STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115721	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Senior Care Center - Brunswick	2611 Wildwood Drive Brunswick, GA 31520

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on observations, staff interviews, record review, and a review of the facility policy titled Self-Administration Program, the facility failed to ensure that one of 34 residents (R115) did not have unsecured unauthorized medications stored at the bedside in the facility's secure Memory Care Unit. This deficient practice had the potential to allow unauthorized access to medications to other residents and visitors in the facility. Finding include: Review of the facility policy titled, Self-Administration, last reviewed dated 6/2/2023, stated . The right to self-administer his/her own medication is explained to the patient by the nurse on admission. Procedure: (A). A request to self -medicate is documented on the Signature Acknowledgement form. (B). The attending physician, in conjunction with the Interdisciplinary Team determines if it is safe for the patient to self-administer drugs prior to the commencement of a self -medication program. (C). The Interdisciplinary Team determines if it is safe for the patient to self -administer medication by assessing the patient's cognitive, physical and visual ability to carry out this responsibility. The result of the team's assessment is documented using a self-medication assessment form or in the progress note. (D). A physician order is written for the patient to self-administer/her medication. (E). If a patient is approved for the self-medication program, the team decides and notes. 1. Where the medication will be stored. 2. Who is responsible for storage 3. How to secure and safeguard the medication 4. Method of documentation 5. Determination of success of medication delivery. (F). The decision to self -medicate will be noted in the M.A.R. (G). The Director of Nursing or designee supervises implementation and continued progress of all self-medication. (H). The need to self-medicate is care planned. Progress /results are reviewed at the Interdisciplinary Team meeting. Record review of R115's clinical record revealed the following diagnoses but not limited to dementia unspecified severity and anxiety. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status Score (BIMS) of nine indicating moderate cognitive impairment. R115 was also assessed for wandering behaviors. Observation on 5/28/2024 at 7:25 pm in R115' s room revealed a prescription bottle of medication labeled Nyamyc (an antifungal powder) sitting on the sink counter in R115 's bathroom within visual view. A closer observation of the medication label revealed that the prescription medication belonged to another resident on the Memory Care Unit (MCU). (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was conducted on 5/28/2024 at 7:25 pm with Licensed Practical Nurse (LPN) LLL who confirmed that there were no residents in the MCU who had been assessed to self-administer medications. LPN LLL confirmed that the medication belonged to another resident and the medication should not have been in the R115's room. She could not provide an explanation for the medication being in the resident room. LPN LLL reported that she had been in the room earlier but had not entered the bathroom. She then removed the medication from the bathroom. Interview on 5/31/2024 at 11:46 am, with Director of Nursing (DON) FFF who reported that nurses should conduct rounds of the residents' rooms to monitor for medications. During an interview with Administrator DDD on 5/31/2024 at 1:55 pm, it was reported that per her knowledge, the facility does not have any residents who have been assessed to self -administer medications. She reported that the MCU nurses and all nurses should monitor residents' rooms for medications. Administrator DDD acknowledged that the medications should not have been left out.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - 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** 36377 Based on observations, staff interviews, record review, and a review of the facility policy titled Abuse Prohibition, the facility failed to protect the resident's right to be free from sexual abuse by a resident and physical and verbal abuse by staff. Specifically, R84 was sexually abused by R41, and R14 was physically and verbally abused by a Certified Nursing Assistant (CNA) AA. There were five residents reviewed for abuse. On 5/28/2024, 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. Facility Administrator DDD and Director of Nursing (DON) FFF, were informed of the Immediate Jeopardy (IJ) on 5/28/2024 at 1:45 pm. The noncompliance related to the Immediate Jeopardy was identified to have existed on 3/21/2023. At the time of exit on 5/31/2024, an acceptable Immediate Jeopardy Removal Plan had not been received therefore the Immediate Jeopardy remained ongoing. Findings include: Record review of facility policy titled Abuse Prohibition (last reviewed 6/16/2022) revealed It is the policy .the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this policy. Allegations of abuse means a report complainant, grievance incident or other facts that reasonable person would understand mean that abuse (as defined in this policy is occurring, has occurred or might realistically have occurred. Immediately means as soon as possibility, but not later than 2 hours after the allegation is made, if the events that causes the allegation involve abuse or result in serious bodily injury, or not later 24 hours if the event that cause the allegation do not involve abuse and do not result in serious bodily injury. Procedure Guidelines A. Upon identification of alleged abuse, the employee will take measures to ensure resident safety and then report the alleged incident to the Abuse Coordinator or designee immediately. Investigation A. 5. Observation of the physical environment pertinent to the allegation, and interaction between the resident and other residents and/or staff. 1.Record review of R84's Electronic Medical Record (EMR) record revealed the following diagnoses but not limited to unspecified dementia, unspecified severe, unspecified psychosis, hypertensive heart disease, and acute chronic-combined systolic. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed for Section C (Cognitive Pattern) a Brief Interview Score (BIMS) of 4, which indicated severe cognitive impairment, Section GG (Functional Abilities and Goals) required supervision and set up with most Activities of Daily Living (ADL) skills and was ambulatory with supervision/safety requirements. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of R84's nurse note dated 3/22/2023 at 1:16 am revealed that R84 was in bed while his roommate was rubbing his genitals, legs, and feet. The notes revealed staff intervened and the nursing supervisor was notified. R84 was moved to another room for safety. The incident was verified to have occurred on 3/21/2023 at 11:00 pm from the facility Investigation final report dated 3/24/2023. Record review of R84's Nurses Note dated 3/23/2023 at 5:27 am documented change in mental status, describing R84 as seeming more confused, depressed, and jumpy. Record review of nurses' note dated 3/24/2023 at 6:29 pm revealed that R84 was redirected several times during the day as to where his room is located. R84 talked about the situation concerning the incident that occurred on 3/21/2023. The resident stated that a man in his past attempted to do the same thing, Monkey Ball him, and he did have protection on him then. Staff reassured R84 that he was safe and okay. A record review of the census dated 3/22/2023 documented that R84 was moved to a different room away from R41's room. R84 's room is directly across from the nurse station. Review of R41's care plan initiated 3/16/2022 indicated a problem related to resident exhibiting inappropriate sexual behaviors and having a history of touching other residents in a sexual manner with/without consent. A review of the Nurses Progress Note dated 3/22/2023 at 1:10 am for R41 in the electronic medical record (EMR) revealed upon making rounds, R41 was observed sitting on the roommate's bed (R84) rubbing his genitals as well as his legs and feet. Staff heard R41 ask R84, Does that feel okay? Record review of R41's EMR record revealed the following diagnoses but not limited to Alzheimer's, dementia with severe behavioral disturbances, and anxiety disorders. The Annual MDS assessment dated [DATE] R41 revealed for Section C (Cognitive Pattern) a Brief Interview Score (BIMS) of 6, a score of 6 out of 15 indicated cognitive impairment. Section D (Mood) resident had no mood behavior, Section E (Behavior) resident had no behaviors, Sect GG (Functional Abilities and Goals) required set up and partial assistance with set up with most Activities of Daily Living (ADL) skills and was ambulatory with supervision/safety requirements. Interview on 5/23/2024 at 3:10 pm with Licensed Practical Nurse (LPN) DD reported that she was unable to recall the names of the Certified Nursing Assistant (CNA) that night and the actual time of the incident involving R84 and R41. She could not recall if she wrote a written statement. LPN DD stated that if she had written a statement, then she would have dated the form and signed her name. She recalled two incidents of sexually inappropriate behaviors of R41 with other residents prior to the incident with R84. She reported that she separated both residents. R84 was taken to another hall that night. (Record review revealed that R84 remained on the hall but in a different room). She noticed that R84 and R41 were on the bed. She did not document a skin check assessment on the sheet, but she did check the residents 's vitals. She doesn't recall seeing anything wrong with the resident or changes in condition with R84 before he left the hall. Both residents seem okay, just kind of caught off guard that they were caught. She recalls speaking only with the RN Supervisor that was on duty night but cannot remember the name. The Administrator and DON, at that time, did not ask her any questions that she recalled. She was not instructed to assess all the residents in the hall. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R41 was seen by the Nurse Practitioner (NP) QQQ the next day. NP QQQ note dated 3/22/2023 revealed LTC male seen secondary to behavior rubbing roommate genitals, legs, feet, and making sexual statements x1 on 7 pm-7 am shift. Nursing staff redirected resident. Family decided to make room private. Today no reports of behaviors. The resident doesn't recall events of last night due to dementia. An interview on NP QQQ on 5/31/2024 at 2:20 pm confirmed that on 3/22/2023, according to her progress note, her recommendation was for the R41 to be placed in a private room and referred for psych services. Interview with Social Services (SS) WW on 5/23/2024 at 12:38 stated that she doesn't remember a lot about the incident between R84 and R41 and that both residents had advanced dementia. SS WW reported that she visits her memory care unit at least once a day. SS WW further revealed that if there are any behavior concerns or reports of sexual abuse in the unit, staff will address it with the nurse and then report it to Social Services. A report is filed for all abuse/ sexual abuse incidents. She reported that a floor monitor has been placed on the unit to ensure the safety of the residents. R41 and R84 have been assigned to private rooms. SS WW feels that the sexual abuse risk has been reduced by evidence of R84 and R41 having private rooms, and a monitor is now in the hall. It was further reported that their MD was aware of the incident. SS WW then reported that the residents were referred to receive psychiatric services, but she's not sure who made that referral. Interview on 5/23/2024 at 11:35 am with Psychiatric NP reported that he is the only Psychiatric NP on duty and that he does evaluations, medication adjustments, and assessments. He initially reported that R41 was not a patient; however, he recalled after reviewing his note and verifying that R41 was a patient of his a few years ago. R41 was last seen in 2022. The Psychiatric NP reported being unaware of R41's last incident of sexually aggressive behavior towards R84. Psychiatric NP reported that if he was called about residents with inappropriate sexual behaviors, he would have prescribed a medication to decrease the libido. He reported that R84 was not referred for services. He has seen other residents in the facility. He reported any resident who is admitted with psychotropic meds needs to be evaluated. The Psychiatric NP stated that he visits the facility once a month and, if needed, will do a virtual visit. Interview on 5/28/24 at 7:33 pm with CNA AAA, who reported that she has been employed at the MCU since August 2023. She was aware of incidents of abuse for residents R84 and R41. She reported that she was unaware of monitoring sexual abuse for any residents on the unit. She has received training on abuse and has not been assigned or given specific instructions to monitor R84 or R41. She has been working in the MCU with both residents and has not observed any behaviors of sexual abuse or any type of abuse. If she observed, then she will report to the supervisor. Interview on 5/28/24 at 7:45 pm with Patient Companion GGG, she reported that her job as a patient companion is to watch the residents in the MCU and give them snacks and water, and sit close to one particular resident who may fall. She stated that she is not a CNA and is not really required to go into the resident's room unless to give snacks. She stated that the nurse and CNA provide patient care. She was never told to watch out for sexual abuse from any residents. She was unaware of incidents of sexual abuse occurring between residents. She did receive training on abuse during her orientation. She has been working only for a month and a half. She works 12 hours shift. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 5/31/2024 at 12:31 pm with Administrator DDD reported that once the incident had been discovered between R41 and R84, the physician and psychiatric services should have been contacted for an evaluation. She stated that education would be provided to teach the staff how to redirect and, if appropriate, allow him privacy to satisfy his sexual tendencies with himself (masturbating). Administrator DDD further revealed the family should have been notified, possibly medication adjustment, and witness/resident statements. She stated that law enforcement would also be notified. 49138 2. Record review revealed that R14 had a diagnosis that included but was not limited to dementia, alert with confusion. A review of the facility documents revealed the following: Incident: R14 was lying in a bed in the early morning hours of June 8, 2023. CNA AA walked into the room and attempted to get the resident out of a bed that was not his own bed. The resident was alone in bed. CNA AA hit the resident on the arm three times in an attempt to get his attention. It was witnessed by two staff. The staff in the room stated that CNA AA was rough when attempting to get R14 attention to get out of bed. After CNA, AA removed R14 from the bed and stated, Get your ass out of this room, while walking out of the room with the resident. R14 was unaware of the statement and did not respond to her/him. The investigation was unsubstantiated, and CNA AA was given a written reprimand and final warning. Documents revealed staff and residents have described CNA AA to be verbally abusive. Interview on 5/23/2024 at 11:51am with NP XX revealed that residents should have an evaluation even if non-verbal. NP XX reported that he was not informed of any abuse towards R14. During an interview on 5/23/2024 at 2:28 pm with the former DON BBB confirmed the alleged verbal and physical abuse from CNA AA to R14 occurred on 6/7/2023. DON BBB stated that the incident was reported to local law enforcement and to the State Agency (SA) on 6/8/2023. DON BBB stated that she made the report once she was notified of the incident. Interview on 5/29/2024 at 9:35 am with RN Supervisor LL confirmed that she had written a statement regarding the concerns of CNA AA snatching the covers off R14 and returning to assist the resident. The RN Supervisor LL stated that she tried to discuss the issue with CNA AA, but she was uncooperative. RN Supervisor LL revealed that this occurred on the night shift. RN Supervisor LL expressed that once abuse is found, it should be reported to the DON, called law enforcement, and then called the family. Telephone contact with CNA AA was attempted but unsuccessful due to the phone number being disconnected. Interview on 5/29/2024 at 12:02 pm with Social Services (SS) WW revealed R14 could ambulate and move around and was not considered a target for abuse. SS WW further reported that CNA AA is no longer employed at the facility.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49138 Based on interview, record review, and review of the facility policy titled Abuse Prohibition, the facility failed to ensure that allegations of abuse were reported to the State Agency (SA) in a timely manner for one resident (R14) from a total sample of five residents. Findings include: A review of the facility's Policy titled Abuse Prohibition, last reviewed 6/16/2022. Procedure Guidelines: D. The Abuse Coordinator (AC) or designee with notify the State Survey Agency (Department of Community Health (DCH),Healthcare Facility Regulations Division(HFRD), immediately , but not longer than two hours after the allegation is made ,if the events that cause the allegation involved abuse or result in serious bodily injury, or not later than 24 hours if the event that cause the allegations do not involve abuse and do not result in serious bodily injury. Review of the Facility Incident Form submitted to the State Agency (SA)was dated 6/13/2023 and indicated staff to resident abuse. The details of the abuse indicated that Certified Nursing Assistant (CNA) AA was physically abusive to a resident. The alleged incident was reported to take place on 6/7/2023. Review of the final report that was submitted to the SA indicated that two CNA students observed CNA AA hit R14 on the arm and was rough when trying to get the resident's attention to get him out of another resident's bed. CNA AA was also heard using profanity as she walked R14 out of the room. During an interview on 5/23/2024 at 2:28 pm with the former Director of Nursing (DON) BBB, she confirmed the alleged verbal and physical abuse from CNA AA to R14 occurred on 6/7/2023. She went on to explain that the incident was reported to local law enforcement and to the SA on 6/8/2023. DON BBB stated that she made the report once she was notified. It is noted that there is no evidence to support that the SA was notified of the alleged verbal and physical abuse before 6/13/2023. Interview on 5/31/2024 at 8:50 am with Administrator DDD, who confirmed that the incident between CNA AA and R14 occurred on 6/7/2023 and was reported late.

