STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165355	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keota Health Care Center	204 North Keokuk Washington Road Keota, IA 52248

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on observation, interview, clinical record review, and facility policy review, the facility failed to ensure residents were treated in a manner to preserve dignity and respect for 1 of 2 residents reviewed for dignity (Resident #20) when staff failed to ensure residents had been kept clean and free from odors following episodes of incontinence in a timely manner (Resident #20), made unkind comments in the presence of residents in the dining room, and staff interview revealed concerns with a staff member being unkind. The facility reported a census of 26 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated moderate cognitive impairment. Resident #20 required substantial to maximal amount of staff assistance for toilet hygiene and frequently incontinent of urine. Diagnoses included non-traumatic brain dysfunction, non-Alzheimer's dementia, heart failure, depression, and psychotic disorder. The Care Plan, revised on 9/27/24 revealed Resident #20 had impaired cognitive function evidenced by short and long term memory deficits, impaired decision making, and impaired ability to understand others related to a diagnosis of dementia with mood disturbance. Resident #20 at risk for impaired skin, Urinary Tract Infections, and irritation in perineal area related to incontinence of bowel and bladder. Interventions instructed staff to encourage fluids, provide prompt voiding responses, and provide perineal cares twice per day and as needed with each episode of incontinence. Review of Resident #20's Hospice Provider Visit Notes, revealed the following documented entries: 1. On 8/26/24 during a visit from a Hospice Provider, Resident #20 found to be incontinent of large amount of urine with strong odor. Resident noted to be very lethargic and weak. 2. On 9/04/24, during a visit from a Hospice Provider, Resident #20 found laying in bed, flat on back, with lunch plate on her abdomen. Provider observed Resident #20 eating from plate with fingers while laying flat on back. Note indicated Hospice Provider removed food from Resident #20's hair and noted a very strong urine odor. Resident #20 assisted to bathroom and Provider saw that Resident #20 was wearing both a tabbed brief and pull up type incontinent product, and had both saturated in urine and stool incontinence. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 10:00 AM, Nurse for Hospice stated it seemed like for a while every time they would come in to visit Resident #20, she would be saturated in urine with dirty brief on and when asked, facility staff would report Resident #20 had refused cares. Hospice Nurse reported during more recent visits, Resident #20 had been clean, and her room had been cleaner. On 11/13/24 at 12:03 PM, Social Worker for Hospice reported during a recent visit, Resident #20 found laying in bed at approximately 9:00 AM, with gown falling off, and appeared as if morning cares had not yet been completed as resident had not been dressed for the day. Social Worker informed this was reported to facility staff who then assisted Resident #20 with cares. 45338 2. A dining observation conducted 11/5/24 revealed the following: On 11/5/24 at 11:24 AM during a dining observation with residents present in the dining room, Staff C, Certified Nursing Assistant (CNA) heard to say the following to a resident: Slow down, look at all that food in your mouth. When something dropped to the floor, Staff C stated, Every day. Staff C also heard to say the following during a dining observation: It's not a race .smaller bites. On 11/19/24 at 2:37 PM during an interview with the facility Administrator about the above observation, the Administrator explained it would depend on the tone and how was said. Per the Administrator, sometimes became more like buddies than caretakers, and not malicious, and described as banter. 35434 3. On 11/18/24 at 11:31 a.m., via phone, Staff K Certified Nursing Assistant(CNA) stated Staff C CNA could be kinder with her demeanor and a little more compassionate. On 11/19/24 at 11:59 p.m. via phone, the Director of Nursing(DON) of a sister facility stated staff should treat residents as they would treat their own mothers and fathers. They should be kind and compassionate. The facility policy Resident Rights, revised January 2019, directed employees to treat all residents with kindness, respect, and dignity.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 51573 Based on observation, facility policy, and clinical record review, the facility failed to safeguard the resident ' s personal and medical information. The facility reported a census of 26 residents. Findings Include: On 11/06/24 between 08:23a.m. -8:26 a.m., State Agency (SA) observed the computer left on and no one at the nurses desk with the point click care system (electronic charting software) open to document on residents and several names displayed. On 11/06/24 between 09:22 a.m. -11/06/24 09:31 a.m. when the computer timed out, the point click care (PCC) was open with several residents ' names displayed and no one sitting at desk. On 11/06/24 at 12:54 p.m., PCC system was open on a resident ' s chart and no one was sitting at the desk. On 11/06/24 at 02:25 p.m., Staff D, LPN walked away and left the resident chart open. Staff D, LPN Went to grab something in a different room and came back to the computer. Resident Rights Policy Statement with revised date of January 2019, directed staff as follows; The unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues. All inquiries concerning the release of resident information should be directed to the Health Insurance Portability and Accountability Act (HIPAA) Compliance Officer.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from sexual abuse for two of twelve residents reviewed for abuse (Resident #12, Resident #19). Resident #12, was a severely cognitively impaired resident with a previous history of unsolicited sexual touching. On 10/26/24, Resident #12, was touched on the breast underneath her clothing by Resident #19. On an unknown date, Resident #19 touched Resident #12 on the buttock. On an unknown date, staff reported Resident #19 grabbed/groped Resident #12. Resident #12's family explicitly instructed the facility staff that they did not consent to Resident #12 engaging in sexual contact with another resident. This deficient practice resulted in an Immediate Jeopardy (IJ) to the health and safety of residents. The facility failed to protect the resident's right to be free from resident to resident physical abuse for 5 of 15 residents reviewed for abuse(Residents #11, #12, #13, #21, #77). Resident #22 hit Resident #77, grabbed and scratched Resident #12, slapped Resident #11, slapped and pinched Resident #13, and grabbed the arm of Resident #2. The IJ was determined on 11/14/24 at 1:57 PM. The IJ began on 10/26/24. The IJ immediacy was removed on 11/18/24 at 12:27 PM. The Facility Staff removed the Immediate Jeopardy on 11/18/24 through the following actions: a. Care Plan revision for Resident #12 and Resident #19. b. All staff education about abuse. c. An ad-hoc Quality Assurance Performance Improvement (QAPI) meeting completed 11/14/24. The scope lowered from K to E at the time of the survey after ensuring the facility implemented education and their policy and procedure. Findings include: 1. Review of the Quarterly Minimum Data Set (MDS) assessment for Resident #12 dated 9/13/24 revealed the resident scored 5 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment, the resident cognitive patterns were documented as inattention which fluctuated and had behaviors described as having delusions. Review of Medical Diagnoses for Resident #12 included Wernicke's encephalopathy, dementia with psychotic disorder, dementia with mood disturbance, restlessness and agitation, and delusional disorders. Review of Resident #12's Care Plan dated 7/5/23 revealed the following: Trauma Informed Care: [Resident #12] is at risk for alterations in my psycho-social well being related to: Allegation of abuse. History of being recipient of unsolicited sexual touching. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #12's Care Plan dated 7/7/24 revealed, [Resident #12] has a Mutual friendship with a resident of the opposite sex. Interventions per the Care Plan included the following: a. (Created 7/7/24, revised 9/10/24): Do not shame or embarrass [Resident #12] for her friendship. b. (Created 7/7/24, revised 9/10/24): If [Resident #12's] friendship escalates beyond hugging/hand holding/sitting together, please redirect in a calm manner and we will re-assess the plan with staff, family and medical advice. c. (Created 7/7/24, revised 9/10/24): Mild affection (hugging/hand holding/sitting together) is acceptable for both families. d. (Created 10/28/24): Per POA: hand holding, sitting together, resident sitting on other male resident's lap, and a gentle kiss on the lips is within her scope for approval of behavior. Please separate residents if behaviors become more sexual in nature such as touching of one another's private areas e. (Created 7/7/24, revised 9/10/24): Report interactions as needed to Charge Nurse. f. (Created 7/7/24, revised 9/10/24): This friendship is acceptable if [Resident #12] is safe and happy. Review of Progress Notes for Resident #12 revealed the following: The Nursing Note dated 7/4/24 at 6:10 PM revealed, [Name Redacted] POA (Power of Attorney) aware of this resident engaging in activities of hand holding, hugging et (and) sitting together with another male resd (resident), POA consents to above activity continuing in public settings, not behind closed doors. Review of the Care Conference note dated 9/3/24 at 3:10 PM revealed, in part, [Resident #12] is declining in mental status. She is becoming increasingly confused and aggressive with cares. [Resident #12] is no longer able to take her medications whole, as she pockets them, or becomes confused by what to do with them and puts them in cups, bowls, or anywhere that she no longer can see them .[Resident #12] is increasingly confused. She is sleeping more and spending a significant amount of time in her room. She no longer sits in the common area or with the cat. The Nursing Note dated 10/26/24 at 5:56 PM revealed, CNA (Certified Nursing Assistant) reports to this nurse that at around 1555 (3:55 PM) a male resd reached up this resd (resident) shirt et groped her lt (left) breast while she was standing next to him. These 2 resd are care planned to have a friendly relationship that involve holding hands et hugging. This nurse witnessed female resd approach male resd seated in lobby, they proceeded to hold hands before this nurse had left to attend another resd. CNA separated the 2 resd. CNA reports that resd was asking where male resd went? CNA redirected et kept them apart. When female resd asked by this nurse if the male resd had touched her breast she states No. Administrator made aware. Called x 2 numbers for POA (Power of Attorney) with no answer et (and) left message. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a Nursing Note dated 10/28/24 at 8:04 AM revealed, Spoke with POA [name redacted] regarding potential incident from 10/26 where male friend may have touched resident's breasts. [POA name redacted] verbalizes that hand holding, sitting together, resident sitting on other male resident's lap, and a gentle kiss on the lips is within her scope for approval of behavior. She states to please separate residents if behaviors become more sexual in nature such as touching of one another's private areas. Care plan updated. On 11/13/24 at 12:06 PM, Resident #12 observed in her room in bed. On 11/18/24 at 2:10 PM, Resident #12 observed standing up by the nurses station near the lobby area of the facility. 2. Review of the Minimum Data Set (MDS) assessment for Resident #19 dated 10/9/24 revealed Resident #19 scored 14 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Review of diagnoses for Resident #19 included schizophrenia and dementia with anxiety. Review of Resident #19's Care Plan dated 7/4/24 and revised 7/5/24 revealed, [Resident #19] has a Mutual friendship with a resident of the opposite sex. Interventions per Resident #19's Care Plan included the following: a. (Initiated 7/5/24, Revised 9/10/24): Do not shame or embarrass [Resident #19] regarding this relationship. b. (Initiated 7/5/24, Revised 9/10/24): If [Resident #19's] friendship escalates beyond hugging/hand holding/sitting together, please redirect in a calm manner and we will reassess the plan with staff, family and medical advice. c. (Initiated 7/5/24, Revised 9/10/24): Mild affection (hugging/hand holding/sitting together) is acceptable for both families. d. (Initiated 10/28/24): POA (Power of Attorney) [Name Redacted] verbalizes that hand holding, sitting together, female resident sitting this resident's lap, and a gentle kiss on the lips is within his scope for approval of behavior. He states to please separate residents if behaviors become more sexual in nature such as touching of one another's private areas. [POA name redacted] also requests to be made aware if resident's behaviors with female friend appear to become inappropriate and not reciprocated. e. (Initiated 7/5/24, Revised 9/10/24): Report interactions as needed to Charge Nurse. f. (Initiated 7/5/24, Revised 9/10/24): This friendship is acceptable as long as [Resident #19] is safe and happy Review of Progress Notes for Resident #19 revealed: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Communication-with Family/NOK/POA dated 7/4/24 at 6:07 PM revealed, [Name Redacted] POA aware of this resident engaging in activities of holding hands, hugging et sitting together with another female resd, POA consents to above activity continuing in public settings, not behind closed doors. The Nursing Note dated 10/26/24 at 5:43 PM revealed, CNA reports to this nurse that at around 1555 (3:55 pm) this resident (resd) reached up a female resd shirt and groped her breast while she was standing next to him. These 2 resd are care planned to have a friendly relationship that involve holding hands et hugging. This nurse witnessed female resd approach male resd seated in lobby, they proceeded to hold hands before this nurse had left to attend another resd. No other resd in lobby witnessed event when asked. [Resident #19] was confronted and asked if anything happened when female resd approached him? resd states No. when asked if they were holding hands? He states yeah we were holding hands. Resd was asked if he touched female resd anywhere else? states her back side a little. Resd asked if he reached up female resd shirt? States no. Administrator made aware. POA [POA Name Redacted] made aware. The Nursing Note dated 10/28/24 at 8:12 AM revealed, Spoke with POA [Name Redacted] regarding potential incident from 10/26 where resident may have touched female friend resident's breasts. [Name Redacted] verbalizes that hand holding, sitting together, female resident sitting this resident's lap, and a gentle kiss on the lips is within his scope for approval of behavior. He states to please separate residents if behaviors become more sexual in nature such as touching of one another's private areas. [Name Redacted] also requests to be made aware if resident's behaviors with female friend appear to become inappropriate and not reciprocated. Care plan updated. The Behavior Note dated 11/1/24 at 2:22 PM revealed, Resd inappropriately touched activity director, when confronted that it is not appropriate to touch staff like that, resd becomes upset, made rude comment regarding situation to activity assistant ER ignored activity director. On 11/6/24 at 9:23 AM, Incident Reports for Resident #19 for the last six months requested via email to the facility's Administrator and Director of Nursing (DON). The Incident Report received did not address any interactions between Resident #12 and Resident #19. On 11/6/24 at 1:12 PM, Staff B, Licensed Practical Nurse (LPN) queried if had any residents who were boyfriend and girlfriend. Staff B responded they said that Resident #12 and Resident #19 were allowed to touch, kiss, and said I'm not really sure. Per Staff B, she had not seen them touch each other or speak word to each other. When queried how to know what was appropriate, Staff B responded she believed the POA said ok to do those things for both of those two. On 11/12/24 at 11:47 AM during an interview with Staff E, Registered Nurse (RN), Staff E explained Resident #12 and Resident #19 were not a couple, and were friends. Per Staff E, up until recently the residents had no notice of each other. Resident #19 started talking to Resident #12, and Resident #12 talking, not daily. Staff E explained they would hold hands, nothing had happened, and Staff E didn't think Resident #12 would let it as Resident #12 was very [NAME] and proper. Per Staff E, one day she was working second or day shift, and Resident #19 went down to Resident #12's room. Staff E responded to situation, and Resident 19 exited. When queried if ever heard of touching over or under clothes, Staff E responded no. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/12/24 at 2:27 PM, Staff D, Licensed Practical Nurse (LPN) explained the following about Resident #12 and Resident #19: Per Staff D, she (Staff D) was the one that brought to the DON's attention, ok with family, because kept on doing stuff holding hands, hugging. Per Staff D, had gotten approval from family that ok for friendly relationship, peck on the lips, sit with each other, hold hands, and nothing behind closed doors. Staff D explained Resident #12 would seek Resident #19 out, and Resident #19 calmed Resident #12 down. Staff D explained an aide said he saw Resident #19 reach up Resident #12's shirt. Staff D further explained the aide did not want them (residents) to be together because the aide thought Resident #12 could not make decisions for herself. The aide was identified as Staff H. When queried if Resident #12 had ever had a negative reaction, Staff D responded no. Per Staff D, she had never seen Resident #19 pursue Resident #12, and when she saw, Resident#12 went to Resident #19. On 11/13/24 at 12:22 PM, Staff H, Certified Nursing Assistant (CNA) explained the following about Resident #12 and Resident #19: Staff H explained they had seen interactions between Resident #12 and Resident #19 on two or three different times, and Resident #19 had inappropriately touched Resident #12 in some way. Per Staff H, Resident #12 stood there not doing anything, Resident #12 would bring herself to Resident #19, and needed to separate constantly and redirect to keep them away from each other. Staff H further explained they thought only one time Resident #19 grabbed Resident #12's breast, and they thought occurred the weekend of October 26/27. Per Staff H, another time Resident #19 grabbed Resident #12's butt. A third time, Staff H did not remember if Resident #19 grabbed or groped, Resident #19 did touch Resident #12 and Staff H did not remember how. Staff H provided the following details about when Resident #12's incident with breast touching: Staff H explained the grabbing of Resident #12's breast was under the clothes with full arm up When queried how Staff H knew what interactions were appropriate, Staff H explained they did not need a degree to see inappropriate anywhere. Staff H explained don't need to be grabbed/groped. Staff H explained they reported all of them (incidents) to staff at facility. When queried which staff Staff H talked to, Staff H responded the Director of Nursing (DON) one time, then talked to the floor nurses every time. Staff H further explained Resident #12 would just stand there and let Resident #19 do everything. When queried if Resident #12 said anything when it was happening, Staff H responded no. On 11/13/24 at 1:07 PM, Staff G, RN queried about any interactions between Resident #12 and Resident #19, responded yes, explained the DON said was ok, and Staff G thought inappropriate. Staff G explained Resident #12 sat on Resident #19's lap right in the middle of the day hall with all the residents there. Staff G explained she (Staff G) thought probably not good idea related to behaviors, and if approved by family, ok she supposed. Staff G explained the DON said had it approved by families could see each other. Staff G explained Resident #12 was not really with it. Per Staff G, it wasn't like sitting beside him (Resident #19) holding hands, was sitting on his (Resident #19's) lap. Staff G further explained she had told CNAs (Certified Nursing Assistants) why don't let divert these two, and got their attention somewhere else, which was easy to do. On 11/14/24 at 1:56 PM, the Administrator responded Resident #19 and Resident #12 were friends, the Administrator explained had heard holding hands came to light. The Administrator acknowledged not aware of touching of the resident's breast and butt. Per the Administrator, if unaware of touching of the resident's breast, then could not report. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/18/24 at 9:03 AM, Staff I, CNA queried about how Resident #12 and Resident #19 interacted. Staff I explained, part, Resident #12 was very sweet, and Staff I explained Resident #19 would take advantage of someone who's medicated. When queried what Staff I meant by take advantage, Staff I responded, like touch, explained I'm sitting beside you where would my hands go, and further explained I'm your friend can we take a walk. Staff I explained she got that feeling, and didn't think Resident #19 would do anything sexual but touching. When queried about touching between Resident #12 and Resident #19, Staff I responded holding hands walking down the hall, further explained she had seen them walk to breakfast, and Resident #19 would walk Resident #12 into the breakfast room. When queried about Resident #12's cognition, Staff I responded 50/50, and explained the resident had insomnia and was sometimes up at night. Per Staff I, Resident #12 wondered where her parents were, and would say here for memory not so good, then would flash back, and thought in [Another State Redacted] at times. On 11/18/24 at 10:39 AM, Staff J, CNA queried about Resident #12 and Resident #19. Per Staff J, Resident #19 a very independent guy and did not like getting too much in his space. Staff J described Resident #19's interactions with Resident #12 as normal, and Staff J further explained she felt like Resident #12 got confused when she (Resident #12) looked at Resident #19. Per Staff J, there were times when Resident #12 looked and asked to sit on Resident #19's lap, and Resident #19 said no. Staff J denied seeing any physical interactions between the residents, and said no, he's (Resident #19's) really with it. Per Staff J, Resident #19 had respect for Resident #12 and other residents. When queried about Resident #12's cognition, Staff J explained Resident #12 was anxious, loved to pace up and down the halls, and loved to sleep. Per Staff J, around the afternoon Resident #12 would start pacing back and forth, would get really anxious, and did not stop walking. Staff J explained Resident #12 had a hard time breathing because resident walked back and forth, which was usually a 4 hour thing or all night thing, and during the day resident slept all day. Staff J explained this was normal for the resident. On 11/19/24 at 10:43 AM, the Activities Director/Social Worker (SW) queried regarding consent process, and queried regarding Resident #12 and Resident #19. The Activities Director/SW explained she came to work one day and was told about consent (for Resident #12), the Activities Director/SW did not actually get a verbal from Resident #12's Power of Attorney (POA), and the Activities Director/SW was told POA was called and consent obtained to hold hands, talk, to sit on his lap, nothing else. The Activities Director/SW explained this was communicated via the facility's Director of Nursing (DON). When queried about a documented assessment for Resident #12 regarding consent to sexual activity, the Activity Director/SW explained she did a recent BIMS, resident scored a 6, and other than that no. When queried about consent regarding Resident #19, the Activities Director/SW explained it was all told to her (Activities Director/SW) on that same day. When queried about the facility's process for obtaining consent, the Activities Director/SW responded she was told as long as no touching of private areas it was ok, and it was residents rights. Per the Activities Director/SW, she felt had rights to hold hands, and nothing more than that. When queried if any staff had come to her with concerns, the Activities Director/SW denied, explained she even witnessed them talking to each other, and other than that nothing sexual going on. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Per the Activities Director/SW, there was an allegation that transpired that the DON mentioned when in morning meeting, which was when the DON told Activities Director/SW she had gotten consent from Resident #12's POA and had talked to Resident #19 about not doing anything inappropriate. When queried what the allegation entailed, the Activities Director/SW explained was about him putting his hand in her shirt. The Activities Director/SW explained there was an incident a couple weeks ago that Resident #19 did to the Activities Director/SW which she documented and talked to Resident#19 that inappropriate. The Activities Director/SW explained Resident #19 had grabbed the Activities Director/SW's butt. On 11/19/24 at 2:43 PM when queried if there was a process of whether or not resident able to give consent on the resident level, the facility's Administrator shook her head. Per the Administrator, went by the BIMS score, and the POA and see what consent they give. The Administrator further explained a situation where maybe the POA would say resident in their own mind and could make their own decisions, and the POA may be able to make consent for the resident to make their own decisions. Review of the Facility Policy titled Abuse Policy, undated, revealed the following: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart .Sexual abuse is defined as non-consensual sexual contact of any type with a resident, including sexual harassment, sexual coercion or sexual assault. 35434 On 11/4/24 at 11:26 a.m., Resident #19 sat in a chair in the main dining room and ate lunch. The State Agency(SA) made multiple attempts throughout the survey to speak with him with no success. 3. The Minimum Data Set(MDS) assessment tool, dated 6/21/24, listed diagnoses for Resident #22 which included diabetes, arthritis, and hip fracture. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 1 out of 15, indicating severely impaired cognition. The MDS stated the resident had the following: a. physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) which occurred 1-3 days out of the 7 day review period. b. verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) which occurred 4-6 days out of the 7 day review period. c. other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) which occurred 1-3 days out of the 7 day review period. A 6/21/24 Care Plan entry directed staff to intervene as necessary to protect the rights and safety of the other residents, divert attention, remove from the situation/location if needed, and approach/speak in a calm manner. An 8/22/24 Care Plan entry directed staff to redirect the resident when she became notably agitated and to monitor her when she was around others. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An 8/26/24 Care Plan intervention directed staff to monitor the resident when she was in the hallways to ensure safe interactions with other residents. The entry directed staff to remove her from other residents and intervene when she headed toward other residents. An 8/28/24 Care Plan entry stated the physician made medication changes as an intervention to behaviors and resident to resident interactions. A 9/30/24 Care Plan entry directed staff to place the resident in an area where not within an arm's length of other residents. A Care Plan entry, revised 10/21/24, stated the resident had episodes of behaviors/potential for behaviors as evidenced by combativeness, negative verbalizations, name calling, screaming out, throwing things at staff, cursing at staff and other residents, stabbing the dining table with a fork, scratching staff, cussing at staff and other residents, flipping staff off with middle finger, yelling, as well as other aggressive behaviors. The resident had the following incidents: On 8/22/24, the resident hit another resident. On 8/26/24, the resident grabbed and scratched another resident. On 9/6/24, the resident slapped another resident. On 9/30/24, the resident slapped and pinched another resident while she called them names. On 10/20/24, the resident grabbed the arm of another resident. a. Resident #22 and Resident #77 The MDS assessment tool, dated 7/10/24, listed diagnoses for Resident #77 which included diabetes, non-Alzheimer's dementia, and chronic pain. The MDS listed his BIMS score as 0 out of 15, indicating severely impaired cognition. An 8/22/24 Resident to Resident Altercation report stated the resident approached another resident who sat in the lobby area watching TV and hit him in the head. An 8/22/24 Nursing Note stated Resident #77 sat in the TV room and Resident #22 walked over to him, began talking, and hit him on the head several times. The CNA intervened and took Resident #22 to her room to lie down. b. Resident #22 and Resident #12 The MDS assessment tool, dated 6/13/24, listed diagnosis for Resident #12 which included arthritis, Alzheimer's, and non-Alzheimer's dementia. The MDS listed the resident's BIMS score as 5 out of 15, indicating severely impaired cognition. An 8/26/24 Resident to Resident Altercation report stated the Resident #22 had a hold of another resident's bilateral(referring to both sides) arms and scratched the resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An 8/26/24 Progress Note stated another resident grabbed and scratched Resident #12's arms. c. Resident #22 and Resident #11 The MDS assessment tool, dated 8/28/24, listed diagnoses for Resident #11 which included non-Alzheimer's dementia, anxiety, and psychotic disorder. The MDS listed a BIMS score of 0 out of 15, indicating severely impaired cognition. A 9/6/24 Resident to Resident Altercation report stated a female resident told Resident #22 to shut up and Resident #22 slapped the female resident across the face to the left cheek. A 9/6/24 Nursing Note stated Resident #11 told another resident to shut up and the other resident slapped Resident #11. Staff separated the residents. d. Resident #22 and Resident #13 The MDS assessment tool, dated 8/21/24, listed diagnoses for Resident #13 which included non-Alzheimer's dementia, depression, and psychotic disorder. The MDS listed the resident's BIMS score as 4 out of 15, indicating severely impaired cognition. A 9/30/24 Physical Aggression Initiated report hit and pinched another resident. The other resident also hit Resident #22. A 9/30/24 Nursing Note stated the resident sat in the lobby next to another resident and started hitting and pinching her. The other resident also hit and pinched. e. Resident #22 and Resident #21 The MDS assessment tool, dated 9/13/24, listed diagnoses for Resident #21 which included diabetes, Parkinson's(a disease which causes tremors), and depression. The MDS listed the resident's BIMS score of 0 out of 15, indicating severely impaired cognition. A 10/20/24 Verbal Aggression Received report stated another resident yelled at Resident #22 and Resident #22 carried out a light grasp of the right upper arm(of the other resident). A 10/20/24 Incident Note stated a resident grabbed Resident #21's arm when Resident #21 asked her not to tap the couch. On 11/7/24 at 2:04 p.m., the Administrator stated she wanted residents treated with respect,compassion and kindness. On 11/13/24 at 8:38 a.m., Staff D Licensed Practical Nurse(LPN) stated Resident #22 was banging on the couch and Resident #21 yelled at her to stop. She stated Resident #22 reached over and took Resident #21's arm. She stated Resident #22 could be pretty rough but Resident #21 did not scream out. She stated Resident #22 will snap. She stated she assumed the facility reported the altercation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/18/24 at 8:44 a.m., via phone, Staff I Certified Nursing Assistant(CNA) stated Resident #22 did act out against other residents. She stated if she thought people were in her bubble, she would point her finger at them, cuss at them, and sometimes she slapped them. She stated they kept an eye on her but there were not enough staff to monitor her and they were busy. She stated when she worked there were only 2 people on staff and this was not enough. On 11/19/24 at 11:59 a.m. via phone, the Director of Nursing(DON) of a sister facility stated with regard to a resident with a history of resident to resident physical altercations, she would not sit that person near residents where she could reach them. Staff should carry out checks and monitoring. On 11/19/24 at 1:57 p.m., the Administrator stated Resident #22 was spontaneous. She stated it could get congested(in the TV area) and they needed to come up with a better plan because the residents were too close together. She stated they needed to educate staff so they were more aware of what was best to keep everyone safe. The undated facility Abuse Policy stated the resident had the right to be free from abuse which would include physical and sexual abuse.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on observation, interview, and record review the facility failed to conduct thorough investigations into allegations of abuse including injury of unknown origin, following concerns with staff rough treatment towards residents resulting in fear, following resident to resident incidents, and failed to ensure separation of alleged perpetrators following staff after becoming aware of allegations of abuse for eight of twelve residents reviewed for abuse (Resident #7, Resident #11, Resident #12, Resident #15, Resident #16, Resident #19, Resident #20, Resident #21). This failure resulted in Immediate Jeopardy to the health, safety, and security of the resident. The facility reported a census of 26 residents. The State Agency informed the facility of the Immediate Jeopardy (IJ) on 11/14/24 at 1:57 PM. The IJ began on 9/26/24. Facility staff removed the Immediate Jeopardy on 11/18/24 at 12:28 PM by implementing the following actions: 1. All residents interviewed on 11/14/24, with no further allegations of abuse or neglect identified. 2. All staff interviewed on 11/14/24, with 4 allegations reported to State Agency and initiated investigation. Any associated staff suspended pending investigation. 3. Facility provided all staff education on abuse, immediate separation, and reporting of any abuse immediately to the Facility Administrator. Education completed by end of the day 11/14/24, or prior to working next shift. 4. An ad hoc Quality Assurance and Performance Improvement (QAPI) meeting conducted on 11/14/24, to review policy on abuse, immediate separation, reporting of abuse, and completing thorough investigation. The scope lowered from K to E at the time of the survey after ensuring the facility implemented education and their policy and procedure. Findings Include: 1. The Minimum Data Set (MDS), dated [DATE], revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated moderate cognitive impairment. MDS revealed Resident #20 had delusions, verbal and physical behaviors, and rejection of cares. Resident #20 had impairment of bilateral lower extremities, utilized a wheelchair for mobility, and required substantial to maximal amount of staff assistance to transfer. Diagnoses included non-traumatic brain dysfunction, non-Alzheimer's dementia, heart failure, depression, and psychotic disorder. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Care Plan, revised on 9/27/24 revealed Resident #20 had impaired cognitive function evidenced by short and long term memory deficits, impaired decision making, and impaired ability to understand others related to a diagnosis of dementia with mood disturbance. The Care Plan identified a risk for chronic pain and revealed Resident #20 had displaced comminuted fracture of the left humeral neck and greater tuberosity with soft tissue swelling on 9/26/24. Intervention instructed staff to apply left shoulder immobilizer as ordered and as tolerated by resident, for comfort. A Nursing Progress Note, dated 9/25/24 at 5:53 AM, revealed Resident #20 was found to have swelling and slight bruising on left shoulder spread down arm to the elbow, resident unable to move arm. Note informed that nurse reported Resident #20's condition to an on call Provider and received orders to send resident to the hospital for an evaluation. On 9/25/24 at 8:18 AM, a Nursing Note revealed that Resident #20's Hospice Provider notified the Hospital of resident and family wishes for no treatment and resident sent back to the facility. On 9/25/24 at 8:50 AM, Note informed that Resident #20 had returned to facility with pain rated 8 on a scale of 1 to 10., and left arm charted as purple and black around the entire upper arm. At 10:00 AM, facility received an order from Provider for portable x-ray, 2 views, of left shoulder. An x-ray report, dated 9/26/24, revealed findings of displaced comminuted fracture of the left humeral neck and greater tuberosity with soft tissue swelling. Incident Report for injury of unknown cause completed on 9/26/24 by Director of Nursing (DON). The Report description of incident revealed, Resident #20 found by Certified Nursing Assistant (CNA) with pain to left shoulder, Nurse assessed resident observed bruising and abnormal range of motion. Incident Report identified an injury located on the front of left shoulder, unable to identify injury type, and immediate action had been Resident #20 sent to emergency room (ER). Review of Skin Assessments completed on Resident #20, revealed the following information documented on left shoulder bruising: 1. 9/26/24: Bruise to front of left shoulder measuring 16 centimeters (cm) by 26 cm. 2. 9/30/24: Large bruise to front of left shoulder with Resident #20's arm in sling. No measurements or wound description documented. 3. 10/03/24: Bruise to left shoulder, migrated down front of left chest and down left arm to the wrist and hand. No measurements or wound description documented. 4. 10/07/24: Large bruise starting at left shoulder and extending down the left chest/breast and left arm/hand. Bruising noted to be different colors of healing and Resident #20 continued to have sling in place. Review of the facility's submitted list of self reported incidents revealed a report had been submitted on 9/26/24 at 3:22 PM to the State Agency, which listed the incident date as 9/25/24 and incident type as accident with major injury. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's 5 day investigation summary for self-reported incident revealed an investigation was completed for an unwitnessed incident and informed that an incident occurred on 9/25/24 at approximately 2:15 PM. The investigation summarized incident as Resident #20 being fine and without pain or bruising noted to left shoulder on 9/25/24, between 8:00 AM and 5:38 PM. Bruising then observed to left shoulder on 9/26/24 at 6:00 AM and nurse sent Resident #20 to the hospital. Upon return from the hospital a portable x-ray had been completed and results of fracture shared with Provider, who stated this injury had to come from trauma or a fall, no staff had witnessed. The 5 day investigation revealed intervention for incident would be to redirect Resident #20 as she required staff assistance and often ambulated on her own. The root cause analysis of incident informed that Resident #20 is not able to recall event and had not stressed any long term effects from the incident. Facility's 5 day summary did not identify potential for abuse and lacked abuse related investigation for injury of unknown origin. The facility provided a document to State Surveyor on 11/14/24 at 12:46 PM, titled Injury Timeline, and listed that the following events had taken place on 9/25/24 and 9/26/24: 1. On 9/25/24, no time documented, Resident #20 observed standing in doorway of another resident's room, leaning heavily on left arm/elbow against the doorframe and was assisted by 2 staff into wheelchair. 2. On 9/25/24, no time documented, Resident #20 found in bathroom by nurse, self-transferred to toilet, assisted by 2 staff to ambulate with walker back to bed. 3. On 9/26/24, no time documented, night shift Certified Nursing Assistant (CNA) found bruise to Resident #20's left shoulder and reported to nurse who sent Resident #20 to the hospital. Resident #20 returned to facility and had x-ray completed on left shoulder, results received and reported to Attending Physician, family, and Hospice Provider. 4. On 9/26/24, no time documented, facility began self report process, and obtained statements from all staff members who worked with Resident #20 on 9/25/24 and 9/26/24. A Provider Note, dated 10/23/24, revealed that Resident #20 had a fall and sustained a fracture to left humerus and left upper extremity in an immobilizer. Addendum to 10/23/24 Visit Note, documented on 11/13/24, revealed that there is no facility documentation of a fall and how arm fracture occurred is unknown. On 11/06/24 at 1:00 PM, Staff L, CNA, stated they had found bruise on Resident #20's left shoulder, on 9/26/24 around 5:00 AM, when the resident stated that her arm hurt and immediately reported this to nurse. Staff L recalled that Resident #20 had previously complained of a male CNA being rough with her, Staff L unable to provide specific dates or times for these occurrences and had not personally witnessed any rough handling of Resident #20 by any staff. Resident #20 unable to provide Staff L with a name, instead described male CNA as that big guy. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/12/24 at 11:15 AM, Staff E, Registered Nurse (RN) stated that around 5:00 AM on 9/26/24, Staff L had called nurse into room to report left shoulder bruise. Staff E recalled that Resident #20's left shoulder appeared huge with black and blue colored bruising. Staff E stated that this injury had not been passed along in shift report and no one had reported anything previously about bruising or falls that she was aware of. Staff E informed that if Resident #20 had fallen, there would be no way resident could get up off the floor independently. Staff E also recalled that Resident #20 had previously mentioned both a male CNA, and a female CNA being rough with her, Resident #20 unable to provide Staff E with staff names. Staff E unable to provide specific dates or times for these occurrences with Resident #20. On 11/12/24 at 1:30 PM Staff G, RN, confirmed working as charge nurse on the evening of 9/25/24 and stated they did not receive any report or have any observation of Resident #20's left shoulder being bruised or swollen. Staff G reported finding Resident #20 alone in her bathroom, sitting on the toilet and called for CNA staff to assist resident with cares. Staff G stated that Staff C (CNA) and Staff J (CNA) entered Resident #20's room to assist with toileting and Staff G left the room. Staff G stated that after leaving Resident #20's room, she did hear resident call out for help and when Staff G re-entered Resident #20's room, the resident was laying in bed while Staff C and Staff J stood next to the bed. Staff G recalled that Resident #20 complained that she was hurting all over, but refused pain medication when nurse offered. Staff G stated she did not receive any report from Staff C or Staff J that any incidents or injuries occurred. On 11/13/24 at 9:16 AM, Staff C, CNA, confirmed working with Resident #20 on the evening of 9/25/24 and informed that she had been called by Staff G (RN) into bathroom to assist after Resident #20 had self-transferred to toilet. Staff C reported that Staff J also assisted with Resident #20's toileting cares and recalled that Resident #20 had difficultly when walking with walker from the bathroom back to bed. Staff C informed that Resident #20 had complained of having pain all over and reported this to the nurse. Staff C denied any incident or injury observed or reported while assisting Resident #20 with cares. On 11/18/24 at 10:30 AM, Staff J, CNA, confirmed working with Resident #20 on the evening of 9/25/24 and revealed that Resident #20 had self transferred to bathroom so charge nurse asked Staff J and Staff C to assist her. Staff J recalled Resident #20 had been sitting on toilet when approached with tabbed brief off on the floor of the bathroom, staff assisted resident with cares and when ambulating her back to bed, Resident #20 became weak and required transfer into wheelchair, then a stand-pivot transfer into bed. Staff J stated Resident #20 had complained of her whole body hurting when CNA staff repositioned her in bed. On 11/19/24 at 12:30 PM, Director of Nursing for sister facility, provided assistance with State Survey, revealed the expectation for an injury of unknown origin to be automatically turned in to State Agency and investigated as potential abuse. Sister facility DON revealed that the investigation would include a root cause analysis, interviews with staff and residents, to try and figure out what happened. On 11/19/24 at 2:06 PM, Facility Administrator revealed that Resident #20's injury of unknown origin had been reported to the State Agency after notification had been received from DON that resident had a left shoulder fracture. 