STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045245	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conway Healthcare and Rehabilitation Center	2603 Dave Ward Drive Conway, AR 72034

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42016 Based on observations, interviews, and record reviews, it was determined the facility failed to ensure residents call devices were in reach in the resident's room for 1 (Resident #29) of 1 sampled resident with call devices not in reach. The findings include: A review of Resident #29's Admission Record indicated the facility admitted Resident #29 on 05/17/2019 and listed diagnoses to included Parkinson's Disease with dyskinesia, Altered mental status, Repeated falls, Supraventricular tachycardia, Headache, Type 2 diabetes, and Unspecified pain. A review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #29 had a Brief Interview for Mental Status (BIMS) score of 02, which indicated the resident had severe cognitive impairment. The resident was dependent on staff for oral hygiene, toileting hygiene, shower/bathe, upper and lower body dressing, putting on/taking off footwear, personal hygiene, and with transfers from chair/bed-to-chair transfer. Resident #29 was independent with eating and used a manual wheelchair for ambulation. A review of Resident #29's Care Plan initiated on 06/01/2020, revealed Resident #29 attempts to slide out of wheelchair, crawls out of bed, and is at risk for falls and falls with serious injury. Approaches/Tasks listed, Ensure call light is in reach. with a date initiated 12/02/2021. On 05/01/2024 at 10:16 AM, Resident #29 was sitting in the middle of the room in a wheelchair. The call light was lying across the bed on top of the linens. A fall mat was on the floor, parallel, next to the bed. Resident #29 was unable to reach the call light due to the fall mat impeding access to bed. During an interview on 05/01/2024 at 10:18 AM, CNA #2 stated all lights should be in reach and are in reach of the residents and if they are not the resident would not be able to call for assistance and they push the call light to get assistance. On 05/01/2024 at 10:19 AM, CNA #2 accompanied the Surveyor to Resident #29's room, Resident #29 was sitting in a wheelchair. CNA #2 stated the call light was not in reach and CNA #2 believed Resident #29 to be in bed. The call light should have been in reach. CNA #2 moved the resident's wheelchair closer to the bed in reach of the call light.

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 49689 According to observation, record review, and interview the facility failed to ensure residents were free from abuse with continuous altercations of verbal abuse and physical abuse between two residents (Resident #47 and Resident #54). This failed practice had the potential to affect all 66 residents currently in the facility to psychosocial harm from repeated resident to resident abuse altercations. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.25 (Quality of Care) at a scope and severity of J. The IJ began on 03/12/2024 at 12:30 PM, when Resident #47 and Resident #54 had an altercation in the dining room. The altercation from witness statements began when Resident #54 was impatient at the coffee area and rammed into Resident #47, which caused an argument between the two residents. A few minutes later after separation Resident #47 bumped into Resident #54's wheelchair and another argument began in the dining area. The Administrator and Nurse Consultant were notified of the IJ on 05/03/2024 at 11:00 AM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on 05/03/2024 at 05:32 PM. The IJ was removed after the survey team performed onsite verification that the Removal Plan had been implemented. Noncompliance for F600 remained at the lower scope and severity of no actual harm with an isolated potential for more than minimal harm that was not immediate jeopardy: These were our findings: A review of the Care Plan indicates that Resident #47 had diagnoses of chronic inflammatory demyelinating polyneuritis, cerebral palsy, bipolar disorder, major depressive disorder, and post-traumatic stress syndrome (PTSD). A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/22/2024 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status. A review of the Care Plan indicated Resident #47 makes false accusations against staff, yells at other residents without provocation, and will argue with others and get in their personal space. A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/28/2024 indicated Resident #54 had a score of 7 (0-7 indicates moderate cognitive impairment) on a Brief Interview of Mental Status. A review of the order summary indicated Resident #54 had diagnoses of Down Syndrome, generalized anxiety disorder, and unspecified intellectual disabilities. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the medication administration record indicates no charting for behavioral symptoms. A review of the Care Plan indicated on 03/12/2024 a revision was made that stated, [Resident #54] is obsessed with certain other resident's and becomes physically and verbally aggressive towards them. placed on male secured unit for decreased stimuli . A review of the Care Plan with an initiated date of 05/04/23 and a revision date of 04/23/2024 indicated, . [Resident #54] can be disruptive. Yelling at other residents and staff, will throw food, plastic wrappers, other items on the floor. Also, will throw food on the walls. Sits in wheelchair in the middle of the hallway and watches television. Wants other residents doors closed. Grabs other residents. Goes into other residents rooms and yells at them, physically aggressive, agitated, frustration/anger at others, makes disruptive sounds, threatens others, anxious, exit seeking behaviors. Refuses bath. Scratches others .' A review of documentation from a care plan conference held on 03/19/2024 for Resident #54 stated, Care plan conference regarding behaviors - possible room change per family [the resident] perceives that somebody will take his stuff. Had a psych [psychological] eval which recommends [Facility Name]. [Resident #54] is going to return to regular room on 400 hall. Family does not want [Facility Name] placement. On 05/02/2024 at 10:55 AM, the Surveyor heard a commotion in the hallways, while walking toward the dining room on the 300 Hall side could hear raised voices. There were several staff members standing at the entrance, ten residents were in the dining room and residents around the nurse ' s station were looking around confused at where the raised voices were coming from. Two residents down the 300 Hall were in the hallway looking down the hall towards the dining room. Staff were standing around Resident #47. The Dietary Manager had a hold of Resident #47's wheelchair handles, the resident was saying if, [Resident #54] wants to [expletive] fight [Resident #54] can [expletive] fight, [Resident #54] said [Resident #54] was going to kill him. Resident #47 then stated, [Resident #54] kicked me, [Resident #54] kicked me I am telling you [Resident #54] kicked me. The Surveyor observed Resident #47 kept yelling as the Dietary Manager wheeled the resident over to a table to calm the resident down. Resident #47 was stating that [Resident #54] kicked me, and I did not do [expletive] to [Resident #54] him. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Surveyor observed Resident #54 was nowhere in sight. The Surveyor then observed Resident #47 wheeling over to the 400 Hall stating over and over again, I am going to [expletive] kill [Resident #54], if [Resident #54] wants to go, I will go. I am going to beat [Resident #54's] [expletives]. The Surveyor observed Resident #47 was red in the face, spit was flying from the resident's mouth, legs straight, and visibly shaking threatening to go down the hall to Resident #54's room with staff attempting to calm the resident down. The Surveyor heard Resident #54 yelling back down the hall threatening Resident #47. The Surveyor walked with Licensed Practical Nurse (LPN) #2 to Resident #54's room. LPN #2 asked what happened. The Surveyor heard Resident #54 stating, I am not going to lie, I kicked [Resident #47]. LPN #2 asked if [Resident #54] was good, the resident was calm. Resident #54 said yes and asked about the resident's cokes. LPN #2 said [Resident #54] was getting two boxes this afternoon. Resident #54 then started complaining about how cold the room was and wanting the vents closed. LPN #2 said what are we going to do when we see [Resident #47] again today. Resident #54 stated, I will beat [Resident #47's] [expletive]. LPN #2 said no we will not engage again. LPN #2 asked if the resident was good, [Resident #54] was calm. Resident #54 then said yes and started complaining about the vents being cold. LPN #2 asked if [Resident #54] wanted to stay in the resident's room to calm down for a while if maintenance will close the vents, and Resident #54 started rubbing the resident's stomach to ask for a snack being agreeable with staying in the resident's room as long as they closed the vents. On 05/02/2024 at 11:00 AM, Dietary Aide #2 stated, This happens all the time, it's only the two of them. The Surveyor asked what happened with today's altercation. Dietary Aide #2 stated, [Resident #54] was getting a cup of coffee and [Resident #47] wheeled into the dining room. When [Resident #54] saw [Resident #47], [Resident #54] pointed the resident's finger at [Resident #47] and yelled, I am going to kill you. Resident #54 then ran the resident's wheelchair into [Resident #47] and then kicked the resident in the left leg. On 05/02/2024 at 12:09 PM, the Surveyor interviewed Resident #9 and Resident #1 in the resident's room. The Surveyor asked if any interaction or incidents of yelling between residents has happened before. Resident #9 laughs and said, All the time. Constant hollering between Resident #54 and Resident #23 a lot of times they say they want to kill each other and cursing. I have never heard such filthy talking men. I don't go for that kind of stuff and when you say anything they say nothing they can do. The Surveyor asked who have you told, whoever is around, staff. Resident #9 said, yes, they holler and wake you out of a sound sleep. It is disturbing. I would not let a child do that in my home, it was never allowed. I'm told they can't help it. I hate when they start as you are falling off to sleep. I don't know the resident's name, but is handicapped and, in a wheelchair, and they hit the resident, and the resident's words are bad. The Surveyor asked how often the incidents occur. Resident #9 said off and on all the time and early afternoon and night too. The Surveyor asked what has been done to prevent the negative interactions. Resident #9 stated they try to keep them apart and it lasts maybe 2 minutes. The Surveyor asked does this ever involve or happen to other residents. Resident #9 said usually at the dining table and whoever is at the table. That is why [Resident #1] and I eat in here. (In room) I don't want to get in on that. The Surveyor asked do you feel safe here. Resident #9 said I do not feel safe here. I am teetering on my feet and now in a wheelchair. The Surveyor asked Resident #1 if there had been any incidents of yelling. Resident #1 said yes. It happens all the time, but I grew up in a house full of kids, so noise doesn ' t bother me. I hear [Resident #23] all the time. The Surveyor asked is that why you don't go to the dining room. Resident #1 said I don't ever leave my room. I don't feel good. The Surveyor asked do you feel safe here. Resident #1 said yes, I feel safe here. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/02/2024 at 12:30 PM, the Surveyor interviewed the Assistant Director of Nursing (ADON). The Surveyor asked if the interaction/incidents between Resident #47 and Resident #54 happened before. The ADON stated yes. The Surveyor asked how often has these incidents occurred. The ADON said April and March maybe. I would have to check. The Surveyor asked what has been done to prevent the negative interactions. The ADON said immediately separated, medication reviews, and psych visits for each. The Surveyor asked that is after the fact, what was done to prevent the incidents. The ADON said one intervention was to put coffee machine up front as Resident #54 usually eats in the resident's room. The Surveyor asked does this ever involve or happen to other residents. The ADON said just those two. The Surveyor asked if any other residents have complained. The ADON said yes in the dining room and a grievance was done from someone in a room. On 05/02/2024 at 1:23 PM, Certified Nursing Assistant (CNA) #3 had worked in the facility almost 1 month on the 7:00 AM to 3:00 PM shift. The Surveyor asked if interaction/incidents between Resident #47 and Resident # 54 had happened before. CNA #3 said yes, every other week. We try to keep