STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035247	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maryland Gardens Post Acute	31 West Maryland Avenue Phoenix, AZ 85013

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49399 Based on clinical record review, staff interviews, policy review, and facility document review, the facility failed to ensure one resident (#46) had the right to refuse use of psychotropic medication was honored. The deficient practice could result in the resident not able to make decisions regarding their choice of treatment. Findings include: Resident #46 was admitted to the facility on [DATE] with diagnoses that included schizophrenia, bipolar disorder, and peripheral vascular disease. The admission Minimum Data Set (MDS) assessments dated February 7, 2024 revealed a Brief Interview for Mental Status (BIMS) score was 12 indicating the resident had moderate cognitive impairment. The MDS assessment also revealed the resident had hallucination and no delusions, physical behavioral symptoms not exhibited, and verbal behavioral symptoms occurred. Review of care plan initiated in January 31, 2024 revealed the resident had a behavior problem related to diagnoses of schizophrenia, bipolar disorder, anxiety disorder, disorientation, cognitive communication deficit. It also included that the resident had monitoring for delusions, hallucinations, refusal of cares/treatment, restlessness, verbal aggression, false accusations at times, and touching and kissing the hands of other female residents. Interventions included to administer medications as ordered, monitor/document for side effects and effectiveness, anticipate and meet resident's needs, encourage and educate the resident to keep his hands to himself for safety purposes, intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, and remove from situation and take to alternate location as needed. The care plan revised on February 27, 2024 included the resident had impaired cognitive function/dementia or impaired thought processes related to BIMS score at time of assessment, behaviors exhibited and resistive to cares. Interventions included to administer meds as ordered, keep resident's routine consistent, and try to provide consistent care givers as much as possible in order to decrease confusion. The physician order with a start date of April 10, 2024 included for Haldol (antipsychotic) topical gel 5 milligram (mg)/milliliter (ml) apply 1 ml topically to back of wrist three times a day for schizophrenia. (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This order was transcribed onto the MAR (medication administration record) for April 2024 and had a discontinued date of April 11, 2024. A health status note dated April 11, 2024 revealed that the resident continued to refuse scheduled medications, including the Haldol gels, but was compliant with scheduled accuchecks. per the documentation, the resident reported that he did not want to take his medications because the medications did not work. The documentation also included that Haldol gel had not been delivered from pharmacy; and, a consent had not been given as of yet. The behavior note dated April 12, 2024 revealed that the Haldol gel arrived at facility but the resident refused to sign consent to administer medication to him; and that, the resident was his own responsible party. However, despite documentation that the resident refused to give consent on use of Haldol, the psychoactive medication consent dated April 11, 2024 included a verbal consent for use of Haldol for verbal aggression that was signed and dated by two different staff. Review of the health status note dated April 12, 2024 included that the resident continued to be on alert charting for continued refusal of all scheduled medications; and, had not signed consent for the administration of Haldol gel so medication was not given. Per the documentation the risks and benefits related to the refusal of medications were reviewed with the resident. The IDT (interdisciplinary team) note dated April 22, 2024 included that Haldol gel was on hold related to the medication required prior authorization; and that, the prior authorization had been submitted and the medication will be administered upon arrival and availability. The IDT psychotherapeutic review note dated April 29, 2024 revealed diagnoses of schizophrenia, bipolar disorder and anxiety disorder. Per the documentation, the resident was monitored for delusions, hallucinations, refusal of cares and treatment, restlessness and verbal aggression. Interventions included redirection, 1:1 and redirecting the resident to his room with little effectiveness. The documentation also included that there was no psychotropic medication related to refusal of most medications to include psych medications. The health status note dated May 5, 2024 included that the resident refused medications; and that, the resident reported that he did not want and need them. The behavior notes dated May 7, 2024 revealed that the resident was alert and oriented and was able to make some of his needs/wants known. Per the documentation, the resident refused his medications and was not compliant with medications The physician assistant (PA) dated May 23, 2024 revealed that resident had been refusing all psych medications since arriving at the facility; and, was frequently verbally aggressive and used profanity frequently at staff. Plan was to continue Haldol topical gel three times daily. It also included that benefits of the current treatment plan outweigh the risks, and the lowest possible dose of all psychotropic medications was pursued. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Despite documentation that the Haldol was discontinued on April 11, 2024 in the MAR for April 2024, the order continued to be transcribed onto the MAR for May 2024 with a start date of April 11, 2024. Review of the MAR for May 2024 revealed that the resident was administered with Haldol on multiple dates and shifts. However, there was no evidence found that the resident gave consent to the use of Haldol. The PA progress note dated July 3, 2024 revealed the resident continued to intermittently refuse medications; and that, this was a repetitive pattern since arrival to this facility. Per the documentation, the resident continued with intermittent episodes of verbal aggression and using profanity with staff. It also included that the resident continued to deny any suicidal ideations, homicidal ideations, thoughts of self-harm, or death wishes; and, staff reported that the resident had a verbal disagreement with another resident. The plan was to continue Haldol topical gel 5 mg TID (three times daily) for schizophrenia AEB (as evidenced by) disorganized behavior; and, for psychotropic medications administered when nonpharmacologic interventions are ineffective. An interview was conducted on July 11, 2024 at 12:24 p.m. with a licensed practical nurse (LPN)/staff #34 who stated that her routine starts with doing medication counts, getting report which included any change of condition, stat laboratory; and, starting her morning medication pass, charting, and skin assessments. The LPN stated that there should be a psychotropic medication consent for any psychotropic medication such as Ativan, Zoloft, and Haldol; and, once the resident consented to the medication, then the medication will be administered as ordered. She stated that for residents who were not cognitively intact, the consent for the use of psychotropic medication will be signed by the resident's guardian or representative. Regarding resident #46, the LPN stated that the clinical record revealed an order for Haldol topical gel for schizophrenia; and that, there was no signed consent for Haldol found. The LPN further stated that she would notify the director of nursing (DON) and the provider and would get a consent signed. In an interview with the DON (staff #81) conducted on July 11, 2024 at 12:41 p.m., the DON stated that when staff receives an order for a psychotropic medication, staff would get the consent to administer from the resident/responsible party, send the order to pharmacy; and, once the medication was delivered, staff would administer the medication. She also stated that the order for the psychotropic medication had to have an actual diagnosis for its use. The DON also said that all psychotropic medications, such as Haldol needed consent; and that, staff cannot administer the medication without a consent signed. Further, the DON stated that if a resident cannot consent, the staff would get the consent from the resident's power of attorney (POA) or guardian. During the interview, a clinical record review was conducted with the DON who stated that there was an order for Haldol topical gel for resident #46; and the consent for its use was not uploaded in the electronic record. The DON stated that the Assistant Director of Nursing (ADON/staff # 70) recently conducted an audit for consents and the ADON would give the consent to medical records staff to upload in the electronic record. An interview with the ADON (staff #70) was conducted on July 11, 2024 at 1:09 p.m. The ADON provided a verbal consent for the use of Haldol dated April 11, 2024 and signed by two different staff signatures. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy on Psychoactive/Psychotropic Medication Use revealed the facility nurse, on behalf of the prescribing clinician, will obtain informed consent from the resident (or, as appropriate, the resident representative) for use of a Psychotropic medication. It also revealed that a licensed nurse must verify informed consent has been obtained from the resident or the resident's representative prior to administering psychotropic medication and if verbal consent is provided, two nurses may sign the consent to confirm.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49199 Based on clinical record review, interviews, facility documentation and policy review, the facility failed to protect the rights of two residents (#11 and #205) to be free from abuse by another resident (#160 and #18). The deficient practice could result in resident not protected from continued abuse. Findings include: -Resident #11 was admitted to the facility on [DATE] with diagnoses of paranoid schizophrenia and anxiety disorder. Review of the care plan revision on February 27, 2024 included that the resident had behavior problem related to psych diagnoses, had behaviors, was monitored for agitation, paranoia, verbal aggression and can be resistive to care and had exhibited false accusations. Interventions included to administer medication as ordered, to intervene as necessary to protect the rights and safety of others, divert attention and remove from situation and take