STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115287	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chulio Hills Health and Rehab	1170 Chulio Road Rome, GA 30161

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and family interviews, record review, and review of the facility's policies titled, Notification of Changes, Change in Resident's Condition or Status, the facility's Senior Medical Systems Protocols, and New Facility Procedure, the facility failed to ensure timely physician and responsible party notification regarding a significant change in condition of resident (R) (R3) who had a decline in condition. Harm was identified to have occurred on 2/19/2026 when R3 was hospitalized due to a fall after a decline in condition. Findings included:A review of the electronic medical record (EMR) revealed that R3 was admitted to the facility on [DATE] with pertinent diagnoses including, but not limited to, cognitive communication deficits, generalized weakness, hypertension, myasthenia gravis, difficulty walking, impaired coordination, multiple orthopedic conditions (including prior hip and shoulder arthroplasties and a healed left humerus fracture), blindness in the left eye, and the need for assistance with personal care.A review of R3's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated R3 was cognitively intact. Section GG, functional status, revealed R3 required partial/moderate assistance for activities of daily living (ADLs) with one-person assistance and utilized a walker and wheelchair for mobility. Section E revealed no behaviors exhibited. Section H revealed the resident was frequently incontinent of bladder and always continent of bowel.A review of R3's care plan revised 2/26/2026 revealed the resident was identified as high risk for falls related to impaired mobility, generalized weakness, impaired coordination, dementia with reduced safety awareness, visual impairment, prior falls, polypharmacy with CNS-active medications, dizziness risk, and medical conditions including myasthenia gravis. Goals included maintaining the resident free from falls with injury requiring hospitalization. Interventions included one-person assist with gait belt for transfers and ambulation, fall-risk assessments, therapy involvement, monitoring for dizziness, sedation, confusion, and adverse medication effects, maintaining a safe, clutter-free environment with call light within reach, non-skid footwear, bed in lowest position, behavioral redirection, supervision during ADLs, and monitoring for weakness, fatigue, and impaired balance.A review of the Physician's Orders for R3 included, but was not limited to:Order dated 2/16/2026 for Ondansetron HCl (Zofran) Oral Tablet 4 milligrams (mg): give 1 tablet by mouth one time only for nausea until 2/16/2026.Order dated 9/30/2025 for Hydrochlorothiazide 12.5 mg: give 1 tablet by mouth one time daily related to essential hypertension.Order dated 11/06/2025 for Potassium Chloride ER Tablet 20 milliequivalent (mEq): give 1 tablet by mouth one time a day related to essential hypertension.Order dated 10/31/2025 for weekly vital signs every Friday night shift.A review of hospital records revealed that R3 was admitted to the local hospital on 2/19/2026 following an unwitnessed fall at the facility while experiencing ongoing nausea and vomiting. Documentation revealed the resident sustained facial fractures and a closed odontoid cervical spine fracture. Hospital records further revealed severe hyponatremia (sodium level 121), hypokalemia, acute kidney injury, weakness, continued vomiting, aspiration pneumonia/pneumonitis, acute hypoxemic respiratory failure requiring intubation and ICU admission, septic shock, and prolonged critical illness. A review of Physical Therapy Treatment Encounter (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 0580 Level of Harm - Actual harm Residents Affected - Few	Note(s) provided in hard copy dated 2/16/2026 through 2/18/2026 revealed repeated documentation of nausea and decline in condition, including:2/16/2026: Pt (patient) not feeling well today, low energy, and indicated she is nauseated.2/17/2026: Pt not doing well today, c/o (complaint of) nausea. nursing and SW (Social Worker) notified.2/18/2026: Pt nauseated, nurse aware.2/19/2026: Pt still c/o abdominal pain, but nausea is better. enjoyed being outside but indicates ?I never feel good anymore'A review of R3 Medication Administration Record (MAR) revealed a one-time administration of Ondansetron HCl (hydrochloride) (Zofran) Oral Tablet 4 mg one time on 2/16/2026 for nausea.A review of R3 Progress Notes in the EMR revealed an Order Note dated 2/17/2026 entered by Licensed Practical Nurse (LPN) NN documenting MD AWARE. CONTINUE ORDER related to a one-time order for Ondansetron 4 mg for nausea initiated on 2/16/2026. Additional hard copy nursing documentation by LPN NN dated 2/16/2026 at 0700 noted resident c/o nausea x1, requested Zofran, drinking fluids, at baseline. A review revealed no documented assessment, provider notification, or ongoing monitoring despite continued symptoms over several days. The surveyor attempted multiple telephone contacts with Licensed Practical Nurse (LPN) NN regarding physician notification without success.Further review of Progress Notes revealed a note dated 2/19/2026 at 10:35 pm indicating the resident sustained an unwitnessed fall from the toilet, resulting in left facial swelling, left eye injury, laceration, and bruising to the neck. Nursing documentation revealed the resident had been throwing up several times before the fall and reported becoming entangled in her pant leg while attempting to vomit into the toilet. Documentation revealed Emergency Medical Services (EMS) was contacted, and the resident was transferred to the local hospital at 10:52 pm.A review of R3 Task: Nutrition-Amount Eaten/ADL-Eating records provided in hard copy for February 2026 revealed that 2/16/2026 through 2/19/2026 revealed decreased oral intake and meal refusals. Documentation revealed intake scores of 0-1 on 2/16/2026, indicating poor intake, refusal of lunch and dinner on 2/18/2026, and continued poor intake/incomplete meal documentation on 2/19/2026. An interview with Certified Nurse Aide (CNA) II revealed the resident had refused both breakfast and lunch on 2/19/2026.A review of R3's vital signs documentation failed to identify any recorded vital signs, blood pressure measurements, or evidence of increased monitoring between 2/16/2026 and 2/19/2026. This absence of monitoring occurred despite the resident exhibiting clinical symptoms including nausea, vomiting, decreased oral intake, weakness, and an overall decline in condition before the resident's fall and subsequent hospitalization. Documentation review identified only a pain assessment completed on 2/19/2026; however, the most recent vital signs before this period were documented on 2/14/2026 and 2/13/2026. This lack of monitoring was inconsistent with facility protocol requiring assessment, monitoring, and escalation of care in response to changes in a resident's condition.A review of the facility's Communication Record-Problems or concerns regarding resident for MD and/or NP to be made aware of revealed a single entry dated 2/19/2026 documenting fall with facial injury, sent to ER for eval & tx. MD & family notified. Review failed to reveal additional documented physician or nurse practitioner notification entries related to the resident's nausea, vomiting, decreased oral intake, weakness, or decline in condition during the period of 2/16/2026 through 2/19/2026. The resident's persistent nausea, vomiting, poor oral intake, weakness, and decline in functional status constituted a significant change in condition requiring physician and responsible party notification in accordance with facility policy.A review of progress notes revealed R3 was last evaluated by Nurse Practitioner (NP) MM on 1/28/2026 during a monthly regulatory visit. Documentation revealed review of systems noted No weakness or fatigue, no nausea, vomiting, diarrhea, heartburn. No abdominal pain. Review of a previous monthly routine management visit dated 12/29/2025 by the Medical Director noted, Patient offers no acute or chronic concerns or changes at this time. Nursing staff reports no acute or chronic concerns or changes at this time. This resident requires frequent monitoring and management to prevent avoidable decline. Despite the development of persistent nausea, vomiting, weakness, poor oral intake, and decline in condition beginning on or about 2/16/2026, review failed to reveal timely physician or nurse practitioner notification, further evaluation, or reassessment by a medical provider (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	before the resident's hospitalization on 2/19/2026.A review of staffing records for the period of 2/16/2026 through 2/19/2026 revealed LPN DD worked the 7:00 am to 7:00 pm shift daily on the 200 Hall, where R3 resided, during the period of decline before hospitalization.An interview on 5/21/2026 at 1:14 pm with LPN DD revealed that she was the nurse assigned to R3 during the day shift from the week of 2/16/2026 through 2/19/2026. LPN DD recalled that in the days leading up to the incident, R3 had remained in bed more frequently, but she did not recall any other notable changes. LPN DD stated that R3 regularly participated in and enjoyed physical therapy and would independently ambulate to the therapy area located at the end of the 300 hall. LPN DD further stated that the facility's process for addressing changes in condition included monitoring and documenting the changes and notifying the provider. She stated that significant changes also required completion of a change in condition form, nursing progress notes, and other pertinent charting to ensure close monitoring, and that family members were notified of significant changes.An interview on 5/21/2026 at 1:55 pm with Physical Therapist (PT) FF revealed that R3 had been receiving physical therapy five days per week, and the week of the fall, R3 complained of gastrointestinal symptoms including nausea and diarrhea, with decreased appetite and intake.An interview on 5/22/2026 at 11:05 am with the Medical Director revealed that he was unable to answer questions regarding R3 at that time and stated that any specific questions would need to be submitted via email. The follow-up interview further revealed that NP MM was unavailable to answer questions.An interview on 5/22/2026 at 12:11 pm with R3's daughter revealed that although she had not seen her mother during the week leading up to the fall, she spoke with her daily by telephone and recalled R3 repeatedly complaining of not feeling well, including symptoms of nausea, vomiting, stomach discomfort, and decreased appetite. R3's daughter stated that these symptoms had been present for approximately five days before the fall and that R3 had informed her that the nursing staff was aware she was not feeling well. She further stated that the facility did not contact her regarding her mother's condition. R3's daughter reported that she was notified on 2/20/2026 between approximately 4:00 pm and 5:00 pm that her mother had fallen and was being sent to the hospital because the situation looked bad. She stated that she was not notified at the time the fall occurred and later learned while at the hospital that the fall had reportedly occurred the previous day. R3's daughter stated she was unsure whether the resident had been transported to the hospital immediately after the fall or if the transfer occurred the following day.An interview on 5/22/2026 at 12:33 pm with LPN JJ revealed that she was caring for R3 on the evening of the fall, 2/19/2026. LPN JJ stated that R3 had reported not feeling well that day and the day prior, complained of nausea, and requested medication for nausea. She stated that R3 approached her twice, at approximately 8:00 pm, reporting nausea, and again at approximately 9:30 pm, stating she did not feel well. LPN JJ recalled that R3 was carrying a basin/sick pail and reported episodes of vomiting. LPN JJ stated that she intended to contact the physician regarding the resident's condition and request anti-nausea medication; however, she did not have the opportunity to do so because she was in the process of passing medications before the fall. LPN JJ further stated that she was at the nurses' station when she was notified that R3 had fallen. Upon assessment, she observed R3 bleeding, and the resident reported that she was sitting on the toilet when she attempted to turn and vomit into the toilet and got caught in her pant leg and fell. LPN JJ stated that emergency medical services were immediately contacted and R3 was transferred to the hospital. She further stated that, during shift report, day shift nurse LPN DD had informed her that the resident had not been feeling well earlier in the day. LPN JJ stated that she did not notify R3's representative or any other individual of the fall and was unsure who had done so, as her primary concern was arranging for R3's transfer to the emergency room (ER).An interview on 5/22/2026 at 10:22 am with the Assistant Director of Nursing (ADON)/Acting DON revealed that the facility utilizes standing physician orders as well as established procedures outlining conditions for changes in resident condition. The ADON stated that staff are expected to follow the facility's policies and procedures when a resident's condition changes.An interview on 5/20/2026 at 4:20 pm with the Administrator acknowledged (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	discrepancies in the facility report submitted to the State Survey Agency, specifically that the date of the fall was documented as 2/20/2026 instead of 2/19/2026. Follow-up interview on 5/22/2026 at 10:28 am with the Administrator revealed that her expectation is for staff to follow policy and procedures when it comes to a resident exhibiting a change in condition.An interview on 5/22/2026 at 12:48 pm with CNA II revealed that she worked the day shift on the 200 Hall, the date of the incident, 2/19/2026, and recalled that R3 reported not feeling well and refused both breakfast and lunch that day. CNA II further stated that R3 complained of nausea and vomiting and had a basin/pail for emesis. According to CNA II, R3 informed her that she could not eat because doing so made her nauseous. CNA II stated that she notified the nurse on duty, LPN DD, that R3 was not feeling well, explaining that LPN DD routinely worked Monday through Thursday. CNA II further stated that she did not know whether LPN DD took any action regarding the resident's condition, as her responsibility was to report the information to the nurse, after which the nurse assumed responsibility for follow-up care. CNA II also stated that R3 had already been experiencing symptoms during the prior shift, as the resident had previously been provided a basin/pail for episodes of emesis.A review of the facility's Senior Medical Systems Protocols revised 2/14/2025 revealed, ***Any medication protocol implemented should be written as a verbal order in the resident's chart, sent to pharmacy and documented in the nurses' notes and provider's communication book***. Review of section Nausea/Vomiting: abdominal assessment-notify medical provider by phone of abnormal findings. If assessment is normal (good bowel sounds in all quadrants, no blood or coffee-ground colored emesis), give Zofran 4 mg PO or IM q6h x 24 hours. Notify medical provider by phone if it continues beyond 24-hours or if coffee ground appearance or if no urine output x 8 hours. Further review on page 3 indicated Notify the medical provider immediately if the resident becomes unstable or conditions persist or worsen.A review of the facility's New Facility Procedure reviewed 5/4/2022 indicated item 4. Change in Condition section A. Review the change in clinical condition requiring notification with the nurse, give recommendations or clinical guidance as needed to properly assess/observe the resident and complete the change in condition form to contact the MD (physician). C. Review the progress notes to ensure documentation of notification of the responsible party, MD notification, and any orders. Also, if any follow-up with the responsible party is required, review to ensure it is completed.A review of the facility policy titled Notification of Changes, revised 1/1/2021, revealed, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Further review of section Circumstances requiring notification include: item 2. Significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health. Item 3. Circumstances that require a need to alter treatment. This may include: New treatment.A review of the facility policy titled Change in a Resident's Condition or Status, revised October 2020, revealed, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. Further review of item 1. The nurse will notify the resident's attending physician or physician on call when there has been a(n): d. Significant change in the resident's physical/emotional/mental condition; i. specific instruction to notify the physician of changes in the resident's condition. Item 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: a. the resident is involved in any accident or incident that results in an injury, including injuries of an unknown source; b. There is a significant change in the resident's physical, mental, or psychological status.