them separated. The Surveyor asked what has been done to prevent negative interactions with these residents. CNA #3 said we keep an eye on Resident #54, was on monitor sheet for every 15 minutes. The Surveyor asked does this ever involves or happens to other residents. CNA #3 said Resident #47 is sweet to everybody else so is Resident #54. Resident #54 was yelling at Resident #44 his roommate that is dependent on care. Resident #47 and Resident #54 had an altercation on my second day here. They said they usually do that. The Surveyor asked who said they usually do that. CNA #3 said the other staff, Resident #54 usually doesn't eat in the dining room. The Surveyor asked has any resident told you they were tired of hearing the two of them. CNA #3 said no. On 05/02/2024 at 01:30 PM, during an interview with Dietary Manager, the Surveyor asked if this interaction between Resident #47 and Resident #54 had happened before. The Dietary Manager said yes. The Surveyor asked how often the incidents occur. The Dietary Manager stated it used to happen every other day. I talk to Resident #47 a lot and talk about the values the resident has, common sense, and calm the resident and redirect the resident. The Surveyor asked what has been done to prevent the negative interaction. The Dietary Manager said we put a coffee pot up front for Resident #54 to go get coffee. I ask Resident #47 to ignore Resident #54 when the resident points and makes noises. Resident #54 was at one point on the unit. Resident #47 wanted to go to another facility and referrals were sent out. The Surveyor asked who the aggressor was. The Dietary Manger stated, When I see them, it is usually [Resident #54] with finger pointing and words. The Surveyor asked why was Resident #54 taken off the unit. The Dietary Manager said I do not know why. The Surveyor asked does this ever involve or happen to other residents. The Dietary Manger said yes. Resident #23 and Resident #54. One gets loud and the other starts getting loud. I don't remember Resident #47 having physical issues with anyone else. Just verbal between Resident #54 and Resident #23. On 05/02/2024 at 1:30 PM, the Surveyor interviewed residents in the facility: The Surveyor asked Resident #19, have you heard any yelling and fighting. Resident #19 stated yes, three or four times a day. The Surveyor asked do you know their names. Resident #19 said no I do not. The Surveyor asked do you feel safe. Resident #19 responded yes; I do. The Surveyor asked when you saw the fighting, did you tell anyone. Resident #19 said no I have not. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Surveyor asked Resident #26 have you heard any yelling and fighting, Resident #26 said yes. The Surveyor asked how often does it happen. Resident #26 said every day, I think. The Surveyor asked do you know their names. The resident indicated no. The Surveyor asked, have you told anyone? Resident #26 said no they have never asked me. The Surveyor asked do you feel safe. Resident #26 said yes. The Surveyor asked Resident #12 if the resident had heard any yelling and fighting, Resident #12 said in the dining room. The Surveyor asked how often this happens. Resident #12 said every day, it keeps me up and I can ' t sleep. The Surveyor asked do you know their names. Resident #12 said no I do not but its men and women. The Surveyor asked, have you told anyone. Resident #12 said yes, I tell the Certified Nursing Assistants and it makes me feel like they do not care for me as they cannot make them go to bed or to their room that is what they said. The Surveyor asked do you feel safe. Resident #12 said yes, I think I do. The Surveyor interviewed Resident #42, who had been in the facility 6 months and was Resident Council President. The Surveyor asked has there been any interactions or incidents with residents. Resident #42 said at lunch today Resident #23, and Resident #14 hollered during the meal and Resident #47 got in the wheelchair got a little loud. No peace or quiet while eating here. The Surveyor asked do you feel safe here. Resident #42 said sure. The Surveyor asked what has been done to prevent the negative interactions. Resident #42 said nothing. It needs something done. The Surveyor interviewed Resident # 24 who stated he had heard a resident named (Resident #54) and a resident named (Resident #47) that yell and cuss at each other. That I've heard, but I've never seen it happen and 2 males that yell and cuss each other. Resident #24 was asked what the staff does when this happens. Resident #24 stated, Staff separate them. Resident #24 denied feeling afraid to be here in the facility, and no resident has cussed him or hit him. Resident #24 said this happens every other day. On 05/02/2024 at 2:58 PM, the Administrator was asked about [Facility Name] placement. She said no referral, it was just a suggestion in the care plan meeting that was shut down by the family. The Administrator was asked about why Resident #54 was placed on the unit then taken out. She stated it was to see if a decrease in stimuli would help. (Resident #54) ended up getting hit back there, so it was not helping. We ended up placing him back in the hall. The Administrator was asked what do you feel is the underlying cause of these altercations. The Administrator said they had a time frame and it usually occurred in the dining room but was not sure what the underlying issue was. The Administrator was asked what they were doing to protect the other residents. The Administrator said that they redirect and separate during altercations and that no other residents have been involved. The Administrator was asked what they were doing to protect Resident #54's vulnerable roommate. The Administrator said, I do not know of any issue or incident with his roommate. The Surveyor informed the Administrator that during interviews, a CNA said that they have witnessed Resident #54 yelling at their roommate. The Administrator said I was not informed of this and will look into it. Dates and Times of the Incidents: 03/11/2024 at 12:30 PM, the Witness Statement completed by Dietary Aide #3 stated, [Resident #54] got mad at [Resident #47] cause [Resident #47] was at the coffee table getting coffee. [Resident #54] rammed [the residents] wheelchair into [Resident #47] wheelchair. This is when the argument started between them. The facility then in-serviced on managing behaviors, filled out witness statements, separated, and redirected the residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	04/10/2024 at 12:45 PM, the Witness Statement completed by Restorative CNA (RCNA) stated, [Resident #54] started to enter dining room. I stopped [Resident#54] to remind [the resident] to be nice. I turned away to help assist a resident eating. [Resident#54] entered the dining room, wheeled .up to [Resident #47], the two started to argue. The resident, [Resident #47] hit [Resident #54]. [Resident #54] kicked [Resident #47], me, and other staff member separated the two. The facility then in-serviced on managing behaviors, filled out witness statements, separated, and redirected the residents. 