to alternate location as needed. A change of condition note dated April 17, 2024 included that the CNA (certified nurse assistant) reported that the resident #11 reported being hit by another resident (#160). Per the documentation, resident #11 reported that the other resident (#160) walked up to him while he was sitting on the bench outside socializing and struck his left cheek with a closed fist. It also included that there was redness to the resident's left cheek. The eINTERACT SBAR note dated April 17, 2024 included that resident #11 was hit on his left cheek by another resident; and that, the incident was unprovoked. -Resident #160 was admitted on [DATE] with diagnoses of schizophrenia, depression and antisocial personality disorder. The social service note dated April 16, 2024 included that resident #160 became verbally aggressive, was cursing and belligerent with staff. The medical practitioner narrative note dated April 16, 2024 revealed the resident was alert and oriented. Assessments included schizophrenia, depression, antisocial personality disorder and Parkinson's disease. Review of the care plan dated April 17, 2024 revealed the resident had a behavior problem related to psych diagnoses of schizophrenia, depression and antisocial personality disorder. The care also included that the resident had been the aggressor toward staff and peers and would exhibit physical and verbal aggression, agitation and refusal of medications. Interventions included to administer medication as ordered, to intervene as necessary to protect the rights and safety of others, divert attention, remove from situation and take to alternate location as needed and to monitor behavior episodes and attempt to determine underlying cause. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Another care plan dated April 17, 2024 included that the resident demonstrated physical behaviors and was the physical aggressor towards another peer. Interventions included cognitive assessment, psychiatric/psychogeriatric consult as indicated and evaluate for side effects of medications. The eINTERACT note dated April 17, 2024 included that the change in condition reported were behavioral symptoms of physical aggression, agitation and psychosis. The mood/behavior note dated April 17, 2024 included that resident #160 had an altercation with another peer in the courtyard at approximately 9:15 a.m. The documentation included that the resident reported that the altercation was personal; and, the resident was not cooperating with the nurse for questions being asked. A social service note dated April 17, 2024 included that when asked about what happened during the incident, the resident reported that It's just personal; and, the resident could not elaborate on why it was personal. The health status note dated April 18, 2024 included the resident had been very aggressive this shift and was verbally and attempted to physically attack staff. Per the documentation, the resident refused all medications, accuchecks and wound care; and, was yelling and cursing at other residents and staff. Further, the documentation included that the IV pole was placed at the nurse station because the resident attempted to swing it at staff; and that, redirection was ineffective. A behavior note dated April 18, 2024 revealed that resident was sitting out on the patio yelling profanity and racial slurs at peers and staff. Per the documentation, the resident was administered with medication with positive effect. The physician assistant (PA) note dated April 18, 2024 included that resident #160 had a history of violent assaults and was previously deemed to be incompetent to stand trial. The PA note dated April 25,2024 revealed that resident #160 continued to have explosive and verbal aggression; and, had refused his medications multiple times. An initial MDS Assessment was completed on April 19, 2024 and revealed the resident had a BIMS score of 14, which indicated he was cognitively intact. The MDS also identified behaviors of inattentiveness and disorganized thinking. The behavior note dated April 24, 2024 included that resident was in the dining room and was yelling and cursing at staff and peers. per the documentation, the resident was swinging fist in the air and threatening to beat up staff and peers; and that, the resident was escorted out of the dining room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility investigative report dated April 23, 2024 included that on April 17, 2024 at approximately 9:10 a.m., resident #11 was sitting on the bench out in the grassy part of the courtyard speaking to another resident. Both resident #11 and the other resident were having a conversation by themselves when resident #160 walked up to resident #11 and quickly, out of the blue, hit him (referring to resident #11) on the left side of his face and, resident #160 immediately walked away without saying anything. The investigative report included an interview conducted by the facility with resident #160 who reported that the incident was personal, did not want to talk about it and would not divulge any details. The documentation included that resident #160 claimed barely touching resident #11. Continued review of the facility investigative report included an interview conducted by the facility with the other resident (who was present at the time of the incident) who confirmed the story of