STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105566	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Winter Haven	1120 Cypress Gardens Blvd Winter Haven, FL 33884

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 - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768 Based on observation, record review and interviews, the facility failed to protect one (#1) resident from witnessed physical abuse by a staff member and failed to protect two residents (#2, #3) following allegations of abuse out of a total sample of four residents. Findings included: (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 - Actual harm Residents Affected - Few	1. During an interview on 04/02/2024 at 12:50 p.m. Staff B, Licensed Practical Nurse (LPN) stated she worked a double on 3/26/24 with Staff A, LPN. Staff A, LPN was with Resident #1, and I heard him state, If you don't stop swearing, I am going to slap the shit out of you. The first time I heard him I was at my med cart down the 40s hall. It was loud enough I could hear it. Staff A, LPN was standing next to the resident's wheelchair; I was probably about 25 feet away. I went back to my desk at the nursing station after med pass. I sat at the nursing station. Resident #1's chair was between the enclave and the nursing station. Staff A, LPN had just finished the dining cart. After cursing at Resident #1, Staff A, LPN moved about to check the dining trays in the dining cart, in front of the nursing station. There were other residents, but I cannot recall who was out there. There were possibly other aides out there, but I don't remember. I was sitting at the computer and Resident #1 swore again. Staff A, LPN stopped what he was doing and walked over to him and slapped him on the back of the head and stated if he swore again, he would slap the shit out of him again. Resident #1 wheeled himself into the enclave and Staff A, LPN walked back to the dining room trays. I looked down so Staff A, LPN would not see I saw him slap Resident #1. I had never been in that position before. I tried to call a manager, Staff C, Registered Nurse (RN)/Unit Manager (UM), my UM. She was not working that night. I did not call the supervisor (Staff F, LPN/ 3-11 Supervisor). I did not know what to do. I spoke to Staff C, RN/UM, and she told me to call DOQA/RM (Director of Quality Assurance/Risk Manager) and go to Cypress Unit and notify the supervisor (Staff F, LPN/3-11 Supervisor). It took me a couple of minutes to figure out what I should do. It probably took me 30-45 minutes. I was not sure what Staff A, LPN was doing because I left the area. I did not want him to know I was reporting him. I had to go outside to call Staff C, RN/UM. The DOQA/RM had gotten there by then, and I was sitting in the classroom. I cannot remember if the DOQA/RM went to the other floor or not before the police got there. The supervisor and the DOQA/RM went to the other floor after the police got there, I think. The ITNHA (In Training Nursing Home Administrator) came in and talked to us about it (abuse and neglect). We have received training in what we are not supposed to do. Not training in what we are supposed to do. I thought I had two hours to report it. It puts you off when it happens. I should have removed the resident and taken the resident with me and made the appropriate calls. The DOQA/RM is the abuse coordinator. I have been re-educated since the incident to ensure immediate protection of the residents and immediately notify the supervisor on-site. Review of the Admission Record revealed Resident #1 was admitted on [DATE], readmitted on [DATE] and discharged on [DATE]. The Admission Record showed diagnoses included cerebral vascular accident (CVA) with hemiplegia, syncope and collapse, hypertension, recurrent moderate major depression, anxiety, dysphagia, history of falling. Review of the Annual Minimum Data Set (MDS), dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 08 (moderately impaired). Section GG, Functional Abilities and Goals showed Resident #1 required substantial assistance for care. Review of the Skin Check Form, dated 3/26/24 at 21:09 (9:09 p.m.), showed no new skin issues observed, back of head and neck also assessed and there are no new skin issues or irregularities observed will continue to monitor. Review of the progress notes showed on 03/26/2024 at 21:00 (9:00 p.m.), late entry, pt (patient) skin check completed, no new skin issues observed, back of head and neck also assessed and no irregularities nor abnormalities observed. MD (medical doctor) aware and will see pt in a.m. pt denies any pain or discomfort at this time. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview and review of the investigation on 04/02/2024 at 11:23 a.m. the Director of Quality Assurance (DOQA) Risk Manager (RM) stated she received a call last Tuesday (03/26/2024) from Staff B, Licensed Practical Nurse (LPN). Staff B, LPN was working on the Palm Unit, she called at approximately 6:30 p.m. Staff B, LPN told her she overheard Staff A, LPN verbally abusing Resident #1 and when she looked up from the desk, she saw Staff A, LPN slap the back of Resident #1's head. Staff B, LPN told her the incident was at approximately 5:45 p.m. The DOQA/RM stated she got dressed, and called the police as she was driving to the facility. She told Staff B, LPN to get the supervisor. She told Staff B, LPN to tell the supervisor to monitor Staff A, LPN until she and the police could get there. Staff F, LPN, 3-11 Supervisor was the 3-11 supervisor, she had no assignment. The DOQA/RM stated Staff A, LPN was sitting at the nursing station and Staff F, LPN, 3-11 Supervisor was sitting with him. So, he was away from the residents with the supervisor when she arrived. The DOQA/RM took Staff B, LPN to the education room and had her write her statement. Then the police arrived. The police wanted to talk to Staff B, LPN first and the DOQA/RM went with Staff B, LPN and the police. The police recorded Staff B, LPN's statement and contact information. The police went to the Palm Unit to see Resident #1 and took him to his room. The police asked Resident #1 a couple of questions. Resident #1 was mumbling and unable to put together sentences, the police reviewed that he was a disabled adult and unable to remember the event. The police wanted to speak to Staff A, LPN and they took him into another room and the DOQA/RM waited outside. When the police and Staff A, LPN came out Staff A, LPN was in hand cuffs and the medication keys were given to the DOQA/RM. Staff A, LPN and the police left together. We changed the assignments and pulled a nurse to come over to the Palm Unit at approximately 7:30 p.m. The DOQA/RM stated, I got statements from five aides and the supervisor and did my report to AHCA and DCF. I called and notified the Medical Director at 2100 (9:00 p.m.). The family was called and a left a voice mail at 8:50 p.m. for the [family member]. The DOQA/RM stated she called the spouse again on 03/27 and at 10:11 a.m. and left another voice mail and called the (family member) again 03/27 at 16:47 (4:47 p.m.) and she picked up. The DOQA/RM stated she left the facility at 9 p.m. The ITNHA (In Training Nursing Home Administrator) / SSD (Social Services Director) came in and started abuse training. The Director of Education was overseeing the education. The DOQA/RM stated the education was completed yesterday when she submitted the 5-day report. The DOQA/RM substantiated the allegation. The DOQA/RM asked both Staff A, LPN and Staff B, LPN if there were any other witnesses. The DOQA/RM stated she interviewed all the interviewable residents, and no one saw anything. The DOQA/RM stated she asked for statements of all the staff that evening. The DOQA/RM stated Staff A, LPN had been working here since 2017. The DOQA/RM stated his only corrective action was for unapproved overtime. Staff F, LPN, 3-11 Supervisor did a skin check and wrote a nurses note. The DOQA/RM stated, the Medical Director was going to see him (Resident #1) the next day and Resident #1 was not seen by psych but was on the list to be seen. During the DOQA/RM interview the Director of Nursing (DON) entered on 04/02/2024 and stated Resident #1 was on Depakote, and psych only saw him every so often. The DON stated the psychologist should have seen the resident. The DON stated the psychologist was scheduled to be at the facility on Wednesdays and Thursdays. The DON stated the resident was not on the psychologist's list to be seen. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Both the DON and DOQA/RM stated they did not ask the psychologist to see the resident. The DON stated the psychologist would have seen the resident if she had been asked. The DOQA/RM stated she did not interview Staff A, LPN until after he posted bail on 03/29 at 1749 (12:49 p.m.). The DOQA/RM stated Staff A, LPN stated everything went according to plan, how it usually does, like with dinner and checking trays and getting everyone fed. He stated, Nothing out of the sort until the commotion happened. The DOQA/RM stated Staff A, LPN stated he did not recall seeing anyone in the enclave area. He stated at 1745 / 5:45 p.m. he was giving Resident #1 his medications. He said Resident #1 got his wheelchair tangled up with Resident #4's wheelchair. He had to untangle him from Resident #4 to give Resident #1 his medication. He had to maneuver them a little bit and get Resident #1 free and bring him to the medication cart. He brought Resident #1 to the cart to give him his medication (the cart was near the nursing station). Staff A, LPN stated his voice carries, a very bold loud tone when he needs to get a resident's attention. Staff A, LPN stated, Resident #1 was doing his normal cursing, and I said Resident #1 stop cursing. I may have said it loud because he was cursing all evening, more than normal. Staff A, LPN never admitted to hitting Resident #1. Staff A, LPN stated, I would never hit Resident #1. When asked if he had any issues with any coworkers, he said not at all, if there is someone, I don't pay attention to it and it is unknown to me. The DOQA/RM stated she, Staff B, LPN and Staff F, LPN/3-11 Supervisor did, in passing, discuss Staff B had done the right thing to report, and Staff B stated she would have reported it if it had happened before. The DOQA/RM stated Staff B, LPN told her she got out of the building to call DOQA/RM as soon as she could. Staff B, LPN told DOQA/RM the incident happened at 1744 (5:44 p.m.), but she did not reach out until 1830 (6:30 p.m.). The DOQA/RM stated, I think she spoke with others because I was getting text messages from others before [Staff B, LPN] called me. The DOQA/RM