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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. 45813 Based on interviews, record review, and review of the facility's policy titled, Abuse Prohibition, the facility failed to complete a thorough investigation for two of five sampled Residents (R) (R84 and R41) reviewed for abuse. Specifically, there was no evidence the facility interviewed R84 the victim, other staff, or residents regarding the allegations of potential sexual abuse as a part of the facility's investigations. On 5/28/2024, 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. Facility Administrator DDD and Director of Nursing (DON) FFF, were informed of the Immediate Jeopardy (IJ) on 5/28/2024 at 1:45 pm. The noncompliance related to the Immediate Jeopardy was identified to have existed on 3/21/2023. At the time of exit on 5/31/2024, an acceptable Immediate Jeopardy Removal Plan had not been received therefore the Immediate Jeopardy remained ongoing. Findings include: Record review of facility policy titled Abuse Prohibition (last reviewed 6/16/2022) revealed It is the policy .the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this policy. Allegations of abuse means a report complainant, grievance incident or other facts that reasonable person would understand mean that abuse (as defined in this policy is occurring, has occurred or might realistically have occurred. Immediately means as soon as possibility, but not later than 2 hours after the allegation is made, if the events that causes the allegation involve abuse or result in serious bodily injury, or not later 24 hours if the event that cause the allegation do not involve abuse and do not result in serious bodily injury. Procedure Guidelines A. Upon identification of alleged abuse, the employee will take measures to ensure resident safety and then report the alleged incident to the Abuse Coordinator or designee immediately. Investigation A. 5. Observation of the physical environment pertinent to the allegation, and interaction between the resident and other residents and/or staff. 1. A review of an undated document provided by the facility titled, Face Sheet indicated R84 was admitted with a diagnosis of dementia with behavior disturbances, psychosis not due to a substance or known physiological condition, and major depressive disorder Review of Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/8/2024, indicated R84 had a Brief Interview for Mental Status (BIMS) score of three out of 15 indicating severely impaired cognition. The assessment indicated the resident transferred independently with use of a walker. Further review revealed R84 had no impairments of bilateral upper and lower extremities. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Review of an undated document provided by the facility titled, Face Sheet indicated R41 was admitted with a diagnosis of Alzheimer's disease with late onset, dementia with behavioral disturbances, altered mental status, major depressive disorder with severe psych symptom, mood disorder due to known physiological condition, other impulse disorders, restlessness and agitation onset, and anxiety disorder. Review of Annual MDS assessment with ARD of 2/16/2023, indicated R41 had a Brief Interview for Mental Status (BIMS) score of six of 15 indicating severe cognitive impairment. Section E indicated R41 did not display any behaviors. Resident required assistance from staff with Activities of Daily Living (ADLs). This assessment was completed prior to the incident which occurred 3/21/2023. Review of R41's care plan initiated 3/16/2022 indicated a problem related to resident exhibiting inappropriate sexual behaviors and having a history of touching other residents in a sexual manner with/without consent. Approaches: included: Set limits and discuss appropriate vs inappropriate behaviors, if resident tries to touch in appropriate, place your hands over his and gently but firmly push it away; intervene and redirect resident when any inappropriate behavior is observed, intervene while helping him maintain a sense of dignity, in a potentially embarrassing situation, and referral for Behavior Health as indicated. Review of R41's physician orders revealed an order to monitor for inappropriate sexual behavior. Review of Nurses Progress Note dated 3/22/2023 at 1:10 am in the electronic medical record (EMR) revealed upon making rounds, R41 was observed sitting on roommate's bed (R84) rubbing his genitals as well as his legs and feet. Staff heard R41 ask R84, does that feel okay? Nurse supervisor was called to the unit made aware and observed the situation. As staff began to intervene and ask R41 questions, he denied the actions and stated, I don't know. R41 was observed making his way over to his own bed to lie down. R84 was moved to another room for safety. R84 had no visible injuries or bruises noted. Protocol followed. Review of a file provided by the facility (referred to as the facility's investigation of a 3/21/2023 incident). There were only two sheets of paper in the file for the alleged abuse investigation. One of the papers was on facility letterhead, dated 3/24/2023, and addressed to the State Agency. The second paper was an undated, unsigned handwritten statement. There was no evidence the facility interviewed other staff regarding the incident of potential sexual abuse. In addition, there was no evidence R84 (the victim), or other residents residing on the unit were interviewed as part of the facility's investigation. There was no evidence a documented assessment was completed for R84 or R41 at the time of the incident, the physician and local police were notified at the time of the alleged incident, residents involved in incident were referred for psychiatric evaluation, the facility obtained written statements from witnesses pertaining to the incident, or other residents on the unit were interviewed to see if that had been affected by the same type of abuse. The record indicated R41 was moved to another room on the unit, even though R41 ambulated independently. There was no evidence the facility interviewed other staff regarding the allegations of potential sexual abuse. In addition, there was no evidence R84, the victim, or other residents residing on the unit were interviewed as part of the facility's investigation. (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 R84's and R41's electronic and paper clinical records revealed there were no staff witness statements documented for the incident dated 3/21/2023. Interview 5/21/2024 at 1:10 pm with Administrator DDD revealed she had only worked at the facility for 2 weeks. She further stated that she brought in all the Facility Reportable Incidents and investigations that she was able to locate in the office. She further stated she was learning that things were everywhere, and it was hard to locate any files from previous Administrator CCC. Adminstarator DDD looked at the red folder and verified there were only 2 sheets of paper in the folder pertaining to the allegation of sexual abuse. Administrator DDD responded That's what it is, that's all I got. Interview 5/23/2024 at 3:10 pm with Licensed Practical Nurse (LPN) DD revealed she was the nurse working when the incident occurred. She further stated she was not able to recall the names of the Certified Nursing Assistants (CNAs) working with her the night the incident occurred, the actual time of the incident, or if she wrote a statement detailing the incident. LPN DD stated that if she had written a statement, it would have been dated and signed. LPN DD further stated she recalled the incident with R41 and R84 and she separated the two residents. She further stated she did not document a skin assessment or any other type of assessment for the two residents. She also stated both residents seemed okay, just kind of caught off guard due to being caught in a sexual act. LPN DD stated she reported the incident to the Nurse Supervisor and DON EEE or Administrator CCC did not ask her any questions related to the incident. LPN DD further stated she was not asked to interview or assess any other residents on the unit. Interview on 5/24/2024 at1:38 pm with Social Services (SS) WW who reported she was never informed to monitor R41and R84 for any negative effects from abuse related to any mental status changes depression or behavior problems. She stated that her position was always limited when it came to investigating and following up on abuse allegations. SS WW further stated the former Administrator CCC never informed her to become involved in the abuse incident between the two residents. SSW WW stated she took directives from Administrator CCC. A follow-up interview on 5/28/2024 at 11:12 am with Administrator DDD revealed she was not able to locate any other documents pertaining to the resident-to-resident sexual incident between R41 and R84 which occurred 3/21/2023. Interview on 5/28/2024 at 2:41 pm with the Director of Nursing (DON) FFF reported that she started the position in April 2024 and prior to that she was a contract RN Supervisor at the facility. DON FFF further stated she was not made aware of the incident with R41 and R84 until it was brought to her attention during this survey. She confirmed that she had completed her search and there were no additional documents pertaining to the incident found in the facility. A follow-up interview on 5/28/2024 at 3:14 pm with DON FFF verified the one handwritten statement in the investigation file did not contain a date or signature of who provided the statement. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Final interview on 5/31/2024 at 12:31 PM with Administrator DDD revealed she could not locate any evidence the previous Administrator completed a thorough investigation after receiving knowledge of the allegation of abuse with R41 and R84. She further states she could not speak on behalf of him, but the investigation should have consisted of the physician and psychiatric service provider being contacted to evaluate and possible adjust medications for the residents involved, police notified, written statements from all staff members who had knowledge of the incident, each residents care plans should have been updated and the staff should have received education related to the incident. Administrator DDD stated due to the lack of evidence, she believed proper channels of investigating the incident were not followed.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on staff interviews, record review, and the facility policy titled Nursing Care Plan, the facility failed to develop a care plan for two residents, R84 for sexual abuse from another resident and R14 for verbal and physical abuse by staff. In addition, the facility failed to ensure a care plan was created for elopement and safety concerns for R115. There were 52 residents sampled. This deficient practice had the potential to have an adverse effect for the residents. On 5/28/2024, 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. Facility Administrator DDD and Director of Nursing (DON) FFF, were informed of the Immediate Jeopardy (IJ) on 5/28/2024 at 1:45 pm. The noncompliance related to the Immediate Jeopardy was identified to have existed on 3/21/2023. At the time of exit on 5/31/2024, an acceptable Immediate Jeopardy Removal Plan had not been received therefore the Immediate Jeopardy remained ongoing. Findings include: Record review of the facility policy titled Nursing Care Planning review dated 9/6/2023 stated It is the policy of facility that a framework for Nursing Care Plans for those patients in inpatient hospital settings in order to ensure the highest quality patient care, from admission to discharge. Nursing Care Plans are based on nursing diagnoses derived from detailed assessment findings and encompass the nursing process, including assessment, diagnosis, planning, implementation, and evaluation. Procedure: (1) Initiation (a). A Nursing Care Plan is to be started for each patient within 24 hours of admission and is initiated by a Register Nurse. (2). Components of Care Plans (a). The Nursing care Plan is comprised of three main components: i. Goals or Expected Outcomes: List the behaviors or results to be achieved within a specified timeframe. ii. Nursing Actions or Interventions: List appropriate actions necessary to meet the established goals. iii. Evaluations of Established Goals: Documentation of the progress made towards the set goals. (4). Updating and Revision. (a). The care plan is updated and revised throughout the patient's stay, based on their response to the nursing intervention. 