resident #11 being hit by resident #160; and that, it happened in a split second with no time to react. Further, the report concluded that the allegation could not be verified because resident #160 had a BIMS score of 14 and reported that he barely touched resident #11 and would not speak of any incident; and that, resident #11 had a BIMS of 11 and the other resident who witnessed that incident had a BIMS score of 7. The documentation also included that the other resident was unable to recall the situation in subsequent interviews. The facilities Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy, dated April 2021 states Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Also, to protect residents from abuse from facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors and/or any other individual. 49399 Regarding resident #18 and resident #205 -Resident #205 was admitted at the facility on April 15, 2022 with diagnoses of bipolar disorder, major depressive disorder, and unspecified dementia. The MDS admission assessment dated [DATE] revealed resident had a BIMS score of 8 indicating the resident had moderate cognitive impairment. The assessment also included that the resident was receiving antipsychotic and antidepressant medication. The care plan initiated dated April 20, 2022 revealed the resident was dependent on staff for activities, cognitive stimulation, social interaction related to immobility. Interventions included for alll staff to converse with resident while providing care. assist with arranging community activities. arrange transportation and assure that the activities were compatible with physical and mental capabilities, known interests and preferences and needs and abilities. The care plan dated April 23, 2022 included that the resident had impaired cognitive function/dementia or impaired thought processes related to dementia; had potential for a behavioral problem related to psych diagnoses; was monitored for refusing meals, self-isolation and verbal aggression. Interventions included to administer medications as ordered, anticipate and meet needs keep routine consistent and provide a homelike environment. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the eINTERACT note dated July 29, 2022 revealed that resident was hit by another resident causing injury to the right elbow. 7 The skin/wound note dated July 29, 2022 included the resident had skin tear; and that, the small area was closed with no drainage. The behavior note dated July 30, 2022 included resident was monitored for signs of acute distress and discomfort; and, was s/p (status post) altercation with peer. Per the documentation, the resident denied being fearful no signs of aggressive behavior. -Resident #18 was admitted on [DATE] with diagnoses of schizophrenia, vascular dementia, and type 2 diabetes mellitus. The annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10 indicating the resident had moderate cognitive impairment. The MDS also included that the resident had hallucination, verbal behavior symptoms towards, rejection of care, and was receiving antipsychotic and antidepressant medications. The care plan dated July 29, 2022 included that the resident had a potential to demonstrate physical behaviors related to poor impulse control. Interventions included to keep hands to himself, analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document, assess and address for contributing sensory deficits, assess and anticipate resident's needs; intervene before agitation escalates; guide resident away from source of distress; engage calmly in conversation and if response was aggressive for staff to walk calmly away, and approach the resident later. The care plan with revision date of August 3, 2022 revealed resident had a behavior problem related to schizophrenia, major depressive disorder, bipolar disorder and can exhibit physical/verbal aggression towards peers; monitoring for auditory hallucinations, self isolation, verbal aggression at staff. Interventions included to educate resident getting along with peers, charting as appropriate, keep hands to himself, administer medications as ordered, anticipate and meet needs, if reasonable, discuss his behavior and explain/reinforce why behavior is inappropriate and/or unacceptable to the resident, and intervene as necessary to protect the rights and safety of others. The eINTERACT note dated July 29, 2022 included resident had a change in condition related to behavior symptoms; and that, the resident had an altercation with another resident causing a minor injury. The health status note dated July 29, 2022 included that the resident was in the court yard this morning with peers when another resident (#205) came too close to the resident who then hit the other resident (#205) on the arm causing injury. The health status note dated July 30, 2022 revealed the resident had an episode of aggression towards others manifested by resident striking another resident (#205). Review of facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised date April 2021 revealed residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 47341 Based on resident and staff interviews, clinical record review, and facility policy, the facility failed to ensure an allegation of abuse for one resident (#41) was reported to the State Agency (SA) within the required timeframe. The deficient practice could result