stated Staff F, LPN/3-11 Supervisor was on the short-term unit and the incident happened on the long-term unit. The DOQA/RM stated Staff B, LPN did not remove Staff A, LPN from the resident at the time she witnessed the incident (slapping). The DOQA/RM stated Staff B, LPN did not call Staff F, LPN/3-11 Supervisor. Staff F first heard of the incident from the DOQA/RM. The DON stated on 04/02/24 at 12:10 p.m. that Staff B, LPN should have removed the resident from danger and called Staff F, LPN/3-11 Supervisor then the DOQA/RM. The DON stated she told Staff B, LPN she should have gotten the supervisor ASAP (as soon as possible) and not waited. The staff know the procedures. Timeline provided by the DOQA/RM: Staff B, LPN observed the incident at 1744/5:44 p.m. DOQA/RM was called by Staff B, LPN at 1830/6:30 p.m. Police notified at 6:42 p.m. while driving to the facility by DOQA/RM DOQA/RM to facility at 6:55 pm Police arrived at 7:14 pm. NHA (Nursing Home Administrator) and regional nursing consultant and DON were called at 7:48 p.m. DON called ITNHA at about 8:00 p.m. NHA was on leave; SSD/ITNHA came in; DON did not come in (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	DCF was informed at 8:09 p.m. AHCA was informed at 8:29 pm. (Family member) was called and Voice mail left at 8:50 p.m. Staff F, LPN/3-11 Supervisor called Resident #1's physician at 9:00 p.m.; he stated he would be in the next morning Medical director called by DOQA/RM at 9:00 p.m. 03/27/24 called (family member) at 10:11 a.m. and Voice mail left 03/27/24 called (family member) at 4:47 p.m. and informed. During an interview on 04/02/2024 at 1:07 p.m. with the facility psychologist she stated she was not aware of the incident with Resident #1. She comes to the facility on Wednesdays and Thursdays and was there last week. She stated no one told her about the verbal and physical abuse with Resident #1. If she had been informed, last week, she would have seen him. To my knowledge, the psych APRN, would see the resident also. If something happens, we are always, if asked, to see the patient if there was some kind of allegation. We see if the resident is ok. We talk with the resident as to their perception of what happened. If it happened on a Tuesday, I would be there the next day (Wednesday) to see the person. I would see them for an assessment of their reaction to the incident. During an interview on 04/02/2024 at 1:31 p.m. the Director of Education stated she had been at the facility for about six months. The abuse, neglect and exploitation in-service was started on the 03/25/2024. She stated, I was just doing an education to keep us updated including when to report and who to report it to. She stated they have computer class on (software program), education on abuse and neglect. She stated she also does in-person education. She goes from shift to shift, calls the staff to the education room. All the nurses, all the aides are in-serviced. She stated she in-services the kitchen staff and laundry. Therapy department does their own. She stated they finished on the 03/29/2024. She educated the staff to notify the DOQA/RM or their immediate supervisor at the time of the event. If the resident is with the abuser, we separate them immediately. She stated she will ask the staff if they can tell me a type of abuse. They have to explain what happens. They have to tell me who to notify and how soon. She stated they are told to notify immediately. They don't have two hours to notify; it is immediate. During an interview on 04/02/2024 at 1:54 p.m. the DON stated Resident #1's physician did not come in and see the resident. The supervisor (Staff F, LPN/3-11 Supervisor) asked him to come see him and he stated he would see him the next day. The DON stated the DOQA/RM spoke with him today (04/02/2024) and he did not come in to see the resident the next day. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 04/02/2024 at 3:03 p.m. the Staff F, LPN/3-11 Supervisor stated, [DOQA/RM] called me to go over to Resident #1 and secure him. Make him safe. When I got over there, I did not see anything, [Staff A, LPN] was still passing meds. I removed [Staff B, LPN] and kept her in my office. [Staff A, LPN] was left on the floor and was being observed by me (Staff F, LPN, 3-11 Supervisor). [DOQA/RM] got there. [DOQA/RM] had called the police while driving. [DOQA/RM] spoke to [Staff B, LPN] and spoke to her. The police arrived. They (the police) interviewed [Staff B, LPN]. They (the police) went to [Resident #1's] room and spoke to him. He stated yes but was not able to give the details of what happened. The police and [DOQA/RM] took [Staff A, LPN] off the floor. [Staff A, LPN] was walking up down the halls and pacing. Staff F, LPN, 3-11 Supervisor stated she was watching him (Staff A, LPN). She stated, After he realized what was going on he was pacing, he was not interacting with the residents. The police handcuffed him and left with him. The DOQA/RM and Staff B, LPN gave the police statements. We all had to give written statements to the facility. She stated another nurse took over his floor. She stated she had never been involved with abuse before. She stated Staff A, LPN had been here a while, and it was a surprise. He was a jovial person. Not angry. He did a good job. She stated Resident #1 was not hard to work with. Staff F, LPN/3-11 Supervisor stated Staff A, LPN and Resident #1 seemed to have a good relationship prior to this. She does not know what happened that evening. Staff F, LPN/3-11 Supervisor stated (DOQA/RM) called her after supper, 6 or 6:30ish. Staff F, LPN/3-11 Supervisor stated she had abuse and neglect in-service before and since this incident. Staff F, LPN/3-11 Supervisor stated we are to move the patient immediately to safety. The abuser needs to be moved away. When asked why he was still giving meds? Staff F, LPN/3-11 Supervisor stated the resident (Resident #1) was moved to the enclave and Staff A, LPN was straight down the hall, passing meds to other residents. When Staff A, LPN realized something was going on, was not off the floor but he was pacing and not in the area of the residents (at the nursing station). She stated this was her first abuse situation. She stated she had never seen this before, especially someone being taken away in handcuffs. Staff F, LPN/3-11 Supervisor stated, We had an in-service that day, he (Staff A, LPN) was at it. I gave it to him. Staff F, LPN/ 3-11 Supervisor stated, [Resident #1] was known to cuss, I had not heard him, but heard he uses the F bomb a lot. During an interview on 04/02/2024 at 5:40 p.m. Resident #1's physician returned the phone call and stated he thought his APRN saw Resident #1. He had not seen the resident. He stated he makes rounds at the facility on Mondays and Thursdays. He stated, I do not know where the facility got, I was seeing him (Resident #1). The facility called me on Tuesday p.m. (evening) to let him know of the incident. He stated he thought his APRN was to see him Thursday morning. His APRN was there on Thursday mornings, and he was there on Thursday afternoons. He stated he had tried to call his APRN, but she had not called him back. No documentation could be found to show the resident was seen by the physician or APRN following the incident. 22481 2. A review of Resident #3's Transfer/Discharge Report documented an admitted [DATE]. The record documented the resident had a spouse. The resident had medical diagnoses to include: aphasia following cerebral infarction; essential (primary) hypertension; hemiplegia and hemiparesis following cerebral infarction affecting right dominant side; unspecified dementia and chronic obstructive pulmonary disease. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #3's care plan revealed a Focus as: ADL(Activity of Daily Living) Self-Care and/or mobility deficit. Needs assistance with ADL's. At risk of developing complications associated with decreased ADL self-performance related to: cognitive impairment, hemiplegia and monoplegia following CVA's (Cerebral vascular accident) , requires weight bearing support, weakness, dependent for basic ADL's, initiated 11/21/2023. Interventions included: Bed Mobility, dependent for bed mobility w/2 (with two) assistance. Transfers-dependent for transfers via mechanical lift and 2 assistance. Toileting, dependent for incontinence care. Dressing, bathing, grooming, dependent. On 04/02/2024 at 3:47 p.m. a Report for Resident #3 was reviewed with the DOQA/RM. It was confirmed the report reflected the incident date was 03/21/2024 at 1130 (11:30 a.m.) as a physical abuse allegation and staff became aware of the incident on 03/21/2024 at 11:30 a.m. The description of the allegation was confirmed to include, On 03/21/2024 at 11:30 a.m., the [DOQA/RM] was made aware of a new skin injury that was observed to (Resident #3's) left inner lip area, on the inside of his mouth. [Resident #3] is nonverbal, but can communicate by nodding/shaking head for yes/no. During an interview with [Resident #3], it was asked if he had been hit, he nodded his head for yes. When asked if it was a female staff member, he shook his head no. When asked if it was male staff member, he nodded his head for yes. When asked if it was today, he nodded his head yes. It was then asked if it was today while the sun was up, he nodded his head for yes. Injuries documented: Small markings observed to inside of lip/mouth near teeth. Steps taken immediately in response to the incident: After review of the assignment/schedule for the day shift, no male staff members were identified that have any type of encounter with [Resident #3]. The allegation of abuse has been reported to DCF (Department of Children and Families) and law enforcement . The summary: Based on medical diagnoses review, SSD (Social Service Director) evaluations, skin check documentation, staff, POA (Power of Attorney), and resident interviews held, the allegation of abuse is unsubstantiated. Abuse, neglect, exploitation education to team members has been started and is ongoing. