STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jamestown Nursing and Rehab, LLC	2001 Hampton Place Rogers, AR 72758

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42016 Based on interviews and record review, the facility failed to ensure physical and psychosocial care interventions were implemented and modified to meet a resident ' s activities of daily living needs and failed to exhaust all available remedies as evidenced by the deterioration of a resident ' s physical status resulting in death for 1 (Resident #1) of 8 sampled residents. 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, 483.12 (Freedom from Abuse, Neglect, and Exploitation) at a scope and severity of J. The IJ began on [DATE] when maggots were observed to be imbedded in the body of Resident #1 by staff providing care, and pain was identified by the resident as the rationale for refusal of additional assessment and care. The Administrator and Nurse Consultants were notified of the IJ on [DATE] at 11:07 AM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on [DATE] at 9:13 AM. The IJ was removed on [DATE] at 3:32 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Findings include: A review of a facility policy titled, Resident Rights, revised on [DATE], indicated facility staff were trained on resident rights and involved in the implementation of the policy and procedure. Residents have a right to be informed of their health, medical condition and treatment, participate in or refuse treatment, be advised of alternative care and treatments and their consequences. Residents have the right to 15. Receive adequate and appropriate medical care, nursing care, protective and support services, and personal cleanliness in a safe and clean environment. , 22. Be transferred or discharged on ly for medical reasons, for your welfare or that of others . , 33. Be free from physical abuse and neglect . (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a facility policy titled, Abuse, Neglect, Misappropriation and Exploitation Investigation and Reporting Policy, revised [DATE], indicated, The Facility will endeavor to protect residents from maltreatment, which means adult abuse, sexual abuse, neglect, misappropriation of resident property, and exploitation of residents. It recognizes resident rights to be free from physical, verbal, or mental abuse, corporal punishment, involuntary seclusion, and any chemical and physical restraints as defined by federal regulation. Section II - Staff training and competency included in-service training programs that addressed resident rights, abuse policy including definitions and terminology, recognizing signs and symptoms of abuse, how and when and to whom allegations of mistreatment, neglect, and abuse will be reported, investigations on injuries of unknown origin. Section III - Identifying, investigating, and reporting, general policy included, all alleged, witnessed, or suspected resident maltreatment, including abuse and neglect shall be immediately reported to the Administrator or immediate supervisor and investigated by Facility management. All facility personnel, including all employees and any physician, owner, and Administrator, must immediately report all incidents of alleged, witnessed, or suspected resident maltreatment, including abuse and neglect, to the Administrator, or the Administrator ' s Designee who will report events as required by State law or regulation. When determining whether to report an incident, the definitions of abuse and neglect shall be considered. Any person in the facility suspecting the facility Administrator of any form of resident maltreatment or failing to report resident maltreatment is encouraged to go to the DON, consultant, or the State Agency. The Administrator or designee will immediately conduct an investigation of all incidents of alleged, witnessed, or suspected resident maltreatment. All alleged, witnessed, or suspected incidents must be reported according to state and federal law, within time restrictions required by law. All alleged violations are to be reported immediately but no later than 2 hours after allegation is made, to the Administrator, State Agency, local law enforcement, physician, coroner, State Registry, and resident ' s responsible party or emergency contact. Section IX - Definitions included Neglect, An act or omission by a caregiver responsible for the care and supervision of an endangered person or an impaired person constituting the negligent failure to: 1. Provide necessary treatment, rehabilitation, care, food, clothing, shelter, supervision, or medical services to an endangered person or an impaired person; , and 4. Provide goods or services to a long-term care facility resident necessary to avoid physical harm, mental anguish, or mental illness. Impaired person - A long-term care facility resident is presumed to be an impaired person. A Policy and Procedure was requested for catheters. The Administrator provided policy statement, We do not have a policy on urinary catheters. On [DATE] at 12:25 PM, the Administrator stated the facility did not have a policy for wound care. The Medical Director was an independent contractor, and the facility did not have a job description for the Medical Director. Review of the job description for Administrator indicated the position was to manage and direct the day-to-day operations of the facility, and to learn and implement state and federal regulations. Responsibilities of the position included resident safety, reviews complaints and grievances, maintain written policies and procedures, assist department head with eliminating and correcting problem areas. Review of the job description for the Director of Nursing (DON) indicated the position responsibilities included assuring resident safety, day to day operation and management of the nursing department and working closely with the Administrator regarding coordination of resident services and functions of the nursing department. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the job description for the Assistant Director of Nursing (ADON) indicated the position responsibilities included assuring resident safety and day-to-day operations of the nursing department, meeting with team members regarding coordination of resident services. Review of the job description for the Charge Nurse indicated the position responsibilities included assuring resident safety; perform nursing services for the comfort and well-being of the residents; check residents daily to determine status, assess, record, and report changes in residents ' condition to supervisor and attending physician; complete treatment orders; complete skin audits; identify nursing problems and respond and initiate immediate action; communicate problems to DON; provide emergency care to residents; assess resident needs and provide input for care. Review of the job description for the Treatment Nurse indicated the position responsibilities included assuring resident safety; completing treatment orders; assist and complete skin audits; safety of residents; identify safety hazards and special nursing problems and initiate immediate action; communicate problems and needs in nursing department; assess and report changes in resident condition and take follow-up action as necessary; provide emergency care to residents; assess resident ' s needs and provide input. Review of the job description for Certified Nursing Assistant (CNA) indicated the position responsibilities included assuring resident safety; identify resident problems and concerns and report them immediately to charge nurse or a licensed nurse; report changes in residents ' condition. A review of the Medical Director Retainer Agreement with an effective date [DATE], indicated the duties of the Medical Director included guidance and oversite in the development and implementation of resident care policies that reflect current standards of practice; responsible for coordination of medical care in the facility; identifying, evaluating, and resolving medical and clinical concerns and issues affecting resident care, medical care or quality of life or were related to the provision of services by physicians and other licensed health care practitioners. Medical care through medical doctors, Advanced Practice Registered Nurse (APRN) ' s, and telehealth services provided by the contracted provider limited liability company. A review of the medical director statement, provided by the Administrator, dated [DATE], indicated the physician designated as the Medical Director was not the physician named as the Medical Director in the Medical Director Retainer Agreement, as the agreement was between the limited liability company providing a Medical Director and the facility and not with the individual provider. A review of the Admission Assessment Communication, dated [DATE] indicated Resident #1 was a hospital referral for possible long-term care (LTC) placement. Nursing information included Resident #1 required maximum assistance of two for rolling over in bed and moving from a laying to sitting position; required assistance with oral hygiene; maximum assistance toileting and perineal care, incontinent at times; mechanical lift for transfers and no restrictions on ambulation; cognitive status was alert and oriented; had a sacral decubitus ulcer; required a wheelchair; had a mood disorder and was receiving medication. A review of the Level I Preadmission Screen, also known as the DMS-787, with a completion date of [DATE], indicated Resident #1 had a diagnosable major mental disorder indicated as panic or other severe anxiety disorder. (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 Report of Disability Examination, also known as the DCO-0107S, with a signed date of [DATE], indicated Resident #1 had a medical history that included severe morbid obesity, unspecified mood disorder, and chronic pain. Further review indicated Resident #1 had pain with movement classified as 10 on a scale of ,d+[DATE], 10 being the worst Medications listed included a serotonin reuptake inhibitor (antidepressant), a selective serotonin reuptake inhibitor (antidepressant), two blood pressure medications, a muscle relaxant, oral opioid (pain reliever), opioid analgesic patch, and three medications for elevated blood sugar. A check box response to the question, Has the patient followed treatment recommendations? was No. Comments indicated Multiple instances - refusal of Care. A review of the Medical Review Team (MRT) Social Report for Adults, also known as the DCO-0108S, with an application date of [DATE] indicated Resident #1 ' s illness, injury, or conditions limiting ability to work or perform household activities included chronic pain described as constant pain with treatment that included wound care and pain medication. MD #1 and APRN #11 were listed as physicians seen by Resident #1 in the past year, and Resident #1 was hospitalized from [DATE] to [DATE]. A review of the Hospital Medical Discharge Summary, with a discharge date d of [DATE], indicated Resident #1 had morbid obesity, was chronically bedbound related to deconditioning and not moving much, surgically implanted catheter, poor social living scenario, and chronic pain. A note dated [DATE] indicated resident continued to refuse physical therapy and turning and there was a high concern for continued decline with refusal to comply. A note on [DATE]-[DATE] indicated Resident #1 had not been compliant with any activity. Instructions included wound care to perineal and gluteal area. A review of the Admission Agreement, signed by Resident #1 on [DATE], indicated due diligence would be used by the facility to obtain the services of a physician when the resident ' s condition required such medical attention and would attempt to obtain the services of another physician if resident ' s personal physician was unavailable. Further, the facility would obtain, at the discretion of the physician or the facility, ancillary services, such as physician or ambulance services, deemed necessary for the health and welfare of the resident. A review of the Acknowledgment of Receipt of Advanced Directive Information-Resident, signed by Resident #1 on [DATE] indicated Resident #1 chose to have continued administration of all possible medical treatment, as ordered by the physician, to prolong life to the greatest extent possible without regard to condition, chance of recovery, or expense. A review of the Capacity Verification, dated [DATE] did not indicate a capacity (an individual ' s mental or physical ability) and was signed by the resident and an unidentified facility representative. A review of the Admission Record, indicated the facility admitted Resident #1 on [DATE] with diagnoses that included pressure ulcer of the sacral region, type 2 diabetes mellitus, malaise (an indefinite feeling of debility or lack of health often indicative of or accompanying the onset of an illness), morbid obesity, mood affective disorder, and chronic pain. (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 admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], indicated Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Resident #1 ' s mood interview, sections C through I were not completed related to negative symptom responses to the first two questions, and a total mood severity score indicated 00. Resident #1 had impairment of bilateral lower extremities, used a wheelchair for mobility, was dependent on staff for toileting and dressing; required substantial/maximal assistance with oral hygiene and personal hygiene; required setup/cleanup assistance with eating; and refused shower/bathing self. Resident #1 was dependent on staff to roll left and right, refused to sit up, refused to transfer to a chair, refused to use wheelchair, and refused to transfer for a tub or shower. Resident #1 had an indwelling urinary catheter and was continent of bowel. Active diagnoses were identified as diabetes mellitus, morbid obesity, mood affective disorder, and chronic pain described as occurring frequently and not interfering with daily activities. Prognoses of life expectancy of less than 6 months indicated no. Skin condition indicated a stage IV (most severe stage, significant tissue loss, damage extends through all layers of skin exposing muscle, tendon/bone, high risk of infection) pressure ulcer was present on admission and Resident #1 was at risk of developing pressure ulcers. Resident #1 medications received included an antidepressant and opioid. Resident #1 had a goal to remain in the facility and not return to the community. Care areas identified included activities of daily living (ADL) functional/rehabilitation potential; urinary incontinence and indwelling catheter; falls; nutritional status; dehydration/fluid maintenance; pressure ulcer; psychotropic drug use; and pain. A review of the significant change MDS, with an ARD of [DATE], indicated changes from the admission MDS included the following: Resident #1 exhibited behavior described as worsening for rejection of care occurring daily. Resident #1 refused shower/bathe, dressing, rolling left or right in bed, and any transferring; required supervision with oral hygiene. Resident #1 was always incontinent of bowel. Pain was described as effecting sleep, interfering with therapy activities, and day to day activities almost constantly, and rated as a 10 on a scale of ,d+[DATE] with 10 being the worst pain imagined. Resident #1 did not receive scheduled pain medication. Medications included an antibiotic. Care areas identified included cognitive loss/dementia and behavioral symptoms. A review of Resident #1 ' s care plan with a resolved date of [DATE], indicated Resident #1 ' s code status as full code, indicating wanting cardiopulmonary resuscitation. Interventions included providing the opportunity for resident to discuss feelings and ask questions related to end of life decisions and review code status; and a change in code status to do not resuscitate (DNR) with interventions that included checking for resident signature on consent form; verify physician order; review code status with resident annually and as needed; acknowledge right to revoke DNR status; and a. Resident #1 was placed on contact isolation on [DATE] due to wound and wound myiasis (a parasitic infection that occurs when fly larvae [maggots] burrow into the skin of a live animal and feed on its tissue) related to refusal of wound care. Interventions included pest control with a fly light trap, treatment of myiasis as ordered by physician, and wound care as ordered by physician resident refused; and (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. Resident #1 had an ADL self-care performance deficit related to chronic pain, refusing ADL care, turning, wound treatment, incontinent care and catheter care. Interventions included, resident was totally dependent on 2 staff for bathing/showering, mobility, dressing, toileting, transferring with mechanical lift, was bedfast, used bedrails for independence with turning and positioning, dependent on 1 staff for personal and oral hygiene, required skin inspection and was to be observed for redness, open areas, scratches, cuts, bruises and report changes to nurse; and c. Resident #1 exhibited behaviors that included rejection of care with interventions that included providing staff training on behaviors, notification to the physician of changes in behavior, and administering and monitoring effectiveness of medications; and d. Resident #1 was resistant to care evidenced by refusal of care, to be repositioned, refused skin assessments and treatments. Interventions included allowing Resident #1 to make decisions about treatment to provide sense of control, educate on outcome of non-compliance, encourage participation during care activities, clearly explain care activities prior to contact, negotiate ADL care times to allow resident participation, change approach if Resident #1 becomes agitated and notify charge nurse of situation; and e. Resident #1 had no impaired cognitive function/dementia based on BIMS score of 15, would remain oriented to person, place, situation and time, and would maintain current level of decision-making ability. Interventions included engaging in pleasant topic conversation prior to initiating care; and f. Resident #1 was receiving opioid pain medication therapy with interventions that included administering medication as ordered by physician and monitoring side effects of the medication; and g. Resident #1 had antidepressant medications related to affective mood disorder with interventions that included administering medications as ordered and monitoring side effects and effectiveness every shift. A black box medication warning indicated observation and monitoring for suicidality, unusual changes in behaviors, and clinical worsening; and h. Resident #1 had a mood problem related to mood affective disorder with interventions that included behavioral health consults, monitoring for irritability, mood changes, and agitation; and i. Resident #1 had chronic pain with interventions to anticipate need for pain relief, evaluate effectiveness of interventions, monitor for non-verbal pain, mood/behavior changes and review impact on functional ability and impact on cognition; and j. Resident #1 had a pressure ulcer to coccyx/sacrum and potential for development of pressure ulcers and refused treatment that included wound care, turning and repositioning, wound assessments per protocol and full skin assessments. Goals included healing of the pressure ulcer, remain free of infection, and maintain or develop clean intact skin. Interventions included administration of medication and treatments as ordered, educating resident on causes of breakdown and frequent positioning; and (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	k. Resident #1 had an indwelling catheter. Interventions included changing catheter as ordered, resident refused catheter changes and care; monitor and report signs and symptoms of urinary tract infection, that included foul smelling urine, altered mental status, change in behavior. Resident #1 refused a follow up urology appointment. A review of Order Summary Report, with active orders as of [DATE], indicated Resident #1 had an order to admit to LTC (long term care); a pain assessment every shift with a start date of [DATE]; treatment of coccyx wound daily and as needed with a start date of [DATE]; an antidepressant daily for mood affective disorder, with a start date of [DATE]; oral opioid pain medication every 4 hours as needed for severe pain with a start date of [DATE]; an opioid pain medication every 4 hours as needed for pain; an antidepressant at bedtime for mood affective disorder, with a start date of [DATE]. A review of the Nsg [Nursing] Admit/Readmit/Quarterly Assessment, dated [DATE] indicated a skin assessment integrity comment, Stage four noted to resident ' s coccyx with wet to dry treatment in place. Sensory Perception indicated Resident #1 ' s ability to meaningfully respond to pressure related discomfort was slightly limited, was able to respond to verbal commands, cannot always communicate discomfort or the need to be turned OR has some sensory impairment limiting the ability to feel pain or discomfort in 1 or 2 extremities. Resident was bedfast and had very limited mobility and was unable to make changes independently and was at moderate risk for dehydration. Cognition did not identify current psychiatric diagnoses or behavioral problem. Neurological assessment indicated resident was alert and oriented to person, place, time, and situation and was verbally appropriate. Resident #1 indicated pain occurred frequently in the last 5 days affecting sleep and day to day activities, and current pain was severe and rated it a 10 on scale of ,d+[DATE]. No behaviors were documented. A review of the Nsg Admit Skin Audit, dated [DATE] indicated Resident #1 had bruising to right and left antecubital areas related to IV sticks, dry skin, a stage 4 wound to coccyx (Stage 4 indicates full thickness tissue loss with exposed bone, tendon, or muscle.). A review of the Nsg Functional Abilities and Goals-Admission, with an effective date of [DATE] indicated Resident #1 had bilateral lower extremity impairment, required a wheelchair for mobility and was dependent for manual wheelchair use, required substantial/maximal assistance with personal hygiene, was dependent for toileting, dressing, rolling left and right, sitting to lying, lying to sitting, transferring from chair to bed and bed to chair, refused to stand from seated position, and refused shower/bathing. On [DATE] Resident #1 was seen by APRN #11 for hospital follow up. Reviewed problems included type 2 diabetes mellitus (DM), morbid obesity, anxiety, panic disorder with agoraphobia, depressive disorder, chronic pain, pressure injury of buttock, open wound of buttock, and pain in right hip joint. History of present illness (HPI) included urinary catheter surgically implanted, denied depression. Physical examination revealed morbid obesity and limited ambulation. Psychiatric mental status was normal mood and lethargic; was oriented to time, place, and person. Musculoskeletal revealed limited range of motion (ROM) and right hip pain. Assessment plan included: DM, chronic pain continue opioid; depressive disorder continue antidepressant. Open wound of buttock was not assessed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], Resident #1 was seen by APRN #4 for open wound assessment. Reviewed problems included unstageable pressure injury, open wound of buttock with complication, pain right hip joint. HPI included reported stage 4 pressure ulcer to coccyx, present on arrival to facility. Visit was first wound care visit. APRN #4 indicated they were unable to access Stage 4 pressure ulcer to coccyx and other unknown wounds as patient currently refuses to turn for full body skin assessment. Resident reported due to pain, would turn once per day when goes to the bathroom. Review of system (ROS) indicated unable to assess wounds. Orders given for wound care, if unable to perform tele visit at time of turning. On [DATE], Resident #1 was seen via telemedicine by APRN #22 for report of change in condition, HPI indicated expired opioid order, pressure ulcer required dressing change, and pain at wound site during wound care. ROS included mental status as active and alert. The Assessment/Plan was chronic pain with a change in opioid medication. Review of a Progress Note, dated [DATE], indicated Resident #1 refused to be cleaned and refused wound care more than one time daily, and stated would allow nurse to provide care at a later time. At 10:00 PM staff notified LPN #32 Resident #1 did not want care provided. A review of Nsg Weekly Skin Audit, dated [DATE], indicated skin was intact, no wounds with narrative note that stated, Resident refuses any and all skin audits. Review of a Progress Note, dated [DATE] at 5:26 PM indicated an odor in Resident #1 ' s room suspected coming from wound. The former Assistant Director of Nursing (F-ADON) entered Resident #1 ' s room and was aware of incontinent bowel, care was attempted and resident refused to allow staff to complete incontinent care and wound care. Feces were in wound dressing, resident was advised of risk of not allowing care, resident reported that (pronoun) did not care about wound becoming infected and would rather lay in feces than to be moved. On [DATE], Resident #1 was seen by Primary Care Physician (PCP) as new admission. The problem list included morbid obesity, heart failure, DM type 2, hypertension, malaise, mood affective disorder, and chronic pain. HPI included incontinent of bladder, continent of bowel, mood stable without behavioral problems, and was compliant with medications and care. Functional assessment indicated one person assist for ADLs and transfers. ROS included no anxiety or depression. Assessment/Plan included depressive disorder - continue antidepressant, impaired ADLs - assist and monitor, degenerative joint disease (DJD) - continue pain control with opioid, assist with ADLs and monitor, moderate to severe frailty syndrome - bedbound, assist with ADLs and monitor, sarcopenia (muscle loss) - assist with ADLs and monitor, poly-pharmacy - educate on medication interaction/adverse effects and monitor for adverse effects. Review of a Progress Note, dated [DATE] at 4:43 PM indicated Resident #1 continued to refuse incontinent care and wound care, and stated, I would rather lay here and die, than to let you move me. A review of Medication Administration Record (MAR), for [DATE] ([DATE] through [DATE]) indicated Resident #1 had pain documented 9 times above a level of 0, with medication administered. A review of Treatment Administration Record (TAR), for [DATE] indicated Resident #1 refused to allow wound care [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. No as needed (PRN) wound care was documented. (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 Nsg Weekly Skin Audit, dated [DATE], narrative note indicated Resident refuses all cares, an (sic) treatments. On [DATE] Resident #1 was seen by APRN #11 for follow-up on chronic pain. HPI indicated follow up for sacral ulcer, refusing bed and incontinence changes, wound care and repositioning related to pain. ROS revealed psychiatric mental status was active and alert and normal mood, oriented to time, place, and person. Assessment/Plan indicated chronic pain, continue oral opioid and PCP ordered opioid transdermal patch. On [DATE] Resident #1 was seen by PCP for acute visit for toenail care. ROS and Exam indicated skin had no rash, itching or skin changes and was warm dry (W/D) and intact. Assessment and plan included pressure ulcer on coccyx - resident does not want to be rolled due to pain. Continue facility wound care and Monitor for infection . DJD indicated staff reporting refusal of care due to pain; resident reports pain in hips, back and bilateral knees, educated on taking medication to stay ahead of pain, resident reported still has pain 40 minutes after taking medication; educated on importance of care compliance; opioid patch ordered for pain. Review of a Progress Note, dated [DATE] at 3:20 PM and 11:29 PM indicated Resident #1 refused incontinent and wound care. On [DATE] at 2:22 PM, Resident #1 refused 3 attempts at shower to be given. On [DATE] at 4:25 AM, indicated Resident #1 rejected care. At 3:27 PM, Resident #1 continued to reject care related to incontinence and positioning. On [DATE] at 12:41 AM, Resident #1 rejected care, to be changed, and was laying in stool. On [DATE] at 7:39 PM, Resident #1 refused shower. On [DATE] at 11:37 AM, Resident #1 continued to refuse care, showers, incontinent care and wound treatment. On [DATE] at 7:37 PM, Resident #1 continued to refuse care, laying in feces. On [DATE] at 6:39 PM Resident #1 continued to refuse incontinent care and personal care, CNA offered bed bath resident became angry and threw dinner tray stating, I hate this (explicit word) place and the people here, when CNA stated they would get assistance to provide bath. Resident #1 refused positioning, incontinent care, or other ADL assistance. On [DATE] at 6:03 PM Resident #1 allowed partial bed bath and refused to be turned off back to allow for wound assessment or care. On [DATE] at 09:15 AM, Resident #1 refused 3 attempts to give shower. On [DATE] at 3:56 PM, Resident #1 had no shower given. On [DATE] at 01:09 AM, Resident #1 continued to refuse care. On [DATE] at 3:33 PM, Resident #1 refused laxative and stated has bowel movement (BM) once a week and intentionally does not eat much so does not produce much waste. On [DATE] at 02:06 AM, Resident #1 continued to refuse care. On [DATE] at 10:23 AM, Resident #1 continued to refuse care, was currently lying in feces, refuses to allow staff to clean, and stated what is the point anyway. On [DATE] at 1:14 PM, F-ADON spoke with Resident #1 regarding continued refusal of care. Resident #1 became upset and asked to be left alone. A review of a PCP note indicated on [DATE], Resident #1 was seen for an acute visit for toenail care. HPI indicated mood stable with no behavioral problems and was compliant with care. Exam included a psychiatric evaluation that described Resident #1 as calm, cooperative, alert and oriented (AO) x 3 (indicating person, place, situation), and followed commands. The Assessment/Plan indicated the facility was unable to access the wound due to refusal because the resident did not want to be rolled. Staff reported refusal of all care. Options were provided if the resident continued to refuse care, which included comfort care and transfer to another facility. Continue facility wound care. The opioid patch dose was increased and an oral opioid medication was added. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jamestown Nursing and Rehab, LLC	2001 Hampton Place Rogers, AR 72758

