed Norco 7.5-325 mg. There was a discrepancy of fifty-four (54) tablets between the narcotic control sheet and the resident's MAR, from 04/15/2022 to 04/28/2022. Review of Resident #521's MAR revealed he/she was prescribed Hydrocodone-Acetaminophen 5-325 mg, give one (1) tablet by mouth every twelve (12) hours as needed for chronic pain. However, there was a discrepancy of thirty-three (33) tablets between the narcotic control sheet and the resident's MAR, from 12/01/2021 to 12/18/2021. Further, the facility failed to determine that drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled. Review of multiple Controlled Medication Shift Change Log sheets, from different nursing units, revealed they were not signed off by two (2) licensed nurses. The findings include: Review of the facility's policy titled, Accepting Delivery of Medications, revised February 2021, revealed all staff shall follow a consistent procedure in accepting medications. Medications were to be delivered to and signed for by a nurse. Review of the facility's policy titled, Controlled Substances, dated 08/27/2018, revealed the storage of controlled substances must be strictly monitored. The number of controlled substances on hand must be counted and verified at the end of each shift. The Narcotic Sign In Sheet must be completed at the end of each shift every day. The Out-Going Nurse or his/her designee would count all controlled substances being stored at the community while the On-Coming Nurse or his/her designee watched. Both staff members must sign that the count and verification have been completed. Per the policy, if the count did not match the controlled substances on hand, the Administrator/Designee would be notified immediately. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Pharmacy Services Agreement, signed 10/01/2021, revealed the facility retained responsibility for reconciling the applicable orders against the records supplied by Pharmacy. Continued review revealed the Pharmacy shall conduct sample audits of nursing stations, drug storage areas, and medication carts to review compliance with Pharmacy policies and procedures and Applicable Laws regarding drug handling, storage, and distribution. Per the policy, Pharmacy shall provide reports to the facility of any findings and recommendations related to such audits. 1.a. Review of Resident #71's medical record revealed the facility admitted the resident on 01/21/2021 with diagnoses of Quadriplegia, Anxiety Disorder, and Protein-Calorie Malnutrition. Review of Resident #71's Physician's Orders revealed an order for Norco tablet 7.5-325 mg, give one (1) tablet by mouth every six (6) hours as needed for pain. The medication had a start date of 04/04/2022. Review of Resident #71's Medication Administration Record (MAR) revealed he/she was prescribed Norco (Hydrocodone-Acetaminophen, an opioid pain reliever) 7.5-325 milligram (mg) to be administered every six (6) hours as needed for pain. However, there was a discrepancy of thirty-five (35) tablets between the narcotic control sheet and the resident's MAR, from 04/20/2022 to 05/12/2022. Review of Resident #71's Controlled Drug Receipt/Record/Disposition form (CDRRDF), dated 04/20/2022, revealed the resident was dispensed Hydrocodone-Acetaminophen 7.5-325 mg every six (6) hours for pain. However, the nurse's signature that received the medication was illegible, and there was only one (1) signature. Also, the quantity received was illegible. Further review of the CDRRDF from 04/20/2022 to 04/29/2022, revealed Resident #71 received twenty-nine (29) tablets from 04/20/2022 to 04/29/2022. Review of Resident #71's Medication Administration Record (MAR), dated 04/20/2022 to 04/29/2022, revealed an entry for Hydrocodone-Acetaminophen tablet 7.5-325 mg, give one (1) tablet by mouth every six (6) hours as needed for pain, with a start date of 04/18/2022 and a discontinue date of 04/28/2022; there was a new order written on 04/28/2022 with an end date of 07/05/2022. The MAR showed Resident #71 received one (1) tablet on 04/20/2022; 04/21/2022; 04/25/2022; 04/26/2022; 04/27/2022; and 04/29/2022. This was a total of six tablets taken by Resident #71 during this time. Review of the CDRRDF, from 05/01/2022 to 05/12/2022, revealed Resident #71 received twenty-eight (28) tablets of Hydrocodone-Acetaminophen 7.5-3.25 mg from 05/01/2022 to 05/12/2022. Review of Resident #71's MAR, from 05/01/2022 to 05/12/2022, revealed Hydrocodone-Acetaminophen Tablet 7.5-325 mg, give one (1) tablet by mouth every six (6) hours as needed for pain, with a start date of 04/28/2022 and a discontinue date of 07/05/2022. Further review revealed Resident #71 received two (2) tablets on 05/01/2022; one (1) tablet on 05/02/2022; one (1) tablet on 05/03/2022; two (2) tablets on 05/04/2022; one (1) tablet on 05/07/2022; three (3) tablets on 05/09/2022; one (1) tablet on 05/10/2022; three (3) tablets on 05/11/2022; and two (2) tablets on 05/12/2022. This was a total of sixteen (16) tablets taken by Resident #71 during this time. Telephone interview with Registered Nurse (RN) #17, on 03/30/2023 at 4:15 PM revealed she might have given a medication to a resident and not documented it on the MAR. She further stated this was a mistake, and it should not have occurred. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #71's medication invoice from the pharmacy revealed Medicare A was billed on 05/13/2022 for Hydrocodone-Acetaminophen tablets 7.5-325 for a quantity of sixty (60) tablets. 1.b. Review of Resident #21's medical record revealed the facility admitted the resident on 03/29/2021 with diagnoses to include Muscle Weakness, Unsteadiness on Feet and Morbid Obesity. Review of Resident #21's Physician's Orders revealed an order for Norco 7.5-325 mg, give one (1) tablet by mouth every eight (8) hours as needed for pain, with a start date of 04/12/2022 and an end date of 05/16/2022. Review of Resident #21's CDRRDF, dated 04/15/2022, page 3 of 3, revealed a quantity received of thirty (30) tablets of Hydrocodone/Acetaminophen 7.5/325 mg, one (1) tablet by mouth three (3) times a day. It also revealed, from 04/17/2022 to 04/27/2022, the resident received twenty-eight (28) tablets. Review of Resident #21's MAR revealed Norco Tablet 7.5-325 mg, give one (1) tablet by mouth every eight (8) hours as needed for pain, with a start date of 04/14/2022 and a discontinue date of 05/16/2022. Per the MAR, from 04/17/2022 to 04/26/2022, Resident #21 received one (1) tablet on 04/23/2022 and two (2) tablets on 04/26/2022. This was a total of three (3) tablets taken by Resident #21 during this time. Review of Resident #21's MAR revealed there was a discrepancy of fifty-four (54) tablets between the narcotic control sheet and the resident's MAR, from 04/15/2022 to 04/28/2022 Review of the facility's Investigation Report, dated 05/13/2022, revealed on 05/08/2022, the facility identified Resident #71 and #21 were missing narcotics. Stat orders (orders that were to be done immediately) were placed by the facility to replace the residents' missing medications. Per the report, RN #13 was identified as the nurse who signed for the missing medications. RN #13 was placed on suspension pending investigation and then resigned from her position on 05/11/2022. Review of the pharmacy invoices, dated 05/31/2022, and an email from the Account Services Director to the facility's [NAME] President of Operations, dated 05/09/2022, revealed sixty (60) tablets of Norco had been replaced for Resident #71, and thirty (30) tablets of Norco had been replaced for Resident #21 at the facility's expense. Interview with the Pharmacy Manager, on 03/31/2023 at 3:57 PM revealed the account management department audited the medication carts monthly. He stated he did not audit the medication carts, but he monitored the trends of audits. He stated his role was the Pharmacist in Charge. In addition, after the State Survey Agency (SSA) Surveyor requested records of controlled substances and the facility's audits. The fax was sent on 03/31/2023. Telephone call follow-up to the Pharmacy Manager, on 04/04/2023 at 11:45 AM revealed they were compiling the information on controlled substances at the facility. Further interview revealed they needed approval from their cooperate compliance team prior to sending the report. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Pharmacist in the Account Management Department, on 03/31/2023 at 5:19 PM revealed if there was a narcotic diversion, the facility would contact her. She stated she would look to see how the supply was filled and if it was billed to a third party. She stated she would change the billing to the facility and send the controlled substance only if the resident needed the medication. She stated she would reach out to the prescriber and get a new prescription. She stated she looked in her computer to see if there were any narcotic diversions. Continued interview revealed there had been a diversion with Norco 7.5-325 mg in May 2022. She stated it had been billed because the resident was on Medicare. However, she stated, on 05/09/2022 the pharmacy billed ninety (90) tablets to the facility. Telephone interview with the pharmacy Account Manager, on 04/04/2023 at 5:35 PM revealed she had been the account manager for about three (3) years. She stated the last audit of the facility was March 31, 2023. She stated, since COVID, they did not inspect the carts or the narcotic sheets. She stated she did a paper audit of the narcotic sheets. Continued interview revealed they did look at the Controlled Substance Books. She stated, about a year ago, the facility stopped using the pharmacy's forms and started using blue logs instead. She stated she was not personally aware of the facility asking them to account for narcotics