STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045456	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pink Bud Home for the Golden Years	400 So Coker Greenwood, AR 72936

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 47916 Based on observation, record review, interview, and facility policy review, the facility failed to ensure that one (Resident #16) of one resident sampled for self-administration of medications did not self-administer nasal spray without the interdisciplinary team determining the practice was clinically appropriate. The findings include: A review of Physician Orders, dated 04/01/2025, revealed Resident #16 had diagnoses which included seizure disorders, depression, and atrial fibrillation. A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/20/2024, revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. Section B0200/B0300 indicated Resident #16 was moderately hearing impaired and had a hearing aid. A review of Physician Orders, dated 02/24/2025, revealed Resident #16 received nasal spray, two (2) sprays, twice a day, for allergic rhinitis symptoms. A review of a Care Plan, dated 03/10/2025, revealed Resident #16 received nasal spray, two (2) sprays, twice a day, for allergic rhinitis symptoms. On 04/22/2025 at 4:15 PM, this surveyor observed Medication Aide- Certified (MA-C) #1 handing Resident #16 their prescribed nasal spray. After Resident #16 sprayed once in each nostril, MA-C #1 instructed Resident #16 to spray each nostril one more time. On 04/22/2025 at 4:17 PM, MA-C #1 stated she was not sure if Resident #16 had been assessed to safely self-administer medication. MA-C #1 said that she did not know if there was a reason Resident #16 should not administer their own nasal spray. MA-C #1 revealed Resident #16 was sometimes resistant to taking nasal spray but might take it when allowed to give it themselves. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 04/22/2025 at 4:25 PM, the Administrator was asked if any residents had self-administration rights. After reviewing facility records, the Administrator stated that no residents had self-administration rights. The Administrator provided a copy of a policy titled Self-Administration of Medication, that revealed the Director of Nursing (DON) or Assistant Director of Nursing (ADON) must provide a mini mental assessment where residents scored at least 75%, the Medical Director had to agree with self-administration, and the resident had to demonstrate they were capable of giving themselves their medication. The Administrator reiterated that no residents had self-administration rights at this time. The DON, ADON, and staff had stand up meetings daily, along with other opportunities for staff to discuss and determine if a resident was safe for self-administration, after completing a mini assessment. On 04/23/2025 at 8:53 AM, the DON said the process to determine if a resident had self-administration rights was for the DON or ADON do a mini mental assessment. Nursing and MA-Cs were expected to follow medication administration rights when giving a resident nasal spray. The DON stated a nurse or MA-C should have administered the nasal spray, because Resident #16 did not have self-administration rights. The DON said it was not appropriate for residents to administer their own medication, including nasal spray, without rights, because they might not do it appropriately.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 49596 Based on observations, interviews, and record reviews, the facility failed to ensure the Facility Abuse and Neglect policy was implemented to include reporting of abuse allegations for one (Resident #12) of three sampled residents, reviewed for abuse allegations. The findings are: A review of the facility Abuse / Neglect Policy and Procedures revealed, [Facility Name] will follow these written policies and procedures to ensure that incidents, including suspected abuse/neglect of residents, accidents, deaths from violence and unusual occurrences are reported and documented, as required by all applicable state and federal laws and these regulations. Item D, Reporting Suspected Abuse/Neglect part three (3) indicated [Facility] personnel, including but not limited to, licensed nurses, nursing assistants, physicians, social workers, mental health professional and other employees in the facility who have reasonable cause to suspect that a resident has been subjected to conditions or circumstances which have or could have resulted in abuse/neglect are required to immediately notify the Administrator. A review of the Face Sheet indicated Resident #12 was admitted to the facility with diagnoses that included: Parkinson's Disease, other chronic pain, and anxiety disorder. A review of Resident #12's Care Plan dated 10/27/2024, with a review date of 01/08/2025, identified Resident #12 needed transfer assistant of one (1) staff sit to stand lift, Resident #12 needed assist of one (1) with dressing, toilet use, personal hygiene and bathing, Resident #12 was non-ambulatory with walking. A review of Resident #12 ' s Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/28/2025, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. A review of Resident #12 ' s Nurse's Notes revealed on 04/08/2025 the resident's right index and left ring finger were noted to be red and edematous. Resident #12 reported I woke up this morning with it hurting, denies any injury. A review of the Nurse's Notes revealed, on 04/11/2025, Resident #12 complained of pain and swelling in their hand, the Physician ordered labs to rule out gout, followed by an X-ray. A review of the (name of imaging provider) Radiology Interpretation with an exam date of 04/11/2025 revealed an impression of Questionable acute fracture along the base of the right fourth metacarpal .Erosive osteoarthritis changes in the .joint spaces. On 04/11/2025 at 3:00 PM, a Physician Telephone Order: Right hand X-ray due to swelling; Put in Splint. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/11/2025 at 11:00 PM, a Nurse ' s Note: Splint placed to right index finger, The nurse asked if the resident bumped it into something or fell and resident stated no, [pronoun] did not. No signs or symptoms of pain or discomfort noted. On 04/15/2025 at 12:50 PM, a Nurse ' s Note: Resident #12 noted with increased anxiety. Requesting more (Sedative used to treat anxiety) every day around 12:00 PM - 2:00 PM. Faxed Primary Care Physician. New order noted to discontinue current (sedative used to treat anxiety) order and start (sedative used to treat anxiety) 0.5 milligram twice a day. Notified family. On 04/17/2025, the Body Audit note indicated swelling related to a fracture to the right index finger. During an interview on 04/23/2025 at 3:00 PM, the Administrator revealed they had not reported the incident as abuse, because Resident #12 and the PCP (Primary Care Physician) initially thought it was gout. Then the PCP ordered the x-ray, and it showed a questionable fracture. The Administrator said they had not completed an Incident & Accident (I&A) report on the resident ' s finger either. During a phone interview on 04/23/2025 at 3:27 PM, the PCP revealed he was informed of Resident #12 ' s finger swelling and said the resident thought it was their gout flaring up. The PCP ordered lab work to determine if it was gout causing the swelling. The PCP said the lab work ruled out gout as a cause for the swelling. The PCP then ordered an X-ray on 04/11/2025. The X-ray revealed a questionable fracture. During an interview with Resident #12, on 04/24/2025 at 7:33 AM, Resident #12 said [pronoun] finger might have gotten hurt when that girl tried to beat the (expletive) out of me. Her name started with an A, a simple name like (CNA #2). I told somebody about her beating me up. (RN #4) knows because she told me that girl would not be back in my room anymore. I could not tell you if she used the lift or not. I do not know. You know it has been a couple of weeks ago and I forgot. On 04/24/2025 at 8:01 AM, this surveyor interviewed RN #4. RN #4 said Resident #12 complained on one occasion about CNA #2, saying CNA #2 had gotten Resident #12 up to go to the bathroom, then put Resident #12 in their chair. Resident #12 said, she got rough with me. RN #4 said this occurred sometime between 04/07/2025 and 04/10/2025, a couple weeks ago. RN #4 said the day Resident #12 complained about CNA #2 being rough with Resident #12, RN #4 told CNA #2 not to go back in Resident #12 ' s room and RN #4 told Resident #12 that CNA #2 would not be back in resident's room. RN #4 said, I honored Resident #12 ' s preference that CNA #2 not come back in [pronoun] room . RN #4 stated, I believe I reported it to the Assistant Director of Nursing (ADON), that is who I am to report to if the Director of Nursing (DON) is not here, I go to the ADON. The DON was off, so I told ADON about Resident #12 making the statement that CNA #2 had been rough with Resident #12. I informed ADON of the resident ' s preferences. On 04/24/2025 at 8:37 AM, during an interview, another of Resident #12 ' s family members said the facility reported the resident's finger fracture to them. They said it was late, and they were the only one of the three [family members] who took calls that late. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/24/2025 at 9:09 AM, the ADON said she had heard that someone had been rough with Resident #12. The ADON said she spoke with Resident #12 about the pain in the resident ' s hand and the resident did not remember doing anything to it and did not know what happened. The ADON said, at first, the facility staff thought it was gout. The doctor ordered lab work, and gout was ruled out. Resident #12 continued to have pain, so the doctor ordered an x-ray and that was when they found out it was possibly fractured. The ADON said we let the doctor know and he said to splint it. The ADON said We really don't know what caused the fracture. The ADON said she reported the findings to the doctor, the Administrator and the DON but she did not chart this anywhere. The ADON said she did visit with Resident #12 about their finger, but the resident did not know what happened. It was swollen and had pain in it. The ADON said Resident #12 did not say a staff member did it. The ADON said she did not really remember what night or evening Resident #12 said a staff member did it. The ADON said she did not do a body audit of Resident #12 when the resident said somebody had been rough with [pronoun] and said it was before the finger issue, it seemed like it was three or four days before. The ADON said she did not know if the allegation was investigated. During an interview with the Administrator on 04/24/2025 at 2:10 PM, the Administrator stated they had not been informed of the allegation involving a CNA being rough with Resident #12 until today. Today, they told me that (Resident #12) had told one of the nurses that (CNA #2) had been rough with (Resident #12). The nurse did not find any injuries and they went on. The Administrator said they (staff) should have reported it to her the day the resident said someone had been rough with (the resident). I would have gone and investigated it myself, along with them to find out for sure what happened. I will have our investigator do the investigation and make the report to the Office of Long-Term Care as soon as we are done talking since I found out about the allegation. During an interview on 04/24/2025 at 3:00 PM, the DON said she found out today (04/24/2025) that Resident #12 had said a staff member had been rough with the resident. The DON said she did not have any knowledge of a CNA being rough with Resident #12, but she thought the ADON had known. The DON said she did a visual assessment and interviewed Resident #12 on 04/24/2025, when she found out about the allegation. The DON said the facility was investigating and reporting the allegation today, 04/24/2025. The DON said the ADON was doing the investigation. The DON said she had informed the police about the alleged abuse today at 2:22 PM, and that the police officer went and talked to Resident #12. The DON said she gave CNA #2 ' s information to the officer. During an interview on 04/24/2025 at 3:39 PM, CNA #2 said she had worked at [Facility Name] from 02/14/2025 - until about a week and half ago. CNA #2 said, Resident #12 said I was rough with [pronoun] and the nurse told me I could not go back in Resident #12 ' s room, and said Resident #12 does not want you in (the resident's) room anymore because you were too rough with the resident ' s stand lift. During an interview with the ADON on 04/25/2025 at 9:00 AM, the ADON said Resident #12 told her about a CNA being rough with them on 04/08/2025 or 04/09/2025, sometime late in the afternoon between 1:30 PM and 2:00 PM, because the ADON got off at 2:30 PM. The ADON said, Resident #12 called me to come in the resident's room and reported that a CNA had been rough with (the resident) . The ADON said RN #4 was passing by and stopped by Resident #12 ' s room and told me that she knew about it. The ADON said RN #4 told the ADON that RN #4 had talked to the CNA and instructed the CNA not to go back in Resident #12 ' s room. The ADON stated the CNA was CNA #2, a fairly new aide. The ADON said she could not remember if she reported the allegation to the Administrator or not, but that she did not remember talking to the administrator or DON. The ADON said she did not assess the resident. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/25/2025 at 9:15 AM, RN #4 reported being on East Hall, it had to be the 7th, 8th, or 10th before lunch, between 8:00 - 9:00 AM. RN #4 said she reported the allegation to the ADON immediately. RN #4 said she walked to the ADON ' s office at the end of East Hall and told the ADON in the ADON's office. RN #4 said she told the ADON that Resident #12 had a complaint. RN #4 said she and the ADON both went to Resident #12 ' s room and talked to the resident. RN #4 said she did assess the resident but did not document the assessment. RN #4 said Resident #12 was upset and that Resident #12 stated CNA #2 had taken the resident to the bathroom and then put the resident back in [pronoun] chair and was rough with the resident. RN #4 said she did not report the allegation to the administrator or DON. RN #4 said she did not send CNA #2 home but instructed her to continue working but not to go in Resident #12 ' s room. RN #4 said she did not send CNA #2 home because she had never witnessed CNA #2 being rough with any resident and that she was very gentle with everyone. On 04/25/2025 at 10:00 AM the Medical Director reported being familiar with Resident #12 and the family. He was made aware of allegations of abuse a week or so ago, but spoke with the Administrator this morning, indicating Resident #12 complained that a staff member was rough with the resident. I expect when there is an allegation of abuse the appropriate parties will be informed and investigated, which is what was done. The Medical Director reviewed the right-hand x-ray from 04/11/2025 and stated it indicated osteoarthritis.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49596 Based on interview, record review, and facility document review the facility failed to ensure an allegation of abuse was reported immediately to the appropriate authorities, which include the state agency, but not later than two hours after the allegation was made for two incidents with Resident #12. This failed practice had protentional to affect all residents residing in the facility. 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) situation was related to State Operation Manual, Appendix PP, 483.12 at a scope and severity of L . The IJ began on 01/07/2025 after review of a record provided by the Administrator regarding Certified Nursing Assistant (CNA) #13 being rough with Resident #12. The Administrator presented the two-page record as her investigation into an allegation of a staff member being rough with Resident #12 as the complete investigation. This was never reported through the State Agency/Office Long Term Care (OLTC) reporting portal. The Administrator was notified of the Immediate Jeopardy (IJ) on 05/20/25 at 3:49 PM. A Removal Plan was requested. An IJ removal plan must include all the actions the facility has taken or will take to immediately address the noncompliance that resulted in or made serious injury, serious harm, serious impairment or death likely. On 05/21/25 at 5:20 PM an acceptable Immediate Jeopardy removal plan was accepted in accordance with Appendix Q. The findings are: A review of the facility ' s undated Abuse/Neglect Policy and Procedures presented to the surveyors on 04/21/2025 stated in section VII Reporting/Response Reports will be filed in all alleged violations and substantiated incidents to the state agency and all other agencies as required and take all necessary corrective action depending on the result of the investigation. A review of facility in-service training dated 02/15/2024 at 01:30 PM and 01/23/2025 at 01:30 PM, revealed staff, including the Administrator and Assistant Director of Nursing (ADON) were trained on Abuse and Neglect and Resident Rights. The Administrator and ADON signed the signature page to acknowledge their training. The in-service training included the types of abuse, identifying abuse, and prevention of abuse. Investigation of abuse and reporting the results to the proper authorities using the proper forms required by the state, and the protection of residents. The training instructed the suspected/alleged employee will be clocked out immediately and the Administrator, Director of Nursing (DON), family, and physician will be notified of the incident, and all reports will be filed in all alleged violations and substantiated incidents to the state agency and all other agencies as required. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #12 ' s Care Plan dated October 27, 2024, identified Resident #12 to need assistance of one staff with transfers with the sit to stand lift, dressing, toilet use, personal hygiene and bathing. Resident #12 is non-ambulatory with walking. Resident #12 ' s Care Plan did not identify the resident to make false allegations. Resident #12 ' s Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 01/28/2025, identified the resident to have a Brief Interview for Mental Status score of 14, which indicated Resident #12 had intact cognition. Resident #12 ' s Physician Orders dated 04/1/2025 thru 05/31/2025 revealed the resident to have diagnoses of Parkinsons Disease, chronic pain, anxiety disorder, atrial fibrillation, overactive bladder, depression, vitamin D deficiency, and dementia. During an interview on 04/24/25 at 7:33 AM, Resident #12 reported some girl beat the (explicit) out of me. Her name was something simple like [Certified Nurse Assistant (CNA) #2]. I told someone and [Registered Nurse (RN) #4] said she would not be in my room anymore. On 04/24/25 at 