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During the review, the DOQA/RM stated the date of the event was 03/21/2024 at 11:30 a.m. The DOQA/RM stated she received notification from the Director of Transitional Services (DTS) that she needed me to look at (Resident #3). She said there was a new skin injury on the inside of his lip. She and I went down to the resident's room. At this time, the Director of Nursing (DON) and Staff E, RN were made aware. All four of us were in the room. The first thing (DTS) did was pull down the resident's lip and there were two discolorations on the inside of the lip, on the mucosa. You had to pull the lip all the way down to see it. After we look (DTS) started to ask the resident questions. He was able to answer questions, yes, or no, by shaking or nodding his head. He nodded yes to being hit, yes to the person doing the action as a male. When asked if the resident was asked if the person was a certified nursing assistant or a nurse, the DOQA/RM stated, no, we were asking him questions, the sun was up, and it was a male. The DOQA/RM stated, We looked at the schedule to see who might have come into contact with the resident. Determined he did not have any male aides or nurses. I then submitted my report to DCF, AHCA, and doctor notification. I then got a list of all male staff members and started my interviews with them. I also asked any therapist if they had come into contact with the resident and looked back a week for male staff members. I interviewed staff from the past 72 hours. That was when I asked social services (SS) on the resident's orientation status. They told me he was not oriented based on the SS evaluations dated 11/14/2023 and 02/15/2024. A review of his medical diagnosis included dementia. I asked the wound care nurse to complete a skin assessment. He was unable to do it because the resident was discharged the same day. The DOQA/RM stated the results of her investigation were Unsubstantiated based on the social service assessment evaluation, and medical diagnoses of seizures and dementia. An interview was conducted on 04/02/2024 at approximately 4:30 p.m. with the DON. The DON stated Resident #3 had been at the facility since November/December of 2023. She stated she was familiar with the resident. The DON stated, The resident could not speak. He was nonverbal. The DON stated, When I asked him how he was doing, he would nod. So, I was thinking he would understand what I was saying. The DON stated, He needed assistance to get out of bed. The DON stated, He was combative towards staff at times. That morning, (DTS) texted, Where are you. My response was I am on Cypress landing, subacute side. She came and she met me in the hallway. She said something is going on with (Resident #3). Then, I said she needed to go get (DOQA/RM), and I would finish what I was doing and come right to that room. It was in the morning, right after our morning meeting, between 9:30 a.m. and 10:00 a.m. Probably, 15-20 minutes after she told me, I was in the room. (DTS) and (DOQA/RM) and the resident were in the room. The DON stated (DTS) was asking the resident if someone had done that to him; he nodded yes. The DON was observed to make a fist and repeatedly move it towards her face as if to hit her face motion. She stated, This is what the resident did. The DON stated, Then, the resident indicated male and this morning. I told (DOQA/RM) she could handle it. Then I went and told the Nursing Home Administrator (NHA). The DON stated, No bruising on his face, but when [DTS] pulled his lips apart and you could see his lip on the inside; old burgundy discolor. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 04/02/2024 at 5:19 p.m. with the DTS. She stated on 3/21/24, I went to visit him. I always go and visit. She stated, He is nonverbal. He had a stroke. She confirmed he could understand and stated, Yes, he can. He shakes his head or nods; yes, no. She stated, I noticed that his lip had blood on it, and it was swollen. I stepped closer. I asked him what happened. He is a [mechanical lift]. He could have hit it then. I started asking him questions. At the time I saw him, he was sitting in his chair. He was dressed . They had gotten him up. She stated, It was his left side. I asked him what happened, and he made a gesture. The DTS was observed to close her fist and hold it up to her face. She stated, Like someone punched him. She stated, I asked him if he hit himself. He said no. I asked him if someone had hit him. He nodded his head yes. Then I opened his mouth to see how bad it was, and it was bruised on the inside (the lower portion); there was blood on his gums and his teeth. Then, I lifted the upper lip, and it was also bruised, and it looked like a tooth mark on the lip. Then I called the DON, asked her where she was; she stated where she was. I told her I was in [Resident #3's] room, and he says someone hit him. Then, she told me to tell the [DOQA/RM]. So, I left the room and went to the [DOQA/RM 's] office; and took her to [Resident #3's] room; she looked at his lip; she asked him what happen. [Resident #3] made the same gesture when she asked him. She asked him if it was a man or a woman. She asked him if it happened today, and he said yes. And then the DON came over to the room. And then [Staff E, RN] came over to the room. And the [DOQA/RM] is like, there is no guys on that shift. The DTS stated, (Resident #3's) sense of time frame was not there; he can answer yes or no. He has not changed his story. He was discharged home. He and (family member) live with us. The DCF (Department of Children and Families) investigator came out to the house. The story was the same. The DCF investigator asked him questions, she asked what race the person was; he indicated (African American). The DOQA/RM was reinterviewed on 04/02/2024 at 5:40 p.m. She stated for her investigation she looked backed at 72 hours for all staff, and one week for male staff. She stated she obtained statements. She stated the questions she asked the staff were: Any new skin conditions to the resident lip area? Anything that would suspect any skin injury? If that staff member had been made aware or seen any abuse towards the resident. The DOQA/RM confirmed no other residents were interviewed or assessed. She stated, No, we did not assess all of the residents for skin or any injuries. She confirmed residents were not interviewed about abuse and neglect. She stated, I did ask one resident who was interviewable on 03/26/2024. The question I asked was if he had any concerns regarding care from the CNAs or nursing. The DOQA/RM stated, (Resident #3) discharged at 3:00 p.m. on the date of the allegation. There were a lot of things I would like to had completed before the discharge like a skin assessment and psych evaluation. A review of Resident #3 Medication Administration Record (MAR) for 03/2024 documented Staff A, LPN administered medications during the evening shift on 03/20/2023 to Resident #3. An interview was conducted on 04/03/2024 at 3:30 p.m. with the DON. She confirmed Staff A, LPN's initials on the MAR for 3/20/2024. The DON confirmed one staff member, Staff A, matched the demographic description that Resident #3 indicated to his family member. (continued on next page)

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	105566	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 04/03/2024 at 3:52 p.m., the DOQA/RM was re-interviewed. A review of the statements she collected from the male staff members was conducted. She stated out of the 17 male staff members, she looked at who had come into contact with Resident #3, 72 hours prior to the allegation, just one, Staff A, LPN, had come into contact with him. She stated she did conduct a phone interview with Staff A. She stated, basically, I just asked if there was any abuse that was going on or if there was any new skin injury to the resident. She provided a statement from Staff A. She stated she collected the statement on 03/26/2024 at 12:48 p.m. The statement documented, No, I did not witness any abuse. I was also not aware of any new skin issue. When asked the reason for the delay in the interview conducted with Staff A, the DOQA/RM stated, I have 5 days to complete the investigation, and so, whenever I get a chance to complete it. I had another reportable that day, and so, I was split between the two. The DOQA/RM confirmed Staff A was African American. When asked if she followed up with Resident #3 to show him a picture of Staff A, LPN to find out if he was the staff member who hit him, the DOQA/RM stated, No, the resident had discharged home. I had a SOC (standards of care meeting), 1:30-3:30 p.m., and the resident discharged between 3:00 p.m. and 4:00 p.m. She stated, This is my first job as a Risk Manager. Started in June of 2023. Before this, I was a unit manager. I had basic orientation. I shadowed another DQOA [Director of Quality Assurance] for two days. 3. A review of Resident #2's Admission Record documented an initial admitted [DATE] and a readmitted [DATE]. Her medical diagnosis information included but was not limited to: encounter for surgical aftercare following surgery on the digestive system, cerebral infarction and chronic obstructive pulmonary disease. A review of a Minimum Data Set Assessment (MDS) Section C - Cognitive Patterns, dated 01/19/2024, documented a Brief Interview for Mental Status (BIMS) score of 15, which meant Resident #2's cognition was intact. A review of a Grievance Concern form for Resident #2 documented a date of contact with Resident #2 as 03/20/2024 but listed no time. The concern revealed, On 3-11 (3:00 p.m. - 11:00 p.m.) shift, not sure what day, a CNA (certified nursing assistant) got in her face and cussed at her. The form was signed by the Life Enrichment Director (LED), but not dated. The areas for the questions, When did it happen?; Date of Incident:; Where did it happen?; and Time of Incident: were left blank. The area for the Desired Outcome Or Resolution, Goal was left blank. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 04/02/2024 at 1:36 p.m. with the Director of Quality Assurance/Risk Manager (DOQA/RM). She stated the date of Resident #2's alleged event was 03/18/2024. She stated, We do not have time, just during the evening shift. She stated, It was an allegation of abuse. She stated, [Resident #2] told the Life Enrichment Director (LED) that during the evening on 03/18/2024 a CNA got in her face and cussed at her. The LED became aware of the allegation during the Resident Council meeting on 03/20/2024. The DOQA/RM provided a second page for the grievance, which documented the grievance had been rolled to reportable. The form documented the grievance had been confirmed. The summary showed: A reportable was opened on 03/21/2024 for allegation of verbal abuse. Education started on ANE (Abuse, Neglect & Exploitation) to staff, signed 03/21/2024. The DOQA/RM stated the CNA was (Staff D, CNA). The DOQA/RM stated she had a statement from Staff D, CNA. The DOQA/RM stated she obtained Resident #2's statement on 03/21/2024, but she did not know what time the statement had been obtained. The DOQA/RM stated she interviewed Resident #2 on 03/21/2024. The DOQA/RM stated she became aware of the allegation on 03/21/2024 at 9:20 a.m. The DOQA/RM stated the Resident Council meeting was on 03/20/2024 at around noon. The DOQA/RM stated she calls an allegation in within two hours of her becoming aware of the allegation. When asked if she reports the allegation within two hours of the facility staff becoming aware of the allegation, the DOQA/RM stated, No, when I become aware of it. The DOQA/RM stated the CNA identity was found out on 03/21/2024, at the same time I became aware of the allegation. She stated, the Director of Nursing (DON) gave me a statement (written by Staff D, CNA). She said it might have to do with the incident. The DOQA/RM stated, Yes, at 9:20 a.m., I called and spoke with the CNA and suspended her. I interviewed the resident on 03/21/2024. Re [TRUNCATED]

