STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115607	A. Building B. Wing	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinewood Nursing Center	433 North McGriff Street Whigham, GA 39897

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 - Minimal harm or potential for 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** 15650 Based on record review and staff interviews, the facility failed to ensure the physician was notified timely of extensive bruising to one resident (R) (R8) from a total sample of 21 residents. Findings include: Review of the facility protocol titled Acute Condition Changes-Clinical Protocol dated March 2018 revealed the following: Before contacting a physician about someone with an acute change of condition, the nursing staff will collect pertinent details to report to the physician; for example, the history of present illness and previous and recent test results for comparison. Phone calls to attending or on-call physicians should be made by an adequately prepared nurse who has collected and organized pertinent information, including the resident/patient's current symptoms and status. The nursing staff will contact the physician based on the urgency of the situation. Foe emergencies, they will call or page the physician and request a prompt response. The nurse and the physician will discuss and evaluate the situation. R8 was admitted to the facility on [DATE] with the following but not limited to diagnoses: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia, chronic pain, adult failure to thrive, and Parkinsons disease. Review of the July 2024 Physician's orders revealed the resident was receiving Eliquis (blood thinner) 5 milligrams twice a day. The 7/13/2024 at 1:48 pm Health Status Note documented a Certified Nursing Assistant (CNA) reported a large area of bruising to the resident's right side. The Licensed Practical Nurse (LPN) observed the area and asked the resident if she fell . The resident shook her head no. The LPN asked the Registered Nurse (RN) to look at the area. Although the LPN documented she notified the Director of Nursing (DON) on 7/13/2024, review of the 7/14/2024 Health Status Note revealed documentation the DON was notified of the bruising 7/14/2024, not on 7/13/2024 due to having an RN on staff 7/13/2024 to observe the situation. The 7/14/2024 Health Status Note by the DON indicated she was notified by the LPN over the phone in regard to the resident's skin being discolored to the right breast and right side. The DON texted the physician who gave orders for lab work and monitor for increase in discoloration or pain. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 7/15/2024 Health Status Note documented at 3:25 pm the physician was notified and gave orders to send the resident to the emergency room for X-ray and evaluation of bruising on the right side. Review of the hospital discharge summary indicated the resident was admitted to the hospital on 7/15/2024 for significant bruising to her right chest. The resident was also transfused two units of packed red blood cells due to a low hemoglobin and hematocrit. The physician noted it was unclear if the contusions was from a fall or a spontaneous bleed that could have been brought on by coughing in the setting of anticoagulation. The resident was discharged from the hospital on 7/22/2024. During an interview with LPN DD on 7/24/2024 at 12:05 pm, she stated on 7/13/2024 a CNA reported the bruising to her. She assessed the resident and saw purple bruising from the resident's right breast down to the hip and tracking around to the resident's back. She stated the resident did not have a fall and did not complain of pain. She stated RN GG assessed the resident and thought the bleeding was under the skin. She stated the physician was not called that day because her vital signs were normal, and she had no complaints of pain. During an interview with RN GG on 7/25/2024 at 3:21 pm, he stated that when he looked at the resident on 7/13/2024 the resident had blue bruising to the upper right shoulder, down her back and her right breast. He stated there were no reports of the resident falling or having been dropped. He stated it was beyond anything he had ever seen. He confirmed they did not call the physician that day and felt they were doing the right thing for her care. He stated on 7/16/2024 the DON told them they should have called her, and she would have told them to send the resident out and start an investigation. During an interview with the DON on 7/24/2024 at 11:45 am, she stated when she saw the bruise on 7/15/2024, the black bruising covered the resident's right breast and went down her right side to her back. She decided to have the resident sent out due to the bruising. She confirmed she was the one who contacted the physician on 7/14/2024 and got the orders for labs. She stated the severity of the bruising was not relayed to her on 7/14/2024 when LPN DD called her. During an interview with the Physician on 7/30/2024 at 4:30 pm, he stated that staff definitely should have notified him of the bruising. He stated to his knowledge, the bruising was enough for staff to intervene, as it was more than a regular bruise. If he had been notified on 7/13/2024 he would have at least ordered some labs.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety 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** 21213 Based on staff interviews, record reviews, and a review of the facility's policies titled Abuse Prevention Policy & Procedure and Identifying Sexual Abuse and Capacity to Consent policy, the facility failed to protect Resident (R) 4's right to be free from sexual abuse by R5. The facility sample size was 21. On 8/8/2024, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator, Minimum Data Set (MDS) Nurse, and Regional Director of Operations were informed of the Immediate Jeopardy (IJ) on 8/8/2024 at 11:25 am. The noncompliance related to the IJ was identified to have existed on 7/7/2024. An Acceptable IJ Removal Plan was received on 8/15/2024. 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 8/12/2024. Findings include: The facility had an Abuse Prevention Policy & Procedure, with revision date of 2/26/2019. The policy included a definition of sexual abuse as any abuse that is of a sexual nature, including harassment, coercion or assault. The facility had an Identifying Sexual Abuse and Capacity to Consent policy, dated September 2022. The policy's statement documented that a resident's consent to sexual activity is not valid if obtained from a resident who lacks the capacity to consent, or if consent was obtained through intimidation, fear or coercion. Review of R4's clinical record revealed that she was admitted to the facility on [DATE] and had diagnoses that included, but were not limited to, Alzheimer's Disease, unspecified psychosis, and anxiety disorder. Review of the 6/17/2024 Brief Interview for Mental Status (BIMS) form revealed that R4 was assessed as having cognitive impairment, with a score of 0 out of 15, indicating severe cognitive impairment. Review of a 3/12/2024 social services quarterly review note revealed that R4 was alert with marked confusion and oriented to person only. The note also documented that R4 required assistance with activities of daily living (ADLs) and used a wheelchair for mobility. Review of R5's clinical record revealed that he was admitted to the facility on [DATE] had diagnoses that included, but were not limited to, hypertension, chronic obstructive pulmonary disease, bipolar disorder, and generalized anxiety disorder. Review of a 7/1/2024 social services quarterly review note revealed that R5 was alert and oriented x2, with a BIMS score of 13 (out of 15). The note further documented that R5 had no behaviors (during the review period), was supervised with ADLs and independent with ambulation. Review of a 7/8/2024 BIMS form revealed that R5 scored a 14 out of 15 on the cognitive assessment, indicating he 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 - Few	Further review of R4's clinical record revealed a 7/7/2024 Medication Administration Note, made by Licensed Practical Nurse (LPN) DD, that documented R4 was observed in the dining area by a staff member having inappropriate sexual behavior with another resident. Further review of 5's clinical record revealed a 7/7/2024 Medication Administration Note, made by LPN DD, that documented R5 was observed in the dining area before breakfast by a staff member having inappropriate sexual behavior. A 7/7/2024 Behavior Note, made by the Director of Nursing (DON), documented that R5 was observed by LPN BB in the dining room involved in inappropriate sexual behavior with another resident. The note also included that LPN BB asked R5 what he was doing, and he stated nothing and went to sit down. LPN BB notified the DON. During an interview on 7/17/2024 at 2:05 pm, LPN BB recalled the incident that occurred between R4 and R5 on 7/7/2024. LPN BB stated that she was walking up the hallway and observed R5 on the left side of the dining room, and he is normally on the right side of the dining room. R5 was standing up close to R4's wheelchair, and LPN BB stepped in to get a closer look. R5's shirt was out of his pajama pants, and his penis was exposed. R5 pushed R4's head twice onto his penis. LPN BB stated she became really stern and called out R5's name and yelled What are you doing? You know you can't do that. R5 immediately stepped away (from R4) and said he was not doing anything. LPN BB stated she told LPN DD what had happened. LPN BB stated that R4 and R5 were LPN DD's residents that day. LPN BB stated that while LPN DD called the Administrator, she made sure the residents were separated. LPN BB stated that she also called the DON on 7/7/2024 and reported the incident to her, and also notified the physician. LPN BB stated she asked R5 if he knew what he had done was wrong and he said he did not remember. During a phone interview on 7/23/2024 at 11:18 am, LPN DD recalled the events of 7/7/2024. LPN DD stated that she did not witness the incident between R4 and R5, that she was at her medication cart getting it ready. She heard LPN BB say something like stop that and then LPN BB walked up to her and told her what had happened (between R4 and R5). LPN DD confirmed that she notified the Administrator and that he came to the facility. LPN DD also stated that she checked both residents out and that R4 remained in the dining room, and R5 was redirected back to his room. Following the 7/7/2024 sexual abuse occurrence, further review of R5's clinical record, including physician's orders, Medication Administration Records (MARs), and behavioral health notes revealed that R5 was started on Zoloft 50 milligrams (mg), one and a half tablets daily for hypersexuality, on 7/9/2024. The behavioral health Nurse Practitioner (NP) also visited on 7/9/2024 and assessed and counseled R5 on his behavior. Further review of R5's clinical record also revealed that the behavioral health NP assessed R4 on 7/9/2024 with no changes in mood or behavior noted at that time. During an interview on 8/8/2024 at 4:20 pm, the behavioral health NP confirmed that she saw R4 and R5 on 7/9/2024. She stated that R5 had no history of sexual behaviors prior. The facility implemented the following actions to remove the IJ: 1. Resident 5 put on one-on-one monitoring on 8/8/2024 to monitor behaviors. Resident 4 was moved to another room and the opposite hall away from Resident 5 on 7/26/2024. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All Residents including R4 and R5 were assessed by the Medical Director's Nurse Practitioner on 8/8/2024. No negative outcomes were noted. Residents R4 and R5 were given a head-to-toe skin assessment on 8/8/2024 by nursing staff. The head-to-toe assessment revealed that R4 and R5 had no bruising, or signs of abuse. This was to ensure that no harm to the residents had occurred. Both R4 and R5 had been on behavior monitoring every shift since 6/2024. Mental Health services evaluated R4 and R5 on 7/9/2024 with no negative outcomes noted. Secondary to the mental health evaluation a pharmacological intervention, Zoloft 75mg daily was ordered for R5 on 7/8/2024. 2. The Social Worker provided Inservice on 8/8/2024 to 35 cognitively intact residents (Brief interview of Mental Statue (BIMS) score of 9 and above) including R5 that no one should touch others in any sexual manner without their permission. The Inservice also informed residents that if anyone makes you feel uncomfortable with unwanted touch report to any staff immediately. The Social Worker provided education on 8/8/2024 to all cognitively intact residents (Brief interview of Mental Statue (BIMS) score of 9 and above) that the facility Abuse Coordinator is the Administrator. The residents were also educated on the location of the bulletin boards where contact information is posted, which included: Facilities Abuse Coordinator, State Survey Agency, Local Police, State Ombudsman, and Adult Protective Service. A copy of all the facility policies titled Abuse and Neglect and Residents Rights was given to all cognitively intact residents. The resident's education included that no abuse of any kind would be acceptable. Residents are educated to tell staff immediately about abuse or neglect including mistreatment, exploitation, misappropriation of property, injury of unknown origin, resident to resident altercation, and suspicions of crime affecting them or other residents. On 8/8/2024 through 8/9/2024, the Social Worker, Registered Nurse (RN), Licensed Practical Nurse (LPN), interviewed all cognitively intact residents regarding abuse. The interview questions included: are you afraid to stay at this facility, if so, why? Do you feel safe here at the facility? Do you know who tell if someone scares you? Has anyone hurt you at this facility? The findings showed all cognitively intact residents felt free from abuse of any kind. On 8/8/2024 the Social Worker and Administrator interviewed all cognitive intact residents. The interview question consists of: Has anyone ever hurt you? Or have you ever seen anyone hurt someone else in the facility? Who would you tell if you saw someone hurting another resident or yourself? When would you tell if you saw someone hurting another resident or yourself? These interviews were given to reinforce with residents when to report allegations of abuse. What to report, who to report to and how to report. The facility has 25 cognitively impaired Residents with a Brief interview Mental Status (BIMS) score of below 9. On 8/8/2024 LPN nurse performed a head-to-toe assessment to assess for signs of abuse or neglect. No signs of abuse of any kind were observed. In addition, the Social Worker assessed (which included visual observation for negative facial expression, review of medical records for changes in behaviors, along with verbal conversation with each resident). The observation findings were that 25 of 25 cognitively impaired residents had no change in mood. The residents did not have negative facial expressions, or behaviors. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/9/2024 the business Officer Manager mailed 36 of 36 responsible parties and or guardian a copy of the facility policies titled Abused and Neglect and Resident Rights, In addition the responsible party or guardian were also provided a copy of the contact information for the facility Abuse Coordinator (Administrator), State Ombudsman, Adult Protective Services, Local Police, and State Survey Agency. On 8/9/2024 the Business Manager called the 36 responsible parties or guardian to inform them that they will receive the Policies mailed regarding Abuse and Neglect along with contact information for who to report abuse of any kind to. The responsible party or guardian were asked if they had any questions regarding Abuse of any kind, such as who to contact, how to contact, what to report. And when to report abuse. On 8/9/2024, Medical Records provided the 9 residents that are their own responsible party with a copy of the facility policies, Abuse and Neglect and Resident Rights. Each of the residents were educated and shown the location of the bulletin boards that have the contact information for the facility. Abuse Coordinator (Administrator), State Ombudsman, Adult Protective Services, Local Police. And State Survey Agency. The residents were questioned to confirm their understanding regarding Abuse and Neglect, location of contact information, who to contact, how to contact, and what abuse and neglect is, including abuse of any kind of other residents. On 8/9/2024, The Social Worker and Activity Director held an additional Residents Council meeting to reinforce the education, that Abuse of any kind including sexual, mistreatment, exploitation, misappropriation of property. Injury of unknown origin. Resident to resident altercation, and suspicions of crime. The education also included that the facility abuse coordinator is the Administrator and that the contact numbers the Administrator, State Survey Agency, Adult Protective Agency, Local Police, and State Ombudsman is located on the 300-hall dining room bulletin board and the bulletin board across from the front office. The Resident were educated to not only report allegations of abuse that occurs to them, but also to report allegation abuse to other resident, The resident was educated to immediately report abuse to Administrator, State Survey Agency, Adult Protective Agency, Local Police, and State Ombudsman. 3. The Administrator was educated by The Regional Director of operation on 8/8/2024 On Recognizing Signs and Symptoms of Abuse, including sexual exploitation and rape. Education on Abuse includes Mental, Physical, and sexual, and verbal abuse. He was also educated on Abuse Policy and Procedures. The Education on Abuse included Sexual abuse, Physical Abuse, and Verbal abuse. The administration was also educated that Allegation of any kind of sexual abuse, Injury of unknown Injury, Resident Falls with severe injury, Resident with missing money. The administrator was also educated that a full investigation must begin immediately after receiving knowledge of the incident. If the allegation is against employee-suspend immediately pending investigation. If resident to resident allegation, immediately separate residents. Obtain statements from all employees in facility at time of incident and 24 hours. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator was also Inservice by the Chief Operating Officer on 8/8/2024 on Allegation of any kind of sexual abuse, Injury of unknown Injury, Resident Falls with severe injury, Resident with missing money. The administrator was also educated that a full investigation must begin immediately after receiving knowledge of the incident. If the allegation is against employee-suspend immediately pending investigation. If resident to resident allegation, immediately separate residents. Obtain statements from all employees in the facility at time of incident and 24 hours. the Chief Operating Officer also educated the Administrator on all residents must be free of Abuse of any kind. All residents with abusive behaviors, including physical, sexual, or verbal must have interventions implemented, all care plans must be reviewed to ensure appropriate intervention were updated, effectiveness of care plans for recognition of instances of abuse, as well as receive appropriate treatment and/or services, including. intervention was updated, effectiveness of care plans for recognition of instances of abuse, as well as receive appropriate treatment and/or services. The Administrator educated staff on 8/8/2024 - 8/9/2024 on the following education: that abuse, and neglect includes mistreatment, exploitation, misappropriation of property, injury of unknown origin, resident to resident altercation, suspicions of crime including sexual and physical abuse. The Staff were educated on recognizing and identifying abuse and neglect, The Staff was educated that the facility Abuse coordinator is the Administrator and all allegation of abuse must be reported immediately to Administrator. The following staff received this education: 1of 1 Director of Nursing, 1of 1 Social Worker, 1of 1 Maintenance Director, 2 of 2 Activity Directors, 8 of 8 Registered Nurses, 9 of 10 Licensed Practical Nurses, 27 of 27 Certified Nurse Assistants, 9 of 9 housekeeping staff, 11 of 12 Dietary Staff, 1 of 1 Business Office Manager, and 6 of 6 Therapists. The staff not present will be educated prior to returning to work by the Director of Nursing. No staff will be allowed to work until educated. As of 8/11/2024 no new staff hired. On 8/10/2024 the staff was given a screen test on sexual abuse to test knowledge of sexual abuse protocol. 76 of 78 staff (totaling 98%) were educated on abuse. 4. The process for when a resident displays aggressive abusive behavior is nursing staff will separate residents immediately. Residents will then be assessed for injury by nurse on duty. The resident's physician will be notified by the nurse on duty and nurse will follow MD orders. The responsible party will be notified by nurse on duty. The aggressor must be put on one-on-one observation immediately, meaning one staff member will be assigned to that resident at all times. The other resident involved will be placed on 15 minute observation. This is to continue until the environment is safe. The nurse on duty must then notify the Administrator immediately and will document in the residents' progress notes. The nurse will document the behavior along with all steps taken to protect all residents from abuse. The Administrator will then start the investigation process and follow through to ensure the safety of all residents. The Administrator will also notify the State Survey Agency of all allegations of abuse within 2 hour time requirement. As of 8/8/2024, the Social Worker, Director of Nursing, and Licensed Nurse Supervisor will audit progress notes daily of all residents displaying verbal and physical aggressive behaviors, sexual inappropriate behaviors, escalation in behavior, and resident to resident physical and verbal behaviors, to ensure that all residents are free from abuse. The Social Worker, Director of Nursing, Licensed Nurse and Supervisor will monitor daily using the audit tool titled, Behavior QAPI Tool, which identifies each aggressive behavior, new interventions, such as one on one observation, mental health services, activities, environmental changes, medications reviews, and pain assessment. This monitoring will occur daily. The monitoring tool will be discussed daily in morning meeting beginning 8/9/2024. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The care plan will be revised during the meeting by Minimum Data Nurse (MDS). Any problems or concerns will be immediately addressed by DON and communicated to the Administrator. 5. On 8/8/2024 the Quality Assurance Committee, including Administrator, DON, MDS, Dietary Manager, Business Office Manager, Nurse Aide, Rehab Manager, Social Worker, Housekeeping Manager, Maintenance Director, and Activity Director reviewed the facility 4 Immediate jeopardy tags. The Medical Director was called by DON on 8/8/2024 and notified of 4 immediate jeopardy tags. The Quality Assurance Committee reviewed and determined the root cause of F600. The facility failed to ensure that R4 was free from sexual abuse from another resident. The facility failed to provide protection for R4 as she resides in the facility. The Quality Assurance Committee reviewed the policies titled, Abuse Policy and Procedure, (revised 05/2017) and Abuse Investigation and Reporting (revised 7/2017) with no further revisions to policies being made. Review of the police determined the need for 100% staff education on Abuse Policy including mistreatment, exploitation, misappropriation, injury of unknown origin, physical abuse, sexual abuse, and protecting residents from abuse. The Quality Assurance Committee implemented and added a tool titled, Behavior QAPI Tool. The tool will be brought to QA daily. 6. All Correction actions were completed on 8/11/2024. 7. The immediacy of the IJ was removed on 8/12/2024. The State Survey Agency (SSA) validated the facility's written IJ Removal Plan as follows: 1. Verified via review of an 8/8/2024 physician's order for R5 for 1:1 monitoring related to sexual behaviors and the accompanying Resident Location Check sheet. R4's room change was verified via review of a communication form, dated 7/26/2024, that documented a room change for R4. R4 was observed in the new room on 7/29/2024 at 4:20 pm. Nurse Practitioner (NP) assessments were verified via review of clinical records, including 8/8/2024 nurse's notes entries, made by the Director of Nursing (DON), in R4's and R5's clinical records that documented the Nurse Practitioner was at the facility doing rounds, with no issues or concerns noted and no new orders for R4 and R5. Review of the skin assessment forms for R4 and R5, dated 8/8/2024, verified they had been completed with no new areas noted. Per review of physician's orders and Medication Administration Records (MARs), R4 and R5 had been on behavior monitoring every shift since June 2023 (the entry of 6/2024 in the AOC is a typing error). Review of behavioral health NP notes from 7/9/2024 for R4 and R5 verified that she visited and assessed them. During an interview on 8/8/2024 at 3:56 pm, the NP confirmed that she saw R4 and R5 on 7/9/2024. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R5's physician's orders and July 2024 MAR confirmed that Zoloft 50 milligrams (mg), 1.5 tablets (75 mg) by mouth daily was started on 7/9/2024 to address hypersexual behavior. 2. Verified via review of the Concern and Comment form signed by the Social Services Director and Administrator. The form documented that on 8/8/2024, the Social Services Director educated residents with BIMS of 9 or greater on residents' rights, abuse and reporting, name of the abuse coordinator, and location of the bulletin boards with contact information for the ombudsman, abuse coordinator, law enforcement, and state regulatory agency. The form also documented that residents were given a copy of the residents' rights and abuse policy. Review of the following information: 35 Sexual Abuse Education for Resident forms, that included a signature for each of the 35 cognitively intact residents, the list of contact names and information on who to report abuse to, copy of the Residents' Rights policy, copy of the Abuse and Neglect- Clinical Protocol, an 8/8/2024 in-service education sign in sheet titled Abuse and Neglect and Residents Rights with 35 resident signatures or names (two residents refused to sign and one was blind), and review of the interview questionnaire forms, one for each resident with their documented answers, also confirmed the residents received the education and information. During an interview on 8/19/2024 at 1:14 pm, the Social Services Director confirmed she provided education and information to the 35 cognitively intact residents. Also, during an observation on 8/18/2024 at 12:52 pm and 12:57 pm, the bulletin boards near the dining room and at the end of the 300 halls were observed to include posted contact information on the state survey agency, law enforcement, state ombudsman, and the abuse coordinator, along with a copy of residents' rights. In addition, during an interview on 8/19/2024 at 2:55 pm the Administrator confirmed interviewing residents and stated, I was fully involved and commented that the resident interviews went well. Also, during interviews on 8/18/2024 at 12:57 pm with R15, at 1:04 pm with R2, and at 1:06 pm with R3 and on 8/19/2024 at 2:25 pm with R17, at 2:47 pm with R18, at 3:35 pm with R9, at 3:38 pm with R21, at 3:40 pm with R19, and at 3:45 pm with R20, the residents were able to verify being interviewed and educated about abuse by staff and who to report concerns to. None of the interviewed residents expressed concerns related to abuse. A review of skin assessment forms revealed that head-to-toe skin assessments were completed on all 60 residents from 8/8/2024 through 8/9/2024. Verified via review of a list identifying 25 residents with a BIMS score of less than 9, dated 8/8/2024, and review of the F557 Resident Dignity and Respect Audit Tool completed on the 25 residents. The audit tool documented that progress notes had been reviewed for moods and behaviors on 8/8/2024 by the Social Services Director. Verified via review of the individual forms that had pictures of facial expressions that were completed on each of the 25 residents and signed by the Minimum Data Set (MDS) Coordinator and dated 8/8/2024. During an interview on 8/19/2024 at 1:14 pm with the Social Services Director and on 8/19/2024 at 2:45 pm with the MDS Coordinator, both confirmed that the residents had been assessed for negative facial expressions/responses and records reviewed for changes in behaviors. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinewood Nursing Center	433 North McGriff Street Whigham, GA 39897

