STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115585	A. Building B. Wing	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Transitional Care & Rehabilitation	460 Auburn Avenue N.E. Atlanta, GA 30312

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20706 Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment on two of four floors (Third Floor and Fourth Floor). Findings included: A review of the facility's resident rights revealed that each resident has the right to a safe, clean, comfortable, and homelike environment including, but not limited to, receiving treatment and support for daily living safely. During an observation tour on the Fourth Floor on 2/20/2024 at 2:00 pm, double occupancy rooms and quad occupancy rooms were observed. The quad shared rooms were set up with four beds lined up in a row with curtain dividers in between them on one side of the room. Clothing closets were on the opposite side of the room near the door entrance for all four residents; these closets are not located near the resident's living space. These rooms appear to be set up institution-like. room [ROOM NUMBER]D was observed to have a broken and peeling bed stand. The divider privacy curtains were broken. room [ROOM NUMBER]D was observed to have a cloth covered chair that was badly stained at the resident's bedside. room [ROOM NUMBER]D was observed to have a bedside stand with peeling and chipped paint. room [ROOM NUMBER], which was a quad room, revealed broken privacy curtains and missing wall moldings. During an observation tour on the Third Floor on 2/20/2024 at 3:00 pm, room [ROOM NUMBER] was set up as a quad room with four residents. The quad shared rooms were set up with four beds lined up in a row with curtain dividers in between them on one side of the room. Clothing closets were on the opposite side of the room near the door entrance for all four residents; these closets were not located near the resident's living space. These rooms appeared to be set up institution-like. room [ROOM NUMBER] was observed to have a busted hole in the wall near the door entrance. During an observation and interview with R13 on 3/1/2024 at 9:10 pm, he revealed that his over-bed light does not work, and he had reported it several times. It was observed that the string on the light did not reach the resident and the resident could not turn his bed light on and off as needed. (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: 115585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2024
NAME OF PROVIDER OR SUPPLIER Legacy Transitional Care & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 460 Auburn Avenue N.E. Atlanta, GA 30312	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Administrator and Maintenance Director on 3/6/2024 at 12:59 pm. It was revealed that broken furniture in resident rooms is due to be replaced and that they were aware that some of the furniture had begun to fall apart. Further interviews revealed that privacy curtains were only replaced on the Second Floor but had not yet been replaced on the other floors. The administrator acknowledged and confirmed that the quad rooms were set up in an institutional-like manor and stated that they would look into changing the layout. On 3/6/2024 at 1:30 pm during a tour with the Maintenance Director, he confirmed the broken furniture and confirmed that some of the rooms on the Fourth Floor (the quad rooms) did not have nightstands at all. During an observation on the Fourth Floor on 3/11/2024 at 12:15 pm, room [ROOM NUMBER] was observed with a broken cabinet. room [ROOM NUMBER]A was observed with no privacy curtain. During an interview with the Resident Counsel President, R31, on 3/11/2024 at 12:15 pm revealed that all the rooms should have privacy curtains but some of them don't.

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 49470 Based on observations, interviews, and record review, the facility failed to ensure eight of 30 sampled residents (R) (R16, R17, R19, R12, R1, R18, R30 and R22) were free from abuse. On 2/28/2024, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator and Director of Nursing were informed of the Immediate Jeopardy (IJ) on 2/28/2024 at 3:05 pm. The noncompliance related to the IJ was identified to have existed on 9/30/2023. An Acceptable Removal Plan was received on 3/4/2024. Based on observation, record reviews, review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice was removed on 3/2/2024. The facility remained out of compliance while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures governing abuse in the facility. Findings included: A review of the facility Abuse Prevention Policy dated 9/5/2016 and last revised 11/1/2021 documented the following: The resident has the right to be free from verbal, sexual, physical, and mental abuse including corporal punishment and involuntary seclusion. The resident has the right to be free from mistreatment, neglect, and misappropriation of property. The facility has a zero-tolerance abuse standard regarding all proven allegations of verbal, sexual, physical, mental, neglect, misappropriation of resident property and involuntary seclusion. Abuse means, willful infliction of injury unreasonable confinement intimidation or punishment including physical harm pain or mental anguish. And this also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being abuse maybe resident to resident, staff to resident, family to resident, or visitor to resident. 1. A review of the clinical record for R16 revealed that the resident was admitted to the facility on [DATE] with diagnosis including but not limited to alcohol abuse dependence, vascular dementia with psychotic disturbance, and adjustment disorder. A review of the discharge Minimum Data Set (MDS) assessment dated [DATE] revealed R16 presented with a Brief Interview for Mental Status (BIMS) score of 15, indicating that the resident was cognitively intact. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. A review of the clinical record for R17 revealed that the resident was admitted to the facility on [DATE] with diagnosis including but not limited to mood disorder due to known physiological diagnosis, delusional disorder, and anxiety disorder. A review of the quarterly MDS assessment dated [DATE] revealed R17 presented with a BIMS score of 15, indicating that the resident was cognitively intact; R17 required staff supervision and oversight for dressing, eating, bathing and toileting; and R17 was independent in mobility. 3. A review of the clinical record for R19 revealed that the resident was admitted to the facility on [DATE] with diagnosis including but not limited to adjustment disorder, a history of alcohol abuse, and a history of falling. A review of the quarterly MDS assessment dated [DATE] revealed R19 presented with a BIMS score of 15, indicating that the resident was cognitively intact. 4. A review of the clinical record for R12 revealed that the resident was admitted to the facility on [DATE] with diagnosis including but not limited to major depressive disorder, schizoaffective disorder, and dementia without behavioral disturbance. A review of the annual MDS assessment dated [DATE] revealed R12 presented with a BIMS score of 13, indicating that the resident had mild cognitive impairment; R12 required staff supervision and oversight for dressing, eating, bathing and toileting; and R12 was independent in mobility. 5. A review of the clinical record for R1 revealed that the resident was admitted to the facility on [DATE] with diagnosis including but not limited to adjustment disorder with depressed mood, psychotic disorder with delusions due to known physiological diagnosis, and dementia with agitation. A review of the quarterly MDS assessment dated [DATE] revealed R1 presented with a BIMS score of 3, indicating that the resident had severe cognitive impairment; R1 required staff supervision and oversight for dressing, eating, bathing and toileting; and R1 was independent in mobility. 6. A review of the clinical record for R18 revealed that the resident was admitted to the facility on [DATE] with diagnosis including but not limited to vascular dementia, psychotic disturbance, mood disturbance, and difficulty walking. A review of the discharge MDS assessment dated [DATE] revealed R18 presented with a BIMS score of 3, indicating that the resident had severe cognitive impairment; and R18 required staff assistance with activities of daily living. 7. A review of the clinical record for R30 revealed that the resident was admitted to the facility on [DATE] with diagnosis including but not limited to spinal stenosis (when the space inside the backbone is too small), unsteadiness on feet, repeated falls, and cognitive communication deficit. A review of the quarterly MDS assessment dated [DATE] revealed R30 presented with a BIMS score of 7, indicating that the resident had severe cognitive impairment; and R30 required staff assistance with activities of daily living and used a wheelchair. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	8. A review of the clinical record for R22 revealed that the resident was admitted to the facility on [DATE] with diagnosis including but not limited to cognitive communication deficit, liver disease, and difficulty walking. A review of the discharge MDS assessment dated [DATE] revealed R22 presented with a BIMS score of 12, indicating that the resident had mild cognitive impairment; and R22 was independently mobile and did not require assistance with activities of daily living. A review of the clinical record, observations, and interviews revealed the following incidents of resident-to-resident abuse: A review of the progress notes documented by Licensed Practical Nurse (LPN) KKKK dated 9/30/2023 revealed that R17 was involved in a resident-to-resident altercation. It was documented that R17 was slapped by R1, a male resident; R17 was removed from immediate danger; and LPN KKKK observed redness to right of R17's face. A review of the progress notes documented by LPN FFFF dated 9/30/2023 revealed R1 slapped R17. When R18 attempted to intervene, R1 hit R18 and R19. Staff intervened. A review of the written statement of Certified Nursing Assistant (CNA) LLLL dated 9/30/2023 revealed that she observed R1 being physically aggressive towards other residents. She stated that R1 picked up a chair and an unknown resident grabbed the chair from R1, R1 fought R18 outside the breakroom, and that R1 was the aggressor. A review of the written statement of CNA MMMM dated 9/30/2023 revealed that she heard residents shouting in the dining room. She stated that some residents were stating that R1 grabbed R17's hair and slapped her. CNA MMMM stated that she was unable to calm R1 and R1 continued fighting, striking R18 before he was subdued and placed in his room. A review of the facility investigation summary written by the Director of Nursing (DON) dated 9/30/2023 revealed that R17 was seated in the common area in her wheelchair; R1 walked up to R17 and slapped R17 across her face unprovoked; and R18 and R19 attempted to intervene and R1 struck R18 and R19. The DON documented R1 directed his aggression towards staff when staff intervened and was not redirectable. Police were notified and R1 was hospitalized for three days. A review of the written statement of LPN GGGG dated 10/23/2023 revealed that R1 wandered into R12's room, and an argument occurred; and R1 was scratched by R12 on his hands. LPN GGGG documented that she cleansed R1 with nontoxic cleansing solution and notified the Unit Manager. A review of the progress notes documented by LPN IIII dated 11/13/2023 revealed he notified the police department following a verbal altercation between R1 and R16. LPN IIII documented he heard R16 yelling at R1 to get out of R16's room. A review of the facility incident report dated 11/19/2023 revealed that LPN YY documented R1 was exhibiting aggressive behavior; R22 came to get a snack at the nurses' station; and R1 slapped R22, stating that R22 got too close. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the progress notes documented by LPN IIII dated 12/13/2023 revealed R1 wandered into R12's room and attempted to pull R12 out of bed by her wrists. Staff immediately intervened and assisted R1 out of the room. A review of the progress notes documented by LPN JJJJ dated 1/25/2024 revealed R1 wandered into R12 room and R12 pushed R1. R1 fell and sustained a fracture of the left elbow. During an observation and interview on 2/20/2024 at 1:30 pm, R17 was observed in her room. When interviewed, she was unable to recall the events on 9/30/2023. R17 stated she does not want male residents in her room. During an observation on 2/20/2024 at 2:30 pm, R1 was observed unsupervised and independently ambulating back and forth in the hallway on the third-floor secured memory unit with his head facing down. During an interview on 2/21/2024 at 2:55 pm, R31 revealed that he is afraid of R1 and that R1 always comes into his room and sits on his bed without his permission. He stated that he has to wait for several hours before staff come in to redirect R1. During an interview on 2/26/2024 at 1:44 pm the DON stated R1 was not cognitively intact and wanders into other resident rooms. The DON stated that staff must constantly redirect R1 and confirmed that R1 has been involved in multiple resident-to-resident altercations when he wandered into other residents' rooms. The DON stated R1 was not intentionally aggressive towards other residents but R1 was involved in three or four physical altercations with other residents due to his wandering. The DON stated that R1 was referred to receive psych services and is being seen by a consultant once every quarter as an intervention. During an observation on 2/26/2024 at 3:15 pm, R1 was not in his room and an attempt to locate him was unsuccessful. Approximately five to six minutes later, CNA FFF located R1 in R20's room. During an interview at this time, R20 stated R1 was in his room messing with his table. R20 stated his attempts to make R1 leave were unsuccessful. R20 stated on numerous occasions staff had to help remove R1 from his room. R20 further stated that no one likes to be around R1 and that he was afraid that R1 was going to continue to be physically abusive towards other residents. R20 stated he was afraid R1 would eventually get hurt by other residents. A review of the progress notes documented by LPN TT dated 2/26/2024 revealed that R1 was wandering through hallway and LPN TT observed an altercation between R1 and R30. LPN TT documented that R30 yelled at R1 and pushed R1; R1 retaliated and hit R30 in the face; R1 was immediately separated by staff, assessed for injury, no noted injury; and the family and physician were notified. During an interview on 2/27/2024 at 9:34 am, the administrator stated she was aware of R1's aggression when she came on board at the facility in September 2023. She stated R1's aggressive behavior was discussed in meetings with the Medical Director on several different occasions. She confirmed that the facility was unable to assign a staff member to the resident for one-to-one supervision. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 2/27/2024 at 1:23 pm, CNA DDD revealed R1 had dementia and was a wanderer. They further stated the DON instructed staff to continue redirecting R1 when he gets into other residents' rooms. They confirmed that there was never an assigned staff to manage R1's behavior. CNA DDD stated that they always hear female residents in the unit yelling at R1 to leave their rooms. During an interview on 2/27/2024 at 1:30 pm LPN TT revealed on 2/26/2024 at approximately 7:30 pm, they noticed R30 was irritable and then R30 pushed R1, causing R1 to stumble back. They stated that R1 then swung and hit R30 on the face. LPN TT stated the incident happened at the nurse's station which was located a few feet from R30's room. R30 stated he was fed up with R1 messing with his possessions. TT instructed staff to continue redirecting R1. TT stated redirection was the only intervention staff had been successfully implemented by the facility. TT stated most of the residents in the locked unit were unbale to verbalize their concerns and it was normal for the residents to retaliate when confronted. TT stated there were sixty-four residents in the locked unit. During an interview on 2/27/2024 at 1:40 pm, CNA EEE revealed that R1 did not like to stay in his room and walked continuously around the unit. CNA EEE stated that R1 gets aggressive and violent when other residents confront him and that she would hate to see R1 get hurt by other residents. CNA EEE confirmed that R1 is not always supervised and that it was impossible for the staff to continuously watch all the residents. During an interview on 2/27/2024 at 4:33 pm, the Physician Assistant (PA) QQ revealed she was aware R1 had behaviors and was physically aggressive towards other residents. She stated R1 wanders into other residents' rooms and has trouble sleeping so they made some medication adjustments and non-pharmacological interventions such staff redirecting R1 to his room. PA QQ stated she advised staff to leave R1 alone when R1 gets agitated and to attempt to reapproach later. During an interview on 2/27/2024 at 4:33 pm, Nurse Practitioner (NP) RR revealed that she had worked with R1 and visits with him monthly. NP RR stated R1 was ambulatory, walked freely around the secured memory unit and went into other resident rooms. NP RR stated they were aware that R1 has had resident-to-resident altercations and confirmed that R1 required closer surveillance. They stated that the most plausible way for that to happen is to increase staff on the unit. During an interview on 2/27/2024 at 6:49 pm, R1's representative revealed R1 used to walk continuously on his previous job. She stated that R1 enjoyed exercise and was unable to sit down for long periods, but over the last two years, R1 has been unable to hold a conversation and his confusion has progressed. She stated that she visited R1 on 2/24/2024 and staff took approximately five minutes to locate R1. She said that when the staff found R1, he was in another resident's bathroom. She stated that she was unaware of an action plan staff implemented to stop R1 from roaming and wandering in other resident rooms. The facility implemented the following actions to remove the IJ: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. On 2/26/2024, R1 was assessed by the Psych Physician Assistant per physician order. On 2/27/2024, a skin assessment was conducted on R1 with no skin alterations noted. On 2/28/2024, the Corporate Operations Consultant, the Administrator and the Social Services Director met to discuss placement options for the R1. On 2/28/2024 at 9:00 pm, the R1 was transferred to a Psychiatric Facility per the physician order. The facility Social Worker will assist the Psychiatric facility with finding placement for R1. On 2/29/2024, an immediate discharge notice was issued to R1 and R1's legal representative. 