45338 (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Review of the Quarterly Minimum Data Set (MDS) assessment for Resident #12 dated 9/13/24 revealed the resident scored 5 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment, the resident inattention which fluctuated and delusions. Review of Resident #12's Care Plan dated 7/5/23 revealed the following: Trauma Informed Care: [Resident #12] is at risk for alterations in my psycho-social well being related to: Allegation of abuse. History of being recipient of unsolicited sexual touching. Review of Resident #12's Care Plan dated 7/7/24 revealed, [Resident #12] has a Mutual friendship with a resident of the opposite sex. Interventions per the Care Plan included the following: a. (Created 7/7/24, revised 9/10/24): Do not shame or embarrass [Resident #12] for her friendship. b. (Created 7/7/24, revised 9/10/24): If [Resident #12's] friendship escalates beyond hugging/hand holding/sitting together, please redirect in a calm manner and we will re-assess the plan with staff, family and medical advice. c. (Created 7/7/24, revised 9/10/24): Mild affection (hugging/hand holding/sitting together) is acceptable for both families. d. (Created 10/28/24): Per POA: hand holding, sitting together, resident sitting on other male resident's lap, and a gentle kiss on the lips is within her scope for approval of behavior. Please separate residents if behaviors become more sexual in nature such as touching of one another's private areas e. (Created 7/7/24, revised 9/10/24): Report interactions as needed to Charge Nurse. f. (Created 7/7/24, revised 9/10/24): This friendship is acceptable if [Resident #12] is safe and happy. The Nursing Note for Resident #12 dated 10/26/24 at 5:56 PM revealed, CNA (Certified Nursing Assistant) reports to this nurse that at around 1555 (3:55 PM) a male resd reached up this resd (resident) shirt et groped her lt (left) breast while she was standing next to him. These 2 resd are care planned to have a friendly relationship that involve holding hands et hugging. This nurse witnessed female resd approach male resd seated in lobby, they proceeded to hold hands before this nurse had left to attend another resd. CNA separated the 2 resd. CNA reports that resd was asking where male resd went? CNA redirected et kept them apart. When female resd asked by this nurse if the male resd had touched her breast she states No. Administrator made aware. Called x2 numbers for POA (Power of Attorney) with no answer et (and) left message. 3. Review of the Annual MDS assessment for Resident #19 dated 10/9/24 revealed Resident #19 scored 14 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Review of Resident #19's Care Plan dated 7/4/24 and revised 7/5/24 revealed, [Resident #19] has a Mutual friendship with a resident of the opposite sex. Interventions per Resident #19's Care Plan included the following: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	a. (Initiated 7/5/24, Revised 9/10/24): Do not shame or embarrass [Resident #19] regarding this relationship. b. (Initiated 7/5/24, Revised 9/10/24): If [Resident #19's] friendship escalates beyond hugging/hand holding/sitting together, please redirect in a calm manner and we will reassess the plan with staff, family and medical advice. c. (Initiated 7/5/24, Revised 9/10/24): Mild affection (hugging/hand holding/sitting together) is acceptable for both families. d. (Initiated 10/28/24): POA (Power of Attorney) [Name Redacted] verbalizes that hand holding, sitting together, female resident sitting this resident's lap, and a gentle kiss on the lips is within his scope for approval of behavior. He states to please separate residents if behaviors become more sexual in nature such as touching of one another's private areas. [POA name redacted] also requests to be made aware if resident's behaviors with female friend appear to become inappropriate and not reciprocated. e. (Initiated 7/5/24, Revised 9/10/24): Report interactions as needed to Charge Nurse. f. (Initiated 7/5/24, Revised 9/10/24): This friendship is acceptable as long as [Resident #19] is safe and happy The Nursing Note for Resident #19 dated 10/26/24 at 5:43 PM revealed, CNA reports to this nurse that at around 1555 (3:55 pm) this resd reached up a female resd shirt et groped her lt (left) breast while she was standing next to him. These 2 resd are care planned to have a friendly relationship that involve holding hands et hugging. This nurse witnessed female resd approach male resd seated in lobby, they proceeded to hold hands before this nurse had left to attend another resd. No other resd in lobby witnessed event when asked. [Resident #19] was confronted and asked if anything happened when female resd approached him? resd states No. when asked if they were holding hands? He states yeah we were holding hands. Resd was asked if he touched female resd anywhere else? states her back side a little. Resd asked if he reached up female resd shirt?States no. Administrator made aware. POA [POA Name Redacted] made aware. On 11/12/24 at 2:27 PM, Staff D, Licensed Practical Nurse (LPN) explained the following about Resident #12 and Resident #19: Per Staff D, she (Staff D) was the one that brought to the DON's attention, ok with family, because kept on doing stuff holding hands, hugging. Per Staff D, had gotten approval from family that ok for friendly relationship, peck on the lips, sit with each other, hold hands, and nothing behind closed doors. Staff D explained Resident #12 would seek Resident #19 out, and Resident #19 calmed Resident #12 down. Staff D explained an aide said he saw Resident #19 reach up Resident #12's shirt. Staff D further explained the aide did not want them (residents) to be together because the aide thought Resident #12 could not make decisions for herself. The aide was identified as Staff H. When queried if Resident #12 had ever had a negative reaction, Staff D responded no. Per Staff D, she had never seen Resident #19 pursue Resident #12, and when she saw, Resident#12 went to Resident #19. Review of the self report list emailed by the Administrator on 11/4/24 lacked the alleged incident between Resident #12 and Resident #19 which occurred 10/26/24. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/6/24 at 9:23 AM, Incident Reports for Resident #12 and #19 for the last six months requested via email to the facility's Administrator and Director of Nursing (DON). The Incident Report received did not address any interactions between Resident #12 and Resident #19. Review of an updated self report list emailed by the facility's Administrator on 11/13/24 lacked the alleged incident between Resident #12 and Resident #19 on 10/26/24. On 11/19/24 at 2:44 PM. the Administrator explained, in part, she had received a text message over the weekend; Staff D did the investigation, and was told one thing versus what the CNA said. Per the Administrator, she trusted the Charge Nurse to do investigation. When queried more about the text message, the Administrator explained she had received a voicemail, and acknowledged she listened to the voicemail maybe a couple of days ago. When queried about the voicemail, the Administrator explained said there's an allegation of CNA saying Resident #19 put hand up Resident #12's shirt, and doing investigation. Per the Administrator the voicemail was from Staff D. The Administrator explained Staff D asked Resident #12 and Resident #19 what really happened, and both denied. From there, separated and made sure no more contact. The Administrator further explained the DON investigated when she got back to work, there was care plan for holding hands, hugging, not to do other stuff. The Administrator acknowledged there was no statement from Staff H, CNA until 11/19/24 or 11/18/24. It was noted Staff H reported to State Agency having witnessed multiple interactions between Resident #12 and Resident #19, and it was also documented in both Resident #12 and Resident #19's clinical record on 10/26/24 that a CNA reported Resident #19 touched Resident #12's breast. 35434 On 11/4/24 at 11:26 a.m., Resident #19 sat in a chair in the main dining room and ate lunch. The State Agency(SA) made multiple attempts throughout the survey to speak with him with no success. 4. The Admission Minimum Data Set (MDS) assessment tool, dated 6/21/24, listed diagnoses for Resident #22 which included diabetes, arthritis, and hip fracture. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 1 out of 15, indicating severely impaired cognition. The MDS stated the resident had the following: a. physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) which occurred 1-3 days out of the 7 day review period. b. verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) which occurred 4-6 days out of the 7 day review period. c. other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) which occurred 1-3 days out of the 7 day review period. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A 6/21/24 Care Plan entry directed staff to intervene as necessary to protect the rights and safety of the other residents, divert attention, remove from the situation/location if needed, and approach/speak in a calm manner. An 8/22/24 Care Plan entry directed staff to redirect the resident when she became notably agitated and to monitor her when she was around others. An 8/26/24 Care Plan intervention directed staff to monitor the resident when she was in the hallways to ensure safe interactions with other residents. The entry directed staff to remove her from other residents and intervene when she headed toward other residents. An 8/28/24 Care Plan entry stated the physician made medication changes as an intervention to behaviors and resident to resident interactions. A 9/30/24 Care Plan entry directed staff to place the resident in an area where not within an arm's length of other residents. A Care Plan entry, revised 10/21/24, stated the resident had episodes of behaviors/potential for behaviors as evidenced by combativeness, negative verbalizations, name calling, screaming out, throwing things at staff, cursing at staff and other residents, stabbing the dining table with a fork, scratching staff, cussing at staff and other residents, flipping staff off with middle finger, yelling, as well as other aggressive behaviors. The resident had the following incidents: On 8/22/24, the resident hit another resident. On 8/26/24, the resident grabbed and scratched another resident. On 9/6/24, the resident slapped another resident. On 9/30/24, the resident slapped and pinched another resident while she called them names. On 10/20/24, the resident grabbed the arm of another resident. 5. The Quarterly MDS assessment tool, dated 9/13/24, listed diagnoses for Resident #21 which included diabetes, Parkinson's (a disease which caused symptoms such as tremors), and depression. The MDS listed the resident's BIMS score of 0 out of 15, indicating severely impaired cognition. A 10/20/24 Verbal Aggression Received report stated another resident yelled at Resident #22 and Resident #22 carried out a light grasp of the right upper arm(of the other resident). A 10/20/24 Incident Note stated a resident grabbed Resident #21's arm when Resident #21 asked her not to tap the couch. The facility Self Reports log lacked documentation they reported the 10/20/24 incident. The facility also lacked documentation they conducted an investigation regarding the above incident or took steps to separate Resident #22 from other residents. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/13/24 at 8:38 a.m., Staff D Licensed Practical Nurse(LPN) stated Resident #22 was banging on the couch and Resident #21 yelled at her to stop. She stated Resident #22 reached over and took Resident #21's arm. She stated Resident #22 can be pretty rough but Resident #21 did not scream out. She stated Resident #22 will snap. She stated she assumed the facility reported the altercation. On 11/18/24 at 8:44 a.m., via phone, Staff I Certified Nursing Assistant(CNA) stated Resident #22 did act out against other residents. She stated if she thought people were in her bubble, she would point her finer at them, cuss at them, and sometimes she slapped them. She stated they kept an eye on her but there were not enough staff to monitor her and they were busy. She stated when she worked there were only 2 people on staff and this was not enough. On 11/19/24 at 1:59 p.m. via phone, the Director of Nursing (DON) of a sister facility stated with regard to a resident with a history of resident to resident physical altercations, she would not sit that person near residents where she could reach them. Staff should carry out checks and monitoring. On 11/19/24 at 1:57 p.m., the Administrator stated Resident #22 was spontaneous. She stated it could get congested(in the TV area) and they needed to come up with a better plan because the resident were too close together. She stated they needed to educate staff so they were more aware of what was best to keep everyone safe 6a. The MDS assessment tool, dated 10/23/24, listed diagnoses for Resident #7 which included diabetes, non-Alzheimer's dementia, and anxiety disorder. The MDS stated the resident's BIMS score was 1 out of 15, indicating severely impaired cognition. A 6/20/19 Care Plan entry stated the resident was independent with transfers. b. The MDS assessment tool, dated 8/28/24, listed diagnoses for Resident #11 which included non-Alzheimer's dementia, anxiety, and psychotic disorder. The MDS stated the resident required partial to moderate assistance for walking and listed a BIMS score of 0 out of 15, indicating severely impaired cognition. A 2/24/24 Care Plan entry stated the resident required the assistance of 1 staff for short and long distance walking as the resident allowed. c. The MDS assessment tool, dated 9/11/24, listed diagnoses for Resident #15 which included Alzheimer's disease, non-Alzheimer's dementia, and anxiety disorder. The MDS stated the resident walked independently and listed the resident's BIMS score as 0 out of 15, indicating severely impaired cognition. A 2/22/24 Care Plan entry stated the resident walked independently. d. The MDS assessment tool, dated 9/20/24, listed diagnoses for Resident #16 which included Alzheimer's, non-Alzheimer's dementia, and depression. The MDS stated the resident walked independently and listed her BIMS score as 0 out of 15, indicating severely impaired cognition. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A 7/7/21 Care Plan entry stated the resident walked independently. On 11/7/24 at 1:28 p.m., via phone, Staff E Registered Nurse(RN) stated there were a couple staff members, Staff O Certified Nursing Assistant(CNA) and Staff P CNA who were a little rough with the residents when walking down the hall. She stated they pull them instead of walking with them and say come on. She stated they pull them with both of their hands and do this with Residents #7, #11, #15, and #16. She stated it was unsafe and the residents were scared and shaking. She stated she reported this to the Business Office Manager. The facility lacked documentation they investigated the above allegations of abuse and lacked documentation they separated residents from Staff O and Staff P during the investigation. On 1/7/24 at 2:04 p.m., the Administrator stated she wanted residents treated with respect,compassion and kindness. She stated Staff O and Staff P were both kind and no staff reported any concerns to her about them. On 11/12/24 at 12:00 p.m., via phone Staff E stated she spoke to the Administrator about staff walking with staff in an unsafe manner and stated the Administrator told her she didn't like how they pulled people but she was stuck between a rock and a hard place. On 11/12/24 at 1:06 p.m., Staff G RN stated staff pulled residents by the arms while they walked them. She stated they were not abusive but rushed and rude. On 11/19/24 at 11:59 a.m. via phone, the Director of Nursing(DON) of a sister facility stated staff should report allegations of abuse to the DON and then the Administrator and they would investigate and report. She stated the staff in question would be suspended. The facility policy Abuse Reporting and Investigation revised 11/28/16, stated the facility would thoroughly investigate all reports of suspected or alleged abuse and stated if an employee was involved in the suspected violation, they would be immediately removed from duty for the duration of the investigation.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 35434 Based on clinical record review, policy review, and staff interview, the facility failed to notify the Office of the State Long-Term Care Ombudsman of a hospital transfer for 1 of 4 residents reviewed for hospitalization s(Resident #3). The facility reported a census of 26 residents. Findings include: The Quarterly Minimum Data Set (MDS) assessment tool, dated 9/18/24, listed diagnoses for Resident #3 which included diabetes, non-Alzheimer's dementia, and psychotic disorder. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 0 out of 15, indicating severely impaired cognition. The facility policy Transfer or Discharge, Facility-Initiated, dated October 2022, stated the facility would provide notice of therapeutic discharges to the long-term care ombudsman. A 10/19/24 Physician's Order Note stated the facility received an order to send the resident to the ER for evaluation and treatment. A 10/21/24 Health Status Note stated the resident returned to the facility. The facility lacked documentation of notification of the transfer to the Office of the State Long-Term Care Ombudsman. On 11/19/24 at 1:57 p.m., the Administrator stated she fixed a filter on her discharge report so that all transfers would be on the report sent to the ombudsman.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on interview, record review, and facility policy review the facility failed to ensure Care Plan revision following discontinuation of antidepressant medication, failed to revise to include receipt of hospice services, failed to revise to include new skin concerns, and failed to revise to accurately reflect resident transfer status for four of sixteen residents reviewed for Care Plans (Resident #3, Resident #5, Resident#10 Resident #22). The facility reported a census of 26 residents. Findings include: 1. Review of the Annual Minimum Data Set (MDS) assessment for Resident #5 dated 9/18/24 revealed the resident scored 00 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment, the resident took antidepressant medication. On 11/19/24 at 9:21 AM, review of Resident #5's Care Plan revised 2/15/24 included the following: [Resident #5] receives antidepressant medication related to diagnosis of Dementia (Antidepressant). Review of the Pharmacist's Recommendation to Prescriber dated 8/19/24, agreed upon by the Prescriber on 9/25/24, revealed the following recommendation: Discontinue Trazodone Tab 50 mg (milligram) via taper as follows: Trazodone Tab 50 mg: Take 1/4 tab (12.5 mg) by mouth at bedtime for fourteen days then stop. On 11/19/24, review of Resident #5's Physician Orders lacked receipt of antidepressant medication. Preview of prior Physician Orders for Resident #5 revealed Trazodone, an antidepressant medication, was discontinued on 10/10/24. Review of the resident's Medication Administration Record (MAR) dated November 2024 lacked receipt of antidepressant medication for Resident #5. 2. Review of the Quarterly Minimum Data Set (MDS) assessment for Resident #22 dated 9/18/24 revealed the resident scored 00 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Per this assessment, the resident did not receive hospice services while a resident. The next MDS for the resident was a quarterly assessment dated [DATE], which remained in progress. Review of the Care Plan for Resident #22 dated 6/19/24 revised on 10/21/24 revealed, in part, the following: [Resident #22] has episodes of behaviors/potential for behaviors as evidenced by being combative, negative verbalizations, name calling, refusal of medications and cares, resists cares, screaming out, throwing things at staff, cursing at staff and other residents, Stabbing dining table with fork, scratching staff, cussing at staff and other residents, flipping staff off with middle finger, yelling, restless, exit seeking, asking other residents for cigarettes, accusing female CNA (Certified Nursing Assistant) of being a male, as well as other aggressive behaviors. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Intervention dated 9/6/24, revised 9/10/24, revealed: Pending hospice referral to help with pain and anxiety/behavior management awaiting POA (Power of Attorney) to choose hospice company at this time. Review of Resident #22's Hospice IDG (Interdisciplinary Group) Comprehensive Assessment and Plan of Care Update Report dated 10/1/24 revealed start of care date for hospice services on 9/19/24. On 11/19/24 at 12:36 PM, interview conducted with a sister facility's Director of Nursing (DON). The DON acknowledged if joins hospice, should be on the care plan. When queried about care plan revision if was on antidepressant then taken off of them, the DON responded would have so many days of follow up, so still looking for signs and symptoms. When queried about medication which ended 10/10, the DON responded it should be off by now. The Facility Policy titled Care Plans, Comprehensive Person-Centered dated 2001, most recently revised 11/19, revealed the following: 13. Assessment of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 35434 3. The MDS assessment tool, dated 10/23/24, listed diagnoses for Resident #3 which included non-Alzheimer's dementia, depression, and psychotic disorder. The MDS stated the resident was dependent on staff for toilet and chair transfers and listed his BIMS score as 0 out of 15, indicating severely impaired cognition. A 9/10/24 Care Plan entry stated the resident transferred independently. On 11/6/24 at 12:15 p.m., Staff C Certified Nursing Assistant(CNA) and Staff M CNA assisted the resident with a gait belt to stand up in order to pull down his pants and remove his brief. On 11/19/24 at 1:59 via phone, the Director of Nursing of a sister facility stated Care Plans should be up to date with regard to transfer status. 51573 4. A Weekly Skin Review dated 10/07/24 documented Resident#10 had the following skin concerns; a stage three open pressure area to the coccyx measuring 0.8 centimeters (cm) by 0.8 cm with depth of 0.2cm, four plus pitting edema to the right leg with 4/5 open areas, right great toe purplish in color. The Hospice Admission Note dated 10/14/24 documented skin interventions as follows; assess wound for location, size, stage, drainage, wound bed and peri wound to left inner buttock- use barrier cream with incontinence cares, Assessed area also included right anterior shin- cover with bordered foam every 3 days and as needed . Measure wounds weekly. The Care Plan for Resident#10 identified focus area with revision date 8/7/24 as follows; the resident has potential for impaired skin integrity and is at risk for edema, skin/tissue color changes, swelling, pain and pressure ulcers related to diagnosis of dementia. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan interventions included; 1. Administer treatments as ordered and monitor for effectiveness. Treatments as per orders/facility protocol. (7/18/24) 2. Encourage resident to shift weight, if able, every 2 hours to assist with skin integrity (7/18/24) 3. Monitor/document location, size and treatment of skin injury. Report any abnormalities, failure to heal. s/sx of infection, maceration, ets to physician as indicated (7/18/24) 4. Encourage good nutrition/hydration in order to promote healthier skin. (7/18/24). The Care Plan lacked update for the skin areas identified on the Weekly Skin Review dated 10/07/24.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on observation, interview, clinical record review, and facility policy review, the facility failed to provide adequate assessment and intervention for 3 of 4 residents reviewed for a change in condition. On [DATE] at approximately 12:30 PM, Resident #25 had difficulty transferring, which was a significant change in status, then at 2:35 PM the resident later had an unwitnessed fall, and was found face down in another resident's room, with laceration to the left forehead, Physician was sent a fax on [DATE], however, there was no response from physician until [DATE] which noted they should could continue to monitor per facility protocol. There was no follow-up from the facility between [DATE] and [DATE]. Staff acknowledged continued decline in Resident #25's condition when Resident #25 required assistance and cueing with all meals when independent prior. The Resident declined to a non-weightbearing of the left leg. The physician was notified on [DATE] of decline in transferring, at which time x-ray of a hip performed, no diagnostic tests were completed at this time for the head injury, there was no fracture of the hip. On [DATE] Resident #25 transferred to the Hospital, due to experiencing stroke-like symptoms and was diagnosed with Subdural Hematoma. Resident #25 died on [DATE]. Resident #25's death certificate revealed the immediate cause of death as complications due to accidental elderly fall, Due to or as a consequence of: subdural hematoma, and due to or as a consequence of an unsteady gait. The facility additionally failed to complete neurological assessments and post fall follow up documentation for Resident #20 following an unwitnessed fall and further failed to provide continued assessment for Resident #226 after an episode of excessive coughing caused by consuming the incorrect consistency of food during lunch meal for a resident with dysphagia. This failure resulted in Immediate Jeopardy to the health, safety, and security of the resident. The facility reported a census of 26 residents. Findings include: The State Agency informed the facility of the Immediate Jeopardy (IJ) on [DATE] at 5:12 PM. The IJ began on [DATE] . Facility staff removed immediacy of the Immediate Jeopardy on [DATE] at 3:02 PM by implementing the following actions: 1. A comprehensive head to toe assessment conducted and completed on [DATE], for all residents to identify any changes that deviated from their baseline status. 2. All staff members received training on how to identify changes in residents' conditions and the importance of reporting these changes to charge nurse. Staff training completed [DATE]. 3. All Charge Nurse staff trained on how to recognize a change in condition and the expectation to notify the attending provider via phone immediately when a change is identified. Charge Nurse training completed on [DATE]. 4. Facility conducted an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting on [DATE], to review the change of condition process, assess staff education, and develop auditing mechanisms to monitor and prevent recurrence. The scope lowered from J to G after ensuring the facility implemented education and their policy and procedure. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The Admission Minimum Data Set (MDS), dated [DATE], revealed Resident #25 had severely impaired cognitive skills for daily decision making and occasional behaviors that included wandering and rejection of cares. Resident #25 had no impairment of the upper or lower extremities and did not require use of mobility devices. The Admission MDS revealed that Resident #25 was able to ambulate at least 150 feet independently, transfer independently, and eat independently after set up assistance. Resident #25 had history of a fall in the last ,d+[DATE] months prior to facility admission and utilized a wander/elopement alarm on a daily basis. Diagnoses included Alzheimer's Disease and osteoporosis. A Significant Change MDS, dated [DATE], revealed Resident #25 received Hospice Care services, while a resident at facility, and had one fall with non-major injury since admission (major injury defined in MDS as fall resulting in bone fracture, joint dislocation, closed head injury with altered level of consciousness, or subdural hematoma). The Significant Change MDS revealed that Resident #25 required use of walker and wheelchair for mobility with substantial to maximal staff assistance to ambulate at least 10 feet and dependent on staff to transfer. Resident #25 required supervision or touching assistance with eating and substantial to maximal staff assistance with hygiene and dressing tasks. Diagnoses included: Non-traumatic brain dysfunction, Alzheimer's Disease, and osteoporosis. The Care Plan, initiated [DATE], identified Resident #25 at risk for falls and injury due to wandering and decreased safety awareness. The Care Plan revealed Resident #25 had an unwitnessed fall on [DATE] with a bruise to hip, interventions included a urine dip and an evaluation to be completed by Physical/Occupational Therapy. Fall risk interventions listed in the Care Plan instructed staff to: anticipate the resident's needs, ensure resident wore appropriate footwear when ambulating, provide safe environment with floor free of spills or clutter, adequate light, call light in reach, bed in low position at night, side rails as ordered, handrails on walls, and personal items within reach. On [DATE] at 3:26 PM, Nursing Progress Note revealed a yell had been heard down East Hall at 2:35 PM, Resident #25 observed face down on the floor in another resident's room. The Progress Note informed that Resident #25 had been known to wander, was last seen in lobby area, last toileted around 1:15 PM, and wore grippy socks. Progress Note revealed that active range of motion was intact and that Resident #25 was assisted by one staff to a standing position, then walked down the hall until a staff arrived with wheelchair when Resident #25 still appeared to be unsteady. Resident #25 noted to have sustained a skin tear to left forehead, measuring 2 centimeters (cm) long by 0.5 cm wide, and required skin to be approximated (closed) using 3 steri strips (adhesive skin closures). Nursing documented Resident #25's Power of Attorney (POA) was notified of fall and that the Provider had been faxed with results of a urine dip performed and Resident #25's injuries. A facility facsimile (fax), dated [DATE], revealed an FYI notification sent to Provider which informed that Resident #25 observed prone on the floor in another resident's room and had skin tear to left forehead with steri strips in place. Fax revealed that nursing would monitor every shift for 3 days, then weekly for 3 weeks and included results of a urine dip performed related to POA's indication of past falls with Urinary Tract Infection (UTI). Provider response to fax, dated [DATE], instructed nursing to monitor per facility protocol and to obtain a Urinalysis with culture and sensitivity if indicated. On [DATE] at 10:08 AM, Nursing Progress Note revealed Resident #25 continued on post fall monitoring and had utilized a wheelchair due to an unsteady, weak gait. Progress Note informed that facility was awaiting response from Provider regarding Resident #25's urine dip. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #25 Electronic Health Records (EHR), revealed a neurological assessment had been completed on the following dates and times: [DATE] at 2:35 PM, [DATE] at 6:35 PM, [DATE] at 10:35 PM, [DATE] at 2:54 AM, [DATE] at 6:35 AM, [DATE] at 2:25 PM, [DATE] at 10:35 PM, and [DATE] at 7:59 AM. Neurological assessments included normal findings of vital signs, orientation to person/place/time, level of consciousness, pupil size, ability to response appropriately, pain, and movement of extremities. The facility provided two additional hand written neurological assessments, both dated [DATE], and both lacked documentation of the time completed. One hand written neurological assessment informed that Certified Nursing Assistant (CNA) reported difficulty with lower extremity movement when ambulating Resident #25 to the toilet. The second hand written neurological assessment informed that Resident #25 had 3 steri strip closures to left forehead, a large purple bruise to left hip, and bruising to 2 digits on the left hand. The facility provided two pages of hand written Nursing Progress Note. Review of note dated [DATE] at 1:00 PM, revealed a fax had been received related to fall with an order to obtain Urinalysis (UA) with culture and sensitivity. Progress Note also revealed that Resident #25 was unable to stand on her own, leaning to the left when walking, utilizing a wheelchair, and had large bruises noted on left outer hip. Review of a hand written Nursing Progress Note, dated [DATE] at 6:30 PM, revealed Resident #25 ambulated with staff assist of one, was noted to favor left side, and stumble during ambulation. A Provider Visit Note, dated [DATE], revealed Resident #25 had fall on [DATE] with skin tear to head and stable neuros. Provider documented that review of systems taken with assistance from nursing staff and chart review due to Resident #25 poor cognition, with no concerns or acute issues per nursing staff. Provider listed the following under orders and requisitions: monitor unsteadiness and weakness, complete neuro checks per protocol, complete skin checks per protocol, and continue current medications and treatment. On [DATE] at 1:07 PM, a Nursing Progress Note revealed that Resident #25 had not been bearing weight on left leg after fall and a fax was sent to physician about possible x-ray. On [DATE] at 8:40 PM Provider ordered x-ray to include 2 view of pelvis and left hip for acute pain post fall and to monitor bruise until healed. On [DATE] at 1:23 PM, a portable x-ray performed on Resident #25 left hip, results were negative for fracture. Review of Resident #25's Electronic Health Records and paper clinical records, revealed no Provider notification related to change in transfer ability or notification of left hip bruising was documented between the dates of [DATE] and [DATE]. A Change in Condition Assessment completed on [DATE], revealed Resident #25 had recent fall with a decline in mobility, utilized a wheelchair, and required total staff assistance with transfers, mobility, and hygiene. Change in Condition Assessment informed that Resident #25 was unable to bear at least 50% weight on at least 1 leg and unable to sit upright without physical assistance. A Care Conference Note, dated [DATE], revealed that prior to fall, Resident #25 was often found walking around and sitting in staff offices to visit with staff and other residents. At time of Care Conference, Resident #25 required increased assistance in activities of daily living and feeding assistance post fall. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a facility fax, dated [DATE], revealed notification to Provider the following information: Physical Therapy (PT) to evaluate, Resident #25 not walked since fall 2 weeks ago. Fax included results of x-ray completed [DATE] of left pelvis/hip. Provider response received [DATE] with order for PT to evaluate and treat. On [DATE] at 6:04 PM, Nursing Progress Note revealed that Resident #25 continued to have a decline, sat at resident assisted feeding table but did not eat, and was noted to be lethargic. Note informed that POA was notified, no documentation of Provider notification for decline in condition. On [DATE] at 10:37 AM, Nursing Progress Note revealed that nurse spoke to on-call Provider at 8:45 AM and received order to send Resident #25 to emergency room for evaluation to rule out stroke. Resident #25 noted to continue with lethargy and decrease in level of consciousness. Resident #25 transferred from facility to hospital via ambulance at 9:40 AM. Hospital Discharge Report, dated [DATE], revealed that Resident #25 had a large subdural hematoma and likely the cause for decline in mental status and functional abilities. Diagnoses listed as Altered Mental Status and Subdural Hematoma. On [DATE] at 1:19 PM, Nursing Progress Note revealed Resident #25 returned to facility via ambulance with diagnosis of subdural hematoma. Note indicated POA requested Resident #25 be admitted to Hospice. On [DATE] at 1:26 PM, verbal orders received from Provider for referral to Hospice services and to discontinue Physical/Occupational Therapy orders. Review of Provider Visit Note, dated [DATE], informed that Resident #25 had unwitnessed fall, was admitted to the hospital, and found to have a subdural hematoma. Provider documented that Resident #25 had significant decline in her status, was weak, lethargic, and slow to respond. Visit Note revealed that Resident #25 had been admitted to Hospice. On [DATE] at 9:45 AM, Resident #25 deceased . Hospice and family present at facility. Note informed that Hospice had contacted Medical Examiner. Resident #25 Certificate of Death, revealed immediate cause of death from complications due to accidental elderly fall, due to or as a consequence of subdural hematoma, due to or as a consequence of unsteady gait and dementia. Manner of Resident #25's death listed as accident with the date and time of injury occurring on [DATE] at 2:35 PM at the facility. A description of injury informed that on [DATE] at 2:35 PM, facility heard a yell and nurse found Resident #25 laying prone, face down on the floor of another residents room, sustained a skin tear on left side of the forehead and that resident did not bear weight on her left leg. On [DATE] at 11:00 AM, Staff B, Licensed Practical Nurse (LPN) revealed that Resident #25 wandered independently throughout the facility prior to fall and that around the same the time of fall, she never walked again. Staff B recalled coming back to work after a weekend and finding that Resident #25 had steri strips on her head and a dark bruise on left hip after a fall. Staff B did not recall speaking with the Provider about Resident #25's decline in transfer ability. Staff B informed that facility protocol for completing neurological assessments was to assess resident every 4 hours, then every 8 hours for 3 days. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:40 PM, Staff D, Licensed Practical Nurse (LPN), revealed that Resident #25 had difficulty transferring and ambulating, and required use of a wheelchair, on the morning of her fall. Staff D stated that she had been called to Resident #25's bathroom, sometime shortly after lunch, by Staff N, Certified Nursing Assistant (CNA) due to resident struggling to get up from the toilet. Staff D stated that she helped CNA get Resident #25 up from toilet and recalled that Resident #25 had struggled to get up from the toilet but was able to ambulate once up. Staff D informed that she did not put Resident #25 back in wheelchair because she normally ambulated independently. Staff D stated that about 3 hours after helping to assist Resident #25 up from toilet, fall occurred. Staff D reported that another resident came out of their room and told nurse that Resident #25 fell . When Staff D approached the other resident's room, she recalled that Resident #25 had been laying face down on the floor. Staff D stated that Resident #25 had skin tear to forehead with flap of skin hanging down. Staff D recalled, Resident #25 had been able to move all extremities, was assisted to sit up on the floor, then assisted to a standing position and ambulated out of room and into the hallway. When ambulating in the hallway, Staff D said Resident #25 had been a bit wobbly so another staff got the wheelchair. Staff D stated Resident #25 sat in wheelchair the rest of the day. Staff D stated Provider had been notified of fall with skin tear to head on [DATE] via fax and explained that on weekends the Provider would be faxed unless a resident needed to be sent out. On [DATE] at 2:50 PM Staff N, CNA, stated Resident #25 was in wheelchair prior to fall due to weakness, attempted to get up from wheelchair but couldn't. Staff N recalled reporting to nurse that Resident #25 was unstable in the bathroom from toilet. Staff N stated it was unlike Resident #25 to need help getting up from the toilet, normally transferred and ambulated independently. On [DATE] at 11:58 AM, Director of Nursing (DON) confirmed that Resident #25 ambulated independently without use of assistive device and wandered with steady gait prior to fall. DON recalled Resident #25 had been declining and was sent to the hospital for stroke like symptoms. DON confirmed that a fax was sent to Provider to notify of fall with head injury and revealed an expectation that nurses call Provider for a fall with head injury. DON stated Resident #25 should have been sent to the emergency room (ER) the first day because of head injury. DON unable to provide documentation of additional communication with the Provider related to Resident #25 decline in mobility or condition change. On [DATE] at 12:30 PM, DON for sister facility, assisted facility during State Survey, revealed the expectation for post fall monitoring to include documentation at least every shift for 3 days and, in addition, nursing staff would need to complete neurological checks every 15 minutes x4, then every hour x4, then every 2 hours x4, then every 4 hours x4, then every shift for a total of 3 days. The sister facility DON revealed the expectation of nurses to call, not fax, a Provider immediately when a resident has any condition change and expected if a head injury is known for staff to call Provider and send resident to ER to evaluate. The facility policy titled, Change in a Resident's Condition or Status, dated [DATE], revealed that the nurse will notify resident's Attending Physician or physician on call when there has been a significant change in the resident's physical, emotional, or mental condition and informed that notifications will be made within 24 hours of change, except in medical emergencies. The policy defined significant change of condition as a major decline or improvement in a resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:38 a.m., interview from Staff A, Cook, revealed that the dietary staff get the dietary information from the nurses. Staff A, Cook, acknowledged that he provided the resident with regular consistency food and then noticed that his count was off for plates so he and went back to fix it. Staff A, Cook, acknowledged that Resident #226 would probably choke if he ate regular consistency food. When queried about the location of the modified diet postings in the kitchen, Staff A, stated that it is posted in the kitchen and that it is also in a book. Staff A, stated that he does not utilize the books because he has struggled with them. On [DATE] at 11:48 a.m., Resident #226 was found lying in his room alone. The Resident stated that he was fine and he did not feel short of breath. At that time, the resident was noted to still have an intermittent cough. The resident denied feeling like there was anything stuck in his throat. On [DATE] at 12:14 p.m., a second interview with the DON revealed that the resident had not yet had vitals or had an assessment and the physician had not been aware of the resident receiving the wrong consistency of food. The DON stated that she had a text out to the physician but had not talked with him yet. The DON reported that she had not yet done an assessment or vitals due to behavioral issues with this resident. Observation on [DATE] at 12:47 p.m., revealed Resident #226 was observed lying in bed with a blanket covering him, and a nurse walked out of the room at that time. On [DATE] at 12:50 p.m., interview with Staff B, LPN revealed that she had assessed Resident #226 at approximately 12:30 p.m. and that vitals and lung sounds did not reveal anything out of the ordinary to her. When asked for the vitals, she stated that she had provided them to the DON for her to document.

