STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155338	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Avon	445 S County Road 525 E Avon, IN 46123

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 37981 Based on observation, interview, and record review, the facility failed to ensure resident assessments were completed for 1 of 1 resident who self-administers medications (Resident 15). Findings include: On 8/4/24 at 12:01 p.m., Resident 15 was observed to have medications in her room and bathroom. On her over the bed table, she had fluticasone nasal spray (treats chronic rhinosinusitis) and carboxymethylcellulose eye drops (treats dry eyes), and on her bathroom counter she had metronidazole (treats facial rosacea). On 8/6/24 at 10:28 a.m., Resident 15's record was reviewed. Her physician orders included, but were not limited to: fluticasone nasal spray dated 1/3/24, may keep at bedside to self-administer; carboxymethylcellulose eye drops dated 1/3/24, may keep at beside and self-administer; and metronidazole lotion dated 5/17/24, unsupervised self-administration. A document titled, Medication Self-Administration Safety Screen, dated 1/3/24, indicated Resident 15 could keep at bedside and self-administer fluticasone nasal spray. It indicated eye drops and topical creams were not applicable. No other medications were listed or assessed. Resident 15's electronic medical record lacked documentation of quarterly self-administration assessments for fluticasone. Resident 15's electronic medical record lacked documentation of quarterly self- administration assessments for carboxymethylcellulose and metronidazole. A new document titled, Medication Self-Administration Safety Screen, dated 8/5/24, indicated Resident 15 could keep at bedside and self-administer carboxymethylcellulose eye drops. The fluticasone and metronidazole were not listed or assessed. A medication care plan, dated 4/4/24, indicated Resident 15 could self-administer eye medication and face cream, the names of the medication were not specifically listed. The metronidazole lotion was not listed. The goal was to take medications safely as prescribed. An approach included to assess the residents ability to safely self-administer medication specified on admission, quarterly, and with significant changes in condition. (continued on next page)

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	During an interview, on 8/8/24 at 12:10 p.m., Resident 15 indicated the facility staff took away her rosacea medication on 8/8/24. Previously, they let her keep it in her room because her rosacea flared up so much and she just bugged and bugged them until they gave it to her. She still had her fluticasone nasal spray and carboxymethylcellulose eye drops in the her room. They were observed on her over the bed table. A current policy, titled, Self-Administration of Medications, with no date, was provided by the Executive Director (ED), on 8/8/24 at 9:50 a.m. A review of the policy indicated, .A resident may only self-administer medications after the facility's interdisciplinary teams has determined which medications may be self-administered safely .The results of the interdisciplinary team assessment are recorded on the Medications Self-Administration Assessment Form, which is placed in the resident's medical record All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage. Unauthorized medications are given to the charge nurse for return to the family or responsible party 3.1-11(a)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38768 Based on interview and record review, the facility failed to ensure Resident Council Grievance concerns related to call light wait and response times was addressed in a timely and effective manner to prevent ongoing concerns for 5 of 82 residents who attended the Resident Council Meeting and complained on behalf of all 82 residents who resided in the facility. Findings include: During an interview on 8/7/24 at 8:53 a.m., the Executive Director (ED) indicated, he could not find Resident Council Minutes from October 2023 through (-) February 2024. The ED indicated, since he and the new Activity Director (AD) started, they had been keeping track of and organized the minutes. At that time, the ED provided copies of the minutes from March 2024 - July 2024. Minutes from a meeting held on 3/26/24 at 2:30 p.m. indicated, .overnight staff call lights on for 1-2 hours-staff on phones all the time including during resident care Minutes from a meeting held on 4/29/24 at 1:30 p.m., indicated, .night shift, rude-'companionate-less' call lights- on over an hour or more, on phone while providing patient care Minutes from a meeting held on 5/29/24 at 1:55 p.m., indicated, .old business reviewed . night shift- call light wait times not getting better. Phones- still talking and texting while providing care Minutes from a meeting held on 6/19/24 at 3:00 p.m., indicated, .old business reviewed . night shift: call lights still not being answered . new business: night shift call lights too long, phones during care or in hallway [NAME] lights are going off Minutes from a meeting held on 7/23/24 at 2:10 p.m., indicated, .call lights still not being answered at night During a Resident Council Meeting on 8/8/24 at 10:00 a.m., the Resident Council President and 4 other residents who regularly attended the meetings indicated, they had ongoing concerns related to nightshift call light wait and response times. They indicated they had to wait a long time for call lights to be answered, and sometimes if the nurse came in, they would turn the light off, say they would come right back, but never did. Three of the five residents in attendance indicated they had to wait too long, and on several occasions they had accidents in their briefs while waiting for assistance to the bathroom. The residents indicated they complained about call lights at every meeting, but nothing was ever done about it because it never seemed to get better. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/8/24 at 10:38 a.m., the AD indicated, since she had started the biggest ongoing concern had been related to call lights not answered in a timely manner and residents had to wait a long time. Residents also complained that staff would be on their phones at inappropriate times especially during resident care. The AD indicated when the Resident Council group had shared concerns, like the call lights and phone use, she would fill out a grievance form and submit it to the Social Service Director, who would review the grievance and facilitate delegation to appropriate Department Heads for responses. The AD indicated sometimes she got grievances responses, and sometimes she didn't. On 8/8/24 at 11:00 a.m., the ED provided copies of Grievance responses from the Resident Council Meetings. A Grievance Response, dated 4/5/24, to address concerns from the 3/26/24 meeting indicated, Department Head review and action taken: Staff has been educated on call lights and not using phone/earbuds on floor A Grievance Response, dated 5/15/24, to address concerns from the 4/29/24 meeting indicated, Department Head review and action taken: Staff has been educated on rounding and answering call lights A Grievance Response, dated 5/12/24, to address concerns from the 5/8/24 meeting indicated, Department Head review and action taken: Staff education on making sure call light in reach and answered in kind and timely manner There were two Grievance Response forms which addressed concerns from the 6/19/24 meeting. The first was related to a specific resident's request for snacks, and the second was related general dietary/food concerns. There was no Grievance Response form to address 6/19/24 concerns related to call light and staff response times. There was a Grievance Response form, dated 7/24/24, to address an individual concern from the 7/23/24 meeting. There was no Grievance Response related to the 7/23/24 concern related to call lights and staff response. During an interview on 8/8/24 at 11:15 a.m., the Assistant Director of Nursing (ADON) indicated, she had come in a couple times for night shift observations, but never had concerns related to call lights, and that staff had been educated multiple times. On 8/8/24 at 1:53 p.m., the Regional Nurse Consultant (RNC) provided a copy of current facility policy titled, Grievances, with an effective dated of 1/2/24. The policy indicated, It is the policy of this facility to support each resident's and family member's right to voice grievance without discrimination, reprisal or fear of discrimination or reprisal . the Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident . the facility will make prompt efforts to resolve grievances (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-3(k)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 38768 Based on record review and interview the facility failed to accurately code falls on the MDS (Minimum Data Set) for 1 of 2 Residents reviewed for MDS accuracy (Resident 53). Findings include: On 8/6/24 at 2:18 p.m., Resident 53's medical record was reviewed. She was a long-term care resident who resided on the secured Memory Care (MC) unit with diagnoses which included, but were not limited to, Alzheimer's disease with late onset (Alzheimer's is a type of dementia, dementia is an irreversible degenerative brain disease which affects memory and cognitive function). A nursing progress note, dated 5/14/24 at 5:53 a.m., indicated, Resident 53, .was up in the hall several times in the night, and escorted back to bed. During a.m. bed check she was seen in a male patient's bed, while being escorted back to her room she fell on her right hip that had a brush in the pocket and c/o [complains of] pain at that hip . A hospital History & Physical, dated 5/15/24, indicated, Resident 53 sustained a fall and had suffered an acute, impacted, nondisplaced right subcapital femoral neck fracture. Resident 53 underwent surgical repair. A significant change Minimum Data Set (MDS) assessment, dated 5/30/24, section J1800, Any falls since admission or prior assessment . was answered no. A significant change MDS assessment, dated 6/17/24, section J1800, Any falls since admission or prior assessment . was answered yes, but did not indicate she had sustained a fall which resulted in a fracture. On 8/8/24 at 10:09 a.m. the Executive Director (ED) provided a copy of current facility policy titled, Accurate Assessment, with an effective date of 1/2/24. The policy indicated, The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37981 Based on observation, interview, and record review, the facility failed to ensure the facility's non-smoking policy was followed and allowed unassessed residents who smoked to smoke on the facility grounds and keep smoking materials in their rooms for 6 of 6 residents reviewed for smoking (Resident 6, 22, 26, 67, 77, and 79). Findings include: A list of smokers in the facility was requested from the Executive Director (ED) and Director of Nursing (DON) several times on 8/4 and 8/5/24. The facility provided the list on 8/6/24 at 1:52 p.m. 1. On 8/6/24 at 1:08 p.m., Resident 6 was observed smoking a cigarette. He was in his wheelchair, in the parking lot in front of the facility. On 8/6/24 at 10:14 a.m., Resident 6's record was reviewed. His diagnosis included, but were not limited to, chronic obstructive pulmonary disease (COPD), hemiplegia and hemiparesis of left non-dominant side (partial paralysis), epilepsy (brain disorder with recurring seizures), diabetes mellitus (DM) (blood sugar disorder), and tobacco use. A smoking care plan, dated 4/23/24, indicated Resident 6 was a smoker. He had been educated on the, smoking policy. The goal was for