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Progress Note, dated [DATE] at 11:50 AM, indicated Resident #1 continued to refuse perineal care and repositioning. On [DATE] at 12:41 PM, Resident #1 refused 3 attempts to provide shower. On [DATE] at 04:01 AM, Resident #1 continued to refuse perineal and other care. On [DATE] at 12:47 AM, Resident #1 refused care, was provided scheduled pain medication, and Resident #1 stated that is not the problem nurse should be worried about. On [DATE] at 3:27 PM, Resident #1 ' s room smelled like BM and refused to allow old brief to be removed, refused to allow skin assessment. On [DATE] at 10:48 AM, a foul odor was observed in Resident #1 ' s room and sitting area outside room. The nurse asked if pain medication was needed to allow for wound care in the afternoon. Resident #1 closed eyes, held [TRUNCATED]

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F 0641 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50924 Based on observations, interviews, and facility document review, it was determined that the facility failed to accurately identify resident verbal, physical, or other self-directed behavior symptoms as potential indicators of mental instability for 1 (Resident #1) of 1 resident reviewed for significant change assessment. The findings include: A review of Resident #1 ' s Admission Record, indicated the facility admitted Resident #1 on 05/20/2024 with diagnoses that included unspecified mood disorder, chronic pain, morbid obesity, malaise, and treatment refusal. Review of the Signification Change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/23/2024, revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. No potential indicators for psychosis were identified, such as hallucinations [the perceptual experiences in the absence of real external sensory stimuli or delusions the misconception or beliefs that are firmly held, contrary to reality.] No verbal behavioral symptoms of threatening, screaming or cursing were identified. No other self-directed behavioral symptoms were identified, stated examples, but not limited to: hitting or scratching self, rummaging, disrobing, throwing or smearing food or body waste, or screaming. As a result of no behavioral symptoms identified, further areas were not assessed for the resident behaviors interfering in; care, risk of significant physical illness or injury, social interactions, risk of injury to others, intruding on others privacy or activity, disruptive care, or the living environment. Resident #1 was identified with rejection of care behaviors occurring daily which interfered with the resident ' s health and well-being. Resident #1's behavior status was identified as worsening from the prior assessments due to the daily rejection of care behaviors. Resident #1's functional mobility revealed dependence requiring the helper to do all the effort for toileting hygiene, substantial/maximum assistance for personal hygiene, and resident refused for bathing, upper body dressing, lower body dressing, rolling left and right, and lying to sitting. A review of Resident #1's Care Plan, last modified on 10/25/2024, revealed Resident #1become agitated and distressed when out of bed due to pain, self-directed activities like television programs, writing letters, balloon toss, Bible reading, inspirational music were initiated with activities to boost Resident #1's self-esteem. The goals included: making eye contact, making a verbal response, reaching for items, smiling, and engaging in activities. Resident #1 had a self-care deficit and refused wound care interventions, skin assessments, urinary catheter care, bowel incontinence care, and turning. Interventions included: assistance of two staff members for bathing and turning, and staff was to inspect skin for redness, open areas, scratches, cuts, and bruises. The goal was for Resident #1 to maintain current level of care. Resident #1 was care planned for an antidepressant for mood disorder interventions which included a (Name Brand) antidepressant with a black box warning to caregivers for appropriate monitoring and close observation for clinical worsening, suicidality, or unusual changes in behavior. Resident #1 was only care planned for behavioral health interventions of medication and no counseling or therapy sessions. Resident #1 had a wound infestation issue related to refusal of wound care. Interventions included pest control measures via a fly light trap and treatment of the wound for fly/magot infestation, the goal was for Resident #1 to allow wound treatment. (continued on next page)

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F 0641 Level of Harm - Actual harm Residents Affected - Few	Review of documents provided revealed, Social Services Director (SSD) graduated with a bachelor's degree in Sociology on 05/07/2022 and completed Social Services Director Training on 03/31/2023. During an interview on 12/11/2024 at 10:14 AM, the SSD stated, the process was to interview the resident one-on-one and look at notes going back two weeks. The SSD stated they had been trained on MDS forms and had training an SSD and completed sections B, C, D, E, and Q of the MDS dated [DATE], used for the significant Change Assessment. A two week look back of the Resident #1's Progress Notes revealed the following charted behaviors: 1.A review of a Progress Note, dated 08/09/2024 at 10:24 PM, revealed Resident #1 continued to refuse care, the room was odorous, and the resident had an obvious need for care. 2.A review of a Progress Note, dated 08/10/2024 at 10:36 PM, revealed Resident #1 had refused personal care three times in the shift, the room was odorous, and Resident #1 had an obvious need for care. 3.A review of a Progress Note, dated 08/12/2024 at 3:28 PM, revealed Resident #1 refused to allow staff to assist with personal care and hygiene. Resident #1 did not perform those tasks for self or allow staff to assist. Resident #1 would not allow staff to touch, turn, clean, or reposition resident. 4.A review of a Progress Note, dated 08/13/2024 at 7:44 PM, revealed Resident #1 continued to refuse all activities of daily living care. 5.A review of a Progress Note, dated 08/14/2024 at 6:03 PM, revealed Resident #1 had eaten less than 25% or refused meals for 48 hours. 6.A review of a Progress Note, dated 08/15/2024 at 00:47 AM, revealed Resident #1 complained of feeling sore, but was not able to elaborate. Resident #1 continued to refuse care from the Certified Nursing Assistants (CNA). 7.A review of a Progress Note, dated 08/15/2024 at 00:57 AM, revealed Resident #1 refused pain medication for soreness. 8.A review of a Progress Note, dated 08/16/2024 at 10:02 AM, revealed Resident #1 was educated by a nurse on possible outcomes of not allowing nursing staff to give wound care including sepsis and death. Resident #1 stated, It can't be that bad. Resident #1 refused care from charge nurse, CNAs, wound care, and the doctor. 9.A review of a Progress Note, dated 08/17/2024 at 2:59 AM, revealed Resident #1 refused perineal care or any activity requiring movement in the bed. 10.A review of a Progress Note, dated 08/17/2024 at 3:48 AM, revealed Resident #1 was again educated on the importance of good hygiene related to bacteria and yeast infections. 11.A review of a Progress Note, dated 08/17/2024 at 2:37 PM, revealed Resident #1's room smelled as if the resident had a bowel movement but would not allow staff to change them. (continued on next page)

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F 0641 Level of Harm - Actual harm Residents Affected - Few	12.A review of a Progress Note, dated 08/17/2024 at 10:23 PM, revealed Resident #1's room was odorous, and the resident had obvious need for care, but refused personal care. 13. Review of a Progress Note, dated 08/18/2024 at 12:40 PM, the provider stated, Resident #1 refused wound care from the Wound Care Nurse Practitioner (NP) from 05/15/2024 through 08/16/2024. Resident #1 was stated to have a stage IV open wound to the coccyx upon arrival to the facility, the wound was not assessed and had no dressing applied. Resident #1 had not allowed nursing staff to fully view the back, coccyx, or sacrum at any point since admission to the facility to assess how many wounds existed. Resident #1 is incontinent, and feces was likely in the wound. Resident #1 was informed of the infection risk and possible rehospitalization . Resident #1 was offered a visit with the mental health NP, but stated there was nothing wrong with them mentally. Resident #1 stated their favorite CNA was out with covid and the resident would not turn until they returned. 14.A review of a Progress Note, dated 08/18/2024 at 5:55 PM, revealed Resident #1 had a bowel movement but would not allow staff to clean the resident and there was a pungent smell emanating to the hallway. 15. A review of a Progress Note, dated 08/19/2024 at 00:37 AM, revealed staff noted maggots imbedded in Resident #1's flesh. Resident #1 initially refused the nurse's attempt at assessment, but did agree to the resident ' s leg being lifted a few inches. A maggot was noted on Resident #1's skin. Resident #1 stated, no desire to go to the hospital or do a telehealth visit with the on-call provider. Resident #1 stated, I am not in immediate danger. 16.A review of a Progress Note, dated 08/19/2024 at 9:19 AM, revealed the SSD informed Resident #1 continued refusal of care meant the doctor could fire them as a patient resulting in the facility issuing a letter of discharge because no one would be over seeing Resident #1's care. Resident #1 called the doctor a Little [expletive] and stated they never liked doctors anyway. Resident #1 refused to sign any paperwork for the facility and stated only one CNA could place a sheet under them. Resident #1 would not name whom the specific CNA was. 17.A review of a Progress Note, dated 08/19/2024 at 12:53 PM, revealed Resident #1 did not want to move onto a bariatric bed and stated to the SSD, I guess you'll have to find me another place to live then. 18.A review of a Progress Note, dated 08/19/2024 at 3:32 PM, revealed Resident #1 was aware of the wound situation with the maggots. 19.A review of a Progress Note, dated 08/19/2024 at 3:48 PM, revealed Resident #1 made excuses and pushed out every care intervention. 20.A review of a Progress Note, dated 08/19/2024 at 5:24 PM, revealed Resident #1 was coughing and had a grey skin color, covid test, lab work and a chest x-ray was ordered and refused. 21.A review of a Progress Note, dated 08/20/2024 at 9:44 AM, revealed Resident #1 had eaten less than 25% of meals or refused them for 48 hours. (continued on next page)

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F 0641 Level of Harm - Actual harm Residents Affected - Few	22.A review of a Progress Note, dated 08/20/2024 at 10:38 AM, revealed Resident #1 was denied a transfer to a human development center because the resident did not have autism, down syndrome, or any intellectual disabilities and had a urinary catheter present. 23.A review of a Progress Note, dated 08/20/2024 at 11:51 AM, revealed Resident #1 had a Care Plan meeting in their room. The resident was asked about their food intake and stated, I'd rather just not eat, refused staff to use a mechanical lift to get them out of bed related to pain but refused pain meds, refused a wound care discussion which they did not think they needed stating they would not die from wounds. Resident #1 would not answer why they were on medication for their mood, stating I have never been depressed, nor am I depressed. Resident #1 wanted multiple medications stopped. Resident #1 was reapproached about wound care and stated, It would be best for you to leave. I really like you, so let's just end it here. 24.A review of a Progress Note, dated 08/20/2024 at 3:41 PM, revealed Resident #1 became agitated when the nurse asked the resident about how they were feeling and the issues they were having. 25.A review of a Progress Note, dated 08/21/2024 at 9:47 AM, revealed the SSD updated the ombudsman indicating the resident was aware of the maggots but still refused any care. The resident did not believe maggots were going to kill him. Resident #1 refused hospice services. The SSD expressed concern for the maggots and their danger to other residents. 26.A review of a Progress Note, dated 08/21/2024 at 2:21 PM, revealed Resident #1 was placed on isolation related to the maggots. Nursing staff explained the reason for the isolation to the resident and Resident #1 refused any care. Resident #1 stated, No you can just come in to give me my medicine, but everyone else can stay out. 27.A review of a Progress Note, dated 08/22/2024 at 00:18 AM, revealed a nurse asked Resident #1 to allow for pre-medication for pain followed by wound care in one hour. Resident #1 stated they would think about it. 28.A review of a Progress Note, dated 08/22/2024 at 7:40 AM, revealed Resident #1 had eaten less than 25% of meals or refused them for 48 hours. 29.A review of a Progress Note, dated 08/22/2024 at 10:30 AM, revealed Resident #1 was evaluated by a provider for Behavioral symptoms (e.g. agitation, psychosis): Other change in condition, Talks/Communicates Less, Change in skin color or condition. Outcomes of physical assessment were: Mental Status Evaluation: Altered Mental Status; Behavioral Status Evaluation: Other behavioral symptoms; Respiratory Status Evaluation: cough; Skin status Evaluation: wound. Recommendation from the provider was to Send to ER [emergency room] for eval and treat. 30.A review of a Progress Note, dated 08/22/2024 at 10:41 AM, revealed Resident #1 refused wound assessment from Advanced Practice Registered Nurse (APRN) #11. Former-Assistant Director of Nursing (F-ADON) informed Resident #1 the need for wound care, new wounds on the legs, maggots seen near hips and now around legs, and failure to accept care could result in death. Resident #1 was informed of APRN #11's plan to send the resident to the ER for evaluation and treatment of change in skin color, unknown condition of the backside, maggots in the bed, and increased drowsiness. Emergency Medical Services (EMS) entered Resident #1's room and attempted to transfer resident to the ER at 10:25 AM. Resident #1 stated get out now. EMS left the building at 10:37 AM. (continued on next page)