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F 0689 Level of Harm - Actual harm Residents Affected - Some	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** 45338 Based on observation, interview, and record review the facility failed to ensure evaluation of a mobility device prior to resident use, failed to ensure gait belt utilized for transfer, failed to remain with a resident when a non-verbal resident suspected to have a seizure resulting in a fall, failed to ensure adequate supervision for resident with known history of falls when the resident was found multiple times post unwitnessed fall in the lobby of the facility, failed to ensure residents' feet were placed on wheelchair foot pedals when residents assisted via wheelchair, and failed to ensure residents remained free from environmental hazards when one resident ingested a [NAME] egg and another resident obtained access to a locked restroom without the knowledge of facility staff for six of ten residents reviewed for accidents (Resident #2, Resident #3, Resident #5, Resident #10, Resident #21, and Resident #22). This deficient practice resulted in the following injuries: Resident #2 sustained bruises and a head laceration on 6/22/24. Resident #22 sustained a laceration to the right orbit with surrounding bruising, pain, and multiple skin tears sustained from falls on 7/5/24, 8/22/24, and 9/3/24. Resident #5 sustained bruising to the right forehead, pain, and a shattered humerus related to a fall on 11/1/24 and was hospitalized . Findings include: 1. Review of the Annual Minimum Data Set (MDS) assessment for Resident #5 dated 9/18/24 revealed the resident scored 00 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. a. Review of Resident #5's Care Plan dated 4/2/21, revised 11/1/24, revealed the following: [Resident #5] is at risk for injury from falls r/t (related to) hx (history) of right (R) femur fx (fracture), dementia, diabetes, anemia, neurogenic bladder, muscle atrophy, hx of TIA/CVA (Transient ischemic attack/Cerebrovascular accident). Falls: 11/1/24 witnessed fall with injury. Interventions per the Care Plan included the following: a.(Initiated 2/15/24, revised 9/10/24): Gripper strips to bed. b. (Initiated 2/15/24, revised 9/10/24): Gripper strip toilet. c. (Imitated 11/1/24): Send to ER (emergency room) for evaluation d. (Initiated 2/15/24, revised 9/10/24): Toilet rails Review of the Therapy Communication Form dated 1/26/24 revealed, in part, pt. (patient) is functional independent with 4 ww (wheeled walker) gait in hallway & common spaces after assist with stance WBAT (weight bearing as tolerated). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Review of the Late Entry Nursing Note dated 10/30/24 at 11:00 AM revealed, Maintenance gave three wheel walker to resident after being notified by Maintenance manager that this is the only walker that he has available at this time. [NAME] was given to resident by Maintenance manager. Maintenance Manager had been notified of wheels loose on resident's normal four wheel walker and needing it to be fixed or replaced. Review of the Fall Incident Report dated 11/1/24 at 7:38 AM for Resident #5 revealed, Nurse made aware of witnessed fall at 0738 from house keeping down [NAME] hall way. Resd (resident) utilizing new 3ww (wheeled walker) et was turning around when she lost her footing. Resd Observed lying on rt side, head against wall, sensation et movement to extremities, able to move rt hand when asked, unable to assess AROM (active range of motion) to rt (right) arm at this time as she was lying on it. Resd x1 (times one) assisted to chair in activity room, utilized walker with rt (right) hand, gripping activity director shirt with lt (left). 3x3cm (centimeter) bruise noted to rt (right) forehead .When skin protectant sleeve on rt arm rolled back up from obtaining BP (blood pressure) resd called out in pain. Swelling noted to rt arm et resd does not move extremity when asked. Verbal order to send to ER obtained at 0755 from [Name Redacted] fax out for signature .Ambulance arrived at 0835 (8:35 AM), paramedic notes crepitus to rt arm, when requested to transport to [Location Redacted] medics refuse as hey state We're not sure if its broken so we will start with x-ray in [Location Redacted]. [Resident #5] left facility via ambulance at 0841, MAR (Medication Administration Record)/TAR (Treatment Administration Record), IPOST (Iowa Physician Orders for Scope of Treatment), face sheet et hospital transfer form sent with. Per the Incident Report dated 11/1/24, Resident #5 had a bruise to the top of the scalp and pain score of 6. The Incident Note dated 11/1/2024 at 1:58 PM revealed, [Name Redacted] ER (emergency room) nurse from [Location Redacted] called facility, informed this nurse that [Resident #5's] humorous <sic> is shattered. [Resident #5] is to be transported to [Location Redacted], et ER has already notified POA (Power of Attorney). Review of a Radiology Report of the resident's right elbow completed on 11/1/24 at 9:45 AM, with reason for process documented as bruising around elbow and fall, revealed the following: Findings/Impression: Comminuted fracture of the distal humerus with separation of medial and lateral epicondyles. Note of 49 mm (millimeter) butterfly fragment. There is foreshortening and posterior displacement of the distal fracture fragments with respect of the proximal humerus. There is dislocation of the humeral ulnar joint. Review of Hospital Records dated with admitted [DATE], and date of discharge 11/4/24, revealed the following admitting diagnoses: fall, hematoma over R (right) frontal area, just above R eye, distal R humerus fracture, and slightly angulated/overlapping, and UTI (urinary tract infection). (continued on next page)

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Keota Health Care Center	204 North Keokuk Washington Road Keota, IA 52248

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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 0689 Level of Harm - Actual harm Residents Affected - Some	On 11/07/24 at 10:55 AM Staff F, Housekeeper queried regarding Resident #5. When queried if she was familiar with the resident, Staff F responded she was. When queried if she worked when the resident had fallen, Staff F explained here recently she was getting ready to mop the [NAME] hall, happened to turn, and [Resident] was losing balance when tried to turn her walker around. Staff F explained the resident's walker had gotten stuck when [Resident] was turning around and happened to lose balance. Staff F explained went to try to catch [Resident], and didn't get to her in time. Staff F queried where occurred, and responded between the activity door and [NAME] hall. Per Staff F, the resident had walker with her, and walker was 3 wheel walker the resident had recently gotten. When queried if Staff F saw resident fall, said yes. When queried what happened next, Staff F explained the resident had fell and hit head on the wall, and landed on her right side. When queried about visible injuries, Staff F responded she did not notice any visible injuries. Staff F acknowledged there were no staff around that (Staff F) saw when resident fell . Per Staff F, after the fall was a bruise on the resident's forehead. Staff F explained resident did not say anything when she fell , and did not call out or anything like that. On 11/7/24 at 11:50 AM, the Director of Nursing (DON) explained there was not a PT/OT evaluation done for Resident #5's 3 wheeled walker. The DON explained for a new piece of equipment, usually got from maintenance. The DON explained called maintenance because of resident's walker wheel. Per the DON, the resident was ordered to use 4 wheeled walker, and DON explained called to have it fixed and replaced with other 4 wheeled walker. The DON further explained facility was getting a new admission at the time, maintenance came out with a walker, was told it was the wrong walker, maintenance said it was brand new, and DON said it was wrong walker. The DON explained she went to the admission, staff had the resident sitting in a chair, maintenance gave 3 wheeled walker, and definitely should not have. The DON explained did not know if was another 4 wheeled walker or not, and didn't have access to storage. The DON explained if a witnessed fall, they would do statements and had a fall report checklist. Per the DON, statements were turned into the DON if witnessed, otherwise everything was typed into notes in [electronic health record system]. The DON statements for witnessed falls were very rare, and most if not all were unwitnessed. When queried about root cause analysis, the DON explained do follow up when go though the fall incident report. When queried where would find root cause, the DON explained it was also in the incident report, and did not know if it was printed into the incident report or not. On 11/12/24 at 11:38 AM, Staff E, Registered Nurse (RN) queried about resident's arm/injury. Staff E responded the resident had four breaks, and was just told she fell . Staff E further explained was not present when it happened, and got it in report. Per Staff E, the resident normally had a 4 wheel walker with seat, the bearings were out she guessed, and someone got the resident a 3 wheeled walker. Staff E explained a staff member (Staff I, Certified Nursing Assistant) said they were not getting resident up with the 3 wheeled walker, and another staff member said the resident had used it yesterday fine, and would get her up. Per Staff E, Staff I had already said wanted no part in that. Staff E queried what she thought about the 3 wheeled walker, and provided the following description: little kid's walker, very tiny width, handles, no seat, really narrow and didn't look maneuverable. Staff E further explained in a conversation with staff member (staff member who had previously said not getting resident up with 3 wheeled walker), Staff E told Staff I they called it, [Resident #5] broke arm. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	On 11/12/24 at 2:19 PM an interview completed with Staff D, Licensed Practical Nurse (LPN) who had completed the resident's incident report on 11/1/24. Staff D explained she didn't see it happen, and Staff F, Housekeeping witnessed and brought to attention. Per Staff D, resident in hall, walked independently with walker, and had new walker that Staff D not aware of at all. Resident #5 using new walker, was normally pretty steady, could have lost balance, and fell right side. Per Staff D, the resident was not in pain, was able to move, and was holding onto walker with broken arm. Staff D explained Resident #5 pretty much non-verbal, and when ask if in pain the resident doesn't say anything. Staff D further explained with upward motion and bringing geri sleeve up, the resident cried out in pain. Staff D explained she contacted medics and family, and when the medics got there didn't think the arm was broken, Staff D tugged geri sleeve again, and the resident screamed in pain. Per Staff D, medics said didn't think was broken and to start x-ray in [Location Redacted], while the other medic felt crepitus. Per Staff D, the resident did have a bump on the head. On 11/18/24 at 8:54 AM, Staff I, Certified Nursing Assistant (CNA) explained, in part, Resident #5 walked with a front wheeled 4 wheel walker, because she could not do a 3 [NAME] had never been trained on it. When queried if Resident #5 ever had a 3 wheeled walker, Staff I responded two weeks ago before fall had the bearing going out of her (Resident #5's) walker and maintenance gave her a 3 wheel walker. Per Staff I, she thought the resident got the walker on a Thursday, Staff I had worked that night 10 to 6, and Friday morning the resident had it sitting there. Staff I explained she did not get Resident #5 out of bed because Staff I did not feel comfortable. Per Staff I, that morning (Resident #5) fell . Staff I explained Resident #5 was like a cylinder and Staff I did not feel comfortable to use the 3 wheel walker. Per Staff I, the resident stayed in bed until the day shift got her up, and Staff I asked the nurse if was ok to leave Resident #5 in bed until the day shift as there were no notes for her to use it (3 wheel walker). Staff I explained just played it safe. When queried about communication would occur, Staff I explained usually in nurses notes, and during report when walked in room checked resident if something different, then would ask the nurse. Per Staff I, she passed it to day shift, and they said would check into it. Observation on 11/05/24 at 12:36 PM revealed Resident #5 in the common area with bruising present to the right side of the resident's head. Resident had green bruise to right forehead. No staff observed in line of sight of the nursing desk/common area at time of observation. There was a housekeeping staff observed in the North hall. Other staff not observed to be present. Observation on 11/13/24 at 9:59 AM revealed Resident #5 in wheelchair in the common area. On 11/13/24 at 12:13 PM, the Maintenance Supervisor interviewed about Resident #5's walker. Per the Maintenance Director, somebody said the resident's walker wheels were acting weird, the Maintenance Supervisor looked at it, and the bearings were popped out. The Maintenance Supervisor explained found other one (walker) that had brought in. The Maintenance Supervisor described the walker with the bearings popped out as a walker with 4 wheels with handles and breaks on it. The replacement walker was described as follows by the Maintenance Supervisor: Had same stance, 3 wheels, and had break cables like the resident was used to. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	When queried if facility had any 4 wheel walkers available, the Maintenance Supervisor responded just the ones without wheels that put tennis balls on. The Maintenance Supervisor queried not like the walker the resident had, and confirmed. Per the Maintenance Supervisor, he was not sure where the 3 wheeled walker came from, it was in facility's storage. When queried if any staff expressed concerns with using the 3 wheeled walker for the resident, the Maintenance Supervisor denied, and explained he adjusted the handles down to meet the height of the resident's old one (walker) so it was the same height. On 11/19/24 at 2:56 PM the facility's Administrator explained was not the fault of the walker, was the fault of her (Resident #5's) feet. Per the Administrator, had done education about with any change in equipment, maintenance, therapy, and the DON review. The Administrator then explained she was not sure the cause was related to the resident's footing. When queried regarding an evaluation for a resident's new piece of equipment, the Administrator explained should be evaluated by therapy. When queried if there should be an evaluation when going from 4 wheel to 3 wheel walker, the Administrator responded yes. b. Review of Resident #5's Care Plan dated 4/2/21 and revised 2/15/24 revealed, [Resident #5] requires assist with ADL's (activities of daily living) due to impaired mobility, recent hip fx (9/2023), Alzheimer with dementia, diabetes mellitus, anemia, edema, neurogenic bladder, atrophy of muscles, depression/anxiety, TIA & CVA. The Intervention revised on 9/10/24 revealed, ASSISTIVE DEVICES: w/w (wheeled walker); w/c (wheelchair) PRN (as needed) for appointment. Observation conducted 11/5/24 at 12:41 PM revealed Staff C, Certified Nursing Assistant (CNA) assisted Resident #5 down the hallway in the wheelchair, and the resident's right foot observed off of the foot pedal and skimmed across the floor while the resident was assisted. 