1.Record review of R84's Electronic Medical Record (EMR) revealed that resident had the following diagnoses but not limited to unspecified dementia unspecified severe and unspecified psychosis. The Minimum Data Set (MDS) revealed that R84 had a Brief Mental Status Score (BIMS) of 3 (which indicated severe cognitive impairment). (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Facility Self Reportable documented submitted to the State Agency (SA) documented that on 3/21/2023 at 11:00 pm, R84 was sexually abused by R41. Record review of R84's progress note dated 3/22/2023 provided detailed evidence of the abuse incidents describing inappropriate touching of the resident arms, legs, and genital areas. The nurse note dated described the traumatic experience that led to nurse describing the resident as becoming more confused, depressed, and reliving a past similar sexual life experience that he referred to as someone in the past monkey balling him. There was no care plan or interventions in place to address the abuse of R84 by R41. Interview with the Social Services (SS) WW on 5/24/2024 at 1:38 pm, who reported that she was never informed to develop a care plan for abuse. She was also never informed to follow up with the nursing staff and monitor residents for any negative effects from abuse relating to any mental status changes depression or behavior problems. 2. Record review revealed that R14 was admitted to the facility on [DATE]. R14 had diagnosis that included but was not limited to dementia, neoplasm, prostate, kidney failure. alert with confusion. Record review revealed alleged verbal and physical abuse towards R14 from Certified Nursing Assistant (CNA) AA on 6/7/2023 as evidenced by CNA AA using profanity and hitting R14 on the arm when trying to get him out of another resident's bed. There was no evidence that an abuse care plan had been created for R14. Interview on 5/29/2024 at 12:02 pm with SS WW who revealed R14 could ambulate and move around and was not considered a target for abuse. Therefore, abuse was not added to his care plan. 3. Record review of R115 's EMR revealed that resident has the following diagnoses but not limited to dementia severe and anxiety disorder. The Quarterly MDS assessment dated [DATE] (BIMS 10 and Quarterly MDS 4/19/2024 (BIMS score of 9) assessed both resident for moderate cognitive impairment and disorganized thinking. Both MDS assessment assessed resident for Section E (Behavior) for psychoses with delusion and wandering behaviors occurring at least 1 to 3 days. Record review revealed the resident was placed on Memory Care secure unit to prevent further elopement from the building. Record review of a Facility Self Reportable dated 2/3/2024 documented an elopement from the facility that occurred on 2/2/2024 at 6:16 pm. Record review of R115's Elopement Risk Assessment for dates of 12/4/2023, 1/10/2024, and 2/2/2024, and revealed that resident was assessed for Moderate Risk for wandering/elopement behavior. Record review of the resident care plan revealed no care plan for elopement to address safety precautions to prevent future elopement. Interview with Register Nurse (RN) Supervisor LL on 5/30/2024 at 2:10 pm, who reported that resident was found by her, outside the facility. The resident was observed standing outside the exit door. The physician had just left the resident's room, and the resident left the room. She reported that the resident did not leave the grounds of the facility. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Administrator DDD on 5/31/2024 at 1:55 pm, who reported being unaware that care plans were not created for R84 and R115. She reported that a care plan for a resident who was abused should have been created. The social worker or any nursing staff would have been the designated staff to put the abuse care plan into the system. She reported being unaware that the R115 's care plan was not created for elopement. She reported that her expectation that an elopement care plan should be done for residents who are at risk for elopement.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on record reviews, staff interviews, and the facility polices titled Discharge Planning Policy and Nursing Care Planning, the facility failed to develop a discharge plan of care for seven residents (R78, R81, R84, R98, R115, R104, and R454) 52 sampled residents. Findings include: Record review of the facility policy titled Discharge Planning Policy (undated), the policy stated .The facility discharge and the patient 's transition from the acute care setting, initial discharge planning is completed by a Resource Management case manager assigned to the patient at the time of admission. Procedure: To the extent possible throughout the inpatient stay, discharge planning actively includes the patient and/or the patient's representative as not only a source of information required for the assessment of self-care, but also to incorporate the patient's goals and preferences. Record review of the facility policy titled Nursing Care Planning (last reviewed 9/6/2023) stated .Nursing Care Plans are based on nursing diagnoses derived from detailed assessment findings and encompass the nursing process including assessment, diagnosis, planning, implementation, and evaluation. A Nursing Care Plan is to be started for each patient within 24 hours of admission and is initiated by a Register Nurse. 1.Record review of R78's Electronic Medical Record (EMR) revealed that resident was admitted to the facility on [DATE] with the following diagnoses but not limited to cerebral palsy unspecified and functional quadriplegia. However, a further review of the records revealed no actual discharge plan or discharge care plan documented for R78. Review of Minimum Data Set (MDS) Admission assessment dated [DATE] and Quarterly assessment dated [DATE], Section Q, Participation in Assessment and Goal Setting, revealed R78 had participated in discharge planning and expected to remain in this facility. Interview on 5/20/2024 at 12:33 pm, with R78's legal Guardian documented that R78's immediate family had passed away years ago and decision was for resident to remain the facility. 2.Record review of R81's EMR revealed that the resident was admitted to the facility on [DATE] with the following diagnoses but not limited to dementia with severe psych moods, psychoses, and cerebral infarction due to embolism of cerebral artery. However, a further review of the records revealed no actual discharge plan or discharge care plan documented for R81. Review of MDS Admission assessment dated [DATE] and Quarterly assessment dated [DATE], Section Q, Participation in Assessment and Goal Setting, revealed R81 had participated in discharge planning and expected to remain in this facility. 3.Record review of R84's EMR revealed that the resident was admitted to the facility on [DATE] with the following diagnoses but not limited to dementia severe, acute chronic disorder-combined systolic, hypertensive heart disease, and major depressive disorder. However, a further review of the records revealed no actual discharge plan or discharge care plan documented for R84. Review of MDS Admission assessment dated [DATE] and Quarterly assessment dated [DATE], Section Q, Participation in Assessment and Goal Setting, revealed R84 had participated in discharge planning and expected to remain in this facility. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4.Record review of R98's EMR revealed that the resident was admitted to the facility on [DATE] with the following diagnoses but not limited to respiratory failure with hypercapnia, acute chronic respiratory failure with hypoxia, unspecified diastolic heart failure and bipolar disorder. However, a further review of the records revealed no actual discharge plan or discharge care plan documented for R98. Review of MDS Admission assessment dated [DATE] and 5-Day assessment dated [DATE], Section Q, Participation in Assessment and Goal Setting, revealed R98 had participated in discharge planning and expected to remain in this facility. 5.Record review of R104 's EMR revealed that the resident was admitted to the facility on [DATE] with the following diagnoses but not limited to insomnia, encounter for surgical aftercare following surgery on the nervous system, hypertension, and signs/symptoms involving the musculoskeletal system. However, a further review of the records revealed no actual discharge plan or discharge care plan documented for R104. Review of MDS Admission assessment dated [DATE] and Quarterly assessment dated [DATE], Section Q, Participation in Assessment and Goal Setting, revealed R104 had participated in discharge planning and expected to remain in this facility. 6.Record review of R115 's EMR revealed that the resident was admitted to the facility on [DATE] with the following diagnoses but not limited to dementia severe, anxiety disorder, and peripheral vascular disease. However, a further review of the records revealed no actual discharge plan or discharge care plan documented for R115. Review of MDS Admission assessment dated [DATE] and Quarterly assessment dated [DATE], Section Q, Participation in Assessment and Goal Setting, revealed R115 had participated in discharge planning and expected to remain in this facility. 7.Record review of R454 's Electronic Medical Record (EMR) revealed that the resident was admitted to the facility on [DATE] with the following diagnoses but not limited to dementia severe, anxiety disorder, and peripheral vascular disease. However, a further review of the records revealed no actual discharge plan or discharge care plan documented for R454. Review of Minimum Data Set (MDS) Admission assessment dated [DATE]., Section Q, Participation in Assessment and Goal Setting, revealed R454 had participated in discharge planning and expected to discharge to the community facility. Interview with Social Services (SS) WW on 5/31/2024 at 11:03 am reported that this was an omission for leaving out the discharge care plan. She stated that usually the discharge care plan is completed by her. She confirmed that the care plan for the following residents were not in the EMR record for resident R81, R84, R115, R78, R104, R98, and R454. She also confirmed that R454's discharge summary was not done. She reported that she was not responsible for doing this. She stated that discharge care plan is usually completed by her after the resident admission to the facility. She was not really sure about who completed the discharge summary. Interview with Administrator DDD on 5/31/2024 at 1:55 pm, who reported that discharge summary and discharge care plan should be completed by the nursing staff or social worker. It was further explained that the discharge summary should be completed, and all medications signed by the discharge nurse.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on record review and staff interview the facility failed to provide a completed discharge summary with a recapitulation of the resident's stay for one of one discharged resident (R) 454. Findings include: Record review of R454 's (Electronic Medical Record) EMR record revealed an admitted [DATE] with diagnosis that included fracture hip (femur) and Stage 2 Pressure Ulcer. R454 discharged from the facility on 10/13/2023. Review of document titled, Physician's Discharge Summary dated 10/13/2023 revealed a discharge summary that R454 was to discharge to home with all meds, home health, physical therapy, occupational therapy, and nursing for evaluation and treatment. R454 was to also follow up with a primary care physician within 10 days and to follow up with the orthopedic doctor. Lastly, evaluate and treat left buttock and heal wound. However, there is no evidence that a medication list was provided to the resident at discharge. There was also no evidence of a post-discharge plan of care being developed. Interview on 5/30/2024 at 1:39 pm with the Financial Counselor MMM who confirmed that a fully completed discharge summary was not in R454's hard copy record (overflow) nor the EMR for R454. During an interview and record review with Registered Nurse (RN) Supervisor LL and the MDS Coordinator UU on 5/20/2024 at 1:44 pm, both staff confirmed the omission of a discharge summary with recapitulation in R454's record. RN Supervisor LL confirmed that she was the nurse who discharged R454 on 10/13/2023. RN Supervisor LL also reported being unaware of the requirement at discharge to complete a form to reconcile the medication with the resident/family. She was also unaware of the process to complete a discharge summary. MDS Coordinator UU explained that the discharge form should have been completed at the time of discharge. The MDS Coordinator stated that the form was easily accessible in the EMR system. Interview with Administrator DDD on 5/31/2024 at 1:55 pm, who confirmed that the nursing staff or social worker should complete discharge summary and the post discharge plan of care. It was further explained that the discharge summary should be completed, and all medications signed off by the discharge nurse with the family.