STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115730	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oceanside Care Center LLC	7 Rosewood Avenue Tybee Island, GA 31328

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, staff interviews, and review of the facility policy titled Promoting/ Maintaining Resident Dignity, the facility failed to promote dignity for one of 18 residents (R) (R1) in an environment that promotes the maintenance or enhancement of each resident's quality of life. This failure had the potential to diminish R1's quality of life.Findings include:Review of the facility policy titled Promoting/Maintaining Resident Dignity, revised 10/21/2024, revealed the Policy section stated, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintain or enhances resident's quality of life by recognizing each resident's individuality. The Compliance Guidelines section included, 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.Observation on 7/14/2025 at 9:55 am revealed Certified Nursing Assistant (CNA) II and CNA JJ pushing R1 in a geriatric chair outside of the facility. Further observation revealed R1 was wearing a hospital gown, which was pulled up above his stomach with a blanket folded across his chest. R1's legs and lower torso were exposed, revealing a brief and bandages on his right leg stump. Continued observation revealed construction workers on site working on the facility and cars passing on the nearby street.In concurrent interviews, at the time of observation, on 7/14/2025 at 9:55 am, CNA II and CNA JJ confirmed they did not ensure the resident's body was covered and should have. In an interview on 7/15/2025 at 2:00 pm, the Director of Nursing (DON) reported that her expectations were for staff to ensure that residents were properly dressed and not exposed. She confirmed that this was a dignity issue.

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On July 15, 2025, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator, Regional Director of Clinical Operations, and Director of Operations were informed of the Immediate Jeopardy (IJ) on July 15, 2025, at 3:48 pm. The noncompliance related to the IJ was identified to have existed on June 13, 2025.An acceptable Immediate Jeopardy Plan of Removal was provided on July 18, 2025, and included interviews and skin assessments, education on abuse policy, threatening or violent behavior in the workplace, policy review, no weapons signage, night receptionist and weekend managers' new addition. The survey team validated the implementation of the removal plan, and the Immediate Jeopardy was removed on July 24, 2025. After the removal of the Immediate Jeopardy, the deficiency remained at a scope and severity of an L, no actual harm, with potential for more than minimal harm widespread.Based on observations, interviews, record reviews, and review of the facility policies titled, Abuse, Neglect, and Exploitation, Work Place Violence, and Active Shooter, the facility failed to ensure residents were free from staff to resident abuse by not preventing two Certified Nursing Assistants (CNAs), BB and CC, from bringing a firearm into the workplace on the East Wing and threatening other employees in a resident-occupied environment for Resident (R) (R1, R2, R3, R4, and R5) on 7/1/2025. This failure placed all residents at serious risk of physical injury or death, as well as significant psychosocial trauma. Findings include:Review of the facility policy titled, Abuse Prevention dated 3/25/2025 stated, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibited and prevent abuse, neglect, exploitation, and misappropriation of funds. Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment, with resulting physical harm, pain or mental anguish, which can include staff to resident abuse, etc. VI.Protection of resident (F) providing emotional support and counseling to residents during the investigations and as needed.Review of the facility policy titled, Workplace Violent Prevention Program dated 7/1/2025 stated, It is the policy of this facility to promote a safe, respectful, and productive environment in which to deliver quality healthcare and administrative services. Violence in the workplace will not be permitted or tolerated. The facility will develop a workplace violence prevention program to identify and prevent episodes of workplace violence. Workplace violence is defined as any threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the worksite.Review of the facility policy titled, Active Shooter/Violent Incidents dated 9/16/2024 stated Our facility is committed to maintaining a safe environment, including a safety from violence and threats of violence. Intent of Policy: to minimize the potential to residents, employees, visitors, and property resulting from individuals brandishing firearms or other weapons or claiming to possess a