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Verified via review of copies of individually stamped and addressed envelopes to 35 resident responsible parties. There were 35 responsible parties for 36 residents because two residents (R3 and R20), who were related, had the same responsible party. During an interview on 8/19/2024 at 1:40 pm the Business Office Manager confirmed mailing information to residents' responsible parties. Verified via review of the list of 36 residents who have a responsible party along with the progress notes made on 8/9/2024 that documented calls or call attempts to the responsible parties to notify them of the information being mailed out. During an interview on 8/19/2024 at 1:40 pm the Business Office Manager confirmed calling the responsible parties to notify them of the information being mailed. She stated that she the ones she was able to speak to seemed appreciative of the call and did not have any abuse concerns or questions. Verified via review of the Abuse and Neglect-Clinical Protocol, Residents' Rights policy and list of contact information for the facility abuse coordinator, state contacts, and law enforcement. Review of the list of residents who are their own responsible party revealed there were 24 residents, not nine as listed in the AOC. During an interview on 8/16/2024 at 2:30 pm the Regional Director of Operations confirmed that the 9 was a typing error and that 24 residents had been provided with the information. During an interview on 8/19/2024 at 1:40 pm the Business Office Manager confirmed that she was also over medical records. She confirmed that she provided abuse information to the 24 residents who were their own responsible parties. During interviews with residents who were listed as their own responsible party on 8/18/2024 at 12:57 pm with R15, on 8/19/2024 at 2:25 pm with R17, at 3:35 pm with R9 and at 3:40 pm with R19, the residents verified they received information on abuse. During the interview on 8/19/2024 at 2:25 pm with R17, the paperwork she had received was visible on the nightstand in her room. During the interview on 8/19/2024 at 3:40 pm, R19 confirmed receiving paperwork from staff but stated she did not keep it. Verified via review of the resident council meeting notes, dated 8/9/2024 and signed by the Social Services Director. The meeting information included eight residents attended. In addition, 18 residents who were gathered outside for a smoke break, were also informed. During an interview on 8/19/2024 at 1:14 pm, the Activity Director and Social Services Director confirmed the resident council meeting was held, that the meeting went well, and the residents understood the information. During an interview on 8/19/2024 at 2:25 pm, the resident council president (R17) confirmed the meeting was held on 8/9/2024. During interviews on 8/18/2024 at 1:06 pm with R3 and on 8/19/2024 at 3:45 pm with R20, the residents (who were included in the list of 18 residents who were gathered for smoke break and educated on 8/9/2024) confirmed receiving information on abuse and resident's rights. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Verified via review of the in-service and training sign-in sheet titled Recognizing Signs and Symptoms of Abuse. The educator was listed as the Regional Director of Operations and the form was signed by the Administrator and dated 8/8/2024. Verified via review of the Recognizing Signs and Symptoms of Abuse/Neglect policy and accompanying information on the reporting timeline to the state survey agency and immediate action once notified of a reportable incident. Verified via review of the Event Management Abuse Policy and Procedure power point slide copies which were signed and dated 8/8/2024 by the Regional Director of Operations. Verified via review of the in-service and training sign-in sheet titled Abuse Investigation and Reporting which listed the educator as the Regional Director of Operations and was signed by the Administrator and dated 8/8/2024, along with the accompanying education information on abuse reporting and immediate interventions. Verified via review of the in-service education titled Abuse Policy and Procedure which was dated 8/8/2024 and sign by the Administrator and Regional Director of Operations. During an interview on 8/19/2024 at 2:45 pm, the Regional Director of Operations confirmed educating the Administrator on 8/8/2024. Review of the in-service education form titled Abuse Prevention Policy and Procedure and the accompanying abuse education information which was signed by the Administrator and Chief Operating Officer and dated 8/8/2024. Verified via review of the in-service education form titled Identifying Sexual Abuse and Capacity to Consent that was signed and dated 8/8/2024 by the Administrator and Chief Operation Officer, along with the Identifying Sexual Abuse and Capacity to Consent policy and Abuse Prevention Policy and Procedure. During an interview, via phone, on 8/19/2024 at 3:17 pm, the Chief Operation Officer confirmed providing in-service education to the Administrator and stressed the importance of the information. During an interview on 8/19/2024 at 2:55 pm the Administrator confirmed receiving in-service education from the Chief Operating Officer on 8/8/2024 related to abuse policy and procedures, investigations, and reporting. A master list of staff was cross-referenced with the sexual abuse screening quiz questions that were completed individually by staff to verify that they did receive the information. Verified via review of in-service education sign in sheets labeled with Abuse and Neglect, recognizing signs and symptoms of abuse, Abuse Coordinator, Reportables must be reported in 2 hours, along with the accompanying education information, dated 8/8/2024 and 8/9/2024. The staff signature sheets included a total of 79 staff were educated. During an interview with the Regional Director of Operations and MDS Coordinator on 8/19/2024 at 12:06 pm, it was clarified that 12 of 12 dietary staff were in-serviced and 5 of 6 therapy staff were in-serviced. They confirmed that one LPN and one therapy staff were out on leave and would be educated upon return to work. Staff interviews conducted on 8/18/2024 at 12:40 pm with LPN DD, at 12:49 pm with housekeeper BBB, at 12:55 pm with RN JJ, on 8/19/2024 at 11:30 am with the Housekeeping Manager, at 11:38 am with housekeepers SSS and CCC, at 12:15 pm with the Dietary Manager, at 12:20 pm with the Maintenance Director, at 1:02 pm with activity assistant MM, at 1:14 pm with the Social Services Director and Activity Director, at 1:32 pm with CNA DD, at 1:35 pm with dietary staff EEE and FFF, at 1:40 pm with the Business Office Manager, and at 2:45 pm with the MDS Coordinator confirmed they had received education that abuse and neglect and what it included, recognizing signs of abuse and neglect, that the Abuse Coordinator is the Administrator and that all allegations of abuse must be reported immediately. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/19/2024 at 2:55 pm the Administrator confirmed providing the in-service education information on 8/8/2024 and 8/9/2024. 4. Interviews conducted with nursing staff on 8/18/2024 at 12:40 pm with LPN DD, at 12:55 pm with RN JJ, and on 8/19/2024 at 1:32 pm with CNA DD, and at 2:45 pm with the MDS Coordinator confirmed they were knowledgeable of the process for when a resident displays aggressive abusive behavior. Verified via review of the Behavior Quality Assurance Performance Improvement (QAPI) Tool dated daily from 8/8/2024 through 8/25/2024 that documented all residents were audited with no aggressive behaviors noted. Interviews conducted on 8/19/2024 at 1:14 pm with the Social Service Director, at 2:35 pm with the DON, and at 2:45 pm with the MDS Coordinator and Regional Director of Operations confirmed that audits of resident progress notes were done daily to identify any residents displaying aggressive or inappropriate behaviors or an escalation in behaviors. Verified via interview on 8/19/2024 at 2:45 pm with the MDS Coordinator related to the revision of care plan during the morning meeting as needed for residents displaying behaviors. 5. Verified via review of the 3rd Quarterly Monthly QA/PI Meeting Agenda form, dated 8/8/2024 that documented an ad hoc meeting was held and the Immediate Jeopardy and abuse policies were reviewed. The signature[TRUNCATED]

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21213 Based on staff interviews, record reviews, and review of the policy titled Abuse Prevention Policy & Procedure, the facility failed to ensure that allegations of abuse or injury of unknown origin were reported to the State Survey Agency in a timely manner for four Residents (R) (R4, R5, R3, and R8), failed to ensure that an allegation of sexual abuse involving two residents (R4 and R5) was reported to law enforcement in a timely manner, and failed to ensure that the initial and follow up reports to the State Survey Agency, for an allegation of sexual abuse involving two residents (R4 and R5), contained complete and accurate information, from a total sample of 21 residents. On 8/8/2024 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator, Minimum Data Set (MDS) Nurse, and Regional Director of Operations were informed of the Immediate Jeopardy (IJ) on 8/8/2024 at 11:25 am. The noncompliance related to the IJ was identified to have existed on 7/7/2024. An Acceptable IJ Removal Plan was received on 8/15/2024. 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 8/12/2024. Findings include: The facility had an Abuse Prevention Policy & Procedure, with revision date of 2/26/2019. The policy's statement included that any allegation of abuse is reported immediately to the state agency and to all other agencies as required, per state and federal guidelines. The policy defined sexual abuse as any abuse that is of a sexual nature, including harassment, coercion, or assault. Verbal abuse was defined as any use of oral, written, or gestured language that willfully included the disparaging and derogatory terms to residents, their families or within hearing distance. An example of verbal abuse included saying or doing something with intent to frighten a resident or otherwise make him/her feel unsafe or insecure. Mental abuse included, but was not limited to, humiliation, harassment, threats of punishment or deprivation. Section 5 of the policy Reporting/Investigation/Response Policy included that the Administrator or designee shall call local police when sexual abuse is suspected and/or confirmed by investigation. 1. Review of R4's clinical record revealed that she was admitted to the facility on [DATE] and had diagnoses that included, but were not limited to, Alzheimer's Disease, unspecified psychosis, and anxiety disorder. Review of the 6/17/2024 Brief Interview for Mental Status (BIMS) form revealed that R4 was assessed as having cognitive impairment, with a score of 0 out of 15, indicating severe cognitive impairment. Review of a 3/12/2024 social services quarterly review note revealed that R4 was alert with marked confusion and oriented to person only. The note also documented that R4 required assistance with activities of daily living (ADLs) and used a wheelchair for mobility. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R5's clinical record revealed that he was admitted to the facility on [DATE] and had diagnoses that included, but were not limited to, hypertension, chronic obstructive pulmonary disease, bipolar disorder, and generalized anxiety disorder. Review of a 7/1/2024 social services quarterly review note revealed that R5 was alert and oriented x2, with a BIMS score of 13 (out of 15). The note further documented that R5 had no behaviors (during the review period), was supervised with ADLs and independent with ambulation. Review of a 7/8/2024 Brief Interview for Mental Status form revealed that R5 scored a 14 out of 15 on the cognitive assessment, indicating he was cognitively intact. Further review of R4's clinical record revealed a 7/7/2024 Medication Administration Note, made by Licensed Practical Nurse (LPN) DD, that documented R4 was observed in the dining area by a staff member having inappropriate sexual behavior with another resident. Further review of 5's clinical record revealed a 7/7/2024 Medication Administration Note, made by LPN DD, documented R5 was observed in the dining area before breakfast by a staff member having inappropriate sexual behavior. A 7/7/2024 Behavior Note, made by the Director of Nursing (DON), documented that R5 was observed by LPN BB in the dining room involved in inappropriate sexual behavior with another resident. The note also included that LPN BB asked R5 what he was doing, and he stated nothing and went to sit down. LPN BB notified the DON. During an interview on 7/17/2024 at 2:05 pm, LPN BB recalled the incident that occurred between R4 and R5 on 7/7/2024. LPN BB stated that she was walking up the hallway and observed R5 on the left side of the dining room, and he is normally on the right side of the dining room. R5 was standing up close to R4's wheelchair, and LPN BB stepped in to get a closer look. R5's shirt was out of his pajama pants and his penis was exposed. R5 pushed R4's head twice onto his penis. LPN BB stated she became really stern and called out R5's name and yelled What are you doing? You know you can't do that. R5 immediately stepped away (from R4) and said he was not doing anything. LPN BB stated she went and told LPN DD what had happened. LPN BB stated that R4 and R5 were LPN DD's residents that day. LPN BB stated that while LPN DD called the Administrator, she made sure the residents were separated. LPN BB stated that she also called the DON on 7/7/24 and reported the incident to her, and also notified the physician. LPN BB stated she asked R5 if he knew what he had done was wrong and he said he did not remember. During a phone interview on 7/23/2024 at 11:18 am, LPN DD recalled the events of 7/7/2024. LPN DD stated that she did not witness the incident between R4 and R5, that she was at her medication cart getting it ready. She heard LPN BB say something like stop that and then LPN BB walked up to her and told her what had happened (between R4 and R5). LPN DD confirmed that she notified the Administrator and that he came to the facility. LPN DD also stated that she checked both residents out, and R4 remained in the dining room, and R5 was redirected back to his room. Although the Director of Nursing and Administrator were both aware of the sexual abuse occurrence on the day that it occurred, on 7/7/2024, an initial report to the state survey agency was not submitted until 7/8/2024. In addition, the initial report to the state survey agency contained inaccurate information. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Facility Incident Report Form, dated 7/8/2024 and submitted to the state survey agency by the DON, revealed that the sexual abuse occurrence between R4 and R5 was correctly documented as having occurred on 7/7/2024. However, the details of the incident included in the report incorrectly documented that the incident was reported to the DON and Administrator by staff on 7/8/2024 at 1:07 pm. During interviews on 7/16/2024 at 4:15 pm and 4:25 pm, the Administrator confirmed that he was made aware of the incident between R4 and R5 on 7/7/2024, and he then he reported that he came to the facility, and spoke with R4 and R5's nurse, LPN DD. During the interview on 7/16/2024 at 4:25 pm, the DON stated that she found out about the incident on 7/8/2024, when she was reviewing incident notes, which was something she did as part of risk management. However, during an additional interview on 7/17/2024 at 2:43 pm, when questioned about the nurse's note entry she made in R5's clinical record, dated 7/7/2024, the DON confirmed that LPN BB called her on 7/7/2024 and reported the inappropriate sexual act that had occurred between R4 and R5. The DON also stated that she spoke with the Administrator on 7/7/2024. During an interview on 7/31/2024 at 10:55 am, the DON was questioned as to why the initial report to the state survey agency included that she and the Administrator were made aware of the incident on 7/8/2024, but they both knew about it on 7/7/2024. The DON stated that when LPN BB called her on 7/7/2024 and told her about the incident, she called the Administrator. The Administrator then called her back and said that it turned out not to be what it was. However, when she pulled the report the next day and read it, it was inappropriate sexual behavior. Review of the facility's follow-up report, submitted to the state survey agency revealed that the result of the facility's investigation was inconclusive, even though it was witnessed by LPN BB. The follow- up report also omitted the information that the Administrator and DON were aware of the incident on the date it occurred, 7/7/2024. During an interview on 7/16/2024 at 4:25 pm, the Regional Director of Operations stated that she was not aware the Administrator knew of the incident on 7/7/2024 and that she was the person who completed the 5-day follow-up summary to the state survey agency. During a subsequent interview on 7/18/2024 at 3:25 pm, the Regional Director of Operations stated that not too long after the 7/7/2024 incident, the DON was out for a few days. The 5-day follow-up report to the state survey agency was coming due, so she did the report based off what was told to her at that time by staff. There was no evidence that the resident-to-resident sexual abuse incident involving R4 and R5 was reported to law enforcement. During the interview on 7/17/2024 at 2:43 pm, the DON stated no police were contacted. During an interview on 7/23/24 at 1:25 pm, when asked if law enforcement should have been notified, the Regional Director of Operations responded yes. After surveyor inquiry, the sexual abuse incident between R4 and R5 was reported to law enforcement. During an interview on 7/23/2024 at 2:15 pm the Regional Director of Operations reported the incident to Patrol Officer EE. 2. R3 was admitted to the facility on [DATE] and had diagnoses that included, but were not limited to, generalized anxiety disorder, type 2 diabetes, gout, low back pain, cerebral infarction, and hypertension. Review of the 6/22/2024 Quarterly Minimum Data Set (MDS) assessment revealed that R3 was assessed as being cognitively intact with a BIMS score of 15 out of 15. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 7/18/2024 at 10:28 am, Ombudsman CC stated that she spoke with R3 on 5/30/2024 at the facility, and R3 complained to her that Registered Nurse (RN) AA had threatened to give him an injection and would not let him go outside. R3 did not specify when the incident had occurred. Ombudsman CC stated that she reported the allegation to the Administrator on 5/30/2024. She made another in-person visit to the facility on [DATE], and R3 told her that the Administrator had come to talk to him about his allegation (against RN AA) and asked him to report any concerns immediately. During an interview on 7/22/2024 at 2:05 pm, R3 stated that about three months ago, they (staff) kept bringing him food he said he was not going to eat. RN AA told him if he kept acting up, she would give him a shot. R3 said RN AA would not let him go back to his room or outside to cool down. He confirmed that he spoke with Ombudsman CC about it on 5/30/2024 but had not reported it to anyone prior to that. R3 also confirmed that the Administrator had talked to him about it, after the Ombudsman. However, there was no evidence that the allegation of RN AA's verbal threat to give R3 an injection was reported to the State Survey Agency. During an interview on 7/22/2024 at 3:05 pm, the Administrator confirmed he was aware of R3's allegation and stated that he went to talk to R3 on 5/30/2024, immediately after Ombudsman CC reported the allegation. However, R3 could not recall any information when they went to talk to him about it. 15650 4. Review of the 7/13/2024 at 1:48 pm Health Status Note for R8 revealed documentation that a Certified Nursing Assistant (CNA) reported a large area of bruising to the resident's right side. The Licensed Practical Nurse (LPN) observed the area and asked the resident if she fell . The resident shook her head no. Although the LPN documented she notified the Director of Nursing (DON) on 7/13/2024, review of the 7/14/2024 Health Status Note revealed documentation the DON was notified of the bruising 7/14/2024, not on 7/13/2024. Review of the 7/13/2024 skin assessment noted bruising to the left and right iliac crest and under the right breast. Review of the 7/15/2024 Facility Incident Report Form revealed an incorrect date of the incident as 7/15/24 and indicated bruising was noted the resident's diaphragm and left breast area. During an interview with Licensed Practical Nurse (LPN) DD on 7/24/2024 at 12:05 pm, she stated although she observed the bruising to the resident on 7/13/2024 she did not report the bruising to the DON until 7/14/2024. During an interview with the DON on 7/24/2024 at 11:45 am, she confirmed although the LPN reported the bruising to her on 7/14/2024, the State Survey Agency was not notified until 7/15/2024. The facility implemented the following actions to remove the IJ: (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Resident 8 was transferred to the hospital on 7/15/2024 then transferred from the hospital to another facility on 7/22/2024. Resident 5 was put on one-on-one monitoring on 8/8/2024 to monitor for sexual behaviors. R4 was moved to another room on the opposite hall away from R5 on 7/26/2024. Resident 4, 5, 8, 3 and all other residents were assessed by the Medical Director's Nurse Practitioner on 8/8/2024. No adverse effects were noted. All Residents were given a head-to-toe skin assessment on 8/8/2024 and 8/9/2024 by nursing staff. The head-to-head assessment revealed that 60 out of 60 residents had no bruising or signs of abuse. This was to ensure that no harm to the residents had occurred. Both R4 and R5 had been on behavior monitoring every shift since 6/2024. Mental Health services evaluated R4 and R5 on 7/9/2024 with no adverse effects noted. Secondary to the Mental Health evaluation a pharmacological intervention, Zoloft 75mg daily was ordered for R5 on 7/8/2024. 2. On 8/8/2024 the Administrator audited reportable events (abuse and neglect) which includes mistreatment, exploitation, misappropriation of property, injury of unknown origin, resident to resident altercations, and suspicions of sexual crimes) using the audit tool titled, New Reportable Audit for Events for the last 30 days. The audit identified 4 reportable events with 3 of the 4 initial reportable events were not reported within the 2 hour time requirement per federal guidelines. The 4 final summaries were completed on 7/12/2024, 7/19/2024, and 7/30/2024. The Administrator added a new QAPI tool titled, New Reportable Audit for Events, which audits reportable events with date and time, report to supervisor, employee involvement including suspension date, date investigation starts and ends, report to state initial date and time, report to state final date and time, and date of care plan revision. Effective use of QAPI tool will ensure that the facility reports reportable events within the federal guidelines. The Administrator will be notified of any allegations of abuse, mistreatment, exploitation, misappropriation of property, injury of unknow origin, resident to resident altercation, and suspicions of sexual crimes; by the licensed nurse, immediately, to ensure timely reporting to the state agencies. The result of the audit will be presented daily in morning meeting and any problems will be addressed immediately. 3. The Administrator educated staff on 8/8/2024 -8/9/2024 on the following education: abuse and neglect includes mistreatment, exploitation, misappropriation of property, injury of unknown origin, resident to resident altercation, suspicions of crime including sexual and physical abuse. The staff were educated on recognizing and identifying abuse and neglect. The staff was educated that the facility Abuse Coordinator is the Administrator and all allegations of abuse must be reported immediately to the Administrator. The staff was educated to report allegations immediate to the Administrator due to the 2 hour requirement for the Administrator to report to the State Agency of all allegations of abuse. The following staff received this education: 1of 1 Director of Nursing, 1of 1 Social Worker, 1 of 1 Maintenance Director, 2 of 2 Activity Directors, 8 of 8 Registered Nurses, 9 of 10 Licensed Practical Nurses, 27 of 27 Certified Nurse Assistants, 9 of 9 housekeeping staff, 11 of 12 Dietary Staff, 1of 1 Business Office Manager, and 6 of 6 Therapists. The staff not present will be educated prior to returning to work by the Director of Nursing. No staff will be allowed to work until educated. As of 8/11/2024 no new staff hired. 76 of 78 staff (totaling 98%) were educated on abuse. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinewood Nursing Center	433 North McGriff Street Whigham, GA 39897

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. The Administrator was educated on 8/8/2024 that all reportables must be reported within 2 hours which includes sexual abuse, injury of unknow origin, and any allegations of abuse. Immediate actions to be taken once notified of reported abuse are make sure residents are safe, if resident on resident abuse immediately separate, if allegations are against an employee suspend immediately pending investigation, obtain statements from all employees in facility at time of incident and 24 hours prior to incident occurrence. Notify physician of residents involved, call police, responsible party, and Ombudsman. 5. As of 8/9/2024 the Administrator will audit each new event to ensure timely reporting to the State Survey Agency with the tool titled New Reportable Audit for Events. The Administrator will bring the New Reportable Audit for Events tool to the morning meeting daily (Monday-Friday) for review beginning on 8/9/2024 and weekends will be reviewed on Monday in morning meeting through 8/11/2024 with no new negative findings. If the tool identifies that an event was not reported in a timely manner, the staff and Administrator will be reeducated on timely reporting by the Regional Director of Operations immediately. 6. On 8/9/2024 the Quality Assurance committee reviewed the facility's 4 cited immediate jeopardy (IJ) tags. The committee determined the root cause of F609. The root cause was the facility failed to ensure that allegations of abuse and injury of unknown origin were reported to the state survey agency in a timely manner for 4 residents (R4, R5, R3, and R8) and failed to identify that an allegation of sexual abuse involving R4 and R5 contained inaccurate information or omitted information. The facility failed to timely investigate allegations of abuse and failed to investigate resident to resident sexual abuse. The facility failed to recognize patterns in behaviors and failure to protect all residents. The Quality Assurance committee reviewed the facility policies titled, Investigating Injuries revised 2016 and Protection of Residents During Abuse Investigation revised April 2017. No further revisions to policies were made. The Medical Director viewed the policy on 8/9/2024 with no revisions suggested. Review of policy determined the need for 100% staff education for investigating allegations of abuse in a timely manner. 7. All corrections were completed 8/11/2024. 8. The immediacy of the IJ was removed on 8/12/2024. The State Survey Agency (SSA) validated the facility's written IJ Removal Plan as follows: 1. Verified transfer to hospital via review of R8's clinical record. Verified via review of the 8/8/24 physician's order for R5 and the accompanying monitoring forms. Review of R5's clinical record revealed that 75 mg of Zoloft was started on 7/9/2024. R4's room change was verified via review of a communication form, dated 7/26/2024, that documented a room change to a different hall. R4 was observed in the new room on 7/29/2024 at 4:20 pm. Review of R3, R4 and R5's clinical records revealed that the Nurse Practitioner visited and assessed them on 8/8/24. A review of skin assessment forms revealed that a skin assessment was completed on 60 residents from 8/8/24-8/9/24. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Verified via review of the Audit of Reportable Events form, dated 8/8/2024 and review of the New Reportable Audit for Events for July 2024, which included four events involving R4, R5, R8 and R16. The events involving R4, R5, and R8 were already known to surveyors. A record review on R16 for an injury of unknown origin was conducted which verified the information on the audit form was correct and the incident was reported to the state survey agency in a timely manner. During an interview on 8/15/2024 at 4:15 pm the Regional Director of Operations clarified that the QAPI tool titled New Reportable Audit for Events was a form that was already in use. The new tool developed is titled Daily Reportable Log and provided a copy to review. The Regional Director stated that the Administrator brings the tool to the daily morning meetings Monday through Friday. During an interview on 8/19/2024 at 2:55 pm the Administrator confirmed the use of the Daily Reportable Log tool during morning meetings. Verified the tool had been implemented via review of the Daily Reportable Log that included documentation of reviews 8/9/2024-8/15/2024. 3. Confirmation of in-service education sign in sheets labeled with Abuse and Neglect, Recognizing signs and symptoms of abuse, Abuse Coordinator, Reportables must be reported in 2 hours, along with the accompanying education information, dated 8/8/2024 and 8/9/2024. The staff signature sheets included a total of 79 staff were educated. During an interview with the Regional Director of Operations and MDS Coordinator on 8/19/2024 at 12:06 pm, it was clarified that 12 of 12 dietary staff were in-serviced and 5 of 6 therapy staff were in-serviced. They confirmed that one LPN and one therapy staff were out on leave and would be educated upon return to work. Staff interviews conducted on 8/18/2024 at 12:40 pm with LPN DD, at 12:49 pm with housekeeper BBB, at 12:55 pm with RN JJ, on 8/19/2024 at 11:30 am with the Housekeeping Manager, at 11:38 am with housekeepers SSS and CCC, at 12:15 pm with the Dietary Manager, at 12:20 pm with the Maintenance Director, at 1:02 pm with Activity Assistant MM, at 1:14 pm with the Social Services Director and Activity Director, at 1:32 pm with CNA DD, at 1:35 pm with dietary staff EEE and FFF, at 1:40 pm with the Business Office Manager, and at 2:45 pm with the MDS Coordinator confirmed they had received education that abuse and neglect and what it included, recognizing signs of abuse and neglect, that the Abuse Coordinator is the Administrator and that all allegations of abuse must be reported immediately. They were also knowledgeable about the 2-hour requirement for the Administrator to report to the state survey agency. During an interview on 8/19/2024 at 2:55 pm the Administrator confirmed provide the in-service education information on 8/8/2024 and 8/9/2024. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Verified via review of the in-service and training sign-in sheet titled Recognizing Signs and Symptoms of Abuse. The educator was listed as the Regional Director of Operations and the form was signed by the Administrator and dated 8/8/2024. Verified via review of the Recognizing Signs and Symptoms of Abuse/Neglect policy and accompanying information on the reporting timeline to the state survey agency and immediate action once notified of a reportable incident. Verified via review of the Event Management Abuse Policy and Procedure power point slide copies which were signed and dated 8/8/2024 by the Regional Director of Operations. Verified via review of the in-service and training sign-in sheet titled Abuse Investigation and Reporting which listed the educator as the Regional Director of Operations and was signed by the Administrator and dated 8/8/2024, along with the accompanying education information on abuse reporting and immediate interventions. Verified via review of the in-service education titled Abuse Policy and Procedure which was dated 8/8/2024 and signed by the Administrator and Regional Director of Operations. During an interview on 8/19/2024 at 2:45 pm, the Regional Director of Operations confirmed educating the Administrator on 8/8/2024. During an interview on 8/19/2024 at 2:55 pm the Administrator confirmed receiving in-service education from the Regional Director of Operations on 8/8/2024 and that he was aware of the requirements of reporting to the state survey agency and law enforcement. 5. During an interview on 8/15/2024 at 4:15 pm the Regional Director of Operations clarified that the QAPI tool titled New Reportable Audit for Events was a form that was already in use. The new tool developed is titled Daily Reportable Log and provided a copy to review. The Regional Director of Operations stated that the Administrator brings the tool to the daily morning meetings Monday through Friday. During an interview on 8/19/2024 at 2:55 pm the Administrator confirmed the use of the Daily Reportable Log tool during morning meetings. Verification that the tool had been implement via review of the Daily Reportable Log that included documentation of reviews from 8/9/2024 through 8/15/2024. During an interview on 8/19/2024 at 2:45 pm, the Regional Director of Operations confirmed that if concerns were identified related to events not reported in a timely manner, re-education would be provided. She stated that she would oversee the completion of the QA audit forms for accurate information. 6. Verified via review of the 3rd Quarterly Monthly QA/PI Meeting Agenda form, dated 8/8/2024 that documented an ad hoc meeting was held and the Immediate Jeopardy and abuse policies were reviewed. The signatures of the QA committee members were included along with copies of the completed Immediate Jeopardy Templates and copies of the Investigating Injuries policy and Protection of Residents During Abuse Investigations policy. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews conducted on 8/19/2024 at 11:30 am with the Housekeeping Supervisor, at 12:15 pm with the Dietary Manager, at 12:20 pm with the Maintenance Director, at 1:14 pm with the Activity Director and Social Services Director, at 1:40 pm with the Business Office Manager, at 2:35 with the DON, at 2:45 pm with the MDS Coordinator and Regional Director of Operations, and at 2:55 pm confirmed that they held a QA meeting on 8/8/2024, reviewed policies, and reviewed and determined the root cause of F609. During an interview on 8/12/2024 at 1:04 pm the Medical Director confirmed knowledge of the Immediate Jeopardy.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21213 Based on interviews, record reviews, and review of the Abuse Prevention Policy & Procedure, the facility failed to conduct an investigation and implement protective measures in a timely manner following an allegation of resident-to-resident sexual abuse involving two Residents (R) (R4 and R5) from a total sample of 21 residents. On 8/8/2024 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator, Minimum Data Set (MDS) Nurse, and Regional Director of Operations were informed of the Immediate Jeopardy (IJ) on 8/8/2024 at 11:25 am. The noncompliance related to the IJ was identified to have existed on 7/7/2024. An Acceptable IJ Removal Plan was received on 8/15/2024. 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 8/12/2024. Findings include: The facility had an Abuse Prevention Policy & Procedure, with revision date of 2/26/2019. Section 4 of the policy titled Resident-To-Resident Policy documented that it is the policy of the facility to take all steps reasonable and necessary to protect the residents from harm at all times, including protection from physical and verbal abuse from other residents. Number 8 of the Procedure portion of the Resident-to-Resident Policy documented all incidents are to be documented in the resident's medical record with intense monitoring to continue for at least 72 hours. Section 5 of the policy titled Reporting/Investigation/Response Policy documented that if the incident has resulted in an injury or a suspected sexual assault, the resident will be transferred to the hospital emergency room . Review of R4's clinical record revealed that she was admitted to the facility on [DATE] and had diagnoses that included, but were not limited to, Alzheimer's Disease, unspecified psychosis, and anxiety disorder. Review of the 6/17/2024 Brief Interview for Mental Status (BIMS) form revealed that R4 was assessed as having cognitive impairment, with a score of 0 out of 15, indicating severe cognitive impairment. Review of a 3/12/2024 social services quarterly review note revealed that R4 was alert with marked confusion and oriented to person only. The note also documented that R4 required assistance with activities of daily living (ADLs) and used a wheelchair for mobility. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R5's clinical record revealed that he was admitted to the facility on [DATE] had diagnoses that included, but were not limited to, hypertension, chronic obstructive pulmonary disease, bipolar disorder, and generalized anxiety disorder. Review of a 7/1/2024 social services quarterly review note revealed that R5 was alert and oriented x2, with a BIMS score of 13 (out of 15). The note further documented that R5 had no behaviors (during the review period), was supervised with ADLs and independent with ambulation. Review of a 7/8/2024 BIMS form revealed that R5 scored a 14 out of 15 on the cognitive assessment, indicating he was cognitively intact. Further review of R4's clinical record revealed a 7/7/2024 Medication Administration Note, made by Licensed Practical Nurse (LPN) DD, that documented R4 was observed in the dining area by a staff member having inappropriate sexual behavior with another resident. Further review of 5's clinical record revealed a 7/7/2024 Medication Administration Note, made by LPN DD, that documented R5 was observed in the dining area before breakfast by a staff member having inappropriate sexual behavior. A 7/7/2024 Behavior Note, made by the Director of Nursing (DON), documented that R5 was observed by LPN BB in the dining room involved in inappropriate sexual behavior with another resident. The note also included that LPN BB asked R5 what he was doing, and he stated nothing and went to sit down. LPN BB notified the DON. During an interview on 7/17/2024 at 2:05 pm, LPN BB recalled the incident that occurred between R4 and R5 on 7/7/2024. LPN BB stated that she was walking up the hallway and observed R5 on the left side of the dining room, and he is normally on the right side of the dining room. R5 was standing up close to R4's wheelchair, and LPN BB stepped in to get a closer look. R5's shirt was out of his pajama pants and his penis was exposed. R5 pushed R4's head twice onto his penis. LPN BB stated she became really stern and called out R5's name and yelled What are you doing? You know you can't do that. R5 immediately stepped away (from R4) and said he was not doing anything. LPN BB stated she went and told LPN DD what had happened. LPN BB stated that R4 and R5 were LPN DD's residents that day. LPN BB stated that while LPN DD called the Administrator, she made sure the residents were separated. LPN BB stated that she also called the DON on 7/7/2024 and reported the incident to her, and also notified the physician. LPN BB stated she asked R5 if he knew what he had done was wrong and he said he did not remember. During a phone interview on 7/23/2024 at 11:18 am, LPN DD recalled the events of 7/7/2024. LPN DD stated that she did not witness the incident between R4 and R5, that she was at her medication cart getting it ready. She heard LPN BB say something like stop that and then LPN BB walked up to her and told her what had happened (between R4 and R5). LPN DD confirmed that she notified the Administrator and that he came to the facility. LPN DD also stated that she checked both residents out and that R4 remained in the dining room and R5 was redirected back to his room. However, review of R4's clinical record revealed no skin assessment documented until 7/10/2024. Review of R5's clinical record revealed no skin assessment documented until 7/11/2024. R4 was also not sent to the hospital for an examination. In addition, although the DON and Administrator were both aware of the sexual abuse incident on the day that it occurred, on 7/7/2024, and the Administrator came to the facility, he failed to initiate a timely investigation and interview the only witness, LPN BB, or obtained a written statement from her until 7/8/2024. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews on 7/16/2024 at 4:15 pm and 4:25 pm, the Administrator confirmed that he was made aware of the incident between R4 and R5 on 7/7/2024, came to the facility, and spoke with R4 and R5's nurse, LPN DD. During the interview on 7/17/2024 at 2:26 pm, LPN BB stated that the Administrator did not talk with her on 7/7/2024, and she was not sure what LPN DD told him. Review of R4 and R5's clinical records revealed that both residents were already on behavior monitoring every shift, related to psychotropic medication use, since June 2023. The behavior monitoring was documented on the Medication Administration Records (MARS). After 7/7/2024, additional nurses' notes entries related to behavior monitoring were also documented on R4 and R5 one to two times daily in their clinical records through 7/12/2024. Review of R4's clinical record revealed nurses' notes entries on 7/8/2024 at 1:35 am and 9:29 pm, on 7/9/2024 at 1:05 am, on 7/10/2024 at 6:36 am and 8:26 pm, on 7/11/2024 at 3:19 am and 7:54 pm, and on 7/12/2024 at 1:48 am and 8:29 pm documented R4 continued on behavior charting and/or no behaviors noted at that time. Review of R5's clinical record revealed nurses' notes entries on 7/8/2024 at 1:34 and 9:28 pm, on 7/10/2024 at 6:29 am and 8:28 pm, on 7/11/2024 at 3:17 am and 7:53 pm, and on 7/12/2024 at 1:46 am and 8:34 pm documented R5 continued on behavior charting and/or no behaviors noted at that time. However, there was no evidence of intense monitoring until 7/29/2024. Review of R5's physician's orders revealed an order for one hour checks every shift for any inappropriate behaviors. In addition, both R4 and R5 continued to reside in rooms that were on the same end of the hall, in close proximity to each other until 7/26/2024. Review of R4's clinical record revealed a 7/28/2024 social services note that documented R4 was relocated to another room on a different hall on 7/26/2024. During an interview on 7/31/2024 at 10:55 am, when asked if any additional frequent checks/monitoring or intense monitoring was implemented on R4 or R5 after 7/7/2024 and prior to the one-hour checks were ordered on 7/29/2024 for R5, the DON stated no. The DON did say that the staff have made sure R4 and R5 were on different sides of the dining room. During an interview on 7/31/2024 at 11:25 am, when asked about R4 and R5 continuing to reside on the same hall with their rooms in close proximity to each other until 7/26/2024, the Administrator responded that there was no proof that R5 wandered into resident rooms. When asked if any intense monitoring or frequent monitoring was implemented and documented for R4 or R5 before the q1h was ordered on 7/29/2024, the Regional Director of Operations responded that she knew the staff were monitoring. The facility implemented the following actions to remove the IJ: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Resident 5 was put on one-on-one monitoring on 8/8/2024 to monitor behaviors. R4 was moved to another room on the opposite hall away from R5 on 7/26/2024. All Residents including R4 and R5 were assessed by the Medical Director's Nurse Practitioner on 8/8/2024. No negative outcomes were noted. Residents R4 and R5 were given a head-to-toe skin assessment on 8/8/2024 and 8/9/2024 by nursing staff. The head-to-toe assessment revealed that R4 and R5 had no bruising or signs of abuse. This was to ensure that no harm to the residents had occurred. Both R4 and R5 had been on behavior monitoring every shift since 6/2024. Mental Health services evaluated R4 and R5 on 7/9/2024 with no negative outcomes noted. Secondary to the Mental Health Evaluation a pharmacological intervention, Zoloft 75mg daily was ordered for R5 on 7/8/2024. 2. Because the facility failed to conduct an investigation, prevent, and correct alleged violations, the Administrator and DON were educated on abuse investigations to protect all residents. If an incident or suspected incident of abuse is reported, the administrator will assign the investigation to DON. The Administrator will provide any supporting documents related to the alleged incident to DON who's in charge of the investigation. The Administrator will keep the resident and responsible party informed of the progress of the investigation. The Administrator will suspend immediately any employee who has been accused of resident abuse pending the outcome of the investigation and interview other residents to whom the accused employee provided during the time of the alleged incident, this is to ensure safety and protection of the resident. If resident-to-resident abuse is reported, staff will immediately intervene and separate residents to protect and prevent them from further abuse. The DON will review the residents' medical records to determine events leading up to the incident. The DON will interview the person reporting the incident. The DON will interview any witnesses of the incident. The DON will interview the resident if medically appropriate. The DON will interview staff on all shifts who worked during the time of the alleged incident. The DON will interview the resident's roommate and any other resident whom the accused employee provided care for during the period of the alleged incident. The DON will obtain written witness statements. The DON will notify the Ombudsman that an abuse investigation is being conducted. Upon conclusion of the investigation, the results of the findings will be provided to the resident, responsible party, Ombudsman, and medical director. 8/8/2024, the Administrator audited reportable events (abuse and neglect which includes mistreatment, exploitation, misappropriation of property, injury of unknown origin, resident to resident altercation, and suspicions of sexual crimes) using the audit titled New Reportable Audit for Events daily and will bring to morning meeting daily. The audit identified 4 reportable events with 3 of 4 initial reportable that were not reported timely. The 3 reportables was reported and finalized 7/12/2024, 7/19/2024 and 7/30/2024. The administrator added a new QAPI tool titled New Reportable Audit for Events, which audits reportable events with date and time, report to supervisor, employee involvement including suspension date, date investigation starts and ends, report to state initial date and time, report to state final date and time and date of care plan revision. Effective use of QAPI tool will ensure that the facility reports reportable events within the federal guidelines. The Administrator will be notified of any allegations of abuse, mistreatment, exploitation, misappropriation of property, injury of unknown origin, resident to resident altercation, and suspicions of sexual crime by the licensed nurse immediately to ensure timely reporting to the state agencies. The result of the audit will be presented by the Administrator to the morning meeting daily. If any problems or issues are identified, they will be addressed immediately by the Administrator. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. The Administrator in-serviced staff from 8/8/2024 through 8/9/2024. The staff was educated that the facility abuse coordinator is the Administrator and all allegations of abuse and neglect must be reported immediately to the administrator due to the 2 hour requirement for the administrator to notify the State Survey Agency of all allegations of abuse. The following staff received this education: 1 of 1 Director of Nursing, 1 of 1 Social Worker, 1 of 1 Maintenance Director, 2 of 2 Activity Directors, 8 of 8 Registered Nurses, 9 of 10 Licensed Practical Nurses, 27 of 27 Certified Nurse Assistants, 9 of 9 housekeeping staff, 11 of 12 Dietary Staff, 1 of 1 Business Office Manager, and 6 of 6 Therapists. The staff not present will be educated prior to returning to work by the Director of Nursing. No staff will be allowed to work until educated. As of 8/11/2024 no new staff hired. 76 of 78 staff (totaling 98%) were educated on abuse. 4. As of 8/9/2024 the Administrator will audit each new event to ensure timely reporting to the State Survey Agency with the tool titled New Reportable Audit for Events. The Administrator will bring the New Reportable Audit for Events tool to the morning meeting daily (Monday-Friday) and the weekends will be reported on Monday morning in our morning meeting for review beginning on 8/9/2024. The Administrator will continue to complete the New Reportable Audit for Event tool daily through 8/11/2024 with no new negative findings. If the tool identifies that an event was not reported in a timely manner, the staff and Administrator will be reeducated on timely reporting by the Regional Director of Operations immediately. 5. On 8/8/2024 the Quality Assurance committee which consist of Administrator, DON, MDS, Dietary Manager, Business Office Manager, Nurse Aide, Rehab Manager, Social Worker, Housekeeper Manager, Maintenance Director, and Activity Manager reviewed the facility 4 cited immediate jeopardy (IJ) tags. The committee determined the root cause of F610. The facility failed to conduct an investigation and provide protective measures in a timely manner following an incident of resident-to-resident sexual abuse involving R4 and R5 that occurred on 7/7/2024. The Quality Assurance committee reviewed the facility policies titled Investigation of Injuries revised 2016 and Protection of Residents during Abuse Investigation revised April 2017. No further revisions to policies were made. The Medical Director was notified of the policy on 8/9/2024 with no changes or suggestions. Review of policy determined the need for 100% staff education for investigating allegations of abuse in a timely manner. Quality Assurance committee implemented a new QAPI tool New Reportable Audit for Events. and Behavior QAPI tools will be brought to morning meeting daily (Monday-Friday) and the weekends will be addressed on Monday. The committee includes the Administrator, DON, MDS, Dietary Manager, Business Office Manager, Nurse Aide, Rehab Manager, Social Worker, Housekeeping Manager, Maintenance Director, and Activity Manager. 6. All corrections actions were completed on 8/11/2024. 7. The immediacy of the (IJ) tag was removed on 8/12/2024. The State Survey Agency (SSA) validated the facility's written IJ Removal Plan as follows: 1. Verified via review of an 8/8/2024 physician's order for R5 for 1:1 monitoring related to sexual behaviors and the accompanying Resident Location Checksheet(s). R4's room change was verified via review of a communication form, dated 7/26/2024, that documented a room change to a different hall. R4 was observed in the new room on 7/29/2024 at 4:20 pm. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinewood Nursing Center	433 North McGriff Street Whigham, GA 39897

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse Practitioner (NP) assessments were verified via review of clinical records, including 8/8/2024 nurse's notes entries, made by the Director of Nursing (DON), in R4's and R5's clinical records that documented the Nurse Practitioner was at the facility doing rounds, with no issues or concerns noted and no new orders for R4 and R5. Review of the skin assessment forms for R4 and R5, verified completed with no new areas noted. Per review of physician's orders and Medication Administration Records (MARs), R4 and R5 had been on behavior monitoring every shift since June 2023 (the entry of 6/2024 in the AOC is a typing error). Review of behavioral health NP notes from 7/9/2024 for R4 and R5 verified that she visited and assessed them. During an interview on 8/8/2024 at 3:56 pm, the NP confirmed that she saw R4 and R5 on 7/9/2024. Review of R5's physician's orders and July 2024 MAR confirmed that Zoloft 50 milligrams (mg), 1.5 tablets (75 mg) by mouth daily was started on 7/9/2024 to address hypersexual behavior. 2. Verified via interview on 8/19/2024 at 2:35 pm with the DON and with the Administrator on 8/19/2024 at 2:55 pm. Verified via review of the Audit of Reportable Events form, dated 8/8/2024 and review of the New Reportable Audit for Events for July 2024, which included four events involving R4, R5, R8 and R16. The events involving R4, R5, and R8 were already known to surveyors. A record review on R16 for an injury of unknown origin was conducted which verified the information on the audit form was correct. During an interview on 8/15/2024 at 4:15 pm the Regional Director of Operations clarified that the QAPI tool titled New Reportable Audit for Events was a form that was already in use. The new tool developed is titled Daily Reportable Log and provided a copy to review. The Regional Director stated that the Administrator brings the tool to the daily morning meetings Monday through Friday. During an interview on 8/19/2024 at 2:55 pm the Administrator confirmed the use of the Daily Reportable Log tool during morning meetings. Verified the tool had been implemented via review of the Daily Reportable Log that included documentation of reviews 8/9/2024-8/15/2024. 3. Verified via review of in-service education sign in sheets labeled with Abuse and Neglect, recognizing signs and symptoms of abuse, Abuse Coordinator, Reportables must be reported in 2 hours, along with the accompanying education information, dated 8/8/2024 and 8/9/2024. The staff signature sheets included a total of 79 staff were educated. During an interview with the Regional Director of Operations and MDS Coordinator on 8/19/2024 at 12:06 pm, it was clarified that 12 of 12 dietary staff were in-serviced and 5 of 6 therapy staff were in-serviced. They confirmed that one LPN and one therapy staff were out on leave and would be educated upon return to work. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff interviews conducted on 8/18/2024 at 12:40 pm with LPN DD, at 12:49 pm with housekeeper BBB, at 12:55 pm with RN JJ, on 8/19/2024 at 11:30 am with the Housekeeping Manager, at 11:38 am with housekeepers SSS and CCC, at 12:15 pm with the Dietary Manager, at 12:20 pm with the Maintenance Director, at 1:02 pm with activity assistant MM, at 1:14 pm with the Social Services Director and Activity Director, at 1:32 pm with CNA DD, at 1:35 pm with dietary staff EEE and FFF, at 1:40 pm with the Business Office Manager, and at 2:45 pm with the MDS Coordinator confirmed they had received education that abuse and neglect and what it included, recognizing signs of abuse and neglect, that the Abuse Coordinator is the Administrator and that all allegations of abuse must be reported immediately. They were also knowledgeable about the 2-hour requirement for the Administrator to report to the state survey agency. During an interview on 8/19/2024 at 2:55 pm the Administrator confirmed provide the in-service education information on 8/8/2024 and 8/9/2024. 4. During an interview on 8/15/2024 at 4:15 pm the Regional Director of Operations clarified that the QAPI tool titled New Reportable Audit for Events was a form that was already in use. The new tool developed is titled Daily Reportable Log and provided a copy to review. The Regional Director stated that the Administrator brings the tool to the daily morning meetings Monday through Friday. During an interview on 8/19/2024 at 2:55 pm the Administrator confirmed the use of the Daily Reportable Log tool during morning meetings and that new events will be audited to ensure timely reporting and investigation. Verified the tool had been implemented via review of the Daily Reportable Log that included documentation of reviews 8/9/2024-8/15/2024. 5. Verified via review of the 3rd Quarterly Monthly QA/PI Meeting Agenda form, dated 8/8/2024 that documented an ad hoc meeting was held and the Immediate Jeopardy and abuse policies were reviewed. The signatures of the QA committee members were included along with copies of the completed Immediate Jeopardy Templates and copies of the Investigating Injuries policy and Protection of Residents During Abuse Investigations policy. Interviews conducted on 8/19/2024 at 11:30 am with the Housekeeping Supervisor, at 12:15 pm with the Dietary Manager, at 12:20 pm with the Maintenance Director, at 1:14 pm with the Activity Director and Social Services Director, at 1:40 pm with the Business Office Manager, at 2:35 with the DON, at 2:45 pm with the MDS Coordinator and Regional Director of Operations, and at 2:55 pm confirmed that they held a QA meeting on 8/8/2024, reviewed policies, and reviewed and determined the root cause of F610. During an interview on 8/12/2024 at 1:04 pm the Medical Director confirmed knowledge of the Immediate Jeopardy.