STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106151	A. Building B. Wing	09/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alwyn C Cashe State Veterans Nursing Home	5255 Raymond St Orlando, FL 32803

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 0604 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview and record review, the facility failed to ensure freedom from a physical restraint that inhibited movement and activity for 1 of 2 residents reviewed for restraints, of a total sample of 10 residents, (#1). The facility's failure to promote resident #1's rights to be treated with respect and dignity and to be free from abuse resulted in psychosocial harm. Using the reasonable person concept there was potential for outcomes such as continued agitation and anxiety, loss of dignity, dehumanization, and feelings of fear and imprisonment. Resident #1, a cognitively impaired resident, was inappropriately restrained in his wheelchair and he struggled to move freely and stand. Improper use and monitoring of an improvised restraint placed resident #1 at risk for skin breakdown, injury during attempts to free himself, and accidents including falls and strangulation. Findings: Cross reference F741. Review of the medical record revealed resident #1, a [AGE] year-old male, was admitted to the facility on [DATE]. His diagnoses included Alzheimer's disease, severe dementia with agitation, right clavicle fracture, generalized muscle weakness, difficulty walking, repeated falls, cognitive communication deficit, and depression. The resident was discharged to a hospice inpatient unit on [DATE], where he died the following day. Review of the Minimum Data Set (MDS) Admission assessment with assessment reference date of [DATE] revealed resident #1 had clear speech, was rarely or never able to express his ideas and wants, and rarely or never understood verbal content. He had short-term memory problems, severely impaired cognitive skills for daily decision making, and exhibited continuous inattention and disorganized thinking. The MDS assessment revealed on one to three days during the 7-day look back period, the resident displayed physical behavioral symptoms that put others at risk for physical injury and significantly disrupted his care or living environment. During this period, resident #1 wandered on one to three days. The MDS assessment indicated resident #1 required partial to moderate assistance for bed mobility, transfers, and ambulation. The document showed the resident did not use restraints. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Actual harm Residents Affected - Few	Review of resident #1's medical record revealed a care plan for his need for a higher level of care than could be met in the community was initiated on [DATE]. The goal was the resident would remain in the long-term care setting to receive biopsychosocial services. The care plan interventions included monitor his mood, behavior, or changes in condition, and report to the physician. A care plan for physical behavioral symptoms toward others was initiated on [DATE]. The interventions instructed staff to assess and intervene, offer one step verbal interventions, and provide care that resembled his prior lifestyle. Resident #1 had a care plan for risk for falls due to poor safety awareness, initiated on [DATE], with an intervention to review his medications. On [DATE] at 4:15 PM, the Director of Nursing (DON) stated resident #1 was admitted to the facility's Memory Care Unit and he was normally agitated. She recalled he was also at risk for falls as he was impulsive and would suddenly stand and walk although he was unsteady on his legs. She recalled on the morning of [DATE], there was an incident that involved this resident. The DON stated Speech Therapist F arrived to the Memory Care Unit and noted resident #1 in his wheelchair with his sweater hooked over the handles of the wheelchair. The DON verified the use of any type of restraint was unacceptable without the proper assessments and a physician order. On [DATE] at 5:07 PM, Registered Nurse (RN) Supervisor D recalled on [DATE] she observed resident #1 seated in his wheelchair in the Memory Care Unit's common area with the back of his t-shirt covering the handles of the wheelchair. RN Supervisor D stated she asked RN Supervisor B if it was safe to have the shirt pulled over the wheelchair handles, and RN Supervisor B told her it was to keep the resident seated in his wheelchair. RN Supervisor D confirmed she did not remove the t-shirt from the handles. On [DATE] at 5:18 PM, the DON confirmed she was made aware that resident #1 was also restrained on [DATE], the day prior to the incident she described in the previous interview. She stated video footage from the Memory Care Unit showed on [DATE], RN Supervisor B utilized the resident's shirt as a restraint to secure him to the wheelchair. On [DATE] at 5:29 PM, Certified Nursing Assistant (CNA) E stated she never witnessed application of resident #1's t-shirt as a restraint but she observed it in place. She recalled an afternoon, date unknown, between the lunch and dinner hours, when she looked across the Memory Care Unit's common area and noted the resident in his wheelchair at one of the tables. She explained he caught her attention because he made repeated attempts to stand but, he couldn't get very far. CNA E stated when she looked closely at resident #1, she discovered he was pulling and straining against the shirt he wore, which was applied over the back of the wheelchair. CNA E stated in her opinion, the resident was restrained, and she said so to RN Supervisor G. CNA E stated RN Supervisor G told her another RN Supervisor replaced resident #1's t-shirt with the one he then wore, as it could stretch more to better cover the back of the wheelchair and secure the resident. On [DATE] at 12:45 PM, in a telephone interview, Speech Therapist F recalled on the morning of [DATE] she entered the Memory Care Unit and resident #1 was seated in the common area. She stated she immediately noticed the resident rocking back and forth in his wheelchair. Speech Therapist F stated on closer inspection, she noticed resident #1 was secured to the chair by his shirt. She said, It was completely over the chair. There is no way he could have gotten it off himself. The entire back of the chair was covered. Speech Therapist F stated she asked a nearby CNA about the situation and the CNA informed her resident #1 was, locked in. Speech Therapist F confirmed she was alarmed as there was a danger of the resident choking if he tried to slide down out of the t-shirt to free himself. (continued on next page)