and billing, which would have gone through the compliance department. She stated the facility did ask her to do a narcotics audit. She stated she did one on 05/18/2022. The Account Manager stated she did a spread sheet, which she provided to the facility, and there were obviously some items missing. She stated the information was in a pharmacy report provided to the facility. Further interview revealed the previous DON received reports of the controlled substances that were dispensed and what the facility showed it had on hand. 1.c. Review of Resident #521's medical record revealed the facility admitted the resident on 09/27/2021 with diagnoses of Bipolar Disorder, Morbid Obesity, and Chronic Pain Syndrome. Review of Resident #521's Physician's Orders revealed an order for Hydrocodone-Acetaminophen Tablet 5-325 mg, give one (1) tablet by mouth every twelve (12) hours as needed for chronic pain, with a start date of 09/30/2021 at 9:15 AM and an end date of 12/30/2021. Review of Resident #521's Dispensed Controlled Medications revealed the facility received sixty (60) tablets of Hydrocodone-Acetaminophen 5-325 mg, dispensed 12/01/2021. Review of the facility's Initial Investigation Report, dated 12/19/2021, revealed Resident #521 requested a pain pill on 12/18/2021, and there were none in the cart. Per the report, the nurse called pharmacy for a refill and was told sixty (60) tablets of Hydrocodone-Acetaminophen 5-325 mg were sent at the beginning of the month. Review of Resident #521's December 2022 MAR revealed the resident had received twenty-seven (27) tablets of Hydrocodone-Acetaminophen 5-325 mg for the month of December 2021 from 12/01/2022 to 12/18/2022. Review of the facility's 5-Day Investigation Report, dated 12/24/2021, revealed the facility could not validate the medication was taken by an employee and whether thirty (30) or sixty (60) tablets were missing. Per the report, the facility obtained a replacement prescription from the Medical Director for thirty (30) tablets to be paid for by the facility. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The narcotic dose count sheets for Resident #521 for 11/01/2021 to 01/30/2022 were requested, but the facility was unable to provide the sheets. 2. Review of the Controlled Substance Book, for the [NAME] Unit, revealed the instructions explained to refer to the facility's pharmacy procedure manual for specific instructions on documenting controlled substances. In general, it stated to fill out and log in all information completely; if an error was made, cross out the mistake and initial next to the error; when a refill was received, add the new quantities to the previous quantity; when completing a controlled substances shift count, examine the page and card (Front and Back) to verify the correct count; and both nurses needed to check the count. Review of the [NAME] Unit Controlled Substances Book, on 04/01/2023, which contained the unit's Controlled Medication Shift Change Logs revealed there were eighty (80) missing signatures out of four hundred twenty-four (424) signature opportunities. Review of the facility's record sheet Controlled Medication Shift Change Log, for the C Unit Medication Cart, dated 11/18/2021 to 11/27/2021, revealed seven (7) instances in which either the On-Coming or the Off-Going staff 's signature spaces were blank. Review of the facility's Controlled Medication Shift Change Log, for the East B Hall Medication Cart, dated 11/19/2021 to 11/29/2021, revealed four (4) instances in which either the On-Coming or the Off-Going staff signature spaces were blank. Additionally, the count sheet quantity from the previous sheet was not signed by either the On-Coming nurse or the Off-Going Nurse. Review of the facility's record sheet Controlled Medication Shift Change Log, for the A Hall Medication cart, dated 11/08/2021 to 11/30/2021, revealed twenty-one (21) instances in which either the On-Coming or the Off-going staff signature spaces were blank. Additionally, the count sheet quantity from the previous sheet was not signed by the On-Coming Nurse. Review of the facility's record sheet Controlled Medication Shift Change Log, for the C/D COVID Hall, dated 11/28/2021 to 11/30/2021, revealed two (2) instances in which either the On-Coming or the Off-Going staff signature spaces were blank. Interview with the Interim Director of Nursing (DON), on 03/30/2023 at 8:50 AM revealed she expected staff to verify all controlled substances when they were delivered from Pharmacy. Further, she stated she expected two (2) licensed nurses to document the receipt and count of controlled substances. Continued interview revealed she had not had any issues with controlled substances since she had been the Interim DON from December 2022 to 03/10/2023. She stated she was now the Resource Nurse at the facility. Interview with the ED, on 03/30/2023 at 10:30 AM revealed she expected the DON to make sure the nurses were educated to document and correctly give controlled substances to residents. She stated she had a discussion with the DON about controlled substances, and they were developing a plan to assure controlled substances were correctly handled. Further, she stated she had not been told of any issues with controlled substances since she had been the ED from October 2022 to today.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44396 Based on observations, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to have an effective system to ensure the proper temperature ranges of the medication refrigerators. Observation revealed six (6) residents' insulin was stored below freezing temperature, at twenty-six (26) degrees Fahrenheit (F). There were influenza vaccines and Tuberculin Purified Protein Derivative (PPD) testing solutions were also stored below 32 degrees F. Additionally, the facility failed to ensure all drugs and biologicals were stored in locked compartments in accordance with State and Federal laws. Observations and interviews revealed a medication cart and a treatment cart, which contained drugs and biologicals, were left unlocked. Residents were observed passing by the unlocked treatment cart. The findings include: Review of the facility's policy, Storage of Medications, revised November 2020, revealed drugs and biologicals used in the facility were stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications. Compartments including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes containing drugs and biologicals were locked when not in use. Unlocked medication carts were not to be left unattended. Review of the Food and Drug Administration's (FDA) article, Information Regarding Insulin Storage and Switching Between Products in an Emergency, dated 09/17/2017, revealed according to the product labels from all three U.S. insulin manufacturers, it was recommended that insulin be stored in a refrigerator at approximately thirty-six (36) Fahrenheit (F) to forty-six (46) F. Unopened and stored in this manner, these products maintain potency until the expiration date on the package. Further review revealed users should not use insulin that has been frozen. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Centers for Disease Control and Prevention's (CDC) article, Storage Best Practices for Refrigerated Vaccines - Fahrenheit (F), undated, revealed users should unpack vaccines immediately then place the vaccines in trays or containers for proper air flow, put vaccines that were first to expire in front, keep vaccines in original boxes with lids closed to prevent exposure to light and separate and label by vaccine type. Further review revealed vaccines should never be frozen, except for Measles-Mumps-Rubella vaccine which can be stored in the refrigerator or freezer and the ideal temperature was forty (40) F with an acceptable range of 36 F to 46 F. Continued review revealed vaccine storage best practices included ensuring the refrigerator door was closed, to replace crisper bins with water bottles to help maintain consistent temperature, label water bottles Do Not Drink, leave two - three inches between vaccine containers and refrigerator walls, and post Do Not unplug signs on the refrigerator and near the electrical outlet. Record review revealed dormitory-style refrigerators should not be used; vaccines should not be stored on the top shelf, the door shelves or on the floor of the refrigerator; water bottles should not be removed or consumed; and food or beverages should not be stored in the same refrigerator. Review of the CDC's article, Vaccine Storage and Handling Toolkit, dated September 2021, revealed refrigerators should maintain temperatures between 36 F and 46 F. Further review revealed every vaccine storage unit must have a temperature monitoring device (TMD) and that an accurate temperature history that reflected actual temperatures was critical for protecting vaccines. Additional review revealed the CDC recommended a specific type of TMD called a digital data logger (DDL) because it provided the most accurate storage unit temperature information, including details on how long a unit had been operating outside the recommended temperature range, also known as a temperature excursion. Additional review revealed a DDL provided detailed information on all temperatures recorded at preset intervals. Record review revealed a refrigerator door that was not sealed properly or left open unnecessarily not only affected the temperature in a unit, it also exposed vaccines to light, which could reduce the potency of some vaccines. Users should consider using safeguards to ensure the doors of the unit remain closed-for example, self-closing door hinges, door alarms, or door locks. Review of the Tuberculin Purified Protein Derivative (PPD) package insert, undated, revealed it should be stored in a temperature range of 35 to 46 F. Further review revealed Tuberculin PPD should not be frozen and should be discarded if exposed to freezing. Continued review revealed Tuberculin PPD should be stored in the dark except when doses were being withdrawn from the vial and the solution could be adversely affected by exposure to light. Additional review revealed a vial of Tuberculin PPD which had been entered and in use for 30 days should be discarded and not used after the expiration date. 1. Observation of the [NAME] Wing medication room refrigerator, on 02/16/2023 at 10:27 AM, revealed Influenza vaccines, two (2) five (5) milliliter (ml) vials with syringes, expiration date 05/25/2023, stored on the top shelf. Observation revealed an insulin pen, 0.25 milligram (mg) - 0.5 mg, stored in the door. Further observation revealed the refrigerator held four (4) influenza vaccine vials on the door, one was opened, with no open date, and an expiration date of 05/25/2023. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation, on 02/16/2023 at 11:20 AM, revealed the medication refrigerator temperature for the Alzheimer's Care Unit (ACU) and Acute Alzheimer's Care Unit (AACU) measured 26 F, and there was no thermometer in the freezer, but there was nothing stored in the freezer. Continued observation revealed the refrigerator contained insulin and four (4) influenza vaccine vials in the refrigerator door. Additional review revealed the temperature log was up to date. However, there was no thermometer found in the refrigeration. Interview, with Registered Nurse (RN) #1, at the same time, revealed she would check the temperatures, but she was not sure what was safe. Observation, of the medication storage refrigerator on the East Wing by Hall D, on 02/16/2023 at 10:40 AM revealed the temperature log was up to date and the temperatures measured, at that time revealed the freezer's temperature was at 20 F and the refrigerator was at 52 F. Further observation revealed the items in stock in the refrigerator were seven (7) vials of influenza vaccine, stored on the bottom shelf. One (1) vial box was opened, but there was no open date. There was also two (2) Tuberculin Purified Protein Derivative (PPD, a solution used to test for the presence of Tuberculosis) received on 02/07/2023. Observation, of the medication storage refrigerator on the East Wing by Hall B, on 02/16/2023 at 10:55 AM, revealed the temperature log was up to date with the current temperature measured at 51 F. Continued observation revealed the refrigerator door was not sealing. The medications stored in the refrigerator, at that time included: Amoxil, delivered on 02/03/2023; Insulin Levemir; intravenous Rocephin and intravenous vancomycin, both with use by date 02/22/2023; and Tuberculin PPD, stored on the bottom shelf. Review of the Email (electronic mail) response from the manufacturer of the influenza vaccine, on 02/16/2023 at 4:20 PM, revealed the temperature excursion was anything outside the range of 34.6 F - 46.4 F. Further review revealed any product stored outside that range should be discarded. Interview, with RN #8, who worked the B Hall, on 02/24/2023 at 7:00 AM, revealed 42 F was in range as the range should be 35-42 degrees F. She stated if the temperature was out of range, she would take the things out and put them on ice, until day shift would come into address. She also stated the potency of the meds could be destroyed if out of range. Observation, of the medication storage refrigerator by Hall D, on 02/17/2023 at 9:30 AM, revealed the current temperature was 22 F. Further observation revealed the medications in the refrigerator at that time included: an insulin pen; thirteen Novolog (type of insulin) insulin pens; eight Humalog insulin pens; three Ozempic (brand) insulin pens; two Trulicity insulin pens; nine Basaglar insulin pens; four Novolog insulin vials and two Lantus insulin vials. Further observation revealed two shingles vaccine vials, two Tuberculin PPD solution vials and seven vials of influenza vaccine, stored on the bottom shelf. Continued observation revealed the Emergency Kit, which held two 'Novolog pens, two Levemir pens, two Humalog pens and one Lantus pen. Observation, of the medication storage refrigerator by D Hall, on 02/20/2023 at 3:43 PM revealed a new refrigerator; however, the temperature shown on the thermometer was 28 degrees F, which was confirmed by Licensed Practical Nurse (LPN) #3. Continued observation with LPN #3 revealed no instruction on the log sheet of the correct temperature range or what action to take if the temperature was out of range. Further review revealed the recorded temperature for the refrigerator, on 02/19/2023 was 30 degrees F. Further observation revealed the insulins and Tuberculin PPD were discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview, with Registered Nurse (RN) #1, on 02/16/2023 at 11:20 AM, revealed she would check temperatures, but she was not sure what was safe. Interview, with RN #4, on 02/16/2023 at 10:40 AM, revealed she understood night shift nurses checked the refrigerator temperatures, crash cart supplies and changed gastrostomy tube bags and tube feeding. She stated she did not know the appropriate temperature range for the medications and vaccine storage. RN #4 stated nor did she know whether there were restrictions on where the medications could be stored inside the refrigerator. Interview, with RN #5, on 02/16/2023 at 10:55 AM, revealed high temperatures were a concern, and if high temperatures were found, she would put in a work order for the refrigerator to be repaired. Further interview revealed medication storage refrigerator temperature was important to maintain quality of medications. She also stated she would put in a work order today. Interview with the Corporate [NAME] President (VP) of Clinical Education, on 02/17/2023 at 10:13 AM, revealed if medications were stored out of temperature range, it would affect the medication efficacy. She further stated she would replace any medications stored out of temperature range. Interview with Pharmacist #2, on 02/1720/23 at 12:57 PM, revealed the facility should store insulin pens in the refrigerator until removed for use. Further interview revealed insulin pens could not be stored at temperatures greater than 86 degrees longer than 14 days and should not be stored below freezing, 32 degrees F. Further interview revealed for tuberculin testing vials if they were stored at less than 35 F, then they could potentially not be active after it thaws. Continued interview revealed insulin should ideally be stored in the middle of the refrigerator, but she was not aware of an official recommendation. She stated the pharmacy did dispense some flu vaccine in the A/B wings of the facility and that excursions would be even just a few hours, but the medication should not be stored below 35 F. Continued interview revealed that specifically flu vaccines should be stored between 36 F and 46 F. Interview with LPN #3, on 02/20/2023 at 3:23 PM, revealed she was not sure what the range medications were supposed to be stored. She stated the effectiveness of the medications could be affected by the wrong temperature. Interview, on 02/20/2023 at 4:59 PM, with the Interim Director of Nursing (IDON) revealed she knew the appropriate temperature range for medication storage refrigerators was 36 - 46 degrees F. She stated there was no specific clarity in how staff would know what the correct temperature range was or what to do if finding the refrigerator was out of range. 2. Observation of the D Hall treatment cart, on 02/21/2023 at 2:42 PM revealed it was located in the hall below the sign, D HALL 135-148 and was unlocked. Observation of the D Hall treatment cart, on 02/21/2023 at 2:49 PM, revealed an Activities staff member placed a sign on the unlocked treatment cart that read Resident Council in Progress. She subsequently took the sign off the cart and placed it on a nearby medication cart. At that time, observation revealed no nurses were supervising the unlocked treatment cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident #103, on 02/21/2023 at 2:55 PM, revealed he/she pushed the treatment cart aside to enter the activities room and attended the upcoming Resident Council meeting. The treatment cart remained unlocked, and at this point, the cart had been unlocked and unattended by staff for thirteen (13) minutes. Observation of the treatment cart, on 02/21/2023 at 3:16 PM, revealed it was locked and RN #2 was now at the nearby nurses station. Observation of the treatment cart contents and subsequent interview with Registered Nurse (RN) #2, on 02/21/2023 at 3:16 PM, revealed it contained the following: silver sulfadiazine cream; povidone-iodine antiseptic spray; hydrogel silver antimicrobial wound gel with the cap removed; nystatin/triamcinolone/acetonide ointment; six (6) zinc oxide formula packets; anti-fungal cream and antifungal powder; petroleum jelly; collagen wound dressing with silver alginate wound dressing; collagenase ointment; wound cleanser spray; and a brown substance on the bottom of the treatment cart drawer. Interview with RN #2 revealed the treatment cart should remain locked for safety purposes and only licensed personnel should be able to access the cart and its contents. Interview, with RN #6, on 02/21/2023 at 5:36 PM, revealed she asked RN #2 to unlock the treatment cart so she could get some supplies, but she could not remember if she re-locked it. RN #6 stated the treatment cart should be locked and if it was not locked residents could get something out of the unlocked treatment cart and ingest it. Observation, on 03/04/2023 at 4:56 PM, revealed the medication cart on the [NAME] Unit was unlocked. The unlocked medication cart was located in a resident common area between the Physical Therapy Gym door and the Nurses' Station. At that time, observation also revealed no nurses were supervising the unlocked medication cart. Interview, with RN #11 on 03/04/2023 at 4:57 PM, who was assigned to the medication cart, revealed she did not lock the cart. She stated the cart should be locked, and if it was not locked residents could get into the cart. Interview, with the Interim Director of Nursing (IDON), on 03/16/2023 at 4:00 PM revealed she expected medication and treatment carts to be locked when not in use. The IDON stated anything could happen if a medication or treatment cart was left unlocked, such as a resident could grab something that was not theirs. Interview, with the Executive Director, on 03/16/2023 at 11:34 AM revealed her expectation was that nurses would keep medications securely stored. Further interview revealed she expected medication carts to remain locked when unattended because this could be a safety risk to the residents. Continued interview revealed she expected to be notified if the medication storage refrigerator temperatures were out of range so she could develop a solution. She also stated she expected staff would remove items from a refrigerator with a temperature that was unsuited for medication storage. 47662