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F 0641 Level of Harm - Actual harm Residents Affected - Few	31.A review of a Progress Note, dated 08/22/2024 at 11:00 AM, revealed during the EMS incident the Former-Director of Nursing (F-DON) informed Resident #1 of the risk of sepsis, worsening of wounds, increase of fly larvae, and possibility death would occur. Resident #1 initially would not allow EMS team to speak, instead saying no, goodbye when they walked in the room and anytime, they began to speak. EMS asked questions to verify Resident #1 was alert and oriented which Resident #1 answered correctly, and EMS left. Resident #1 stated they were tired of people coming into room and bothering them. Resident #1 stated, it feels like I have a boot on my neck because you won't leave me alone. 32.A review of a Progress Note, dated 08/22/2024 at 11:49 AM, revealed a nurse contacted Adult Protective Services (APS). An APS Supervisor was made aware of Resident #1's decline and attempt to transfer them to the ER. APS stated Resident #1 had the right to refuse care even up to death. It was stated to APS, Resident #1 was not making sound decisions, and APS replied, a caseworker would be sent out to have a conversation with the resident and identify options moving forward. 33.A review of a Progress Note, dated 08/22/2024 at 1:09 PM, revealed Resident #1 refused to sign a Refusal of Care form and stated, for Christ's sake. 34.A review of a Progress Note, dated 08/22/2024 at 1:38 PM, revealed an APRN assessed Resident #1, and was found to be more lethargic, likely from risk of sepsis if not already, and would have to be transferred to the hospital if decline continued. Resident #1 stated, We will have to wait for me to get worse then. I don't want to go now. 35.A review of a Progress Note, dated 08/22/2024 at 4:30 PM, revealed attempts to reach out to Resident #1's friend and contact person were unsuccessful. 36.A review of a Progress Note, dated 08/23/2024 at 12:10 PM, revealed Resident #1 refused to acknowledge the Treatment Registered Nurse (Tx RN) or the floor nurse when they entered Resident #1's room, and refused to make eye contact. Resident #1 became angry when told wound care needed to be completed. Resident #1 stated, No you will not touch me and You need to leave. Resident #1 yelled, There is the door and leave now. The F-DON and F-ADON were notified. 37.A review of a Progress Note, dated 08/23/2024 at 3:15 PM, revealed Resident #1 refused to speak to the floor nurse when asked, How are you doing. 38. Review of a Progress Note, dated 08/23/2024 at 6:32 PM, revealed Resident #1's Primary Care Provider instructed the floor nurse to present hospice as an alternative since Resident #1 refuses care. Resident #1 stated. I do not want hospice. 39. A review of a Progress Note, dated 08/23/2024 at 7:00 PM, revealed Resident #1 had eaten less than 25% of meals or refused them for 48 hours. Resident #1 denied hunger and refused any supplements. During an interview on 12/02/2024 at 12:57PM, the Social Services Director (SSD) stated something was off (the SSD used hands, bilateral, with index fingers pointing toward head in circular motion) Resident #1 verbalized one thing appropriately but the actions were different, it didn't mesh up. The SSD stated there was no depression or appearance of depression, the resident was seen by the Psychiatric Mental Health Nurse Practitioner (PMHNP) via telehealth. The SSD stated the PMHNP does not come into the building to see residents in person. (continued on next page)

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F 0641 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/11/2024 at 10:14 AM, SSD stated, they did not identify any verbal behavior in the MDS form because they did not consider the term [expletive] to be cursing for the terms of the criteria, and Resident #1 never threatened anyone. Regarding Resident #1's behavior with bodily waste, dressing, and living environment the SSD stated no other behaviors were identified because the behaviors were the resident's baseline, and they only identified new behaviors. The surveyor questioned suicidal thoughts that were not new behaviors. The SSD stated, suicide is different, it is extreme. The SSD stated yes, Resident #1 was an extreme case. The SSD stated, I think I did all I could with [Resident #1] at the time. I was not considering it as other behaviors, but in hindsight, I would have answered yes to the question, which would have triggered the other assessment questions to be answered. The SSD stated, the unassessed areas of risk for significant illness/injury, significant interference in care, significantly intrude on the activity of others, were all present at the time of the 08/23/2024, assessment. The SSD stated the facility's Regional Ombudsman was an unbiased third party who advocated for the resident. The Regional Ombudsman was contacted regarding Resident #1's situation and the State Ombudsman was also involved; both the state Ombudsman and the Regional Ombudsman agreed, Resident #1 had the right to refuse care. They worked for the state Area Agency on Aging, it was located on the poster in the hall, it has a state seal on it. During a concurrent interview and observation on 12/11/2024 at 10:40 AM, the SSD accompanied the surveyor to the bulletin board where a poster for the Regional Ombudsman was posted. The SSD stated there was no state seal and no indication the ombudsman was part of the Department of Human Services (DHS) or, was with the Area Agency on Aging.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 48808 50924 F686 J Based on interviews, record review, facility document review, facility policy review, it was determined that the facility failed to ensure care and services were provided to prevent new pressure ulcer development and promote healing of existing pressure ulcers including admission and ongoing wound care assessments, appropriate and alternative interventions, and resident understanding of consequences of refusal; specifically no surgical interventions under anesthesia were offered, no intravenous pain medication was offered, no anti-anxiety medication was offered, the Medical Director was not made aware of or involved in care, interventions, or resident education; the Administrator did not participate in resident communications or bedside care plan meetings, no one-on-one in person counseling was sought out, behavioral history or symptoms were not used in interventions, no attempt at a competency evaluation for mental instability was made for 1 (Resident #1) of 8 residents reviewed for wound care services to treat, heal, and prevent pressure injuries. 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 05/23/2024, when Resident #1 began refusing wound and incontinence care due to pain, and the facility did not provide effective interventions to alleviate the symptoms. The Administrator and Nurse Consultants were notified of the IJ on 11/27/2024 at 9:56 PM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on 12/09/2024 at 9:13 PM. The IJ was removed on 12/10/2024 at 5:30 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Findings include: On 11/25/2024 at 12:25 PM, the Administrator stated the facility did not have a policy for wound care. The Medical Director was an independent contractor, and the facility did not have a job description for the Medical Director. A review of the facility ' s undated policy titled Resident Rights, indicated, residents had a right to; receive information in a language the resident understands, receive adequate and appropriate medical care, nursing care, protective supportive services, and personal cleanliness in a safe and clean environment, be advised by a physician or appropriate medical staff of alternative courses of care and treatments and their consequences. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a facility policy titled, Infection Prevention and Control Program, dated 11/22/2017, indicated the medical director was responsible for overseeing the management of an outbreak. Review of the job description for Administrator revealed the position was to manage and direct the day-to-day operations of the facility, and to learn and implement state and federal regulations. Responsibilities of the position included resident safety, reviews complaints and grievances, maintain written policies and procedures, assist department head with eliminating and correcting problem areas. Review of the job description for the Director of Nursing (DON) revealed the position responsibilities included assuring resident safety, day to day operation and management of the nursing department and working closely with the Administrator regarding coordination of resident services and functions of the nursing department. Review of the job description for the Assistant Director of Nursing (ADON) revealed the position responsibilities included assuring resident safety and day-to-day operations of the nursing department, meeting with team members regarding coordination of resident services. Review of the job description for the Charge Nurse revealed the position responsibilities included assuring resident safety; perform nursing services for the comfort and well-being of the residents; check residents daily to determine status, assess, record, and report changes in residents ' condition to supervisor and attending physician; complete treatment orders; complete skin audits; identify nursing problems and respond and initiate immediate action; communicate problems to DON; provide emergency care to residents; assess resident needs and provide input for care. Review of the job description for the Treatment Nurse revealed the position responsibilities included assuring resident safety; completing treatment orders; assist and complete skin audits; safety of residents; identify safety hazards and special nursing problems and initiate immediate action; communicate problems and needs in nursing department; assess and report changes in resident condition and take follow-up action as necessary; provide emergency care to residents; assess resident ' s needs and provide input. Review of the job description for Certified Nursing Assistant (CNA) revealed the position responsibilities included assuring resident safety; identify resident problems and concerns and report them immediately to charge nurse or a licensed nurse; report changes in residents ' condition. A review of a document titled Medical Director Retainer Agreement with an effective date 01/01/2018 stated, the Medical Director ' s services included working with the facility in identifying, evaluating, and resolving medical and clinical concerns and issues affecting resident care, medical care, or quality of life; or related to the provision of services by physicians and other licensed health care practitioners. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Jamestown Nursing and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 2001 Hampton Place Rogers, AR 72758	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Admission Record, indicated the facility admitted Resident #1 on 05/20/2024 with diagnoses that included chronic pain, unspecified mood disorder, morbid obesity, malaise (general sense of unwell, often with fatigue, diffuse pain, or lack of interest in activities), and congestive heart failure. On 05/31/2024 a diagnosis stated, procedure and treatment not carried out because of patient ' s decision for unspecified reasons. On 06/28/2024 a diagnosis stated, pressure ulcer of sacral region, unstageable. On 08/22/2024 a diagnosis stated, wound myiasis (a parasitic infection where fly larvae [maggots] infest and feed on living tissue in wounds). A review of the Nursing Admit Skin Audit dated 05/20/2024 at 10:11 PM, indicated a stage 4 pressure injury to the coccyx with a wet to dry dressing in place (Stage 4 pressure injuries involve full thickness tissue loss with exposed bone, tendon, or muscle.). A review of an Advanced Practice Registered Nurse (APRN) #4 note, dated 05/23/2024 at 9:55 AM, revealed Resident #1 had a medical history of anxiety, morbid obesity, panic disorder with agoraphobia (a fear of places and situations that might cause panic, helplessness, or embarrassment), depressive disorder, insomnia, chronic pain, pressure injury of the buttocks, open wound of the buttocks with complications, pain in the right hip joint. A review of the Level I Preadmission Screen, also known as the DMS-787, with a completion date of 05/17/2024, revealed Resident #1 had a diagnosable major mental disorder indicated as panic or other severe anxiety disorder. A review of Resident #1 ' s hospital records dated 05/20/204 revealed, Resident #1 became very angry when wound care was attempted, screamed out in pain, and yelled Everybody leave the room right now! I am tired of everyone hurting me! When staff attempted to clean stool off, Resident #1 responded I don ' t care, just leave me alone! Hospital records also indicated chronic narcotic use for pain related to multiple joint arthritis especially of the hips and knees, bed bound mobility since November 2023, a risk for falls related to behavior with interventions including appropriate de-escalation techniques, diversion activities, and a sitter, a coping problem possibly related to grieving, lack or control, altered self-image, depression, noncompliance, or impaired social functioning. A review of a hospital record, with a printed date of 05/20/2024, revealed social determinants of health included social isolation. Plan revealed treatment of chronic sacral decubitus ulcer. A review of the Admission Agreement, signed by Resident #1 on 05/20/2024, revealed due diligence would be used by the facility to obtain the services of a physician when the resident ' s condition requires such medical attention and would attempt to obtain the services of another physician if resident ' s personal physician was unavailable. Further, the facility would obtain, at the discretion of the physician or the facility, ancillary services, such as physician or ambulance services, deemed necessary for the health and welfare of the resident. A review of the Acknowledgment of Receipt of Advanced Directive Information-Resident, signed by Resident #1 on 05/20/2024 indicated, Resident #1 chose to have continued administration of all possible medical treatment, as ordered by the physician, to prolong life to the greatest extent possible without regard to condition, chance of recovery, or expense. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Capacity Verification, dated 05/20/2024 did not indicate a capacity (an individual ' s mental or physical ability) and was signed by the resident and an unidentified facility representative. The Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/27/2024, revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Resident #1 ' s mood interview was reported as no symptoms present for little interest or pleasure in doing things and feeling down, depressed, or hopeless. Resident #1 was reported to have no behavioral symptoms physical, verbal, or otherwise and no behaviors of refusal of care. A stage 4 pressure ulcer was identified that was present on admission and Resident #1 was at risk of developing pressure ulcers. Skin and ulcer treatments identified were pressure reducing device for the chair, pressure reducing device for the bed, and ulcer care. A review of Resident #1 ' s Care Plan, last modified on 10/25/2024, revealed Resident #1 became agitated and distressed when out of bed due to pain, self-directed activities like television programs, writing letters, balloon toss, Bible reading, inspirational music were initiated with activities to boost Resident #1 ' s self-esteem. The goals included making eye contact, making a verbal response, reaching for items, smiling, and engaging in activities. Resident #1 had a self-care deficit related to pain and refused wound care interventions, skin assessments, urinary catheter care, bowel incontinence care, and turning. Interventions included assistance of two staff members for bathing and turning, and staff was to inspect skin for redness, open areas, scratches, cuts, and bruises. The goal was for Resident #1 to maintain current level of care. Resident #1 was care planned for an antidepressant for mood disorder interventions included an antidepressant with a black box warning to caregivers for appropriate monitoring and close observation for clinical worsening, suicidality, or unusual changes in behavior. Resident #1 was only care planned for behavioral health interventions of medication and no counseling or therapy sessions. Resident #1 had a wound infestation (maggots) related to refusal of wound care. Resident #1 had contact isolation due to wound and wound myiasis (a parasitic infection that occurs when fly larvae [maggots] burrow into the skin of a live animal and feed on its tissue) related to refusal of wound care. Interventions included pest control with a fly light trap, treatment of myiasis as ordered by physician, and wound care as ordered by physician, resident refused. Resident #1 was on narcotic pain medication therapy. Interventions included narcotic pain administration as ordered and monitor for respiratory side effects; the goal was Resident #1 will be free from any discomfort or adverse side effects from pain medication. A review of Order Summary Report, with active diagnoses as of 10/01/024, revealed Resident #1 had a pain assessment every shift with a start date of 05/20/2024; treatment of coccyx wound daily and as needed with a start date of 05/23/2024; an antidepressant daily for mood affective disorder, with a start date of 05/21/2024; oral opioid pain medication every 4 hours as needed for severe pain with a start date of 07/26/2024; an opioid pain medication every 4 hours as needed for pain; an antidepressant at bedtime for mood affective disorder, with a start date of 05/20/2024. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Nsg [Nursing] Admit/Readmit/Quarterly Assessment, dated 05/20/2024 revealed a skin assessment integrity comment, Stage four noted to resident ' s coccyx with wet to dry treatment in place. Sensory Perception indicated Resident #1 ' s ability to meaningfully respond to pressure related discomfort was slightly limited, was able to respond to verbal commands, cannot always communicate discomfort or the need to be turned OR has some sensory impairment limiting the ability to feel pain or discomfort in 1 or 2 extremities. Resident was bedfast and had very limited mobility and was unable to make changes independently and was at moderate risk for dehydration. Cognition did not identify current psychiatric diagnoses or behavioral problem. Neurological assessment indicated resident was alert and oriented to person, place, time, and situation and was verbally appropriate. Resident #1 indicated pain occurred frequently in the last 5 days effecting sleep and day to day activities, and current pain was severe and rated it a 10 on scale of 0-10. No behaviors were documented. A review of a Progress Note on 05/20/2024 at 4:42 PM, revealed Resident #1 was admitted via stretcher from the hospital. Resident #1 refused to allow staff to perform a skin assessment stating they only wanted to be changed once a day and would not allow staff to perform anything else. Former-Assistant Direct of Nursing (F-ADON) was made aware and after encouragement the resident allowed a limited viewing. On 05/22/2024 at 4:07 PM, there were multiple attempts to complete the admission skin audit were refused by Resident #1. The hospital reported at time of discharge Resident #1 had a stage 4 pressure ulcer to the coccyx and a Deep Tissue Injury (DTI) to the right calf. A review of a Progress Note dated 05/23/2024 at 11:22 AM revealed, the floor nurse and APRN #4 attempted wound assessments. Resident #1 refused care, stating they only get turned once a day because they can ' t turn more than once, and it would be after they had a bowel movement. APRN #4 reviewed hospital records and noted refusal of care history. No new or alternative interventions were offered to Resident #1 ' s refusal. A review of a Progress Note dated 05/23/2024 at 2:04 PM revealed, the F-ADON attempted multiple times with staff to provide wound care. It was stated Resident is own responsible party. No new or alternative interventions were offered to Resident #1 ' s refusal. A review of a Progress Note dated 05/26/2024 at 1:20 AM revealed, Resident #1 ' s chronic opioid pain medication was stopped, floor nurse reported no agitation or anxiety just refusal of care. A review of a Progress Note dated 05/26/2024 at 1:12 PM revealed, Resident #1 called nurse into the room to discuss a plan for staff care. Resident #1 stated while in the hospital a pain pill would be provided and 45 mins later, they would call the nurse to provide peri care and wound care at the same time. Resident #1 only wanted to turn once a day. Resident #1 was informed the chronic opioid pain pill had been stopped yesterday and there were no current orders, nurse stated they would contact the provider. A review of a progress note dated 05/26/2024 at 2:08 PM revealed, a new order had been placed for a replacement opioid pain medication, but not Resident #1 ' s chronic opioid pain medication. A review of a progress note, dated 05/26/2024 at 11:43 PM, revealed Resident #1 stated they did not allow day shift to provide wound care due to pain. Resident #1 suggested the nurse complete it after medication pass, but later stated they were going to bed. No alternative interventions were offered to Resident #1 ' s refusal. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a progress note, dated 05/28/2024 at 6:33 PM, revealed Resident #1 refused all wound care after medicated twice with replacement opioid pain medication stating it was still too painful. No alternative interventions were offered to Resident #1 ' s refusal. A review of a progress note, dated 05/29/2024 at 5:26 PM, revealed the charge nurse reported to management an odor in Resident #1 ' s room suspected causes was the Resident ' s wound. Resident #1 was medicated with replacement opioid pain medication prior, then staff attempted to perform incontinence care and wound care. Resident # 1 agreed but started to complain of pain while on their left side and requested to be left alone. Resident #1 was advised of feces still on their body and the wound and the risk of refusal could lead to infection and sepsis. Resident # 1 was advised they need to roll on the right side and stated, due to the pain they would rather lie in feces than be rolled. Resident #1 refused care without any alternative pain medication or anti-anxiety medication offered. Former-Director of Nursing (F-DON), Administrator, and APRN notified. It was stated Resident was their own responsible party. A review of a progress note, dated 05/30/2024 at 4:43 PM, revealed Resident #1 refused wound assessment, wound care, and incontinence care by nurse and APRN, cited as too painful to even move and stated, I would rather die, than to let you move me. Risk of infection and death explained and Resident #1 verbalized understanding. No alternative intervention, no anti-anxiety medication offered to Resident #1 ' s refusal. A review of a progress note, dated 06/02/2024 at 3:20 PM, revealed Resident #1 allowed staff to pull them up in the bed but screamed and said it hurt. Resident #1 continued to refuse incontinence and wound care, stating it ' s too painful. A review of a progress note, dated 06/03/2024 at 3:20 PM, revealed Social Services Director (SSD), F-DON, and APRN held a care plan meeting at Resident #1 ' s bedside. Resident #1 stated such unbearable pain with attempts to roll, F-DON advised the wound needed to be cleaned to help with infection. Resident #1 verbalized understanding but stated they couldn ' t handle the pain. Resident #1 stated replacement narcotic pain medication helped with soreness but didn ' t come close to touching the pain in their hips and knees when rolling. APRN discussed other possible medications and methods, Resident #1 stated they were open to trying something different. A review of Resident #1 ' s June Medication Administration Record (MAR) revealed a new order for a transdermal opioid pain patch was started on 06/04/2024 at 8:00 AM. A review of a progress note, dated 06/06/2024 at 11:37 AM, revealed Resident #1 continued to refuse all care including bathing, incontinence care, and wound care stated it was too difficult and painful to roll back and forth. Staff offered a mechanical lift; Resident #1 stated it was too painful as well. A review of a progress note, dated 06/07/2024 at 3:15 PM, revealed the SSD contacted the Regional Ombudsman to help facilitate care with Resident #1. SSD stated the facility was looking at issuing a 30-day discharge notice. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a progress note, dated 06/07/2024 at 6:39 PM, revealed Resident #1 continued to refuse all incontinence care and personal care related to pain management. Resident continued complaint of pain which interferes with activities of daily living (ADL ' s), personal care, and inability to turn for wound care. Resident #1 became angry with bedside nursing staff and threw the diner tray down. Resident #1 stated I hate this [expletive] place and the people here, [pronoun] hurts too much to turn, and Resident #1 stated they would need to be put out to have wound care performed. APRN aware of Resident #1 ' s continued refusal of care. Resident is own responsible party was documented. No alternative intervention offered, no alternative plan of care for surgical wound debridement under anesthesia suggested, no anti-anxiety medication offered, no escalation to Medical Director, or visit from the Administrator. A review of a progress note, dated 06/17/2024 at 10:23 AM, revealed Resident #1 was laying in feces and refused to allow staff to roll them and provide care. Resident #1 stated its too painful and what ' s the point anyway. No alternate pain medication or route was sought out, no anti-anxiety medication was offered, the Medical Director was not contacted, and the Administrator did not attempt to assist with the resident. A review of a progress note, dated 06/17/2024 at 1:14 PM, revealed Resident #1 continued to refuse care related to pain from osteoarthritis. Resident #1 reported increased pain since hospitalization in November, the new order for (Name Brand) opioid transdermal pain patch was not helping. Resident #1 reported none of the pain medications were helping the pain. Resident #1 was told if they continued to refuse care other housing options would be sought out. Resident #1 stated they liked the facility and did not wish to leave, then became upset, didn ' t want to finish the conversation, and asked to be left alone. A review of Primary Care Physician (PCP) ' s 06/17/2024 visit note revealed, Resident #1 ' s Mood was stable without behavioral problems noted antidepressant medication was continued with no change, the facility had not been able to assess the wound related to resident refusals, education was provided on wound care, options of comfort care measures, or transferring facilities were offered to Resident #1. No indication of intravenous (IV) pain medication, no anti-anxiety medication, no surgical consult for wound debridement under anesthesia or consult to the Medical Director was noted. Resident #1 reported to PCP the (Name Brand) opioid transdermal pain patch was not touching his pain. A review of a progress note, dated 06/17/2024 at 2:41 PM, revealed Resident #1 ' s replacement opioid pain medication was increased. A review of a progress note, dated 06/17/2024 at 2:42 PM, revealed Resident #1 ' s (Name Brand) opioid transdermal pain patch was increased. A review of a progress note, dated 06/18/2024 at 10:21 AM, revealed Resident #1 told the Regional Ombudsman they liked the facility and refused care related to chronic pain issues. Ombudsman indicated with continued refusal a new placement, or a discharge would happen. No alternative approach or intervention was indicated. A review of a progress note, dated 06/21/2024 at 00:47 AM, revealed Resident #1 continued to refuse care, and when asked to rate their pain, indicated it was fine and not the problem the nurse should be concerned about. No other problem was identified by the resident, no further investigation was done by staff to find out, no counselor was consulted, and the medical director was not notified. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a progress note, dated 06/21/2024 at 12:54 PM, revealed the nurse offered Resident #1 an unscheduled pain pill to premedicate for wound care. Resident #1 responded by lowering their eyes and voice and stated, I ' m perfectly fine right now. Before the nurse could get a response out Resident #1 with eyes closed and head down, held their hand up and repeated, I ' m perfectly fine right now. A review of a progress note, dated 06/21/2024 at 3:27 PM, revealed Resident #1 ' s room had a smell indicating they had a bowel movement. Resident #1 refused attempted to remove the soiled brief, assess their skin, change them, or provide pain medication. Resident #1 would dismiss staff from room when something disagreeable is said. A review of a progress note, dated 06/22/2024 at 10:48 AM, revealed a foul odor was observed in Resident #1 ' s room and the sitting area outside the room. The nurse attempted to provide an extra pain medication, and to attempt wound care. Resident #1 closed their eyes, held up their hand, and stated, Why would you think we are doing it this afternoon?! I ' ve told you people until I ' m blue in the face, I will have to be unconscious for that! What does it take to get through?! Nurse educated Resident #1 on infection risk and sepsis from sitting in stool. Resident #1 responded, I know, [Nurse Name], I know. And I ' m not dealing with the pain, I ' ve already told you. The Medical Director was not made aware of the situation or the Resident #1 ' s request, the Administrator did not engage in any communication with the resident, and no surgical consult was attempted for wound debridement under anesthesia, no anti-anxiety medication was suggested. A review of a progress note dated 06/23/2024 at 1:11 PM revealed, Resident #1 had a bowel movement, was sitting in it, and refused care from staff. The nurse reported Resident #1 Shuts down when staff attempt to provide care. Resident closes eyes as if to ignore us and would dismiss staff from room when they disagreed or became frustrated. The Medical Director was not made aware of the situation or the Resident #1 ' s request, the Administrator did not engage in any communication with the resident, and no surgical consult was attempted for wound debridement under anesthesia, no anti-anxiety medication was suggested. A review of PCP ' s 06/26/2024 at 2:22 PM visit note revealed Resident #1 antidepressant medication was continued with no change, the facility had not been able to assess the wound related to resident refusals, education was provided on wound care, options of comfort care measures, or transferring facilities were offered to Resident #1. Resident #1 was indicated to have degenerative joint disease in multiple sites and refusing to turn for incontinence care or wound care related to pain, plan was continued replacement opioid pain medication as ordered. A depression assessment tool was used to assess Resident #1 for depression results were as follows; Resident #1 indicated feeling little interest or pleasure in doing things several days a week, feeling down, depressed or hopeless several days a week, feeling tired or having little energy several days a week, poor appetite or overeating several days a week, feeling bad about yourself or that you are failure or have let down your family several days a week, trouble concentrating on things, such as reading the newspaper or watching television several days a week, moving or speaking so slowly that other people could have noticed or so fidgety or restless that you have been moving a lot more, several days a week. Resident #1 indicated several days a week these problems made it difficult to do work, take care of things at home, or get along with other people. Resident #1 responded not at all to thoughts that you would be better off dead, or thoughts of hurting yourself in some way. The depression score was 9. Results were changed from Resident #1 ' s MDS admission assessment 30 days ago which had a 0 depression score identified. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a document titled (Medical Group Clinic), Patient consent for Care Management Services signed and dated by Resident #1 on 05/20/2024 indicated, Resident #1 signature agreed to services by the facility employed medical group which included consulting with relevant specialist about your health care . (Medical Group Clinic) will continue to be your primary care provider and will coordinate your care with other providers. A review of a progress note dated 06/26/2024 at 3:15 PM revealed, nurse advised Resident #1 their Primary Care Physician (PCP) was in the facility and wanted complete a wound assessment and send the resident to the emergency room (ER) for evaluation and treatment. Resident #1 was sitting in stool complained of a stomachache, refused care from staff, refused wound assessment from the PCP, and refused transfer to the ER. A review of the Order Summary Report, of discontinued orders, with an order date of 06/26/2024, revealed a psych referral, for 1 day, one time only for refusing care. The end date was 06/27/2024, the order status was completed. No follow through of this order. Resident #1 did not see anyone until second order was placed by APRN #11 on 07/07/2024. A review of a progress note, dated 06/27/2024 at 8:10 AM, revealed PCP discontinued Resident #1 ' s (Name Brand) opioid transdermal pain patch per the resident ' s request and ordered a consult to pain management. A review of the document Informed Consent to Refuse Treatment and/or Services dated 06/26/2024 at 2:53 PM indicated, the facility had offered Resident #1 daily wound care to the coccyx, repositioning, incontinence care, bathing, skin and wounds assessments, body audits, bariatric bed, specialty mattress, and a trapeze bar. The treatments and services were recommended for Resident #1 health and well-being and benefits included wound healing, achieving/maintaining good skin integrity, preventing/decreasing chances of pneumonia, deep view thrombosis, more wounds, infection, and possible death. Risk that might be reasonably expected as a result of refusing treatment and services included worsening of wound with new wounds, pneumonia, deep vein thrombosis, infection, sepsis, and even death could occur. The document is signed by Resident #1, witnessed by the F-ADON, and signed by the PCP. The Medical Director was not aware and did not sign, the Administrator did not sign, and no noted conversation was had regarding the resident ' s new depression symptoms, no surgical consult was attempted for wound debridement under anesthesia, no anti-anxiety medication was suggested. A review of Resident #1 ' s Admission Record from 05/20/2024 indicated 06/26/2024 was Resident #1 ' s 57th Birthday. No notation was made, no notes from the Activity Director or SSD, no indication the facility noticed. A review of a progress note, dated 06/28/24 at 3:24 AM, revealed Resident #1 had the (Name Brand) narcotic transdermal pain patch discontinued because they wanted to look at other means of pain control. Resident continued to take all medications and was tolerating well. A review of a progress note dated 06/29/2024 at 7:55 AM, stated, Advised nurse to try to determine reason for rejection of care. Determine if changes need to be made for those that are providing care such as have male aides working with the resident during care. Modify the plan of care. No indication of any findings or modified interventions noted, no suggestions for anti-anxiety medication, no counseling suggested, no contact to the Medical Director, and no visit from the administrator was made. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a (Medical Group) note, dated 07/03/2024 at 12:52 PM, revealed Resident #1 was seen by APRN #11, findings included a history of obesity (02/19/2024), anxiety (03/25/2024), panic disorder with agoraphobia (a fear of places and situations that might cause panic, helplessness, or embarrassment) (02/19/2024), depressive disorder (02/19/2024), insomnia (05/21/2024), chronic pain (02/16/2024), pressure injury of the buttock (02/28/2024), unstageable pressure injury (05/23/2024), muscle weakness (02/19/2024), open wound of the buttocks with complications (03/29/2024) pain in the right hip joint (03/21/2024). Resident #1 refused to allow staff to turn them, had a wound and refuses wound APRN to assess related to pain and the pain medication had been changed. There have been no changes to Resident #1 ' s psychotropic medications. Resident #1 had pain and pain medication were ordered. It was reported a recent workup had been performed to rule out medical delirium, but the description of the workup, test results, and the diagnosis was left blank. Review of symptoms (ROS) Resident #1 reported exercise intolerance, muscle weaknes [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Jamestown Nursing and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 Hampton Place Rogers, AR 72758	