him to comply with the facility policy. A few approaches were to complete a smoking assessment quarterly and as needed, instruct the resident regarding the facility policy on smoking: facility designated locations, times, and safety concerns, and with his smoking materials to be kept by the facility. Another care plan, dated 3/4/24, indicated Resident 6 was at risk for respiratory distress related to COPD. The goal was for him to free from symptoms of respiratory distress. Resident 6's electronic record lacked documentation of a smoking assessment nor was a smoking assessment provided by the facility during the survey or at survey exit. 2. On 8/6/24 at 10:29 a.m., Resident 22's record was reviewed. Her diagnosis included, but were not limited to, schizoaffective disorder (mental disorder with hallucinations, false beliefs, with depression or mania), COPD, and delusional disorder (mental health condition in which a person can't tell what's real from what's imagined). Resident 22's electronic record lacked documentation of a smoking assessment nor was a smoking assessment provided by the facility during the survey or at survey exit. A smoking care plan, dated 4/23/24, indicated Resident 22 was a smoker. She had been educated on the, non-smoking policy. The goal was for her to comply with the facility policy. A few approaches were to instruct the resident regarding the facility policy on smoking: facility designated locations, times, and safety concerns and to notify the nurse immediately if it was suspected the resident had violated the facility smoking policy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 8/6/24 at 2:22 p.m., Resident 22 indicated she kept her cigarettes in her room with her. 3. On 8/6/24 at 2:04 p.m., Resident 7's record was reviewed. His diagnosis included, but were not limited to, COPD, morbid obesity, DM, and chronic kidney disease (CKD). Physician orders indicated Resident 7 may go on LOA (leave of absence) with medications with responsible party. A smoking care plan, initiated on 8/6/24, was a smoker and was at risk for not following the facility smoking policy. The goal was for her to comply with the facility policy. A few approaches were to instruct the resident regarding the facility policy on smoking: facility designated locations, times, and safety concerns and to notify the nurse immediately if it was suspected the resident had violated the facility smoking policy. Resident 7's electronic record lacked documentation of a smoking assessment nor was a smoking assessment provided by the facility during the survey or at survey exit. During an interview, on 8/6/24 at 2:27 p.m., Resident 7 indicated he had his cigarettes in his room but, he kept his lighter in his car in the parking lot. He smoked in front of the building yesterday, but sometimes went to the sidewalk in front of nearby houses. On 8/7/24 at 2:45 p.m., Resident 7 was observed smoking outside. He was on facility grounds, sitting in the shade of an evergreen tree, unobservable from the front of the building. 4. On 8/6/24 at 2:16 p.m., Resident 67's record was reviewed. Her diagnoses included, but were not limited to, schizophrenia (serious mental health disorder affecting how one thinks, feels, and behaves), psychosis (symptoms that happen when a person is disconnected from reality), dementia (progressive loss of intellectual functioning, especially with impairment of memory, abstract thinking), and nicotine dependence. A smoking care plan, initiated on 8/6/24, was a smoker and had been educated on the facility's smoking policy. The goal was for her to comply with the facility policy. A few approaches were to complete a smoking assessment quarterly and as needed, instruct the resident regarding the facility policy on smoking: facility designated locations, times, notify the charge nurse immediately if it was suspected the resident had violated the facility smoking policy, and smoking material to be kept with facility staff. Resident 67's electronic record lacked documentation of a smoking assessment nor was a smoking assessment provided by the facility during the survey or at survey exit. During an interview, on 8/6/24 at 2:33 p.m., Resident 67 indicated she had her cigarettes in her room. On 8/7/24 at 1:09 p.m., Resident 67 was observed sitting outside, on a white bench, smoking on front of the building. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 8/6/24 at 2:49 p.m., Resident 77's record was reviewed. He was admitted with moderate cognitive impairment. His diagnoses included, but were not limited to, dementia, a history of psychoactive substance abuse with an induced mood disorder, tobacco use, anxiety disorder, and post-traumatic stress disorder (PTSD). A new care plan, dated 8/6/24, indicated Resident 77 was a smoker and he was educated on the facility's non-smoking policy with a goal to have him comply with the facility smoking policy daily. Approaches included quarterly assessments, instruction about smoking risks and hazards, and cessation. Instructions regarding the facility policy on smoking: designated locations time, safety concerns. Notify the charge nurse immediately if it was suspected resident had violated facility smoking policy, and smoking material to be kept with facility staff. A care plan, dated 6/12/24, indicated Resident 77 received psychotropic medication (or psychotropic like medication) and was at risk for adverse side effects. An approach was to observe for adverse reactions to an antidepressant with change in behavior/mood cognition, hallucinations/delusion, social isolation, and suicidal thoughts. A mental health care plan, dated 6/13/24, indicated Resident 77 had a PASRR (preadmission screening and resident review) Level II concern related to serious mental illness. The goal was for him to receive appropriate specialized services to attain or maintain