STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115665	A. Building B. Wing	02/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coastal Manor	128 Coastal Manor Drive SE Ludowici, GA 31316

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 39438 Based on interview, record review, and facility policy review, the facility failed to protect the residents' right to be from physical abuse perpetrated by a resident, Resident #2. On 05/28/2024, Resident #2 hit Resident #11 in the head. On 10/09/2024, Resident #2 scratched Resident #4 under their right eye. On 10/16/2024, Resident #2 grabbed Resident #1 by their neck. These deficient practices affected 3 (Residents #1, #4, and #11) of 11 sampled residents. Findings included: A facility policy titled Abuse Prohibition, effective 02/27/2024, revealed, It shall be the policy of [facility name] to actively preserve each resident's right to be free from mistreatment, neglect, abuse or misappropriation of resident property. The policy specified, Abuse - the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish. Per the policy, Physical Abuse - includes hitting, slapping, pinching and kicking. An Admission Record indicated the facility admitted Resident #2 on 05/02/2024. According to the Admission Record, the resident had a medical history that included diagnoses of autistic disorder, moderate intellectual disabilities, developmental disorder of speech and language, violent behavior, and generalized anxiety disorder. The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/07/2024, revealed Resident #2 had a Staff Assessment for Mental Status (SAMS) that indicated the resident had moderately impaired cognitive skills for daily decision making and short and long-term memory problems. The MDS indicated the resident had other behavioral symptoms not directed toward others one to three days during the assessment period. Resident #2's care plan, included a focus area initiated 08/05/2024, that indicated the resident had a history of physical aggressiveness related to autistic disorder, a history of agitation, and moderate intellectual abilities. Interventions directed staff to monitor behavior episodes and attempt to determine the underlying cause. Resident #2's Progress Notes, dated 05/28/2024 at 10:31 AM, revealed as the resident walked past other residents, Resident #2 hit residents in their head on numerous occasions. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/21/2025 at 3:00 PM, Licensed Practical Nurse (LPN) #6 stated Resident #11 was the resident who Resident #2 hit in their head. Per LPN #6, Resident #2 walked around the unit in an agitated state, looked at Resident #11 and hit the resident. During a follow-up interview on 02/21/2025 at 3:30 PM, LPN #6 stated she did not recall if she notified the Director of Nursing (DON) about the incident. An Admission Record indicated the facility admitted Resident #11 on 07/19/2019. According to the Admission Record, the resident had a medical history to include diagnoses of cerebrovascular disease, aphasia, and dementia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/06/2024, revealed Resident #11 had a Brief Interview for Mental Status (BIMS) of 15, which indicated the resident had intact cognition. Resident #2's Progress Notes, revealed the following: - 08/08/2024 at 2:30 PM, the resident hit another resident twice on their right arm. - 08/16/2024 at 5:03 PM, LPN #4 observed the resident pinch another resident. Per the Progress Note, the other resident began to bruise but had no other injuries. - 09/22/2024 at 4:04 PM, the resident had been redirected most of the day. Per the Progress Notes, the resident had been in and out of other residents' room taking and eating their snacks. The Progress Notes indicated the resident showed signs of agitation towards staff, bit themselves, hit another resident, and charged at the staff when staff attempted to remove them from the situation. - 10/09/2024 at 10:37 PM, the resident attacked two other resident without being provoked. Per the Progress Notes, one of the residents had a skin tear under their right eye and the other resident had no injuries. During an interview on 02/20/2025 at 10:07 AM, LPN #4 stated she did not recall the incident that occurred on 08/16/2024. During an interview on 02/21/2025 at 11:03 AM, the DON stated the facility did not interview the staff who wrote the Progress Notes dated 08/08/2024, 08/16/2024, 09/22/2024, or 10/09/2024 to determine who the residents were that Resident #2 hit and/or pinched. During an interview on 02/21/2025 at 11:57 AM, LPN #9 stated Resident #2 had been walking around the unit as they normally did on 10/09/2024. According to LPN #9, no one provoked Resident #2 and after the resident kicked and screamed at the staff, the resident was lowered to floor. LPN #9 stated once Resident #2 got back up and started to walk around, for no reason, she scratched Resident #4 under their right eye. LPN #9 stated she could not remember who the other resident was that Resident #2 attacked. During an interview on 02/22/2025 at 12:52 PM, the DON stated she did remember being notified of the incident that occurred on 08/16/2024. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/22/2025 at 4:52 PM, the DON stated for the incident that occurred on 10/09/2024, Resident #2 had experienced an outburst episode with the staff, then the resident approached and grabbed the face of Resident #4. According to the DON, this incident resulted in two small scratches to Resident #4's face that did not break the skin. The DON stated after the incident Resident #2 was removed from the situation and taken to their room to deescalate. During an interview on 02/22/2025 at 6:08 PM, Certified Nursing Assistant #11 stated she would consider Resident #2 hitting anyone as abuse. An Admission Record indicated the facility admitted Resident #4 on 08/10/2023. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease, dementia, macular degeneration, dry eye syndrome, glaucoma, and cerebrovascular disease. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/10/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) of 3, which indicated the resident had severe cognitive impairment. Resident #2's Progress Note dated 10/16/2024 at 5:30 PM, indicated the resident showed aggressive behavior towards staff and other residents. Per the Progress Notes, as another resident sat by the window at the nurses' station to make a telephone call, Resident #2 came up and grabbed the other resident (Resident #1) by the neck without being provoked. An Admission Record indicated the facility admitted Resident #1 on 02/27/2023. According to the Admission Record, the resident had a medical history that included diagnoses of dementia and unspecified sequelae of cerebral infarction. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/17/2025, revealed Resident #1 had a Staff Assessment for Mental Status (SAMS) that indicated the resident was severely impaired in cognitive skills for daily decision making and short and long-term memory problems. During an interview on 02/19/2025 at 5:04 PM, the DON stated Resident #2 grabbed Resident #1 at their neck with a single palm and left no injuries. Per the DON, Resident #2 was removed from the situation immediately and redirected to their room. During an interview on 02/20/2025 at 10:07 AM, LPN #4 stated Resident #1 was sitting at the nurses' station to call a family member when Resident #2 came out of nowhere and tried to grab the phone from Resident #1, which caused Resident #1 to receive a scratch on their neck. LPN #4 stated after the incident, Resident #2 was taken to their room to calm down. Per LPN #4, a CNA sat with Resident #2 until the resident fell asleep. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/22/2025 at 12:30 PM, the DON stated the process for conducting abuse investigations depended on who reported the incident. The DON stated sometimes she documented the statements made, but it depended if the information was pertinent. According to the DON, she would contact the police for resident-to-resident incidents, if the resident had a high BIMS score. The DON reported that after Resident #2 discharged from the facility, she became aware that some of the incidents perpetrated by the resident had not been reported to her or investigated. The DON stated the facility discussed each of the incidents during their quality assurance meeting but decided since Resident #2 had been discharged and the reporting time frame had passed, it was okay to not report them or investigate. During an interview on 02/22/2025 at 4:52 PM, the DON stated abuse could be physical, verbal, sexual, emotional, mental. The DON stated if someone were punched in the face, pinched, hit, or choked that would be abuse. According to the DON, the incident between Resident #1 and Resident #2 occurred on 10/16/2024 and was not reported to the state within the two-hour reporting timeframe, as this incident was not reported until sometime on 10/17/2024. During an interview on 02/22/2025 at 1:23 PM, the Administrator stated the DON was responsible for completing abuse investigation. Per the Administrator, the facility would only contact the police during resident-to-resident abuse, if there was major physical harm. The Adminstartor stated the facility thought about the investigation and reporting of these incidents, but because Resident #2 had been discharged , it was appropriate just to educate the staff. During an interview on 02/22/2025 at 5:59 PM, LPN #13 stated she would consider the incidents between Resident #2 and the other residents as abuse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 39438 Based on interview, record review, and facility policy review, the facility failed to ensure staff reported allegation of abuse immediately to the Administrator/designee. The facility further failed to ensure the administrative staff reported allegations of abuse to the state survey agency. This deficient practice was observed in 5 of 7 allegations of abuse reviewed. Findings included: A facility policy titled, Abuse Prohibition, effective 02/27/2024, revealed E. Reporting Procedures - Once a complaint or situation is identified involving alleged mistreatment, neglect, or abuse, including injuries of unknown sources and misappropriation of resident property the incident shall be immediately reported to the Nursing Home Administrator. 1. The Director of Nursing (or his/her designee) or Chief Long Term Care Officer a.k.a. [also known as] Nursing Home Administrator (or his/her designee) shall immediately notify the Complaint Investigation Intake and Referral Unit, the legal representative and/or interested family member, and the attending physician of the incident and the pending investigation. The Ombudsman and Police Department shall also be notified if appropriate. The Chief Long Term Care Officer a.k.a. Nursing Home Administrator shall direct the investigation. 