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 14936 Based on interview, review of the facility's policies, review of the Executive Director's Job Description, and review of the Plans of Correction (PoC) submitted for the On-site Revisit/Abbreviated Survey with exit date 04/04/2023, it was determined the facility failed to ensure it was administered in a manner that enabled it to use its' resources effectively and efficiently to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The State Survey Agency (SSA) identified continued non-compliance in the areas of 42 CFR 483.10 Resident Rights (F550, F578); 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation (F600); 42 CFR 483.20 Resident Assessments (F635, F641); 42 CFR 483.21 Comprehensive Resident Centered Care Plan (F656, F657); 42 CFR 483.24 Quality of Life (F679); 42 CFR 483.25 Quality of Care (F689); 42 CFR 483.35 Nursing Services (F725); 42 CFR 483.45 Pharmacy Services (F755, F761); and 42 CFR 483.70 Administration (F837). Additionally, the facility failed to maintain substantial compliance in the areas of 42 CFR 483.10 Resident Rights (F584); 42 CFR 483.24 Quality of Life (F680); 42 CFR 483.25 Quality of Care (F685, F695); 42 CFR 483.70 Administration (F835, F849); and 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). Review of the facility's Plan of Correction (PoC) revealed its' Administration failed to have an effective process in place to address systemic failures through the Quality Assurance Performance Improvement (QAPI) process. As a result, the facility failed to ensure standards for quality of care regarding performance improvement measures were achieved and sustained. The facility was recited at the highest scope and severity (S/S) of a K, for the 06/02/2023, second (2nd) revisit. (Refer to F578, F656, F657, F689, F835, and F867) The findings include: Review of the facility's, Job Title: Executive Director, undated, revealed the Executive Director (ED) was to direct the administration of the health care facility within the authority of the facility's management company. Per the review, the ED directed and performed Quality Assessment and Assurance functions including but not limited to regulatory compliance rounds to monitor the facility's performance and to continuously improve quality. Further review revealed the ED was responsible for the implementation of programs to gather and analyze data for trends and institute actions to resolve problems promptly, and report and make recommendations to the appropriate committee. Review of the facility's acceptable Plans of Correction (PoC), for the Standard Recertification/Abbreviated/Extended Survey concluded on 03/16/2023 and the On-site Revisit/Abbreviated Survey concluded on 04/04/2023, revealed the Executive Director failed to ensure the facility achieved substantial compliance. The facility remains out of compliance with repeat deficiencies following the second (2nd) revisit, concluded on 06/06/2023. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Review of Resident #2's, Resident #23's and Resident #89's medical records and the Plan of Correction for the survey, revealed the residents had a Do Not Resuscitate (DNR) order. However, there was no evidence that the Emergency Medical Service (EMS) DNR forms had been completed for the residents. The facility's failure to ensure the EMS DNR forms were completed for Resident #2, Resident #23, and Resident #89 has caused or is likely to cause serious harm or serious injury to residents. (Refer to F578) 2. Based on observation, interview, record review and the Plan of Correction for the survey, along with the facility's policy it was determined the facility failed to develop and implement care plans with individualized person-centered interventions to prevent falls for five (5) of thirty-three (33) sampled residents (Residents #20, #35, #97, #146, and #821) who were identified with multiple falls with injuries. (Refer to F656) 3. Based on observation, interview, record review, and facility policy review, it was determined the facility failed to have an effective system in place to ensure care plans were revised to provide proper care and supervision to residents to prevent falls/accidents for two (2) of thirty-three (33) sampled residents (Residents #146 and #821). (Refer to F657) 4. Based on observation, interview, record review, review of the facility policy and Plan of Correction, the facility failed to have an effective system to ensure adequate supervision and monitoring to prevent falls/accidents. The facility failed to identify risks and hazards; failed to establish root cause analyses of previous falls; and failed to implement and evaluate interventions to prevent further falls for six (6) of thirty-three (33) sampled residents (Residents #20, #35, #90, #97, #146 and #821). (Refer to F689) In an interview with the Minimum Data Set (MDS) Coordinator #1 on 06/02/2023 at 3:12 PM, she stated she reviewed care plans with every major assessment quarterly, annually and with a significant change. She stated she made changes as appropriate to update the care plans to the most appropriate interventions based on records found in the residents Electronic Medical Record (EMR) and through observations of the resident. She stated she was responsible for all MDS's now but some things were done by a remote team. In an interview with the Director of Nursing (DON), on 06/02/2023 at 11:46 AM, she stated the facility had not identified any trends as they related to falls. She said they did identify that the D Hall seemed to have more falls, but they could not determine a certain time, shift or staff member involved. When asked who trained her on how to do a root cause analysis (RCA), she said it was the previous [NAME] President of Clinical Operations (VPOC). In an interview with the Executive Director (ED) on 06/02/2023 at 1:20 PM she stated she was a member of the Quality Assurance Performance Improvement (QAPI) Committee and meetings were held weekly now and usually daily as the needs arose with survey, but normally they were held monthly. She stated in attendance generally were the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers (UM), and all department heads naming a few such as Housekeeping, Business office and Human Resources. She added the discussions addressed old business first then new business, employee turnover, retention, orientation, marketing, point click care, infection control, and Relias training. She added mainly they discussed the survey findings and citations and the facility was working through the cited deficiencies. She stated other topics discussed in QAPI, were training of new employees, re-admissions and discharges of residents. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In continued interview with the ED on 06/02/2023 at 1:20 PM she said the Medical Director would be providing In-Services for the staff on falls. Per the interview, the ED stated the care plans should have been developed initially when the residents were admitted , and revised with any change of condition and quarterly. In an interview with the Chief Operations Officer (COO) on 06/02/2023 at 3:41 PM, she stated the facility utilized audit tools and she was just made aware of the findings and the Care Plan Team would be in the facility to work on the concerns the State Survey Agency (SSA) identified on 06/03/2023, to review the care plans and Minimum Data Set (MDS), to ensure they were correct. The COO also stated the team created the audit tools based on the POC to work toward compliance. She said additional rounds were conducted with a new rounding tool, twenty-four (24) hours around the clock. Further, she stated she felt the facility was moving in the right direction and things were getting better. However, review of the PoC for surveys with exit date of 03/16/2023 and 04/04/2023, revealed the facility was recited at the Immediate Jeopardy (IJ) level.