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50924 Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to ensure sufficient staffing to meet residents' needs as evidenced by not following the facility assessment staffing guidelines for 74 of 87 shifts reviewed from 11/10/2024 day shift through 12/07/2024 night shift. The findings include: Facilities are required to conduct and document facility-wide assessment annually and as needed with substantial changes to determine what resources are necessary to care for its residents on a day-to-day basis. These may include resident census, disease types, services required by licensed personnel, equipment, resident's physical limitations and required assistance, residents with cognitive or intellectual impairments, and staff required to meet the needs of the residents. A review of a facility policy titled, Facility Assessment, dated 10/01/2024, indicated, the facility had an average daily census of 90. Common diagnoses of the facility's residents were: 1.Psychiatric/Mood/Substance use disorders- hallucinations, delusions, impaired cognition, mental disorder, depression, bipolar disorder (mania/depression), Schizophrenia (disorganized thinking and behavior usually with auditory hallucinations), Post-Traumatic Stress Disorder (PTSD), anxiety disorder, and behaviors that need interventions. 2.Heart/Circulatory System-congestive heart failure, coronary artery disease (blockages of the heart vessels), angina (chest pain), dysrhythmias (irregular heart rhythm), hypertension, orthostatic hypotension (blood pressure dropping with position changes), peripheral vascular disease, risk for bleeding and clots (deep vein thrombosis, pulmonary thrombo-embolism). 3.Neurological System- Parkinson's disease (neurodegenerative disease of the central nervous system), all or partial paralysis affecting either one side of the body left-right of from bottom to top (waist down or neck down), Multiple Sclerosis (autoimmune disease resulting in nerve damage to the brain and spinal cord), Alzheimer's disease, dementia, seizure disorders, stroke, traumatic brain injuries, Aphasia (language disorder affecting ability to communicate). 4.Intellectual Disabilities- Down Syndrome, Autism, and fetal alcohol syndrome. Vision issues- vision loss, cataracts, glaucoma, macular degeneration. Hearing issues-hearing loss. 5.Musculoskeletal System- fractures and arthritis. 6.Neoplasm- prostate cancer, breast cancer, lung cancer, colon cancer. Metabolic Disorders- diabetes, thyroid disorders, obesity, and morbid obesity. 7.Respiratory System- Chronic Obstructive Pulmonary Disease (COPD), Pneumonia, Asthma, and respiratory failure. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8.Genitourinary System- Renal insufficiency (impaired kidney function), neurogenic bladder (bladder control issues due to nerve problems), renal (kidney) failure, end stage renal (kidney) disease, urinary incontinence. 9.Blood Diseases- anemia and leukemia. Integumentary System- skin ulcers and injuries. Infectious Diseases- Skin and soft tissue infections, respiratory infections, tuberculosis, urinary tract infections, infections with multi drug resistant organisms, septicemia (infection in the blood stream), hepatitis (inflammation of the liver), influenza (the flu), and clostridium difficile (bacterial infection of the colon). The facility assessed acuity affecting licensed nurses were 36 residents on an altered diet or a swallowing disorder, 25 residents on oxygen, 3 residents with behavioral needs, 28 residents with injections, 3 residents requiring dialysis care on hemodialysis, 5 residents with indwelling catheters, 2 residents requiring intermittent catheterization, 12 residents on hospice, 7 residents with wound care, 3 residents on tube feedings. The facility assessed acuity affecting nurse aides revealed 33 residents were dependent upon staff for dressing, 41 for bathing, 36 for transfers, 15 for eating, 36 for toileting, 35 for oral hygiene, 40 for mobility, 34 for upper body dressing and 48 for lower body dressing. The facility assessed their coverage needs to adequately meet the residents' daily needs per shift as: Day Shift: 1 Registered Nurse (RN), 5 Licensed Practical Nurses (LPNs), 15 Certified Nurse Assistants (CNAs), 2 Med Techs, 2 Nurse Aides (NAs), and 1 other Evening Shift: 0 RNs, 4 LPNs, 10 CNAs, 1 Med Tech, 2 NAs, 0 other Night Shift: 1 RN, 3 LPNs, 8 CNAs, 0 Med Techs, 0 NAs, 0 other A review of the facility's Resident Matrix printed 11/25/2024 revealed, 50 out of 97 facility residents had a fall, 13 of those with a major injury, 45 had a diagnosis of Alzheimer's/Dementia, 12 were on transmission based precautions (isolation requiring personal protective equipment), 12 were on hospice care, 10 were being treated for an infection, 6 had a pressure injury, 6 had a urinary catheter in place, 3 required tube feedings, and 1 required IV (intravenous) therapy. A review of the documents Detailed Hours, for November and December daily staffing was reviewed from the employee's time clock punch reports starting with the day shift on 11/10/2024 through the end of the night shift on 12/07/2024. 83 occurrences a Certified Nurse Assistant (CNA) worked more than 13 consecutive hours, 35 occurrences a Licensed Practical Nurse (LPN) worked more than 13 consecutive hours, 11 occurrences a Register Nurse (RN) worked more than 13 consecutive hours, 9 occurrences a Nurse Assistant (NA), and 3 occurrences a Med Tech (Medication Assistant- Certified [MA-C]). 10 occurrences an LPN employed in a non-bedside role was asked to work as a bedside nurse. Using staffing guidelines defined by the facility in their 10/01/2024 Facility Assessment the bedside staff coverage was found lacking coverage by either a partial or complete open shift on: 11/10/2024 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Day Shift-1 RN, 3 LPNs, 2 CNAs, 1 MA-C Evening Shift- 2 MA-C 11/11/2024 Evening Shift-1 LPN 11/12/2024 Day Shift-1 LPN Evening Shift-1 LPN, 1 NA, 1 MA-C Night Shift-1 RN, 1 CNA 11/13/2024 Evening Shift-1 LPN, 1 CNAs, 1 MA-C, 1 NA Night Shift-1 LPN 11/14/2024 Days Shift-1 LPN, 1 NA Evening Shift-1 LPN, 3 CNAs, 1 MA-C, 1 NA Night Shift-1 LPN, 2 CNAs, 1 MA-C, 2 NA 11/15/2024 Days Shift-1 LPN, 1MA-C Evening Shift-2 LPNs, 1 CNA, 1 MA-C Night Shift-2 CNAs 11/16/2024 Day Shift-2 LPNs, 1 MA-C, 1 NA Evening Shift-1 LPN, 1 MA-C, 1 NA Night Shift-2 CNAs 11/17/2024 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Day Shift-1 LPN, 5 CNAs, 1 MA-C, 2 NAs Evening Shift-2 LPNs, 1 CNA, 1 MA-C, 2 NAs Night Shift-1 LPN, 3 CNAs 11/18/2024 Day Shift-1 CNA, 1 NA Evening Shift-1 LPN, 2 CNAs, 1 MA-C Night Shift-1 RN 11/19/2024 Evening Shift-2 NA 11/20/2024 Evening Shift-1 LPN, 1 CNA, 2 NAs, 1 MA-C 11/21/2024 Day Shift-1 NA Evening Shift-1 CNA, 1 MA-C Night Shift-1 LPN 11/22/2024 Day Shift- 1 NA Evening Shift-2 LPNs, 1 CNA, 1 MA-C Night Shift-1 LPN, 3 CNAs 11/23/2024 Day Shift-1 CNA, 1 MA-C, 1NA Evening Shift-1 CNA, 1 MA-C, 2 NAs Night Shift-3 CNAs 11/24/2024 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Day Shift-1 NA Evening Shift-1 LPN, 2 CNAs, 1 MA-C, 1 NA Night Shift-1 LPN 11/25/224 Day Shift-1 RN Evening Shift-1 LPN, 2 NAs Night Shift-1 RN 11/26/2024 Evening Shift-1 LPN Night Shift-1 RN, 2 CNAs 11/27/2024 Evening Shift-1 LPN, 1 MA-C, 1 NA Night Shift-1 CNA 11/28/2024 Day Shift-3 LPNs Evening Shift-1 LPN, 1 MA-C, 1 NA Night Shift-1 LPN, 1 CNA 11/29/2024 Days Shift-1 LPN, 1 CNA, 1 MA-C, 1 NA Evening Shift-1 LPN, 4 CNAs, 1 MA-C, 2 NA Night Shift-1 LPN, 4 CNAs 11/30/2024 Day Shit-2 LPNs, 3 CNAs, 1 MA-C, 2 NAs Evening Shift-1 MA-C, 2 NAs (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Night Shift-3 CNAs 12/01/2024 Day Shift-1 RN, 2 LPNs, 6 CNAs, 1 MA-C, 1 NA Evening Shift-1 CNA, 1 NA Night Shift-1 LPN, 1 CNA 12/02/2024 Day Shift-1 RN Evening Shift-1 LPN, 2 CNAs, 1 MA-C, 2 NAs Night Shift-1 RN 12/03/2024 Day Shift-1 NA Evening Shift-1 LPN, 2 CNAs, 1 MA-C, 1 CNA Night Shift-1 RN, 1 CNA 12/04/2024 Day Shift-1 LPN Evening Shift-1 LPN, 2 CNAs, 1 MA-C, 1 NA Night Shift-1 LPN 12/05/2024 Day Shift-1 LPN, 1 MA-C, 1 NA Evening Shift-1 LPN, 1 MA-C, 1 NA Night Shift-1 LPN 12/06/2024 Day Shift-1 RN, 1 NA Evening Shift-2 LPNs, 1 CNA,1 MA-C, 1 NA (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Night Shift-1 LPN, 2 CNAs 12/07/2024 Day Shift-1 RN, 1 LPN, 5 CNAs, 2 NA, 2 MA-C Evening Shift-1 MA-C, 1 NA A review of a document titled Incident by Incident Type, reviewed for a date range from 11/10/2024 to 11/25/2024, incidents classified as; 3 episodes of physical aggression, 1 in self-inflicted injury, 3 witness falls, 11 unwitnessed falls, 2 bumped/struck incident, 2 other incidents. A review of a document titled Incident by Incident Type, December fall list to current date of 12/07/2024, revealed another 7 falls, 3 witnessed and 4 unwitnessed. During an interview on 12/03/2024 at 6:40 AM, RN #17 stated, she had never been asked to take 3 halls and would not because it was too demanding. RN #17 stated the facility had a lot of staff turnover especially CNAs, and she heard the MDS (Minimum Data Sheet) nurse had quit. During an interview on 12/07/2024 at 10:40 AM, CNA #30 stated, she had been on the unit alone with one LPN when she arrived. CNA #30 stated she had asked the DON twice to obtain assistance. We have 8 showers today and we only have 2 done. There are 6-8 showers scheduled every day. CNA #30 stated the DON was aware of the short staffing and staffing was always short. When state is in the building, we show more staff because the consultants and administrative staff help too. During a concurrent observation and interview on 11/27/2024 at 08:05 AM, Resident #15 was sitting in the secure unit dining room being assisted by staff to eat breakfast. Resident #15 was unable to answer questions. LPN #18 stated Resident #15 received a scheduled opioid pain medication and resident was unable to communicate due to disease progression. Needs are anticipated and pain assessed by facial grimacing. Review of the Incidents by Incident Type, from 08/11/2024 to 11/25/2024, revealed Resident #15 had an unwitnessed fall on 08/31/2024 at 3:55 PM. A review of Incidents by Incident Type, dated 12/01/2024 to 12/07/2024, revealed Resident #15 had an unwitnessed fall on 12/04/2024 at 9:35 AM. A review of Progress Note, dated 12/03/2024 at 12:20 PM, revealed Resident #15 hit head on door frame of room and had a purple bruise to forehead. A review of Progress Note, dated 12/04/2024 at 12:11 PM, Incident & Accident description revealed resident walked into door fame on 12/03/2024 witnessed by aide. New helmet ordered. A review of Resident 15 ' s Admission Record, indicated the facility admitted Resident #15 with diagnoses that included dementia, osteoarthritis, and anxiety disorder. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/12/2024, revealed Resident #15 had a Staff Interview for Mental Status (SAMS) score of 3 which indicated the resident was severely impaired for daily decision making. Resident #15 required setup/cleanup assistance with eating and was dependent upon staff for oral hygiene, toileting, shower/bathing, dressing, and personal hygiene; required substantial assistance transferring to the toilet, and partial to moderate assistance with bed mobility, sitting to standing, laying to sitting on side of the bed, from sitting to standing, and transferring from chair to bed and bed to chair. Resident required a wheelchair for ambulation and was dependent upon staff for mobility. Resident #15 ' s active diagnoses included: arthritis, dementia, anxiety disorder, repeated falls, pain, and vitamin D deficiency. Resident #15 had 2 falls since admission with no injury; was receiving an antianxiety, antidepressant, and opioid medications. Resident #15 was receiving speech, occupational, and physical therapies. Care areas triggered included cognitive loss/dementia, visual function, communication, urinary incontinence, falls, and psychotropic drug use. A review of Resident #15's Care Plan, revised on 10/24/2024, revealed Resident #15 required a secured/special care unit related to dementia to provide a secure safe environment; had actual falls, 1 fall with fracture; had limited physical mobility related to severe cognitive impairment; had behavioral indicators/history of behaviors removing non-skid socks, safety helmet and C-collar; was elopement risk/wandering related to severe cognitive impairment and poor safety awareness; had delirium; had hypertension; had dehydration or potential for dehydration; had anxiety disorder; had psychotropic medications; had alteration of musculoskeletal status, fracture of C1 vertebra; had chronic pain related to a long term condition causing widespread body pain and tiredness; had actual impaired vision related to cataract. Interventions included staff educated to redirect if going into other resident rooms, proper fitting non-skid socks, move to high visual area, provide fidget blanket, ensure wearing proper footwear/non-skid socks, fall mat while in bed, therapy referral, encourage resident to remain in high observation area due to poor safety awareness, non-skid strips placed in front of recliner, redirect to high traffic/visible area, siderails for bed mobility, required supervision by 1 staff to walk independently, encourage participation in activity programs, encourage resident to wear helmet and keep on both non-skid socks, staff to be vigilant and encourage resident to keep on helmet, set routine of wake and sleep times, anticipate needs, assess for fall risk, distract from wandering, offer pleasant diversions, identify pattern of wandering and intervene as appropriate, administer medications as ordered, review medications for side effects, monitor and report onset signs and symptoms, changes in behavior, monitor vital signs; keep call light in reach, needs safe environment with even floors, free of spills, adequate light, bed in low position at night, remove blanket from resident when ambulating, lock wheelchair, behavioral consults as needed, monitor and report adverse reactions of medications including unsteady gait, frequent falls, anticipate and meet needs, keep cervical collar in place may be removed for showers, no sudden turning of head, keep midline while showering, give opioid pain medication and monitor for side effects, clean and maintain glasses daily and as needed. A review of Order Summary, revealed Resident #15 had an order, dated 09/20/2024, to reside on the secure unit related to dementia and behavioral disturbance; 09/05/2024, J-collar to be worn at all times related to a displaced posterior fracture of the first cervical vertebra; 12/04/2024 monitor hematoma to head for signs and symptoms [of] adverse change; 07/10/2022 antihypertensive; 09/16/2024 opioid medication as needed (PRN); 02/13/2024 antidepressant; 01/11/2024 opioid at bedtime for pain; and 09/04/2024 antianxiety. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Medication Administration Record (MAR), revealed Resident #15 received medications on 12/04/2024, that included: an antihistamine, an antihypertensive, an antidepressant, an antianxiety, an opioid, and a cervical collar, PRN opioid medication for pain. Review of (Contract Medical Provider Company) Advance Registered Practice Nurse (APRN) visit notes on 08/31/2024 at 4:02 PM, for Resident #15, revealed a medically necessary visit related to a change in condition for an unwitnessed fall, bleeding from face and confused baseline. Review of Symptoms (ROS) indicated resident was chronically ill, anxious, not oriented to time, place, or person, appeared uncomfortable, and had a significant amount of bleeding from the nose/mouth. Order given to send resident to emergency room (ER). Review of the [Hospital] History and Physical, dated 08/31/2024, revealed Resident #15 was transferred from [Hospital] emergency room for neurological evaluation, after a fall in a long-term care facility, identified a C1 fracture after a computed tomography (CT) scan (radiological test providing a cross section of structures inside the body). Additional diagnoses included vascular dementia, attention deficit disorder, and psychiatric disorder. Resident #15 unable to provide history due to vascular dementia. Assessment revealed cervical spine fracture. Review of the [Hospital] Record, emergency physician note dated 08/31/2024, revealed Resident #15 had an unwitnessed fall, acute fractures of anterior and posterior arch C1 and nasal bone. Physical exam revealed, dry blood in nares, upper lip laceration with sutures in place; neurologic [exam]: speech is rapid and unclear, moves all extremities; psychiatric[exam]: anxious and agitated. Review of the [Hospital] Discharge Summary, dated 09/04/2024, revealed Resident #15 ' s advanced dementia status, was verbal and unable to hold normal conversation, and at best oriented to self, was now failure to thrive and high risk for readmission and clinical deterioration, remained full code, cervical collar in place. Review of (Contract Medical Provider Company) Advance Registered Practice Nurse (APRN) visit notes on 09/06/2024 at 4:02 PM, for Resident #15, revealed a medically necessary visit related to recurrent falls and admitted to facility after hospital stay from 08/31/2024 to 09/06/2024. Resident #15 was found to have a cervical fracture at C1 and nasal bone fracture. ROS revealed, not oriented to time, place, or person with recent memory and remote memory abnormal. Opioid medication refilled for osteoarthritis. Orders included physical therapy, occupational therapy and speech therapy. During a concurrent observation and interview on 12/07/2024 at 10:38 AM, Resident #22 lying in bed, cervical collar noted to neck. CNA #30 stated the resident had a fall and had a neck fracture at C2. CNA #30 was not aware of when the fall occurred. Review of Incidents by Incident Type, dated 12/01/2024 to 12/07/2024, revealed Resident #22 had a witnessed fall on 12/03/2024. Review of Witnessed Fall #5931 revealed CNA #31 was assisting Resident #22 back to room, in wheelchair, and resident fell , striking forehead causing 4 cm laceration. Resident sent to ER per physician order. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the (Hospital) Emergency Department (ED), visit dated 12/03/2024, revealed Resident #22 arrived via ambulance related to fall from wheelchair with 2 cm laceration to forehead and skin tear to right hand. Reported somehow fell forward out of wheelchair earlier in the day striking forehead. Diagnoses revealed an acute (closed fracture of cervical spine odontoid (C2 [second bone/vertebra in the neck]) and 2 cm x 4 cm laceration to forehead. Review of Progress Note Nsg I&A DON Follow Up, dated 12/09/2024, revealed Resident #22 had a 6 cm x 4 cm laceration, after falling out of wheelchair in hallway, hit forehead, physician notified, and order received to send to ER. A review of the Admission Record, indicated the facility admitted Resident #22 with diagnoses that included late onset senile dementia, anxiety disorder, restlessness and agitation, and right hip pain. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/24/2024, revealed Resident #22 had a Staff Interview for Mental Status (SAMS) score of 3 which indicated the resident was severely impaired for daily decision making. Resident #22 exhibited physical and verbal behavior symptoms, required partial/moderate assistance with eating and oral hygiene, required substantial/maximal assistance with toileting, shower/bathing, dressing, putting on/taking off footwear and personal hygiene. Required substantial/maximal assistance with bed mobility, position changes, and transfers; utilized a wheelchair for mobility with supervision to moderate assistance. Active diagnoses included senile dementia, anxiety disorder, right hip pain, and no pain during the assessment period. Falls included 2 without injury. Medications included antianxiety, antidepressant and opioid. A review of Resident #22's Care Plan revised on 10/23/2024, revealed Resident #22 had an activity of daily living (ADL) self-care performance deficit related to dementia and impaired balance and required assistance of 2 staff to move between surfaces. Resident #22had limited physical mobility and required a wheelchair with assistance of 1 staff for locomotion. A goal to remain free of complications related to immobility and fall related injury was initiated on 12/04/2024; Resident #22 had an actual fall on 12/03/2024. Interventions initiated on 12/04/2024 included: leaning forward and resting arms on thighs while sitting in wheelchair, providing supportive assistance with mobility as needed, specialized chair to provide comfort and support due to poor trunk control. A review of Order Summary, revealed Resident #22 had an order to admit to the secured unit, comfort care, send to ER for laceration to forehead on 12/03/2024, antianxiety medication, anticonvulsant, opioid concentrate, and an antidepressant. During an interview on 12/08/2024 at 11:00 AM, LPN #1 stated, during report, received information that Resident #22 fractured their neck when they face planted out of the wheelchair on to the floor during transportation by staff. During an interview on 12/11/2024 at 09:50 AM, the Administrator stated there were falls involving Resident #15 and Resident #22, with major injuries. One fall, Resident #22 was witnessed during care, and Resident #15, unwitnessed, was found sitting on the floor with one sock on, and one off and we considered it a slip and fall. No investigation and no report to the State Agency was done on falls as they were not considered injuries of unknown origin. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 12/07/2024 at 10:40 AM, Resident #24 lying in bed supine with knees bent, feet flat on mattress, bruising (purple/blue) noted to lateral left knee, left eye, temporal area, cheekbone to jaw (deep purple, green, yellow). CNA #30 stated resident had a lot of falls and tried to keep resident comfortable. CNA #30 did not know when bruises or last fall occurred. Review of Progress Note, dated 11/30/2024 at 6:30 AM, revealed Resident #24 was on the floor with knees bent, inside secure unit, back to door, one small lump and one large lump on left side of forehead assisted resident into wheelchair. APRN #11 notified. Review of Progress Note, dated 11/30/2024 at 2:16 PM, revealed Resident #24 was on the floor of TV room on buttocks scooting self, nonskid socks in place, brief wet, care provided, hospice notified. Review of Incidents by Incident Type, dated 12/01/2024 to 12/07/2024, revealed no fall information for Resident #24. Review of the Admission Record, indicated the facility admitted Resident #24 with diagnoses that included: Insufficient blood flow to the brain, a progressive disease that destroys memory and other mental functions, and major depressive disorder. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/17/2024, revealed Resident #24 had a Staff Interview for Mental Status (SAMS) score of 3 which indicated the resident was severely impaired for daily decision making. Resident #24 required setup/cleanup assistance with eating; supervision/touch assistance with oral hygiene; substantial/maximal assistance with toileting, shower/bathing, dressing, putting on/taking off footwear, and personal hygiene; was independent with bed mobility and transfer from lying to sitting, sitting to standing and bed to chair and chair to bed transfers; supervision or touch assistance with toilet transfer and was independent with ambulation and did not require the use of assistive devices. Active diagnoses included depression, decreased blood flow to the brain, and a progressive disease that destroys memory and other mental functions. Health conditions included two falls without injury and two falls with injury. Medications included antipsychotic, antianxiety, antidepressant and opioid, and was currently on hospice care. Review of Resident #24's Care Plan revised on 10/21/2024, revealed Resident #24 had behavioral indicators that included hitting and moving furniture; communication problem; potential for skin tear; actual falls; and cognitive impairment. Interventions included: anticipation of needs, administer and monitor medications, distraction including validation, talk about family and boys, beauty shop; anticipate and meet needs; identify causative factors and eliminate when possible; nonskid socks, toileting every 2 hours while awake, continue to monitor injury related to sitting or crawling on floor, ensure recliner foot rest is down when unoccupied, be in high observation areas for safety, review medications, non-skid strips to floor by bed; and use visual cues, positive approach techniques, engage in conversation. Review of Order Summary, revealed Resident #24 had active orders for hospice services, secure unit, skin tear treatment to left hand and elbow, opioid for pain, and antianxiety medications. During an observation on 12/07/2024 at 11:40 AM, Resident #26 was lying in bed, rubbing their left thigh area, requesting pain medication and (Name Brand) topical pain gel for left leg. Resident #26 stated they had not received medication today. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Jamestown Nursing and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 Hampton Place Rogers, AR 72758	