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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 - Actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768 Based on observation, record review and interview, the facility failed to implement the facility's Abuse, Neglect, Exploitation and Misappropriation policy and procedure for witnessed physical abuse of one resident (#1) and allegations of physical and verbal abuse of two residents (#2 and #3) of four sampled residents. Findings included: A review of facility's Abuse, Neglect, Exploitation and Misappropriation Policy and Procedures, last revised September 2023, documented the policy: The center recognizes each resident's right to be free form abuse, neglect, and exploitation (ANE), misappropriation of resident property . This center reports suspicions of crimes committed against a resident of this center in accordance with section 1150B of the Social Security Act to at least one law enforcement agency and the State Agency. Definitions for F600 Staff: Statute 483.12 define staff as employees of the center, the medical director, consultants, contractors, and volunteers. This definition will also include caregivers that provide care and services to the resident on behalf of the center. Willful: Statute 483.5 in the definition of abuse this means the individual must have acted deliberately, NOT that the individual must have intended to inflict injury or harm. Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish . Physical Abuse: Striking the resident with a part of the body or with an object; non-therapeutic shoving, pushing, pulling, or twisting any part of the resident's body; hitting, slapping, pinching, kicking, burning, or striking a resident with an object . Psychological/ Emotional/ Mental Abuse: Psychological/ Emotional/ Mental abuse is the use of verbal or non-verbal contact which causes the resident to experience humiliation, harassment, malicious teasing, and threats of punishment or deprivation. Verbal Abuse: Verbal abuse is defined as the use of oral, written, or gestured language. Verbal abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Neglect: Neglect as defined in statute 483.5 is the failure of the center, its team members or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This occurs when the center was aware or should have been aware of, goods or services that the resident (s) required but the center failed to provide them resulting in or may result in physical harm, pain, mental anguish, or emotional distress. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	Procedure for prevention: This center maintains a zero tolerance for any form of abuse. The center encourages residents and families, and requires team members to report concerns, incidents, and grievances without fear of retaliation, and is provided feedback, when possible, on these reports. The center identifies, corrects, and intervenes in situations of alleged abuse, neglect, and exploitation (ANE) and misappropriation of resident property . 3. Employee Obligation: All employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating the resident's rights. Any employee who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation, or mistreatment, including injuries of unknown origin or misappropriation of resident property, is obligated to report such information immediately. If the event that results in the allegation involves abuse or resulted in serious bodily injury the center must report to the appropriate agencies to include law enforcement immediately but no later than 2 hours after the allegation is made. If the allegation does not involve abuse or significant bodily injury the event must be reported no later than 24 hours to the immediate supervisor, the Director of Quality Assurance, or the Executive Director of the center who will then report to the appropriate agencies. 4. Identification: Reporting of suspected abuse, neglect, exploitation, or misappropriation is required of all team members. Because not all incidents of abuse, neglect, exploitation, and misappropriation are observed the center will be alert to any signs that abuse has occurred or is occurring and report as per required. Non-action, which results in emotional, psychological, or physical injury, is viewed in the same manner as that caused by improper or excessive action. All actions in which employees engage with residents must have as their legitimate goal, the healthful, proper, and humane care and treatment of the resident. All reported events (bruises, skin tears, falls, inappropriate or abusive behaviors) will be investigated by the Director of Quality Assurance and they will be reviewed by the center's QAPI Committee for detection of patterns and/or trends . 5. Protection: If the circumstances warrant, a resident suspected of being the subject of maltreatment will be relocated to an environment where the resident's safety can be assured .If the alleged suspect is an employee, the team member(s) shall be removed to a non-resident care area and report the incident to the immediate supervisor, the Director of Quality Assurance or Executive director. The executive Director/designee shall place the employee on immediate suspension, pending the outcome of the investigation . 7. Investigation: A thorough investigation will be conducted, as this center has a zero tolerance for abuse of any form. The Director of Quality Assurance/ designee will initiate procedures for conducting the investigation. The investigation shall include the following but is not limited to this list: a. The type of allegation (as defined previously in this policy and procedure) may include the following: Confiscating photographs and/or recordings of residents . (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	b. What occurred, when, where, and to whom? By whom? Get physical description or identify the alleged suspect if possible. c. Describe the injury and any treatment. d. Interview witnesses separately; interview caregivers, roommates; get statements; observe/ document demeanor; include names, addresses, emails, and phone numbers of actual witnesses . It is important to complete an investigation that allows for decision making that is strongly supported. 8. Corrective Action: If an investigation verifies an allegation the center must take the appropriate corrective action to protect the residents. The implementation of the corrective action should have oversight and be evaluated for effectiveness. The center Quality Assessment and Assurance Committee shall monitor the reporting and investigation of all the alleged violations. All corrective actions will be documented. Acts of abuse directed towards residents are absolutely prohibited. Such acts are cause for disciplinary action, including up to termination of employment, reporting to licensing boards and possible criminal prosecution. 1. Review of the Admission Record revealed Resident #1 was admitted on [DATE], readmitted on [DATE] and discharged on [DATE]. The Admission Record showed diagnoses included cerebral vascular accident (CVA) with hemiplegia, syncope and collapse, hypertension, recurrent moderate major depression, anxiety, dysphagia, history of falling. Review of the Annual Minimum Data Set (MDS), dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 08 (moderately impaired). Section GG, Functional Abilities and Goals showed Resident #1 required substantial assistance for care. Review of the Skin Check Form, dated 3/26/24 at 21:09 (9:09 p.m.), showed no new skin issues observed, back of head and neck also assessed and there are no new skin issues or irregularities observed will continue to monitor. Review of the progress notes showed on 03/26/2024 at 21:00 (9:00 p.m.), late entry, pt (patient) skin check completed, no new skin issues observed, back of head and neck also assessed and no irregularities nor abnormalities observed. MD (medical doctor) aware and will see pt in a.m. pt denies any pain or discomfort at this time. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	During an interview and review of the investigation on 04/02/2024 at 11:23 a.m. the Director of Quality Assurance (DOQA) Risk Manager (RM) stated she received a call last Tuesday (03/26/2024) from Staff B, Licensed Practical Nurse (LPN). Staff B, LPN was working on the Palm Unit, she called at approximately 6:30 p.m. Staff B, LPN told her she overheard Staff A, LPN verbally abusing Resident #1 and when she looked up from the desk, she saw Staff A, LPN slap the back of Resident #1's head. Staff B, LPN told her the incident was at approximately 5:45 p.m. The DOQA/RM stated she got dressed, and called the police as she was driving to the facility. She told Staff B, LPN to get the supervisor. She told Staff B, LPN to tell the supervisor to monitor Staff A, LPN until she and the police could get there. Staff F, LPN, 3-11 Supervisor was the 3-11 supervisor, she had no assignment. The DOQA/RM stated Staff A, LPN was sitting at the nursing station and Staff F, LPN, 3-11 Supervisor was sitting with him. So, he was away from the residents with the supervisor when she arrived. The DOQA/RM took Staff B, LPN to the education room and had her write her statement. Then the police arrived. The police wanted to talk to Staff B, LPN first and the DOQA/RM went with Staff B, LPN and the police. The police went to the Palm Unit to see Resident #1 and took him to his room. The police asked Resident #1 a couple of questions. Resident #1 was mumbling and unable to put together sentences, the police reviewed that he was a disabled adult and unable to remember the event. The police wanted to speak to Staff A, LPN and they took him into another room and the DOQA/RM waited outside. When the police and Staff A, LPN came out Staff A, LPN was in hand cuffs and the medication keys were given to the DOQA/RM. Staff A, LPN and the police left together. The DOQA/RM stated, I got statements from