in residents not protected from further abuse. Findings include: Resident # 41 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction, type II diabetes, depression and psychotic disorder with delusions due to known physiological condition. The admission Minimum Data Set (MDS) assessment dated on June 17, 2024 a Brief Interview for Mental Status (BIMS) revealed a score of 14 which indicated the resident was cognitively intact. The care plan dated June 26, 2024 revealed the resident had a behavior problem related to psych diagnoses, was monitored for restlessness, verbalizing anxiety , false accusations, was resistive to cares, refusal of cares, verbally aggressive, had exhibited being impatient, was impulsive, self-isolation, unsafe transfers, and demanding behavior. Interventions included medications as ordered, and cares in pairs. The eINTERACT note dated July 3, 2024 revealed the resident had a fall; and that, the resident attempted to self-transfer and slipped. Review of the clinical record revealed no documentation that the any other incident from July 4 through 9, 2024. The undated written statement signed by resident #41 revealed that the resident needed to go to the bathroom but the leg rest was in the way; and that, the alleged CNA (staff #12) was trying to help and went to get his attention. Per the statement, to help get his attention the alleged CNA (staff #12) tapped the resident on his bad shoulder and it hurt. In an interview with resident #41 conducted on July 9, 2024 at 9:55 p.m. the resident reported that while he was in the bathroom on the toilet around 8:30 a.m. on July 9, 2024, a certified nursing assistant (CNA/ staff #12) slapped his shoulder and demanded him to listen. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview was conducted with the administrator on July 9, 2024 at 11:18 a.m., the administrator stated that he would do a soft file which was essentially a grievance and he will not report the incident to the SA because the resident stated in is own words that he was fine. He stated that for allegations of abuse, he would investigate it first and then reports it because he has 2 hours to report the incident. He stated that he will have the resident sign off on their statement that they feel safe. He also said that the resident population at the facility included residents with a lot of behaviors and often would make false accusation/allegations. He said that if the interview confirmed the reported allegation, then the facility would report it to the SA. Regarding the alleged incident, the administrator stated he had done his investigation and a different staff was assigned to the resident. The administrator stated that the alleged CNA (staff #12) never went in the resident's room or interacted with resident #41. He stated he interviewed the alleged CNA who reported that the alleged CNA only notified another CNA (staff #8) at around 7:45 a.m. that the resident might need help in the bathroom. The administrator also said that he spoke with the other CNA (staff #8) who told him that she went in the resident room with a maintenance staff because the resident must be cared for with two staff present. The administrator also said that he also interviewed resident #41 at 11:00 a.m.; and that, the resident acknowledged that the alleged CNA (staff #12) was not assigned to him. In an interview with the alleged CNA (staff #12) conducted on July 11, 2024 at 12:31 p.m., the alleged CNA (staff #12) stated that he was not aware that the resident felt abused; and the administrator made him aware of the allegation after the fact. He stated that he had just come in for his shift that morning and was helping in the dining room when he told another CNA tto get resident #41 in the bathroom. Further, the alleged CNA (staff #12) stated that after the allegation was made, he was never suspended nor informed that he would be. In a facility policy entitled Abuse, Neglect, Exploitation and Misappropriation-Reporting and Investigating, last revised in April 2021 it states All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported .The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility .Immediately is defined as: within two hours of an allegation involving abuse or result in serious bodily injury.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47341 Based on resident and staff interviews, clinical record review, and facility policy, the facility failed to ensure an allegation of abuse for one resident (#41) was thoroughly investigated. The deficient practice could result in appropriate corrective action not taken to prevent further abuse. Findings include: Resident # 41 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction, type II diabetes, depression and psychotic disorder with delusions due to known physiological condition. The admission Minimum Data Set (MDS) assessment dated on June 17, 2024 a Brief Interview for Mental Status (BIMS) revealed a score of 14 which indicated the resident was cognitively intact. Review of the clinical record revealed no documentation that the any other incident from July 4 through 9, 2024. The undated written statement signed by resident #41 revealed that the resident needed to go to the bathroom but the leg rest was in the way; and that, the alleged CNA (staff #12) was trying to help and went to get his attention. Per the statement, to help get his attention the alleged CNA (staff #12) tapped the resident on his bad shoulder and it hurt. There was no evidence found that the alleged CNA (staff #12) was suspended during the facility's investigation. There was no evidence that the facility conducted a thorough investigation to include observations, interviews with other residents, staff or witnesses to the incident, reporting of the incident to appropriate agencies, conclusion of the investigation and the corrective actions taken, In an interview with resident #41 conducted on July 9, 2024 at 9:55 p.m. the resident reported that while he was in the bathroom on the toilet around 8:30 a.m. on July 9, 2024, a certified nursing assistant (CNA/ staff #12) slapped his shoulder and demanded him to listen. (continued on next page)