firearm/weapon with the expressed intention of causing harms, expressed threats, bomb threaten, threatening individuals while under a restraining order, or hostage situation. All staff will receive training upon hire and annually to increase awareness of potential threat or violent incidents including, but not limited to, acts of terrorism, active shooters, bomb threats/explosives, assaults, hostage situations.Record review of the police incident report dated 7/1/2025 at 11:05 pm documented law enforcement was dispatched to the facility regarding 2 (two) employees with firearms in the east wing, threatening another employee, CNA DD. A continued review of the document revealed that the Administrator wanted all suspects formally trespassed from the property.Record review of the document titled Criminal Trespass Warning/Ban Form dated 7/1/2025 stated Employees advised CNA CC, and another female employee got into a verbal altercation where they announced they had firearms with them. Administrator advised that she wanted both subjects banned.1. Record review of the Electronic Medical Record (EMR) for R1 revealed diagnoses, including but not limited to Alzheimer's disease, unspecified psychosis not due to substances or known physiological conditions. The Quarterly Minimum Data Set (MDS) dated [DATE], Section C (Cognitive Patterns) assessed a Brief Interview Mental Status Score (BIMS) of eight, which indicates moderate cognitive impairment. Section GG (Functional Abilities) assessed dependent for care for all Activities of Daily Living Skills, nonambulatory, and no limitations for Range of Motion (ROM) regarding upper/lower extremities.On 7/1/2025, R1 was sitting in a geriatric chair in front of the nurses' station on the East Wing during the incident and was unable to remove himself, nor did staff remove R1when the incident occurred.Record review of the document titled Social Services Quarterly Evaluation dated

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and record review, the facility failed to ensure safety measures were initiated for one of 18 sampled residents (R) (R1). This deficient practice had the potential to place R1 at risk of avoidable injuries. Findings include: Review of the admission Record for R1 revealed diagnoses including, but not limited to, muscle weakness, epilepsy, and unsteadiness on feet.Review of the Quarterly Minimum Data Set (MDS), dated [DATE], for R1 revealed Section C (Cognitive Patterns) documented a Brief Interview Mental Status (BIMS) score of 00 (indicating severe cognitive impairment). Section J (Health Conditions) documented falls since admission. Review of the Fall Risk Assessment for R1, dated 6/9/2025, revealed a score of 15 (indicating high risk for falls). Review of the Progress Notes for R1 revealed an entry dated 3/4/2025 of the nurse found the resident on the floor in his room. Further review revealed an entry dated 4/2/2025 of the nurse observed R1 trying to get out of bed, and the resident slid to the floor. Continued review revealed an entry dated 7/8/2025 of the resident was observed sitting on the floor in his room. Observation on 7/10/2025 at 3:05 pm revealed R1 sitting in a geriatric chair in his room with the door closed. Further observation revealed there were no fall mats around R1's bed or chair. Observations on 7/16/2025 at 2:25 pm and 7/17/2025 at 10:00 am revealed R1 lying in his bed and there were no fall mats on the floor. Observation on 7/22/2025 at 11:34 am revealed R1 lying in bed, positioned on his back, upper and lower torso turned sideways, with legs dangling off the side of the bed, and the resident's head resting on the wall. Continued observation revealed the head of the bed was elevated straight up, preventing the resident from reclining in a longitudinal position. Observation revealed there were no fall mats on the floor next to the bed. In an interview on 7/23/2025 at 3:00 pm, Licensed Practical Nurse (LPN) WW confirmed that R1 was capable of moving in bed and was identified as a high fall risk. She reported that the resident was placed at the nurse station during the day so staff could monitor him, and he often attempted to get out of the bed and the geriatric chair.In an interview on 7/20/2025 at 3:55 pm, Certified Nursing Assistant (CNA) RR reported that R1 was capable of moving from side to side in the bed and repositioning his body. She further reported that staff were never instructed to place fall mats by the resident's bed, only to place the bed in the lowest position. In an interview on 7/31/2025 at 1:23 pm, the Director of Nursing (DON) reported being unaware that R1 did not have fall mats next to his bed. She reported being aware that the resident was identified as a high falls risk and should have fall mats at his bedside.