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the Admission Record, indicated the facility admitted Resident #26 with diagnoses that included polyneuropathy (condition affecting peripheral nerves causing pain, burning and numbness in the arms and legs), depression, hypothyroidism, chronic lymphocytic leukemia (cancer of the blood and bone marrow with symptoms of swollen lymph nodes, bruising, and pain) not in remission, hypertension, and pain. A review of Medication Administration Record, revealed Resident #26 had medications ordered at 8:00 AM that included, an oral hormone replacement tablet, an external pain patch to left thigh, 2 different oral antihypertensive tablets, an oral opioid for pain and the pain assessment level was documented as 0, an antianxiety tablet, two capsules for neuropathy. All 8:00 AM medications indicated they were provided to Resident #26. No PRN (as needed) medications were documented as administered. Blood pressure monitoring done during the 7a-7p shift indicated a reading of 152/60. Readings from 12/1/2024 to 12/6/2024 during the 7a - 7p shift were 143/76, 120/77, 132/72, 124/62, 126/78, and 118/68 respectively. Administration of the second dose of anxiety, neuropathy, and topical pain medications were changed. A review of the Medication Administration Audit Report, dated 12/11/2024 at 1:35 PM, for all medication, 7A-7P shift, revealed Resident #26 received the hormone replacement medication at 10:21 AM, one antihypertensive medication was given at 10:23 AM, and the opioid pain medication was given at 10:25 AM, the antianxiety tablet was given at 10:21 AM, capsules for neuropathy were given at 10:21 AM, the external pain gel was applied at 10:27 AM, one antihypertensive medication was given at 10:27 AM, and the pain patch was applied at 10:32 AM. Second dose of the opioid pain medication was given at 6:29 PM, the antianxiety tablet was given at 1:26 PM, the neuropathy medication was given at 1:26 PM, and external pain gel was applied at 1:32 PM and not adjusted based upon the actual administration time of the first dose. A review of the controlled drug sign-out book, page 109, revealed Resident #26 ' s controlled opioid pain medication was signed out on 12/07/2024 at 10:00 AM by Social Services Discharge Nurse (SSDN). During an interview on 12/07/2024 at 11:51 AM, the SSDN stated Resident #26 had received pain medication that included the opioid and 2-acetaminophen as well as the topical pain gel, earlier. The SSDN stated she was the On Call this weekend and did not start medication until 8:00 AM due to the number of call-ins, trying to find coverage for the shift, and getting report from night shift. The SSDN stated she had to cover as the floor nurse for a 12-hour shift Saturday and Sunday due to the weekend nurse that worked the shift was no longer working at the facility. The SSDN stated she was responsible for residents on the right side of 500 hall from room [ROOM NUMBER] all the way down hall to the end and back up the left side of the hall to room [ROOM NUMBER], and all residents on 600 hall. The SSDN stated there were 2 CNAs currently on 400 hall, 500 hall, and 600 hall. However, upon arrival for the shift, SSDN stated there were 2 CNAs on 400, 1 CNA on 500, 1 CNA on 6 hall, and 2 nurses for 400, 500 and 600 halls. SSDN stated there were usually 2 nurses and they split 500 hall, and the nurses were trying to help with residents due to only 1 CNA on 500 and 1 CNA on 600 hall. The Director of Nursing (DON) was working to find more help, and CNAs were moved around to have enough for 400, 500, and 600 halls. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/11/2024 at 12:12 PM, the DON stated it had been a hectic day, someone was sent out to the hospital. We are dealing with humans and some people need more time. The nurse needed to call the doctor, needed reeducation on time management, and needed to ask for help. Resident #26 should have received the antihypertensive and opioid pain medication on time because the consequences of giving a twice daily blood pressure medication late, could cause blood pressure medications to be given too close together it could bottom them out (cause blood pressure to drop too low) and late pain medications could cause the resident to be in pain longer than they should be. During an observation on 12/07/2024 at 11:35 AM, Resident #27 stated they had not received their morning medications and was asking for a nurse. LPN #14 overheard Resident #27 from the hallway and stepped into Resident #27's room and stated she would return shortly with medications. A review of the Admission Record indicated the facility admitted Resident #27 with diagnoses that included hypothyroidism, major depressive disorder, anxiety, and pain. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/21/2024, revealed Resident #27 had a BIMS score of 15 which indicated the resident was cognitively intact. Resident #27 required substantial to maximum assistance with oral hygiene, bathing, personal hygiene, and dressing; required setup/cleanup assistance with eating; required substantial to maximum assistance with wheelchair mobility. Active diagnoses included hypertension, anxiety, depression, and pain occasionally interfering with sleep and day to day activities. Current medications included antianxiety, antidepressant, and opioid. A review of an Order Summary, revealed Resident #27 was to receive a daily antidepressant, an opioid pain medication twice daily, a thyroid hormone replacement daily, an antihypertensive twice daily, and an antianxiety medication twice daily. A review of the Medication Administration Record, revealed Resident #27 had medications ordered at 8:00 AM that included, oral antidepressant capsules, an oral opioid pain medication and the pain assessment level was documented as 0, an oral thyroid replacement tablet, an oral antihypertensive tablet, and an oral antianxiety tablet. All 8:00 AM medications indicated they were provided to Resident #27. No PRN medications were documented as administered. A review of the Medication Administration Audit Report, dated 12/09/2024 at 4:50 PM, for all administration, all shift, all documented, revealed Resident #27 received the antidepressant at 12:29 PM, the opioid pain medication at 12:31 PM, the thyroid hormone replacement at 12:29 PM, the antihypertensive at 12:27 PM and the antianxiety medication at 12:29 PM. Time of administration of the second doses of twice daily medications were not adjusted. During an interview on 12/07/2024 at 11:22 AM, Licensed Practical Nurse (LPN) #14 stated they were responsible for all residents on 400 hall and 4 rooms on 500 hall. LPN #14 [TRUNCATED]