2. On 2/29/2024 the Behavioral Health Physician's Assistant, the facility's Psychiatric provider, the Administrator, the Director of Nursing Services, and Corporate Operations Consultant had a telephone conference to discuss alternate placement for current of future residents that may present to be a danger to self or others. 3. On 2/29/2024, an Ad Hoc QAPI meeting was held with the Medical Director, Corporate Operations Consultant, Administrator, Director of Nursing, Social Services Director, MDS staff, and Nurse Managers to review the IJ Removal Plan, altercations involving R1 and alternate placement of R1. The Abuse Policy and the Behavior Management Policy were reviewed, and no changes were made. 4. On 2/29/2024 and 3/1/2024, the Staff Development Coordinator educated the following facility staff on the Abuse Policy, the Behavior Management Policy, and Resident to Resident Altercation Policy: three of four Registered Nurses; 21 of 22 Licensed Practical Nurses; 17 of 17 Medication Technician; the Activity Director, three of three Activity Assistants; 33 of 33 Certified Nursing Assistants; the Administrator; the Human Resources Director; the Admissions Director; the Marketing Director; four of four receptionists; the Business Office Manager; the Business Office Assistant, two of two Medical Records Coordinators; the Dietary Manager; 13 of 13 Dietary Assistants; the Housekeeping/ Laundry Director; the Maintenance Director; the Maintenance Assistant; the Laundry Supervisor; 11 of 11 Environmental Employees; the Therapy Director; three of three therapy assistants; the Social Services Director; two of two Social Services Assistants; the MDS Director; and two of two MDS Coordinators. In-services will be conducted on an ongoing basis by the Staff Development Coordinator and nurse managers. Agency staff will be educated on the facility policies prior to working in the facility. Those employees identified to be on LOA or FMLA will be in-serviced upon return, prior to their shift. All new employees will be in-serviced during the facility orientation. 5. On 3/1/2024, a Skin Assessment Audit was conducted by the nurse management team for 63 of 63 residents on the secured memory unit. There were no new areas of concern identified. 6. The corrective actions were completed on 3/1/2024 and facility alleges that immediate jeopardy is removed on 3/2/2024. All corrective actions were completed on 3/1/2024. The facility alleges that the IJ is removed on 3/2/2024. 1. Review of notes taken revealed three facility physicians and the Medical Director and Corporate Operations Consultant, DON and the Administrator met and discussed placement options for R1. A review of the physician's order dated 2/29/2024 revealed that R1 was transferred to a Psychiatric Facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. During an interview on 3/6/2024 at 6:45 pm the Medical Director (MD) revealed he attended a QAPI meeting on 2/29/2024 and they discussed placement for R1 and other residents with behaviors in the future. 3. During an interview on 3/5/2024 at 1:13 pm, the Corporate Nurse NN confirmed that they educated MDS staff regarding abuse, behaviors were discussed regarding who staff should notify and making sure the residents were safe and notifying the proper authorities' doctors and families. During an interview on 3/7/2024 at 10:25 am Corporate Operations Director (COD) HH revealed the Administrator, Medical Director DON, SSD, MDS Director were educated regarding the immediate jeopardy concerns. HHH stated QAPI staff will be tracking trends, and she will be reviewing abuse logs monthly. HHH stated, Nurse Consultant, will be monitoring incidents and accidents. HH stated, R1 will not be returning to the facility. R1 was given an immediate discharge notice, and the facility is assisting R1 in finding alternative placement. 4.On 3/5/2024 at 2:15 pm, RN KKK Infection Preventionist and educator revealed she educated staff and in serviced all nursing and non-nursing staff on Resident-to-Resident altercations, behaviors, care plans and abuse and neglect reporting on 2/29/2024. RN, KKK, stated the in-service will be ongoing, which will include new hires. Record review showed a total of fifty-six staff were interviewed from 3/5/2024 through 3/6/2024, which included Nursing staff, Dietary staff, housekeeping staff, laundry staff, Maintenance staff, Reception staff and Management staff. Signatures and interviews verified staff were in serviced on 2/29/2024 by RN KKK. On 3/5/2024 the following clinical staff were interviewed: LPN KKK at 2:15 pm; LPN RRR at 7:04 pm; CNA HHH at 1:30 pm; CNA III at 1:38 pm; CNA JJJ at 1:49 pm.; CNA EEE at 1:56 pm; CNA AAA at 2:03 pm; CNA SSS at 7:15 pm. On 3/6/2024 the following clinical staff were interviewed: HK OOO at 2:38 pm; Laundry Aide PPP at 3:03 pm; HK Director QQQ at 3:04 pm; Dietary [NAME] LLL at 3:20 pm; Dietary [NAME] UUU at 2:32 pm; Business Office WWW at 2:05 pm; PTA XXX at 2:19 pm; COTA YYY at 2:23 pm; Human Resources ZZZ at 2:26 pm; Activity Aide AAAA at 2:35 pm; and CMT DDDD at 3:28 pm. 5. Record review revealed skin observations audit was conducted on 3/1/2024, of the sixty-three residents assessed one resident refused to be assessed and two residents were actively being seen by a wound care nurse. During an interview on 3/6/2024 at 1:14 pm, The administrator revealed she attended a personalized additional computerized education. In addition, the NC-NN in-serviced the Medical Director (MD), DON, SSD, Staff Development Coordinator (SDC) regarding QAPI review and ongoing quality assurance performance and improvement, which included wandering residents and residents with aggressive behaviors. For residents with repetitive aggressive behaviors, one staff will be instructed to supervise the resident until the behavior improves other services such as psych services will be provided. She stated Care plans should be updated immediately as soon as an incident arises, and an IDT will make a follow up, assessment All staff were educated regarding abuse and behavioral monitoring. New staff will be educated during orientation and the Inservice will be ongoing. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 3/7/2024 at 10:55 am LPN, TTT revealed on 3/1/2024 she conducted skin assessments on the locked unit on sixty-three residents. TTT was assisted by LPN, XX regarding skin assessments. TTT stated the weekly skin assessments audit will be on going for all the residents. 6. It was verified that the corrective actions were completed by 3/1/2024 and the immediate jeopardy was removed on 3/2/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy Transitional Care & Rehabilitation	460 Auburn Avenue N.E. Atlanta, GA 30312

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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 0641 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49470 Based on observations, interviews, and record review, the facility failed to ensure the accuracy of the comprehensive assessment addressed the wandering behaviors for one of 30 sampled residents (R) (R1). R1's wandering led to physical altercations with multiple residents, including a physical altercation on 1/25/2024 when R1 wandered into R12's room and R12 pushed R1, causing R1 to sustain a fracture of the left elbow. On 2/28/2024, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator and Director of Nursing were informed of the Immediate Jeopardy (IJ) on 2/28/2024 at 3:05 pm. The noncompliance related to the IJ was identified to have existed on 9/30/2023. An Acceptable Removal Plan was received on 3/4/2024. Based on observation, record reviews, review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice was removed on 3/2/2024. The facility remained out of compliance while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff's conformance with the facility's policies and procedures governing abuse in the facility. Findings included: A review of the clinical record for R1 revealed that the resident was admitted to the facility on [DATE] with diagnosis including but not limited to adjustment disorder with depressed mood, psychotic disorder with delusions due to known physiological diagnosis, and dementia with agitation. A review of the quarterly MDS assessment dated [DATE] revealed R1 presented with a BIMS score of three, indicating that the resident had severe cognitive impairment, R1 was independent in mobility. The assessment documented that R1 did not exhibit any wandering behaviors. A review of the clinical record and other facility documents revealed the following incidents of resident-to-resident altercations: A review of the progress notes documented by Licensed Practical Nurse (LPN) KKKK dated 9/30/2023 revealed that R17 was involved in a resident-to-resident altercation. It was documented that R17 was slapped by R1, a male resident; R17 was removed from immediate danger; and LPN KKKK observed redness to right of R17's face. A review of the progress notes documented by LPN FFFF dated 9/30/2023 revealed R1 slapped R17. When R18 attempted to intervene, R1 hit R18 and R19. Staff intervened. (continued on next page)

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F 0641 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the written statement of Certified Nursing Assistant (CNA) LLLL dated 9/30/2023 revealed that she observed R1 being physically aggressive towards other residents. She stated that R1 picked up a chair and an unknown resident grabbed the chair from R1, R1 fought R18 outside the breakroom, and that R1 was the aggressor. A review of the written statement of CNA MMMM dated 9/30/2023 revealed that she heard residents shouting in the dining room. She stated that some residents were stating that R1 grabbed R17's hair and slapped her. CNA MMMM stated that she was unable to calm R1 and R1 continued fighting, striking R18 before he was subdued and placed in his room. A review of the facility investigation summary written by the Director of Nursing (DON) dated 9/30/2023 revealed that R17 was seated in the common area in her wheelchair; R1 walked up to R17 and slapped R17 across her face unprovoked; and R18 and R19 attempted to intervene and R1 struck R18 and R19. The DON documented R1 directed his aggression towards staff when staff intervened and was not redirectable. Police were notified and R1 was hospitalized for three days. A review of the written statement of LPN GGGG dated 10/23/2023 revealed that R1 wandered into R12's room, and an argument occurred; and R1 was scratched by R12 on his hands. LPN GGGG documented that she cleansed R1 with nontoxic cleansing solution and notified the Unit Manager. A review of the progress notes documented by LPN IIII dated 11/13/2023 revealed he notified the police department following a verbal altercation between R1 and R16. LPN IIII documented he heard R16 yelling at R1 to get out of R16's room. A review of the facility incident report dated 11/19/2023 revealed that LPN YY documented R1 was exhibiting aggressive behavior; R22 came to get a snack at the nurses' station; and R1 slapped R22, stating that R22 got too close. A review of the progress notes documented by LPN IIII dated 12/13/2023 revealed R1 wandered into R12's room and attempted to pull R12 out of bed by her wrists. Staff immediately intervened and assisted R1 out of the room. A review of the progress notes documented by LPN JJJJ dated 1/25/2024 revealed R1 wandered into R12 room and R12 pushed R1. R1 fell and sustained a fracture of the left elbow. During an observation on 2/20/2024 at 2:30 pm showed R1 walked along the hallway of the third floor with his head facing down. R1 continued pacing along the hallway in the locked unit. During an interview 2/26/2024, at 1:44 pm the DON stated R1 was not cognitively intact and that R1 wanders into resident rooms. The DON stated that the staff constantly had to redirect R1 and that R1 had been involved in resident-to-resident altercations when he wandered into other residents' rooms. (continued on next page)

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F 0641 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation on 2/26/2024 at 3:15 pm, R1 was not in his room and an attempt to locate him was unsuccessful. Approximately five to six minutes later, CNA FFF located R1 in R20's room. During an interview at this time, R20 stated R1 was in his room messing with his table. R20 stated his attempts to make R1 leave were unsuccessful. R20 stated on numerous occasions staff had to help remove R1 from his room. R20 further stated that no one likes to be around R1 and that he was afraid that R1 was going to continue to be physically abusive towards other residents. R20 stated he was afraid R1 would eventually get hurt by other residents. During an interview on 2/27/2024 at 1:23 pm, CNA DDD revealed R1 had dementia and was a wanderer and that the DON instructed staff to continue redirecting R1 when he gets into other residents' rooms. CNA DDD stated that they always heard female residents in the unit yelling at R1 to leave their rooms. During an interview on 2/27/2024 at 1:40 pm, CNA EEE revealed that R1 did not like to stay in his room. CNA EEE stated R1 walked continuously around the unit. During an interview on 2/27/2024 at 4:33 pm, the Physician Assistant (PA) QQ revealed she was aware R1 had behaviors and was physically aggressive towards other residents. She stated R1 wanders into other residents' rooms and has trouble sleeping so they made some medication adjustments and non-pharmacological interventions such staff redirecting R1 to his room. During an interview on 2/27/2024 at 4:33 pm, Nurse Practitioner (NP) RR revealed that she had worked with R1 and visits with him monthly. NP RR stated R1 was ambulatory, walked freely around the secured memory unit and went into other resident rooms. The facility implemented the following actions to remove the IJ: 1. On 2/28/2024, R1's MDS and care plan was updated to reflect the behavior of wandering. 2. On 2/29/2024, an Ad Hoc QAPI meeting was held with the Medical Director, Corporate Operations Consultant, Administrator, Director of Nursing, Social Services Director, MDS staff, and Nurse Managers to review the IJ Removal Plan. The MDS/Care Plan policy was reviewed with no changes. 3. On 2/29/2024, the Corporate Nurse Consultant conducted an in-service with the three of three MDS department staff and one of two Social Services department staff on the MDS/Care plan Policy and how to develop a comprehensive care plan. 4. On 2/29/2024, a Wandering MDS and Care Plan Audit was completed on the secure unit. A total of 35 of 63 residents were identified as wanderers and care plans were updated to reflect the behavior of wandering. 5. On 2/29/2024, a behavior management meeting was held with the MDS Director, two MDS Coordinators, and the Social Services Director. They were provided with a copy of all residents involved in resident-to-resident altercations from September 2023 through current and care plans were reviewed for those that wander. Care plans were updated as necessary to reflect individualized interventions. 6. The corrective actions were completed on 3/1/2024 and facility alleges that immediate jeopardy is removed on 3/2/2024. (continued on next page)

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F 0641 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All corrective actions were completed on 3/1/2024. The facility alleges that the IJ is removed on 3/2/2024. 1. A review of the MDS assessment and care plans showed, the MDS and care plans were updated for Residents with behaviors and for wandering residents. Staff were educated on 2/29/2024 and interventions were put in place. The following interviews verified; facility interventions were in place: During an interview on 3/6/2024 at 1:57 pm, the SSD revealed she completed an in-service on 2/29/2024, which was conducted by the staff development coordinator. The topics discussed included care plans. SSD expected the MDS coordinator to update care plans in a timely manner. SSD stated, care plans should be updated to include wandering behaviors. The interdisciplinary team (IDT) was responsible for care plan updates. SSD was part of the IDT. SSD stated Abuse and Care plan In-service's will be ongoing. 2. A review of the sign in sheet revealed that the QAPI Meeting was held on 2/29/2024 with the Medical Director, Corporate Operations Consultant, Administrator, Director of Nursing, Social Services Director, MDS staff, and Nurse Managers to review the IJ Removal Plan. The MDS/Care Plan policy was reviewed with no changes. During an interview on 3/5/2024 at 12:46 pm, NC NN revealed on 2/29/2024, she educated the Administrator, DON, and SSD regarding monitoring residents behaviors including verbally aggressive behavior and physically aggressive behavior. NC NN stated that the QAPI policy was reviewed, she talked to the MDS- Coordinator regarding comprehensive care plans. She identified the care plan was not updated on other occasions. Discussed staff the care plan should be updated as soon as an incident or behavior is identified. Documentation revealed staff were educated. 3. A review of the policy education to staff, QAPI minutes and Resident to Resident documentation audit was conducted and was completed as outlined in the plan. During an interview on 3/5/2024 at 11:56 am, ADON revealed all staff received the education. During an interview on 3/5/2024 at 12:46 pm, Nurse Consultant NN stated the QAPI policy was reviewed, she talked to the MDS- Director MM regarding comprehensive care plans on 2/29/2024. During an interview on 3/5/2024, at 1:13 pm, MDS coordinator MMM, confirmed that education was received related to MDS and Care Plans. During an interview on 3/6/2024 at 1:14 pm, the administrator revealed she attended a personalized additional computerized education. During an interview on 03/07/2024 at 1:25 pm, with the MDS Coordinator EEEE, confirmed that education was received related to MDS and Care Plans. During an interview on 03/07/2024 at 1:45 am MDS director/ RN, MM. NN educated all MDS staff on 2/29/2024 in her office. (continued on next page)