five aides and the supervisor and did my report to AHCA and DCF. I called and notified the Medical Director at 2100 (9:00 p.m.). The family was called and a left a voice mail at 8:50 p.m. for the [family member]. The DOQA/RM stated she called the (family member) again on 03/27 and at 10:11 a.m. and left another voice mail and called the (family member) again 03/27 at 16:47 (4:47 p.m.) and she picked up. The DOQA/RM stated she left the facility at 9 p.m. The ITNHA (In Training Nursing Home Administrator) / SSD (Social Services Director) came in and started abuse training. The Director of Education was overseeing the education. The DOQA/RM stated the education was completed yesterday when she submitted the 5-day report. The DOQA/RM substantiated the allegation. The DOQA/RM asked both Staff A, LPN and Staff B, LPN if there were any other witnesses. The DOQA/RM stated she interviewed all the interviewable residents, and no one saw anything. The DOQA/RM stated she asked for statements of all the staff that evening. The DOQA/RM stated Staff A, LPN had been working here since 2017. The DOQA/RM stated his only corrective action was for unapproved overtime. Staff F, LPN, 3-11 Supervisor did a skin check and wrote a nurses note. The DOQA/RM stated, the Medical Director was going to see him (Resident #1) the next day and Resident #1 was not seen by psych but was on the list to be seen. During the DOQA/RM interview the Director of Nursing (DON) entered on 04/02/2024 and stated Resident #1 was on Depakote, and psych only saw him every so often. The DON stated the psychologist should have seen the resident. The DON stated the psychologist was scheduled to be at the facility on Wednesdays and Thursdays. The DON stated the resident was not on the psychologist's list to be seen. Both the DON and DOQA/RM stated they did not ask the psychologist to see the resident. The DON stated the psychologist would have seen the resident if she had been asked. The DOQA/RM stated she did not interview Staff A, LPN until after he posted bail on 03/29 at 1749 (12:49 p.m.). The DOQA/RM stated Staff A, LPN stated everything went according to plan, how it usually does, like with dinner and checking trays and getting everyone fed. Staff A, LPN never admitted to hitting Resident #1. Staff A, LPN stated, I would never hit Resident #1. When asked if he had any issues with any coworkers, he said not at all, if there is someone, I don't pay attention to it and it is unknown to me. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	The DOQA/RM stated she, Staff B, LPN and Staff F, LPN/3-11 Supervisor did, in passing, discuss Staff B had done the right thing to report, and Staff B stated she would have reported it if it had happened before. The DOQA/RM stated Staff B, LPN told her she got out of the building to call DOQA/RM as soon as she could. Staff B, LPN told DOQA/RM the incident happened at 1744 (5:44 p.m.), but she did not reach out until 1830 (6:30 p.m.). The DOQA/RM stated, I think she spoke with others because I was getting text messages from others before [Staff B, LPN] called me. The DOQA/RM stated Staff F, LPN/3-11 Supervisor was on the short-term unit and the incident happened on the long-term unit. The DOQA/RM stated Staff B, LPN did not remove Staff A, LPN from the resident at the time she witnessed the incident (slapping). The DOQA/RM stated Staff B, LPN did not call Staff F, LPN/3-11 Supervisor. Staff F first heard of the incident from the DOQA/RM. The DON stated on 04/02/24 at 12:10 p.m. that Staff B, LPN should have removed the resident from danger and called Staff F, LPN/3-11 Supervisor then the DOQA/RM. The DON stated she told Staff B, LPN she should have gotten the supervisor ASAP (as soon as possible) and not waited. The staff know the procedures. Timeline provided by the DOQA/RM: Staff B, LPN observed the incident at 1744/5:44 p.m. DOQA/RM was called by Staff B, LPN at 1830/6:30 p.m. Police notified at 6:42 p.m. while driving to the facility by DOQA/RM DOQA/RM to facility at 6:55 pm Police arrived at 7:14 pm. NHA (Nursing Home Administrator) and regional nursing consultant and DON were called at 7:48 p.m. DON called ITNHA at about 8:00 p.m. NHA was on leave; SSD/ITNHA came in; DON did not come in DCF was informed at 8:09 p.m. AHCA was informed at 8:29 pm. (Family member) was called and Voice mail left at 8:50 p.m. Staff F, LPN/3-11 Supervisor called Resident #1's physician at 9:00 p.m.; he stated he would be in the next morning Medical director called by DOQA/RM at 9:00 p.m. 03/27/24 called (family member) at 10:11 a.m. and Voice mail left 03/27/24 called (family member) at 4:47 p.m. and informed. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	During an interview on 04/02/2024 at 12:50 p.m. Staff B, Licensed Practical Nurse (LPN) stated she worked a double on 3/26/24 with Staff A, LPN. Staff A, LPN was with Resident #1, and I heard him state, If you don't stop swearing, I am going to slap the shit out of you. The first time I heard him I was at my med cart down the 40s hall. It was loud enough I could hear it. Staff A, LPN was standing next to the resident's wheelchair; I was probably about 25 feet away. I went back to my desk at the nursing station after med pass. I sat at the nursing station. Resident #1's chair was between the enclave and the nursing station. Staff A, LPN had just finished the dining cart. After cursing at Resident #1, Staff A, LPN moved about to check the dining trays in the dining cart, in front of the nursing station. There were other residents, but I cannot recall who was out there. There were possibly other aides out there, but I don't remember. I was sitting at the computer and Resident #1 swore again. Staff A, LPN stopped what he was doing and walked over to him and slapped him on the back of the head and stated if he swore again, he would slap the shit out of him again. Resident #1 wheeled himself into the enclave and Staff A, LPN walked back to the dining room trays. I looked down so Staff A, LPN would not see I saw him slap Resident #1. I had never been in that position before. I tried to call a manager, Staff C, Registered Nurse (RN)/Unit Manager (UM), my UM. She was not working that night. I did not call the supervisor (Staff F, LPN/ 3-11 Supervisor). I did not know what to do. I spoke to Staff C, RN/UM, and she told me to call DOQA/RM (Director of Quality Assurance/Risk Manager) and go to Cypress Unit and notify the supervisor (Staff F, LPN/3-11 Supervisor). It took me a couple of minutes to figure out what I should do. It probably took me 30-45 minutes. I was not sure what Staff A, LPN was doing because I left the area. I did not want him to know I was reporting him. I had to go outside to call Staff C, RN/UM. The DOQA/RM had gotten there by then, and I was sitting in the classroom. I cannot remember if the DOQA/RM went to the other floor or not before the police got there. The supervisor and the DOQA/RM went to the other floor after the police got there, I think. The ITNHA (In Training Nursing Home Administrator) came in and talked to us about it (abuse and neglect). We have received training in what we are not supposed to do. Not training in what we are supposed to do. I thought I had two hours to report it. It puts you off when it happens. I should have removed the resident and taken the resident with me and made the appropriate calls. The DOQA/RM is the abuse coordinator. I have been re-educated since the incident to ensure immediate protection of the residents and immediately notify the supervisor on-site. During an interview on 04/02/2024 at 1:07 p.m. with the facility psychologist she stated she was not aware of the incident with Resident #1. She comes to the facility on Wednesdays and Thursdays and was there last week. She stated no one told her about the verbal and physical abuse with Resident #1. If she had been informed, last week, she would have seen him. To my knowledge, the psych APRN, would see the resident also. If something happens, we are always, if asked, to see the patient if there was some kind of allegation. We see if the resident is ok. We talk with the resident as to their perception of what happened. If it happened on a Tuesday, I would be there the next day (Wednesday) to see the person. I would see them for an assessment of their reaction to the incident. During an interview on 04/02/2024 at 1:54 p.m. the DON stated Resident #1's physician did not come in and see the resident. The supervisor (Staff F, LPN/3-11 Supervisor) asked him to come see him and he stated he would see him the next day. The DON stated the DOQA/RM spoke with him today (04/02/2024) and he did not come in to see the resident the next day. (continued on next page)

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	105566	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Winter Haven	1120 Cypress Gardens Blvd Winter Haven, FL 33884

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F 0607 Level of Harm - Actual harm Residents Affected - Few	During an interview on 04/02/2024 at 3:03 p.m. the Staff F, LPN/3-11 Supervisor stated, [DOQA/RM] called me to go over to Resident #1 and secure him. Make him safe. When I got over there, I did not see anything, [Staff A, LPN] was still passing meds. I removed [Staff B, LPN] and kept her in my office. [Staff A, LPN] was left on the floor and was being observed by me (Staff F, LPN, 3-11 Supervisor). [DOQA/RM] got there. [DOQA/RM] had called the police while driving. [DOQA/RM] spoke to [Staff B, LPN] and spoke to her. The police arrived. They (the police) interviewed [Staff B, LPN]. They (the police) went to [Resident #1's] room and spoke to him. He stated yes but was not able to give the details of what happened. The police and [DOQA/RM] took [Staff A, LPN] off the floor. [Staff A, LPN] was walking up down the halls and pacing. Staff F, LPN, 3-11 Supervisor stated she was watching him (Staff A, LPN). She stated, After he realized what was going on he was pacing, he was not interacting with the residents. The police handcuffed him and left with him. The DOQA/RM and Staff B, LPN gave the police statements. We all had to give written statements to the facility. She stated another nurse took over his floor. She stated she had never been involved with abuse before. She stated Staff A, LPN had been here a while, and it was a surprise. He was a jovial person. Not angry. He did a good job. She stated Resident #1 was not hard to work with. Staff F, LPN/3-11 Supervisor stated Staff A, LPN and Resident #1 seemed to have a good relationship prior to this. She does not know what happened that evening. Staff F, LPN/3-11 Supervisor stated (DOQA/RM) called her after supper, 6 or 