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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 0604 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 1:02 PM, in a telephone interview, CNA C recalled on Monday [DATE] at about lunchtime, resident #1 was in the Memory Care Unit's common area. She described the resident as, getting rowdy and getting up, trying to stand and walk around. She stated the resident's wife and staff tried to get him to sit in the wheelchair and calm down. CNA C stated their efforts were not successful for long, and resident #1 sat for a short time then began pushing and shouting at everyone as he again tried to stand. CNA C stated RN Supervisor B called RN Supervisor H to assist with the resident but they were not able to calm him fully. She stated RN Supervisor B then went to the resident's room, retrieved a stretchy gray shirt, and returned to the unit's common area. She recalled RN Supervisor B removed the t-shirt resident #1 wore, and replaced it with the stretchy shirt which she pulled down over the back of the entire back of the wheelchair. CNA C confirmed RN Supervisor B undressed resident #1 and secured him to the wheelchair with the second shirt in the unit's open common area. She stated he remained like that until he fell asleep in the chair, and was assisted to bed at about dinnertime. On [DATE] at 1:16 PM, in a telephone interview, RN Supervisor H validated on [DATE], she observed resident #1 with his shirt over the back of his wheelchair. She stated RN Supervisor B, who was the resident's assigned nurse at that time, assured her the resident was not restrained as he could still move his arms. On [DATE] at 2:37 PM, in a telephone interview, resident #1's wife confirmed her husband sometimes had impulsive and agitated behaviors which increased his risk for falls. She surmised the symptoms were probably exacerbated by pain from his broken clavicle whenever he moved his right arm. The resident's wife recalled during a lunchtime visit to the facility, staff were having difficulty keeping her husband seated in the wheelchair when a nurse said, I know what to do! The wife stated the nurse got one of her husband's short-sleeved polyester shirts from his room and returned to the common area. She recalled the nurse removed his t-shirt, placed the polyester shirt on him and pulled it over the wheelchair's handles and backrest. Resident #1's wife said, It was incredibly effective. She explained although her husband continued to try to stand, the garment prevented him from doing so as it consistently pulled him back into a seated position. On [DATE] at 3:40 PM, in a telephone interview, Licensed Practical Nurse (LPN) J recalled she observed resident #1 in his wheelchair when she arrived for her shift on [DATE]. She stated the resident was seated in front of the nurses' station and his t-shirt was tied behind the back of his wheelchair to restrain him. LPN J stated RN Supervisor B and the off-going nurse informed her the resident was out of control. LPN J explained all residents, including those on the Memory Care Unit, should be treated with dignity, and staff were responsible for identifying effective approaches to manage behaviors that did not include restraints. When asked about use of the improvised t-shirt restraint for resident #1, she stated she felt the concept started with RN Supervisor B and another nurse, and continued on from there. On [DATE] at 4:01 PM, in a telephone interview, RN Supervisor G stated she worked on the night shift from 6:45 PM to 8:45 AM. She recalled one evening, close to the start of her shift, she found resident #1 in his wheelchair, with one sleeve of his t-shirt hooked over a handle. RN Supervisor G stated she could not recall the date nor the nurse(s) involved. She stated she did not remove the t-shirt from the handle. (continued on next page)

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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 0604 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 11:03 AM, in a telephone interview, CNA I stated she was assigned to resident #1 on the morning of [DATE] at about 5:00 AM when she observed him standing in the doorway of his room. CNA I explained she got the resident dressed and left him in his wheelchair in the common area. She stated she asked the nurse on the Memory Care Unit to watch the resident while she went to ask RN Supervisor G to sit with him. CNA I recalled she searched the facility and was unable to locate RN Supervisor G, but another nurse agreed to supervise resident #1 while she returned to care for her assigned residents. CNA I stated a short while later, she returned to the common area and the nurse she left with resident #1 was no longer there, but RN Supervisor G was present. CNA I stated she noted resident #1 was still in his wheelchair, but now had both sleeves of his t-shirt placed over the handles of the wheelchair. On [DATE] at 11:08 AM, the facility's Risk Manager (RM) stated on [DATE] she was made aware that Speech Therapist F found resident #1 restrained in his wheelchair the day before. The RM validated any device or approach used to restrict a resident's free movement was a restraint. On [DATE] at 10:53 AM, RN Supervisor B confirmed on [DATE] she applied a shirt to resident #1 in a manner that prevented him from moving freely. She explained the resident was violent and posed physical harm to himself and others. She stated he was pushing and hitting staff and even punched her in the chest. RN Supervisor B verbalized she did not want to continue putting her hands on the resident so she inhibited his movements with the shirt as a restraint. She explained during previous employment at a hospital, she restrained patients using that technique. She stated to her knowledge, a resident could be restrained for a certain amount of time without a physician order. However, RN Supervisor B acknowledged she never attempted to obtain an order for a restraint. She verified she did not contact the physician or the DON on that day to inform them she felt resident #1's behavior was so unmanageable that she needed to restrain him. RN Supervisor B stated she was not at work on the morning of [DATE] when Speech Therapist F discovered resident #1 restrained in the Memory Care Unit's common area. She explained RN Supervisor G was the nurse in charge on that morning, at the time the resident was restrained. Review of the facility's policy and procedure for Abuse, Neglect and Exploitation/Misappropriation of Property, revised [DATE], revealed a goal to achieve and maintain an abuse-free environment for all residents. The policy indicated abuse included unreasonable confinement and improper use of restraints. Review of the facility's Restraint Protocol, effective [DATE], revealed the facility would ensure the right of each resident to be free from unnecessary restraints. The document indicated a restraint included any physical or mechanical device or material attached to or adjacent to the body that the individual could not easily remove. The definition revealed a restraint restricted freedom of movement or normal access to one's body and environment. The Restraint Protocol indicated the facility's clinical team would conduct a pre-restraint evaluation to review alternative interventions. If deemed appropriate, the facility would then seek informed consent for the restraint from the resident's representative and licensed nursing staff would obtain the associated physician order. The document read, Physician orders will include: Specific type of restraint. Medical symptoms that warrant use of restraints. Restraint release intervals inclusive of activities of daily living.