04/12/2024 at 10:45 AM, the Witness Statement completed by Medication Attendant Certified #1 stated, [Resident #54] was getting coffee while [Resident #47] was coming in from smoking. [Resident #54] did not say anything to [Resident #47], but [Resident #47] said Do you have a problem to [Resident #54]. That is when [Resident #47] started wheeling towards [Resident #54] as I was taking [Resident #54] out of the dining room I asked [Resident #47] to please stop yelling and [the resident] would not. [Resident #54] then started to yell back stating, I kill [Resident #47]. I removed [Resident #54] away from [Resident #47]. A facility policy titled, Abuse, Neglect and Maltreatment Investigation and Reporting stated, The facility will endeavor to protect Resident/Elders from maltreatment, which means adult abuse, exploitation, neglect, physical abuse, sexual abuse, neglect, and the misappropriation of Resident/Elder property. such maltreatment is strictly prohibited' This policy recognizes Resident/Elder rights to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any chemical and physical restraints. Removal Plan: 1. On 5/2/2024, Resident #47 was placed on 1 on 1 observation by nursing staff for verbal altercation that occurred in the dining room at 11:00 a.m. 2. On 5/2/2024, Resident #54 was placed on 1 on 1 observation by nursing staff for verbal altercation that occurred in the dining room at 11:00 a.m. 3. On 5/2/2024 at 5:04 p.m., Resident #47 was transported to [local hospital] for medical clearance to be evaluated and treated for behavioral health. 4. Nurse consultant in-serviced Administrator, Assistant Administrator, and the Assistant Director of Nursing (ADON) on ensuring any resident-to-resident altercation and any residents that witness the altercation are assessed for psychosocial affects and offered Mental Health Services if needed. This was completed 5/3/2024 at 11:40 p.m. 5. Assistant Administrator in-serviced all staff on duty on Resident-to-Resident altercations, to stop the altercation immediately, and protect the resident involved. This includes any resident that witnessed the altercation to ensure an assessment is completed to ensure their psychosocial wellbeing is addressed and any Mental Health issues are assessed. Assistant administrator will in-service all oncoming employees before starting assigned shifts. This was completed 05/03/2024 at 3:40 p.m. 6. On 05/03/2024, the Assistant Administrator interviewed all residents that are interviewable for any psychosocial distress and offered mental health care as needed. There were no negative findings noted. This was completed on 05/03/2024 at 3:45p.m. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. On 05/03/2024, at 12:15 p.m., the Nurse consultant contacted our behavioral health provider to immediately see any residents that have been negatively affected and were available as needed. There were no negative findings and Mental Health services provider was notified 3:48 p.m. on 5/3/2024. 37878 Onsite Verification: On 05/06/2024 between 9:30 AM and 2:00 PM, the Surveyor was in the facility for verification of removal of Immediate Jeopardy. 1. Record Review of Resident #47's 1 on 1 monitoring log began 05/02/2024 at 11:00 AM and ended at 4:45 after other resident sent out at 5:04 PM. 11:00 AM, resident crying, upset. 11:15 AM calm. no other documentation of emotional upset. 2. Record Review of Resident #54's 1 on 1 log sheet that began on 05/02/2024 at 11:00 AM and ended at 5:04 PM with documentation that Resident #54 was sent out. 3. Record Review of Resident #54's Discharge Instructions & Summary; Sent to local emergency department for medical clearance, then to be transferred to behavioral health facility. Resident #54 continued to have explosive behaviors and is at risk for self-injury and injury to others. All appropriate notifications made. 4.Record review of inservice education provided by Nurse Consultant included: If a resident-to-resident altercation occurs any resident that witnesses or is a part of the altercation should be assessed for any psychosocial injury. If the resident-to-resident altercation occurs with the same resident repeatedly, effective interventions should be implemented to protect the resident. signed by Administrator, Director Of Nursing, Assistant Administrator. 5. Record Review of facility staff in-service conducted on 05/03/2024, the education included: Stop altercation, protect residents involved in altercation as well as residents that may have witnessed altercation for psychosocial well-being, and notify charge nurse, Director of Nursing, and/or Administrator. Reviewed staff audit of all staff inserviced. Between 11:00 AM and 1:00 PM, interviewed the Staff that work various shifts, who confirmed they received inservice training related to resident-to-resident altercation and were able to verbalize understanding of separating/stopping, protecting residents involved as well as any resident that may have witnessed altercation that could affect their psychosocial wellbeing, notify charge nurse, Director of Nursing or Administrator of altercation. Nine Certified Nursing Assistants, 6 Licensed Practical Nurses, 1 Registered Nurse, 2 Medication Assistants, 3 Housekeeping staff, the Activity Director and occupational therapist were the staff interviewed. 