8:01 AM, RN #4 stated it was Resident #12 ' s preference CNA #2 did not return to Resident #12 ' s room because she was rough. RN #4 said she instructed CNA #2 not to go back into Resident #12 ' s room and she had reassigned CNA #2 to work on another hallway. RN #4 stated she reported the incident to the ADON because the DON was not working at the time. During a follow-up interview on 05/19/2025 at 3:52 PM, RN #4 said the incident happened on April 10, 2025. During review of a Nurse ' s Note 7-3 PRN dated 04/10/2025, RN #4 documented Resident #12 was alert and orientated to person, place and time. The resident was able to voice needs. The resident transferred per staff with a sit to stand lift, was mobile in a wheelchair propelled by staff, preferred meals in their room, fed self, and had a fair appetite. The record did not contain a body audit or a resident interview concerning the report of the allegation. On 04/24/2025, at 9:09 AM, the ADON said Resident #12 stated CNA #2 got rough with the resident. The ADON stated she did not complete any paperwork because she was not at the facility. The ADON said she reported the allegation to the Administrator and DON the day following the allegation. The ADON said if a resident said staff had been rough with them, staff needed to do a body audit to make sure they don ' t have something wrong with them and the roughness didn ' t cause a problem. The ADON said she did not know if the allegation was reported. During an interview on 05/19/2025 at 4:16 PM, the DON told the survey team the ADON had a log-in for the state reporting portal for submission of allegations of abuse. During an interview on 05/20/2025 at 8:00 AM, the Administrator provided a list of those employees with access to the state reporting portal, which included the ADON. A review of the facility ' s OLTC Incident and Accident Report (Form 7734) revealed the allegation was reported on 04/24/2025, fourteen days after the allegation. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 04/24/2025 at 9:30 AM Certified Nursing Assistant Supervisor (CNA Supervisor) stated, she was unfamiliar with the incident involving Resident #12 and CNA #2 but was aware of an incident involving Resident #12 and CNA #13. CNA Supervisor removed CNA #13 from working with Resident #12 following an allegation of CNA #13 being rough with Resident #12. CNA #13 was reassigned by CNA Supervisor to work another hall, allowing her to work with other residents the same day. CNA Supervisor said Resident #12 did not want the CNA Supervisor to tell anyone the CNA had been rough with Resident #12. The CNA Supervisor said she did not know if she ever reported to her supervisor about the incident involving CNA #13. CNA Supervisor stated Resident #12 was a [NAME] about us telling what (Resident #12) had said because (Resident #12) feels somebody will be mean. The CNA Supervisor said CNA #13 should have been written up and the nurse should have investigated. CNA Supervisor stated, I don ' t think I wrote her up, I think I just moved her off that hall. On 05/19/2025 at 2:15 PM, the Administrator provided a two-page investigation of the incident involving CNA #13 and Resident #12. One page was a half-page statement made by the CNA Supervisor which stated CNA #13 had been rough with Resident #12. The other half of the page was a written statement made by the Administrator which stated Resident #12 did not remember anything about this and no CNAs had witnessed any abuse or roughness with the conclusion that no injury was noted. The second page of the record was an Employee Warning Record stating Verbally in-serviced (CNA #13) on not being rough with residents. (CNA #13) was told to not go into the room with (Resident #12) and she denied being rough. She was moved to North Hall but was told if she had to work East to not go in (Resident #12 ' s) room. The surveyor asked the Administrator if she had reported this allegation or had any other information regarding this incident. The Administrator said she had not reported the allegation of abuse to the mandatory authorities. The Administrator said the two pages she had given the surveyors were the full report she had done in this investigation. This had not been reported to any authorities or the State Agency/OLTC. No body audit or Nurse assessment was completed for Resident #12. A review of the facility undated Resident Rights document states Each and every resident in this facility has the right to: #12. Be free of verbal, mental, physical, and sexual abuse. Onsite Verification: (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The IJ was removed on 05/22/2025 at 11:00 AM, after the survey team performed onsite verification that the Removal Plan had been implemented. Onsite verification of the Removal Plan began on 05/22/2025 at 8:15 AM with no negative findings regarding the Removal Plan. The survey team verified the Plan of Removal in reviewing the facility in-service training for all staff on reporting abuse and neglect to the Administrator, the DON and Office of Long-Term Care, ensuring all incidents are reported properly and to ensure resident ' s safety. Of the fifty-five residents currently residing in the facility forty-three residents were interviewed regarding abuse, and eleven residents unable to verbalize abuse received body audits. One resident was out of the facility. The DON had been appointed to monitor, investigate and report allegations of abuse and the monitoring tool for documenting and reporting of allegations began on 05/20/2025. The DON was appointed as the Abuse and Neglect Coordinator with all corrections completed on 05/21/2025. A total of ten staff interviews were conducted with staff from all shifts to verify training had been completed. The staff interviewed included the Housekeeping Supervisor, a Housekeeper, a laundry worker, a Nursing Assistant, a Dietary cook, a Medication Assistant Coordinator, a Certified Nursing Assistant, a Licensed Practical Nurse, the Administrator and the Director of Nursing. The staff interviewed verified they had been trained on reporting of abuse. A review of in-service sheets provided indicated sixty-four of seventy-eight employees had been provided training. One staff member was in the hospital and the others are not allowed to return to work until they have been trained.