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 36377 Based on observations, staff and resident interviews, and record review, the facility failed to ensure one of 52 sampled residents (R) R78 reviewed for limited range of motion (ROM) received passive range of motion (PROM) treatment as needed to address limited ROM in his right upper extremity (right hand). This failure had the potential to decrease the residents' quality of life. Findings include: Record review of R78's Electronic Medical Record (EMR) revealed that R78 was admitted to the facility with the following diagnoses but not limited cerebral palsy unspecified and functional quadriplegia. A record review of the therapy form titled Initial Treatment Plan for Rehabilitation dated 5/22/2024 revealed that R78 was referred to skilled occupational therapy services by nursing due to increased stiffness in R hand. Further review revealed recommendations for R78 to demonstrate tolerance to R hand PROM (Passive Range of Motion)/AAROM (Active-Assisted Range of Motion) to prepare for splint wear application. Interview on 5/29/2024 at 1:39 pm with Occupational Therapist (OT) JJJ revealed she performed an evaluation on R78's right hand on 5/22/2024 (after receiving a referral). She stated her findings were that R78 needs a splint on the right hand due to stiffness near the MCP -metal carpal phalangeal joints (-the four fingers at the knuckles). The evaluation shows stiffness, but with therapy with a range of motion, the fingers can fully extend. R78 can straighten his hands with assistance once therapy intervention is established. She has ordered a wrist hand splint for trial. The splint was ordered last Friday, 5/24/2024. She is currently working with the resident and doing some hand stretching exercises. R78 is receptive and okay with therapy. OT JJJ reported that once a resident is discharged from therapy, restorative services should begin. The therapy department is reported as providing training specific to resident care services to the certified nursing assistant (CNA). Interview on 5/30/2024 at 9:49 am with CNA III who reported that working as a Restorative CNA and as a CNA on the floor. She has been working for the facility for almost ten years. She was assigned to assist in restorative as a CNA and worked in this position for the past six months. The assigned restorative position does not include all restorative services; her position requires assisting the resident with ambulation. She provided ambulation assistance to a total of three residents and only provided range of motion to one resident. The majority of her job requires weighing all the residents in the entire facility and providing weekly weights to some residents. She stated that the facility really does not have a Restorative Program. This is just her assignment. The staff who trained her is out of the building on leave at this time. Today, she is working on the floor as a regular CNA. This happens often. Interview on 5/31/2024 at 11:43 am, with the Director of Nursing (DON) FFF who reported that her expectation is that residents receive therapy services for contractures. She reported that any staff can make a referral. She reported that Range Motion on all residents should be done during resident baths and during positioning /turning. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/30/2024 at 5:40 pm OT Director reported that he was unaware that restorative program was closed. He meets with the facility staff nursing staff including the DON, Administrator and all other departments once a week to discuss residents who are receiving therapy service. He confirmed that based on his conversation with his therapy staff, R78 appeared to have had a decline in the right hand. He reported that therapeutic interventions could have prevented further contractures of the right hand. Staff should have performed ROM (Range of Motion) and notified therapy. This resident was not addressed in the morning meetings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45813 Based on observations, staff interviews, record review, and review of the facility's policy titled, Non-invasive long-term Ventilation Support, and Cleaning and Disinfecting Respiratory Therapy Equipment, the facility failed to ensure respiratory equipment was properly stored while not in use for two of five Residents (R)30 and (R49) receiving respiratory treatment. The facility also failed to ensure that nebulizer equipment was dated and properly stored for one of 21 residents, R49. The deficient practice had the potential to increase the probability of respiratory complications for the residents receiving respiratory care and treatment. Findings include: Review of facility's undated policy titled, Non-Invasive Long-term Ventilation Support revealed the use of the long-term non-invasive ventilator type support is to reduce the rising carbon dioxide levels in the lungs, reduce the episodes of respiratory distress for individuals with diagnoses of COPD, emphysema, and other chronic respiratory insufficiencies of the lungs.7. The mask and the tubing will not be removed from the machine but stored in a clear plastic bag when not in use. Review of the facility's undated policy titled, Cleaning and Disinfecting Respiratory Therapy Equipment, indicated the purpose of this policy is to prevent the transmission of infectious organism with respiratory therapy equipment. The facility will maintain appropriate infection control practices when caring for residents requiring oxygen therapy, medication nebulizer/continuous aerosol, suction equipment, and manual ventilation bags. Medication Nebulizer/Continuous Aerosol:13. After each nebulizer treatment, the licensed nurse will: Between uses, store circuit in a plastic bag. 1.Review of the clinical record for R30 revealed admitting diagnosis included, but not limited to, obstructive sleep apnea, insomnia, quadriplegia, and muscle weakness. Record review of the Physician Orders for May 2024 for R30 revealed an order dated 7/18/2023 for Oxygen (O2) at four liters per minute (LPM) via nasal cannula every shift and an order dated 4/1/2020 for Autopap with mask settings are preset. Apply at bedtime. Observation on 5/20/2024 at 11:32 am of R30's room revealed a AutoPap (breathing machine) on the bedside dresser with the mask lying on the table not properly bagged while not in use. Observations and interview 5/21/2024 at 9:49 am with R30 revealed resident lying in bed working on his laptop. R30 stated he uses the Autopap machine each night as he is supposed to do. Observations revealed the Autopap mask on the bedside dresser was not properly stored while not in use. In addition, there was a half-filled gallon jug of distilled water along beside the machine without an open date. Further observations at 2:23 pm revealed the Autopap remained on the dresser and was not properly stored. Interview on 5/21/2024 at 2:29 pm with Certified Nurse Aide (CNA) SS, revealed that R30 asks for the Autopap mask to be applied when he desires it, but he does wear it. CNA SS further stated that she does not do anything with the Autopap because the nurses are responsible for maintaining respiratory supplies. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and walking rounds 5/21/2024 at 2:32 pm with Licensed Practical Nurse (LPN) QQ revealed the Autopap mask should be stored in a plastic bag while not in use. LPN QQ also stated the container of distilled water staff attempted to put the CPAP on while in bed. LPN FF further stated that should be labeled with an open date when it was first opened. LPN QQ verified the Autopap mask was not properly stored, and the distilled water was not properly labeled. 2. Review of the clinical record for R49 revealed admitting diagnosis included, but not limited to, muscle weakness, bradycardia, acute pulmonary edema, ischemic cardiomyopathy, thrombocytopenia, obstructive sleep apnea, altered mental status, dependence on supplemental oxygen, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypercapnia, shortness of breath, and bradycardia. Review of R49's current care plans initiated 4/12/2024 revealed resident has a potential for impaired gas exchange due to chronic respiratory failure. On oxygen and BIPAP (Breathing machine) - Resident is not complaint with use of BIPAP. Intervention: Trilogy BIPAP per MD orders. Current care plan initiated 4/12/2024 indicated R49 consistent refusal of medical treatment. Resident refuses to wear Trilogy BIPAP per MD orders. Interventions: Allow resident to make choices and participate in care. Record review of the Physician Orders for May 2024 for R49 revealed an order dated 5/15/2024 for Albuterol Sulfate 2.5 milligram (MG). Use one dose in nebulizer every eight hours and an order dated 5/7/2024 for Trilogy on at 16 setting every night at bedtime and off in the AM. Record review of R49's electronic Medication Administration Record (eMAR) for April 2024 revealed the Trilogy machine was documented as applied on 4/9/2024, 4/10/2024 - 4/13/2024, 4/19/2024, 4/24/2024, 4/26/2024 and 4/27/2024. Review of the eMAR for May 2024 revealed the albuterol nebulizer treatment was documented as administered as ordered by the physician. Further review of the EMAR revealed the Trilogy was documented as applied at night on 5/2/2024, 5/4/2024, 5/9/2024, 5/10/2024 indicating resident does wear the Trilogy at times as desired. Observation on 5/20/2024 at 12:30 pm of R49's room revealed resident lying in bed with both eyes closed. Further observation revealed the nebulizer and Trilogy masks were lying on the bedside dresser not properly stored while not in use. Observations 5/21/2024 at 10:22 am and 2:39 PM revealed R49 lying in bed with oxygen via nasal cannula intact. The Trilogy and nebulizer masks were still lying on the bedside dresser not properly stored while not in use. Interview 5/21/2024 at 2:41 pm with R49, resident stated she receives the nebulizer treatment in the middle of the day to help with her breathing. R49 further stated that she does not always use the Trilogy machine at night but there are times she does use it. Interview 5/21/2024 at 2:44 PM with CNA OO revealed she was aware that the nebulizer and Trilogy mask needed to be placed in a plastic bag while not in use. She further stated the Trilogy mask is usually in Ziplock bag. CNA OO also stated she saw the two respiratory machines in a chair in R49s room but was not aware resident used the machines or if the equipment was in working order. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview 5/21/2024 at 2:48 pm with LPN PP revealed he did not notice that the Trilogy mask was not in a plastic bag, because the night shift staff are responsible for ensuring that it is stored after use. LPN PP further stated, I know that was not a good answer. LPN PP also stated he did not notice the nebulizer mask was not stored in a plastic bag earlier today, but when he went in to administer R49s 2 pm nebulizer treatment, the resident was not ready to receive the medication. Because he had already placed the medication into the nebulizer, he placed the nebulizer on the machine to not waste the medication. LPN PP walked with surveyor to R49s room and verified the Trilogy and nebulizer masks were not properly stored while not in use. LPN PP also stated this deficient practice could cause a microbe to get on the respiratory masks and cause a respiratory infection. Interview 5/21/2024 at 3:04 pm with Director of Nursing (DON) stated that her expectation is that the supplies are properly stored and that nurses follow the regulations. DON also stated the distilled water was supposed to be labeled and dated when opened. DON also stated that all nurses are responsible for ensuring respiratory supplies are properly stored while not in use.