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review, the facility failed to provide sufficient qualified licensed nursing staff to achieve the highest practicable level of well-being for all residents. Specifically, the facility did not have a licensed nurse (Registered Nurse RN or Licensed Practical Nurse LPN) on duty for at least 30 minutes on [DATE] between 7:00 pm through 7:30 pm. The census was 83 residents. On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator, Regional Director of Clinical Operations, and Director of Operations were informed of the Immediate Jeopardy (IJ) on [DATE], at 3:48 pm. The noncompliance related to the IJ was identified to have existed on [DATE]. An acceptable Immediate Jeopardy Plan of Removal was provided on [DATE], and included additional staffing agency support, daily staffing schedules, shift rounding, emergency staffing plan, education on emergency procedures, state minimum daily PPD requirements, and maintaining a licensed nurse every shift. The survey team validated the implementation of the removal plan, and the Immediate Jeopardy was removed on [DATE]. After the removal of the Immediate Jeopardy, the deficiency remained at a scope and severity of an L, no actual harm, with potential for more than minimal harm widespread. Findings include:A review of the facility document titled Punches Report dated [DATE] to [DATE] revealed that there was no RN or LPN on duty at the facility on [DATE] except for LPN LLL. In an interview with LPN LLL, she revealed that she worked remotely on the morning of [DATE] and clocked out at 5:00 pm the same day, filling out a manual clock form. She stated that she did not work on [DATE] from 7:00 pm to 7:00 am. On [DATE] at 2:06 am, LPN AA documented that Code Blue was called by the receptionist at 8:00 pm. Once on the scene, he observed R6 in the chair, unresponsive. His skin was cold, and he did not have a pulse. LPN AA documented that he then asked the receptionist to call 911 while he initiated CPR [Cardiopulmonary Resuscitation] with nursing staff (Certified Medication Assistant (CMA) and Certified Nursing Assistant (CNA)). He documented that they performed CPR until the Emergency Medical Services (EMS) arrived. R6 was still unresponsive with no pulse upon the EMS arrival. The resident was pronounced dead by EMS at 8:30 pm. Interview with Business Office Manager (BOM) PP on [DATE] at 12:27 pm revealed the BOM stated that there was hardly ever a nurse in the facility on the night shift. She stated that sometimes there were only CMAs in the building. The BOM stated that LPN QQQ left the faciity on [DATE] at 7:00 pm, knowing that there was not a nurse in the facility, and LPN QQQ left the East wing knowing that there was not a nurse or CMA to relieve her. She stated that LPN QQQ gave the keys to one of the CMAs on the [NAME] wing, left, and went home. The BOM further revealed that she called the administrator 17 times on the night that R6 expired, and the Administrator did not respond to her phone calls or texts.Interview with LPN LLL on [DATE] at 3:56 pm revealed that she worked on [DATE] during the day shift and clocked out around 5:00 pm the same day. She stated that when she comes in and helps them, she uses a missed punch form, and that Human Resources (HR) keys her time in the system. She stated that the HR person entered the information incorrectly. LPN LLL stated that she did not work the 7:00 pm to 7:00 am shift on [DATE]. Further interview with LPN LLL revealed that she was not physically in the facility on [DATE], and she worked remotely and did a missed punch form. LPN LLL stated that she normally works the [NAME] wing on Saturday and Sunday, 7:00 pm to 7:00 am. She stated that when she works, there are always two Licensed nurses on the [NAME] wing and one nurse on the East wing. Interview with LPN ZZ on [DATE] at 11:33 am revealed that she was working on [DATE]. She stated that she left at 4:45 pm, and she was relieved by CMA YY. She stated that CMA RRR was working on the top hall of the [NAME] wing.Interview with LPN AA on [DATE] at 11:22 am revealed that he was initially scheduled to work across the street at the sister facility, but ended up at the current facility due to no nurses being in the building. He stated that he took report at the sister facility and came to the current facility around 7:30 pm. LPN AA reported that upon arrival at the facility at 7:30 pm, no nurse was present in the facility. He stated that there were two Certified Medication Assistants (CMAs) on the [NAME] wing. He stated that he got the keys to the medication cart from one of the CMAs from the [NAME] wing. Interview with LPN QQQ on [DATE] at 12:15 pm revealed that on [DATE], she was working on the East wing on the 7:00 am to 7:00 pm shift. She stated that she left the facility at 7:00 pm and gave the keys to the medication cart and the keys to the narcotics to a CMA on the [NAME] wing. She stated that the Director of Nursing (DON) PPP told her she could leave if she gave the