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42016 Based on interview and record review, the facility failed to ensure a newly admitted resident, who continued to refuse activity of daily living (ADL) care and assistance, and assessment and treatment for pressure wounds, and all available remedies were provided to ensure the resident's mental and psychosocial health did not continue to deteriorate for 1 (Resident #1) of 8 residents reviewed for mental and psychosocial health, as evidenced by the failure to ensure a newly admitted resident's wounds were assessed, monitored, and treated to prevent death. 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, 483.40 (Behavioral Health) at a scope and severity of J. The IJ began on [DATE], when Resident #1 began refusing wound care, and the facility failed to provide effective interventions to alleviate declines in the resident's mental and psychosocial health that would potentially allow staff to provide needed care. The Administrator and Nurse Consultants were notified of the IJ on [DATE] at 9:56 PM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on [DATE] at 9:13 PM. The IJ was removed on [DATE] at 5:30 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Findings include: A review of a facility policy titled, Resident Rights, revised on [DATE], indicated facility staff were trained on resident rights and involved in the implementation of the policy and procedure. Residents have a right to be informed of their health, medical condition and treatment, participate in or refuse treatment, be advised of alternative care and treatments and their consequences. Residents have the right to 15. Receive adequate and appropriate medical care, nursing care, protective and support services, and personal cleanliness in a safe and clean environment. 22. Be transferred or discharged on ly for medical reasons, for your welfare or that of others . 33. Be free from physical abuse and neglect . On [DATE] at 12:25 PM, the Administrator stated the facility did not have a policy for wound care, the Medical Director was an independent contractor, and the facility does not have a job description for the Medical Director. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the job description for Administrator described the position was to manage and direct the day-to-day operations of the facility, learn and implement state and federal regulations. Responsibilities of the position included resident safety, reviews complaints and grievances, maintain written policies and procedures, assist department head with eliminating and correcting problem areas. Review of the job description for the Director of Nursing (DON) described the position responsibilities included assuring resident safety, day to day operation and management of the nursing department and working closely with the Administrator regarding coordination of resident services and functions of the nursing department. Review of the job description for the Assistant Director of Nursing (ADON) described the position responsibilities included assuring resident safety and day-to-day operations of the nursing department, meeting with team members regarding coordination of resident services. Review of the job description for the Charge Nurse described the position responsibilities included assuring resident safety; perform nursing services for the comfort and well-being of the residents; check residents daily to determine status, assess, record, and report changes in residents' condition to supervisor and attending physician; complete treatment orders; complete skin audits; identify nursing problems and respond and initiate immediate action; communicate problems to DON; provide emergency care to residents; assess resident needs and provide input for care. Review of the job description for the Treatment Nurse described the position responsibilities included assuring resident safety; completing treatment orders; assist and complete skin audits; safety of residents; identify safety hazards and special nursing problems and initiate immediate action; communicate problems and needs in nursing department; assess and report changes in resident condition and take follow-up action as necessary; provide emergency care to residents; assess resident's needs and provide input. Review of the job description for Certified Nursing Assistant (CNA) described the position responsibilities included assuring resident safety; identify resident problems and concerns and report them immediately to charge nurse or a licensed nurse; report changes in residents' condition. A review of the Medical Director Retainer Agreement with an effective date [DATE] described, the duties of the Medical Director included guidance and oversite in the development and implementation of resident care policies that reflect current standards of practice; responsible for coordination of medical care in the facility; identifying, evaluating, and resolving medical and clinical concerns and issues affecting resident care, medical care or quality of life or were related to the provision of services by physicians and other licensed health care practitioners. Medical care through medical doctors, Advanced Practice Registered Nurse (APRN)'s, and telehealth services provided by the contracted provider limited liability company. A review of the medical director statement, provided by the Administrator, dated [DATE], described the physician designated as the Medical Director, was not the physician named as the Medical Director in the Medical Director Retainer Agreement, as the agreement was between the limited liability company and the facility and not with the individual provider. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Admission Assessment Communication, dated [DATE], revealed Resident #1 was a hospital referral for possible long-term care (LTC) placement. Nursing information included Resident #1 required maximum assistance of two for rolling over in bed and moving from a laying to sitting position; required assistance with oral hygiene; maximum assistance toileting and perineal care, and was incontinent at times; mechanical lift for transfers and no restrictions on ambulation; cognitive status was alert and oriented; had a sacral decubitus ulcer (pressure ulcers that appear on the skin over a bony region of the spine called the sacrum); required a wheelchair; had a mood disorder and was receiving medication. A review of the Level I Preadmission Screen, also known as the CMS-787, with a completion date of [DATE], indicated Resident #1 had a diagnosable major mental disorder indicated as panic or other severe anxiety disorder. A review of the Report of Disability Examination, also known as the DCO-0107S, with a signed date of [DATE], indicated a medical history that included severe morbid obesity, unspecified mood disorder, and chronic pain. Pain with movement classified as 10 on a scale of ,d+[DATE], 10 being the worst. Medications listed included a serotonin reuptake inhibitor (antidepressant), a selective serotonin reuptake inhibitor (antidepressant), two antihypertensives, a skeletal muscle relaxant, oral opioid, opioid analgesic patch, and three medications for elevated blood sugar. A check box response to the question, Has the patient followed treatment recommendations? was No. Comments indicated Multiple instances - refusal of Care. A review of the Medical Review Team (MRT) Social Report for Adults, also known as the DCO-0108S, with an application date of [DATE] indicated Resident #1's illness, injury, or conditions limiting ability to work or perform household activities included, chronic pain described as constant pain with treatment that included wound care and pain medication. MD #1 and APRN #11 were listed as physicians seen by Resident #1 in the past year, and Resident #1 was hospitalized from [DATE] to [DATE]. A review of the Hospital Medical Discharge Summary, with a discharge date d of [DATE], indicated Resident #1 had morbid obesity, was chronically bedbound related to deconditioning and not moving much, implanted catheter, poor social living scenario, and chronic pain. A note dated ,d+[DATE] indicated resident continued to refuse physical therapy and turning and there was a high concern for continued decline with refusal to comply. A note on ,d+[DATE]-,d+[DATE] indicated Resident #1 had not been compliant with any activity. Instructions included wound care to peri and gluteal area. A review of the Admission Agreement, signed by Resident #1 on [DATE], indicated due diligence would be used by the facility to obtain the services of a physician when the resident's condition requires such medical attention and would attempt to obtain the services of another physician if resident's personal physician was unavailable. Further, the facility would obtain, at the discretion of the physician or the facility, ancillary services, such as physician or ambulance services, deemed necessary for the health and welfare of the resident. A review of the Acknowledgment of Receipt of Advanced Directive Information-Resident, signed by Resident #1 on [DATE] indicated, Resident #1 chose to have continued administration of all possible medical treatment, as ordered by the physician, to prolong life to the greatest extent possible without regard to condition, chance of recovery, or expense. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Capacity Verification, dated [DATE] did not indicate a capacity and was signed by the resident and an unidentified facility representative. A review of the Admission Record, indicated the facility admitted Resident #1 on [DATE] with diagnoses that included pressure ulcer of the sacral region, Type 2 diabetes mellitus, malaise, morbid obesity, mood affective disorder, and chronic pain. A review of the admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], indicated Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Resident #1's cognitive patterns for the BIMS score were based on the ability to repeat three words on first attempt; correct response to the current year; correct response to the current month, within five days; correctly identify the day of the week; and recall the words sock, blue, and bed with no cueing. Resident #1's mood interview, sections C through I were not completed related to negative symptom responses to the first two questions, and a total severity score indicated 00. Social isolation indicated Never. Section E - Behavior indicated Resident #1 had no physical, verbal, or other behavioral symptoms that included self-injury, throwing or smearing food or bodily wastes, and verbal/vocal symptoms. No refusal of care was indicated. Resident #1 indicated it was very important to take care of personal belongings, choose type of bathing, choose bedtime, have family or a close friend involved in discussions about care, have reading materials, listen to music, and go outside for fresh air. Resident #1 had impairment of bilateral lower extremities, used a wheelchair for mobility, was dependent on staff for toileting and dressing; required substantial/maximal assistance with oral hygiene and personal hygiene; required setup/cleanup assistance with eating; and refused shower/bathing self. Resident #1 was dependent on staff to roll left and right, refused to sit up, refused to transfer to a chair, refused to use wheelchair, and refused to transfer for a tub or shower. Resident #1 had an indwelling catheter and was continent of bowel. Active diagnoses were identified as diabetes mellitus, morbid obesity, mood affective disorder, and chronic pain described as occurring frequently and not interfering with daily activities. Prognoses of life expectancy of less than 6 months indicated no. Skin condition indicated a stage IV pressure ulcer (most severe stage, significant tissue loss, damage extends through all layers of skin exposing muscle, tendon/bone, high risk of infection) was present on admission and Resident #1 was at risk of developing pressure ulcers. Resident #1 medications received included an antidepressant and opioid. Resident #1 had a goal to remain in the facility and not return to the community. Care areas identified included activities of daily living (ADL) functional/rehabilitation potential; urinary incontinence and indwelling catheter; falls; nutritional status; dehydration/fluid maintenance; pressure ulcer; psychotropic drug use; and pain. A review of the significant change MDS, with an ARD of [DATE], indicated changes from the admission MDS included the following: Resident #1 exhibited behavior described as worsening for rejection of care occurring daily. Resident #1 refused shower/bathe, dressing, rolling left or right in bed, and any transferring; required supervision with oral hygiene. Resident #1 was always incontinent of bowel. Pain was described as effecting sleep, interfering with therapy activities, and day to day activities almost constantly, and rated as a 10 on a scale of ,d+[DATE] with 10 being the worst pain imagined. Resident #1 did not receive scheduled pain medication. Medications included an antibiotic. Care areas identified included cognitive loss/dementia and behavioral symptoms. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #1's care plan with a resolved date of [DATE], indicated Resident #1's code status as full code, wanting cardiopulmonary resuscitation. Interventions included providing the opportunity for resident to discuss feelings and ask questions related to end of life decisions and review code status; and a change in code status to do not resuscitate (DNR) with interventions that included checking for resident signature on consent form; verify physician order; review code status with resident annually and as needed; acknowledge right to revoke DNR status; and a. Resident #1 had contact isolation due to wound and wound myiasis (a parasitic infection that occurs when fly larvae [maggots] burrow into the skin of a live animal and feed on its tissue) related to refusal of wound care. Interventions included pest control with a fly light trap, treatment of myiasis as ordered by physician, and wound care as ordered by physician resident refused; and b. Resident #1 had an ADL self-care performance deficit related to chronic pain, refusing ADL care, turning, wound treatment, incontinent care and catheter care. Interventions included, resident was totally dependent on 2 staff for bathing/showering, mobility, dressing, toileting, transferring with mechanical lift, was bedfast, used bedrails for independence with turning and positioning, dependent on 1 staff for personal and oral hygiene, required skin inspection and was to be observed for redness, open areas, scratches, cuts, bruises and report changes to nurse; and c. Resident #1 exhibited behaviors that included rejection of care with interventions that included providing staff training on behaviors, notification to the physician of changes in behavior, and administering and monitoring effectiveness of medications; and d. Resident #1 was resistant to care evidenced by refusal of care, to be repositioned, refused skin assessments and treatments. Interventions included allowing Resident #1 to make decisions about treatment to provide sense of control, educate on outcome of non-compliance, encourage participation during care activities, clearly explain care activities prior to contact, negotiate ADL care times to allow resident participation, change approach if Resident #1 becomes agitated and notify charge nurse of situation; and e. Resident #1 had no impaired cognitive function/dementia based on BIMS score of 15, would remain oriented to person, place, situation and time, and would maintain current level of decision-making ability. Interventions included engaging in pleasant topic conversation prior to initiating care; and f. Resident #1 was receiving opioid pain medication therapy with interventions that included administering medication as ordered by physician and monitoring side effects of the medication; and g. Resident #1 had antidepressant medications related to affective mood disorder with interventions that included administering medications as ordered and monitoring side effects and effectiveness every shift. A black box medication warning indicated observation and monitoring for suicidality, unusual changes in behaviors, and clinical worsening; and h. Resident #1 had a mood problem related to mood affective disorder with interventions that included behavioral health consults, monitoring for irritability, mood changes, and agitation; and (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	i. Resident #1 had chronic pain with interventions to anticipate need for pain relief, evaluate effectiveness of interventions, monitor for non-verbal pain, mood/behavior changes and review impact on functional ability and impact on cognition; and j. Resident #1 had a pressure ulcer to coccyx/sacrum and potential for development of pressure ulcers and refused treatment that included wound care, turning and repositioning, wound assessments per protocol and full skin assessments. Goals included healing of the pressure ulcer, remain free of infection, and maintain or develop clean intact skin. Interventions included administration of medication and treatments as ordered, educating resident on causes of breakdown and frequent positioning; and k. Resident #1 had an indwelling catheter. Interventions included changing catheter as ordered, resident refused catheter changes and care; monitor and report signs and symptoms of urinary tract infection, that included foul smelling urine, altered mental status, change in behavior. Resident #1 refused a follow up urology appointment. A review of Order Summary Report, with active orders as of [DATE], indicated Resident #1 had a pain assessment every shift with a start date of [DATE]; treatment of coccyx wound daily and as needed with a start date of [DATE]; an antidepressant daily for mood affective disorder, with a start date of [DATE]; oral opioid pain medication every 4 hours as needed for severe pain with a start date of [DATE]; an opioid pain medication every 4 hours as needed for pain; an antidepressant at bedtime for mood affective disorder, with a start date of [DATE]. A review of the Order Summary Report, of discontinued orders, with an order date of [DATE], indicated a psych referral, for 1 day, one time only for refusing care. The end date was [DATE], the order status was completed. A review of the Order Summary Report, of discontinued orders, with an order date of [DATE], indicated a referral to mental health clinic for depression, one time only for 4 days. The end date was [DATE], the order status was completed. A review of the Order Summary Report, of discontinued orders, with an order date of [DATE], indicated an antiparasitic medication, 4 tablets by mouth one time a day for 3 days related to wound myiasis. The end date was [DATE], the order status was completed. A review of the Nsg (Nursing) Admit/Readmit/Quarterly Assessment, dated [DATE] indicated a skin assessment integrity comment, Stage four noted to residents (sic) coccyx with wet to dry treatment in place. Sensory Perception indicated Resident #1's ability to meaningfully respond to pressure related discomfort was slightly limited, was able to respond to verbal commands, cannot always communicate discomfort or the need to be turned OR has some sensory impairment limiting the ability to feel pain or discomfort in 1 or 2 extremities. Resident was bedfast and had very limited mobility and was unable to make changes independently and was at moderate risk for dehydration. Cognition did not identify current psychiatric diagnoses or behavioral problem. Neurological assessment indicated resident was alert and oriented to person, place, time, and situation and was verbally appropriate. Resident #1 indicated pain occurred frequently in the last 5 days affecting sleep and day to day activities, and current pain was severe and rated it a 10 on scale of ,d+[DATE]. No behaviors were documented. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Jamestown Nursing and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 Hampton Place Rogers, AR 72758	