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F 0757 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 45813 Based on staff interviews, record review, and review of the facility's policies titled Abuse Prohibition and General Medication Preparation and Administration, the facility failed to ensure that two residents (R) (R136 and R302) of 52 sampled residents were given medication without having a physician's order. Actual harm was identified on 1/23/2024 when LPN I2 administered her personal Melatonin to R136 and R302, which resulted in the residents becoming lethargic. Findings include: Review of the facility's policy titled Abuse Prohibition revised 3/1/2021 revealed residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this policy. This includes, but not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat resident's medical condition. Review of the facility's policy titled General Medication Preparation and Administration, review dated January 2021, it is the policy of the facility to assure medication preparation and administration is safe and cause no harm to residents. 3. Prior to administration of medication licensed staff should: a. Perform 5 rights - i. verify correct dose, ii. verify correct route, iii. verify correct medication, iv. verify correct time, v. and verify correct resident. Review of the facility's reportable incident file revealed the facility filed an initial Facility Incident Report Form (FRI) on 1/23/2024. This report indicated staff to resident abuse for R136 and R302 related to staff reported to Director of Nursing and Administrator a staff nurse was administering melatonin tablets and/or spray to residents on the Memory Care Unit without a physician's order. Review of the facility's 5 Day follow up report to the State Agency (SA) revealed the facility conducted a thorough investigation related to the incident that involved Licensed Practical Nurse (LPN) I2 administering Melatonin (pills and spray) to memory care residents without a physician order. The investigation concluded the allegation was substantiated. Further review of the file revealed staff witnessed a bottle of over-the-counter Melatonin pills and spray on the LPN I2 medication cart. Staff witnessed LPN I2 spraying melatonin spray around R302. Staff members in the memory care unit reported resident R136 had increased lethargy. Staff member witnessed Melatonin pills that were not on the facilities over the counter stock being poured into medication cups and taken into residents' rooms. LPN I2 admitted to having Melatonin pills on her medication cart and stated the medication was her personal melatonin, as she had difficulty sleeping. She denied having Melatonin spray. LPN I2 left her backpack in a resident's room after LPN I2 had clocked out. Upon searching for the backpack, the facility staff found an empty bottle of Melatonin. Based on investigations findings, the facility had strong reason to believe the LPN I2 was administering Melatonin to residents without a physician order. The facility's response upon knowledge of the alleged use of Melatonin by LPN I2 included: 1. Responsible parties for R136 and R302 were notified of the incident. (continued on next page)

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F 0757 Level of Harm - Actual harm Residents Affected - Few	2. The physician was notified of the incident related to R136 and R302. 3. The Medical Director (MD) evaluated all residents of the Memory Care Unit (MCU) on 1/22/2024, with no negative outcomes or ongoing changes in resident conditions. 4. Staff questionnaires were completed to determine if they had worked on the MCU, identified anything unusual with staff, and who it was reported to. 5.Written statements by staff were also received. 6. On 1/21/2024, 1/23/2024, and 1/28/2024, licensed nurse staff were re-educated on the abuse policy, following MD orders, reporting chemical restraints, and having personal items stored at the facility. 7. The pharmacy was contacted, and it was determined that the Melatonin was not from the contracted pharmacy. No contraindication was identified. 8. LPN I2 was suspended and later terminated on 2/13/2024. 9. LPN I2 was reported to the nursing board. 1.Record review revealed R136 was admitted with diagnosis that included but not limited to dementia, major depressive disorder, delusional disorder, altered mental status, adult failure to thrive and metabolic encephalopathy. Record review of the most recent Quarterly Minimum Data Set (MDS) for R136, dated 2/20/2024, revealed a Brief Interview for Mental Status (BIMS) score of 4 (a BIMS score between 0 and 7 indicated severe cognitive impairment). Record review revealed R136 had a care plan initiated 11/20/2023 that indicated resident had the right to have personal preferences/choices for bathing, bedtime and awakening honored. Interventions included: resident will be assisted with bedtime routine as near to preferred time as possible, as resident will allow. Record review revealed R136's Physicians Orders for January 2024 did not have a physician order for melatonin tablets or spray. Record review of the January 2024 electronic Medication Administration Record (eMAR) for R136 revealed melatonin was not documented as administered. 2. Record review revealed R302 was admitted with diagnosis that included but not limited to dementia severe with agitation, weakness, other toxic encephalopathy, and altered mental status Record review of the most recent Admission Minimum Data Set (MDS) for R302, dated 12/03/2024, revealed a Brief Interview for Mental Status (BIMS) score of 8 (a BIMS score between 8 and 12 indicated moderate cognitive impairment). (continued on next page)

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F 0757 Level of Harm - Actual harm Residents Affected - Few	Record review revealed R302 had a care plan initiated 12/01/2023 that indicated resident exhibited changing awareness of environment related to medication interaction or toxicity. Record review revealed R302's Physicians Orders for January 2024 did not have a physician order for melatonin spray. Record review of the January 2024 electronic Medication Administration Record (eMAR) for R136 revealed melatonin was not documented as administered. Telephone interview on 5/23/2024 2:39 pm with former Director of Nursing (DON) BBB revealed a Certified Nursing Assistant (CNA) reported that LPN I2 was spraying Melatonin spray around residents and administering Melatonin tablets to residents on Memory Care Unit (MCU). She stated it was also reported that the nurse in questioned verbally told the other staff members she was medicating the residents. DON BBB revealed R136 was sleepy the next day after being medicated with melatonin. DON BBB stated she believed the LPN I2 was administering melatonin to all residents on MCU without a current physician's order. DON BBB further stated even though it was believed all residents on the MCU were dosed with melatonin, she was only able to prove 2 residents were dosed without an order. Interview on 5/29/2024 at 2:10 pm with DON FFF revealed she had worked at the facility for a short time and was not aware of the allegation/incident at this time. Interview on 5/29/2024 at 4:48 pm with Registered Nurse (RN) LL Nurse Supervisor revealed the nurse who witnessed LPN I2 with the melatonin, medicating residents on the MCU no longer worked at the facility. She further stated, the day nurse reported to her and RN MM that the nurse was medicating residents on the unit with Melatonin without a physician's order. RN LL stated she reported the allegation to DON BBB. A telephone interview on 5/30/2024 at 6:16 am with RN MM revealed the day nurse who reported the allegation of nurse having melatonin on the medication cart to administer to resident on the MCU no longer worked at the facility. RN MM stated after the allegation was reported to her, she went to the MCU and witnessed the bottle of Melatonin on the medication cart. She stated the LPN I2 stated the medication was hers and she brought the medication in to show her co-workers what she took to help her sleep. She stated another empty bottle of Melatonin was also discovered in the LPN's personal bag. Telephone Interview 5/30/2024 at 9:44 am with LPN KK revealed that LPN I2 relieved her from her duties on two separate occasions. LPN KK further stated she witnessed the nurse place a large container of Melatonin tablets and Melatonin spray on the medication cart after retrieving them from her personal belongings. LPN KK stated the nurse informed her that she was going to medicate the residents with melatonin to help them sleep better. LPN KK also stated she noticed residents on the unit were sedated and sleepy the next day but didn't think much of it because she did not routinely work the unit to know their normal behavior. Telephone interview 5/30/2024 at 9:54 am with former Administrator CCC revealed he was involved in the investigation related to the allegation. He further stated LPN I2 did not own up to the medications, but an empty Melatonin bottle was found in her personal bag which was left on the unit. He stated the nurse was seen on video surveillance spraying something around R302. Administrator CCC stated there was enough evidence through staff interviews to substantiate the allegation. (continued on next page)