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Pink Bud Home for the Golden Years	400 So Coker Greenwood, AR 72936

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49596 Based on interview, record review, and facility document review, the facility failed to thoroughly investigate two allegations of abuse for Resident #12 and failed to prevent potential abuse or maltreatment of all residents by removing the alleged perpetrator during an on-going investigation. Specifically, no evidence of a resident statement, accused statement, assessment of the resident, bedside staff interviews, and a police report were completed for review and the accused was allowed to continue working with residents in the facility immediately following both allegations. 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) situation was related to State Operation Manual, Appendix PP, 483.12 at a scope and severity of L . The IJ began on 01/07/2025 after review of a record provided by the Administrator regarding Certified Nursing Assistant (CNA) #13 being rough with Resident #12. The Administrator presented the two-page record as her investigation into an allegation of a staff member being rough with Resident #12 as the complete investigation. This was never reported through the State Agency/Office Long Term Care (OLTC) reporting portal. The Administrator was notified of the IJ on 5/20/25 at 3:46 PM. A Removal Plan was requested. An IJ removal plan must include all the actions the facility has taken or will take to immediately address the noncompliance that resulted in or made serious injury, serious harm, serious impairment or death likely. On 05/21/2025 at 5:20 PM an acceptable Immediate Jeopardy removal plan was accepted in accordance with Appendix Q. The findings are: 1. A review of the facility ' s undated Abuse/Neglect Policy and Procedures presented to the surveyors on 04/21/2025 stated in section V Investigation: The Administrator or Designee will investigate all types of incidents and identify the staff member responsible for the initial reporting of alleged violation(s) and a report of the results will be reported to the proper authorities using the proper forms required by the state. 2. A review of facility in-service training dated 02/15/2024 at 1:30 PM and 01/23/2025 at 1:30 PM, revealed staff, including the Administrator and Assistant Director of Nursing (ADON), were trained on Abuse and Neglect and Resident Rights. The Administrator and ADON signed the signature page to acknowledge their training. The in-service training included types of abuse, identifying abuse, and prevention of abuse. Investigation of abuse and reporting the results to the proper authorities using the proper forms required by the state, and the protection of residents. The training instructed the suspected/alleged employee will be clocked out immediately and the Administrator, Director of Nursing (DON), family and physician will be notified of the incident, and all reports will be filed in all alleged violations and substantiated incidents to the state agency and all other agencies as required. Section III of the training instructs staff to encourage family members, staff and residents to report concerns, incidents, and grievances without the fear of retribution. Supervision of staff will be on-going to identify inappropriate behavior, such as .rough handling, . (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	3. Resident #12 ' s Care Plan, dated October 27, 2024, identified Resident #12 needed assistance of one staff with transfers with the sit to stand lift, dressing, toilet use, personal hygiene and bathing. Resident #12 was non-ambulatory with walking. Resident #12 ' s Care Plan did not identify the resident to make false allegations. 4. Resident #12 ' s Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/28/2025, identified resident to have a Brief Interview for Mental Status of 14, which indicated Resident #12 had intact cognition. 5. Resident #12 ' s Physician Orders dated 4/1/2025 thru 5/31/2025 identifies resident to have diagnoses of Parkinsons disease, chronic pain, anxiety disorder, atrial fibrillation, overactive bladder, depression, vitamin D deficiency, dementia. 6. During an interview on 04/24/25 at 7:33 AM, Resident #12 reported some girl beat the (explicit) out of me. Her name was something simple like [Certified Nurse Assistant (CNA) #2]. I told someone and [Registered Nurse (RN) #4] said she would not be in my room anymore. a. On 04/24/25 at 8:01 AM, Registered Nurse (RN) #4 stated it was Resident #12 ' s preference CNA #2 did not return to Resident #12 ' s room because she was rough. RN #4 said she instructed CNA #2 not to go back into Resident #12 ' s room and she had reassigned CNA #2 to work on another hallway. RN #4 stated she reported the incident to the ADON because the DON was not working at the time. During a follow-up interview on 5/19/2025 at 3:52 PM, RN #4 said the incident happened on April 10, 2025. b. During record review of a Nurse ' s Note 7-3 PRN, dated 04/10/2025, RN #4 documented Resident #12 was alert and orientated to person, place and time. Resident #12 was able to voice their needs. Resident transferred per staff with a sit to stand lift, was mobile in a wheelchair, propelled by staff, preferred meals in room their room, fed self, and had a fair appetite. The record does not contain a body audit or a resident interview concerning the report of the allegation. c. During an interview on 05/19/2025 at 3:52 PM, RN #4 stated she reported the incident to her superior, the ADON. RN #4 stated she did not feel like due diligence was done. RN #4 stated she interviewed staff and other residents, since no one had a problem, she allowed CNA #2 to continue work. She stated she was not the abuse coordinator; she would let a superior complete them. It should have been brought to the Administrator and DON attention. The facility did not have any record of the investigation; there was not a body audit or assessment documented in the medical record. d. During an interview on 04/24/2025, at 9:09 AM, the ADON said Resident #12 stated CNA #2 got rough with Resident #12. The ADON stated she did not complete any paperwork because she was not at the facility. The ADON said she reported the allegation to the Administrator and DON the following day. The ADON said if a resident said staff had been rough with them, staff needed to do a body audit to make sure the resident don ' t have something wrong with them and the roughness didn ' t cause a problem. The ADON said she did not know if the allegation was investigated and she did not do a body audit, and one should have been conducted to make sure they don ' t have something wrong with them and the roughness didn ' t cause a problem e. A review of the facility ' s OLTC Incident and Accident Report (Form 7734) revealed the investigation was completed on 04/24/2025, fourteen days after the allegation on 04/10/2025. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	7. During an interview on 04/24/2025 at 9:30 AM, the Certified Nursing Assistant Supervisor (CNA Supervisor) stated, she was unfamiliar with the incident involving Resident #12 and CNA #2 but was aware of an incident involving Resident #12 and CNA #13. The CNA Supervisor removed CNA #13 from working with Resident #12 following an allegation of CNA #13 being rough with Resident #12. CNA #13 was reassigned by the CNA Supervisor to work another hall, allowing her to work with other residents the same day. The CNA Supervisor said Resident #12 did not want the CNA Supervisor to tell anyone the CNA had been rough with Resident #12. The CNA Supervisor said she did not know if she ever reported to her supervisor about the incident involving CNA #13. The CNA Supervisor stated Resident #12 was a [NAME] about us telling what (Resident #12) has said because (Resident #12) feels somebody will be mean. The CNA Supervisor said CNA #13 should have been written up and the nurse should have investigated. CNA Supervisor stated, I don ' t think I wrote her up, I think I just moved her off that hall. This allegation was not investigated or reported to the appropriate authorities or the State Agency/OLTC. 8. On 05/19/2025 at 2:15 PM, the Administrator provided a two-page investigation of the incident involving CNA #13 and Resident #12. One page was a statement made by the CNA Supervisor which stated CNA #13 had been rough with Resident #12. The other half of the page was a written statement by the Administrator stating Resident #12 did not remember anything about this and no CNAs had witnessed any abuse or roughness with the conclusion that no injury was noted. The second page of the record was an Employee Warning Record stating Verbally in-serviced (CNA #13) on not being rough with residents. (CNA #13) was told to not go into the room with (Resident #12) and she denied being rough. She was moved to North Hall but was told if she had to work East to not go in (Resident #12) room. The Administrator stated she had not reported this allegation or had any other documentation regarding this incident. The Administrator said she had not reported the allegation of abuse to the mandatory authorities. The Administrator said the two pages she had given the surveyors were the full report she had done in this investigation. This had not been thoroughly investigated or reported to any authorities or the State Agency/OLTC. There was no body audit or Nurse assessment completed for Resident #12. 9. On 05/19/2025 at 4:16 PM, during an interview on 05/19/2025 at 4:16 PM the DON stated the ADON is who the staff reported incidents to when the DON was not in the building, but the ADON could have called her at any time. Resident #12 had never made any abuse accusation before, and accusation should be investigated when the report is made. The DON stated she goes to the source of the accusations, the staff being accused, and everyone including kitchen staff, CNAs, Nurses. The first step is to make sure the resident is ok. Separate the accused, they should go home until the investigation is done. The DON stated she usually does the reportables, but the ADON had a login. She used to be the DON here so she would have known the time frames. The DON stated ADON was one of the staff who have access to the State Reporting system and could have input the allegation of abuse. 10. On 05/19/2025, at 4:55 PM, the Administrator stated the facility did not have an abuse coordinator, but the highest-ranking person in the building was responsible for the investigation. 11. A review of the facility ' s undated Resident Rights document revealed, Each and every resident in this facility has the right to: #12. Be free of verbal, mental, physical, and sexual abuse. Onsite Verification: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The IJ was removed on 05/22/2025 at 11:00 AM, after the survey team performed onsite verification that the Removal Plan had been implemented. Onsite verification of the Removal Plan began on 05/22/2025 at 8:15 AM with no negative findings regarding the Removal Plan. The survey team verified the Plan of Removal in reviewing the facility in-service training for all staff on reporting abuse and neglect to the Administrator, the DON and Office of Long-Term Care, ensuring all incidents are reported properly and to ensure resident ' s safety. Of the Fifty-five residents currently residing in the facility forty-three residents were interviewed and the eleven residents were interviewed regarding abuse, and resident ' s unable to verbalize abuse received body audits. One resident was out of the facility. The DON had been appointed to monitor, investigate and report allegations of abuse and the monitoring tool for documenting and reporting of allegations began on 05/20/2025. The DON was appointed as the Abuse and Neglect Coordinator with all corrections completed on 05/21/2025. A total of ten staff interviews were conducted with staff from all shifts to verify training had been completed. The staff interviewed included the Housekeeping Supervisor, a Housekeeper, a laundry worker, a Nursing Assistant, a Dietary cook, a Medication Assistant Coordinator, a Certified Nursing Assistant, a Licensed Practical Nurse, the Administrator and the Director of Nursing. The staff interviewed verified they had been trained on reporting of abuse. A review of in-service sheets provided indicated sixty-four of seventy-eight employees had been provided training. One staff member was in the hospital and the others are not allowed to return to work until they have been trained.