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on staff interviews, record review, and review of facility documents, the facility failed to ensure that Certified Medication Aides (CMAs) completed a skills competency check-off before being allowed to administer medications. In addition, the facility failed to ensure CMAs did not administer narcotic medications to one of 18 sampled residents (R) (R12). This deficient practice had the potential to place the 83 residents residing in the facility at risk of receiving medication from incompetent staff. Findings include: Review of the facility-provided undated document titled Medication Technician/Aide revealed the Position Purpose section stated, Assists licensed nursing staff by administering daily medications as ordered by the physician in accordance with established nursing standards, facility policies, and procedures and state requirements.1. The facility was unable to provide current annual competencies that were signed and dated for six of the seven Certified Medication Aides (CMAs) (CMA JJ, CMA GGG, CMA KKK, CMA RRR, CMA UUU, CMA YY) actively working at the facility. 2. Review of the facility-provided document titled Medication Administration Clinical Skills Checklist, dated 2/14/2025, for CMA EE revealed the section titled 12. Administered medications using appropriate technique for dosage form/route & administered accurate amount: C. Liquid Morphine (a narcotic medication used to treat pain) stated Not certified to give. The document was initiated by a Registered Nurse and signed by CMA EE. Review of the Medication Administration Record (MAR) for R12, dated 6/1/2025 through 6/30/2025, revealed that the schedule 5-325 milligram (MG) hydrocodone-acetaminophen (a narcotic medication used to treat pain) was initialed as given by CMA YY on 6/4/2025 at 9:00 am and 3:03 pm. Review of the Staff Administration Legend: June 2025, located on the MAR, revealed the medication was administered by CMA YY. In an interview on 6/24/2025 at 9:05 am, CMA GGG stated that she works on the floor as a Certified Nursing Assistant (CNA) most of the time, and she fills in on the medication cart on the 7:00 pm to 7:00 am shift. She stated that she had signed off on the narcotics sheets and administered narcotics to residents. CMA GGG further stated that she had a skills check-off at the facility's sister facility, but she could not remember who completed the check-off or when it was completed. In an interview on 7/9/2025 at 1:48 pm, the Regional Consultant Nurse (RNC) OOO stated that CMAs completed a quarterly check-off with a Registered Nurse (RN) or a Pharmacist. She further stated that the CMAs were not checked off on or allowed to administer narcotics, and she was unaware that the CMAs were administering narcotics to residents. In an interview on 6/24/2025 at 2:19 pm, the Interim Director of Nursing (DON) PPP stated that she was not aware that the CMAs were giving narcotics or controlled substances. She stated that they have started education on what they can and cannot do. She stated that going forward, the CMAs will not have access to the narcotic keys. In an interview on 6/25/2025 at 12:32 pm, Registered Nurse (RN) FFF stated that she had worked alongside a CMA; she had one cart, and the CMA had the other cart. RN FFF stated that she pulls the narcotics from the box and gives them to the CMA to administer them. She stated that she trusts CMA YY because she is really thorough.In an interview on 6/25/2025 at 2:20 pm, the Operations Consultant (OC) NNN revealed he was not aware that CMAs were administering narcotics. In an interview on 6/26/2025 at 3:38 pm, the Medical Director (MD) stated that he was not aware that CMAs were administering narcotics. He stated he was sure that the CMAs were not allowed to administer narcotics. In an interview on 6/26/2025 at 4:10 pm, Nurse Practitioner (NP) VVV stated that she was not aware that the CMAs were administering narcotics or controlled substances. She stated that CMAs should not be administering narcotics or controlled substances. In an interview on 7/8/2025 at 12:40 pm, CMA EE stated that she had relieved a CMA and counted the narcotics with a CMA. In an interview on 7/7/2025 at 4:42 pm, the Interim DON TTT stated that CMAs should not be administering narcotics. She stated that she was not aware that the CMAs were administering narcotics.