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F 0757 Level of Harm - Actual harm Residents Affected - Few	Interview on 5/30/2024 at 11:46 am with Administrator DDD who revealed she was aware of the incident that occurred prior to her being employed at the facility. She stated that she expected that medications would not be administered to any resident in the facility unless a physician has ordered it. Interview 5/31/2024 at 10:47 am with CNA NN revealed in the evening the residents on the MCU started to sundown and have increased behaviors. She stated she observed LPN I2 pulled out a bottle of melatonin, began putting the melatonin into medication cups on the medication cart and stated, I am finna fix them up, I got something for them. CNA NN stated the nurse began to administer the melatonin to the resident and she reported this incident to the former DON BBB who was on the MCU at the time. CNA NN further stated on a different occasion she witnessed LPN I2 spray melatonin spray around R302. She stated she knew it was melatonin spray because she saw the label on the bottle.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45813 Based on record review, interviews, and the facility's policy's titled Automatic Stop orders and Psychoactive Medications, the facility failed to ensure an antipsychotic medication was not ordered as needed (PRN) beyond 14 days and failed to document the rationale in the resident's medical record and indicate the duration for the PRN order for one of six sampled residents (R) R111. Findings include: Review of facility's undated policy titled Automatic Stop Orders indicated the purpose of the policy was to promote safe and effective resident medication regimen. 1. An Automatic stop order is a statement limiting the duration of therapy by drug class in the absence of a specific physician's order. A medication discontinuation order will be obtained to indicate the medication was discontinued as a result of an automatic stop. 3. The following classes of medications are stopped automatically after the indicated number of days, unless the prescriber specifies a different number of doses or duration of the therapy to be administered. Drug - Psychoactive Automatic Stop Date - 14 days. 10. Any remaining medication is removed from the resident's supply and disposed of appropriately. Review of the facility's policy titled Psychoactive Medications dated of 5/21/2008 indicated a systematic method is established to ensure that if a patient requires psychoactive agents, they are appropriately dosed and monitored so as to not receive unnecessary drugs. The definition of an unnecessary drug is any drug when used: 2. For excessive duration and 4. Without adequate indications for its use. Review of the clinical record for R111 revealed resident was admitted to the facility on [DATE] with diagnoses of but not limited to dementia unspecified severity with behavioral disturbances, psychotic disorder with delusions due to known physiological condition. Review of the medical records revealed that R111 was readmitted to the hospital on 4/20/2024 and returned on 5/6/2024. He returned from the hospital to the facility with a medication order that included the prn Ativan. Review of the prescription sent from the hospital revealed the dispense/supply: 24 tablets. Review of the Physician Orders for R111 for May 2024 revealed the following medication: Ativan 1 milligram (mg) give 1 tablet via G tube every eight hours as needed for anxiety, with an order date of 5/06/2024 and no stop date indicated. Review of the electronic Medication Administration Record (eMAR) for May 2024 revealed R111 received the PRN Ativan on 5/21/2024 at 12:10 pm, 5/24/2024 at 9:46 am, 5/25/2024 at 10:22 am, 5/26/2024 at 9:56 am, 5/27/2024 at 10:22 am. Review of R111's electronic and paper record revealed no evidence that that Physician or Nurse Practitioner had been contacted to address continuation of the PRN Ativan or a rationale for the continued use beyond the 14 days. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the medication cart 5/28/2024 at 12:24 pm with Licensed Practical Nurse (LPN) JJ revealed a card of lorazepam (Ativan) on the medication cart currently in use for R111. Review of the Controlled Drug Record revealed the medication was currently being utilized to sign out/document use of the controlled substance (Lorazepam). Interview 5/28/2024 at 12:03 pm with LPN JJ revealed R111 is currently on hospice Service. She further stated the Hospice nurse was in the facility earlier this morning and did not make any changes to resident orders. LPN JJ stated resident occasionally has inappropriate behaviors where he would las out at staff during care, but since last hospital return, she had not noticed any behaviors. Interview 5/28/2024 at 12:12 pm with Director of Nursing (DON) and Assistant Director of Nursing (ADON) both verified the current Ativan PRN order did not have a stop date. Both the DON and ADON stated they were not aware that PRN psychotropic medications had to have a stop date and/or needed to be re-evaluated or reassessed by a provider to be continued or with a duration and rationale for continued use beyond 14 days. They reviewed R111's paper chart and electronic record and verified that the provider was not contacted to address the PRN Ativan order. DON further stated the pharmacy consultant would usually give a recommendation for the physician to address and the nurse who received the order on admission should have called the provider and received further orders. DON further stated she was not sure if all nurses were aware of the regulations related to PRN psych medications. DON and ADON reviewed the May 2024 pharmacy recommendations in a book in the nursing office and confirmed R111 did not have any recommendations related to the PRN Ativan usage. Interview 5/28/2024 at 12:36 pm with Registered Nurse (RN) Supervisor II revealed that she is fairly new to the facility. She further stated that usually the pharmacy consultant and the DON are responsible for ensuring PRN psychotropic medications are followed up on and are in compliance. She further stated she was not certain but believed PRN psychotropic medications should be discontinued or followed up on at the 14-day mark. Telephone interview on 5/28/2024 at 1:10 pm with the Pharmacist HH revealed the pharmacy received the order for the Ativan on 5/6/2024 and sent it out to the facility on [DATE]. Pharmacist HH also stated the medication was filled with an order from the hospital for an eight-day supply. She verified no additional orders for Ativan had been received for R111. Telephone interview on 5/28/2024 at 2:07 pm with Pharmacy Consultant (PC) GG revealed R111 was a readmit from the hospital, so resident's medication regimen was reviewed on 5/7/2024 and again with the monthly review on 5/16/2024. PC GG further stated recommendations to address the PRN Ativan usage were provided to the facility's DON at this time on both of the beforementioned dates. Follow-up interview 5/28/2024 at 2:21 pm with DON, DON entered room with surveyor with a pharmacy recommendation for R111. The consult appears to be the recommendation from 5/16/2024 that contained a physician date and signature for 5/16/2024 indicating to continue PRN use of Ativan for 180 days, as the benefit outweighs the risk. Further review of the record revealed the recommendation was not addressed in the progress notes, there was not a new order written and/or stop dated added to current order, there was not a documented rationale in the medical record for continued use. Verified again by DON. DON further stated the RN Supervisor II had the signed recommendation in her possession. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Follow-up interview on 5/28/2024 at 2:28 pm with RN supervisor II revealed she received the second recommendation on 5/16/2024. She further stated the physician was in the facility and handed the recommendations to her. She further stated she placed the recommendations on a clip board and placed in DON's office because she was working the medication cart. RN Supervisor II further stated she was responsible for following up on pharmacy recommendations but had not had the opportunity to do so, because of her scheduled off days and working on the medication cart. RN Supervisor II also verified she did not write a progress note, a new order to continue the medication, or add a stop date to the order. She also stated she did not receive a recommendation on 5/8/2024 for R111.