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 36489 Based on interview and record review, the facility failed to implement its abuse prohibition policy and procedures by ensuring frontline staff recognized and reported the use of an unauthorized physical restraint for 1 of 2 residents reviewed for restraints, of a total sample of 10 residents, (#1), and failed to ensure thorough and accurate reporting of investigative findings. Findings: Review of the facility's policy and procedure for Abuse, Neglect and Exploitation/Misappropriation of Resident Property, revised on 3/01/24, revealed a goal to achieve and maintain an abuse-free environment for all residents. The policy indicated abuse was any willful act or failure to act which caused or was likely to cause significant negative physical, mental and/or emotional outcomes. The document revealed the definition of abuse also included threats, intimidation, and unreasonable confinement or punishment. The policy read, All employees are responsible for reporting all suspicions of abuse.If a case involves an employee who is licensed or certified, notify the Department of Health as appropriate. The facility's Restraint Protocol, effective 3/15/15, revealed the facility would ensure the right of each resident to be free from a restraint imposed for any purpose other than to treat medical symptoms. The document indicated a restraint could not be removed easily and restricted freedom of movement or normal access to the body and environment. The Restraint Protocol indicated the facility's clinical team would conduct a pre-restraint evaluation to review alternative interventions. If deemed appropriate, the facility would then seek informed consent for the restraint from the resident's representative, and licensed nursing staff would obtain the associated physician order. Review of the medical record revealed resident #1, a [AGE] year-old male, was admitted to the facility on [DATE]. His diagnoses included Alzheimer's disease, severe dementia with agitation, clavicle fracture, generalized muscle weakness, difficulty walking, repeated falls, cognitive communication deficit, and depression. Review of the Minimum Data Set (MDS) Admission assessment with assessment reference date of 8/21/24 revealed resident #1 had clear speech, was rarely or never able to express his ideas and wants, and rarely or never understood verbal content. He had short-term memory problems, severely impaired cognitive skills for daily decision making, and exhibited continuous inattention and disorganized thinking. The MDS assessment revealed during the 7-day look back period, the resident displayed physical behavioral symptoms that put others at risk for physical injury and significantly disrupted his care or living environment on one to three days. During this period, resident #1 wandered on one to three days. The document showed the resident did not use restraints. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #1's medical record revealed a care plan for his need for a higher level of care than could be met in the community, initiated on 8/15/24. The goal was the resident would remain in the long-term care setting to receive biopsychosocial services. The care plan interventions included monitor his mood, behavior, or changes in condition, and report to the physician. A care plan for physical behavioral symptoms toward others was initiated on 8/19/24. The interventions instructed staff to assess and intervene, offer one step verbal interventions, and provide care that resembled his prior lifestyle. Review of the facility's investigation report revealed on 8/20/24 at approximately 8:30 AM, the Administrator was notified by the Director of Nursing (DON) that Speech Therapist F observed resident #1 seated in his wheelchair with the back of his sweater pulled over the handles of his wheelchair. The document indicated Speech Therapist F, a contracted employee, removed the resident's garment from the handles of the wheelchair and notified her direct supervisor, the Director of Rehabilitation. The report indicated the facility conducted a detailed investigation which included record review and staff interviews. Interviews were conducted with staff who interacted with the resident that morning. The assigned night shift and day shift nurses and Certified Nursing Assistants (CNAs), a nurse from the adjacent unit, and Registered Nurse (RN) Supervisor H all denied knowledge of who restrained resident #1. RN Supervisors D and G confirmed they observed resident #1 secured in the wheelchair with his shirt, but they were not aware it was classified as a restraint. The facility's investigation showed RN Supervisor B, who was not at work on 8/20/24, confirmed she had previously used the resident's shirt to keep him seated in his wheelchair for safety purposes. According to the investigative findings, RN Supervisor B stated she was also not aware it was a restraint. The report revealed the facility verified the allegation of physical abuse of resident #1. Review of written employee statements provided by the facility and interviews with nursing staff revealed resident #1 was also restrained in his wheelchair on other days. In a statement dated 8/20/24 by CNA C, she noted on 8/19/24 she observed a Nurse Supervisor retrieve a shirt from resident #1's room, return to the common area on the Memory Care Unit, and remove the t-shirt the resident wore. The statement indicated the Nurse Supervisor applied the other shirt to the resident and pulled it over the back of the wheelchair and he remained like that until CNA C put him to bed. She noted RN Supervisor H, resident #1's wife, and other residents were present in the common area at the time of the incident. In a statement dated 8/20/24 by RN Supervisor D, she indicated on an unknown date/time she observed resident #1 in his wheelchair with his shirt pulled over the handles. She noted that when she asked RN Supervisor B if the resident was safe, she was told, It was to keep him sitting in his chair. In a statement dated 8/20/24 by RN Supervisor H, she noted on 8/19/24 at an unknown time, she arrived on the Memory Care Unit and saw resident #1's t-shirt pulled back over the handles of his wheelchair. The statement indicated an unnamed nurse on the unit said it was not a restraint. On 9/12/24 at 5:07 PM, RN Supervisor D confirmed during rounds one day, she saw resident #1 in the common area of the Memory Care Unit, with the back of his t-shirt covering the handles of his wheelchair. She stated she deferred to RN Supervisor B who explained the resident was not restrained. RN Supervisor D said, I wasn't OK with what she said. It was not something that I personally would have done. RN Supervisor D validated although she received education on abuse and neglect when she was hired, she did not report her concern to the DON or the Administrator. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 5:29 PM, CNA E stated to her knowledge, resident #1 was restrained with his t-shirt on at least two days. She described observing the resident unsuccessfully straining and struggling to get out of his wheelchair. CNA E stated upon closer observation she noted his shirt was placed over the back of the wheelchair. She said, I thought it was a restraint and said it to [name of RN Supervisor G], but she told me the other supervisor changed the shirt and gave him one that could stretch more. CNA E acknowledged she did not report her observations to the DON or the Administrator. On 9/13/24 at 1:02 PM, in a telephone interview, CNA C confirmed she observed RN Supervisor B openly remove and replace resident #1's shirt in the common area of the Memory Care Unit on 8/19/24. CNA C stated RN Supervisor H worked that day and assisted with efforts to calm the resident prior to application of the shirt. She recalled the resident fell asleep in the wheelchair and CNA E assisted her to put him to bed. CNA C recalled as she removed the resident's shirt from the back of the wheelchair, CNA E asked her if it was not considered a restraint. CNA C responded, I said a nurse did it, but I was pretty sure it was a restraint. CNA C confirmed she did not report the incident to another supervisor or the Administrator. On 9/13/24 at 1:16 PM, in a telephone interview, RN Supervisor H recalled on 8/19/24 at about 11:15 AM, she observed resident #1 with his shirt over the back of the chair. She stated RN Supervisor B told her it was not a restraint as the resident could move his arms. RN Supervisor H said, I told her I did not think it is appropriate. However, RN Supervisor H acknowledged she did not report the possible restraint to the DON or the Administrator. On 9/13/24 at 3:40 PM, in a telephone interview, Licensed Practical Nurse (LPN) J stated on 8/17/24, she observed resident #1 in his wheelchair with his shirt tied behind the back of the chair. LPN J validated she did not report this observation to management staff. On 9/13/24 at 4:01 PM, in a telephone interview, RN Supervisor G recalled seeing resident #1 with his t-shirt over one of the handles of his wheelchair. She could not remember the date, but stated it was close to the start of a night shift. RN Supervisor G explained she did not report her observation to administration. On 9/14/24 at 11:03 AM, in a telephone interview, CNA I stated she got resident #1 dressed in the early morning hours of 8/20/24 and left him in the Memory Care Unit's common area under the supervision of a nurse. She recalled when she returned a short time later, the nurse was gone, RN Supervisor G was now with resident #1, and both sleeves of his shirt were over the handles of the wheelchair. CNA I said, When I saw it, I kind of like, I thought it was wrong, but I went along with what I was doing. Next time I will report. On 9/14/24 at 10:53 AM, RN Supervisor B confirmed she utilized resident #1's shirt to keep him seated in his wheelchair as he had aggressive behaviors. She stated she was not aware this approach met the definition of a restraint. She explained on one of the occasions she secured the resident to his wheelchair with his shirt over the handles, the Advanced Practice Registered Nurse (APRN) was at the nurses' station. She stated the APRN saw it and even commented that she did not know what we were going to do with him. RN Supervisor B recalled on 8/20/24, the facility notified her she was being suspended and/or placed on administrative leave related to resident #1's restraint. She stated since she was not at work that day, she asked the Administrator if RN Supervisor G would also be suspended since she was in charge that morning. RN Supervisor B stated to her knowledge, no other staff were suspended. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 4:15 PM, the DON stated once Speech Therapist F informed her supervisor that resident #1 was restrained in his wheelchair with his shirt, the facility initiated its abuse and neglect protocol. The DON stated staff who worked on the Memory Care Unit that morning were interviewed but nobody admitted to restraining the resident. She verified there were cameras in the Memory Care Unit and the facility reviewed footage, but they were not able to identify who applied the resident's shirt as a restraint on the morning of 8/20/24 as it was done in a blind spot. The facility was asked to provide a copy of the video footage. On 9/12/24 at 5:18 PM, the DON stated the facility suspended RN Supervisor B once the investigation showed she restrained resident #1 with a t-shirt. The DON stated she was off work for a while during the investigation, but when she returned, she saw the video that confirmed RN Supervisor B's actions. A second request was made to view video footage used in the facility's investigation. On 9/12/24 at 5:57 PM, the Administrator stated she checked her computer and discovered video footage for the entire timeframe resident #1 was on the Memory Care Unit no longer existed. She explained in the past, it was her practice to write a statement based on video observations. The Administrator was not able to clearly describe the video footage she watched related to occurrences of resident #1's behaviors and the frequency and duration of his shirt being used as a restraint. The Administrator acknowledged she neither saved a copy of the video(s) for the resident's medical record nor wrote a narrative statement to described what she watched. On 9/13/24 at 9:56 AM, the DON stated during the incident investigation she discovered staff felt use of the resident's shirt to restrain him was inappropriate, yet nobody reported it to her, the Administrator, or the Risk Manager (RM). The DON verified the facility's investigation report did not clearly indicate the facility's finding that the use of the improvised restraint was not a one-time occurrence. She was informed staff interviews indicated the resident was restrained on at least three days. The DON validated the facility reviewed video footage of RN Supervisor B switching the resident's t-shirt in the common area and securing him to the wheelchair with another one. She acknowledged that information was not included in the report. On 9/13/24 at 11:08 AM, the facility's RM stated she was responsible for completion and submission of the final report regarding restraint use for resident #1. The RM confirmed she included the findings of the investigation and the corrective action taken. She stated the facility viewed the incident as an isolated case. She was informed that staff statements and interviews showed this was not a one-time incident, and none of the many nursing staff who observed resident #1 secured to his wheelchair reported it appropriately as an allegation of abuse. The RM acknowledged written statements referred to an incident on 8/19/24, which was not documented in the investigative findings, but should have been included. She stated she never reviewed video footage of the incident(s), therefore she did not reference those findings in the final report. The RM confirmed although the allegation of abuse was verified, the facility did not report licensed staff who were involved to the appropriate agencies, per the policy and procedure. Review of the Facility Assessment Tool, reviewed by the Quality Assurance and Performance Improvement committee on 8/07/24 and updated on 9/06/24, revealed the facility would provide care and services to identify risks and hazards for residents and prevent abuse and neglect.