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15650 Based on observations, record review, staff interviews, and review of facility policy titled Pressure Ulcers/Skin Breakdown-Clinical Protocol, the facility failed to ensure pressure ulcer treatments were provided according to the wound physician's dressing treatment plans for two residents (R) (R1and R7) from a total sample of 21 residents. Findings include: Review of the facility policy and procedure titled Pressure Ulcers/Skin Breakdown-Clinical Protocol dated 2001 revealed the following Treatment/Management: 1. The physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressings and application of topical agents if indicated for type of skin alteration. 2. The physician will help identify medical interventions related to wound management: for example, treating soft tissue infection surrounding an ulcer, removing necrotic tissue, addressing comorbid medical conditions, managing pain related to the wound treatment, etc. 1. R1 was admitted to the facility on [DATE] with the following but not limited to diagnoses: cerebrovascular disease, atherosclerotic heart disease, morbid obesity and diabetes. Review of the 2/9/2024 Skin/Wound Note revealed the resident's heels were boggy with discoloration. New orders were obtained to treat both heels with skin prep every shift and as needed. On 2/13/2024 the resident had an Initial Wound Evaluation and management Summary by the wound care physician who noted the resident had an unstageable full thickness pressure ulcer to the left heel and right heels. The wound physician noted the wounds were unavoidable due to dementia, peripheral artery disease, uncontrolled diabetes so that can't feel feet, weak lower extremities that resident can hardly move legs and general noncompliance. The wound physician's dressing treatment plan for the left heel was to apply skin prep once daily and a secondary dressing of gauze island with border once daily for 30 days. The dressing treatment plan for the right heel was for Leptospermum honey with a secondary dressing of gauze island with border once daily for 30 days. Review of the February 2024 and March 2024 Treatment Administration Records revealed documentation of staff treating the right heel with skin prep through 3/5/2024 instead of Leptospermum honey and gauze island with border dressing as recommended by the wound physician. Review of the 3/19/2024 Wound Evaluation and Management Summary by the wound care physician indicated the dressing treatment plan was changed for the left heel from skin prep to Leptospermum honey and gauze island with border dressing once daily. However, review of the March 2024 Treatment Administration Record revealed staff started treating the left heel with the Leptospermum honey on 3/12/2024 although the wound physician did not make the change until 3/19/2024. 2. R7 was admitted to the facility on [DATE] with the following but not limited to diagnoses: schizophrenia, major depressive disorder, bipolar disorder, dementia and hypertension. Per review of the clinical record the resident developed a deep tissue injury to the left heel on 8/26/2023 and eventually declined to a Stage 4 pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 5/7/2024 Wound Evaluation and Management Summary the wound physician applied a skin substitute graft to the resident's left heel. According to the dressing treatment plan instructions were do not remove or disturb wound bed, change the secondary dressing, gauze island with border once daily for 30 days. This dressing treatment plan continued through 5/28/2024 when the treatment plan was changed to Leptospermum honey with gauze island border dressing once daily and continued through 7/23/2024. However, review of the 5/2024, 6/2024 and 7/2024 Treatment Administration Records revealed the left heel was treated with Xeroform gauze and covered with island dressing every day. During an observation of pressure ulcer treatment to the left heel on 7/22/2024 at 3:00 pm Licensed Practical Nurse BB applied Xeroform gauze to the wound and covered with an abdominal pad and wrapped with kling. During an interview with the Director of Nursing on 7/30/2024 at 2:40 pm, she stated she thought the treatment order was for Xeroform. After looking at the most recent wound physician treatment plan, she confirmed the treatment plan was Leptospermum honey and not Xeroform.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 21213 Based on a staff interview and record reviews, the facility failed to ensure that annual performance reviews were completed, to enable in-service education based on the outcome of the reviews for 10 of 27 Certified Nurse Assistants (CNAs) reviewed. Findings include: Review of Certified Nursing Assistant Skills Competency Checklist forms for 27 CNA's revealed that 10 of the 27 CNAs had not had a skills competency review completed annually. There was no evidence of any additional CNA performance reviews. During an interview on 8/16/2024 at 2:30 pm, the Regional Director of Operations stated that they were unable to find any additional CNA performance evaluations. She stated that they had contacted the former Director of Nursing (DON), who told them where she left them (the competency evaluations), but the evaluations were not there. When questioned about who was responsible for completing the annual CNA performance evaluations, the Minimum Data Set (MDS) Coordinator stated it would be the DON. When questioned about who sets up or schedules the skills competency evaluations for the CNAs, the MDS Coordinator stated that it would be the Staff Development Coordinator, but that she was only at the facility part time.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 21213 Based on interviews, record reviews, and review of the job descriptions for Nursing Home Administrator and Director of Nursing (DON), facility Administration failed to ensure that all components of the facility's abuse prevention system were implemented in a thorough and timely manner to address allegations of abuse or injury of unknown origin for four Residents (R) (R4, R5, R3, and R8), from a total sample of 21 residents. On 8/8/2024, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator, Minimum Data Set (MDS) Nurse, and Regional Director of Operations were informed of the Immediate Jeopardy (IJ) on 8/8/2024 at 11:25 am. The noncompliance related to the IJ was identified to have existed on 7/7/2024. An Acceptable IJ Removal Plan was received on 8/15/2024. 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 8/12/2024. Findings include: The facility had a job description for the Nursing Home Administrator. The general purpose of the Administrator was to lead and direct the overall operations of the facility in accordance with customer needs, government regulations and company policies, with focus on maintaining excellent care for the residents while achieving the facility's business objectives. The description included job duties and responsibilities for the categories of facility management, compliance management, facility staff and retention, business management, marketing and revenue management, community relations, and other duties. The category of Compliance Management included to maintain a working knowledge of and confirm compliance with all governmental regulations. The category of Other Duties included to protect residents from neglect, mistreatment, and abuse. The facility had a job description for the Director of Nursing. The general purpose of the DON was to manage the overall operations of the nursing department in accordance with company policies, standards of nursing practices and governmental regulations so as to maintain excellent care of all residents' needs. The description included job duties and responsibilities included administrative functions, meeting functions, personnel functions, nursing care functions, safety and sanitation, equipment and supply functions, care plan and assessment functions, documentation, and budget and planning functions. The category of Administrative Functions included to organize, develop, and direct the administration and resident care of the nursing service department. The category of Nursing Care Functions included to perform nursing services and deliver resident care services in compliance with corporate policies and state and federal regulations. Also, inform state of any reportable incidents within appropriate time frames, and complete investigative analysis as required. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility Administration failed to consistently and effectively oversee areas of the facility that were included in their job descriptions. 1. Administration failed to maintain an environment free from sexual abuse for one resident (R5). The sexual abuse was caused by another resident. Cross refer to F600 2. Administration failed to ensure that abuse allegations or injury of unknown origin were reported to the state survey agency in a timely manner for four residents (R3, R4, R5, and R8) Cross refer to F609 3. Administration failed to ensure that an allegation of sexual abuse involving two residents (R4 and R5) was reported to law enforcement in a timely manner. Cross refer to F609 4. Administration failed to ensure that the initial and follow-up reports to the state survey agency for an allegation of sexual abuse involving R4 and R5 contained accurate and complete information. Cross refer to F610 5. Administration failed to ensure that an allegation of sexual abuse involving two residents (R4 and R5) was thoroughly investigated, and corrective actions implemented, including protection of the resident, in a timely manner. Cross refer to F610 During an interview on 7/31/2024 at 10:55 am, the DON stated that she started working at the facility at the end of May 2024. When questioned about the sexual abuse incident that occurred between R4 and R5 on 7/7/2024, the DON responded that she had never dealt with that situation before. She stated that the training she had at the facility was minimal to none. When asked if she knew what her role was and what she was supposed to do when that situation occurred, she responded no. During an interview on 7/31/2024 at 11:25 am, the Administrator confirmed he was the facility's Abuse Coordinator. When questioned about what he does when there is an allegation of abuse, the Administrator left the interview and returned a short time later and stated that the first thing to do is to decode the information. He then provided a copy of a paper in-service titled In-Service Allegation of Abuse or Sexual Act, that included the protocol for staff to follow when a sexual act or abusive act was observed. The Administrator stated that he gave a copy to everyone in the building and would give a copy to new employees during orientation. The in-service information did not include what the Administrator's role was in the protocol. The facility implemented the following actions to remove the IJ: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. R 8 was discharged to the hospital from our facility on 7/15/2024 and then was transferred from the hospital to another facility on 7/22/2024. Resident 5 put on one-on one monitoring on 8/8/2024 to monitor behaviors. R4 was moved to another room on the opposite hall away from R5 on 7/26/2024. Residents 3, 4, 5, and all other residents was assessed by the Medical Director's Nurse Practitioner on 8/8/2024. No adverse effects were noted. All residents were given head-to-toe skin assessments on 8/8/2024-8/9/2024 by nursing staff. The head-to-toe assessments revealed that 60 out 60 residents had no bruising or signs of abuse. This was to ensure that no harm to the residents had occurred. Mental Health services evaluated R4 and R5 on 7/9/2024 no adverse effects were noted. The regional Director of Operations reviewed job duties with the Administrator and the Director of Nursing on 8/10/2024. 2. The Administrator was in-service on 8/8/2024 by the Chief Operations Officer. The Director of Nursing was in-serviced on 8/9/2024 by the Regional Director of Operations, on protecting all residents from abuse and neglect. The education included that abuse and neglect includes mistreatment, exploitation, misappropriation of property, injury of unknown origin, resident to resident altercation, and sexual abuse. Recognizing and Identifying Abuse and Neglect, The Administrator and Director of Nursing, education included notification of all state agencies that consist of Police, State Ombudsman, State Survey Agency, and Adult Protective Services. The education included the importance of timely and effective investigation of events with final summary submitted to the State Agency within the five-day time frame. The Administrator's education included protecting all residents from abuse and neglect. Job duties were reviewed with the Administrator and DON in addition to the in-service that was provided. 3. The Administrator in-serviced staff from 8/8/2024 through 8/9/2024, the staff was educated that the facility abuse coordinator is the Administrator and all allegations of abuse and neglect must be reported immediately to the Administrator. Staff were educated to report allegations of abuse immediately to the Administrator due to the 2-hour requirement for the administrator to notify the State Agency of all allegations of abuse. The following staff received this education: 1 of 1 Director of Nursing, 1of 1 Social Worker, 1of 1 Maintenance Director, 2 of 2 Activity Directors, 8 of 8 Registered Nurse, 9 of 10 Licensed Practical Nurse, 27 of 27 Certified Nurse Assistants, 9 of 9 housekeeping staff, 11 of 12 Dietary Staff, 1 of 1 Business Office Manager, and 6 of 6 Therapists on protecting all residents from abuse and neglect. This includes all full-time, part-time and as needed staff. No contract or agency staff used. The staff not present will be educated prior to returning to work by the Director of Nursing. No staff will be allowed to work until educated. As of 8/11/2024 no new staff have been hired. A total of 98% of total staff were educated on abuse. 