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14936 Based on interviews, review of the facility's policy, and review of the facility's personnel records, it was determined the facility's Governing Body failed to ensure their Human Resources (HR) timely obtained background information, to include the requirements of 906 Kentucky Administrative Regulations ([NAME]) 1:190, Section 1(4), a disqualifying offense, and Kentucky Revised Statues (KRS) 209.032, prior to hiring for potential employees, and failed to establish and implement adequate policies related to employee screening to ensure safe management and operation of the facility as related to employing staff with adverse actions. (Refer to F606) The findings include: Review of the facility's policy Background Screening, dated 06/14/2019, revealed the company would conduct background investigations on all candidates for employment prior to making an employment offer and may use a third party to conduct these background checks. Further review revealed the company would not employ a person who was convicted of any offense listed on the State-specific disqualifying offenses list. However, review of the policy further revealed a reported criminal offense would not necessarily disqualify a candidate from employment. The nature and seriousness of the offense, the surrounding circumstances, rehabilitation, and the relevance of the offense to the specific position(s). The Company would follow company procedures for making decisions regarding potential adverse actions. Review of KRS 209.032 revealed a vulnerable adult services provider, which included long-term care facilities as defined by KRS 216.510, shall query the cabinet as to whether a validated substantiated finding of adult abuse, neglect, or exploitation has been entered against an individual who was a prospective employee of the provider. Review of the facility's Personnel Files revealed thirty (30) of thirty-one (31) employee files reviewed revealed a lack of documentation to support the facility completed thorough background checks prior to employment, to include Kentucky's Caregiver Misconduct Registry. Further review revealed the facility hired four (4) employees who had documented evidence of convictions that would be considered disqualifying offenses. Continued review revealed there were seventeen (17) employees who were noted to have Client Review Required located within their employee files, which, per interview, indicated the employee needed further review by Corporate HR before hiring would be approved. Interview with the Executive Director (ED), on 03/30/2023 at 9:00 AM, revealed the facility sent all applications to Corporate HR to complete, what she thought, was all federal and state required information and background checks, to ensure the candidates for employment were cleared for all required federal and state background checks. She stated Corporate HR would inform the facility's HR and or the ED within a few days of the decision of whether the facility could hire the potential employee. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the [NAME] President (VP) of HR, on 03/30/2023 at 1:30 PM, revealed the process for hiring was for the facility HR to forward the application to Corporate HR to review and complete the third-party background check. She said she was not aware of the required check with the Kentucky Cabinet as per KRS 209.032 (the Caregiver Misconduct Registry). She stated the review of the third-party background check results was conducted by Corporate HR and if there were any questionable offenses, they would make the final decision if the applicant would be cleared for hire. She further revealed any candidate that came back from the third party with Client Review Required, or that was not 100% cleared for employment, would be reviewed by the Corporate Director of HR. Continued interview with the VP of HR, on 03/31/2023 at 7:00 PM revealed the Corporate HR Director would review the offenses, consider the timeframe and the offense, then would make the decision on whether to hire the employee. She stated she was not aware of all federal and state-required background checks. Further interview revealed the third-party reports were difficult to read, in order to determine if the applicant had a disqualifying offense, and she thought they were all inclusive of the requirements to be compliant with federal and state laws. Interview with the Chief Operating Officer (COO), on 03/30/2023 at 1:45 PM, revealed she became aware that an employee of the facility, may have convictions that would be a disqualifying offense on 02/17/2023. Further interview revealed she reached out to Corporate HR and found out the background check completed on 12/06/2021, for the Maintenance Director, at that time, contained prior convictions listed as a disqualifying offense, which prompted a sweep of all current employee files. The COO revealed she was not aware the pre-employment checks did not include the required Caregiver Misconduct Registry as per KRS 209.032.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 14936 Based on interview, record review, and review of the facility's policy, it was determined the facility failed to obtain the most recent Hospice agency plan of care and designate a member of the facility's interdisciplinary team (IDT), who was responsible for working with the hospice representative to coordinate care of the resident for one (1) of thirty-three (33) sampled residents, Resident #35. Review of Resident #35's Electronic Medical Record (EMR) revealed no Hospice agency care plan (CP). On 06/02/2023, Nurse Consultant #1, after a request, provided this Surveyor a copy of the Hospice agency CP. In the interview with the SSD, she stated she was not aware of the facility requirement to obtain the Hospice agency's CP for incorporation into the facility's CP. She further stated she only obtained the Hospice agency CP upon request The findings include: Review of the facility's policy titled, Hospice Program, last revised July 2017, revealed the policy provided a space for the facility to identify their designated representative, who was to be a member of the Interdisciplinary Team (IDT). The policy stated the designated representative would have clinical and assessment skills and was operating within the State scope of practice act. Per the policy, this person was responsible to ensure the most recent hospice plan of care was obtained and incorporated into the facility's person-centered care plan. Review of Resident #35's Admission Record revealed the facility admitted the resident on 09/09/2021 with diagnoses of Dementia, Malnutrition, Colostomy, and a History of Falls. Review of hospital records revealed Resident #35 was in the hospital from 02/06/2023 until 03/08/2023 for Aspiration Pneumonia. Review of Resident #35's 5-day Admission Minimum Data Set (MDS) Assessment, dated 03/13/2023, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of zero-zero (00), signifying the resident was severely cognitively impaired. Also, the facility assessed the resident for two (2) person physical assistance for transfers, dressing, and toileting. He/She was assessed for one (1) person physical assistance for bed mobility and personal hygiene. The resident was assessed for the use of a wheelchair only and noted to be absent of upper/lower extremity impairments. Review of Resident #35's Progress Notes, revealed the resident was placed in hospice care, on 03/14/2023. Review of Resident #35's Electronic Medical Record (EMR) on 05/10/2023, revealed no Hospice agency care plan was located in the resident's medical record. On 05/25/2023 at 4:07 PM, an email request was sent to the Director of Nursing (DON) for the facility to provide a copy of Resident #35's hospice care plan and the identity of the facility's IDT hospice representative. The DON provided a copy of the facility's hospice care plan and two (2) names of the Hospice agency staff, not a staff member from the facility. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 06/02/2023 at 8:45 AM, with the facility's Nurse Consultant #1, this surveyor requested a copy of Resident #35's Hospice agency care plan. The facility Nurse Consultant #1 provided a faxed copy of the Hospice agency care plan, with a cover sheet. Review of the faxed copy revealed the Hospice agency faxed it over on 06/02/2023 at 8:58 AM. Interview on 06/02/2023 at 9:00 AM, the DON stated the facility's Hospice staff representative was the Social Service Director (SSD). Review of Resident #35's facility Hospice CP, revealed it was initiated on 03/16/2023, with interventions of administer medication as ordered, collaborate with the hospice team to optimize care, encourage support of friends and family, honor their preferences, notify Hospice agency of any changes to the resident's condition, and observe pain and discomfort. The agency's contact information was also listed as an intervention. Review of Resident #35's Hospice agency CP, dated 03/14/2023, revealed nineteen (19) interventions listed for the resident's care. These interventions were related to seven (7) problems related to the dying process and hospice care. The problem areas were anxiety, bowels, hydration/nutrition, pain related to disease progression, requirements for comprehensive assessments, ensuring all parties involved in the resident's care understood and participated in the plan of care, safety risks for the resident, and skin integrity. In an interview with the SSD, on 06/02/2023 at 12:00 PM, she stated she was the facility's hospice representative. When asked about Resident #35's hospice agency care plan, she stated she only got them upon request. She stated she was not aware of the requirement to integrate the hospice care plan with the facility's care plan. She also stated she had not read the facility's hospice policy. The SSD said she had been the hospice representative for about one (1) year. In an interview with the Director of Nursing (DON), on 06/02/2023 at 11:46 AM, she said she would have to read the hospice policy to be able to speak on it completely. She stated the facility was to communicate with the hospice agency for any changes to the resident's needs and work with them to determine if the resident needed any therapy or medication changes. She said staff members were to call hospice, and the agency would send someone in. The DON stated the SSD conducted the hospice meetings and was responsible for getting the hospice care plan. The DON also stated the hospice agency would email their care plan over or discuss it with the SSD. In an interview with the Executive Director (ED), on 06/02/2023 at 1:23 PM, when asked who the facility representative was for hospice, the ED stated she could not think of her name, right now. She stated they are invited to the meetings but if they do not come, what can they do about it? She said she was not able to identify the hospice representative at this time.