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F 0741 Level of Harm - Actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview and record review, the facility failed to ensure the Memory Care Unit had sufficient staff with appropriate competencies and skill sets to meet the needs and ensure the safety of 1 of 4 residents reviewed for behavioral symptoms, of a total sample of 10 residents, (#1). The facility's failure to ensure there were adequate staff to supervise and monitor residents on the specialized Memory Care Unit; and failure to ensure staff demonstrated competencies related to recognizing behavior patterns and implementing appropriate approaches, resulted in psychosocial harm. Using the reasonable person concept there was potential for outcomes such as continued agitation and anxiety, loss of dignity, dehumanization, and feelings of fear and imprisonment for resident #1, and placed all residents on the unit at risk. Resident #1, a cognitively impaired resident, was physically restrained by nursing staff as a method to manage his verbal and physical behavioral symptoms and address his safety needs. Findings: Cross reference F604. Review of an Application for Admission to the Veterans Association nursing home program dated 8/07/24, completed by resident #1's wife, revealed the facility was made aware of the resident's diagnoses and behaviors prior to admission. The document indicated resident #1 had Alzheimer's disease or dementia, sundowning and exit-seeking or eloping behaviors. The application showed the resident had hallucinations, delusions, paranoia, and wandered. Review of resident #1's Hospital Discharge Summary, dated 8/13/24, revealed resident #1's discharge medication orders included an antipsychotic drug, Seroquel 100 milligrams (mg), to be given at 8:00 AM and 12:00 PM daily, and Tramadol 50 mg every eight hours as needed for moderate pain. The note revealed resident #1 was agitated and required a one-to-one sitter at his bedside until the day before he was discharged from the hospital to the facility. The Discharge Summary indicated the physician deemed resident #1 appropriate for hospice services. Review of the facility medical record revealed resident #1, a [AGE] year-old male, was admitted on [DATE]. His diagnoses included Alzheimer's disease, severe dementia with agitation, right clavicle fracture, generalized muscle weakness, difficulty walking, repeated falls, cognitive communication deficit, and depression. (continued on next page)

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Alwyn C Cashe State Veterans Nursing Home	5255 Raymond St Orlando, FL 32803

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F 0741 Level of Harm - Actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) Admission assessment with assessment reference date of 8/21/24 revealed resident #1 had clear speech, was rarely or never able to express his ideas and wants, and rarely or never understood verbal content. He had short-term memory problems, severely impaired cognitive skills for daily decision making, and exhibited continuous inattention and disorganized thinking. The MDS assessment revealed during the 7-day look back period, the resident displayed physical behavioral symptoms that put others at risk for physical injury and significantly disrupted his care or living environment on one to three days. During this period, resident #1 wandered on one to three days. The MDS assessment indicated resident #1 required partial to moderate assistance for bed mobility, transfers, and ambulation. The document showed the resident did not use restraints. Review of resident #1's medical record revealed a care plan for his need for a higher level of care than could be met in the community, initiated on 8/15/24. The goal was the resident would remain in the long-term care setting to receive biopsychosocial services. The care plan interventions included determine of the resident and his representative were satisfied with his care; and monitor his mood, behavior, or changes in condition, and report findings to the physician. A care plan for nutritional status, initiated on 8/15/24, instructed staff to administer medication for agitation as ordered. A care plan for physical behavioral symptoms such as hitting, kicking, punching, scratching and abusing others was initiated on 8/19/24. The goal was the resident would not harm others secondary to physically abusive behavior. The interventions instructed staff to assess whether behaviors endangered the resident or others and intervene if necessary; offer one step verbal interventions and allow extra time to process information; and provide care, activities, and a daily schedule that resembled his prior lifestyle. Resident #1 had a care plan for risk for falls due to poor safety awareness, initiated on 8/22/24. The care plan interventions included a comprehensive review of his medications by the pharmacist and continue current medications per psychiatry. On 9/12/24 at 4:15 PM, the Director of Nursing (DON) stated resident #1 was admitted directly to the facility's Memory Care Unit and he was normally agitated. She recalled he was also at risk for falls as he was impulsive and would suddenly stand and walk although he was unsteady on his legs. She recalled on the morning of 8/20/24, Speech Therapist F arrived in the Memory Care Unit and noted resident #1 in his wheelchair with his sweater hooked over the handle of the wheelchair. The DON verified the use of any type of restraint was unacceptable without the proper assessments and a physician order. She stated her expectation was staff would try behavioral approaches and medication interventions before even considering a restraint. (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Few	On 9/13/24 at 2:37 PM, in a telephone interview with resident #1's wife, she stated her husband experienced a rapid decline in the 2-month period before he was admitted to the facility. She described him as very strong and stubborn and confirmed he sometimes had impulsive and agitated behaviors which increased his risk for falls. The resident's wife stated there was definitely a pattern to his behaviors as he became particularly agitated everyday at lunchtime. She said, He would start ratcheting up and doing whatever his brain told him to do. They would medicate him in the hospital at that time. It was usually at about 11:00 AM. You could almost tell the time. The resident's wife recalled in the hospital, her husband had a one-to-one sitter and adequate medication to keep him calm. She confirmed she observed nursing staff in the facility's Memory Care Unit restrain her husband by securing him to the wheelchair with a shirt during one of his lunchtime episodes. The resident's wife recalled another day when she noticed the same escalating agitation starting at about 11:30 AM. She asked the nurse to medicate her husband, but was told he would have to wait another two hours until the medication was due. She surmised the symptoms were probably exacerbated by pain from his broken clavicle whenever he moved his right arm. The resident's wife explained to her knowledge, he did not receive regular pain mediation for the broken bone, and she got the impression the facility's physician would not order the amount of medication necessary to keep her husband calm. She said, I told them this can't keep going on. It was painful to watch what he was going through.I would have expected the staff to have specialized knowledge of his medication and how to handle his behavior. The result was the entire experience was unpleasant for my husband, myself, and the staff. Review of the Physician Order Report revealed the administration time of resident #1's Seroquel 100 mg dose was changed from 12:00 PM as noted in the