2. The initial report of the investigation shall be completed online within 24 hours of the incident to the Complaint Investigation Intake and Referral Unit. An Admission Record indicated the facility admitted Resident #2 on 05/02/2024. According to the Admission Record, the resident had a medical history that included diagnoses of autistic disorder, moderate intellectual disabilities, developmental disorder of speech and language, violent behavior, and generalized anxiety disorder. The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/07/2024, revealed Resident #2 had a Staff Assessment for Mental Status (SAMS) that indicated the resident had moderately impaired cognitive skills for daily decision making and short and long-term memory problems. The MDS indicated the resident had other behavioral symptoms not directed toward others one to three days during the assessment period. Resident #2's care plan, included a focus area initiated 08/05/2024, that indicated the resident had a history of physical aggressiveness related to autistic disorder, a history of agitation, and moderate intellectual abilities. Interventions directed staff to monitor behavior episodes and attempt to determine the underlying cause. Resident #2's Progress Notes, dated 05/28/2024 at 10:31 AM, revealed as the resident walked past other residents, Resident #2 hit residents in their head on numerous occasions. During an interview on 02/21/2025 at 3:00 PM, Licensed Practical Nurse (LPN) #6 stated Resident #11 was the resident who Resident #2 hit in their head. During a follow-up interview on 02/21/2025 at 3:30 PM, LPN #6 stated she did not recall if she notified the Director of Nursing (DON) about the incident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Admission Record indicated the facility admitted Resident #11 on 07/19/2019. According to the Admission Record, the resident had a medical history to include diagnoses of cerebrovascular disease, aphasia, and dementia. A quarterly MDS, with an ARD of 12/06/2024, revealed Resident #11 had a BIMS of 15, which indicated the resident had intact cognition. Review of facility documents revealed no evidence to indicate the allegation of abuse perpetrated by Resident #2 towards Resident #11 was reported to the Administrator/designee or the state survey agency. Resident #2's Progress Notes, revealed the following: - 08/08/2024 at 2:30 PM, the resident hit another resident twice on their right arm. - 08/16/2024 at 5:03 PM, LPN #4 observed the resident pinch another resident. Per the Progress Note, the other resident began to bruise but had no other injuries. - 09/22/2024 at 4:04 PM, the resident had been redirected most of the day. Per the Progress Notes, the resident had been in and out of other residents' room taking and eating their snacks. The Progress Notes indicated the resident showed signs of agitation towards staff, bit themselves, hit another resident, and charged at the staff when staff attempted to remove them from the situation. - 10/09/2024 at 10:37 PM, the resident attacked two other resident without being provoked. Per the Progress Notes, one of the residents had a skin tear under their right eye and the other resident had no injuries. During an interview on 02/21/2025 at 11:57 AM, LPN #9 stated Resident #2 had been walking around the unit as they normally did on 10/09/2024. According to LPN #9, no one provoked Resident #2 and after the resident kicked and screamed at the staff, the resident was lowered to floor. LPN #9 stated once Resident #2 got back up and started to walk around, for no reason, she scratched Resident #4 under their right eye. LPN #9 stated she could not remember who the other resident was that Resident #2 attacked. During an interview on 02/22/2025 at 12:52 PM, the Director of Nursing (DON) stated she did remember being notified of the incident that occurred on 08/16/2024. During an interview on 02/22/2025 at 4:52 PM, the DON stated for the incident that occurred on 10/09/2024, Resident #2 had experienced an outburst episode with the staff, then the resident approached and grabbed the face of Resident #4. According to the DON, this incident resulted in two small scratches to Resident #4's face that did not break the skin. The DON stated after the incident Resident #2 was removed from the situation and taken to their room to deescalate. An Admission Record indicated the facility admitted Resident #4 on 08/10/2023. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease, dementia, macular degeneration, dry eye syndrome, glaucoma, and cerebrovascular disease. A quarterly MDS, with an ARD of 01/10/2025, revealed Resident #4 had a BIMS of 3, which indicated the resident had severe cognitive impairment. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility documents revealed no evidence to indicate the allegation of abuse perpetrated by Resident #2 that were specified in the resident's Progress Notes dated 08/08/2024, 08/16/2024, and 09/22/2024 were reported to the Administrator/designee or the state survey agency. Resident #2's Progress Note dated 10/16/2024 at 5:30 PM, indicated the resident showed aggressive behavior towards staff and other residents. Per the Progress Notes, as another resident sat by the window at the nurses' station to make a telephone call, Resident #2 came up and grabbed the other resident (Resident #1) by the neck without being provoked. An Admission Record indicated the facility admitted Resident #1 on 02/27/2023. According to the Admission Record, the resident had a medical history that included diagnoses of dementia and unspecified sequelae of cerebral infarction. An annual MDS, with an ARD of 01/17/2025, revealed Resident #1 had a Staff Assessment for Mental Status (SAMS) that indicated the resident was severely impaired in cognitive skills for daily decision making and short and long-term memory problems. During an interview on 02/22/2025 at 12:30 PM, the DON stated after Resident #2 discharged from the facility, she became aware that some of the incidents perpetrated by the resident had not been reported to her or investigated. The DON stated the facility discussed each of the incidents during their quality assurance meeting but decided since Resident #2 had been discharged and the reporting time frame had passed, it was okay to not report them or investigate. During an interview on 02/22/2025 at 4:52 PM, the DON stated the incident between Resident #1 and Resident #2 occurred on 10/16/2024 and was not reported to the state within the two-hour reporting timeframe, as this incident was not reported until sometime on 10/17/2024. During an interview on 02/22/2025 at 1:23 PM, the Administrator stated the facility thought about the investigation and reporting of these incidents, but because Resident #2 had been discharged , it was appropriate just to educate the staff.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 39438 Based on interview, record review, and facility policy review, the facility failed to investigate 5 of 7 allegations of abuse perpetrated by a resident, Resident #2. Findings included: A facility policy titled, Abuse Prohibition, effective 02/27/2024, revealed F. Investigation - Once a complaint or situation is identified involving alleged mistreatment, neglect, or abuse, including injuries of unknown sources and misappropriation or resident property, the following investigation and reporting procedures shall be followed: 1. The description of the alleged complaint is written on the investigation form. Any physical evidence and description of emotional state shall be documented. 2. Information gathering - The following information shall be gathered: a. Name of suspect b. Name of the resident c. Specific information about what happened d. Specific information about when it happened - include date and time of occurrence e. Specific information about where it happened f. Specific information about why it happened or any extenuating circumstances that you might have information about. 3. The QAPI [quality assurance performance improvement] Coordinator, Director of Nursing, Social Services Coordinator or Chief of Long Term Care Officer a.k.a. [also known as] Nursing Home Administrator shall conduct interviews of all pertinent parties. Written signed statements shall be gathered from the suspect, person making accusations, resident involved, reliable residents who shall have witnessed the incident, and any other person who shall have some information. An Admission Record indicated the facility admitted Resident #2 on 05/02/2024. According to the Admission Record, the resident had a medical history that included diagnoses of autistic disorder, moderate intellectual disabilities, developmental disorder of speech and language, violent behavior, and generalized anxiety disorder. The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/07/2024, revealed Resident #2 had a Staff Assessment for Mental Status (SAMS) that indicated the resident had moderately impaired cognitive skills for daily decision making and short and long-term memory problems. The MDS indicated the resident had other behavioral symptoms not directed toward others one to three days during the assessment period. Resident #2's care plan, included a focus area initiated 08/05/2024, that indicated the resident had a history of physical aggressiveness related to autistic disorder, a history of agitation, and moderate intellectual abilities. Interventions directed staff to monitor behavior episodes and attempt to determine the underlying cause. Resident #2's Progress Notes, dated 05/28/2024 at 10:31 AM, revealed as the resident walked past other residents, Resident #2 hit residents in their head on numerous occasions. Resident #2's Progress Notes, revealed the following: - 08/08/2024 at 2:30 PM, the resident hit another resident twice on their right arm. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 08/16/2024 at 5:03 PM, Licensed Practical Nurse #4 observed the resident pinch another resident. Per the Progress Note, the other resident began to bruise but had no other injuries. - 09/22/2024 at 4:04 PM, the resident had been redirected most of the day. Per the Progress Notes, the resident had been in and out of other residents' room taking and eating their snacks. The Progress Notes indicated the resident showed signs of agitation towards staff, bit themselves, hit another resident, and charged at the staff when staff attempted to remove them from the situation. - 10/09/2024 at 10:37 PM, the resident attacked two other resident without being provoked. Per the Progress Notes, one of the residents had a skin tear under their right eye and the other resident had no injuries. During an interview on 02/21/2025 at 11:03 AM, the Director of Nursing (DON) stated the facility did not interview the staff who wrote the Progress Notes dated 08/08/2024, 08/16/2024, 09/22/2024, or 10/09/2024 to determine who the residents were that Resident #2 hit and/or pinched. During an interview on 02/22/2025 at 4:52 PM, the DON stated for the incident that occurred on 10/09/2024, Resident #2 had experienced an outburst episode with the staff, then the resident approached and grabbed the face of Resident #4. According to the DON, this incident resulted in two small scratches to Resident #4's face that did not break the skin. The DON stated after the incident Resident #2 was removed from the situation and taken to their room to deescalate. During an interview on 02/22/2025 at 12:30 PM, the DON stated the process for conducting abuse investigations depended on who reported the incident. The DON stated sometimes she documented the statements made, but it depended if the information was pertinent. According to the DON, she would contact the police for resident-to-resident incidents, if the resident had a high BIMS score. The DON reported that after Resident #2 discharged from the facility, she became aware that some of the incidents perpetrated by the resident had not been reported to her or investigated. The DON stated the facility discussed each of the incidents during their quality assurance meeting but decided since Resident #2 had been discharged and the reporting time frame had passed, it was okay to not report them or investigate. During an interview on 02/22/2025 at 1:23 PM, the Administrator stated the DON was responsible for completing abuse investigation. Per the Administrator, the facility would only contact the police during resident-to-resident abuse, if there was major physical harm. The Adminstartor stated the facility thought about the investigation and reporting of these incidents, but because Resident #2 had been discharged , it was appropriate just to educate the staff. Review of facility documents revealed no evidence to indicate the allegation of abuse perpetrated by Resident #2 listed above were investigated by the facility.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39438 Based on interview, record review, and facility policy review, the facility failed to ensure a preadmission screening and resident review (PASARR) screening was completed on or before admission or after the resident remained in the facility past 30 days for 1 (Resident #2) of 11 sampled residents. Findings included: A facility policy titled, Admissions (LTC), with an original date of 10/29/2001 and an effective date of 04/23/2024, indicated I. Introduction: The Admissions policy applies to residents admitted to the department of Long Term Care without regard to race, color, creed, national origin, age, sex, religion, handicap, ancestry, marital or veteran status, and/or payment source. The policy specified, H. Documentation for Medical Record: included f. PASARR Level I Evaluation. An Admission Record indicated the facility admitted Resident #2 on 05/02/2024. According to the Admission Record, the resident had a medical history that included diagnoses of autistic disorder, moderate intellectual disabilities, developmental disorder of speech and language, violent behavior, restlessness and agitation, and generalized anxiety disorder. The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/07/2024, revealed Resident #2 had a Staff Assessment for Mental Status (SAMS) that indicated the resident had moderately impaired cognitive skills for daily decision making and short and long-term memory problems. The MDS indicated the resident had other behavioral symptoms not directed toward others one to three days during the assessment period. Resident #2's care plan, included a focus area initiated 08/05/2024, that indicated the resident had a history of physical aggressiveness related to autistic disorder, a history of agitation, and moderate intellectual abilities. Interventions directed staff to monitor behavior episodes and attempt to determine the underlying cause. Resident #2's medical record revealed no evidence to indicate a PASARR screening was conducted on or before the resident admitted to the facility on [DATE] or after the resident remained in the facility after 30 days. A document dated 08/23/2024, titled Treatment Service: [PASARR] Level II, indicated Resident #2 was not appropriate for skilled nursing facility level of care and should be considered for alternative community setting and the resident had an intellectual disability (ID)/developmental disability (DD) and needed specialized services for ID/DD in a community setting. During an interview on 02/22/2025 at 9:57 AM, the Administrator stated a PASARR screening was not done when Resident #2 admitted to the facility. During an interview on 02/22/2025 at 10:13 AM, the Director of Nursing (DON) stated a PASARR was not done because the resident admitted to the facility under respite care. Per the DON, when the facility reached out to state agencies to get a PASARR done, the facility was told the nursing facility was not an appropriate environment for the resident and denied the completion of a PASARR screening. According to the DON, it was expected to always get a PASARR screening for all residents prior to admission to the facility.