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Maryland Gardens Post Acute	31 West Maryland Avenue Phoenix, AZ 85013

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview was conducted with the administrator on July 9, 2024 at 11:18 a.m., the administrator stated that for allegations of abuse, he would investigate it first and then reports it because he has 2 hours to report the incident. He stated that he will have the resident sign off on their statement that they feel safe. He also said that the resident population at the facility included residents with a lot of behaviors and often would make false accusation/allegations. He said that if the interview confirmed the reported allegation, then the facility would report it to the SA. Regarding the alleged incident, the administrator stated he had done his investigation and a different staff was assigned to the resident. The administrator stated that the alleged CNA (staff #12) never went in the resident's room or interacted with resident #41. He stated he interviewed the alleged CNA who reported that the alleged CNA only notified another CNA (staff #8) at around 7:45 a.m. that the resident might need help in the bathroom. The administrator also said that he spoke with the other CNA (staff #8) who told him that she went in the resident room with a maintenance staff because the resident must be cared for with two staff present. The administrator also said that he also interviewed resident #41 at 11:00 a.m.; and that, the resident acknowledged that the alleged CNA (staff #12) was not assigned to him. In an interview with the alleged CNA (staff #12) conducted on July 11, 2024 at 12:31 p.m., the alleged CNA (staff #12) stated that he was not aware that the resident felt abused; and the administrator made him aware of the allegation after the fact. He stated that he had just come in for his shift that morning and was helping in the dining room when he told another CNA tto get resident #41 in the bathroom. Further, the alleged CNA (staff #12) stated that after the allegation was made, he was never suspended nor informed that he would be. In a facility policy entitled Abuse, Neglect, Exploitation and Misappropriation-Reporting and Investigating, last revised in April 2021 stated that the individual conducting the investigation as a minimum: -Reviews the documentation and evidence; -Reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; -Observes the alleged victim, including his or her interactions with staff and other residents; -Interviews the person(s) reporting the incident; -Interviews any witnesses to the incident; -Interviews the resident (as medically appropriate) or the resident's representative; -Interviews the resident's attending physician, as needed, to determine the resident's condition; -Interviews staff members (on all shifts as needed) who have had contact with the resident during the period of the alleged incident; -Interviews the resident's roommate, family members, and visitors, as necessary; -Interviews other residents to whom the accused employee provides care or services; (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	-Reviews all events leading up to the alleged incident; and -Documents the investigation completely and thoroughly Continued review of the policy included that any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete; and, if the investigation reveals that the allegation(s) of abuse are unfounded, the employee(s) may be reinstated to his/her/their former position with back pay.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47341 Based on resident and staff interviews, clinical record review, and facility policy, the facility failed to ensure medication was administered as ordered by the physician for one resident (#13). The deficient practice could result in resident not receiving the necessary treatment for their condition. Findings include: -Resident #13 was admitted on [DATE] with diagnoses of schizoaffective disorder, schizophrenia, generalized anxiety disorder, and depression. The hospital record of the resident's medication list dated 05/23/2024 revealed Abilify (antipsychotic) 400 mg (milligram) was administered on 05/18/2024. A physician order dated 05/30/2024 included for Aripiprazole (generic name for Abilify) intramuscular prefilled syringe 400 mg injection every 28 days to treat her schizophrenia as evidenced by paranoia. This order was transcribed onto the MAR (medication administration record) for May 2024. Despite documentation that the last Aripiprazole injection that the resident received was on 05/18/2024, the documentation in the MAR