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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 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Nsg Admit Skin Audit, dated [DATE] indicated Resident #1 had bruising to right and left antecubital areas related to IV (intravenous needle) sticks, dry skin, and a stage 4 wound to coccyx. A review of the Nsg Functional Abilities and Goals-Admission, with an effective date of [DATE] indicated Resident #1 had bilateral lower extremity impairment, required a wheelchair for mobility and was dependent for manual wheelchair use, required substantial/maximal assistance with personal hygiene, was dependent for toileting, dressing, rolling left and right, sitting to lying, lying to sitting, transferring from chair to bed and bed to chair, refused to stand from seated position, and refused shower/bathing. A review of the Nsg Functional Abilities and Goals-Interim, with an effective date of [DATE] indicated Resident #1 had no functional impairment of the upper extremities, had bilateral impairment of the lower extremities, utilized no devices for mobility, required substantial/maximal assistance with personal hygiene, was dependent with toileting hygiene, and refused shower/bathing, dressing, mobility that included rolling left and right, sit to lying and lying to sitting on side of bed, sit to standing, chair to bed and bed to chair transfer, toilet transfer, tub/shower transfer, was not assessed for walking or use of wheelchair. A review of Medication Administration Record (MAR), for [DATE] ([DATE] through [DATE]) indicated Resident #1 had pain documented 9 times above a level of 0, with medication administered. A review of Treatment Administration Record (TAR), for [DATE] indicated Resident #1 refused to allow wound care [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. No as needed (PRN) wound care was documented. A review of MAR, for [DATE] indicated Resident #1 had an opioid transdermal patch applied [DATE] every 72 hours with a dosing change on [DATE]. Refused urinary catheter to be changed on [DATE]. Refused weekly weight on [DATE], [DATE], and [DATE]. Pain was assessed 24 times above a level of 0, with medication administered. A review of TAR, for [DATE] indicated Resident #1 refused wound care 29 days. No PRN wound care was documented. Psych referral was documented as done on [DATE]. A review of MAR, for [DATE] indicated Resident #1 had pain was assessed 14 times above a level of 0, with medication administered. A review of TAR, for [DATE] indicated Resident #1 refused wound care 30 days. No PRN wound care was documented. A review of MAR, [DATE] indicated Resident #1 refused urinary catheter to be changed on [DATE], antiparasitic tablets administered on [DATE], [DATE], and [DATE]; was received a diuretic daily for fluid overload on [DATE] through [DATE]. Pain was assessed 20 times above a level of 0, with medication given. An antibiotic was administered three times a day for 7 days for wound myiasis. A review of TAR, [DATE] indicated Resident #1 refused wound care to coccyx for 31 days and had a new order for wound care on bilateral lower extremities and refused care. No PRN wound care was documented. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of MAR, [DATE] indicated Resident #1 had catheter changed however, progress notes documented refusal of care and did not address the catheter. Pain was assessed 25 times above the level of 0, medication was not administered 5 times for pain levels of ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and ,d+[DATE], due to blood pressure being below 100 systolic. A review of TAR, [DATE] indicated Resident #1 refused wound care to coccyx and wound care to bilateral lower extremities for 30 days. A review of MAR, [DATE] indicated Resident #1 began intermittent refusal of oral medications. Pain was assessed 32 times above the level of 0, with medication administered. A review of TAR, [DATE] indicated Resident #1 refused wound care to coccyx and wound care to bilateral lower extremities for 23 days. On [DATE], Resident #1 was seen by APRN #11 for hospital follow up. Reviewed problems included Type 2 diabetes mellitus (DM), morbid obesity, anxiety, panic disorder with agoraphobia, depressive disorder, chronic pain, pressure injury of buttock, open wound of buttock, and pain in right hip joint. History of present illness (HPI) included Urinary catheter surgically implanted, denies depression. Physical examination indicated morbid obesity and limited ambulation. Psychiatric mental status was normal mood and lethargic; was oriented to time, place, and person. Musculoskeletal indicated limited range of motion (ROM) and right hip pain. Assessment plan included: DM, chronic pain continue opioid; depressive disorder continue antidepressant. Open wound of buttock was not assessed. On [DATE], Resident #1 was seen by APRN #4 for open wound assessment. Reviewed problems included unstageable pressure injury, open wound of buttock with complication, pain right hip joint. HPI included reported stage 4 pressure ulcer to coccyx, present on arrival to facility. Visit was first wound care visit. unable to access Stage 4 pressure ulcer to coccyx and other unknown wounds as patient currently refuses to turn for full body skin assessment. Resident reported due to pain, would turn once per day when goes to the bathroom. Review of system (ROS) indicated unable to assess wounds. Orders given for wound care, if unable to perform tele visit at time of turning. On [DATE], Resident #1 was seen via telemedicine by APRN #22 for report of change in condition, HPI indicated expired opioid order, pressure ulcer required dressing change, and pain at wound site during wound care. ROS included mental status as active and alert. Assessment/Plan was chronic pain with a change in opioid medication. On [DATE], Resident #1 was seen by PCP as new admission. The problem list included morbid obesity, heart failure, DM type 2, hypertension, malaise, mood affective disorder, and chronic pain. HPI included incontinent of bladder, continent of bowel, mood stable without behavioral problems, and was compliant with medications and care. Functional assessment indicated one person assist for ADLs and transfers. ROS included no anxiety or depression. Assessment/Plan included depressive disorder - continue antidepressant, impaired ADLs - assist and monitor, degenerative joint disease (DJD) - continue pain control with opioid, assist with ADLs and monitor, moderate to severe frailty syndrome - bedbound, assist with ADLs and monitor, sarcopenia (muscle loss) - assist with ADLs and monitor, poly-pharmacy - educate on medication interaction/adverse effects and monitor for adverse effects. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], Resident #1 was seen by APRN #11 for follow-up on chronic pain. HPI indicated follow up for sacral ulcer, refusing bed and incontinence changes, wound care and repositioning related to pain. ROS indicated psychiatric mental status was active and alert and normal mood, oriented to time, place, and person. Assessment/Plan indicated chronic pain, continue oral opioid and PCP ordered opioid transdermal patch. On [DATE], Resident #1 was seen by PCP for acute visit for toenail care. ROS and Exam indicated skin had no rash, itching or skin changes and was warm dry (W/D) and intact. Assessment and plan included pressure ulcer on coccyx - resident does not want to be rolled due to pain. Continue facility wound care and Monitor for infection. DJD indicated staff reporting refusal of care due to pain; resident reports pain in hips, back and bilateral knees, educated on taking medication to stay ahead of pain, resident reported still has pain 40 minutes after taking medication; educated on importance of care compliance; opioid patch ordered for pain. On [DATE], Resident #1 was seen by PCP for acute visit for toenail care. HPI indicated mood stable with no behavioral problems and was compliant with care. Exam included psychiatric evaluation described as calm, cooperative, alert and oriented (AO) x 3 (indicating person, place, situation), and follows commands. Assessment/Plan indicated facility was unable to access wound due to refusal, resident does not want to be rolled. Staff reported refusal of all care. Provided options if continued refusal of care that included comfort care and transfer to another facility. Continue facility wound care. Opioid patch dose increased; oral opioid medication added. On [DATE], Resident #1 was seen by PCP for annual wellness visit. ROS indicated no joint pain, joint swelling, or restricted movements. Psychiatric indicated no anxiety or depression. Physical findings included, psychiatric as calm, cooperative, AOx3, and followed commands. Assessment indicated normal routine history and physical senior citizen (,d+[DATE]). (Resident #1 was [AGE] years old.) A PHQ (patient health questionnaire) -9 score (screening, diagnosing, monitoring, and measuring severity of depression) was performed with a score of 9.0 indicating mild depression. Counseling/Education included nutritional needs, resident verbalized/demonstrated understanding of medical condition and disease process, educated on proper diet, proper use of medications and hygiene. Plan indicated wound had not been assessed due to resident refusal due to pain when rolled, staff reported refusal of all care. Continue facility wound care, monitor for infection, Not knowing what the wound looks like, send to emergency room (ER) for evaluation, referred to psych for evaluation. DJD indicated resident refused care due to pain, refused to allow staff to change after incontinent episode, refused wound care, resident refused PRN medications for pain, stated hurts too much to roll over for care. Opioid patch discontinued. Medication continued for depressive disorder. Review of Informed Consent to Refuse Treatment and /or Services, dated [DATE] indicated Resident #1 signed the informed consent, at 2:53 PM, that outlined the PCP orders for daily wound care to coccyx, turning and repositioning, incontinent care, bathing, skin/wound assessments, body audits, bariatric bed, specialty mattress, and trapeze bar. Resident provided with the benefits and results of refusal up to and including death. Review of a Progress Note, dated [DATE] at 07:55 AM, indicated Resident #1 rejected care and the nurse was advised to try to determine reason care rejected such as staff providing care being changed to male aides and to modify care plan as necessary. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Jamestown Nursing and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 2001 Hampton Place Rogers, AR 72758	

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] Resident #1 was seen by APRN #11 for anxiety. Resident refused repositioning, refused wound care evaluation by APRN care, and stated it was related to severe pain. PCP previously adjusted pain medication. No trends/patterns documented; no pain assessment performed; a Yes response to Has there been a recent workup related to this issue to rule out medical delirium was documented with no response to description of workup or diagnosis. ROS revealed resident had fatigue. Physical exam revealed psychiatric mental status was active and alert and normal mood. Assessment/Plan included depressive disorder, continued antidepressant and referred to mental health clinic. On [DATE] Resident #1 was seen via telemedicine by Psychiatric Mental Health Nurse Practitioner (PMHNP) #20 for staff reported behaviors of refusal of care. HPI contained no documentation regarding anxiety, panic disorder, or depressive disorder. Appearance documented as casually gloomed, good eye contact; mood indicated resident reported doing just fine. Affect was documented as euthymic (optimistic and in control); thought process documented as mostly linear (sequential logical order), [NAME][TRUNCATED]