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and a review of the Administrator and Director of Nursing (DON) Job Description, the Administration failed to provide oversight related to workplace violence, failed to provide sufficient qualified licensed nursing staff to achieve the highest practicable level of well-being for all residents, and failed to protect residents from alleged emotional and potential physical abuse during an active shooter incident. The census was 83.On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator, Regional Nurse Consultant, and Operations Consultant were informed of the Immediate Jeopardy (IJ) on [DATE], at 3:48 pm. The noncompliance related to the IJ was identified to have existed on [DATE]. An acceptable Immediate Jeopardy Plan of Removal was provided on [DATE] and included education on emergency plan, workplace violence and an active shooter situation, policy review, job description review, additional education related to managing daily operations, coordinate and oversee department heads, providing education and compliance training, ensure licensure staff have appropriate education, competency checks are maintained. The survey team validated the implementation of the removal plan, and the Immediate Jeopardy was removed on [DATE]. After the removal of the Immediate Jeopardy, the deficiency remained at a scope and severity of an L, no actual harm, with potential for more than minimal harm widespread. Findings include:The facility had a Job Description for the job title of Administrator. The description documented the purpose of this position is leads, guides, and directs the operations of the healthcare facility in accordance with local, state, and federal regulations, standards, and established facility policies and procedures to provide appropriate care and services to residents. Identifies, in conjunction with the Director of Nursing and selected department heads, the facility's key performance indicators. Establishes an ongoing system to monitor these key indicators such as the Quality Assurance and Performance Improvement process throughout the facility. Promotes and encourages an environment of trust among all employees related to the overarching goal of resident safety and abuse prevention. The facility had a Job Description for the job title of Director of Nursing. The description included that the Director of Nursing position purpose is to planning, organizing, developing, and directing the overall operation of the Nursing Service Department in accordance with local, state, and federal standards and regulations, established facility policies and procedures and as may be directed by the Administrator and the Medical Director, to provide appropriate care and services to the residents. Interprets and communicates policies and procedures to nursing staff, and monitors staff practices and implementation. Oversees nursing schedules to ensure resident needs, regulatory and budget standards are met. Ensures delivery of compassionate quality care and nursing supervision as evidenced by adequate staff coverage on the units, general cleanliness, and maintaining optimal resident functions. Monitors for allegations of potential abuse or neglect, or misappropriation of resident property and participates in the investigative process. Facility Administration, specifically the Administrator and DON, failed to protect residents and effectively oversee areas of the facility that were included in their job descriptions. 1. The facility's Administration failed to implement and enforce policies and procedures that ensure the safety and security of residents when two staff members, Certified Nursing Assistant (CNA) BB and CNA CC, accessed the facility on [DATE] with concealed firearms and engaged in threatening behavior in the presence of residents. Additionally, the facility failed to ensure that a licensed nurse (Registered Nurse (RN) or Licensed Practical Nurse (LPN)) was present in the building on [DATE] from 7:00 pm to 7:30 pm and available to respond to medical emergencies. Cross-reference to F600, F725.2. The Administration failed to protect residents from alleged emotional and potential physical abuse during an active shooter incident. Cross-reference to F600.3. The Administration failed to provide sufficient qualified licensed nursing staff to achieve the highest practicable level of well-being for all residents. The facility did not have a licensed nurse on duty for at least 30 minutes on [DATE] between 7:00 pm to 7:30 pm. Cross-reference to F725. 4. The Administration failed to utilize Quality Assurance Performance Improvement (QAPI) for adverse events related to workplace violence and staffing. Cross- reference to F600, F725, F867 On [DATE] at 2:06 am, LPN AA documented that Code Blue was called by the receptionist at 8:00 pm. Once on the scene, he observed R6 in the chair, unresponsive. His skin was cold, and he did not have a pulse. LPN AA documented that he then asked the receptionist to call 911 while he initiated CPR [Cardiopulmonary Resuscitation] with nursing staff (Certified Medication Assistant