6. Reviewed residents interviewed for psychosocial effect of Resident to Resident altercation, documented no negative effects, residents clamed no affect. Between 1:00 PM and 1:40 PM, interviewed 7 alert and oriented residents who reported being aware of or witnessed altercations between residents. They were asked if they were upset, worried, or felt fearful due to witnessing the altercations. All residents verbalized feeling safe now that the resident is no longer in the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. Reviewed Nurse Consultant note on 05/03/2024, contacted our Behavioral health Provider to be available for possible Telemed Psychosocial eval and treatment for any resident that may have been affected negatively by any Resident-to-Resident altercation. After Resident interviews, there were no noted negative findings. Behavior Health Providers were notified that there were no negative findings from Resident interviews. At 1:06 PM, the Nurse Consultant reported education was provided to all staff through audit to ensure all staff had received inservice, confirmed the Mental Health Consultants were notified of possible need to have residents referred for evaluation and treatment. At 11:58 AM, the Assistant Administrator confirmed that all staff were inserviced and that she participated in the resident audit to ensure all residents were evaluated for psychosocial effects. At 12:57 PM, the Administrator was interviewed and confirmed any altercation between residents are to be reported, all residents are to be protected and assessed for any effect and referred to Mental Health consultants for evaluation and treatment. The Administrator and the Regional Nurse Consultant were informed of the Immediate Jeopardy Plan of Removal with a completion date of 05/03/2024, verified removal on 05/06/2024 at 2:00 PM.

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F 0657 Level of Harm - Minimal harm or potential for actual harm 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. 49689 Based on record review and interview, the facility failed to update a care plan regarding a resident's placement on the unit for 1 (Resident #54) of 1 sampled resident. The findings are: 1. A review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/28/2024 indicated Resident #54 had a score of 7 (0-7 indicates severe cognitive impairment) on a Brief Interview of Mental Status (BIMS). 2. A review of the Order Summary indicated Resident #54 had diagnoses of Down Syndrome, Generalized Anxiety Disorder, and Unspecified Intellectual Disabilities. 3. A facility review of the Care Plan indicated on 03/12/2024 a revision was made that stated, [Resident #54] is obsessed with certain other resident's and becomes physically and verbally aggressive towards them. placed on male secured unit for decreased stimuli . 4. A review of the Care Plan with a revision date of 04/23/2024 indicated [Resident #54] can be disruptive. Yelling at other residents and staff, will throw food, plastic wrappers, other items on the floor. Also, will throw food on the walls. Sits in wheelchair in the middle of the hallway and watches television. Wants other resident's doors closed. Grabs other residents. Goes into other resident's rooms and yells at them, physically aggressive, agitated, frustration/anger at others, makes disruptive sounds, threatens others, anxious, exit seeking behaviors. Refuses bath. Scratches others. 5. A review of a Care Plan Conference held on 3/19/24 for Resident #54 stated, Care plan conference regarding behaviors possible room change per family he perceives that somebody will take his stuff. Had a psych eval which recommends [Name of facility]. He is going to return to regular room on 400 hall. Family does not want [Name of facility] placement . 6. On 05/02/24 at 2:58 PM, the Administrator was asked about [Name of facility] placement, she stated no referral, it was just a suggestion in the care plan meeting that was shut down by the family. The Administrator was asked about why Resident #54 was placed on the unit then taken out. She stated it was to see if a decrease in stimuli would help. He ended up getting hit back there, so it was not helping. We ended up placing him back in the hall. The Administrator was asked what do you feel is the underlying cause of these altercations. The Administrator stated they had a time frame and it usually occurred in the dining room but was not sure what the underlying issue was. The Administrator was asked what they are doing to protect the other residents. She stated that they redirect and separate during altercations and that no other residents have been involved. The Administrator was asked what they were doing to protect Resident #54's vulnerable roommate. She said she did not know of any issue or incident with his roommate. The Surveyor then stated that the roommate was 100% dependent and non-verbal and Resident #54 had yelled at the roommate. The Administrator said I will look into that. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. On 05/03/24 at 9:40 AM, during an interview with the MDS Coordinator the Surveyor asked why it is important to have an accurate care plan. The MDS Coordinator stated so that the best quality of care can be provided to the resident. The Surveyor asked what could happen if a care plan was not accurate. The MDS Coordinator said we may not be able to provide something that a resident needs.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49689 Based on record review, observation and interview, the facility failed to ensure interventions were utilized to prevent worsening of contractures for 2 (Residents #40 and #66) of 2 sampled residents. The findings are: 1. A review of the Order Summary indicated Resident #40 had diagnoses of abnormal posture, stiffness of left shoulder, and stiffness of left elbow. A review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/29/2024 indicated Resident #40 had a Staff Assessment for Mental Status (SAMS) completed with a memory problem for short-term and long-term and has impairment on both sides of upper and lower extremities. A review of the Care Plan with an initiated date of 01/10/2024, indicated Resident #40 required, Problem: .is receiving a restorative program . Goal: Will maintain a ROM (range of motion), balance in order to reduce risk for contractures and skin breakdown by next review .Approaches/Tasks Left Elbow Extension [NAME] up to 4 hours . Further review indicates Resident #40 was to have cushion boots on at all times. On 04/30/2024 at 10:00 AM, the Surveyor observed Resident #40 in bed with no interventions in place for left arm or cushion boots on feet. On 05/01/2024 at 8:30 AM, the Surveyor observed Resident #40 in bed with no interventions in place for left arm or cushion boots on feet. On 05/02/2024 at 9:25 AM, the Surveyor asked Certified Nursing Assistant (CNA) #3 if Resident #40 had had a left elbow extension brace. CNA #3 stated, No. The Surveyor asked if Resident #40 wears cushion boots at all times. CNA #3 stated, No. The Surveyor asked, without interventions in place what could happen without the brace or cushion boots. CNA #3 said contracture could worsen and the residents' feet could get sores on them without interventions. On 05/01/2024 at 9:45 AM, the Surveyor asked Registered Nurse (RN) #1 what could happen if Resident #40 does not have interventions in place for contractures. RN #1 stated they could become worse. The Surveyor asked what could happen without interventions for feet such as cushion boots. RN #1 said the resident could develop pressure ulcers. 