hospital discharge summary to 2:00 PM. Review of the General Administration History indicated although ordered on admission, the resident did not receive any doses of Tramadol 50 mg for pain until 8/22/24 at 4:41 PM, eight days after admission. Review of Resident Progress Notes revealed the following: On 8/15/24, the facility's Social Services Director met with resident #1 but she was unable to communicate effectively with him. Later that day, she met with his wife who informed her resident #1 was not allowed to refuse medication. On 8/15/24 at approximately 9:20 AM, resident #1 hit his assigned nurse in the abdomen. The facility notified his wife and asked her to come to the facility to assist with calming him. On 8/15/24 at 8:29 PM, resident #1 was agitated and aggressive throughout the shift and medication was not effective. The note read, Provider aware of behavior, consult placed for [psychiatrist]. On 8/16/24 at 11:13 AM, a note indicated the resident began exhibiting agitation and aggression again. On 8/17/24 at 12:48 PM, staff had difficulty redirecting resident #1, and by approximately 4:00 PM his behaviors escalated and he ultimately became aggressive with staff and refused to take his medication. On 8/17/24 at approximately 9:00 PM, resident #1 was transported to the hospital for mental health evaluation and treatment. (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Few	On 8/18/24 at 5:57 AM, resident #1 returned to the facility. He was calm and had a new order for an over-the-counter sleep aid, Melatonin. On 8/19/24 at 2:00 PM, resident #1 was again agitated and Registered Nurse (RN) Supervisor B documented that she gently placed arms around patient to subdue any potential harmful behavior and ensure the patient's safety. This description conflicted with the wife's description of how the nurse restrained resident #1 with his shirt. The note indicated the DON, Assistant DON, Administrator, Advanced Practice Registered Nurse (APRN), and RN Supervisor H were made aware of the resident's behaviors. The document revealed the APRN was onsite, and she ordered an immediate consultation with the psychiatry provider, and staff continued plan of care. The progress note did not indicate input from nurse management staff regarding any immediate changes in interventions or increased supervision by assigned staff members to manage resident #1's behavior. On 8/20/24 at 10:49 AM, and 12:06 PM, RN Supervisor D noted resident #1 began to show agitated behaviors which continued to escalate despite attempts to redirect him and administration of medication. On 8/20/24 at 8:19 PM, RN Supervisor G noted she was informed resident #1 kicked a Certified Nursing Assistant (CNA) without any provocation. She informed the assigned nurse and wrote, Plan of care continues. On 9/13/24 at 4:38 PM, and 9/14/24 at 9:50 AM, the DON validated she reviewed resident #1's hospital record which included his diagnoses, medication orders, and physician notes prior to his admission, and she determined facility staff were able to meet the resident's needs. The DON explained resident #1 had a physician order for antipsychotic medication and his behavior should have been monitored by nurses every shift to determine if the medication and behavior management approaches were effective. However, during joint review of the resident's medical record with the DON, she verified behavior monitoring was never initiated as a scheduled task to provide information for analysis of behaviors and to identify successful non-pharmacological interventions. She confirmed the resident's chart showed no physician order or care plan intervention related to increased supervision or specific behavioral management approaches during resident #1's periods of extreme agitation. The DON stated she believed nursing staff cared for resident #1 adequately during his stay, except for the single nurse who made the bad decision to restrain him. When reminded that investigative findings showed the resident was restrained on at least three days, by and with the knowledge of an unknown number of nursing staff, she acknowledged they all made bad decisions. The DON stated she was not aware staff felt resident #1's behavior required restraints and she did not know the details of how and when this approach was used. She recalled on 8/17/24, he was highly agitated with physically aggressive behavior. She stated a psychiatry provider gave an order to transfer the resident to the hospital for temporary, involuntary detention to receive emergency mental health services. The DON explained resident #1 was not admitted to the hospital and returned less than 12 hours later with no new psychotropic medication orders. The DON acknowledged the nursing progress notes did not clearly show the physician was notified of the resident's refusal of medication, or patterns and severity of his behaviors. She was not able to show the facility attempted one-to-one supervision by a designated CNA prior to 8/21/24. She confirmed the facility never initiated a hospice consult until requested by resident #1's wife the day before his discharge. (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Few	On 9/12/24 at 5:07 PM, RN Supervisor D recalled on 8/19/24 she observed resident #1 seated in his wheelchair in the Memory Care Unit's common area with the back of his t-shirt covering the handles of the wheelchair. RN Supervisor D stated she asked RN Supervisor B if it was safe, and RN Supervisor B told her it was to keep the resident seated in his wheelchair. RN Supervisor D stated she deferred to the other supervisor's knowledge and did not release the resident. When asked if she received education from the facility on abuse and neglect prevention and the use of restraints prior to 8/19/24, RN Supervisor D said, To be very honest, we did a lot of training, but I don't honestly remember. On 9/12/24 at 5:35 PM, CNA A explained resident #1 would have needed constant supervision to ensure he was safe. She confirmed she received education on prevention of abuse and neglect and the use of restraints on hire. However, CNA A expressed uncertainty regarding whether the use of the resident's t-shirt to keep him in the wheelchair was a concern. She said, It could be a restraint I guess, but it didn't hurt him. CNA A offered the justification that the intervention was done to prevent the resident from falling. On 9/13/24 at 12:45 PM, in a telephone interview, Speech Therapist F recalled on the morning of 8/20/24 she entered the Memory Care Unit and resident #1 was seated in the common area. She stated she immediately noticed the resident was rocking back and forth in his wheelchair. Speech Therapist F stated on closer inspection, she noticed resident #1 was secured to the chair by his shirt which she recognized as a restraint. Speech Therapist F stated she never received education from the facility during almost two years that she worked with its residents. Review of a written statement by Speech Therapist F, dated 8/20/24, revealed after she removed the resident#1's shirt from the back of the wheelchair, he remained seated and calm for 30 minutes while she conversed with him. On 9/13/24 at 1:02 PM, in a telephone interview, CNA C stated she was present on Monday 8/19/24 at lunchtime, when RN Supervisors B and H attempted to redirect and calm resident #1. She recalled RN Supervisor B applied a shirt to the resident and pulled it over the back of his wheelchair to prevent him from getting out of the chair. CNA C stated she and the other CNA on the unit thought he was restrained but they deferred to the RN Supervisors' decision. CNA C did not recall if or when she received education on restraints prior to this incident. She stated she used to work on the Memory Care Unit on the night shift and