his highest psychological and psychosocial well-being. A fall care plan, dated 6/12/24, indicated Resident 77 was at risk for fall related to ad lib ambulation,, used of medication, poor safety awareness, and impaired memory. A PTSD care plan, dated 6/14/24, indicated Resident 77 exhibited the following due to history of trauma: feelings of guilt and flashbacks (sudden, vivid, distracting memories). An approach included maintain a safe environment for him. Resident 77's electronic record lacked documentation of a smoking assessment nor was a smoking assessment provided by the facility during the survey or at survey exit. During an interview, on 8/6/24 at 2:23 p.m., Resident 77 indicated he had his cigarettes in his room. The facility staff took his lighter, he could get his lighter back at the front desk. He could not smoke in front of building, but had to go into the outside corners of the building. He pulled a box of cigarettes out of his pocket. 6. On 8/7/24 at 2:45 P.M., Resident 26's record was reviewed. His diagnosis included, but were not limited to, dementia with psychotic disturbance, COPD, asthma, and generalized anxiety disorder. A smoking care plan, dated 4/10/24, indicated Resident 26 was a smoker and had been educated on the facility's smoking policy with a goal for him to comply with the facility's smoking policy daily. Approaches included a complete smoking assessment quarterly, educate him on the non-smoking facility policy as outlined by his behavior contract initiated on 7/25/23, instructions about smoking risks, hazards, and smoking cessation including designated locations, times, and safety concerns, notify charge nurse immediately and if it was suspected the resident had violated the facility smoking policy. Observed clothing and skin for signs of cigarette burns. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan, dated 11/14/23, indicated Resident 26 exhibited signed of cognitive impairment due to his score on the Brief Interview of Mental Status (BIMS) with a goal to be able to make simple decision regarding care. Approaches included to give to direction or question at a time, provide him with cues and reminder to assist with decision making and recall, repeat questions or comments as needed, and use simple yes or no questions and allow resident time to respond. A medication care plan, dated 4/3/23, indicated Resident 26 received psychotropic medication (or psychotropic like medication) and was at risk for adverse side effects: sleep aid. A PASRR care plan, dated 6/12/23, indicated Resident 26 had a serious mental illness and with received specialized services to attain or maintain their highest practicable psychological and psychosocial well-being. A behavioral care plan, date 4/3/23, indicated Resident 26 had past behavioral symptoms of suicidal ideation with a goal of demonstrating effective coping skills. An approach was to maintain a safe environment. Resident 26's electronic record lacked documentation of a smoking assessment nor was a smoking assessment provided by the facility during the survey or at survey exit. A document, titled, Resident Behavioral Contract, with no date, was provided by the Executive Director (ED), on 8/8/24 at 9:50 a.m. The ED indicated the facility was unaware he had a behavioral contract in place. A review of the contract, indicated the specific issue with smoking by put himself/others at risk for burns, etc (further smoking issues included). Specific thing he would not do was to smoke on facility grounds. The things he would do were to not smoke on facility ground and turn in my cigarettes/lighter to facility staff. If he chose not to comply with this contract he could expect the following results: a 30 day notice issued for discharge of the facility. It was signed by Resident 26 on 8/9/23. During an interview, on 8/6/24 at 2:36 p.m., Resident 26 indicated he did not have any cigarettes to smoke. When he did smoke he would ask another resident for one. On 8/7/24 at 2:45 p.m., Resident 26 was observed smoking outside. He was on facility grounds, standing in the shade of an evergreen tree, unobservable from the front of the building. Resident 7 provided a cigarette for him and lit it. During an interview, on 8/5/24 at 2:30 p.m., the ED indicated this was a non-smoking facility, residents signed out to smoke, and they kept their smoking utensils with them. A list of residents that signed out to smoke and kept smoking materials in their rooms was requested from the ED multiple times on 8/4/24, 8/5/24, and twice on 8/6/24. During an interview, on 8/6/24 at 11:39 a.m., the ED indicated the facility was not a smoking building. He indicated the Director of Nursing (DON) provided a smoking policy in error. They did not have smoking assessments for residents who signed out and smoked. The residents kept their smoking materials in their rooms and signed in and out to go smoke. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 8/8/24 at 11:25 a.m., the receptionist in the lobby, who could observe the residents in front of the building, indicated she observed residents smoking in the front of the building routinely. During an interview, on 8/8/24 at 1:29 p.m., the ED indicated the facility staff had not yet implemented removing cigarettes out of resident rooms yet. During an interview, on 8/8/24 at 1:33 p.m., the Regional Nurse Consultant (RNC) indicated the staff needed time to prepare the residents for a change in policy with behavioral management preparations. On 8/5/24, admission documents provided by the facility upon resident entry indicated the residents received smoking information with their admission packet. The smoking information, titled, Non-Smoking Policy - Residents. A review of the policy indicated, This facility shall establish and maintain safe resident smoking practices .The facility is a NON-SMOKING facility