6:30ish. Staff F, LPN/3-11 Supervisor stated she had abuse and neglect in-service before and since this incident. Staff F, LPN/3-11 Supervisor stated we are to move the patient immediately to safety. The abuser needs to be moved away. When asked why he was still giving meds? Staff F, LPN/3-11 Supervisor stated the resident (Resident #1) was moved to the enclave and Staff A, LPN was straight down the hall, passing meds to other residents. When Staff A, LPN realized something was going on, was not off the floor but he was pacing and not in the area of the residents (at the nursing station). She stated this was her first abuse situation. She stated she had never seen this before, especially someone being taken away in handcuffs. Staff F, LPN/3-11 Supervisor stated, We had an in-service that day, he (Staff A, LPN) was at it. I gave it to him. Staff F, LPN/ 3-11 Supervisor stated, [Resident #1] was known to cuss, I had not heard him, but heard he uses the F bomb a lot. During an interview on 04/02/2024 at 5:40 p.m. Resident #1's physician returned the phone call and stated he thought his APRN saw Resident #1. He had not seen the resident. He stated he makes rounds at the facility on Mondays and Thursdays. He stated, I do not know where the facility got, I was seeing him (Resident #1). The facility called me on Tuesday p.m. (evening) to let him know of the incident. He stated he thought his APRN was to see him Thursday morning. His APRN was there on Thursday mornings, and he was there on Thursday afternoons. He stated he had tried to call his APRN, but she had not called him back. No documentation could be found to show the resident was seen by the physician or APRN following the incident. 22481 (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	2. On 04/02/2024 at 3:47 p.m. a Report for Resident #3 was reviewed with the DOQA/RM. It was confirmed the report reflected the incident date was 03/21/2024 at 1130 (11:30 a.m.) as a physical abuse allegation and staff became aware of the incident on 03/21/2024 at 11:30 a.m. The description of the allegation was confirmed to include, On 03/21/2024 at 11:30 a.m., the [DOQA/RM] was made aware of a new skin injury that was observed to (Resident #3's) left inner lip area, on the inside of his mouth. [Resident #3] is nonverbal, but can communicate by nodding/shaking head for yes/no. During an interview with [Resident #3], it was asked if he had been hit, he nodded his head for yes. When asked if it was a female staff member, he shook his head no. When asked if it was male staff member, he nodded his head for yes. When asked if it was today, he nodded his head yes. It was then asked if it was today while the sun was up, he nodded his head for yes. Injuries documented: Small markings observed to inside of lip/mouth near teeth. Steps taken immediately in response to the incident: After review of the assignment/schedule for the day shift, no male staff members were identified that have any type of encounter with [Resident #3]. The allegation of abuse has been reported to DCF (Department of Children and Families) and law enforcement . The summary: Based on medical diagnoses review, SSD (Social Service Director) evaluations, skin check documentation, staff, POA (Power of Attorney), and resident interviews held, the allegation of abuse is unsubstantiated. Abuse, neglect, exploitation education to team members has been started and is ongoing. During the review, the DOQA/RM stated the date of the event was 03/21/2024 at 11:30 a.m. The DOQA/RM stated she received notification from the Director of Transitional Services (DTS) that she needed me to look at (Resident #3). She said there was a new skin injury on the inside of his lip. She and I went down to the resident's room. At this time, the Director of Nursing (DON) and Staff E, RN were made aware. All four of us were in the room. The first thing (DTS) did was pull down the resident's lip and there were two discolorations on the inside of the lip, on the mucosa. You had to pull the lip all the way down to see it. After we look (DTS) started to ask the resident questions. He was able to answer questions, yes, or no, by shaking or nodding his head. He nodded yes to being hit, yes to the person doing the action as a male. When asked if the resident was asked if the person was a certified nursing assistant or a nurse, the DOQA/RM stated, no, we were asking him questions, the sun was up, and it was a male. The DOQA/RM stated, We looked at the schedule to see who might have come into contact with the resident. Determined he did not have any male aides or nurses. I then submitted my report to DCF, AHCA, and doctor notification. I then got a list of all male staff members and started my interviews with them. I also asked any therapist if they had come into contact with the resident and looked back a week for male staff members. I interviewed staff from the past 72 hours. That was when I asked social services (SS) on the resident's orientation status. They told me he was not oriented based on the SS evaluations dated 11/14/2023 and 02/15/2024. A review of his medical diagnosis included dementia. I asked the wound care nurse to complete a skin assessment. He was unable to do it because the resident was discharged the same day. The DOQA/RM stated the results of her investigation were Unsubstantiated based on the social service assessment evaluation, and medical diagnoses of seizures and dementia. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 04/02/2024 at approximately 4:30 p.m. with the DON. The DON stated Resident #3 had been at the facility since November/December of 2023. She stated she was familiar with the resident. The DON stated, The resident could not speak. He was nonverbal. The DON stated, When I asked him how he was doing, he would nod. So, I was thinking he would understand what I was saying. The DON stated, He needed assistance to get out of bed. The DON stated, He was combative towards staff at times. That morning, (DTS) texted, Where are you. My response was I am on Cypress landing, subacute side. She came and she met me in the hallway. She said something is going on with (Resident #3). Then, I said she needed to go get (DOQA/RM), and I would finish what I was doing and come right to that room. It was in the morning, right after our morning meeting, between 9:30 a.m. and 10:00 a.m. Probably, 15-20 minutes after she told me, I was in the room. (DTS) and (DOQA/RM) and the resident were in the room. The DON stated (DTS) was asking the resident if someone had done that to him; he nodded yes. The DON was observed to make a fist and repeatedly move it towards her face as if to hit her face motion. She stated, This is what the resident did. The DON stated, Then, the resident indicated male and this morning. I told (DOQA/RM) she could handle it. Then I went and told the Nursing Home Administrator (NHA). The DON stated, No bruising on his face, but when [DTS] pulled his lips apart and you could see his lip on the inside; old burgundy discolor. An interview was conducted on 04/02/2024 at 5:19 p.m. with the DTS. She stated on 3/21/24, I went to visit him. I always go and visit. She stated, He is nonverbal. He had a stroke. She confirmed he could understand and stated, Yes, he can. He shakes his head or nods; yes, no. She stated, I noticed that his lip had blood on it, and it was swollen. I stepped closer. I asked him what happened. He is a [mechanical lift]. He could have hit it then. I started asking him questions. At the time I saw him, he was sitting in his chair. He was dressed . They had gotten him up. She stated, It was his left side. I asked him what happened, and he made a gesture. The DTS was observed to close her fist and hold it up to her face. She stated, Like someone punched him. She stated, I asked him if he hit himself. He said no. I asked him if someone had hit him. He nodded his head yes. Then I opened his mouth to see how bad it was, and it was bruised on the inside (the lower portion); there was blood on his gums and his teeth. Then, I lifted the upper lip, and it was also bruised, and it looked like a tooth mark on the lip. Then I called the DON, asked her where she was; she stated where she was. I told her I was in [Resident #3's] room, and he says someone hit him. Then, she told me to tell the [DOQA/RM]. So, I left the room and went to the [DOQA/RM 's] office; and took her to [Resident #3's] room; she looked at his lip; she asked him what happen. [Resident #3] made the same gesture when she asked him. She asked him if it was a man or a woman. She asked him if it happened today, and he said yes. And then the DON came over to the room. And then [Staff E, RN] came over to the room. And the [DOQA/RM] is like, there is no guys on that shift. The DTS stated, (Resident #3's) sense of time frame was not there; he can answer yes or no. He has not changed his story. He was discharged home. He and (family member) live with us. The DCF (Department of Children and Families) investigator came out to the house. The story was the same. The DCF investigator asked him questions, she asked what race the person was; he indicated (African American). A review of Resident #3's Transfer/Discharge Report documented an admitted [DATE] and a discharge date of [DATE]. The resident had medical diagnoses to include: aphasia following cerebral infarction; essential (primary) hypertension; hemiplegia and hemiparesis following cerebral infarction affecting right dominant side; unspecified dementia and chronic obstructive pulmonary disease. A review of Resident #3 Medication Administration Record (MAR) for 03/2024 documented Staff A, LPN administered medications during the evening shift on 03/20/2023 to Resident #3. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	The DOQA/RM was reinterviewed on 04/02/2024 at 5:40 p.m. She stated for her investigation she looked backed at 72 hours for all staff, and one week for male staff. She stated she obtained statements. She stated the questions she asked the staff were: Any new skin conditions to the resident lip area? Anything that would suspect any skin injury? If that staff member had been made aware or seen any abuse towards the resident. The DOQA/RM confirmed no other residents were interviewed or assessed. She stated, No, we did not assess all of the residents for skin or any injuries. She confirmed residents were not interviewed about abuse and neglect. She stated, I did ask one resident who was interviewable on 03/26/2024. The question I asked was if he had any concerns regarding care from the CNAs or nursing. The DOQA/RM stated, (Resident #3) discharged at 3:00 p.m. on the date of the allegation. There were a lot of things I would like to had completed before the discharge like a skin assessment and psych evaluation. An interview was conducted on 04/03/2024 at 3:30 p.m. with the DON. She confirmed Staff A, LPN's initials on the MAR for 3/20/2024. The DON confirmed one staff member, Staff A, matched the demographic description that Resident #3 indicated to his family member. On 04/03/2024 at 3:52 p.m., the DOQA/RM was re-interviewed. A review of the statements she collected from the male staff members was conducted. She stated out of the 17 male staff members, she looked at who had come into contact with Resident #3, 72 hours prior to the allegation, just one, Staff A, LPN, had come into contact with him. She stated she did conduct a phone interview with Staff A. She stated, basically, I just asked if there was any abuse that was going on or if there was any new skin injury to the resident. She provided a statement from Staff A. She stated she collected the statement on 03/26/2024 at 12:48 p.m. The statement documented, No, I di [TRUNCATED]