2. A review of the Order Summary indicated Resident #66 had a diagnosis of hemiplegia and hemiparesis after a cerebral vascular incident. Further review indicated an order with a start date of 12/09/2023 that stated, Ensure hand brace is in place at least 16 hours a day, every shift for brace. A review of Resident #66's May 2024 Medication Administration Record documented a check mark for every shift but the evening shift on May 2, 2024. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Quarterly MDS with an ARD of 03/15/2024 indicated Resident #66 had a SAMS indicated Resident #66 was severely cognitively impaired and had no impairment of the upper or lower extremities. A review of the Care Plan with an initiated date of 05/01/2024, documented Resident #66 had a right hand contracture and right foot drop, and occupational therapy (OT) was to evaluate and treat as indicated for right hand splint. On 04/30/2024 at 10:05 AM, the Surveyor observed Resident #66 up in a geriatric chair in the resident's room, with a right-hand contracture. Resident #66 was unable to open the right hand and had no interventions in place. On 05/01/2024 at 8:30 AM Surveyor observed Resident #66 up in a geriatric chair up in room, with no interventions in place for right hand contracture. On 05/02/2024 at 9:25 AM, the Surveyor asked CNA #3 if Resident #66 had any interventions for the right hand contracture. CNA #3 said oh yeah, they were talking about changing it to a carrot, the contracture has worsened, and Resident #66 cannot hand the brace anymore. The Surveyor asked CNA #3 what could happen if interventions are not in place. CNA #3 said that the contracture could worsen. The Surveyor observed CNA #3 insert a washcloth in the right hand of Resident #66 after the interview. On 05/02/2024 at 9:45 AM, the Surveyor asked RN #1 what interventions were in place for Resident #66's right hand contracture. RN #1 said she would have to look. The Surveyor asked what could happen without interventions in place for the right hand contracture. RN #1 said the contracture could worsen. On 05/02/2024 at 10:34 AM, the Administrator reported there was no relevant policy.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 42016 Based on interviews, record review, and medication prescribing information, it was determined that the facility failed to ensure residents were free from unnecessary psychotropic medication for 1 (Resident #51) of 2 residents reviewed for unnecessary psychotropic medications. The findings include: A review of physician orders revealed Resident #51 had Depakote Oral Tablet Delayed Release (a medication used to treat manic episodes associated with bipolar disorder, seizures and migraine headaches) 250 milligrams (mg), Give 1 tablet by mouth three times a day for seizures/behaviors related to Alzheimer's disease with late onset. The order status is Active, with an order date of 03/08/2024, a start date of 03/08/2024, and no end date indicated. A review of medical diagnoses revealed Resident #51 had Alzheimer's disease with late onset, unspecified dementia, depression, post-traumatic stress disorder (PTSD), and unspecified convulsions. A review of the Depakote Full Prescribing Information, Revised March 2024, available through the Food and Drug Administration at www.accessdata.fda.gov, 1 Indications and Usage, revealed Depakote is indicated in the treatment for 1.1 Mania, 1.2 Epilepsy, and 1.3 Migraine. A review of the physician orders revealed Resident #51 had Quetiapine Fumarate (Seroquel) Tablet 50 mg (a medication used for the management of the manifestations of psychotic disorders and schizophrenia) Give 1 tablet by mouth two times a day related to Post-Traumatic Stress Disorder (PTSD), unspecified. The order status is Active, with an order date of 09/29/2022 and a start date of 09/29/2022, and no end date indicated. A review of the Quetiapine Full Prescribing Information, Revised October 2013, available through the Food and Drug Administration noted, 1 Indications and Usage, revealed Quetiapine is indicated for 1.1 Schizophrenia and 1.2 Bipolar Disorder. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/05/2024 revealed Resident #51 had a Brief Interview for Mental Status (BIMS) score of 3 which indicated the resident had severe cognitive impairment. Section D Mood, D0500 Staff Assessment of Resident Mood, 2. J. Being short-tempered, easily annoyed did not indicate symptom presence or frequency. Section E Behaviors, E0200. Behavioral Symptom - Presence & Frequency A. Physical Behavioral symptoms directed at others, indicated, 1 the behavior of this type occurred 1 to 3 days. B. Verbal behavioral symptoms directed toward others, indicated 1, behavior of this type occurred 1 to 3 days. C. Other behavioral symptoms not directed toward others indicated, 1 behavior of this type occurred 1 to 3 days. Section I Diagnoses indicated Psychiatric/Mood Disorder, I5800. Depression (other than bipolar) and I6100 Post Traumatic Stress Disorder (PTSD). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/03/2024 at 04:33 PM, Licensed Practical Nurse (LPN) #3 stated Resident #51 was currently receiving Depakote for behaviors. LPN #3 stated clinical indications for the use of Depakote were seizures and behaviors. During an interview on 05/03/2024 at 04:42 PM, the Assistant Director of Nursing (ADON), stated Resident #51 was taking Depakote for seizures and behaviors but did not know the indications for the use of Depakote. During an interview on 05/03/2024 at 04:33 PM, Licensed Practical Nurse (LPN) #3 stated Resident #51 was currently receiving Quetiapine for behaviors and the clinical indication is to help Resident #51's mood and behavior. During an interview on 05/03/2024 at 04:42 PM, the ADON stated Resident #51 was taking Quetiapine for Post Traumatic Stress Disorder (PTSD) and the clinical indication was an antipsychotic. LPN #3 was asked how the Interdisciplinary Team (IDT) addresses unnecessary medications with the physician. LPN #3 stated, they would look at behaviors notes to determine if Resident #51 should be on it. The ADON was asked how the IDT addresses unnecessary medication with the physician. The ADON stated, sometimes try a gradual dose reduction (GDR) to see if they can go off of it. The ADON stated the physician would be questioned about prescribing for an off-label purpose. The ADON stated no residents in the facility were currently part of any drug testing study.