and residents are not permitted to smoke on the premises . If a resident chooses to smoke they must sign out LOA [leave of absence] with a responsible party (if applicable) and leave the facility property 3.1-45(a)(1) 3.1-45(a)(2)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 38768 Based on interview and record review, the facility failed to ensure sufficient licensed nurse coverage was available on the weekends for 1 of 4 quarters of staffing reviewed which had the potential to effect 82 of 82 residents who resided in the facility. Findings include: On 8/6/24 at 9:30 a.m., the facilities CASPER report was reviewed and indicated, staffing concerns had been triggered in the second quarter of 2024 for low weekend staffing. On 8/8/24 at 8:36 a.m., the actual worked licensed nursing schedule was request for the month of May 2024. On 8/8/24 at 10:47 a.m., the above requested schedule was provided by the Executive Director (ED) and reviewed at that time. For the first week of the month, May 1 through (-) 7th, the licensed staff per-patient-per-day (licensed staff PPD- the number of hours a licensed nursing staff member is granted per patient, per day) averaged to 0.74. For the second week of the month, May 8th-14th, the licensed staff PPD averaged 0.62. For the third week of the month, May 15th-21st, the licensed staff PPD averaged 0.61. For the fourth week of the month, May 22nd-28th, the licensed staff PPD averaged 0.54. Upon review for patterns, the schedule revealed PPD trended down throughout the month. Starting on Thursdays, and through the weekends the schedule did not meet the minimum 0.50 PPD as evidenced by the following: Thursday the 2nd, PPD= 0.48. Saturday the 4th, PPD= 0.49. Saturday the 11th, PPD= 0.37. Sunday the 12th, PPD= 0.36. Friday the 17th, PPD= 0.45. Saturday the 18th, PPD= 0.39. Sunday the 19th, PPD= 0.38. (continued on next page)

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Majestic Care of Avon	445 S County Road 525 E Avon, IN 46123

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Thursday the 23rd, PPD= 0.43. Saturday the 25th, PPD= 0.27. Sunday the 26th, PPD= 0.19. Friday the 31st, PPD= 0.39. During an interview on 8/8/24 at 11:38 a.m., the ED reviewed the above schedule review and indicated, it appeared there were an appropriate amount of staff, such as leadership staffing like the Medical Records Coordinator, (MR), who was a licensed practical nurse, (LPN) the Minimum Data Set (MDS) Coordinator, who was a Registered Nurse (RN), several Licensed Nurse Preceptors (LNPs) and the Assistant Director of Nursing, who was a LPN were mainly scheduled Monday - Thursday for routine office hours. The ED indicated some of those weekday nursing hours could be moved and/or rearranged to help cover the weekends as well. On 8/8/24 at 12:02 p.m., the Facility Assessment Tool, dated, 5/20/24, Part 3 indicated, .Facility Resources needed to provide competent support and care for our resident's populations every day and during emergencies . RNs to acuity = 0.54 and LPNs to acuity = 0.74 During an interview on 8/8/24 at 1:23 p.m., the ED indicated, the Facility Assessment Tool was up to date, and it was his understanding that the minimum PPD of RNS and LPNs to acuity of care, meant according to the Facility Assessment and Resident Population Review, the facility required a minimum of the above RN and LPN PPD daily coverage. The ED indicated the Facility Assessment tool served as the policy for facilities staffing policy and requirements.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38768 Based on observation, interview, and record review, the facility failed to ensure two cognitively impaired residents who wished to have a relationship and resided on the secured memory care unit had assessments for appropriateness, ongoing supervision, and person-centered goals and interventions for 2 of 3 residents reviewed for dementia services (Residents 53 and 55). Findings include: On 8/6/24 at 2:07 p.m., Resident 53 was unable to be located after looking in her room, her private bathroom, the secured memory care (MC) activity/dining room and in the therapy gym. During an interview on 8/6/24 at 2:08 p.m., the MC Facilitator (MCF) indicated, Resident 53 was probably visiting with her friend, Resident 55, and asked two passing Certified Nursing Aides (CNAs) to find Resident 53. CNA 17 and CNA 18 went to Resident 55's room. Resident 55 and Resident 53 were observed lying in bed together with Resident 55's arm wrapped around Resident 53's waist. The CNAs indicated Resident 53 visited Resident 55 all the time and they liked to sleep together. The CNAs indicated Resident 55 was in love with Resident 53. When the CNAs asked Resident 53 to get out of his bed, Resident 53 refused, so the CNAs allowed the residents to remain in bed together. During an interview on 8/6/24 at 2:10 p.m., the MCF indicated both residents' families were ok with the residents' relationship, and it was care planned. The MCF indicated Resident 53 would sometimes wander into other resident's room, but had only laid down with Resident 55. During an interview on 8/7/24 at 11:16 a.m., CNA 19 indicated Residents 53 and 55 were very good friends and she believed Resident 53 thought Resident 55 might have looked like her late husband, and Resident 55 enjoyed her company. CNA 19 indicated staff was supposed to encourage them to visit in common areas for more supervision, but Resident 53 would sneak into his room. Even if Resident 55's stop sign was up, Resident 53 would duck under it. CNA 19 never observed anything untoward or inappropriate. Their relationship seemed to be more about companionship. 