revealed that Aripiprazole was administered to the resident on 05/30/2024 which was approximately 8-9 days early than the ordered timing of the injection. The eINTERACT note dated 05/30/2024 included that resident was given her monthly 28 day injection 20 days in advance due to transcription error. The health status note dated 06/01/2024 included that the resident was on change of condition status for a medication error. The physician progress note dated 06/01/2024 revealed that the resident had a diagnosis of schizoaffective disorder, bipolar type; and that, the resident got 2 doses of her IM (intramuscular) Aripiprazole. Per the documentation, there was no immediate adverse effect with the extra dose injection; and that, Aripiprazole overdose can include combination of symptoms such as severe sedation, unstable arrhythmia, unstable blood pressure, respiratory depression, EPS (extra pyramidal symptoms) seizures normal lactic syndrome and GI (gastrointestinal) symptoms. The documentation also included that the resident did not need to be in the emergency room . The change of condition note dated 06/03/2024 included that the resident was on s/p (status post) change of condition for a medication error. The care plan dated 06/11/2024 revealed the resident had a behavior problem related to her schizophrenia and anxiety; and was monitored for auditory hallucinations, impulsiveness, paranoia, psychotic agitation, restlessness and verbalized anxiety. Interventions included administering medications as ordered and monitor and document effectiveness. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The order for Aripiprazole injection continued to be transcribed onto the June 2024 MAR. Review of the MAR for June 2024 revealed that code 9 which meant to see nursing note was documented on 06/30/2024 for Aripiprazole. The eMAR (electronic MAR) note dated 06/30/2024 revealed that Aripiprazole was unavailable. There was no evidence that Aripiprazole was administered as ordered on 06/30/2024; and that, the physician was notified. In an interview with a Licensed Practical Nurse (LPN/staff #34) conducted on 07/11/2024 at 11:45 a.m., the LPN stated that she stated that a change of conditioning monitoring for side effects was initiated and done for resident #13 because the resident received 2 doses of Abilify injection within 12 days. The LPN said that the resident initially refused the medication so she notified the provider; and that, the psychiatric provider came in and talked with Resident #13 about being noncompliant with medication and the consequences due to court ordered treatment. The LPN said the resident consented and she then administered the medication as ordered on the MAR. She stated that she had not personally given the resident an injection since 05/30/2024. During the interview, a review of the clinical record was conducted with the LPN who stated that if the resident continued with the IM injection as ordered, it would be every 28 days and after the 05/30/2024 dose, the next dose will be due on 06/30/2024. The LPN also stated that the MAR showed the Aripiprazole IM injection was still an active order; however, the nurse on 06/20/2024 did not give the medication to the resident; and that, the medication was not available for administration on 06/20/2024. She stated in a situation like this she would call the pharmacy to see when it could be delivered; and, she would this with the oncoming nurse, Director of Nursing (DON), and the provider so that it was not missed. Further, the LPN stated that she would also document in the progress note if the problem was not resolved on her shift and she would follow up the next day. An interview was conducted on 07/11/2024 with the DON who stated that the MDS nurse (staff #70) took the orders to put into the electronic record system for resident #13. The DON said that the hospital did not specify the last given date for the resident's IM injection so the team was doing research to find out; and that, the provider ordered to hold the injection until he got back. The DON said that while they were doing the research on the date of the last injection, the LPN (staff #34) administered the Aripiprazole IM injection to the resident. Regarding the resident not receiving her IM injection for 8 days past its due date, the DON stated that the registry night nurse said it was unavailable, but the registry night nurse did not call the pharmacist. Further, the DON stated that she spoke with the pharmacy and the provider; and, the medication should be delivered in the morning and if it arrives today the provider told staff that staff can give the IM Aripiprazole to the resident today.