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 14936 Based on interview, record review, review of the facility's policy, and review of the Plans of Correction (PoC) submitted for the 04/04/2023 survey, it was determined the facility failed to have an effective process in place to address systemic failures through the Quality Assurance Performance Improvement (QAPI) process. As a result, the facility failed to ensure standards for quality of care regarding performance improvement measures were achieved and sustained. The facility failed to effectively track adverse resident events, analyze their causes, and implement preventive action. The facility failed to ensure there was an effective system in place to regularly review and analyze audit data, including data collected under the QAPI program, and act on available data to make improvements and maintain substantial compliance. 1. Review of the facility's Form CMS-672 Resident Census and Conditions of Residents, identified forty-four (44) residents were assessed to be at risk for falls. The facility reported residents had over thirty (30) falls between 04/16/2023 and 05/26/2023. However, there was no evidence the facility was discussed the falls, reviewed previous falls, analyzed the time of day and staff patterns for each fall in order to determine the root cause of the falls and to implement person centered intervention to prevent further falls. 2. Review of the facility's audit tool for residents' Care Plans showed multiple times the care plans were inaccurate. 3. Review of the facility's audit tool for Accurate Coding revealed three (3) residents, who had inaccurate coding on the Minimum Data Set (MDS) assessments, and the care plans that did not match the coding/assessments. 4. Review of the facility's Controlled Substances Log Book Shift Count revealed multiple times two (2) Licensed Nurses' signatures were not present. This was not reflected on the audit tool. 5. Review of the audit tool for Drugs and Biologicals revealed it had not been completed for seven (7) days. Further, observation revealed unlocked medication carts; inconsistent temperatures taken by two (2) different thermometers; and insulin stored at an inappropriate temperature. 6. Review of the audit tool for 04/17/2023, 04/18/2023, and 04/19/2023 revealed they were incomplete. The findings include: (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's policy titled, Quality Assurance and Performance Improvement (QAPI) Program-Governing and Leadership, last revised March 2020, revealed the Administrator (Executive Director) was a member and was ultimately responsible for the QAPI Program and for interpreting its results and findings to the Governing Body. The QAPI Coordinator coordinated the activities of the QAPI Committee. The policy stated the responsibilities of the QAPI Committee were to collect and analyze data, identify, evaluate, monitor, and improve the facility's systems and processes of care and services, identify and help to resolve negative outcomes and quality of care problems identified during QAPI. The committee would also determine the root cause analysis to help identify problems pointed to underlying systemic problems, help departments, consultants, and ancillary services implement a system to correct potential/actual issues of quality of care. The policy also revealed the committee was to establish benchmarks and goals to measure performance improvement projects to achieve specific goals. It also was to communicate all phases of the QAPI process to the Administrator (Executive Director) and Governing Body through sharing meeting minutes, committee activities, and results of QAPI activities. Continued review of the QAPI policy revealed the committee had full authority to oversee the implementation of the QAPI program, to establish performance and outcome indicators for quality of care and services delivered in the facility, choosing, and implementing the tools that best captured and measured the data about chosen indicators, appropriately interpreting data within the context of standards of care, benchmarks, targets and the strengths and challenges of the facility. Per the policy, the committee was responsible to communicate the information gathered and their interpretation to the Owner/Governing Body. The policy also revealed the QAPI Committee was made up of the Administrator/Executive Director or designee, the Director of Nursing (DON), the Medical Director (MD), and the Infection Preventionist. Additionally, the Administrator/Executive Director could request a representative from each department: pharmacy, social services, activities, environmental services, human services, and medical records. Per the policy, the committee must meet at least quarterly and should be reminded of the meeting day, time, and location via e-mail at least two (2) days prior to the meeting. The policy stated special meetings could be called prior to the next scheduled meeting by the Administrator/Executive Director as needed. Review of the facility's 04/17/2023 audit tool the facility created revealed it covered each tag, F550, F656, F689, F725, F726, F761, F880 and F919. Staff members were to randomly pick ten (10) residents to audit daily. They were to audit to ensure urinary catheters were covered with a dignity bag, the Kardex (an abbreviated care plan for aides) was followed by aides as the plan of care, residents were turned and repositioned, to check water temperatures, to ensure call lights were answered timely, residents' supervision needs were being met, gait belts were used during transfer, unused medication was discarded from the medication carts, and the unit medication carts were locked. Additionally, the same ten (10) residents were to be observed as staff interacted with them to ensure proper Personal Protection Equipment (PPE) was used, hand hygiene between meals, gloves were used by staff when touching food, clean trays and dirty trays were kept separate, the dining room was clean, items on the floor were disposed of, hand hygiene between carts, call lights were functional, and the toilets worked. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Review of the facility's Plan of Correction (PoC), with an alleged compliance date of 04/16/2023, revealed the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Staff Development Coordinator (SDC) conducted education to all Licensed Nurses (LN), starting 03/08/2023 and ongoing related to ensuring the facility provided an environment free from accident hazards and provided supervision and assistive devices to prevent accidents including falls based on the root cause of the falls. Further review revealed management staff including the Executive Director, DON, ADON, and SDC would make visual observation rounds daily to determine resident needs were met to prevent accidents including falls, and these audits would be submitted to the Quality Assurance Performance Improvement (QAPI) Committee weekly. Review of the weekly QAPI meeting documentation presented by the facility revealed a flow sheet outlining each non-compliance tag. Review of the information related to F689 (falls) revealed the QAPI was identifying the number of falls for each week; however, there was no documented evidence the facility was discussing the falls, looking at previous falls, analyzing the time of day and staff patterns for each fall in order to determine the root cause of the falls and to implement person centered intervention to prevent further falls. Review of the facility's Quality Assurance and Performance Improvement (QAPI) meeting minutes for 04/21/2023 for F689 revealed there were six (6) falls for the prior week. It was noted a Root Cause Analysis (RCA) was done for each fall and appropriate interventions were in place for all residents. However, this statement written in the minutes could not be verified because there was no other documented evidence, and the facility was not able to provide any details in interviews that this occurred. Review of the signature sheet revealed the Executive Director (ED) was present as well as the Staff Development Coordinator (SDC), the Director of Rehabilitation (DOR), Environment Services Supervisor (ESS), Admissions Coordinator (AC), the Director of Maintenance, the Business Office Manager (BOM), the [NAME] President of Maintenance (VPM), the Medical Director (MD), a nurse aide, and a licensed nurse. Review of the facility's QAPI meeting minutes for 04/28/2023 for F689 revealed it was documented there were five (5) falls for the previous week, an RCA was done for each fall, and appropriate interventions were in place for all residents. However, this statement written in the minutes could not be verified because there was no other documented evidence, and the facility was not able to provide any details in interviews that this occurred. Review of the signature sheet revealed present at the meeting was the Director of Nursing (DON), a Registered Nurse (RN), the Assistant Director of Nursing (ADON), the Social Service Director (SSD) and the [NAME] President of Clinical Education (VPCE). Review of the facility's QAPI meeting minutes for 05/05/2023 for F689 revealed it was documented the facility had thirteen (13) falls during the previous week. The minutes also documented an RCA was done for each fall, and all residents involved had appropriate interventions in place. However, this statement written in the minutes could not be verified because there was no other documented evidence, and the facility was not able to provide any details in interviews that this occurred. Review of the signature sheet revealed present for this meeting was the ED, DON, ADON, DOR, Medical Records, the Dietary Manager (DM), SSD, BOM, Minimum Data Set (MDS) Coordinator and the MD, as well as a licensed floor nurse. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's QAPI meeting minutes for 05/12/2023 for F689 revealed it was documented the facility had seven (7) falls during the previous week, an RCA was done for each fall, and each resident had the appropriate interventions in place. However, this statement written in the minutes could not be verified because there was no other documented evidence, and the facility was not able to provide any details in interviews that this occurred. Review of the signature sheet revealed present at the meeting was the ED, DON, DOR, a Unit Manager (UM) illegible name, Environment Services Supervisor, MDS Coordinators #1 and #2, DM, and a floor CNA #18. Review of the facility's QAPI meeting minutes for 05/19/2023 for F689 revealed it was documented the facility had six (6) falls the previous week, an RCA was completed on each fall, and each resident had appropriate interventions. However, this statement written in the minutes could not be verified because there was no other documented evidence, and the facility was not able to provide any details in interviews that this occurred. Review of the signature sheet revealed present at the meeting were the ED, DM, ADON, SSD, Medical Records, and two (2) illegible names. In an interview with the Director of Nursing (DON), on 05/25/2023 at 11:55 AM, the DON stated when a fall occurred, the nurse on duty was to contact her and start the fall event in the Electronic Medical Record (EMR). She said then she came up with the root cause of the fall and made sure an intervention was implemented. She said she had received training on determining the root cause for falls but could not remember what the training was called or when she received it. She said she usually used the information provided by the reporting nurse to determine the root cause. The DON also stated the falls were discussed in the Interdisciplinary Team (IDT) meetings that included the ED, ADON, Unit Managers, Department Heads and the MD. She was unable to provide documented evidence the IDT was analyzing the falls to review staffing patterns, time of day, previous falls, or what level of monitoring/supervision was being provided at the times of the falls. She said she realized the IDT needed to do more analysis of the falls and document this. In another interview with the DON, on 05/25/2023 at 12:55 PM, she stated she did not have knowledge of Resident #90 falling in the early morning hours today. She added either she, the Assistant Director of Nursing (ADON), or the Executive Director (ED) should be notified immediately when a fall occurred, and care plan interventions should be placed immediately as well. The ED was also in the room and stated she had not been informed of Resident #90's fall. The ED stated this notification was not in the facility's policy, but they preferred to be notified. At this point, the DON contacted the ADON, and she came to the ED's office. When the ADON was asked if she had been notified of the fall, she stated she had not. All three (3) stated that perhaps one (1) of the unit managers had been notified. When asked if the process had been followed, the DON said probably not, and the nurse should have notified one (1) of them. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the ED, on 05/25/2023 at 12:15 PM, she stated the DON received a report of every fall. She stated the DON reviewed what the nurse on duty at the time documented and determined the root cause of the fall. She stated the IDT discussed the falls in their meeting each morning. She further stated she was not sure if the DON had received any training on determining the root cause of falls. The ED stated there was no set format to follow when discussing the falls. She stated they used to have a falls meeting specifically to talk about and analyze the falls, using the environment, time of day, pattern of falls, and the use of assistive devices to come up with the root cause of the falls. That way, she stated, appropriate interventions could be implemented. She said she could not put all residents with repeat falls on one-to-one (1:1) observation; the facility just did not have enough staff for that to be done. When the ED was asked how many residents the facility had that had been assessed to be a fall risk, she said she was not sure, but she thought the falls had decreased. In an interview with the DON, on 06/02/2023 at 11:46 AM, she stated the facility had not identified any trends as they related to falls. She said they did identify that the D Hall seemed to have more falls, but they could not determine a certain time, shift or staff member involved. When asked who trained her on how to do a root cause analysis (RCA), she said it was the previous [NAME] President of Clinical Operations (VPOC). In an interview with the ED, on 05/19/2023 at 3:43 PM, she stated the DON was responsible to complete an RCA of a fall. She stated once the DON had identified a root cause, it was then discussed in the clinical meetings. She said the team would give input and determine if they all agreed with the DON's analysis of the incident. The ED also stated interventions were discussed daily in the clinical meetings and with each fall that occurred. She stated the team looked over the interventions and determined if they had been effective. She stated if not, the IDT would identify a new intervention. The ED stated the facility had not determined a trend related to their falls, but if she had to pick an area, it was related to the residents' behaviors. The VPCO stated, in an interview on 06/02/2023 at 3:12 PM, facility staff was looking into a new program that would help detect a resident's movement before a fall. She stated the increased rounding, including by management staff, being done throughout shifts helped decrease the amount of falls they have had. She reported resident falls were down eighty percent (80%). 2. Review of the audit tool created to check on care plans and to make observations of staff providing care for residents, any corrective action, and the signature of the auditor, dated 04/19/2023, revealed one (1) resident was still care planned for a wheelchair and a walker that the resident no longer used. However, these assistive devices remained on the care plan. Another resident was care planned for a cushion on his/her wheelchair, but the resident did not have a cushion, which was not needed, and it still remained on the care plan. An additional resident, who did not use a cane, had been care planned to use a cane. Review of the audit tool for 04/20/2023, revealed a resident was care planned for a walker but did not use a walker. Another resident's care plan reflected the resident had one-half (1/2) side rails, when in fact it was one-quarter (1/4) side rails. Also this resident was care planned for two (2) staff for care, which was noted as inaccurate, and it was deleted from the care plan. Additionally, the two (2) residents, who previously requested the side rails to be removed revealed they were still present. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the QAPI Review-Entire Survey document and meeting minutes for 04/21/2023, revealed for F656 the team discussed a wandering resident who was placed on one-to-one (1:1) supervision, and six (6) falls in which the root cause was identified, and the care plans were noted to be revised. However, there was nothing documented on any audits to show the items were addressed. For F657, it was noted they found no concerns. The signature sheet for this meeting showed the ED was present as well as the SSD, licensed floor nurse, the DOR, Admissions, Activities Assistant, the DON, the MD, the BOM, and the [NAME] President of Maintenance (VPM). Review of the QAPI Review-Entire Survey document and meeting minutes for 04/28/2023, revealed no concerns were identified for F656 and F657. However, review of the audits for 04/21/2023, revealed one (1) resident who required a perimeter mattress be added to his/her care plan; one (1) resident was noted to still not have side rails to his/her bed, and one (1) resident was noted to have a walker and bedpan on the care plan, which the resident no longer used. Review of the 04/24/2023 audit revealed a resident still had a urinal care planned but no longer used it; another was care planned for the use of a jumpsuit and binders, which the resident refused to use. Review of the 04/26/2023 audits revealed two (2) residents had perimeter mattresses but were not care planned for them. Review of the QAPI Review-Entire Survey document and meeting minutes for 05/05/2023, revealed F656 had two (2) residents that were readmitted from the hospital, with wander guards in place for both and all orders in place. The document noted F657 had no concerns noted. However, review of the 05/03/2023 audit tool, revealed one (1) resident was found to have non-skid strips next to the bed, but it was not noted on the care plan as an intervention. Another resident was found to be with the bed against the wall, but it was not noted on the care plan as an intervention; it was later added to