1. During an interview on 8/7/24 at 11:25 a.m., Resident 53's family member indicated Resident 53 did like to spend time with Resident 55 and often went into his room. Resident 55 seemed to be friendly with her and the family did not mind if they continued to see each other, or conducted a more intimate relationship i.e. held hands, and snuggled in bed. Resident 53's family indicated they would want Resident 53 to be monitored and supervised sufficiently enough to prevent the possibility of her getting hurt. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/6/24 at 2:18 p.m., Resident 53's medical record was reviewed. She was a long-term care resident who resided on the secured MC unit with diagnoses which included, but were not limited to, Alzheimer's disease with late onset (Alzheimer's is a type of dementia, dementia is an irreversible degenerative brain disease which affects memory and cognitive function), unspecified dementia with other behavioral disturbances, insomnia (sleep disorder when one wakes often and easily through the night), nightmare disorder, and psychotic disorder with delusions, (thinking or believing things that are not real). A significant change Minimum Data Set (MDS) assessment, dated 6/17/24, indicated Resident 53 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 3 out of 15. A routine Psychiatry assessment, conducted on 1/3/24 at 7:19 p.m., indicated, .[Resident 53] is assessed in peers room - resting in bed- she is alert and pleasant. Staff reports patient has periods of low frustration tolerance. Staff reports patient becomes physically violent when redirected. Reviewed medications- noted patient with GDR [gradual dose reduction] 11/6/23- plan to consider that a failed GDR and increase fluoxetine to previous dosing . A routine Psychiatry assessment, conducted on 1/15/24 at 4:14 p.m., indicated, .staff reports patient has been overly sexual- attempting to kiss multiple male residents on the unit. Staff have intervened- however patient behavior continues/repeats. Prozac increased - to decrease sexual libido and stabilize mood . started on cimetidine [an antiacid, gastric acid reducer which has been reported to decrease libido and hypersexual behavior] A routine Psychiatry assessment, conducted on 4/8/24 at 12:11 p.m., indicated, .staff reports resident is having periods of verbal aggression. Staff reports patient is difficult to redirect and inflicts self-harm at times. Plan to introduce low-dose Zyprexa to address obsessiveness, self-harm, and physical and verbal aggression. Likewise resident receiving fluoxetine to address sexual inhibition, plan to transition resident to Zoloft. Sexual inhibition being managed with cimetidine in place . A routine Psychiatry assessment, conducted on 4/22/24 at 5:56 p.m., indicated, .Staff reports patient continues to display physical aggression towards staff - recently assessed for UTI [urinary tract infection] but specimen was contaminated- ordered repeat UA [urinalysis]. Started on Zyprexa [an antipsychotic medication with side effects which can include, but are not limited to; dizziness, weakness, difficulty walking and restlessness]] to address physical aggression and delusional behaviors. Received a pharmacy recommendation to decrease fluoxetine [an antidepressant medication]- recommendation declined at this time The assessment indicated she already received: a. Namenda (a medication used to treat dementia, which can cause dizziness and fatigue) 10 mg twice a day b. Aricept (a medication used to treat dementia, which can cause fatigue, insomnia, muscle cramps and fainting), 10 mg every night c. terazosin (a medication used in the treatment of trauma-related nightmares which can cause drowsiness, blurred vision, dizziness and fainting) 2 mg at night d. melatonin (a supplemental hormone used as a sleep aide) 5 mg every night (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A routine Psychiatry assessment, conducted on 5/6/24 at 4:38 p.m., indicated, .Staff reports resident is cooperative with care continues to seek affection from male resident however she is easily redirected . At that time, the pharmacist recommended a dose decrease of cimetidine from 200 mg twice a day, to 200 mg once a day. The Psychiatrist accepted and put the order in place. Resident 53's behavioral assessments were reviewed from January 2024 through current date. The Behavioral assessments reviewed psychotropic medication management and adjustments related to her psychiatric related diagnoses, the assessments lacked documentation of Resident 53's seeking affection, from her male peer. Resident 53's Activity Assessments were reviewed from January 2024 through the current date. The Activity Assessments lacked documentation of her preference to have a meaningful relationship with Resident 55 as an overall part of her life enrichment program. Resident 53's comprehensive care plans were reviewed, which included, but were not limited to the following: a. a comprehensive care plan initiated 1/25/22 which indicated, [Resident 53] resides on a secured memory care unit due to diagnosis of dementia and benefits from specialized activity care programming. Interventions for this plan of care included but were not limited to: keep resident involved in activities and o socialization to divert behaviors, loneliness, sadness. No new interventions for this plan of care had been added/revised since the initial implementation to include her preference to maintain an ongoing relationship with Resident 55 which may include more intimate contact such as snuggling in bed. b. a compressive care plan initiated 2/13/24 indicated, [Resident 53] exhibits behavior symptoms of wandering in and out of other resident's rooms and refusing to leave. The care plan lacked revision to include Resident 53's preference/habit of going to Resident 55's room, and that it may be allowed as tolerated by Resident 55. c. a comprehensive care plan initiated on 3/24/23 indicated, [Resident 53] has difficulty sleeping related to [diagnosis] of insomnia as evidenced by sleep disturbance. The