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F 0600 Level of Harm - Minimal harm or potential for 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** Based on staff interviews, record review, and review of the facility's policy titled Abuse, Neglect and Exploitation, the facility failed to ensure a resident (R) (R2) remained free from sexual abuse. Findings included:A review of the electronic medical record (EMR) revealed R2 was admitted to the facility on [DATE] with pertinent diagnoses including but not limited to left-sided hemiplegia/hemiparesis following cerebral infarction, seizure disorder, dysphagia, cognitive communication deficit, and generalized muscle weakness and wasting.A review of R2's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 11, which indicated moderate cognitive impairment. Section GG, functional status, revealed R2 had upper and lower impairment on one side and required substantial maximum assistance with Activities of Daily Living (ADLs). Section E revealed that no behaviors were exhibited.A review of R2's care plan dated 4/14/2026 identified the resident as high risk for abuse and non-consensual interactions due to impaired communication following a Cerebrovascular Accident (a stroke) (CVA) with mixed receptive-expressive language disorder, cognitive deficits, and dependence on staff for activities of daily living. The care plan noted the resident may have difficulty understanding questions and may be unable to effectively report or describe abuse. Goals included maintaining resident safety and ensuring the resident can report unwanted interactions. Interventions included use and reinforcement of a designated safety word (PISTACHIO), routine safety checks, use of simple yes/no questions to assess safety, monitoring for behavioral or emotional changes, prompt reporting of concerns to nursing leadership, maintaining consistent caregivers when possible, and ensuring calm, supportive communication to promote dignity and emotional safety during care.A review of the facility investigation documents revealed that on 4/10/2026, Certified Nurse Aide (CNA) LL observed R4 inside R2's room while R2 was lying in bed and observed R4 kissing R2 on the mouth. CNA LL immediately instructed R4 to leave the room and reported the incident to the Assistant Director of Nursing (ADON/Acting DON). The ADON notified the Social Services Director (SSD) and the Administrator, and the facility immediately initiated an abuse investigation. Review revealed that R2 was interviewed by the SSD, ADON, and later law enforcement regarding the incident. Documentation reflected that R2 reported the kiss occurred on her lips, described it as a wet kiss, and stated that the interaction was unwanted and non-consensual. Documentation further revealed R2 reported feeling uncomfortable with R4 being in her room. Staff provided reassurance and emotional support to R2 during the investigation process. Review further revealed that R2 was referred for and received mental health/behavioral health services following the incident. Further review revealed that R4 was interviewed by facility administration and admitted to kissing R2. Documentation reflected that R4 demonstrated limited insight into the inappropriate nature of the interaction and acknowledged awareness that the conduct was wrong due to R2's cognitive impairment. Local law enforcement responded to the facility, interviewed both residents, and subsequently placed R4 under arrest. Review revealed that the physician, responsible parties, local law enforcement, corporate leadership, and the State Survey Agency (SSA) were notified of the incident. Facility documentation reflected that the allegation was reported in a timely manner in accordance with facility policy and regulatory requirements. Additional review revealed that witness statements were obtained, interviewable residents and staff were interviewed, abuse observations were conducted throughout the facility, and abuse education/in-services were provided to facility staff following the incident. Review further revealed R4 was discharged from the facility due to concerns related to resident safety and being identified as an immediate risk to other residents.An observation and interview on 5/20/2026 at 4:14 pm of R2 in her room revealed that R2 was sitting upright in bed, appeared appropriately groomed, and was only able to answer simple yes and no questions. When asked if she felt safe at the facility, R2 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated yes. When asked about the incident involving another resident kissing her the previous month, R2 stated no when asked if she wanted to be kissed. When asked if staff came to help her when the incident occurred, R2 answered yes. When asked if she had spoken with a counselor regarding the incident, R2 stated yes and confirmed it had only occurred one time when asked. When asked if staff treated her with respect and did not abuse her, R2 answered yes. Follow-up observation and interview on 5/21/2026 at 2:30 pm in R2's room revealed R2 was lying in bed and appeared calm. When asked how she was doing, R2 responded, ok. When asked if she would like to continue speaking with someone regarding the incident, such as a counselor on an ongoing basis, R2 answered yes.A review of R2 Progress Notes in the EMR revealed a note dated 4/10/2026 that documented that a CNA reported a male resident was observed in R2's room leaning over her and kissing her. Staff immediately removed the resident from the room and notified nursing leadership. The SSD and ADON interviewed R2, who reported the kiss occurred on her lips, described it as a wet kiss, and stated she did not consent to the interaction. R2 further indicated she felt uncomfortable and reported she did not know how to express no. Staff provided reassurance, reviewed safety measures with the resident, and encouraged her to alert staff if she felt unsafe. Law enforcement was contacted, and the officer interviewed R2 and completed a report consistent with her statements.A review of R2's Behavioral Health Progress Note dated 4/14/2026 in the EMR revealed the resident participated in an onsite individual psychotherapy session following a reported sexual abuse incident involving another resident. The resident was diagnosed with an unspecified anxiety disorder related to adjustment difficulties associated with facility placement and