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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** 47916 Based on observation, record review, interview, and facility policy review, the facility failed to ensure the refrigerated narcotic box was permanently affixed in the North medication room, and failed to ensure expired anti-angina medication was not stored in the North medication room. The findings include: On [DATE] at 7:41 AM, Licensed Practical Nurse (LPN) #7 was accompanied to the North Hall medication room by this surveyor. LPN #7 was asked to open the narcotic box. This surveyor observed LPN #7 open a small, unlocked white refrigerator. She reached in and pulled out a small locked black box. LPN #7 placed the unaffixed narcotic box on the cabinet and opened it. The box contained three (3) boxes of multidose anti-anxiety medication. LPN #7 revealed the narcotic box had never been affixed in the refrigerator. LPN #7 stated she had no concerns related to storage, because the medication room door and narcotic box were locked, and medications were counted each shift. LPN #7 revealed that night shift would call off the page numbers and day shift nurses named off the count and compared it to the book. On [DATE] at 8:28 AM, the Director of Nursing (DON) was asked the process, for storing narcotics in the refrigerator. The DON stated refrigerated narcotics were stored in a locked box in the refrigerator, behind a locked medication room door. The DON revealed that the narcotic box had been removeable ever since the DON came to work here over two years ago. This surveyor requested a medication storage policy and nurse in-services on medication storage. The DON stated she would need to get the requested information. On [DATE] at 9:38 AM, LPN #7 unlocked a black tackle-style box that was located in the upper cabinet above the narcotic refrigerator. The box contained a bottle of anti-angina medication. LPN #7 stated the anti-angina medication was left in the old emergency kit (E-Kit), and it should have been disposed of when the E-kit was changed out. LPN #7 revealed someone could have accidentally administered the medication and pointed out that it had expired in March of 2025. On [DATE] at 10:00 AM, the DON said the anti-angina medication should not have been left in the old E-Kit, to prevent someone from giving it to a resident, and revealed the nursing staff was responsible for medication storage. On [DATE] at 10:51 AM, the Administrator stated the narcotic box was behind a locked door, and the box was locked. She revealed the nursing staff counted the narcotics, with each shift change. If the narcotic box was removed, it would be noticed as soon as the nurse count between the next shift, and only one nurse had a key to the room and the narcotic box. The Administrator stated the expired anti-angina medication should not have been left in the former E-Kit tackle-style box, and someone must have accidentally left it. The Administrator confirmed there was a risk that someone could have given it [expired anti-angina medication] to a resident. The nursing staff was responsible for medication storage. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a policy titled Storage revealed medications that required refrigeration should be kept in a locked drug room, or in a locked box in the refrigerator, if the refrigerator was not in a locked drug room. Discontinued medication will be stored in a central area for destruction. The policy did not address the need for the narcotic box to be permanently affixed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51885 Based on observations, interviews, and facility policy review, it was determined that the facility failed to ensure dietary staff washed their hands and changed their gloves, before handling food items, in one of one kitchen. This failed practice had the potential to affect all residents residing in the facility who receive food from the kitchen. The findings include: Review of a facility policy titled, Hand Washing, dated 2010, indicated, Clean hands and exposed portions of arms (or surrogate prosthetic devices) immediately before engaging in food preparation including working with exposed food. [When to Wash Hands]: After touching bare human body parts other than clean hands and clean, exposed portions of arms. After handling soiled equipment or utensils. During food preparations, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. After engaging in other activities that contaminate the hands. During a concurrent observation and interview on 04/21/2025 at 11:44 AM, this surveyor observed Dietary Employee (DE) #11 in the back dining room [East dining], standing at the steam table. This surveyor observed that DE #11 had gloves on and was scooping out a portion of the lunch meal onto a plate. DE #11, then took the plate to a resident and sat it on the table. DE #11 came back to the steam table, picked up a plate and tray card, contaminating her hands, then without changing gloves or washing hands, got the scoop and started to scoop out another meal. DE #11 walked around the steam table, picked up a cup of tea and silverware, and took it to a resident. This surveyor observed DE #11 touch a resident on the shoulder, then with the same contaminated gloves on and without washing their hands or removing their gloves, DE #11 came back to the steam table and began to prepare another plate of food. This surveyor asked DE #11 what she should have done, after going between the steam table making resident meals and the residents. DE #11 said, I should have taken my gloves off and washed my hands. DE #11 stated, she had been in-serviced on handwashing. Handwashing is important, so you do not spread germs and get the residents sick. During a concurrent observation and interview on 04/21/2025 at 11:54 AM, this surveyor observed DE #10 in the main kitchen area, at the steam table, serving lunch. This surveyor observed DE #10, with gloves on, take hamburger buns out of the microwave, still in the package. DE #11 took the hamburger buns out of the package and placed the buns in a container on the steam table, without changing gloves or washing hands. DE #10 opened the hamburger bun wrapper and started taking the buns out. DE #10 stated he did have the same gloves on when he took the buns (that were in the package) out of the microwave. When asked if the hamburger buns were touched by the same gloves, DE #10 indicated yes. DE #10 stated that the gloves should have been taken off, and he should have washed his hands and put new gloves on. DE #10 indicated that handwashing was important to prevent the spread of germs. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/22/2025 at 12:33 PM, the Assistant Dietary Manager (ADM) indicated that handwashing should have been done before any kind of food preparation. The ADM stated, If I drop something and have to pick it up, like off the floor, hands should be re-washed. If gloves are contaminated, we should take them off, wash hands, and put new gloves on. If cooking with raw meat, wash hands and put on gloves. Put whatever meat you are using into product for seasoning, place food on baking sheet, or wherever it is supposed to go. Change gloves and wash hands. Remove food from cooking area. Add to appropriate area, wash hands, and put on clean gloves. Washing your hands is important, to try a stop the spread of germs, so no one gets sick. During an interview on 04/22/2025 at 3:58 PM, the Dietary Manager (DM) indicated, When serving the residents, servers must wash their hands and put on gloves. If staff touched anything other than the scoops or anything on the kitchen side, that could possibly be contaminated, staff should wash their hands and put on new gloves. Dietary staff must wash their hands with soap and warm water for at least 20 seconds and dry their hands. Good hand hygiene is important to prevent the spread of germs that might cause any kind of infection.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47916 Based on observation, record review, interview and facility policy review, the facility failed to follow Enhanced Barrier Precautions (EBP) for one (Resident #4) of one resident, with an open wound, observed for EBP. Specifically, staff did not wear a gown during wound care of a stage II, open moisture associated, pressure wound on the coccyx, with a leaking catheter. The findings include: A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/24/2025 indicated Resident #4 had diagnoses that included cerebral palsy, seizure disorder, and depression, with short and long-term memory problems and moderately impaired cognitive decision making. Section H indicated Resident #4 had a catheter in place. Section M indicated Resident #4 had an unhealed pressure ulcer/injury moisture associated and required a pressure reducing device. A review of the Medication Administration Record (MAR) , dated 04/23/2025, revealed Resident #4 had a stage II pressure ulcer to the buttocks, with orders to: cleanse the wound, apply collagen, and cover. On 04/23/2025 at 5:10 PM, this surveyor observed Certified Nursing Assistant (CNA) #8 and CNA #9 approach Resident #4, at the bedside, and reposition the resident onto the resident ' s left side while the Director of Nursing (DON) removed the resident ' s coccyx dressing. None of the three staff members had donned a gown before beginning this high contact activity. The DON described the resident ' s wound as an open stage II wound, and stated it was a moisture related wound, and not a pressure ulcer. CNAs #8 and #9 stated that the catheter foley was leaking, and the padding under the resident was soaked. The DON stated that the Medical Director (MD) had mentioned there may have been something growing in Resident #4's urine. The DON was asked if staff should have followed EBP and worn gloves and gowns during wound care. The DON stated they forgot. CNAs #8 and #9 agreed they should have put on gowns during wound care. The DON confirmed Resident #4's catheter was leaking and their gloves encountered the saturated padding under Resident #4. The DON, CNA #8, and CNA #9 agreed that staff could introduce infection to Resident #4, and staff could carry infection to other residents. The DON confirmed EBP signage was in place on Resident #4's door, and Personal Protection Equipment (PPE) could be found at the nurse ' s station. On 04/23/2025 at 5:30 PM, the Administrator stated she expected staff to gown and glove anytime they provided personal care for a resident on EBP. Staff had masks that were stored in a bag, and PPE could be found in the supply closets. The Administrator confirmed that not wearing PPE, during personal care for a resident with a wound and leaking catheter, could have introduced infection to the resident, and infection could be spread to others. This surveyor requested the EBP policy/protocol, and in-service documentation on EBP. On 04/25/2025 at 10:00 AM, the Medical Director said that his expectation was that staff would follow EBP to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a policy titled Enhanced Barrier Precautions, reviewed on 08/01/2023, revealed EBP reduced the risk of transmitting multidrug resistant organisms (MDROs). During EBP, gowns and gloves are worn during high contact resident care including wound care, dressing changes, and changing briefs. Open wounds are generally larger than stage one (I) and require a dressing change. The care plan should reflect the changes in care needs, and EBP signage should be placed outside the door identifying the room as resident requires high care contact. PPE should be in carts or containers in easy to locate areas near the resident's door. A trash can should be placed near the room exit to discard gowns and provide alcohol gel outside the door. A review of an in-service titled Implementing the use of EBP, revealed EBP is used to reduce the risk of spreading multidrug resistant organisms (MRDOs) and involves the use of wearing gowns and gloves during high contact resident care including open wound care.