care plan was not revised to include Resident 53's habit/tendency to go to Resident 55's room and/or that she may sleep better with her companion. A nursing progress note 5/14/24 at 5:53 a.m., indicated, Resident 53, .was up in the hall several times in the night, and escorted back to bed. During a.m. bed check she was seen in a male patient's bed, while being escorted back to her room she fell on her right hip that had a brush in the pocket and c/o pain at that hip . On 5/14/24 at 10:39 a.m., the Interdisciplinary team (IDT) met to review Resident 53's fall.review for witnessed fall on 5/14. Resident had been up and down throughout night shift and had to be re-directed back to room. During last bed round, it was noted that she had wandered into another resident's room and was in their bed. Resident again redirected back to her room. Staff assisted resident, showing resident location of room. While ambulating back to room, she stumbled and fell . the IDT team determined, .Resident resides on a secured unit, has poor safety awareness and a dx [diagnosis] of dementia . therapy to evaluate (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an interview on 8/7/24 at 1:10 p.m., Resident 55's family member indicated they were aware Resident 55 and Resident 53 were close. In fact, Resident 55 often indicated, he was in love with [Resident 53], but in May and June of 2024, Resident 55 had experienced a progression in the worsening of his dementia and started to have aggressive physical and verbal outbursts. The family thought he would never hurt Resident 53, but was concerned about the safety of anyone who might try to intervene between the two or make perceived advances towards Resident 53. Resident 55 was very protective, of Resident 53. Resident 55's family indicated they wanted Resident 55 to be able to continue his relationship with Resident 53, but was worried that when his dementia got worse he might be more of a danger to her or other residents. On 8/7/24 at 3:18 p.m., Resident 55's medical record was reviewed. He was a long-term care resident who resided on the secured MC unit with diagnoses which included, but not limited to, vascular dementia, unspecified mild dementia with psychotic disturbance, psychotic disorder with delusion, other problems related to lifestyle, mood disturbance, anxiety. A quarterly MDS assessment, dated 7/2/24, indicated Resident 55 was moderately cognitively impaired with a BIMS score of 10 out of 15. A routine Psychiatry assessment, conducted on 5/15/24 at 4:06 p.m., indicated, .[Resident 55] is alert and pleasantly confused. States he is doing well- makes good eye contact- conversation is logical and linear. Patient focused on female resident he keeps company with at times. States he enjoys her, but she is a 'two -timer.' The psychiatry note indicated Resident 55 was to continue taking cimetidine 200 mg twice a day for inappropriate sexual behavior. A nursing progress note, dated 6/18/24a t 6:51 a.m., indicated, Resident asking for his social security check, staff attempted to tell resident that bank was not open yet, resident became combative attempting to strike at staff with closed fist and screaming names at nurse. Resident than went to his room and slammed door A nursing progress note, dated 6/24/24 at 10:11 a.m., indicated, .Resident making delusional statements, believes that other residents are conspiring against him and making plans to 'mess up' his life. Resident aggression increased toward staff. Resident has been making statements that he will 'mess them up.' Resident states he isn't talking about anyone in particular. POA said that when she took res [resident] to BINGO, he was ranting and punching her car An acute Psychiatry progress note, dated 6/25/24 at 1:27 p.m., indicated, .Staff reports patient is displaying acute changes in mood and anxiety. Medications reviewed with no recent changes in psychotropic medications since 2/2025. Patient with recent outing with family - where he was reported as verbally and physically aggressive. This was not witnessed during the assessment today (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note, dated 6/26/24 at 9:22 a.m., indicated, .Resident having increased [behaviors] becoming verbally aggressive with staff and threatening to 'hu' them this day. Redirection difficult, resident hyper-fixated on another male resident, he states that this resident 'wants to date him,' said resident is friendly and non-verbal. All attempts to encourage resident to understand that his thinking is not correct are met with resistance as he believes this to be true. Resident in activity room playing game, other resident entered room to also participate, which set resident off, he instantly became agitated, other resident had not said or done anything. When asked why resident became agitated, he said that he just 'knows he wants me, and I don't want to be around that' . Notified psych NP [Psychiatric Nurse Practitioner] yesterday of ongoing increased bx [behaviors], order obtained for labs to r/o medical cause, resident had GDR of antipsychotic medication in [DATE]. Will notify NP of bx On 6/26/24 the Psych NP started Resident 55 on Trazadone (an antidepressant medication) 50 mg daily and 25mg as needed every 6 hours for 14 days for agitation. A nursing progress note, dated 6/30/24 at 9:08 p.m., indicated, .patient was upset and vented to me in his room saying he thinks we are drugging people that he takes a baby aspirin in the morning for his heart and that was all he was ever going to take. He talked about a woman here that he likes calling her his girlfriend and that she does not return the feeling working himself up into a frenzy Resident 55's behavioral assessments were reviewed from January 2024 through current date. The Behavioral assessments reviewed psychotropic medication management and adjustments