the care plan. Review of the signature sheet for 05/05/2023, revealed the ED was present as well as the DON, the ADON, a licensed floor nurse, Medical Records, SSD, DM, BOM, an illegible name, and the MD. Review of the QAPI Review-Entire Survey document and meeting minutes for 05/12/2023, revealed no concerns were found with F656 or F657. However, on the 05/06/2023 audit tool, three (3) residents were noted to have perimeter mattresses, none of which were care planned. The audit tool noted they were added as an intervention. Review of the 05/07/2023 audit tool, revealed a resident was care planned with a rollator but no longer had one, and it was resolved on the care plan. Another resident was noted not to be walking, and the care plan had not been revised to reflect the March 2023 MDS. Another resident was identified with a perimeter mattress which had not been care planned before a staff member informed management of the finding. Review of the 05/10/2023 audit tool revealed Resident #821 did not have anti-tippers on his/her wheelchair; however he/she had an anti-rollback device, and it was not care planned. Review of the signature sheet for 05/12/2023, revealed the ED was present as well as the DOR, Minimum Data Set Coordinator (MDSC) #1, a licensed floor nurse, DON, MDSC #2, Housekeeping, Receptionist #1, Activity Assistant #5, and two (2) illegible signatures. Review of the QAPI Review-Entire Survey document and minutes for 05/19/2023, revealed F656 had a note which revealed some wandering residents had been identified, and their care plans had interventions implemented. F657 had a note which revealed some behaviors were identified, and the care plans were revised. However, review of the audit tools for F656 and F657 on 05/14/2023 revealed a resident was identified with a perimeter mattress, and it had not been care planned; later, the care plan was revised. Review of the audit tool dated 05/15/2023, revealed a resident who was care planned for dycem in the chair, but the dycem was under the chair instead of in the chair. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Review of the facility's PoC for F641, revealed all residents' MDS Assessments, care plans, and Kardex would be audited by 04/04/2023 by the MDS nurse to ensure accuracy of MDS coding, the care plan in place, and the Kardex to reflect use of devices. Further review revealed any MDS with coding errors had been modified to reflect accurate coding in Section G0600 Mobility Devices and care plans, and the Kardex accurately reflected the use of any mobility device, including wheelchairs. Continued review revealed the Director of Clinical Reimbursement, MDS nurse, and/or a licensed nurse would conduct a weekly audit of up to ten (10) completed MDS's to ensure any resident with a mobility device was appropriately coded on the MDS in Section G0600, and the care plan/Kardexes were up to date. This audit would continue for four (4) weeks, and if no issues were identified, the audit would decrease to monthly by the fifteenth (15th) of each month for the next six (6) months. Per the PoC, if no issues were identified after six (6) months of monthly audits, the audits would end. If issues were identified, audits would remain weekly until four (4) weeks were completed without errors. The results of the initial, weekly, and monthly audits would be reviewed by the MDS Coordinator, Director of Clinical Reimbursement, [NAME] President of Clinical Reimbursement, and Facility Executive Director (ED), and the findings and Performance Improvement Plan would be presented in the facility QAPI plan monthly until the audits were no longer required. Review of the facility's initial audit revealed multiple modifications were needed to the Care Plan and Kardex. The facility alleged compliance on 04/16/2023 with their audits. Review of the audits revealed all weekly audits were conducted by the [NAME] President of Clinical Reimbursement. A. Review of the Quarterly MDS Assessment, dated 02/10/2023, for Resident #146 revealed it was coded for a walker and wheelchair. Review of the 04/16/2023 audit for Resident #146 revealed the resident used a walker and a wheelchair during the look back period for the MDS, and the care plan and Kardex were correct. Review of the 05/07/2023 audit for Resident #146 revealed the resident used a wheelchair and walker during the MDS look back period, and the walker was not on the care plan or Kardex. Further review revealed the audit stated the walker was added to the care plan and Kardex. Review of the Quarterly MDS Assessment, dated 05/08/2023, for Resident #146 revealed it was coded for a walker and wheelchair. Review of the 05/21/2023 audit for Resident #146 revealed the resident used a walker and wheelchair during the MDS look back period and they were both on the care plan and Kardex. However, in review of Resident #146's care plan, there was no evidence it included an intervention for a walker. Further, review of Resident #146's Kardex revealed there was no evidence of a walker documented on the Kardex. B. Review of the 04/30/2023 audit for Resident #821 revealed the resident used a walker (with rehab only) and a wheelchair during the MDS look back period, and this was accurately reflected on the Care Plan and Kardex. Review of the resident's Quarterly MDS Assessment, dated 04/08/2023, and Quarterly MDS Assessment, dated 04/24/2023, revealed they were coded for a walker and wheelchair. Review of the Care Plan for Resident #821 revealed interventions for a wheelchair. However, there was no evidence of an intervention for a walker. Review of the resident's Kardex revealed the wheelchair was listed under devices, but there was no documentation the resident required a walker. Observation on 06/02/2023 at 4:10 PM, revealed Certified Nursing Assistant (CNA) #6 sitting with Resident #821 one-to-one (1:1) with a walker in the resident's room. CNA #6 stated she requested it to help the resident ambulate as he/she loves to walk. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185165	A. Building B. Wing	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lyndon Woods Care & Rehab, LLC	1101 Lyndon Lane Louisville, KY 40222

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	C. Review of the 05/14/2023 audit for Resident #48 revealed the resident used a walker and a wheelchair during the MDS look back period, and this was reflected accurately on the Care Plan and Kardex. Review of the resident's Quarterly MDS Assessment, dated 04/07/2023, and Quarterly MDS Assessment, dated 05/11/2023, revealed they were coded for a walker and wheelchair. Review of Resident #48's care plan revealed an intervention for a walker. However, there was no evidence of wheelchair use documented. Review of Resident #48's Kardex revealed use of a walker. However, there was no intervention documented for a wheelchair. Observation of Resident #48, on 06/02/2023 at 1:38 PM, revealed the resident was sitting on a couch in the unit's common area and did not have a wheelchair present. Upon interview, on 06/02/2023 at 1:38 PM, CNA #88 stated Resident #48 did not use a wheelchair. Upon interview, on 06/02/2023 at 3:12 PM, MDS #1 stated she was responsible for making sure MDS assessments were completed, and she reviewed residents' care plans as she completed quarterly and annual MDS assessments. She stated she made changes appropriately so the residents' care plans and MDS assessments were aligned. She further stated Resident #48's 05/11/2023 Quarterly MDS Assessment was completed by another nurse off site by reviewing the resident's medical record. She also stated she did not participate with the audit process, and the audits were completed by the [NAME] President of Clinical Reimbursement solely. During interview with the Director of Nursing (DON), on 05/30/2023 at 11:45 AM, she stated all audits for F641 were completed by the [NAME] President of Clinical Reimbursement remotely, and the DON did not participate in any way with completing or reviewing the audits. The State Survey Agency (SSA) Surveyor left voice messages per telephone to the [NAME] President of Clinical Reimbursement, on 06/02/2023 at 1:32 PM and 3:38 PM, with no call back. During interview with the ED, on 06/01/2023 at 3:46 PM, she stated she did not participate in the audit process for F641. 4. Review of the facility's PoC for F755, with an alleged compliance date of 04/16/2023, revealed the facility had conducted education for all Licensed Nurses (LN) and Certified Medication Technicians (CMT) to include agency staff on documenting that the on-coming nurse and the off-going nurse both signed that the count verification had been completed at the end of each shift by 04/15/2023. Review of the PoC further revealed starting on 04/14/2023, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) or the Unit managers (UM), would visually audit three (3) narcotic blue books to ensure on-coming and off-going nurses signed the count verification daily. The audit information would be reported to the Quality Assurance Performance Improvement (QAPI) committee weekly. Review of the facility's Controlled Substances Log Book Shift Count for the six (6) of six (6) medication carts, revealed omissions of the required two (2) signatures of either coming on duty or going off duty licensed nurses on fifty-four (54) occasions between 04/16/2023 and 05/30/2023. Review of the facility's document titled Survey Education for 755 test, revealed question number four (4) was: two (2) licensed nurses count the narcotic medications at the beginning of each shift with the correct answer as true. Further review of the test revealed twenty-eight (28) tests had a one-hundred percent (100%) passing grade. (continued on next page)

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