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22481 Based on record review and interviews, the facility failed to thoroughly investigate an allegation of physical abuse for one resident (#3) of four sampled residents. Findings included: A review of facility's Abuse, Neglect, Exploitation and Misappropriation Policy and Procedures, last revised September 2023, documented the policy as: The center recognizes each resident's right to be free form abuse, neglect, and exploitation (ANE), misappropriation of resident property . This center reports suspicions of crimes committed against a resident of this center in accordance with section 1150B of the Social Security Act to at least one law enforcement agency and the State Agency. Definitions for F600 Staff: Statute 483.12 define staff as employees of the center, the medical director, consultants, contractors, and volunteers. This definition will also include caregivers that provide care and services to the resident on behalf of the center. Willful: Statute 483.5 in the definition of abuse this means the individual must have acted deliberately, NOT that the individual must have intended to inflict injury or harm. Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish . Physical Abuse: Striking the resident with a part of the body or with an object; non-therapeutic shoving, pushing, pulling, or twisting any part of the resident's body; hitting, slapping, pinching, kicking, burning, or striking a resident with an object . Psychological/ Emotional/ Mental Abuse: Psychological/ Emotional/ Mental abuse is the use of verbal or non-verbal contact which causes the resident to experience humiliation, harassment, malicious teasing, and threats of punishment or deprivation . Procedure for prevention: This center maintains a zero tolerance for any form of abuse. The center encourages residents and families, and requires team members to report concerns, incidents, and grievances without fear of retaliation, and is provided feedback, when possible, on these reports. The center identifies, corrects, and intervenes in situations of alleged abuse, neglect, and exploitation (ANE) and misappropriation of resident property . 4. Identification: Reporting of suspected abuse, neglect, exploitation, or misappropriation is required of all team members. Because not all incidents of abuse, neglect, exploitation, and misappropriation are observed the center will be alert to any signs that abuse has occurred or is occurring and report as per required. Non-action, which results in emotional, psychological, or physical injury, is viewed in the same manner as that caused by improper or excessive action. All actions in which employees engage with residents must have as their legitimate goal, the healthful, proper, and humane care and treatment of the resident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All reported events (bruises, skin tears, falls, inappropriate or abusive behaviors) will be investigated by the Director of Quality Assurance and they will be reviewed by the center's QAPI Committee for detection of patterns and/or trends . 5. Protection: If the circumstances warrant, a resident suspected of being the subject of maltreatment will be relocated to an environment where the resident's safety can be assured .If the alleged suspect is an employee, the team member(s) shall be removed to a non-resident care area and report the incident to the immediate supervisor, the Director of Quality Assurance or Executive director. The executive Director/designee shall place the employee on immediate suspension, pending the outcome of the investigation . 7. Investigation: A thorough investigation will be conducted, as this center has a zero tolerance for abuse of any form. The Director of Quality Assurance/ designee will initiate procedures for conducting the investigation. The investigation shall include the following but is not limited to this list: a. The type of allegation (as defined previously in this policy and procedure) may include the following: Confiscating photographs and/or recordings of residents . b. What occurred, when, where, and to whom? By whom? Get physical description or identify the alleged suspect if possible. c. Describe the injury and any treatment. d. Interview witnesses separately; interview caregivers, roommates; get statements; observe/ document demeanor; include names, addresses, emails, and phone numbers of actual witnesses . It is important to complete an investigation that allows for decision making that is strongly supported. 8. Corrective Action: If an investigation verifies an allegation the center must take the appropriate corrective action to protect the residents. The implementation of the corrective action should have oversight and be evaluated for effectiveness. The center Quality Assessment and Assurance Committee shall monitor the reporting and investigation of all the alleged violations. All corrective actions will be documented. Acts of abuse directed towards residents are absolutely prohibited. Such acts are cause for disciplinary action, including up to termination of employment, reporting to licensing boards and possible criminal prosecution. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/02/2024 at 3:47 p.m. a Report for Resident #3 was reviewed with the DOQA/RM. It was confirmed the report reflected the incident date was 03/21/2024 at 1130 (11:30 a.m.) as a physical abuse allegation and staff became aware of the incident on 03/21/2024 at 11:30 a.m. The description of the allegation was confirmed to include, On 03/21/2024 at 11:30 a.m., the [DOQA/RM] was made aware of a new skin injury that was observed to (Resident #3's) left inner lip area, on the inside of his mouth. [Resident #3] is nonverbal, but can communicate by nodding/shaking head for yes/no. During an interview with [Resident #3], it was asked if he had been hit, he nodded his head for yes. When asked if it was a female staff member, he shook his head no. When asked if it was male staff member, he nodded his head for yes. When asked if it was today, he nodded his head yes. It was then asked if it was today while the sun was up, he nodded his head for yes. Injuries documented: Small markings observed to inside of lip/mouth near teeth. Steps taken immediately in response to the incident: After review of the assignment/schedule for the day shift, no male staff members were identified that have any type of encounter with [Resident #3]. The allegation of abuse has been reported to DCF (Department of Children and Families) and law enforcement . The summary: Based on medical diagnoses review, SSD (Social Service Director) evaluations, skin check documentation, staff, POA (Power of Attorney), and resident interviews held, the allegation of abuse is unsubstantiated. Abuse, neglect, exploitation education to team members has been started and is ongoing. During the review, the DOQA/RM stated the date of the event was 03/21/2024 at 11:30 a.m. The DOQA/RM stated she received notification from the Director of Transitional Services (DTS) that she needed me to look at (Resident #3). She said there was a new skin injury on the inside of his lip. She and I went down to the resident's room. At this time, the Director of Nursing (DON) and Staff E, RN were made aware. All four of us were in the room. The first thing (DTS) did was pull down the resident's lip and there were two discolorations on the inside of the lip, on the mucosa. You had to pull the lip all the way down to see it. After we look (DTS) started to ask the resident questions. He was able to answer questions, yes, or no, by shaking or nodding his head. He nodded yes to being hit, yes to the person doing the action as a male. When asked if the resident was asked if the person was a certified nursing assistant or a nurse, the DOQA/RM stated, no, we were asking him questions, the sun was up, and it was a male. The DOQA/RM stated, We looked at the schedule to see who might have come into contact with the resident. Determined he did not have any male aides or nurses. I then submitted my report to DCF, AHCA, and doctor notification. I then got a list of all male staff members and started my interviews with them. I also asked any therapist if they had come into contact with the resident and looked back a week for male staff members. I interviewed staff from the past 72 hours. That was when I asked social services (SS) on the resident's orientation status. They told me he was not oriented based on the SS evaluations dated 11/14/2023 and 02/15/2024. A review of his medical diagnosis included dementia. I asked the wound care nurse to complete a skin assessment. He was unable to do it because the resident was discharged the same day. The DOQA/RM stated the results of her investigation were Unsubstantiated based on the social service assessment evaluation, and medical diagnoses of seizures and dementia. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 04/02/2024 at approximately 4:30 p.m. with the DON. She stated she was familiar with the resident. The DON stated, The resident could not speak. He was nonverbal. The DON stated, When I asked him how he was doing, he would nod. So, I was thinking he would understand what I was saying. The DON stated, He needed assistance to get out of bed. The DON stated, He was combative towards staff at times. That morning, (DTS) texted, Where are you. My response was I am on Cypress landing, subacute side. She came and she met me in the hallway. She said something is going on with (Resident #3). Then, I said she needed to go get (DOQA/RM), and I would finish what I was doing and come right to that room. It was in the morning, right after our morning meeting, between 9:30 a.m. and 10:00 a.m. Probably, 15-20 minutes after she told me, I was in the room. (DTS) and (DOQA/RM) and the resident were in the room. The DON stated (DTS) was asking the resident if someone had done that to him; he nodded yes. The DON was observed to make a fist and repeatedly move it towards her face as if to hit her face motion. She stated, This is what the resident did. The DON stated, Then, the resident indicated male and this morning. I told (DOQA/RM) she could handle it. Then I went and told the Nursing Home Administrator (NHA). The DON stated, No bruising on his face, but when [DTS] pulled his lips apart and you could see his lip on the inside; old burgundy discolor. An interview was conducted on 04/02/2024 at 5:19 p.m. with the DTS. She stated on 3/21/24, I went to visit him. I always go and visit. She stated, He is nonverbal. He had a stroke. She confirmed he could understand and stated, Yes, he can. He shakes his head or nods; yes, no. She stated, I noticed that his lip had blood on it, and it was swollen. I stepped closer. I asked him what happened. He is a [mechanical lift]. He could have hit it then. I started asking him questions. At the time I saw him, he was sitting in his chair. He was dressed . They had gotten him up. She stated, It was his left side. I asked him what happened, and he made a gesture. The DTS was observed to close her fist and hold it up to her face. She stated, Like someone punched him. She stated, I asked him if he hit himself. He said no. I asked him if someone had hit him. He nodded his head yes. Then I opened his mouth to see how bad it was, and it was bruised on the inside (the lower portion); there was blood on his gums and his teeth. Then, I lifted the upper lip, and it was also bruised, and it looked like a tooth mark on the lip. Then I called the DON, asked her where she was; she stated where she was. I told her I was in [Resident #3's] room, and he says someone hit him. Then, she told me to tell the [DOQA/RM]. So, I left the room and went to the [DOQA/RM 's] office; and took her to [Resident #3's] room; she looked at his lip; she asked him what happen. [Resident #3] made the same gesture when she asked him. She asked him if it was a man or a woman. She asked him if it happened today, and he said yes. And then the DON came over to the room. And then [Staff E, RN] came over to the room. And the [DOQA/RM] is like, there is no guys on that shift. The DTS stated, (Resident #3's) sense of time frame was not there; he can answer yes or no. He has not changed his story. He was discharged home. He and (family member) live with us. The DCF (Department of Children and Families) investigator came out to the house. The story was the same. The DCF investigator asked him questions, she asked what race the person was; he indicated (African American). A review of Resident #3's Transfer/Discharge Report documented an admitted [DATE] and a discharge date of [DATE]. The record documented the resident had a spouse. The resident had medical diagnoses to include: aphasia following cerebral infarction; essential (primary) hypertension; hemiplegia and hemiparesis following cerebral infarction affecting right dominant side; unspecified dementia and chronic obstructive pulmonary disease. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105566	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Winter Haven	1120 Cypress Gardens Blvd Winter Haven, FL 33884

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's care plan revealed a Focus as: ADL(Activity of Daily Living) Self-Care and/or mobility deficit. Needs assistance with ADL's. At risk of developing complications associated with decreased ADL self-performance related to: cognitive impairment, hemiplegia and monoplegia following CVA's (Cerebral vascular accident) , requires weight bearing support, weakness, dependent for basic ADL's, initiated 11/21/2023. Interventions included: Bed Mobility, dependent for bed mobility w/2 (with two) assistance. Transfers-dependent for transfers via mechanical lift and 2 assistance. Toileting, dependent for incontinence care. Dressing, bathing, grooming, dependent. The DOQA/RM was reinterviewed on 04/02/2024 at 5:40 p.m. She stated for her investigation she looked backed at 72 hours for all staff, and one week for male staff. She stated she obtained statements. She stated the questions she asked the staff were: Any new skin conditions to the resident lip area? Anything that would suspect any skin injury? If that staff member had been made aware or seen any abuse towards the resident. The DOQA/RM confirmed no other residents were interviewed or assessed. She stated, No, we did not assess all of the residents for skin or any injuries. She confirmed residents were not interviewed about abuse and neglect. She stated, I did ask one resident who was interviewable on 03/26/2024. The question I asked was if he had any concerns regarding care from the CNAs or nursing. The DOQA/RM stated, (Resident #3) discharged at 3:00 p.m. on the date of the allegation. There were a lot of things I would like to had completed before the discharge like a skin assessment and psych evaluation. A review of Resident #3 Medication Administration Record (MAR) for 03/2024 documented Staff A, LPN administered medications during the evening shift on 03/20/2023 to Resident #3. An interview was conducted on 04/03/2024 at 3:30 p.m. with the DON. She confirmed Staff A, LPN's initials on the MAR for 3/20/2024. The DON confirmed one staff member, Staff A, matched the demographic description that Resident #3 indicated to his family member. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/2024 at 3:52 p.m., the DOQA/RM was re-interviewed. A review of the statements she collected from the male staff members was conducted. She stated out of the 17 male staff members, she looked at who had come into contact with Resident #3, 72 hours prior to the allegation, just one, Staff A, LPN, had come into contact with him. She stated she did conduct a phone interview with Staff A. She stated, basically, I just asked if there was any abuse that was going on or if there was any new skin injury to the resident. She provided a statement from Staff A. She stated she collected the statement on 03/26/2024 at 12:48 p.m. The statement documented, No, I did not witness any abuse. I was also not aware of any new skin issue. When asked the reason for the delay in the interview conducted with Staff A, the DOQA/RM stated, I have 5 days to complete the investigation, and so, whenever I get a chance to complete it. I had another reportable that day, and so, I was split between the two. The DOQA/RM confirmed Staff A was African American. When asked if she followed up with Resident #3 to show him a picture of Staff A, LPN to find out if he was the staff member who hit him, the DOQA/RM stated, No, the resident had discharged home. I had a SOC (standards of care meeting), 1:30-3:30 p.m., and the resident discharged between 3:00 p.m. and 4:00 p.m. She stated, This is my first job as a Risk Manager. Started in June of 2023. Before this, I was a unit manager. I had basic orientation. I shadowed another DQOA [Director of Quality Assurance] for two days.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22481 Based on record review and interviews, the facility failed to develop a person-centered care plan to include a communication plan for a non-verbal resident for one resident (#3) of four sampled residents. Findings included: A review of Resident #3's Transfer/Discharge Report documented an admitted [DATE]. The record documented the resident had a spouse. Resident #3 had medical diagnoses to include aphasia following cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side; unspecified dementia and chronic obstructive pulmonary disease. A review of Resident #3's care plan revealed no focus, goal or interventions related to Resident #3 being non-verbal and with the ability to answer yes and no questions. A review of Resident #3's Minimum Data Set Assessments (MDS) Section C - Cognitive Patterns documented the Brief Interview for Mental Status, dated 01/16/2024, and 02/15/2024, as the resident was rarely/never understood. During an interview conducted on 04/03/2024 at 9:40 a.m. the Social Services Assistant (SSA) stated she visited with the resident. She stated he was nonverbal, unable to communicate verbally, he could make gestures if she asked him a question. Sometimes he would not communicate, he would look off in another direction. She confirmed she completed the cognitive patterns assessment. She stated for the cognitive patterns assessment, the resident could not or would not answer the questions. An interview was conducted on 04/02/2024 at approximately 4:30 p.m. with the Director of Nursing (DON). She confirmed she was familiar with Resident #3. She stated he had been at the facility since November/December of 2023. The DON stated the resident could not speak; he was nonverbal. When asked if the resident could understand what she was saying, the DON stated, When I asked him how he was doing, he would nod; so, I was thinking he would understand what I was saying. An interview was conducted on 04/03/2024 at 9:49 a.m. with the Minimum Data Set (MDS) Coordinator/Licensed Practical Nurse (LPN). She stated she was somewhat familiar with Resident #3. The MDS Coordinator stated, I saw him a couple of times. He could nod and would try to tell you with his hands. I would go to him and speak slowly. His [family member] was always with him. She would fill in for him. He could not speak. The MDS Coordinator confirmed she thought Resident #3 could understand, from his responses. The MDS Coordinator confirmed there was no communication care plan and there should have been. An interview was conducted on 04/03/2024 at 2:50 p.m. with the Regional Nurse Consultant (RNC) and Regional MDS/LPN. They stated they did not have a policy and procedure for the development and implementation of a care plan. They stated the facility goes by the RAI (Resident Assessment Instrument). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a copy of the CMS RAI Version 3.0 Manual, October 2023, Chapter 4: Care Area Assessment (CAA) Process and Care Planning revealed on page 4-1: The MDS is a starting point. The Minimum Data Set (MDS is a standardized instrument used to assess nursing home residents .The information in the MDS constitutes the core of the required CMS-specified Resident Assessment Instrument (RAI) . 4.3: The completed MDS must be analyzed and combined with other relevant information to develop an individualized care plan .