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F 0641 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. During an interview on 3/5/2024, at 1:13 pm, MDS coordinator MMM, revealed care plans are updated quarterly, annually, whenever there was a significant change and whenever an incident happened. She was part of a facility wide in service. Review of the wandering Care Plan Audit revealed that it was completed on the secure unit. A total of 35 of 63 residents were identified as wanderers and care plans were updated to reflect the behavior of wandering. 5. A review of the sign in sheet revealed that on 2/29/2024, a behavior management meeting was held with the MDS Director, two MDS Coordinators, and the Social Services Director. 6. It was verified that the corrective actions were completed by 3/1/2024 and the immediate jeopardy was removed on 3/2/2024.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49470 Based on observations, interviews, record review, the facility failed to provide Activities of Daily Living (ADL) care for eight of 30 sampled residents (R) (R4, R21, R29, R23, R25, R26, R27, and R28) related to toileting and nail care. Findings included: A review of the facility policy titled Activities of Daily Living (ADLs) Bath Shower Hygiene Care, revised November 2022, policy documented showers will be given for cleanliness, increased circulation, and comfort. The policy did not address nail care. 1. A review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed that R4 presented with a Brief Interview for Mental Status (BIMS) score of 15, which indicated that the resident was cognitively intact and that R4 was assessed to require substantial to maximum assistance with personal hygiene. A review of R4's care plan, initiated on 10/8/2019, documented that R4 had an ADL self-care performance deficit related to a decline in ADL Self Care. Staff documented that R4 required extensive to total assistance with ADL care including bed mobility, transfers, eating, dressing, toilet use, and personal hygiene. The care plan directed staff to assist with toileting, dressing and personal hygiene. On 2/22/2024 at 10:15 am R4 was observed sitting sideways across his bed, a strong malodorous odor emanated from his surroundings, and the bed sheets were stained with dark brown substance. At that time, R4 stated that he had a bowel movement (BM). He stated that he had pressed the call light around 7:00 am that morning but no staff assisted him. He further stated that this has been happening for the past three weeks and he told multiple staff, but nothing had been done. He stated that this was the second time that he had to sit in his BM for several hours. During an interview on 2/22/2024 at 10:35 am, Certified Nursing Assistant (CNA) AAA stated the call monitoring system had not been operational for the last three weeks. She stated the expectation is that the monitoring system is supposed to alert staff of how long the resident had been waiting for the call light to be answered and to alert staff of the origin of the call light. CNA AAA confirmed that R4's call light was not working and that the sheets were soiled. 2. A review of the MDS dated [DATE] revealed R21 presented with a BIMS score of four, indicating that the resident presents with severe cognitive impairments and revealed that the resident required substantial to maximum assistance from staff for personal hygiene. A review of the care plan dated 2/7/2024 revealed that R21 had an ADL self-care performance deficit related to impaired balance in ADL Self Care and required staff assistance with personal hygiene. During observation on 3/1/2024 at 8:45 am, R21's fingernails were observed to be several inches long and presented with grime and black substance underneath. The resident stated that his fingernails were too long and that he would prefer his nails trimmed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A review of the MDS dated [DATE] revealed R29 presented with a BIMS score of five, indicating that the resident presents with severe cognitive impairments and revealed that the resident required substantial to maximum assistance from staff for personal hygiene. A review of R29's care plan dated 1/9/2024 documented that R29 had an ADL self-care performance deficit related to confusion and the care plan directed staff to improve and to maintain the resident current level of function. The care plan directed staff to assist with toileting, dressing and personal hygiene. During an observation on 3/1/2024 at 8:54 am R29 had long fingernails with brown substances and grime underneath the nails. R29 said she would like to have her nails trimmed and staff had not assisted, even when she asked for help. During an interview on 3/1/2024 at 9:05 am LPN NNNN stated R29 had been admitted at the facility for a long time and was not diabetic. LPN NNNN stated CNAs are expected to cut and trim nails for non-diabetic residents and she had no explanation as to why the CNAs had not been trimming resident nails. 4. A review of the MDS dated [DATE] revealed R23 presented with a BIMS score of three, indicating that the resident presents with severe cognitive impairments and revealed that the resident required substantial to maximum assistance from staff for personal hygiene. A review of R23's care plan last updated dated 6/12/2022 documented that R23 had an ADL self-care performance deficit related to confusion and the care plan directed staff to improve and to maintain the resident current level of function. The care plan directed staff to assist with personal hygiene. During an observation on 3/1/2024 at 8:45 am, R23's fingernails were long and untrimmed. There was a brown and black substance underneath the nails. During an interview with LPN NNNN at this time, LPN NNNN stated R23's nails were considerably long and stated they needed to be trimmed. NNNN stated that nurses should trim all diabetic residents' nails. 5. A review of the MDS dated [DATE] revealed R25 presented with a BIMS score of 15, indicating that the resident was cognitively intact and revealed that the resident required substantial to maximum assistance from staff for personal hygiene. During an interview on 3/1/2024 at 9:20 am, R25 stated he wanted his nails trimmed and stated staff never offered to trim his nails. His nails were observed to be long and untrimmed. During an interview on 3/1/2024 at 9:30 am LPN TT stated CNA's and activities should be cutting resident nails. LPN TT was unaware several residents' nails had not been trimmed in the secured memory unit and confirmed that R25's nails needed to be trimmed. 6. A review of the MDS dated [DATE] revealed R26 presented with a BIMS score of three, indicating that the resident presents with severe cognitive impairments and revealed that the resident required substantial to maximum assistance from staff for personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R26's care plan last updated dated 11/13/2023 documented that R26 had an ADL self-care performance deficit related to dementia and the care plan directed staff to improve and to maintain the resident current level of function. During observation and interview on 3/1/2024 at 9:45 am, R26's fingernails were observed and were long and dirty. During an interview with LPN TT at this time, she stated R26's nails were too long. 7. A review of the MDS dated [DATE] revealed R27 presented with a BIMS score of 15, indicating that the resident was cognitively intact and revealed that the resident required assistance from staff for personal hygiene. A review of R27's care plan, last updated dated 5/4/2022, documented that R27 had an ADL self-care performance deficit related to confusion and the care plan directed staff to improve and to maintain the resident current level of function. During an observation on 3/1/2024 at 9:55 am R27 was observed walking towards the nurse's station. LPN TT was observed to ask R27 if she could see her nails. R27's raised her hands and her middle finger was chipped and reddish in color. R27 stated she injured herself when she attempted to trim her own nails. LPN TT stated she would cut R27's nails. 8. A review of the MDS dated [DATE] revealed R28 presented with a BIMS score of 13, indicating that the resident was cognitively intact and revealed that the resident was dependent staff for personal hygiene A review of R28's care plan dated 1/8/2024 documented that R28 had an ADL self-care performance deficit related to confusion and the care plan directed staff to improve and to maintain the resident current level of function. The care plan directed staff to assist with personal hygiene. During an observation 3/1/2024 at 10:01 am, R28 was observed with long fingernails. He stated he would prefer to have his nails trimmed and added staff have never offered to trim his nails. During an interview on 3/2/2024 at 10:05 am, the Social Services Director (SSD) stated that the nurses and CNAs were expected to trim residents' nails. The SSD stated that the charge nurses are responsible for making sure the residents nails are being trimmed.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49470 Based on observation, staff interview, and record review, the facility failed to monitor and document behaviors for one resident (R1) who was involved in multiple resident-to-resident physical altercations due to wandering on the unit. The sample size was 30 residents. Findings included: A review of the Behavioral Management Program policy last revised 10/22/2022 revealed that it is the policy of the facility that each resident must receive, and the facility must provide the necessary behavioral health care and services and medically related social services to attain or maintain the highest practicable physical mental and psychosocial well-being. The objective of the Mood and Behavior Policy and Procedure is to provide a plan of care that is individualized to the residents' needs based upon the comprehensive assessment by the interdisciplinary team. The plan of care will include medically related social services to address mood and behavioral health services to attain or maintain the highest practicable well-being. A review of the clinical record revealed that R1 was admitted to the facility on [DATE] with diagnosis of adjustment disorder with depressed mood, psychotic disorder with delusions due to known physiological diagnosis, and dementia with agitation. A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R1 presented with a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive deficit; R1 was assessed to be independently mobile. A review of R1's comprehensive care plan initiated on 5/11/2022 and last revised on 12/8/2023 revealed that R1 had a behavior problem related to auditory hallucinations. Interventions included staff to document behaviors and resident response to interventions. A review of the current behavior monitoring records revealed there was no documentation that R1 was being monitored for any behaviors. During an interview on 2/27/2024 at 9:48 am MDS Director MM revealed R1 had dementia and was confused. MDS Director MM stated R1 had behaviors, but she was not aware of a behavior monitoring plans in place for R1. During an observation on 2/20/2024 at 2:30 pm, R1 was observed unsupervised and independently ambulating back and forth in the hallway on the third-floor secured memory unit with his head facing down. During an interview on 2/27/2024 at 4:33 pm Physician Assistant (PA), she confirmed that she was aware R1 had behaviors and was physically aggressive towards other residents and that the staff should be monitoring for behaviors. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/27/2024 at 4:33 pm with Nurse Practitioner (NP) RR, she had worked with R1 and that he required closer surveillance and monitoring due to his behaviors.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20706 Based on observation, interview, record review, and policy review, the facility failed to ensure one resident (R8) of 30 sampled residents received adequate assistance and support from social services with receiving urgent dental services. Findings included: Review of the facility's dental service policy dated 11/28/2017, and review date of 11/21/2021, revealed routine and emergency dental services are available to meet the residents of oral health service in accordance with the resident's assessment and plan of care. Further review revealed that social service personnel will be responsible for assisting the resident with making appointment transportation as needed. Review of R8 electronic medical record (EMR) Admission Record, revealed he was admitted to the facility on [DATE] and is a current resident. Some of his admitting diagnoses included congested heart failure, diabetes type 2, paranoid schizophrenia, bipolar disorder and bruxism. Review of the physician order dated 11/29/2023 revealed a dental consult for evaluation and treatment was ordered for R8. Review of a progress note entered by social service on 11/30/2023 revealed that the resident requested dental services for toothache and a referral was sent by social services. Review of R8's care plan dated 12/4/2023 revealed resident having potential for pain and discomfort related to his mouth. Interventions is to provide pain medication as needed. The care plan for dental care services was not updated until 2/28/2024 after surveyor interviews were conducted about R8. Review of R8's Minimum Data Set (MDS) assessment dated [DATE] section C -cognitive patterns revealed a brief interview for mental status (BIMS) score of 13 showing the resident is cognitively intact and able to make his needs known. Review of social service assessment dated [DATE] revealed, resident requesting dental services due to tooth pain, and social service sent a referral requests. Interview on 2/20/2024 at 3:00 pm with R8 revealed I need dental care, I'm tired of taking pain medicine for my teeth, I've been asking it's been two to three weeks or so now not sure how long, I don't even like smiling. I was told I was going to see the dentist since I came in here, but I have not seen the dentist yet. They keep telling me I'm going to see the dentist and I want to have all my teeth pulled. Observation at the time of this interview on 2/20/2024 at 3:00 pm revealed R8 has several missing teeth in the front, and some of the upper and lower teeth appear long and jagged. When the resident speaks you can hear his teeth grinding and clinching together. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Legacy Transitional Care & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 460 Auburn Avenue N.E. Atlanta, GA 30312	

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 2/26/2024 at 5:50 pm with the administrator and social service director. The social service director confirmed that she did have R8 on the list since November 2023, however the resident was not seen by the dentist that came. The social service director further revealed that the dentist came to the facility in November 2023, but did not see any residents due to issues with water in the building. The dentist service then returned in December 2023 but did not see residents at that time due to scheduling conflicts. The social service director revealed the last time the dentists came to see residents was on 2/14/2024. However, R8 was missed and not seen, and no additional referrals were made for R8 to be seen outside of the facility. Interview on 3/1/2024 at 9:20 am revealed R8 was still waiting to receive dental care services. The investigation revealed it took the social service director almost 4 months before R8 was provided with dental care as ordered by the physician and requested by the resident. A follow up interview with R8 on 3/4/2024 at 12:00 pm revealed he finally got to see the dentist today and was very happy, the resident was smiling and very thankful, and says the dentist plans for removal of all or most of his teeth just as the resident has been wanting.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20706 Based on observation, interview, record review, and policy review, the facility failed to ensure one resident (R8) of 30 sampled residents received dental services timely, after multiple requests and complaints of mouth pain. Findings included: Review of the facility's dental service policy dated 11/28/2017, and review date of 11/21/2021, revealed routine and emergency dental services are available to meet the residents of oral health service in accordance with the resident's assessment and plan of care. It further reveals that those services will be provided to the residents through a contract agreement with the local dentist a referral to a personal dentist a referral to community dentist or referral to any other Health Organization that provides dental care. It further reveals that selected dentists must be available to provide follow-up care. It also reveals that dental assessments will be conducted at a minimum on a quarterly basis through the MSDS assessment process. Social service personnel will be responsible for assisting the resident making appointment transportation as needed. Review of R8 Admission Record, revealed he was admitted to the facility on [DATE] and is a current resident. Some of his admitting diagnoses included congested heart failure, diabetes type 2, paranoid schizophrenia, bipolar disorder and bruxism. Review of the physician order section revealed a diet of regular thin liquids with no added salt. Additional orders included a dental consult for evaluation and treatment dated 11/29/2023. Review of R8's care plan dated 12/4/2023 revealed resident having potential for pain and discomfort related to his mouth. Interventions is to provide pain medication as needed. The care plan for dental care services was not updated until 2/28/2024 after surveyor interviews. Review of a progress note entered by social service on 11/30/2023 reveals that the resident requested dental services for toothache and a referral was sent by social services. Review of social service assessment dated [DATE] revealed, resident requesting dental services due to tooth pain, and social service sent a referral requests. Review of progress note dated 3/11/2024 revealed that the resident was placed on doxycycline for tooth pain back on 12/08/2023. Interview on 2/20/2024 at 3:00 pm with R8, he stated I need dental care, I'm tired of taking pain medicine for my teeth, I've been asking it's been two to three weeks or so now not sure how long, I don't even like smiling. I was told I was going to see the dentist since I came in here, but I have not seen the dentist yet. They keep telling me I'm going to see the dentist and I want to have all my teeth pulled. Observation of R8 on 2/20/2024 at 3:00 pm revealed he was speaking clearly but with difficulty due to grinding of his teeth. The grinding teeth can be heard from a distance, R8 has several missing teeth in the front, and some of the upper and lower teeth appear long and jagged. When the resident speaks you can hear his teeth grinding and clinching together. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 2/26/2024 at 5:50 pm with the administrator and social service director revealed that all residents are provided dental care, dental care is contracted by a dental group that comes in once a month and provides services in the facility. If additional services are needed prior to that the resident is referred out as needed. The administrator also revealed that even if a resident does not have dental coverage the facility will provide the finances for dental care for the resident. Continued interview, the social service director revealed that they use a contracted dental service that comes to see the residents that are on the scheduled list. The social service director confirmed that she did have R8 on the list since November 2023, however the resident was not seen by the dentist that came. The social service director further revealed that the dentist came to the facility in November 2023, but did not see any residents due to issues with water in the building. The dentist service returned in December 2023 but did not see residents at that time due to scheduling conflicts, the social service director revealed the last time the dentists came to see residents was on 2/14/2024. However, R8 was missed and not seen, and no additional referrals were made for R8 to be seen outside of the facility. Observation and interview with R8 on 3/1/2024 at 9:20 am revealed he has not heard anything and still has not received dental services. A follow up interview on 3/4/2024 at 12:00 pm with R8 revealed he finally got to see the dentist today and was very happy, resident was smiling and very thankful and says the dentist plans for removal of all or most of his teeth just as the resident has been wanting. Interview with the registered dietitian on 3/6/2024 at 10:57 am revealed R8's diet and intake indicated a 10-pound weight loss back in January of 2024 due to a possible hospital admission his weight has increased since then to a 3-pound weight gain however the registered dietitian was not aware of the resident having dental issues.