4. As of 8/9/2024 the Administrator will audit each new event to ensure timely reporting to the State Survey Agency with the tool titled New Reportable Audit for Events. The Administrator will bring the New Reportable Audit for Events tool to the morning meeting daily (Monday-Friday) for review beginning on 8/9/2024 and weekend will be reviewed on Monday in morning meeting. The Administrator will continue to complete the New Reportable Audit for Event tool daily through 8/11/2024 with no new negative findings. If the tool identifies that an event was not reported in a timely manner, the staff and Administrator will be reeducated on timely reporting by the Regional Director of Operations immediately. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. 8/8/2024, the Quality Assurance committee reviewed the facility 4 cited immediate jeopardy (IJ) tags. The committee consists of the Administrator, DON, MDS, Dietary Manager, Business Office Manager, Nurse Aide, Rehab Manager, Social Worker, Housekeeper Manager, Maintenance Director, Activity Manager met to review and determine the root cause of F835. The findings were the Administrator failed to ensure that all components of the facility's abuse policy to address allegations of abuse and injuries of unknown origin for R4, 5, 3, and 8 were implemented in a thorough and timely manner. The committee determined the root cause of F835 also includes the facility's failure to timely investigate allegations of abuse and failed to investigate resident to resident sexual abuse. The facility also failed to recognize patterns and behaviors and failed to protect all residents. The administration failed to ensure that all components of the facility abuse policy addressed allegations of abuse of injury of unknown origin for 4 residents. The Quality Assurance Committee reviewed the facility's policies entitled Investigating Injuries revised 2016 and Protection of Residents during Abuse Investigations revised April 2017. No further revisions were made. Review of policy determined the need for 100% staff education for investigation allegations of abuse in a timely manner. The tool will be brought to daily morning meeting (Mon-Friday) and then the weekend days will be reviewed on Monday mornings. 6. Ala corrections actions were completed 8/11/2024. 7. The immediacy of the (IJ) was removed on 8/12/2024. The State Survey Agency (SSA) validated the facility's written IJ Removal Plan as follows: 1. Verified transfer to hospital via review of R8's clinical record. Verified via review of the 8/8/2024 physician's order for R5 and the accompanying monitoring forms. Verified via review of an 8/8/2024 physician's order for R5 for 1:1 monitoring related to sexual behaviors and the accompanying Resident Location Checksheet. R4's room change was verified via review of a communication form, dated 7/26/2024, that documented a room change to a different hall. R4 was observed in the new room on 7/29/2024 at 4:20 pm. Review of R3, R4 and R5's clinical records revealed that the Nurse Practitioner visited and assessed them on 8/8/2024. A review of skin assessment forms revealed that a skin assessment was completed on 60 residents from 8/8/2024-8/9/2024. Validated review of job duties via review of in-service education information and sign-in sheet, dated 8/10/2024 and titled Job Duties which was signed by the Administrator, DON, and Regional Director of Operations. Interviews on 8/19/2024 at 2:35 pm with the DON, 2:45 pm with the Regional Director of Operations, and at 2:55 with the Administrator confirmed that the Administrator and DON's job duties had been reviewed with them and they acknowledged understanding. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Also, verified via review of in-service education information provided by the Regional Director of Operations titled Abuse and Neglect, which was signed by the Administrator, DON, and dated 8/8/2024. During interviews on 8/19/2024 at 2:35 pm with the DON and at 2:55 pm with the Administrator, they confirmed receiving the in-service education information from the Regional Director of Operations. The Administrator also confirmed receiving inservice education from the Chief Operating Officer on 8/8/2024 related to abuse policy and procedures, investigations, and reporting. 3. Verified via review of in-service education sign in sheets labeled with Abuse and Neglect, Recognizing signs and symptoms of abuse, Abuse Coordinator, Reportables must be reported in 2 hours, along with the accompanying education information, dated 8/8/2024 and 8/9/2024. The staff signature sheets included a total of 79 staff were educated. During an interview with the Regional Director of Operations and MDS Coordinator on 8/19/2024 at 12:06 pm, it was clarified that 12 of 12 dietary staff were in-serviced and 5 of 6 therapy staff were in-serviced. They confirmed that one LPN and one therapy staff were out on leave and would be educated upon return to work. Staff interviews conducted on 8/18/2024 at 12:40 pm with LPN DD, at 12:49 pm with housekeeper BBB, at 12:55 pm with RN JJ, on 8/19/24 at 11:30 am with the Housekeeping Manager, at 11:38 am with housekeepers SSS and CCC, at 12:15 pm with the Dietary Manager, at 12:20 pm with the Maintenance Director, at 1:02 pm with activity assistant MM, at 1:14 pm with the Social Services Director and Activity Director/Manager, at 1:32 pm with CNA DD, at 1:35 pm with dietary staff EEE and FFF, at 1:40 pm with the Business Office Manager, and at 2:45 pm with the MDS Coordinator confirmed they had received education that abuse and neglect and what it included, recognizing signs of abuse and neglect, that the Abuse Coordinator is the Administrator and that all allegations of abuse must be reported immediately. 4. During an interview on 8/15/2024 at 4:15 pm the Regional Director of Operations clarified that the QAPI tool titled New Reportable Audit for Events was a form that was already in use. The new tool developed is titled Daily Reportable Log and provided a copy to review. The Regional Director stated that the Administrator brings the tool to the daily morning meetings Monday through Friday. During an interview on 8/19/2024 at 2:55 pm the Administrator confirmed the use of the Daily Reportable Log tool during morning meetings and that new events will be audited to ensure timely reporting and investigation. Verified the tool had been implemented via review of the Daily Reportable Log that included documentation of reviews 8/9/2024-8/15/2024. 5. Verified via review of the 3rd Quarterly Monthly QA/PI Meeting Agenda form, dated 8/8/2024 that documented an ad hoc meeting was held and the Immediate Jeopardy and abuse policies were reviewed. The signatures of the QA committee members were included along with copies of the completed Immediate Jeopardy Templates and copies of the Investigating Injuries policy and Protection of Residents During Abuse Investigations policy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115607	A. Building B. Wing	08/19/2024

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews conducted on 8/19/2024 at 11:30 am with the Housekeeping Supervisor, at 12:15 pm with the Dietary Manager, at 12:20 pm with the Maintenance Director, at 1:14 pm with the Activity Director/Manager and Social Services Director, at 1:40 pm with the Business Office Manager, at 2:35 with the DON, at 2:45 pm with the MDS Coordinator and Regional Director of Operations, and at 2:55 pm confirmed that they held a QA meeting on 8/8/2024, reviewed policies, and reviewed and determined the root cause of F835. During an interview on 8/12/2024 at 1:04 pm the Medical Director confirmed knowledge of the Immediate Jeopardy.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21213 Based on staff interviews, record reviews, and review of the facility's policies titled Charting and Documentation and Telephone Orders, the facility failed to maintain a clinical record in accordance with accepted professional standards and practice by ensuring that licensed nursing staff did not falsify the physician's signature when completing telephone order forms for one Resident (R) (R14), from a total sample of 21 residents. Findings include: The facility had a Charting and Documentation policy, with revision date of July 2017. The Policy Interpretation and Implementation section included that documentation in the medical record may be electronic, manual or a combination. The policy also documented that documentation will be objective, complete, and accurate. The facility had a Telephone Orders policy, with revision date of February 2014. The Policy and Interpretation and Implementation section included the following information: 1) Verbal telephone orders may only be received by licensed personnel and orders must be reduced to writing, by the person receiving the order, and recorded in the resident's medical record. 2) The entry must contain the instructions from the physician, date, time, and the signature and title of the person transcribing the information. 3) Telephone orders must be countersigned by the physician during his or her next visit. R14 was admitted to the facility on [DATE] and had diagnoses that included, but were not limited to, schizophrenia and bipolar disorder. A review of the July 2024 electronic Medication Administration Record (MAR) revealed that R14 received Klonopin (clonazepam) 1 milligram (mg) twice daily from 4/15/2024 through 7/19/2024. Review of progress notes in the electronic portion of R14's clinical record revealed a 7/19/2024 behavior note, by Licensed Practical Nurse (LPN) II, that documented R14 was yelling out in the hallway and the dining room and cursing at the voices in her head. Behavioral health services and the physician were notified. The behavior notes further documented that orders obtained from the behavioral health practitioner included to increase the clonazepam medication to three times daily. Review of the July 2024 MAR revealed that the Klonopin order for 1 mg three times daily was carried out on 7/19/2024. During an interview on 8/8/2024 at 3:56 pm, the behavioral health Nurse Practitioner confirmed that she did recommend the increase in the Klonopin medication for R14 on 7/19/2024. She stated that the physician would order the medication, if he agreed with the recommendation, and sign the prescription. Review of the manual portion of R14's clinical record revealed a Physician's Interim/Telephone Orders form, dated 7/19/2024 that documented the new order of Klonopin 1 mg, one tablet by mouth three times daily for agitation, schizophrenia, and bipolar disorder. The form included the signature of the receiving nurse, LPN II. However, further review of the order form revealed two different signatures in the physician signature section, for the facility's medical director. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the manual portion of R14's clinical record revealed another Physician's Interim/Telephone Orders form, dated 7/15/2024, that documented an order for 60 clonazepam 1 mg tablets, one tablet by mouth twice daily for schizophrenia. The form also included the signature of LPN II as the receiving nurse and a signature in the physician signature section, for the medical director. At the time of the complaint survey, LPN II was not available for interview. During an interview on 8/15/2024 at 11:00 am, the Medical Director reviewed the 7/15/2024 and 7/19/2024 prescriptions. For the 7/19/2024 Klonopin prescription, the Medical Director confirmed that one of the two signatures in the physician signature section was his and one was not. He stated that the signature (of his name) in the physician signature section of the 7/15/2024 prescription was not his signature. The Medical Director stated that no one should be signing his name, and it was concerning. He did confirm he was aware of the change in the Klonopin order on 7/19/2024 and that he received correspondence (via phone) from the nurse on duty and also the behavioral health Nurse Practitioner that day.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 15650 Based on observation, record review, and staff interview, the facility failed to ensure enhanced barrier precautions (EBP) were implemented for two residents (R) (R4 and R7) who had pressure ulcers from a total sample of 21 residents. Findings include: Review of the facility policy titled Enhanced Barrier Precautions, dated August 2022 revealed EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of multi-drug resistant organisms (MDROs) colonization. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include wound care (any skin opening requiring a dressing). Signs are posted on the door or wall outside the resident room indicating the type of precautions and personal protective equipment (PPE) required. PPE is available outside of the resident rooms. 1. During an observation of pressure ulcer treatment for R7 on 7/22/2024 at 3:00 pm, Licensed Practical Nurse BB provided wound care to the resident's pressure ulcer to the left heel without wearing a gown. There was also no PPE available outside of the resident's room. During an interview with the Infection Prevention Nurse on 7/30/2024 at 1:15 pm, she stated that earlier in the year, around April or May 2024 the nurse consultant informed the previous Director of Nursing (DON) of the new EBP requirements. She stated that they currently do not have any residents on EBPs. She stated that either she or the DON would be responsible for setting up EBPs for residents, such as the signage and the PPE. When she was asked why R4 and R7 were not placed on EBPs she stated she and the DON have been pulled in many directions. 21213 2. During an observation of wound care for R4 on 7/29/2024 at 4:20 pm, Registered Nurse (RN) AA provided wound care treatment to the resident's right ankle pressure ulcer and right lateral calf non-pressure ulcer without wearing a gown. There was no PPE available outside of the resident's room. During the interview on 7/30/2024 at 1:15 pm, the Infection Preventionist Nurse stated that R4 would most likely qualify for enhanced barrier precautions since she had wounds to her ankle.