loss of independence. The resident presented alert and fully oriented, with appropriate behavior, calm psychomotor activity, and euthymic mood. The session focused on emotional support, reassurance, and coping related to the recent incident. The resident reported anxiety regarding what may occur following the event but stated she currently felt safe in the facility since the involved resident had been removed. The clinician documented that no visible post-traumatic stress symptoms were observed or reported at the time of the visit. Treatment goals included stabilization of anxiety and emotional adjustment following the incident, with recommendations for continued supportive counseling and psychotherapy services on an ongoing basis.A review of the EMR revealed R4 was admitted to the facility on [DATE] with pertinent diagnoses including but not limited to chronic cardiopulmonary disease, major depressive disorder, dysphagia, and generalized weakness with impaired mobility.A review of R4's quarterly MDS assessment dated [DATE] revealed a BIMS of 15, which indicated R4 was cognitively intact. Section GG, functional status, revealed R4 utilized a walker for ambulation and required supervision to independent assistance with ADLs.A review of R4's care plan revised 4/20/2026 revealed that multiple prior goals related to consensual intimacy, sexual expression, and provision of a private environment for sexual activity were initiated on 2/14/2024. Interventions included honoring the resident's stated wish to engage in consensual intimacy with another consenting resident, providing a private space for sexual activity, treating the resident and partner with respect, protecting dignity related to sexual expression, and providing education regarding safe sex practices and risk reduction, including sexually transmitted infections. The care plan also included interventions for ongoing assessment of the resident's cognitive capacity and ability to consent to sexual activity, with periodic reassessment of consent capacity per facility policy.A review of R4's Progress Notes in the EMR revealed a note dated 4/10/2026 that documented that R4 was observed in the room of R2 during an inappropriate interaction in which R4 admitted to kissing R2. The resident was interviewed by facility leadership and law enforcement and acknowledged the interaction. The resident was informed that the behavior was inappropriate given the cognitive status and inability of the other resident to consent. R4 was noted to be non-receptive to redirection or counseling regarding the incident and stated he believed his actions were acceptable. Law enforcement subsequently arrested R4, and he was removed from the facility due to being considered an imminent risk to other residents. The resident was discharged from the facility and is no longer residing in the building.A review of R4's (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician Discharge Note dated 4/13/2026 in the EMR revealed that R4 was discharged from the facility effective immediately and transferred into the custody of local law enforcement. The physician concurred with the facility's determination that the resident presented an imminent threat of harm to other residents based on recent unwanted sexual contact toward another resident. An interview on 5/20/2026 at 2:30 pm with the Administrator and ADON revealed that R4 was no longer in the facility, as he was arrested on the date of the incident, and subsequently indicted by the grand jury and remains in custody of law enforcement.An interview on 5/21/2026 at 12:52 pm with SSD revealed she responded immediately following the incident and interviewed R2 and R4. The SSD stated R2 reported that R4 had kissed her. R4 acknowledged the interaction but was described as non-receptive to redirection, stating he believed his actions were appropriate and that he was helping the resident. The SSD reported that law enforcement was notified, and R4 was subsequently arrested after admitting to the interaction. The SSD further stated R2 declined to press charges at that time and was provided follow-up mental health services, including a psychological evaluation with ongoing counseling offered as needed. The SSD also confirmed that staff initiated immediate protective measures and supervision during the investigation.An interview on 5/21/2026 at 1:36 pm with the ADON revealed the incident occurred during the evening shift when staff observed R4 in R2's room engaging in inappropriate physical contact. The ADON stated that staff immediately intervened, removed R4 from the room, and initiated notification to administration and social services. R4 was interviewed and confirmed the contact but minimized the behavior, stating he was giving her some loving. The ADON reported that law enforcement was contacted, and R2 confirmed she did not want the contact. R4 was subsequently arrested following law enforcement's determination. The ADON further stated that facility-wide interviews were conducted with residents, all of whom denied abuse or inappropriate contact. Staff were re-educated on abuse prevention and reporting procedures. The ADON also noted R4 had a history of expressing interest in a consensual relationship with another resident; however, that relationship discontinued due to changes in the cognitive status of the other resident involved.Interview attempts were made on 5/21/2026 and 5/22/2026 to make contact with CNA LL, who was involved in the initial discovery of the incident; however, contact was unsuccessful.An interview on 5/22/2026 at 10:35 am with the Administrator revealed she was present at the facility at the time of the incident and was immediately notified by staff. The Administrator stated she initiated law enforcement contact and the internal investigation process without delay. She further stated she spoke with R4, who acknowledged the interaction but minimized the behavior. The Administrator confirmed R4 was restricted from contact with R2 pending law enforcement arrival. Law enforcement responded to the facility, interviewed both residents, and determined R4 would be arrested due to the nature of the incident and the inability of R2 to consent.A review of the facility's policy titled Abuse, Neglect, and Exploitation, revised 9/17/2025, indicated It is the policy of this facility to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Further review of section Definitions included Sexual Abuse in non-consensual sexual contact of any type with a resident.