sometimes she was only CNA assigned to care for all the residents. She explained if residents required increased monitoring due to behaviors or safety issues, either the nurse or the RN Supervisor would help if possible. CNA C said, Without them, I don't think I could do it all. On 9/13/24 at 1:16 PM, in a telephone interview, RN Supervisor H explained on 8/19/24, she observed resident #1 had a shirt over the back of in his wheelchair. She stated she did not look at the resident closely and accepted RN Supervisor B's explanation that it was not a restraint. RN Supervisor H stated she received education since that day and now realized the resident was restrained and use of the shirt was not an acceptable way to keep him safe. (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Few	On 9/13/24 at 3:40 PM, in a telephone interview, Licensed Practical Nurse (LPN) J stated she was assigned to the residents on the Memory Care Unit on the night shift. She recalled she arrived for her shift on 8/17/24 and observed resident #1 in his wheelchair at the nurses' station, with his shirt tied behind the back of the chair. LPN J stated she never had any issues with resident #1 related to physically aggressive behaviors. She explained her philosophy was all residents were approachable and nursing staff were to identify and implement appropriate, individualized interventions to address their behaviors. LPN J stated the situation was very stressful for resident #1's family as nurses repeatedly called them to intervene when he was agitated. LPN J did not recall receiving education from the facility on restraints and management of behaviors for residents with dementia, until after resident #1 was found restrained. LPN J confirmed the Memory Care Unit was often staffed with one nurse and one CNA. She recalled an incident about two months ago when she left a resident unsupervised in the common area to provide care to another resident. LPN J stated the resident in the common area attempted to stand and slid to the floor. She stated even within the last week she needed to pull a CNA from the other unit, which left them with only two CNAs. LPN J explained when there was only one CNA, she had to assist with washing residents and providing incontinence care. She stated if the CNA was occupied, she would have to supervise residents in the common area. LPN J explained in those circumstances, she would complete medication administration tasks while she brought the residents who needed supervision with her. She described how she placed residents outside the doorway of the room so she was able to watch them while she gave medication or checked blood sugars for other residents. On 9/13/24 at 4:01 PM, in a telephone interview, RN Supervisor G stated she observed resident #1's shirt over the handle of the wheelchair. She said, I did not ask anyone as I had never seen that before. I did not consider it a restraint due to lack of knowledge. She confirmed she had worked as a nurse on the Memory Care Unit on the night shift with only one CNA, and she had to assist with supervising residents. She explained in a supervisor's role she would sometimes monitor residents in the unit's common area if she was free. She validated the Memory Care Unit required two CNAs on the night shift to adequately meet the care and safety needs of the cognitively impaired residents. On 9/13/24 at 4:15 PM, in a telephone interview, CNA K stated she sometimes worked on the Memory Care Unit as the only CNA. She acknowledged it was not possible to give care to her assigned residents and supervise the ones who wandered or were at risk for falls without assistance from the nurse. She said, If the nurse does not help it is difficult. On 9/13/24 at 4:22 PM, in a telephone interview, CNA L confirmed when there was only one CNA scheduled to work on the Memory Care Unit, it was very difficult to care for the residents. She explained the nurse would have to assist with monitoring residents. (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Few	On 9/14/24 at 10:53 AM, RN Supervisor B confirmed she kept resident #1 seated by placing his shirt over the back of the wheelchair. She stated she was not aware using that method of addressing his behavior met the criteria of a restraint. RN Supervisor B explained she had used this method to restrain patients at a previous job. She stated to her knowledge residents could be restrained for a certain timeframe without a physician order. RN Supervisor B confirmed she did not notify the DON or the physician that the resident's behavior was so unmanageable that she had to restrain him. When asked if she received education on hire related to abuse, neglect, and the use of restraints, RN Supervisor B explained when she was hired there was no Human Resources Manager on staff, and she did a self-paced orientation. She confirmed the Memory Care Unit was regularly staffed with one CNA on the overnight shift. She explained although the staffing assignment sheets provided to State Survey Agency staff by the facility reflected two CNAs worked on the unit on 8/19/24, that was not so. RN Supervisor B stated they often had to pull one Memory Care Unit CNA to adequately staff the other larger unit, but the assignment sheets were not always updated to reflect the changes. On 9/14/24 at 11:03 AM, in a telephone interview, CNA I stated she was assigned to resident #1 on the overnight shift that ended on the morning of 8/20/24, the day Speech Therapist F discovered him restrained in his wheelchair. She recalled she was the only CNA on the Memory Care Unit that night, assigned to care for and supervise nine residents. When asked if it was difficult to complete all her duties when she was the only CNA on the unit, she said, That's ok if everyone is in bed and everything goes perfect. If not, I do what I have to do. I try to manage one resident and ask the nurse to help out with another. CNA I explained her ability to complete all tasks d adequately supervise the residents depended on which nurse was assigned to the Memory Care Unit. She said, One of the nurses at night has no memory care experience and she is no help with the residents. I don't think she had specific training since she really doesn't seem to know what to do about behaviors and when they are acting up. CNA I stated she never received special education prior to being assigned to the Memory Care Unit, but she utilized training and experience gained from previous jobs. On 9/13/24 at 9:56 AM and 9/14/24 at 10:22 AM, the Administrator confirmed the purpose of the facility's Memory Care Unit was to provide a secure environment in which cognitively impaired residents could move around freely and receive appropriate levels of supervision and specialized care. She acknowledged the residents on the Memory Care Unit represented a higher level of acuity than the other unit and the residents' care needs supported higher staffing ratios and/or nursing hours. The Administrator verified the unit was sometimes staffed with one CNA on the night shift. When asked if the staffing ratio took into account typical sundowning behaviors of residents with dementia, which included increased wandering, anxiety, agitation, confusion in the evenings and nights, the Administrator stated she felt one CNA was appropriate for the night shift as the nurse was there to help. On 9/13/24 at 11:08 AM, the Risk Manager (RM) verified the Memory Care Unit was a setting that gave specialized care to cognitively impaired residents. When asked why the staffing ratio would be lower at night if that population often required more supervision at that time of day, the RM stated she could neither answer nor provide a rationale for decreased staffing at night. (continued on next page)