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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. 45813 Based on interviews, record reviews, and review of the job summaries for the Administrator and Director of Nursing (DON), the facility Administration failed to effectively oversee an abuse prevention program to promote, foster, and maintain an abuse-free environment. The facility census was 149. On 5/28/2024, 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. Facility Administrator DDD and Director of Nursing (DON) FFF, were informed of the Immediate Jeopardy (IJ) on 5/28/2024 at 1:45 pm. The noncompliance related to the Immediate Jeopardy was identified to have existed on 3/21/2023. At the time of exit on 5/31/2024, an acceptable Immediate Jeopardy Removal Plan had not been received therefore the Immediate Jeopardy remained ongoing. Findings include: Review of job summary for the Administrator revealed, plans, develops, organizes, implements, evaluates, and directs the programs and activities of the Long-Term Care Facility, ensuring the delivery of competent and age-appropriate care that encompasses the physiological and psychological needs of the resident. Promote a culture of safety, follow established policies, and adhere to all stated and federal regulatory requirements, Joint commission requirements, and national patient safety standards. The description included job duties and responsibilities: Ensuring that appropriate standards of resident care and practice are developed, consistent with current nursing and other research findings, as well as state and nationally recognized professional standards, develops and maintains written policies and procedures that govern the operations of the facility, assist department supervisors in the development and use of departmental policies and procedures, and reviews the policies and procedures annually to assure continues appropriateness and compliance with current regulations, interprets the facility's policies and procedures to team members, residents, families, visitors, and others as necessary. Acts as a liaison between the facility and the residents and families, maintains open communication with the medical director and other members of the medical staff, complies with all state and federal regulatory agencies and requirements, and consults with departmental supervisors to assist in correcting/elimination problem areas, or improving services. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of job summary for Director of Nursing revealed, direct and supervises the work of nursing service team members on a designated patient/resident care unit. Is responsible for assignments, scheduling, orientation, supervision, guidance, and evaluation of nursing personnel on the unit so as to ensure and maintain a high quality of patient care. The description included job duties and responsibilities for: Accountable for the provisions of patient care on assigned unit 24 hours/day, 7 days/week, confers with supervisory personnel in other departments as the need arises, encouraging and maintaining good intra and inter departmental relationships and communication, initiates and maintains comprehensive and appropriate records and reports required for the effective functioning of the unit, maintains a high quality for patient care and patient teaching and assisting staff in ideas and implementation pf patient education and teaching, works and communicates with all individuals at the appropriate age, level of education, maturity, and understanding, works with physicians and physician extenders in a collegial manner for the resolution of patient/resident care problems, and contributes to team building by maintaining a positive, motivational attitude and a holistic approach toward nursing management 1.The Administration failed to protect resident (R) 84's right to be free from sexual abuse by not monitoring, supervising, and effectively addressing the sexual aggressive behavior of R41, (a resident with a known history of displaying sexually aggressive behaviors toward residents). This deficient practice resulted in R84 being sexually abused and experiencing psychosocial trauma. In addition, the facility failed to protect R14 from verbal abuse from staff. Cross-reference: F600 2. Administration failed to investigate, correct, and prevent allegations of abuse by resident to resident for one of seven residents (R) (R41) reviewed for sexual abuse. Specifically, the facility did not complete a thorough investigation of a facility reportable incident related to sexual abuse of a resident. Cross-reference: F610 3.Administration failed to develop and implement person-centered comprehensive care plans related to abuse for resident R84. In addition, the facility failed to implement a care plan for one resident R115 related to elopement risks and safety concerns. Cross-reference: F656 Interview on 5/24/2024 at 1:32 pm with Minimum Data Set (MDS) Coordinator VV revealed she was unaware that R84 as the victim of abuse needed to have a care plan, and this was an oversight on her part. She further stated the importance lie with monitoring residents for safety. MDS Coordinator further stated Social Services WW was responsible for ensuring that the care plan was implemented. Interview on 5/24/2024 at 1:38 pm with (Social Services) SS WW who revealed she was aware of the abuse incident with R84 but was not ever informed to develop an abuse care plan for R84. She further stated also was not informed to follow-up with nursing or to monitor R84 for any negative effects stemming from the sexual abuse incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115721	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Senior Care Center - Brunswick	2611 Wildwood Drive Brunswick, GA 31520

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 5/31/2024 at 1:55 pm with Administrator DDD revealed she was unaware that R115's care plan was not developed for identified elopement risks or R84 had not been care planned for abuse. She stated the care plans should have been developed by social services or nursing staff. Interview on 5/31/2024 at 12:31 pm with Administrator DDD revealed she could not locate any evidence the previous Administrator CCC completed a thorough investigation after receiving knowledge of the allegation of abuse with R41 and R84. She further states she could not speak on behalf of him, but the investigation should have consisted of the physician and psych service provider being contacted to evaluate and possible adjust medications for the residents involved, police notified, written statements from all staff members who had knowledge of the incident, each residents care plans should have been updated and the staff should have received education related to the incident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on observations and staff interviews, the facility failed to ensure infection control standard practices were performed to prevent cross contamination of linens and to prevent cross-contamination of resident equipment for resident (R43). The deficient practice had the potential to increase the probability of the spread of infection on two of four halls. Findings include: 1. Observation of Hall OB on 5/20/2024 from the time of 10:13 am to 1:13 pm, revealed a dirty linen cart and a clean linen cart positioned side by side near room [ROOM NUMBER]. During the observation, Certified Nursing Assistant (CNA) HHH was seen on several occasions removing linen items from the clean cart and putting items in the dirty linen cart. Observation on 5/28/2024 at 7:44 pm of Hall OB of clean linen cart and dirty linen cart side by side positioned near room [ROOM NUMBER]. 2. Observations of Turtle Cove Hall on 5/20/2024 at 1:15 pm, 5/21/2024 at 2:00 pm, and 5/29/2024 at 1:30 pm revealed a standup lift with a dark greyish substance build up on the footrest and on the frame of the standup lift. On 5/29/2024 at 1:44 pm, an unidentified CNA was observed using the lift to help transfer R43 to the bathroom. Observation of Turtle Dove Hall on 5/29/224 at 2:00 pm to 3:40 pm revealed a clean linen cart position in between two tall plastic trash cans (facility was using as dirty resident/dirty linen clothing barrels and a trash barrel). Closer observation revealed that to the right of linen cart was a three trash can barrel. The first trash can barrel contained dirty clothing items and lid was labeled resident dirty, second bin labeled resident clothes, and the third bin was labeled trash. The third bin was observed to be open with trash noted piled high to the top. On the opposite side (left side) of the linen cart was a trash can (barrel) exactly in front of the shower room containing dirty linen. All of the barrels contained dirty items. During an observation and interview on 5/29/2024 at 3:04 pm of the trash barrel with Housekeeping Tech, (HK Tech) NNN reported that he was the Trash Tech. He confirmed that the trash barrel was positioned next to the linen cart. HK Tech NNN reported being unaware to separate the trash can barrel from the clean linen cart. He reported that he has been working at the facility for four months. An observation was made with Director of Nursing (DON) FFF on 5/29/2024 at 3:05 pm who confirmed the buildup on the standup lift. She also confirmed that the location of the linen cart, dirty trash barrels, and trash piled up presented an issue with cross contamination for infection. DON FFF reported that staff should follow infection control procedures. DON FFF then explained to the unidentified CNA and HK Tech NNN the importance of following standard practices. 3. Observation on Turtle Dove Hall on 5/29/2024 between the hours of 2:00 pm to 3:45 pm revealed a bath shower bed positioned next to one tall trash can (being used as a dirty linen barrel) labeled dirty. The barrel contained dirty linen items and resident clothing items. (continued on next page)

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	115721	A. Building B. Wing	05/31/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview 5/29/2024 at 3:21 pm, with CNA PPP who reported being unaware of positioning of the carts (linen cart next to dirty trash barrel) on the opposite side of the hall. He confirmed receiving in-service training on infection control and cross contamination. CNA PPP reported being so busy with patient care that failed to notice this issue. He reported had he noticed, he would have separated the carts and shower bath bed. Interview with Licensed Practical Nurse (LPN) OOO on 5/29/2024 at 3:37 pm, who reported being unaware of the positioning of the dirty linen cart and shower bath bed. She confirmed receiving training on cross contamination. She reported that the shower bath bed and dirty linen cart should have been separated. During an interview and observation with Administrator DDD on 5/29/2024 at 3:45 pm, the Administrator was able to observe the positioning of linen carts, dirty linen carts, and shower bed baths on Turtle Cove Hall. The Administrator was shown the photos on OB Hall of the clean linen cart positioned by the dirty linen cart. Administrator DDD stated that this is very concerning, and this is cross contamination. She reported that infection control and cross contamination training was provided to staff a few days ago prior to the surveyor observations. A policy related to these identified concerns was requested but was not provided during the survey.