related to his psychiatric related diagnoses. The assessments lacked documentation of Resident 55's feelings towards Resident 53 and his preference to visit with her, or that he sometimes considered her a two-timer. Resident 55's Activity Assessments were reviewed from January 2024 through the current date. The Activity Assessments lacked documentation of his preference to have a meaningful relationship with Resident 53 as an overall part of her life enrichment program. Resident 55's comprehensive care plans were reviewed, which included, but were not limited to the following: a. a care plan initiated . He prefers to be involved in in mostly independent interest he enjoys sitting by the window in his room and looking out, he likes to talk with his daughter on the phone. Seems to enjoy the daily chronicle. Enjoys westerns, action movie, coffee and conversations, socialization, music, and snacks and hydration. [He] goes to Bingo with his daughter every Thursday and enjoys this. This plan of care lacked revision to address/include person-centered goals/interventions for his preference to visit with and have a meaningful relationship with his peer, Resident 53. b. a care plan initiated 4/4/23 which indicated, . he has difficulty sleeping related to dx of sleep disorder as evidenced by awakens frequently during the night. The care plan lacked revision/documentation to address Resident 53's behaviors of coming into his bed at night. c. a care plan initiated on 4/28/24 which indicated, .he exhibits behavior symptoms of wanting a STOP sign placed outside door to prevent residents from wandering into room The care plan lacked revision/documentation to address his preference that Resident 53 was allowed to come in his room if the STOP sign was up. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. a care plan initiated on 7/18/23 which indicated, .he exhibits behavior symptoms of: behavioral symptoms thinking he has a girlfriend on the unit and will hold hands with female residents. The care plan lacked revision/documentation of goal/interventions to ensure an appropriate and meaningful relationship with Resident 53 could be maintained. On 8/8/24 at 1:53 p.m., the Regional Nurse Consultant (RNC) provided a copy of current facility policy titled, Comprehensive Care Planning, with an effective dated of 1/2/24. The policy indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment . 'person-centered care' means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives . The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma-informed . the comprehensive care plan will describe, at a minimum, the following: . resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated The Facility Assessment tool, dated 5/20/24, indicated, Specific Care and Practices, included but not limited to, .Mental Health and Behavior: Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care pf someone with cognitive impairment Provide person-centered/direct care: psych/social/spiritual support: build a relationship with resident/get to know him/her; engage resident in conversation. Find out what resident's preferences and routines are; what makes a good day for the resident; what upsets him/her and incorporate this information in to the care planning process . record and discuss treatment and care preferences . identify hazards and risks for residents 3.1-37(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46414 Based on observation, interview, and record review, the facility failed to label and date medications when opened and remove expired medications from use for 3 of 5 medication carts and 1 of 2 refrigerators observed for medication storage. Findings include: 1.On 8/4/24 at 10:14 a.m., the 600 hall medication cart was observed for medication storage. a. Resident 26 had an albuterol AER 90 mg (milligram) inhaler (used to treat breathing conditions) with no date to indicate when it was opened. b. Resident 26 had trelegy ellipta (used to treat breathing conditions) 100/62.56/25 mcg (microgram) without a date to indicate when it was opened. c. Resident 22 had a bottle of fluticasone nasal spray (used for allergies) 50 mcg without a date to indicate when it was opened. 2.On 8/4/24 the 700 hall medication cart was observed for medication storage. a. Resident 32 had a Humalog insulin pen with a date opened of 5/24/24. It had expired on 6/23/24. b. Resident 2 had a Humalog insulin pen with a date opened of 5/29/24. It had expired on 6/27/24. c. Resident 2 had a glargine insulin pen with a date opened of 5/26/24. It had expired on 6/23/24. d. Resident 39 had a bottle of carboxymethyl solution 0.5% (natural tears) without a date to indicate when it was opened. 3. On 8/4/24 the 800 hall medication cart was observed for medication storage. a. Resident 18 had a basaglar insulin pen with no date on it to indicate when it was opened. b. Resident 18 had a NovoLog insulin pen with no date to indicate when it was opened. c. Resident 9 had a bottle of deep sea nasal spray with no date to indicate when it was opened. 4.On 8/4/24 the 600, 700 and 800 medication room refrigerator were observed for medication storage. a. Had a vial of tuberculin (used to administer tuberculosis testing) that expired on 7/3/24. b. Had a bottle of aplisol (used to administer tuberculosis testing) with an unclear date on it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/8/24 at 2:10 p.m., the Director of Nursing Services (DNS) and Corporate Clinical Specialist (CCS) indicated they have conducted education regarding medication labeling and dating and indicated they are conducting daily auditing. A policy titled, Interdisciplinary Team (IDT) Risk Review Meeting, was provided by the Executive Director (ED) on 8/8/24 at 10:09 a.m., It indicated, .It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security 3.1-25(j) 3.1-25(m) 3.1-25(n)