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F 0741 Level of Harm - Actual harm Residents Affected - Few	Review of the Facility Assessment Tool, reviewed by the Quality Assurance and Performance Improvement committee on 8/07/24 and updated on 9/06/24, revealed the facility would admit and care for residents with common diseases and conditions, physical and cognitive disabilities, and behavioral health needs. The document listed psychiatric and mood disorders including psychosis (hallucinations and delusions), impaired cognition, mental disorder, depression, anxiety, behavior that needs interventions, and behavioral and psychological symptoms of dementia. The Facility Assessment indicated the facility could also meet the needs of residents with neurological disorders including Alzheimer's disease and dementia. The document revealed the facility would provide care and services for activities of daily living, fall prevention, and pain management. In addition, the assessment tool indicated the facility would identify and implement interventions to support residents with medical and mental health conditions related to psychiatric symptoms, behaviors, Alzheimer's and dementia. In order to provide person-centered care, facility staff would identify residents' preferences, routines, and things that upset them so staff assigned to the resident would have the necessary information.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 36489 Based on interview and record review, the facility failed to utilize its Quality Assurance and Performance Improvement (QAPI) program to identify the root cause of an incident related to unauthorized restraint of a cognitively impaired resident, for 1 of 4 residents reviewed for behavioral symptoms, of a total sample of 10 residents, (#1); and failed to develop and implement a performance improvement plan (PIP) to ensure the safety and provision of appropriate care and services for all residents on the specialized Memory Care Unit. Findings: Cross reference F604 and F741. On 9/12/24 at 4:15 PM, the Director of Nursing (DON) discussed an incident that occurred in the facility's Memory Care Unit on the morning of 8/20/24. She stated Speech Therapist F found resident #1 restrained in his wheelchair in the unit's common area. The DON explained the Administrator and other management staff were informed that the resident's sweater was hooked over the handles of the wheelchair. The DON stated resident #1 was often agitated, sometimes had aggressive behaviors, and was at risk for falls, but physically restraining him was unacceptable without the proper assessments and a physician order. When asked about corrective and preventative actions taken by the facility in response to this incident, the DON stated involved staff were provided with one-to-one education immediately after the incident, and all-staff education began that day. She explained the facility did not develop a PIP or conduct audits after this incident. On 9/12/24 at 3:11 PM, and 4:09 PM, the Staff Developer stated he was responsible for ensuring all staff received education on the topics of abuse and neglect and restraints after the incident that involved resident #1. The Staff Developer explained he educated staff across all shifts, and each staff member signed the in-service attendance sheet to confirm receipt of the education. He stated the education was verbal and there was no post-test given to validate comprehension. He said, I covered almost everyone. I would say about 80%. Review of all-staff education attendance sheets for the topics Abuse, Neglect and Exploitation/Misappropriation of Resident Property and Restraint Protocol, dated 8/20/24, showed a total of 64 signatures on five pages. Reconciliation of the attendance sheets with the 64 names on the facility's employee list revealed one of the five pages of attendees' signatures included dietary staff who were not listed as employees. The other four pages reflected signatures for 33 staff on the employee list, approximately 50% of facility staff, significantly less than the 80% reported by the Staff Developer. In addition, the attendance sheets showed multiple duplicate signatures. The Administrator, DON, Assistant DON, and Registered Nurse (RN) Supervisor D each signed twice. There were two signatures each for CNAs E, M, and N; CNA A's signature was noted three times; and two signatures were illegible. The Staff Developer also provided an attendance sheet for training on the topic Caring for Patients with Dementia. This in-service was provided on 8/18/24, before Speech Therapist F reported resident #1's restraint, and was attended by 28 staff. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/13/24 at 9:36 AM, the Administrator reviewed the QAPI binder with the committee's activities for August and September 2024. The Administrator stated the facility held monthly QAPI meetings which were attended by herself, the Medical Director, the DON, the Risk Manager (RM), and all department heads. She stated the last scheduled meeting was held on 8/21/24, the day after the facility submitted the required mandatory reports related to the physical restraint of resident #1. She stated during that meeting, the committee discussed issues that occurred in the previous month, July 2024; therefore, the restraint incident was not on the agenda. The Administrator confirmed although the agenda included a section for other business, the incident was not discussed. She acknowledged the purpose of QAPI committee was to identify quality concerns and address them by implementing QAPI policy and procedures. The Administrator explained the ultimate goal of the QAPI committee was to ensure the highest possible quality of care and quality of life for all residents. On 9/13/24 at 9:56 AM, the DON verified the QAPI committee did not convene an Ad Hoc meeting to address any other issues after the scheduled monthly meeting on 8/21/24. She explained although the facility conducted investigations for all incidents, it did not always complete a detailed root cause analysis. The DON stated the interdisciplinary team discussed the restraint incident in the daily clinical meeting, and they determined the cause was RN Supervisor B restrained resident #1 and all staff followed her lead. She confirmed the facility did not explore or identify other possible causative factors including lower than optimal staffing ratios, the need for additional, specialized education for staff on the Memory Care Unit, and/or inadequate pre-admission case reviews for potential Memory Care Unit residents. On 9/13/24 at 11:08 AM, the RM stated she returned to work the day after the facility was notified resident #1 was restrained in his wheelchair. She acknowledged either she or the Administrator would usually initiate the QAPI process for an incident or occurrence that was significantly outside the norm of facility operations, especially if there was a negative outcome or the potential to affect multiple residents. The RM said, Now that I think about it, in hindsight, we could have done an Ad Hoc or discussed as other business in the QAPI meeting. Review of the facility's Quality Assurance/Risk Management Program, revised 3/01/24, revealed the facility would develop, implement, and maintain an ongoing facility-wide program designed to monitor, evaluate, and improve the quality of care for residents and to resolve identified problems. The policy indicated the QAPI plan encompassed issues related to clinical care, quality of life, and resident choice that could be identified by internal monitoring, incident reports, resident/family concerns, and rounding. In response to priority concerns, the facility would develop process improvement projects to clarify issues, develop interventions, assess the results, and sustain improvements.