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and family interviews, record review, and review of the facility's policies titled, Notification of Changes, Change in Resident's Condition or Status, the facility's Senior Medical Systems Protocols, and New Facility Procedure, the facility failed to ensure timely assessment, monitoring, escalation, and clinical management of a resident (R) (R3) who exhibited a progressive change in condition. Harm was identified to have occurred on [DATE], when R3 was hospitalized due to a fall after a decline in condition. Findings included:Review of the facility investigation documents revealed R3 sustained a fall on [DATE] (the facility-reported incident submitted to the State Survey Agency incorrectly documented the date of the fall as [DATE]). Documentation reflected that at approximately 10:20 pm, R3 was discovered on the bathroom floor in her assigned room following an unwitnessed fall. Licensed nursing staff immediately responded and initiated assessment. Due to visible facial injuries, emergency medical services (EMS) were activated. R3 had a BIMS score of 14, indicating intact cognition. Before the incident, the resident experienced multiple episodes of nausea and emesis during the evening hours. Nursing documentation reflected that supportive interventions were provided, including ginger ale. Documentation further reflected that the resident reported worsening nausea after consuming the beverage and independently ambulated to the bathroom due to urgency to vomit. The resident stated that while attempting to turn toward the toilet, her foot became entangled in her pant leg, resulting in loss of balance and a fall to the bathroom floor. EMS arrived at approximately 10:52 pm, and the resident was transferred via stretcher to the local hospital for further evaluation.Review of the facility's Accident and Incident Reports for 2025 and 2026 revealed that R3, who required assistance with activities of daily living and was identified as being at high risk for falls, sustained multiple unwitnessed falls on [DATE], [DATE], [DATE], and [DATE].Review of hospital records for R3 revealed the resident was admitted to the local hospital on [DATE] following an unwitnessed fall at the facility while experiencing ongoing nausea and vomiting. admission documentation revealed the resident sustained significant traumatic injuries, including facial fractures and a closed odontoid cervical spine fracture. Hospital records further revealed the resident presented with severe hyponatremia (sodium level 121), Hypokalemia, acute kidney injury, weakness, and continued vomiting following several days of documented nausea, vomiting, and poor oral intake at the facility before hospitalization. Documentation revealed the resident subsequently developed vomiting with aspiration, acute hypoxemic respiratory failure requiring emergent intubation and ICU admission, aspiration pneumonia/pneumonitis, septic shock, and prolonged critical illness. Bronchoscopy revealed purulent secretions within the lung consistent with aspiration-related pulmonary injury. The resident's hospitalization was further complicated by prolonged mechanical ventilation, delirium, ileus, thrombocytopenia, and ongoing respiratory failure. Documentation revealed the resident expired on [DATE] following withdrawal of life support measures.Review of Physical Therapy Treatment Encounter Note(s) provided in hard copy dated [DATE] through [DATE] revealed repeated documentation of nausea and decline in condition, including:[DATE]: Pt not feeling well today, low energy, and indicated she is nauseated.[DATE]: Pt not doing well today, c/o nausea. nursing and SW notified.[DATE]: Pt nauseated, nurse aware.[DATE]: Pt still has abdominal pain, but nausea is better. enjoyed being outside but indicates ?I never feel good anymore'Review of R3 Medication Administration Record (MAR) revealed a one-time administration of Ondansetron HCl (Zofran) Oral Tablet 4 mg one time on [DATE] for nausea.Review of R3 Progress Notes in the EMR revealed an Order Note dated [DATE] entered by Licensed Practical Nurse (LPN) NN documenting MD AWARE. CONTINUE ORDER related to a one-time order for Ondansetron 4 mg for nausea initiated on [DATE]. Additional hard copy nursing documentation by LPN NN dated [DATE] at 0700 noted resident c/o nausea x1, requested Zofran, drinking fluids, at baseline. Review failed to reveal documented assessment, provider notification, or ongoing monitoring despite continued symptoms (continued on next page)

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	115287	A. Building B. Wing	05/22/2026

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F 0684 Level of Harm - Actual harm Residents Affected - Few	over several days. The surveyor attempted multiple telephone contacts with LPN NN regarding physician notification without success.Further review of Progress Notes revealed a note dated [DATE] at 10:35 pm indicating the resident sustained an unwitnessed fall from the toilet resulting in left facial swelling, left eye injury, laceration, and bruising to the neck. Nursing documentation revealed the resident had been throwing up several times prior to the fall and reported becoming entangled in her pant leg while attempting to vomit into the toilet. Documentation revealed EMS was contacted, and the resident was transferred to the local hospital at 10:52 pm. Review of nursing documentation failed to reveal evidence of comprehensive assessment of ongoing nausea/vomiting symptoms, dehydration status, provider notification timing, or documented escalation of symptoms occurring between [DATE] and [DATE].Review of R3 Task: Nutrition-Amount Eaten/ADL-Eating records provided in hard copy for the month of February 2026 revealed that [DATE] through [DATE] revealed decreased oral intake and meal refusals. Documentation revealed intake scores of 0-1 on [DATE], indicating poor intake, refusal of lunch and dinner on [DATE], and continued poor intake/incomplete meal documentation on [DATE]. Interview with Certified Nurse Aide (CNA) II revealed the resident had refused both breakfast and lunch on [DATE].Review of R3's vital signs documentation failed to identify any recorded vital signs, blood pressure measurements, or evidence of increased monitoring between [DATE] and [DATE]. This absence of monitoring occurred despite the resident exhibiting clinical symptoms including nausea, vomiting, decreased oral intake, weakness, and an overall decline in condition before the resident's fall and subsequent hospitalization. Documentation review identified only a pain assessment completed on [DATE]; however, the most recent vital signs before this period were documented on [DATE] and [DATE]. This lack of monitoring was inconsistent with facility protocol requiring assessment, monitoring, and escalation of care in response to changes in a resident's condition.Review of the facility's Communication Record-Problems or concerns regarding resident for MD and/or NP to be made aware of revealed a single entry dated [DATE] documenting fall with facial injury, sent to ER for eval & tx. MD & family notified. Review failed to reveal additional documented physician or nurse practitioner notification entries related to the resident's nausea, vomiting, decreased oral intake, weakness, or decline in condition during the period of [DATE] through [DATE]. The resident's persistent nausea, vomiting, poor oral intake, weakness, and decline in functional status constituted a significant change in condition requiring physician and responsible party notification in accordance with facility policy.Review of Senior Medical Systems, LLC progress notes revealed R3 was last evaluated by Nurse Practitioner (NP) MM on [DATE] during a monthly regulatory visit. Documentation revealed review of systems noted No weakness or fatigue, no nausea, vomiting, diarrhea, heartburn. No abdominal pain. Review of a previous monthly routine management visit dated [DATE] by the Medical Director noted, Patient offers no acute or chronic concerns or changes at this time. Nursing staff reports no acute or chronic concerns or changes at this time. This resident requires frequent monitoring and management to prevent avoidable decline. Despite the development of persistent nausea, vomiting, weakness, poor oral intake, and decline in condition beginning on or about [DATE], review failed to reveal timely physician or nurse practitioner notification, further evaluation, or reassessment by a medical provider before the resident's hospitalization on [DATE].Review of the electronic medical record (EMR) revealed that R3 was admitted to the facility on [DATE] with pertinent diagnoses including, but not limited to, cognitive communication deficits, generalized weakness, hypertension, myasthenia gravis, difficulty walking, impaired coordination, multiple orthopedic conditions (including prior hip and shoulder arthroplasties and a healed left humerus fracture), blindness in the left eye, and the need for assistance with personal care.A review of the R3 quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating R3 was cognitively intact. Section GG, functional status, revealed R3 required partial/moderate assistance for activities of daily living (ADLs) with one-person assistance and utilized a walker and wheelchair for mobility. Section E revealed no behaviors (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	exhibited. Section H revealed the resident was frequently incontinent of bladder and always continent of bowel.Review of R3's care plan revised [DATE] revealed the resident was identified as high risk for falls related to impaired mobility, generalized weakness, impaired coordination, dementia with reduced safety awareness, visual impairment, prior falls, polypharmacy with CNS-active medications, dizziness risk, and medical conditions including myasthenia gravis. Goals included maintaining the resident free from falls with injury requiring hospitalization. Interventions included one-person assist with gait belt for transfers and ambulation, fall-risk assessments, therapy involvement, monitoring for dizziness, sedation, confusion, and adverse medication effects, maintaining a safe, clutter-free environment with call light within reach, non-skid footwear, bed in lowest position, behavioral redirection, supervision during ADLs, and monitoring for weakness, fatigue, and impaired balance.Review of the Physician's Orders for R3 included but was not limited to:Order dated [DATE] for Ondansetron HCl (Zofran) Oral Tablet 4 mg: give 1 tablet by mouth one time only for nausea until [DATE].Order dated [DATE] for Hydrochlorothiazide 12.5 mg, give 1 tablet by mouth one time daily related to essential hypertension.Order dated [DATE] for Potassium Chloride ER Tablet 20 mEq, give 1 tablet by mouth one time a day related to essential hypertension.Order dated [DATE] for weekly vital signs every Friday night shift.Review of staffing records for the period of [DATE] through [DATE] revealed LPN DD worked the 7:00 am to 7:00 pm shift daily on the 200 Hall, where R3 resided, during the period of decline before hospitalization.Interview on [DATE] at 2:30 pm with the Assistant Director of Nursing (ADON/Acting DON) revealed that R3 was transferred to the emergency department on the date of the fall for x-rays. While at the hospital, the resident's condition declined and she required intubation. The family subsequently made the decision to withdraw life support, and the resident expired. Follow-up interview on [DATE] at 12:48 pm revealed that she is responsible for completing the fall assessments on the residents, and she completed one for R3 on [DATE], and at that time, she had received the highest score. Follow-up interview on [DATE] at 1:36 pm revealed that she did not recall R3 reporting feeling unwell during the week leading up to the fall and suggested that R3 may have been attempting to avoid participation in physical therapy. Follow-up interview on [DATE] at 10:22 am revealed that the facility utilizes standing physician orders as well as established procedures outlining conditions for changes in resident condition. The ADON stated that staff are expected to follow the facility's policies and procedures when a resident's condition changes.Interview on [DATE] at 4:20 pm with the Administrator acknowledged discrepancies in the facility report submitted to the State Survey Agency, specifically that the date of the fall was documented as [DATE] instead of [DATE]. Follow-up interview on [DATE] at 4:23 pm revealed that it is the responsibility of the Unit Managers to ensure that the floor nurses notify the physician of any changes in condition. Follow-up interview on [DATE] at 10:28 am