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On [DATE], a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator, Regional Director of Clinical Operations, and Director of Operations were informed of the Immediate Jeopardy (IJ) on [DATE], at 3:48 pm. The noncompliance related to the IJ was identified to have existed on [DATE]. An acceptable Immediate Jeopardy Plan of Removal was provided on [DATE], and included review of policies and procedures for emergency staffing, review of job descriptions, education on additional staffing agency support, daily staffing schedules, shift rounding, emergency staffing plan, education on how to respond to active shooter events and emergency preparedness, and an ad hoc QAPI meeting. The survey team validated the implementation of the removal plan, and the Immediate Jeopardy was removed on [DATE]. After the removal of the Immediate Jeopardy, the deficiency remained at a scope and severity of an L, no actual harm, with potential for more than minimal harm widespread. Based on staff interviews, record review, and a review of the facility's policy titled Quality Assurance-Performance Improvement Management (QAPI) Change Process- Work Instruction, the facility failed to identify concerns and effectively implement Quality Assurance Process Improvement (QAPI) plans related ensure all staff received active shooter/workplace violence training to ensure residents (including R1, R2, R3, R4, and R5) were free from abuse from an active shooter/workplace violence incident. In addition, the facility to ensure availability of sufficient licensed nurse staffing was present and available in the building to respond to medical emergencies for a code blue for R6, who was later pronounced deceased by Emergency Medical Services (EMS). The census was 83.Findings Include: The QAPI policy titled Quality Assurance Performance Improvement Management dated [DATE] stated It is the policy of this facility to develop, implement, and maintain an effective comprehensive data driven program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. Adverse Event is an untoward, undesirable and unsafe unanticipated event that causes death or serious injury, or the risk thereof. 2. Governing and Leadership: (iv) Ensure the program is adequately resourced, including ensuring staff time, equipment, and technique training as needed (vii) Setting clear expectations around safety, quality rights, choices, and respect.1. Record review of the police report and the no trespass ban form, both documents dated [DATE], revealed that two Certified Nursing Assistants (CNAs), CNA BB and CNA CC brought firearms into the building threatening coworkers in the proximity of residents (R5 and an undetermined number of residents were present in the lobby and the smoke area). CNA BB removed the weapon from her purse, waved the weapon in the air, and proceeded to walk down the hallway, making threatening comments with the firearm concealed in her purse. CNA CC was sitting at the East wing nurse station, opening her bookbag, which revealed her firearm, with a resident (R1) at the nurses' station and residents (R2 and R3) present on the East wing.2. Record review revealed on [DATE] between the hours of 7:00 pm through 7:30 pm, R6 was observed by staff to be nonresponsive, sitting on the facility patio. Continued record review revealed that there were no licensed nurses (Licensed Practical Nurse (LPN) or Registered Nurse (RN)) available in the building (7:00 pm through 7:30 pm) to respond to medical emergencies. A blue code was not called until 8:00 pm, and the resident was pronounced deceased by Emergency Medical Services (EMS) at 8:30 pm outside on the patio at the facility.The Administrator was unable to provide evidence that the facility had or was currently addressing workplace violence and active shooter incidents, nor was there a systematic review of the issue to develop an action plan meeting the residents' needs, prior to the incident on [DATE]. Record review revealed that the facility did not post a No Weapons or Firearms poster on the exterior entrance doors until [DATE].R1, R2, R3, R4, and R5 did not receive psychological evaluations until [DATE].Interview on [DATE] at 12:03 pm with the Administrator revealed that the QAPI committee tracks and trends based on identified problems. When asked if the Quality Assurance (QA) program had identified a concern or developed an action plan regarding the firearm incident or staff training, she reported no. She stated that she was unsure of why the facility did not provide training to all employees, including contract workers, regarding workplace violence. She confirmed that training on workplace violence and the prohibition on firearms will be provided this week for all employees. The Administrator revealed that the staffing of licensed nurses was not a part of her QA meetings, because staffing of licensed nurses was not a concern. The QA team never placed emphasis on licensed nurses'