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 49470 Based on record review, interviews, and review of the Administrator's Job Description, Administration failed to provide protective oversight of the facility environment including adequate supervision for wandering residents and failed to protect residents on the secured memory unit from an abuse free environment. This failure had the likelihood of affecting all residents residing on the secured memory unit. In addition, the facility failed to ensure that the call light communication system was functioning to alert staff that residents required assistance on one of four floors (Fourth Floor) in the facility. On 2/28/2024, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator and Director of Nursing were informed of the Immediate Jeopardy (IJ) on 2/28/2024 at 3:05 pm. The noncompliance related to the IJ was identified to have existed on 9/30/2023. An Acceptable Removal Plan was received on 3/4/2024. Based on observation, record reviews, review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice was removed on 3/2/2024. The facility remained out of compliance while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). This oversight process includes the analysis of facility staff conformance with the facility's policies and procedures governing abuse in the facility. Findings included: Review of the Administrator Job Description signed and dated 9/18/2024 by the Administrator, documented the summary of the position is to lead and direct facility functions in accordance with the resident's needs, government regulations, and company policies to maintain care for the residents. Essential job functions include: Plan, develop, organize, implement, evaluate, and direct the facility's programs and activities in accordance with guidelines issued by the governing board. Develop and maintain written policies and procedures and professional standards of practice that govern the operation of the facility. Makes routine inspections of the facility to assure that established policies and procedures are being implemented and followed. Assist the Quality Assurance and Assessment Committees in developing and implementing appropriate plans of action to correct identified quality deficiencies. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Conducts regular rounds to monitor residents' needs are being met. Ensure that all facility personnel, residents, visitors Maintains a working knowledge and ensures compliance with all governmental regulation Ensures that residents rights to fair and equitable treatment, self-determination, individuality, privacy, property, and civil rights, including rights to wage complaints, are well established, and always maintained. Review resident complaints and grievances and make written reports of action taken. Discuss such actions with resident family as appropriate. 1. R1 with a history of wandering, repeatedly engaged in resident-to-resident physical altercations starting on 9/30/2023 with, R16, R17, R18, R19, R22 and R30. In addition, the facility failed to monitor R1 when R1 continuously wandered into R12's room over a three-month time frame and on 1/25/2024, R12 pushed R1 out of her room and R1 fell and sustained a fracture of the left elbow. During an interview on 2/27/2024 at 9:34 am, the administrator stated she was aware of R1's aggression when she came on board at the facility in September 2023. She stated R1's aggressive behavior was discussed in meetings with the Medical Director on several different occasions. She confirmed that the facility was unable to assign a staff member to the resident for one-to-one supervision. Staff interview on 2/27/2024 at 1:40 pm, CNA, EEE revealed, R1 did not like to stay in his room, and R1 walked continuously around the unit. R1, gets aggressive and violent when other residents confront him. EEE further stated she would hate to see R1 get hurt by other residents. CNA EEE concluded it was impossible for staff to continuously watch all the residents. During an interview on 2/27/2024 at 4:33 pm, Nurse Practitioner (NP) RR revealed that she had worked with R1 and visits with him monthly. NP RR stated R1 was ambulatory, walked freely around the secured memory unit and went into other resident rooms. NP RR stated they were aware that R1 has had resident-to-resident altercations and confirmed that R1 required closer surveillance. They stated that the most plausible way for that to happen is to increase staff on the unit. Cross refer to F600 2. An observation and interview on 2/22/2024 at 10:30 am, the Fourth-Floor call light system at the nurse's station was blank and there was no sound or signal alerting that residents needed assistance. Licensed Practical Nurse (LPN) UU was observed behind the nursing station and confirmed that the fourth-floor nursing call system was not functioning and stated the sound was not audible and the monitor did not blink or show residents who required assistance. He stated he was not sure how long the system had not been working. Observations on 2/22/2024 at 10:40 am on the 400 Hall revealed the following rooms were tested by pushing the red button. However, the light above the door did not light up and no sound was heard.: 415 bed A and B; 416 bed A and B; 417 bed A and B; 420 bed A and B and 424 bed A and B. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview on 2/22/2024 at 10:50 am LPN WW stated the nursing call system had not been operational for three weeks and that the maintenance Director had been made aware, and that the staff put in requests for repair in the electronic maintenance care log. An interview on 2/22/2024 at 10:55 am, the Maintenance Director stated he was not sure why the call light monitoring system was not functioning. He stated that he was aware staff documented in the maintenance care system when equipment needed to be repaired. A review of a letter signed and dated by the facility administrator on 10/22/2023 revealed that the facility call light system was malfunctioning at that time. An interview on 2/22/2024 at 12:06 pm, the administrator revealed the monitoring system was a concern when she got hired and added it was not audible. She was unaware the monitors had stopped working again. Cross refer to F919 The facility implemented the following actions to remove the IJ: 1. On 2/29/2024 at 10:00 am, an Ad Hoc Abuse Performance Improvement Meeting was held with the Administrator, Director of Social Services, the DON, Corporate Operations Consultant, and the Corporate Nurse Consultant to identify the root cause of resident-to-resident altercations with a subsequent plan of action. The Abuse Prevention Policy, Resident to Resident Policy, and the Behavioral Management Policy were reviewed no changes made. 2. On 3/1/2024 the Administrator's job description was reviewed with the Administrator by the Corporate Operations Consultant. No revisions were made. 3. On 2/29/2024, the Corporate Operations Consultant in-serviced the Administrator, DON, and Social Services Director (SSD) on how to properly conduct an abuse investigation, how to track and to determine trends, root cause analysis and communication among departments on abuse reporting. The facility QAPI policy was reviewed specifically regarding how to determine root cause analysis. 4. On 2/29/2024, the Corporate Operations Consultant audited, completed, and signed the facility Abuse Log from September 2023 through current for any further areas of concern. Name of Audit- Abuse Log Audit. Trends noted to be primarily on third floor and in the evenings involving R1. Residents and the time of altercations were discussed with the Administrator and Director of Social Services. Interventions were put into place on the Abuse Performance Improvement Plan. 5. On 2/29/2024 the Corporate Nurse Consultant and DON audited the resident-to-resident altercations from September 2023 through current. The audit is named Resident to Resident Documentation Audit. It was identified that care plans were not initiated on all resident-to-resident altercations. Care plans were implemented on 3/1/2024. The DON and Administrator will discuss all abuse allegations in the morning meeting to ensure all departments respond appropriately. Documentation will be monitored through the Abuse Performance Improvement Plan and reported during QAPI by the Director of Nursing and Administrator. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6. On 2/29/2024, the Administrator was educated through the company online training modules on Implementation of QAPI Programs in Nursing Facilities through a one hour approved course. The Administrator successfully completed a post class test and received a certification. On 2/29/2024, the Corporate Operations Consultant conducted educated the Administrator on how to conduct a QAPI meeting and how to identify and complete a Root Cause Analysis. All corrective actions were completed on 3/1/2024. The facility alleges that the IJ was removed on 3/2/2024. 1. A review of Abuse/Resident to Resident Altercations staff education on 2/9/2024 attended by four Registered Nurses (RN) twenty-two Licensed Practical Nurses (LPN), seventeen medical technicians (CMT), four Certified Nurses Assistants (CNA), twelve administration staff, seventeen environmental/maintenance staff, nine Therapy staff, two staff from Social Services and the MDS coordinator. During an interview on 3/5/2024 at 11:51 am, the DON revealed that in services were held regarding abuse, wandering and resident to resident altercations. She verified that all abuse should be reported within two hours to the state. QAPI meetings are addressed monthly, and clinical meetings are held every morning, when interventions are discussed during the QAPI, in service starts the same day if possible. 2. A review of the job description titled, Administrator last revised 3/1/2024, revealed the administrator was hired on 9/18/2024. Review of the administrator's job description included directing day to day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be always provided to all residents. Additionally, duties included Administrative Functions, Committee Functions, Personal Functions, Staff Development, Safety and Sanitation, Equipment and Supply Functions, Budget and Planning Functions, Residents Rights and Working Conditions. 3. The QAPI policy was reviewed and showed the composition of the performance Improvement Committee including, the Administrator, DON, Medical Director, Nurse Practitioner, Resident Assessment Instrument Coordinator. The policy documented QAPI program had the responsibility for designing and implementing corrective action plans as needed to resolve identified resident aspects of care/service problems. During an interview on 3/5/2024 at 12:46 pm, Nurse Consultant (NC) NN, revealed the facility abuse policy was not updated, she stated it was reviewed. On 2/29/2024, she educated the Administrator, DON, and SSD regarding monitoring residents behaviors including verbally aggressive behavior and physically aggressive behavior. The consultant stated, the QAPI policy was reviewed, she talked to the MDS- Coordinator, MMM regarding comprehensive care plans. She identified the care plan was not updated on other occasions. Discussed staff the care plan should be updated as soon as an incident or behavior is identified. Documentation revealed staff received the in-service on 2/29/2024. 4. Documentation and interviews of facility staff (nurses, CNA's, Housekeeping and the Laundry department) and The Abuse Log Audit. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 3/5/2024 at 11:56 am, Assistant Director of Nursing (ADON) revealed the following, all staff were in serviced, regarding behavioral management, specifically the way staff are to manage residents with behaviors, skin assessments, QAPI was reviewed. Staff were informed to immediately assess residents for injuries and report to the abuse coordinator immediately whenever a resident-to-resident altercation occurs. Staff discussed alternative placement for residents involved in repetitive resident to resident altercations. There were no changes made to the Abuse Policy. ADON stated all abuse must be reported to the abuse coordinator immediately and to the state within two hours. 5. The QAPI meeting was held for the following Tags F600, F656 and F835, and signatures were documented regarding completion of the in service. A total of fifty-six staff were interviewed from 3/5/2024 through 3/6/2024, which included Nursing staff, Dietary staff, housekeeping staff, laundry staff, Maintenance staff, Reception staff and Management staff. Signatures and interviews verified staff were in serviced on 2/29/2024 by RN-KKK. 6. Reviewed the audit tools dated 2/29/2024 verified that 100% of audits had been completed. A sample was reviewed for R1, R11, R12, R16, R19, R20, and R22. The documentation reviewed for Care Plans, MDS, and Pocket Guides was accurate.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49470 Based on observations, interviews, and record reviews, the facility failed to ensure that the call light communication system was functioning to alert staff that residents required assistance on one of four floors (Fourth Floor) in the facility. Findings included: A review of the facility policy titled Call System/Light, last revised 10/20/2022, documented that the call system shall allow residents to call for staff assistance through a communication system that relays the call directly to a staff member at a centralized staff work area. The bedside call light and the emergency call light shall be in functioning order. A review of the Maintenance Care Log records dated 2/13/2024, revealed that an unknown staff documented the following concerns: 1. Task Number 28680: room [ROOM NUMBER] . call light not working. 2. Task Number 28673: room [ROOM NUMBER] call light not working. During observation and interview on 2/22/2024 at 10:15 am, R4 was observed sitting sideways across his bed. A strong odor emanated from his surroundings and the bed sheets were stained with dark brown substance. R4 stated he pressed the call light several times and the call light did not work. R4 stated he had a bowel movement around 6:00 am. R4 was observed to have pressed his call button at that time, and the call light was observed to not activate the nursing call system. R4 stated for the past three weeks, he had been pressing the call light and staff were not responding because the call light doesn't work. During an observation and interview on 2/22/2024 at 10:30 am, the fourth-floor call light monitor at the nurse's station was blank and there was no sound or signal alerting that residents needed assistance. Licensed Practical Nurse (LPN) UU was observed behind the nursing station and stated that he was the charge nurse on the floor. He confirmed that the fourth-floor nursing call system was not functioning and stated the sound was not audible and the monitor did not blink or show residents who required assistance. He stated he was not sure how long the system had not been working. During an interview on 2/22/2024 at 10:35 am, Certified Nursing Assistant (CNA) AAA stated the call monitoring system had not been operational for the last three weeks. CNA AAA stated the expectation was that the monitoring system is supposed to show staff on the monitor how long the resident had been waiting for the call light to be answered and show the origin of the call light. CNA AAA stated Maintenance Director was made aware that the monitor was not working. She stated that she also documented a request for repairs to be completed in the electronic maintenance care log. During an interview on 2/22/2024 at 10:50 am LPN WW stated he had been working at the facility for over a year. LPN WW stated the nursing call system had not been operational for three weeks and that the maintenance Director had been made aware, and that the staff put in requests for repair in the electronic maintenance care log. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further observations on 2/22/2024 at 10:40 am revealed the following: 1. On the 400 Hall, room [ROOM NUMBER] bed A and B, the call lights were tested by pushing the red button. The light above the door did not light up and no sound was heard. 2. On the 400 Hall, room [ROOM NUMBER] bed A and B, the call lights were tested by pushing the red button. The light above the door did not light up and no sound was heard. 3. On the 400 Hall, room [ROOM NUMBER] bed A and B, the call lights were tested by pushing the red button. The light above the door did not light up and no sound was heard. 4. On the 400 Hall, room [ROOM NUMBER] bed A and B, the call lights were tested by pushing the red button. The light above the door did not light up and no sound was heard. 5. On the 400 Hall, room [ROOM NUMBER] bed A and B, the call lights were tested by pushing the red button. The light above the door did not light up and no sound was heard. During an interview on 2/22/2024 at 10:55 am, the Maintenance Director stated he was not sure why the call light monitoring system was not functioning. He stated that he was aware staff documented in the maintenance care system when equipment needed to be repaired. A review of a letter signed and dated by the facility administrator on 10/22/2023 revealed that the facility call light system was malfunctioning at that time. During an interview on 2/22/2024 at 12:06 pm, the administrator revealed the monitoring system was a concern when she got hired and added it was not audible. She was unaware the monitors had stopped working again. During an interview on 2/22/2024 at 1:58 pm, LPN GG, who is also the Staff Development Coordinator, stated that she was aware that the system malfunctioned in the past and that she educated staff regarding the call light monitoring system. She stated the monitoring system should reflect the origin of the call light as soon as the resident pushed the call light. LPN GG stated when staff identified malfunctioning equipment, they were required to document on the electronic maintenance care log and to follow up with a verbal phone call to the Maintenance Director. Cross refer to F835