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49689 Based on observation, interview and record review, the facility failed to ensure dishes/utensils were stored under sanitary conditions and food preparation equipment was cleaned properly in the kitchen. These are the findings: A review of the Cleaning Schedule indicated the following were to be completed weekly: ovens inside and outside, Aide tables/microwave area, Outside of the refrigerator, Refrigerator inside cleaning, plate warmer, under cooks table, fryer-cleaning inside and outside, dish machine-cleaning on top of dish machine, steam table under, coffee pots and tea pots, carts-daily. The Dietary Manager stated on [DATE] at 3:30 PM, that this is the only cleaning schedule they use. On [DATE] at 9:10 AM, the Surveyor observed the hand washing station in the kitchen, the hot water side had water coming from the base, creating a red brown stain inside of the sink. The Surveyor then observed the eye wash station was covered in red/brown spots, and that the left cover was missing with debris on the inside of the gray plastic piece. On [DATE] at 9:18 AM, the Surveyor observed in a cardboard box at the bottom of the bread shelf a package of tortillas with a received date of [DATE] and expiration date of [DATE]. The Dietary manager stated there were five packages of 12 flour tortillas left in the box that were expired. On [DATE] at 9:20 AM, the Surveyor observed the backsplash spanning from the left of the oven to the prep table was covered in yellow/brown spots of various sizes. On [DATE] at 9:21 AM, the Surveyor observed a surveillance camera above the prep area that was covered in a brownish gray material, that was dripping off the cord. On [DATE] at 10:51 AM, the Surveyor observed a medium sized hole in the back right corner of the ceiling. On [DATE] at 10:52 AM, the Surveyor observed a white fan that is coated in gray matter on the outside and inside. On [DATE] at 10:52 AM, the Surveyor observed a secondary white fan close to the prep area that was coated in gray/black matter. The right hand corner was buckling from the ceiling, a sprinkler had been placed in the corner with a brown foam like matter surrounding the sprinkler head. On [DATE] at 10:53 AM, the Surveyor observed a small hole under the right hand corner of the venti hood. A nozzle that was over the fryer area was covered in yellow brown matter, and it was dripping off the orange rubber piece on the nozzle. A white plastic pipe was on the left hand side of the venti hood, towards the middle of the stove/oven area, was thickly coated in a yellow/brown matter. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:04 AM, the Surveyor observed in the dishwashing area the tile on the left hand side, under the dishwasher. The tile was discolored in gray black matter. The back wall had a large crack that forks in left and right directions, with missing tile directly underneath. In the back right corner under a shelf was a row of missing tiles, under the left side of the shelf, there was a red/brown stain on a tile with a hole in the middle of it, a cracked tile was observed on the left corner of the shelf. On [DATE] at 11:05 AM, the Surveyor observed the food processor coming out of the dishwasher. Dietary Aide #3 stated that it needed to run again as it had soap still on the inside. The Surveyor observed Dietary Aide #3 run the dishwasher with the food processor again. On [DATE] at 11:06 AM, the Surveyor observed the back wall of the three compartment sink was discolored, the shorter faucet was dripping continuously. On [DATE] at 11:15 AM, the Surveyor observed the Dietary Aide run the food processor through the dishwasher and bring it back to the prep area. The inside of the food processor had white soap bubbles and water inside. Dietary Aide #3 scooped 4 ounces of broth and the potatoes back into the food processor to finish pureeing for lunch. On [DATE] at 11:21 AM, the Surveyor observed two plastic clear bins filled with various ladles, scoops, tongs, spatulas, and whisks sitting with the handles in the bin and the kitchen silverware was exposed to kitchen contaminates. The Surveyor observed Dietary Aide #3 while preparing pureed foods, grab a #8 scoop and touch the inside of the scoop, then proceeded to use it to scoop the potatoes into the food processor for the residents on pureed foods. On [DATE] at 11:30 AM, the Surveyor observed Dietary Aide #3 bring the food processor back to the prep area with white soap suds and water in it. Using a 4 ounce scoop, Dietary Aide #3 added 8 scoops of California blend vegetables to the food processor and blended it for lunch.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39316 Based on observations, interviews, record reviews, facility document review, and facility policy review, it was determined that the facility failed to ensure hand hygiene was performed between resident rooms while delivering clean laundry. This failed practice had the potential to affect 14 residents residing on the secure unit, and the facility failed to keep a trash barrel covered to prevent residents from digging through trash on the secure unit for 1 (Resident #32) of 1 sampled resident observed. This failed practice had the ability to affect 14 residents residing on the secure unit. Findings include: A review of a document to Environmental Services Account Managers and Laundry Employees on 05/02/2024 at 09:40 AM regarding Reminder - Handling, Transport and Storage of Laundry, with a revised date of 10/2023, indicated, Page 2 Transport of Laundry indicates laundry will be handled and transported with appropriate measures to prevent cross-contamination and prevent the spread of infection. During an observation on 04/30/2024 at 12:07 PM, Laundry #1 entered the unit with a laundry cart containing clean laundry. Laundry #1 stopped at Resident