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115730	A. Building B. Wing	07/31/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115730	A. Building B. Wing	07/31/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observations, staff interviews, record reviews, and review of the facility policy titled Laundry, the facility failed to maintain the laundry area in a sanitary manner to ensure residents' clothes were free from contamination. This deficient practice had the potential to place all residents residing in the facility at increased risk for infection related to cross-contamination. Findings include:Review of the facility policy titled Laundry, revised 6/11/2025, revealed the Policy section stated, The facility launders linens and clothing in accordance with current CDC [Center for Disease Control and Prevention] guidelines to prevent transmission of pathogens. The Policy Explanation and Compliance Guidelines section included, .2. The facility's laundry area will provide hand washing facilities and products as well as PPE [personal protective equipment]. 4. Soiled laundry shall be handled as little as possible, with minimum agitation to avoid contamination of air, surfaces, and persons. a. Linens shall be bagged separately from resident's clothing at the point of use. b. Sorting of laundry shall occur after washing. 6. If using fans in laundry processing area, prevent cross-contamination of clean linens from air blowing from soiled processing areas, (i.e., the ventilation should not flow from soiled processing area to clean laundry areas). Observation of the facility's laundry room on 7/22/2024 at 12:33 pm revealed a thick dark greyish substance coating the ceiling and pipes in the laundry room. Further observations revealed: Two racks of clean clothes hanging on hangars, uncovered, coated with dark grey substance. Uncovered blankets on shelves, coated with a dark grey and dark speckled substances. Two piles of uncovered clean clothes stacked on a container, coated with dark grey and dark speckled substances. Uncovered sheets and pillowcases on shelves, and coated with dark grey and dark speckled substances. Two bins of uncovered clean clothes, coated with dark grey and dark speckled substances. One large floor-standing industrial fan frame and blades covered with thick dark grey substances, blowing directly on clean clothes. A window covered with thick grey substance and broken glass, exposing dust and dark black substances. Observation of the PPE revealed one apron, which was coated with dust and debris, and no other PPE. Observation revealed no separate designated hazardous container in the laundry room. The can, which the staff reported as a biohazardous container, was being used as a trash can with trash and debris. In an interview on 7/22/2025 at 12:18 pm, the Housekeeping Manager described the thick grey substances as dust and dark speckled substances as dirt or debris. He stated that all resident clothes and linens should be covered after washing to prevent cross-contamination, and the laundry room should have aprons and goggles for the laundry staff to use. He further stated that the laundry area should have a separate, designated biohazard container. During an observation of the laundry room on 7/22/2025 at 1:36 pm, the Administrator and Operation Consultant NNN confirmed that a heavy layer of greyish color substance and debris was coating the ceiling and the ceiling pipes. Both staff members described the substances as dust, dirt, and debris. The Administrator reported that the dust particles built up on the ceiling, dust on the ceiling pipes, and sanitation of the laundry room were identified earlier this year. The problem was addressed a while back to have a staff to blow the dust off the ceiling and ceiling pipes monthly. She was not aware that the pipes and the ceiling were not being maintained by the staff who was assigned to the task. The Administrator confirmed the uncovered, clean clothing, blankets, and linen, the missing biohazard container, the fan covered with thick, dark grey substances, and broken window glass. Laundry room cleaning logs were requested and not provided. In an interview on 7/22/2024 at 1:40 pm, Laundry Aide (LA) NN reported she had worked in the laundry department for at least one year and had never witnessed staff cleaning the ceiling or pipes. She reported being unaware that residents' clothes and linen should be covered. LA NN reported that no one used the PPE apron and stated there was only one apron and no other PPE in the laundry room. She reported that biohazardous materials were usually placed in the washer first or just kept in a bin with all other laundry items.In an interview on 7/30/2025 at 2:22 pm, the Director of Nursing (DON)/Infection Preventionist (IP) stated her expectation was for all residents' laundry and linen to be maintained in a sanitary manner to prevent cross-contamination. She reported she was unaware of the condition of the laundry room.