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42016 Based on observations, interviews, record review, facility document review, facility policy review, it was determined that the facility failed to maintain an account of all controlled substances for 1 (Medication Cart 300-Hall) of 5 medication carts reviewed for accounting of controlled substances; and maintain a record of controlled substances for 4 Residents on 2 medication carts (Resident #20, Resident #21, Resident #22, and Resident #23) of 5 medication carts reviewed for accurate records; and it was determined that the facility failed to ensure resident medications were administered within the specified time to ensure continued therapeutic status was maintained for 3 (Resident #26, # 27 and #28) of 3 residents who stated medications were not received. Findings include: A review of a facility policy and procedure titled, Medications Oral, revised on 11/22/2016, indicated use of equipment and supplies that included the medication administration record (MAR), a medication cup and medication. The procedure indicated use of the equipment and supplies and identification of resident, explanation of procedure, positioning of resident to take medication, providing and encouraging water intake with medication, remaining with resident during medication administration, documenting information in the medical record and reporting unusual or abnormal findings to charge nurse. A review of the medication package insert for [brand name] (calcium channel blocker), with a revised date of 06/2014, described the indication for usage was to lower blood pressure as part of lowering cardiovascular risk. Concentrations in blood reach plateau in 6 hours of dose and fluctuate over the 24-hour dosing interval. Administration was according to the patient's needs. A review of the medication package insert for [brand name] tablets (a thyroid hormone replacement), with a revised date of 08/2005, described the indication for usage was to supplement or replace thyroid hormone due to hypothyroidism. The general principal goal of replacement therapy included achievement and maintenance of a normal state by individualized dosing. A review of the medication package insert for [brand name] (an opioid agonist), with a revised date of 03/2008, described the indication for usage was treatment of moderate to moderately severe pain. Concentration in blood reaches peak in two hours with a steady state (consistent concentration) in two days. Patient notification included understanding of the dose limit and time interval between doses due to depression of the respiratory system, seizures and death. A review of the medication package insert for [brand name] (an antianxiety agent), with a revised date of 11/2010, described the indication for usage was to treat anxiety. Patient information included taking the medication consistently to assure safe and effective use. A review of the medication package insert for [brand name] (an anticonvulsant), with a revised date of 04/2009, described it was used for neuralgia (pain caused by damaged nerves) and should be taken as prescribed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the medication package insert for [brand name] (a benzodiazepine), with a revised date of 03/2021, described indications for use that included: anxiety disorder, and should be taken exactly as your healthcare provider tells you to take it. A review of the medication package insert for [brand name]topical gel (dermatological NSAID), with a date of 07/2009, described indication for use of pain relief in joints such as knees and hands. Instructions that included: using medication exactly as prescribed, at the lowest dose and for the shortest amount of time. A review of the medication package insert for [brand name] (an ACE inhibitor), with a revised date of 12/2014, described the indication for use was treatment for hypertension and should be adjusted according to blood pressure response. A review of the medication package insert for [brand name] (an antidepressant), with a revised date of 12/04/2008, described the indications for use included: major depressive disorder, anxiety disorder, peripheral neuropathic pain, fibromyalgia, and chronic musculoskeletal pain. Therapy should be continued as directed. A review of the medication package insert for hydrocodone bitartrate and acetaminophen, with a date of 2009, described indications for use as severe pain management, using the lowest effective dosage based on patient treatment goals. The medication guide instructs to take exactly as prescribed. A review of the medication package insert for [brand name] (a beta-blocker), with a revised date of 11/10, described indications for use included: hypertension and dose should be individualized. At the end of a 12-hour dosing interval, blood pressure could rise. A review of the medication package insert for [brand name] (medication used to treat dementia related to Alzheimer ' s disease), with a revised date of 12/2018, described the indication for use was a form of dementia, and taken once daily as prescribed. If a dose was missed, take the next dose at the usual time. A review of the medication package insert for [brand name] (a Beta Blocker), with a revised date of 2/2008, described the indications for use included: hypertension. Information for patients included: taking regularly and continuously and if a dose was missed should only take the next scheduled dose. A review of the medication package insert for [brand name] (an oral NMDA blocker), with a revised date of 11/2018, described the indication for usage was moderate to severe dementia, and if dose was missed, should take the next scheduled dose. A review of the Admission Record, indicated the facility admitted Resident #26 with diagnoses that included: polyneuropathy (condition affecting peripheral nerves causing pain, burning and numbness in the arms and legs), depression, hypothyroidism, chronic lymphocytic leukemia (cancer of the blood and bone marrow with symptoms of swollen lymph nodes, bruising, and pain) not in remission, hypertension, and pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/13/2024, indicated Resident #26 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact. Resident #26 required setup/cleanup assistance with eating, oral hygiene, and personal hygiene; was independent toileting and bed mobility, required supervision or touch assistance with dressing and walking. Active diagnoses included: polyneuropathy, depression, hypothyroidism, cancer, hypertension, and experienced frequent pain that occasionally effected sleep, therapy activities, day to day activities, and required pain medication. Current medications included an opioid. A review of the Care Plan, revised on 08/27/2023, indicated Resident #26 had an Activity of Daily Living (ADL) self-care performance deficit related to impaired mobility and polyneuropathy; had pain medication therapy; exhibited behavioral indicators related to depression that included rudeness, sarcastic remarks, rejection of care, abusive language; had hypertension and would maintain a blood pressure within the normal parameters, remain free of signs and symptoms and complications; had hypothyroidism. Interventions included: providing assistance and administering medications as ordered by the physician. A review of an Order Summary, indicated Resident #26 had blood pressures monitored twice daily, an antihypertensive medication daily, a synthetic compound used to treat neurological condition three times daily, antianxiety medication three times daily, opioid pain medication twice daily, thyroid hormone replacement daily, topically patch for pain applied daily to left thigh, and a topical pain gel applied to knees three times a day. A review of the December Medication Administration Record (MAR), indicated Resident #26 had medications ordered on 12/07/2024 at 8:00 AM that included, an oral hormone replacement tablet, an external pain patch to left thigh, 2 different oral antihypertensive tablets, an oral opioid for pain and the pain assessment level was documented as 0, an antianxiety tablet, two capsules for neuropathy. All 8:00 AM medications indicated they were provided to Resident #26. No PRN (as needed) medications were documented as administered. Blood pressure monitoring done during the 7a-7p shift indicated a reading of 152/60. Readings from 12/1/2024 to 12/6 2024 during the 7a - 7p shift were 143/76, 120/77, 132/72, 124/62, 126/78, and 118/68 respectively. Administration of the second dose of anxiety, neuropathy, and topical pain medications were changed. A review of the Medication Administration Audit Report, dated 12/11/2024 at 1:35 PM, for the administration date of 12/07/2024, included all medication, 7A-7P shift, indicated Resident #26 received the hormone replacement medication at 10:21 AM, one antihypertensive medication was given at 10:23 AM, and the opioid pain medication was given at 10:25 AM, the antianxiety tablet was given at 10:21 AM, capsules for neuropathy were given at 10:21 AM, the external pain gel was applied at 10:27 AM, one antihypertensive medication was given at 10:27 AM, and the pain patch was applied at 10:32 AM. Second doses of the opioid pain medication was given at 6:29 PM, the antianxiety tablet was given at 1:26 PM, the neuropathy medication was given at 1:26 PM, and external pain gel was applied at 1:32 PM and not adjusted based upon the actual administration time of the first dose. A review of the controlled drug sign out book, page 109, indicated Resident #26 controlled opioid pain medication was signed out on 12/07/2024 at 10:00 AM by Social Services Discharge Nurse (SSDN). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/07/2024 at 11:40 AM, Resident #26 was lying in bed, rubbing their left thigh area, requesting pain medication and (Name Brand) topical pain gel for left leg. Resident #26 stated they had not received medication today. During an interview on 12/07/2024 at 11:51 AM, SSDN stated Resident #26 had received pain medication that included the opioid and 2-acetaminophen as well as the topical pain gel, earlier. The SSDN stated she was the On Call this weekend and did not start medication pass until 8:00 AM due to the number of call ins, trying to find coverage for the shift and getting report from night shift. The SSDN stated she had to cover as the floor nurse for a 12-hour shift Saturday and Sunday due to the weekend nurse that worked the shift was no longer working at the facility. The SSDN stated she was responsible for residents on the right side of 500 hall from room [ROOM NUMBER], all the way down hall to the end and back up the left side of the hall to room [ROOM NUMBER], and all residents on 600 hall. The SSDN stated there were 2 CNAs currently on 400 hall, 500 hall, and 600 hall. However, upon arrival for the shift, the SSDN stated there were 2 CNAs on 400, 1 CNA on 500, 1 CNA on 6 hall, and 2 nurses for 400, 500 and 600 halls. The SSDN stated there were usually 2 nurses and they split 500 hall, and the nurses were trying to help with residents due to only 1 CNA on 500 and 1 CNA on 600 hall. The Director of Nursing (DON) was working to find more help, and CNAs were moved around to have enough for 400, 500, and 600 halls. During an interview on 12/11/2024 at 12:12 PM, the DON stated it had been a hectic day, someone was sent out to the hospital. We are dealing with humans and some people need more time. The nurse needed to call the doctor, needed re-education on time management, and needed to ask for help. Resident #26 should have received the antihypertensive and opioid pain medication on time because the consequences of giving a twice daily blood pressure medication late could cause blood pressure medications to be given too close together and it could bottom them out (cause blood pressure to drop too low) and late pain medications could cause the resident to be in pain longer than they should be. A review of the Admission Record indicated the facility admitted Resident #27 with diagnoses that included hypothyroidism, major depressive disorder, anxiety, and pain. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/21/2024, indicated Resident #27 had a BIMS score of 15 which indicated the resident was cognitively intact. Resident #27 required substantial to maximum assistance with oral hygiene, bathing, personal hygiene, and dressing; required setup/cleanup assistance with eating; required substantial to maximum assistance with wheelchair mobility. Active diagnoses included: hypertension, anxiety, depression, and pain occasionally interfering with sleep and day to day activities. Current medications included: antianxiety, antidepressant, and opioid. A review of an Order Summary, indicated Resident #27 was to receive a daily antidepressant, an opioid pain medication twice daily, a thyroid hormone replacement daily, an antihypertensive twice daily, and an antianxiety medication twice daily. A review of the December MAR indicated Resident #27 had medications ordered on 12/07/2024 at 8:00 AM, that included oral antidepressant capsules, an oral opioid pain medication and the pain assessment level was documented as 0, an oral thyroid replacement tablet, an oral antihypertensive tablet, and an oral antianxiety tablet. All 8:00 AM, medications indicated they were provided to Resident #27. No PRN medications were documented as administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Medication Administration Audit Report, dated 12/09/2024 at 4:50 PM, for the administration date of 12/07/2024 included all administration, all shift, all documented, indicated Resident #27 received the antidepressant at 12:29 PM, the opioid pain medication at 12:31 PM, the thyroid hormone replacement at 12:29 PM, the antihypertensive at 12:27 PM and the antianxiety medication at 12:29 PM. Time of administration of the second doses of twice daily medications were not adjusted. During an interview on 12/07/2024 at 11:22 AM, Licensed Practical Nurse (LPN) #14 stated they were responsible for all residents on 400 hall and 4 rooms on 500 hall. LPN #14 has worked for facility 6 months and their normal schedule was 7a-7p Friday, Saturday, and Sunday. LPN #14 has been assigned to work on 400 and 500 halls for one month and usually has 2-3 CNAs with 1 CNA float for 400 and 500 halls. During an observation on 12/07/2024 at 11:35 AM, Resident #27 stated they had not received their morning medications and was asking for a nurse. LPN #14 overheard Resident #27 from the hallway, stepped into Resident #27's room, and stated she would return shortly with medications. During an interview on 12/11/2024 at 12:12 PM, the DON stated Resident #27 not receiving the antihypertensive, opioid pain medication, and antianxiety medication on time was not an effective way to give medications. The DON stated he contacted the provider and was told it was okay to give the medication. The DON stated if it had been him, he would not have been that far behind. A review of the Admission Record, indicated the facility admitted Resident #28 with diagnoses that included: depression, anxiety, hypertension, and neuralgia (pain caused by nerve irritation or damage). The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/15/2024, indicated Resident #28 had a BIMS score of 10 which indicated resident had moderate cognitive impairment. Resident #28 required setup/cleanup assistance with eating, oral hygiene, and personal hygiene; required partial to moderate assistance with toileting, showering and dressing of lower body; and required supervision/touch assistance with wheelchair mobility. Resident #28 active diagnoses included: hypertension, anxiety, and depression. A pain assessment was not completed. Resident #28 was receiving opioid pain medication. A review of Resident #28 ' s Care Plan, revised on 11/14/2024, indicated Resident #28 had a history of behaviors with interventions that included: anticipating and providing needs before resident becomes overly stressed; had impaired cognitive function/dementia as evidenced by the BIMS score; had hypertension; had depression; received a psychotropic medication for anxiety; had pain medication therapy; had a mood problem and depression; and had chronic pain. Interventions included: administering and monitoring the effectiveness of medications as ordered, keep routine consistent to decrease confusion, and report changes in usual routine. A review of Order Summary, indicated Resident #28 was to receive an acetylcholinesterase inhibitor (interferes with the breakdown of an enzyme in the body decreasing anxiety) tablet one time a day for anxiety, a synthetic compound used to treat neurological condition two times daily, an antihypertensive two times daily, and a dementia medication daily. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Jamestown Nursing and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 Hampton Place Rogers, AR 72758	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the December MAR indicated Resident #28 had medications ordered at 8:00 AM that included, an oral acetylcholinesterase inhibitor tablet for anxiety daily, an oral dementia tablet daily, a pain assessment each shift, an antihypertensive tablet two times daily, and a capsule for neuralgia two times daily. No PRN medications were documented as administered. A review of the Medication Administration Audit Report, dated 12/09/2024 at 4:49 PM, for the administration date of 12/07/2024, included all administration, all shifts, all documentation indicated Resident #28 received the acetylcholinesterase inhibitor tablet for anxiety at 10:46 AM, the oral dementia tablet at 10:47 AM, the antihypertensive tablet at 10:47 AM, and the capsule for neuralgia at 10:46 AM. Time of administration of the second doses of twice daily medications were not adjusted. During an observation on 12/07/2024 at 11:33 AM, Resident #28 asked LPN #14 for morning medications. LPN #14 responded, we are running behind and I will let your nurse know. During an interview on 12/11/2024 at 12:12 PM, the DON stated the nurse for Resident #28 should have called the provider and notified them the resident's antihypertensive medication was late and received instructions. Review of Progress Notes dated 11/09/2024 to 12/12/2024, had no entry for provider notification regarding late medications for Resident #26, Resident #27, or Resident #28. During an interview on 12/07/2024 at 11:39 AM, LPN #14 stated the residents should have received medications between 7 and 9. It was a rough morning with call ins. CNA staff was short and we could not get anyone to come in, so the nurses had to cover for the CNAs, putting us behind. LPN #14 stated residents should receive medications on time and the Director of Nursing (DON) was aware of medication being late and staffing. During an interview on 12/11/2024 at 12:12 PM, the Director of Nursing (DON) stated medication administration times were 1 hour before and after the scheduled times in Point Click Care (PCC). If a nurse was outside the 1-hour window, they should call the provider and ask for instructions. In a case with a twice a day medication, the doctor may need to consider whether to give it or not. The nurse would want to pass it on in report. During an interview on 12/11/2024 at 1:37 PM, the SSDN and surveyor reviewed the controlled drug sign out book, page 109. SSDN stated Resident #26 received the opioid pain medication at 10:00 AM, I thought it was sooner. The SSDN stated the on-call provider was notified regarding giving medications late, however, did not recall the name of the provider. SSDN was unable to locate the progress note with the provider notification in the electronic health record, filtered the progress notes to include medication administration notes and was still unable to locate a provider notification for Resident #26, Resident #27, or Resident #28, and stated the note may be on a paper somewhere on the desk that has not been entered yet. The SSDN stated it was important to receive medications when ordered, especially blood pressure and other things to keep medication levels consistent and notification should be documented. On 12/11/2024 at 2:38 PM, surveyor was at the front door exiting the facility and the SSDN stopped surveyor and stated the note regarding provider notification was found right where I said it was and was now in the electronic health record. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a facility policy titled, Medication Storage in the Facility, revised January 2018, indicated, Medications are stored safely and securely accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medication room, carts, and medication supplies are locked when not attended by persons with authorized access. A review of the facility's undated policy titled Abuse, Neglect, Misappropriation and Exploitation Investigating and Reporting indicated, abuse was patterns or deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. A review of an in-service, conducted by Former- Assistant Director of Nursing (F-ADON) on 11/21/2024, indicated, during narcotic counts nursing staff was to look at the medication cards and verify all pills are accounted for. A review of an Incident and Accident Report submitted on 11/21/2024 at 11:17 AM, to the OLTC indicated, during administration of Resident #16's antianxiety medication current Assistant Director of Nursing (ADON) identified a missing pill from the (Name Brand) antianxiety medication card on the 300-Hall cart. On 11/25/2024, findings indicated, current ADON did not catch the missing pill during morning shift narcotic count, the missing pill was not located in the narcotic box by F-ADON, it was believed the card was damaged on the back side due to the tight fit of the large volume of cards in the narcotic box, nurses were in-serviced on visualizing the medication cards to verify the count and the Abuse and Neglect policy with emphasis on misappropriation of property, and a new narcotic box was ordered for additional storage. No drug diversion activities were identified. A review of an Incident and Accident Report submitted on 11/21/2024 at 12:39 PM, to the Office of Long-Term Care (OLTC) by F-ADON indicated, during a full match back completed by the F-ADON and Nurse Consultant #14 on the 300-Hall narcotic box to verify the count due to previously missing narcotics Resident #15 (Name Brand) pill card was missing one pill. On 11/25/2024, findings indicated, current ADON did not catch the missing pill during morning shift narcotic count, the missing pill was not located in the narcotic box by F-ADON or Nurse Consultant #14, it was believed the card was damaged on the top right corner due to the tight fit of the large volume of cards in the narcotic box, nurses were in-serviced on visualizing the medication cards to verify the count and the Abuse and Neglect policy with emphasis on misappropriation of property, and a new narcotic box was ordered for additional storage. No drug diversion activities were identified. A review of an in-service conducted by F-ADON on 11/22/2024 indicated, nursing staff was provided education on properly reading measurements on a morphine bottle. A review of an Incident and Accident Report submitted on 11/22/2024 at 12:43 PM, to the OLTC indicated, during the change of shift narcotic count on 11/22/2024 at 7:23 AM, for the 300-Hall Medication cart Resident #16's (Name Brand) bottle contained 2 milliliters (ML) less liquid medication than expected. The (Name Brand) was immediately surrendered for destruction and a replacement bottle was obtained. On 11/27/2024, findings indicated, no spillage or waste had been reported, an assessment of the nurse's administration knowledge and skills were preformed, and an in-service was conducted to re-educated on how to properly identify the increment marks on the side of the (Name Brand) bottle. No drug diversion activities were identified. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and observation on 11/26/2024 at 5:44 PM, a controlled medication count was completed on the 200-Hall medication cart. Resident #23's (Name Brand) controlled narcotic pain medication had 43 pills in the medication card, the controlled medication book, page 34, reported the (Name Brand) controlled narcotic pain medication count was 44. Licensed Practical Nurse (LPN) #15 stated, they forgot to sign out the morning dose. A review of Resident #23's November Medication Administration Record (MAR) revealed, on 11/26/2024, LPN #15 administered (Name Brand) controlled narcotic pain medication to Resident #23 at 8:54 AM, eight hours and fifty minutes prior to the narcotic count. During a concurrent interview and observation on 11/26/2024 at 5:54 PM, a controlled medication count was completed on the 200-Hall medication cart. Resident #21's (Name Brand) controlled nerve pain medication had 24 pills in the medication card, the controlled medication book, page 37, reported the (Name Brand) controlled nerve pain medication count was 25. LPN #15 stated, they forgot to sign out the morning dose. A review of Resident #21's November MAR revealed, Resident #21's (Name Brand) controlled nerve pain medication was scheduled at 8:00 AM and signed out by LPN #15. During a concurrent interview and observation on 11/26/2024 at 6:23 PM, a controlled medication count was completed on 300-Hall medication cart. Resident #20's (Name Brand) controlled narcotic pain medication had 19 pills in the medication card, the controlled medication book, page 99, reported the (Name Brand) controlled narcotic pain medication count was 20. LPN #18 stated, they forgot to sign out the morning dose. A review of Resident #20's November MAR revealed, Resident #20's (Name Brand) controlled narcotic pain medication was scheduled of 8:00 AM, and not signed out by LPN #18. It was signed out by LPN #1. 50924

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49688 Based on observations, interviews and record reviews it was determined that the facility failed to keep medications safely secured for 1 medication cart of 1 medication cart reviewed for medication storage. A review of a facility policy titled, Medication Storage in the Facility, revised January 2018, indicated, Medications are stored safely and securely accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medication room, carts, and medication supplies are locked when not attended by persons with authorized access. During a concurrent observation and interview on 11/28/2024 at 6:13 AM, Registered Nurse (RN) #12 was seen passing medication at the end of 600-Hall. The medication cart was parked in the hallway outside suite 610. RN #12 took medication into room [ROOM NUMBER]-B. The medication cart was unlocked, Resident #9 ' s medication card was left sitting on top of the cart, and the computer screen was left open. RN #12 returned to the cart at 6:17 AM. RN #12 stated, they should lock the cart because someone could come by and take something. Regarding Resident #9's antifungal medication card sitting on top of the cart RN #12 stated, it's just (brand name). RN #12 stated things like that might matter in other places, but not around here. A review of Resident #9's medication card revealed, a one-time dose of (Name Brand) antifungal 150 milligram (MG) tablet was in an un-popped bubble of the medication cart left sitting unattended on top of the 600-Hall medication cart. During an interview on 11/28/2024 at 6:40 AM, the Administrator was made aware of the potentially dangerous situation by the surveyor. The Nurse Consultant stated they were going to have a talk with RN #12 and immediately exited the room. 50924

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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. 42016 Based on observations, interviews, and facility policy review, it was determined that the facility failed to ensure hand hygiene was performed during meal service for 1 dining room of 4 dining rooms observed during meal service. This failed practice had the potential to affect all residents receiving meals in the 100-hall dining room. Findings include: A review of a facility policy titled, Hand Hygiene, dated 11/22/2017, indicated the primary means of preventing infections was hand hygiene and handwashing/hand hygiene procedures were to be followed by all personnel to prevent spread of infections to residents and others. During an observation on 11/29/2024 at 5:39 PM, Nursing Assistant (NA) #9 removed a meal tray from the insulated cart and served a meal to a resident, removed items from the tray and placed on table, removed lids. NA #9 repeated this process, serving 7 residents in the 100-hall dining room. NA #9 did not perform hand hygiene prior to removing the first tray or between meal trays, during the observation. During an observation on 11/29/2024 at 5:39 PM, Certified Nursing Assistant (CNA) #10 removed a meal tray from the insulated cart and served a meal to a male resident in the 100-hall dining room. CNA #10 removed items from the tray, placed them on the dining table and removed lids. CNA #10 returned to the insulated cart and removed a second tray, returned to the same table, removed items from the tray and placed them on the dining table, in front of a second male resident. CNA #10 removed lids, and opened an 8 oz carton of milk, by folding back the sides at the peak of the top and placed a fingernail of their index finger in the seam and pulled out, inserted the index finger further into the opening and pulled, fully opening the spout. No straw was provided to the resident. No hand hygiene was performed by CNA #10 prior to removing the meal tray from the cart, in between serving the two male residents' meals, and was not wearing gloves while opening the milk carton. During an interview on 11/29/2024 at 5:44 PM, NA #9 stated hands should be sanitized between serving resident trays to keep from spreading germs to the residents and making them sick. During an interview on 11/29/2024 at 5:47 PM, the Administrator stated hands should be sanitized in between serving trays and the aides know it so they do not spread infection. During an interview on 11/29/2024 at 5:49 PM, CNA #10 stated hands should have been sanitized between serving meal trays and should not have placed a finger into the opening of the milk carton where a resident places their mouth to drink, because it spreads infection. 49688