revealed that her expectation is for staff to follow policy and procedures when it comes to a resident exhibiting a change in condition.Interview on [DATE] at 1:14 pm with LPN DD revealed that she was the nurse assigned to R3 during the day shift from the week of [DATE] through [DATE]. LPN DD recalled that in the days leading up to the incident, R3 had remained in bed more frequently, but she did not recall any other notable changes. LPN DD stated that R3 regularly participated in and enjoyed physical therapy and would independently ambulate to the therapy area located at the end of the 300 hall. LPN DD further stated that the facility's process for addressing changes in condition included monitoring and documenting the changes and notifying the provider. She stated that significant changes also required completion of a change in condition form, nursing progress notes, and other pertinent charting to ensure close monitoring, and that family members were notified of significant changes.Interview on [DATE] at 1:55 pm with Physical Therapist (PT) FF revealed that R3 had been receiving physical therapy five days per week, and the week of the fall, R3 complained of gastrointestinal symptoms, including nausea and diarrhea, with decreased appetite and intake.Dual interview on [DATE] at 10:16 am with ADON/Acting DON and the Administrator revealed that the on-call physician/NP to contact after hours and/or weekends was an NP who works for the medical director. No other backup (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	coverage is available, and the Administrator stated that if they cannot reach the on-call NP, then they are to call 911. Additionally, the ADON stated that each physician has a binder with forms to complete, where staff enter information on residents who require follow-up. Interview on [DATE] at 10:49 am with Registered Nurse (RN), Infection Preventionist (IP), and Staff Development (SD) HH revealed that she was the Unit Manager during the week leading up to R3's fall; however, she was transitioning roles. RN HH recalled R3 had reported complaints of nausea, but she was not consistently present on the unit during that time. Further stated that the facility has standing orders and established protocols for the treatment of nausea, which staff are expected to follow when symptoms are identified.Interview on [DATE] at 11:05 am with the Medical Director revealed that he was unable to answer questions regarding R3 at that time and stated that any specific questions would need to be submitted via email. The follow-up interview further revealed that NP MM was unavailable to answer questions.Interview on [DATE] at 12:11 pm with R3's daughter revealed that although she had not seen her mother during the week leading up to the fall, she spoke with her daily by telephone and recalled R3 repeatedly complaining of not feeling well, including symptoms of nausea, vomiting, stomach discomfort, and decreased appetite. R3's daughter stated that these symptoms had been present for approximately five days before the fall and that R3 had informed her that the nursing staff was aware she was not feeling well. She further stated that the facility did not contact her regarding her mother's condition. R3's daughter reported that she was notified on [DATE] between approximately 4:00 pm and 5:00 pm that her mother had fallen and was being sent to the hospital because the situation looked bad. She stated that she was not notified at the time the fall occurred and later learned while at the hospital that the fall had reportedly occurred the previous day. R3's daughter stated she was unsure whether the resident had been transported to the hospital immediately after the fall or if the transfer occurred the following day.Interview on [DATE] at 12:33 pm with LPN JJ revealed that she was caring for R3 on the evening of the fall, [DATE]. LPN JJ stated that R3 had reported not feeling well that day and the day prior, complained of nausea, and requested medication for nausea. She stated that R3 approached her twice, at approximately 8:00 pm, reporting nausea, and again at approximately 9:30 pm, stating she did not feel well. LPN JJ recalled that R3 was carrying a basin/sick pail and reported episodes of vomiting. LPN JJ stated that she intended to contact the physician regarding the resident's condition and request anti-nausea medication; however, she did not have the opportunity to do so because she was in the process of passing medications before the fall. LPN JJ further stated that she was at the nurses' station when she was notified that R3 had fallen. Upon assessment, she observed R3 bleeding, and the resident reported that she was sitting on the toilet when she attempted to turn and vomit into the toilet and got caught in her pant leg and fell. LPN JJ stated that emergency medical services were immediately contacted and R3 was transferred to the hospital. She further stated that, during shift report, day shift nurse LPN DD had informed her that the resident had not been feeling well earlier in the day. LPN JJ stated that she did not notify R3's representative or any other individual of the fall and was unsure who had done so, as her primary concern was arranging for R3's transfer to the emergency room (ER).Interview on [DATE] at 12:48 pm with CNA II revealed that she worked the day shift on the 200 Hall, the date of the incident, [DATE], and recalled that R3 reported not feeling well and refused both breakfast and lunch that day. CNA II further stated that R3 complained of nausea and vomiting and had a basin/pail for emesis. According to CNA II, R3 informed her that she could not eat because doing so made her nauseous. CNA II stated that she notified the nurse on duty, LPN DD, that R3 was not feeling well, explaining that LPN DD routinely worked Monday through Thursday. CNA II further stated that she did not know whether LPN DD took any action regarding the resident's condition, as her responsibility was to report the information to the nurse, after which the nurse assumed responsibility for follow-up care. CNA II also stated that R3 had already been experiencing symptoms during the prior shift, as the resident had previously been provided a basin/pail for episodes of emesis.Review of the facility's Senior Medical Systems Protocols revised [DATE] revealed, ***Any (continued on next page)

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