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47341 Based on clinical record review, staff interviews and facility policy review, the facility failed to ensure staff implemented fall interventions for one resident (#29). The deficient practice could resulted in resident having a fall incident. Findings include: Resident #29 admitted to the facility on [DATE] with diagnoses that included dementia, neuralgia and neuritis, schizophrenia, and anxiety. The fall care plan dated 11/09/2020 revealed that the resident was at risk for falls related to gait/balance problems, incontinence and psychoactive drug use. It also included that the resident will sit herself on the floor and place herself on the floor from her bed and wheelchair. Interventions included call light within reach, ER (emergency room) evaluation and treatment, anticipate and meet resident's needs and bed bolster mattress to help define parameters in bed. The ADL (activities of daily living) care plan dated 11/09/2020 included that the resident had ADL self-care deficit related to dementia and impaired balance. Interventions included extensive assistance with 1-2 person assist with bed mobility, dressing and personal hygiene; and use of mechanical assistance with transfers. The Quarterly MDS assessment dated [DATE] included a BIMS score of 10 indicating the resident had moderate cognitive impairment. The MDS included that there were no falls since admission or the prior assessment. The health status note dated 06/29/2024 revealed that at approximately 5:00 a.m., the certified nurse assistant (CNA) informed the nurse that resident #29 had fallen while being transferred in a Hoyer lift. Per the documentation, the resident was on the floor next to bed and Hoyer lift, with the Hoyer sling still on the resident. It also included that the CNA reported that the Hoyer had tipped over while she was transferring the resident from her bed to her wheelchair; and, the fall from the Hoyer was 4-5 feet high and the resident landed on her right shoulder. The documentation included that the resident reported hitting her head and the Hoyer lift hit her chest; and that, the resident complained of pain to her chest and shoulder but there was no bruising, hematoma, or loss of consciousness was noted. Further, the documentation included that the provider was notified and the resident was sent to the emergency department. Another health status note dated 06/29/2024 included that the resident was sent out to the emergency department at approximately 7:00 a.m. The transfer form notes dated 06/29/2024 included that fall was the reason for the resident's transfer to the hospital. A health status note dated 06/29/2024 revealed that the resident returned to the facility and the computed tomography (CT) scans of spine, pelvis, abdomen, and brain were negative. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CNA that completed the Hoyer lift with Resident #29 on 06/29/2024 was not available for interview. In an interview with the ADON (Assistant Director of Nursing) conducted on 07/11/2024, the ADON stated that the CNA operated the Hoyer lift by herself that resulted in the resident falling; and that, the CNA had been terminated due to this incident. An interview with a registered nurse (RN/staff #69) was conducted on 07/11/2024 at 12:27 p.m. The RN stated that she was not the nurse assigned to resident #29; but she recalled that resident #29 fell . The RN stated that the CNA came to her that night and told her that the resident fell while the CNA was transferring her; and that, the CNA was completing the transfer alone. Further, the RN stated that there must always be two people present when operating a Hoyer lift. During an interview with the Director of Nursing (DON/staff #81) conducted on 07/11/2024 at 3:45 p.m., the DON stated that resident #29 was not injured from the fall, but was sent to the hospital for evaluation because it was not known how high the resident had fallen from. The DON stated that the expectation was for staff to always use two people when operating the Hoyer lift. The facility policy on Lifting Machine, using a Mechanical, with revision date of July 2017 included a purpose to establish the general principles of safe lifting using a mechanical lifting device. General guidelines revealed that at least two nursing assistants are needed to safely move a resident with a mechanical lift.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49399 Based on observation and staff interviews, the facility failed to ensure staff performed hand hygiene during medication pass. The deficient practice could result in residents developing complications and illnesses. Findings include: A medication pass observation with a registry nurse (staff #300) was conducted on July 10, 2024 from 7:59 a.m. through 8:42 a.m. In multiple occasions during this observation, the registry nurse touched the medication cart with bare hands and prepare the medications without performing hand hygiene. The registry nurse then proceeded to administer the prepared medications to the residents without performing hand hygiene after each resident. In an interview conducted with the registry nurse (staff #300) conducted on July 10, 2024 at 8:42 a.m., the registry nurse stated that she did not sanitize her hands after giving medication to each resident out in the patio. She then pointed and indicated that the hand sanitizer was on top of her medication cart. An interview with the director of nursing (DON/staff #81) was conducted at 4:03 p.m. on July 11, 2024. The DON stated that during medication administration, staff would look at the medication administration record (MAR), identify the resident using identifiers and administer the medications as ordered. The DON stated that staff should perform hand hygiene before and after medication administration; any time the hands can potentially be contaminated, staff have to do hand hygiene. She stated that not doing hand hygiene can spread infection; and that, her expectation was for staff to use a hand sanitizer or soap and water for hand hygiene after each resident care/contact.