room [ROOM NUMBER], covered her mouth with two ungloved hands, and coughed into hands. Laundry #1 then exposed clean laundry on cart by lifting the front cover of the cart and folding it back across the top of cart. Laundry #1 removed several items of clothing on hangers, entered Resident room [ROOM NUMBER], delivered the laundry, exited the room with empty hangers and placed them on the left side of the pole in the cart. Laundry #1 pushed the laundry cart to Resident room [ROOM NUMBER], removed clothing on hangers from the cart and entered Resident room [ROOM NUMBER]. Laundry #1 exited room [ROOM NUMBER] with empty hangers, hung the hangers on the left side of the cart on the pole. Laundry #1 pushed the laundry cart to Resident room [ROOM NUMBER], knocked, and announced, and entered Resident room [ROOM NUMBER] with laundry. No hand hygiene was done during this observation. During an interview on 04/30/2024 at 12:16 PM, Laundry #1 stated she had worked for facility for 11 1/2 years. Laundry #1 did not believe it was necessary to sanitize while delivering clean laundry. Laundry #1 stated, I should be, I guess. I just don't think about it. Laundry #1 was asked about the hangers being removed from the resident's rooms and said, I put the hangers here, and indicated to the far left of the bar under the cover. Laundry #1 further stated hangers and cart are sanitized after returning to laundry room. During an interview conducted on 05/01/2024 at 03:55 PM, the Administrator stated the laundry personnel were contracted and are expected to follow the same rules, policies, and procedures as all other staff. Review of the laundry and housekeeping schedule, provided on 05/01/2024 at 04:08 PM, by Laundry #4, documented Laundry #1 was a scheduled laundry employee on 04/30/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/02/2924 at 08:24 AM, Laundry #3 was asked to describe appropriate laundry handling, washing, drying, and delivery of laundry to the halls/the resident rooms. Laundry #3 stated, during delivery, the cart is covered, and hands are to be sanitized before entry to a resident's room and after delivery of clothing. Laundry #2 agreed hands are sanitized prior to entry and after exit. After all laundry is delivered, return to each room to pick up empty hangers and place in clear trash bag to return to laundry for sanitizing. On 04/30/24 at 10:31 AM, Resident # 32 was observed bending over the rim of a gray trash barrel on wheels, and digging/moving garbage around, lifting a white piece of paper with the right hand and dropping it back into the barrel. There was no lid on the barrel located just inside the locked unit to the right of the double door, outside of the dayroom door. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/09/2024, revealed Resident #51 had a Brief Interview for Mental Status (BIMS) score of 3 which indicated the resident had severe cognitive impairment and indicated the resident had Alzheimer's Disease and Non-Alzheimer's Dementia. A review of Resident #32's Care Plan, revised 04/15/2024, revealed the resident digs, pilfers with hands around the resident's bed, between the bed and the wall, and under the mattress. Interventions included, Please provide me with supervision for my safety. with an initiation date of 08/21/2019. A review of Order Summary Report, revealed Resident #32 was to be monitored for behaviors including stealing. Order date of 08/15/2019, start date of 08/15/2019, and no end date entered. During an interview on 05/01/2024 at 09:15 AM, Certified Nursing Assistant (CNA) #2 said a lid should be on the trash barrel and that she spoke with administration Thursday, last week, about getting a lid on the barrel for this and she was going to order one. On 05/01/2024 at 10:04 AM, Dietary #1 was observed placing a lid on the trash barrel. During an interview on 05/03/2024 at 03:25 PM, the Assistant Director of Nursing (ADON) said trash barrels should have lids and be covered to prevent infection and prevent residents from getting into the barrels. The ADON was not aware of who was responsible for having the trash barrels covered. During an interview on 05/03/2024 at 03:28 PM, the Administrator stated if the barrels are the large ones they should have a lid, the CNAs are responsible for the barrels being covered, and lids were recently ordered. 42016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 42016 Based on interviews and record review, it was determined that the facility failed to provide a pneumonia vaccine for 2 (Residents #63 and #69) of 2 residents reviewed for immunizations. Findings include: Review of a facility policy titled, Pneumococcal Vaccine (Series) with a Copyright date of 2022, specified, 1. Each resident will be assessed for pneumococcal immunization upon admission.2. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or resident has already been immunized. Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved standing orders . A review of the Consent for Vaccinations dated 07/24/2023, documented Resident #63 authorized the facility to administer a one-time pneumococcal vaccine. A review of the Immunizations tab in, the electronic health record, Resident #63 did not have information entered that the pneumonia vaccine was received. A review of the Consent for Vaccinations dated 02/26/2024, documented Resident #69 authorized the facility to administer a one-time pneumococcal vaccine. A review of the Immunizations tab in the electronic health record, Resident #69 did not have information entered that the pneumonia vaccine was received. On 05/03/2024 at 02:43 PM, the Infection Control Preventionist (IPC) was asked to provide information on the administration of the pneumococcal vaccine to Resident #63 and Resident #69. During an interview on 05/03/2024 at 02:59 PM, the IPC stated Resident #63 and Resident #69 never received the pneumococcal vaccine. The IPC stated the facility was working on a process for vaccines due to IPC not receiving notification when residents request vaccines. During an interview on 05/03/2024 at 03:10 PM, Social Services stated when new residents enter the facility, they are given an opportunity to consent or decline vaccines for the flu, pneumonia, and COVID-19. Once the document is complete it is uploaded into their chart. Social Services notifies the nurse who then looks at the computer for the document and orders the vaccine. Social Services was not aware of who ensures the orders are done.