2. Review of the Minimum Data Set (MDS) assessment for Resident #22 dated 6/21/24 revealed the resident scored 1 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated the resident severely cognitively impaired. Per the assessment, the resident had not had any falls since admission, entry, reentry, or prior assessment, had physical behavioral symptoms 1-3 days, had verbal behavioral symptoms 4-6 days, and other behavioral symptoms 1-3 days, and wandered 1-3 days. The resident's MDS dated [DATE] revealed the resident scored 00 out of 15 on BIMS exam, which indicated severely impaired cognition. Per this assessment, Resident #22 had falls since admission, entry, reentry, or prior assessment, two with no injury and two with injury (except major). The Care Plan dated 6/17/24 revised 10/14/24 revealed, [Resident #22] is at risk for falls and has had a fall related to impaired balance, poor safety awareness, functional impairment and the use of medications that may increase falls risks. a. 6/17/24 Fall with injury b. 6/24/24 Fall without injury c. 7/2/24 Fall without injury d. 7/5/24 Fall without injury (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	e. 9/3/24 Fall with skin tear f. 9/30/24 unwitnessed fall without injury g. 10/9/24 unwitnessed fall without injury h. 10/14/24 witnessed fall with skin tear Interventions per Resident #22's Care Plan included the following: a. (Initiated 7/2/24, revised 9/10/24): Dycem placed below and on top of cushion in wheelchair. b. (Initiated 9/30/24): Educate and encourage family visits for orientation purposes. c. (Initiated 9/30/24): Educate family about fall risks and increased weakness due to resident weight loss and refusal to eat much at meal or snack times. d. (Initiated 6/17/24, revised 6/19/24): Ensure [Resident #22] is wearing appropriate footwear when ambulating or utilizing their wheelchair. Resident prefers to wear open toe shoes. e. (Initiated 6/19/24, revised 9/10/24): Fall mat at bedside. f. (Initiated 6/17/24): Follow all facility protocol related to falls ie: initiation of neuros (if applicable), fall report/investigation, immediate interventions and long term interventions, informing of physician/family. g. (Initiated 6/17/24, revised 9/10/24): Gripper socks in place when out of bed. h. (Initiated 7/5/24, revised 9/10/24): [Resident #22] was given a different wheelchair that Dycem holds to better than previous wheelchair. i. (Initiated 10/14/24): Offer and encourage resident to rest between meals or when she appears drowsy in wheelchair. j. (Initiated 6/17/24, revised 9/10/24): PT/OT (physical therapy/occupational therapy) to eval and treat if appropriate due to fall. k. (Initiated 10/9/24): Reorient resident to her own room and belongings any time that she is found in the hallways. l. (Initiated 9/3/24, revised 9/10/24): Staff to check on resident frequently when in the area that resident is in. Review of Incident Reports and the clinical record for Resident #22 revealed the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	The Incident Report dated 6/17/24 at 9:00 AM revealed, This nurse was in another resident's room when I heard a yell, walked out the door, resident sitting on floor near North hall back door, with back against wall .R (right) leg moved without pain, L (left) leg-hip pain. Dr. notified, verbal orders to send resident to ER (emergency room) for evaluation and treat for pain to L hip. A predisposing situation factor was improper footwear. The Immediate Action Taken section revealed, ask family about replacing shoes. Discharge instructions from the Emergency Department dated 6/18/24 at 9:47 AM revealed, L (left) hip fx (fracture)-nonsurgical, walk with walker. Review of the Physician Note dated 6/20/24 revealed, in part, the following for Resident #22: Alert and oriented to person. Dementia. Episodes of confusion and disorientation. She has been having delusions about her medications and staff .She has a history of osteoporosis and hip fractures .She was sent to the ED (Emergency Department) after a fall on 6/17/24 and was found to have a left hip fracture. Uncertain if it was new or a previous fracture. It was non-surgical. The Nursing Note dated 6/19/24 at 1:02 PM revealed, Fall Interventions: fall mat next to bed, gripper socks on at all times when out of bed, PT/OT eval and treat if appropriate. The Incident Report dated 6/24/24 at 5:05 PM revealed, Was called to room [number redacted] to find resident sitting on her hands and knees in front of the bathroom facing the bathroom in front of her w/c (wheelchair). The Immediate Action Taken section revealed, in part, was helped by 2 CNAs and gait belt to her w/c then she was transferred to the bathroom, resident was then brought to the nurses station where this writer was able to have one on one with resident, to help with redirecting of resident. The Incident Report dated 7/2/24 at 10:45 AM revealed, Resident was wheeling herself down west hallway, the 2nd door on the left she tried to open, shaking the door handle, when it didn't open resident slid herself, cushion and all to the floor. Witnessed by activity aide, resident, didn't hit head. The Immediate Action Taken section revealed, Place dycem below cushion in wheelchair and on top of cushion in wheelchair. The Incident Report dated 7/5/24 at 1:28 PM revealed, Activity director notified this nurse of resd seated on the floor at 1328 (1:28 PM). Resd previously exit seeking. Resd observed by front lobby entrance seated in front of w/c on w/c cushion dycem in place below et (and) on-top of w/c cushion. AROM (active range of motion) intact, x3 skin tears to outer rt (right) forearm from elbow down 1.7x1cm, 2x1cm, 0.8x0.5cm, areas cleansed with steri strips put in place. The Immediate Action Taken section revealed, New w/c provided that is more suitable for dycem to prevent sliding out. Review of a Fax dated 7/25/24 revealed, in part, post fall injuries x3 skin tears from elbow down to rt (right) outer forearm 1.7x1cm, 2x1 cm, 0.8x0.5cm areas cleansed et approximated c (with) steri strips. The Immediate Action Taken section revealed, New w/c provided that is more suitable for dycem to prevent sliding out. The Incident Report dated 8/22/24 at 1:43 PM revealed, This nurse was called to the reception/lobby area. Resident suffered an unwitnessed fall. [Resident #22] was lying flat on the floor with legs out. Blood noted on right side of forehead with bruising. Bleeding stopped by providing pressure to the area. Resident voices complaints of pain from hitting head on floor. The Immediate Action Taken section revealed, Resident wearing sandals at time of incident, sandals removed and resident allowed grip socks to be placed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Review of the Nursing Note for Resident #22 dated 8/22/24 at 1:43 PM revealed, in part, This nurse was called out to reception/front lobby. [Resident #22] was noted to be lying on the floor with legs outstretched near chairs/table. Blood noted to left forehead. Staff and other residents reporting she fell . Staff did not witness event. The N-Weekly Non Pressure Wound Assessment V2 Form completed 8/22/24 at 3:52 PM revealed the following: FYI (for your information) post fall skin assessment was written on the form. A wound was documented to the resident's face described as follows: rt (right) orbital 1.3x0.3cm (centimeter) laceration with surrounding bruise of 7x7cm. Review of Resident #22's Care Plan to address falls lacked documentation of the resident's fall with injury in the list of resident's falls in the focus area of Resident #22's Care Plan, and lacked any interventions added in August 2024. The Incident Report dated 9/3/24 at 3:44 PM revealed, Called 15:30 (3:30 PM) to North hallway, unwitnessed fall, when resident was with Administrator and another resident standing nearby. Resident was standing and talking when I started initial assessment. Resident denies pain of discomfort at this time Skin tear to right upper arm 5" x1.5". The Immediate Action Taken section documented an assessment of the resident. Review of a Fax dated 9/3/24 at 3:50 PM revealed, in part, unwitnessed fall skin tear to right arm. The Fall-Initial Note dated 9/3/24 at 3:30 PM revealed the following cause: Unwitnessed fall due to confusion. The Incident Report dated 9/30/24 at 2:35 PM revealed, This nurse heard a loud thud, entered lobby to find resident laying on her right side with her wheelchair tipped over top of her. The Immediate Action Taken section revealed, ROM (range of motion) assessed without any abnormal range of motion observed or reported. Resident assisted with x2 assist to wheelchair. Resident denies pain. Review of a Fax dated 9/30/24 at 2:35 PM revealed, unwitnessed fall from wheelchair. no injuries observed at this time. Will monitor per policy. Review of the Fall Risk Evaluation dated 9/30/24 revealed Resident #22 scored 17 on the assessment, which indicated high risk. The Incident Report dated 10/9/24 at 12:45 PM revealed, This nurse alerted by housekeeping that this R (resident) was on the floor and the drawers on other R dresser were open and (et) R arm was in one sleeve of jacket .R was helped up into her wheelchair et back to her room et laid down. R is unable to respond correctly as is her usual. The Immediate Action Taken section revealed, R (resident) helped off floor and taken to bed. Per the Incident Report, a predisposing situation factor was bare feet or inappropriate footwear. The Fall Risk Evaluation dated 10/9/24 revealed Resident #22 scored 21 on the assessment, which indicated high risk for falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	The Incident Report dated 10/13/24 at 6:02 PM revealed, Resident sitting in w/c by nurses desk, slipped to floor hitting left elbow on wall on the way down. The Immediate Action Taken section revealed, Vitals, assisted back into w/c cleansed and applied dressing to elbow. The Fall Risk Evaluation dated 10/13/24 revealed Resident #22 scored 25 on the assessment, which indicated high risk. Observation on 11/13/24 at 10:02 AM revealed Resident #22 tilted back in broda chair in the television area/nursing station in the front of the facility. On 11/13/24 at 9:09 AM, Staff C, Certified Nursing Assistant (CNA) queried if at facility when Resident #22 had fallen, and responded she was sure she was. Staff C explained now the resident did not ambulate at all, and explained the resident went downhill really fast. Staff C explained she thought a lot of the resident's falls happened on the weekends. When queried how fall risk was communicated, Staff C explained usually through the nurses on report. When queried if the resident's current wheelchair was from hospice, Staff C acknowledged it was. Staff C explained the resident was in a regular wheelchair before, and wasn't working out too well. Staff C explained the resident was leaning over and leaning too forward, and was so much comfier in chair and looked so much better in it too. On 11/13/24 at 12:55 PM, Staff G, Registered Nurse (RN) explained when she first went to the facility, resident was walking. Staff G explained not having enough staff at the facility because they were all out on break instead of watching residents Per Staff G, she had CNAs on break all the time not telling that they went on break. Per Staff G, the resident started failing and was put on hospice. When queried if she had ever worked when the resident had fallen, Staff G denied. When queried about increased monitoring for the resident, Staff G responded just the behaviors, explained the resident had tried to bite a staff member when intervened, and further explained made sure to keep an eye on her and know where was at, at least where located. On 11/18/24 at 10:36 AM, interview conducted with Staff J, CNA regarding Resident #22 and falls. When queried if she had been at facility when Resident #22 had fallen, Staff J replied always. Per Staff J, when resident first at facility would walk, would put self on the floor, and was care planned now for laying on the floor. When queried if Resident #22 was someone who could be left in the common area without staff watching her, Staff J responded no, and further explained the resident still had energy and strength to sit self up, and personally she wouldn't do so. Staff J explained now resident in a wheelchair, and have caught her trying to stand up to side of wheelchair, trying to dangle legs. Staff J explained when the resident used to have an actual wheelchair she would get up and start walking down the hallways, and now the resident had a reclining wheelchair. On 11/18/24 at 8:59 AM, Staff I, CNA acknowledged Resident #22 had fallen a couple of times, and not for Staff I. Staff I explained when resident at the front desk liked to climb out of geri chair, and eased self down or sat down. When queried what the resident tried to do, Staff I explained the resident was busy, felt needed to go shopping, traveling, and was in her own world. Staff I further explained the resident had their current chair for a month/month and a half, and could get out of it. Per Staff I, even though it tilted rolled off to the side, and explained the resident was very agile. When queried about watching persons in the lobby, Staff I explained it depended upon who it was, and explained the following pertaining to Resident #22: If people like [another resident redacted] or [Resident #22], tried to keep someone up there behind the desk, a couple times would get laundry to have them help fold towels, and keep them busy, get them out of their bubble so not so agitated. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 35434 Based on clinical record review, policy review, and staff interviews, the facility failed to ensure sufficient nursing staff to provide care to residents in accordance with the care plan by failing to supervise 1 of 1 resident with a history of physical resident to resident altercations from other residents(Resident #22) and by failing to provide timely assistance for 1 of 1 resident reviewed with a history of falls and seizures(Resident #2). The facility reported a census of 26 residents. Findings include: 1. The Minimum Data Set(MDS) assessment tool, dated 6/21/24, listed diagnoses for Resident #22 which included diabetes, arthritis, and hip fracture. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 1 out of 15, indicating severely impaired cognition. The MDS stated the resident had the following: a. physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) which occurred 1-3 days out of the 7 day review period. b. verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) which occurred 4-6 days out of the 7 day review period. c. other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) which occurred 1-3 days out of the 7 day review period. A 6/21/24 Care Plan entry directed staff to intervene as necessary to protect the rights and safety of the other residents, divert attention, remove from the situation/location if needed, and approach/speak in a calm manner. An 8/22/24 Care Plan entry directed staff to redirect the resident when she became notably agitated and to monitor her when she was around others. An 8/26/24 Care Plan intervention directed staff to monitor the resident when she was in the hallways to ensure safe interactions with other residents. The entry directed staff to remove her from other residents and intervene when she headed toward other residents. An 8/28/24 Care Plan entry stated the physician made medication changes as an intervention to behaviors and resident to resident interactions. A 9/30/24 Care Plan entry directed staff to place the resident in an area where not within an arm's length of other residents. (continued on next page)

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	165355	A. Building B. Wing	11/19/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Care Plan entry, revised 10/21/24, stated the resident had episodes of behaviors/potential for behaviors as evidenced by combativeness, negative verbalizations, name calling, screaming out, throwing things at staff, cursing at staff and other residents, stabbing the dining table with a fork, scratching staff, cussing at staff and other residents, flipping staff off with middle finger, yelling, as well as other aggressive behaviors. The resident had the following incidents: On 8/22/24, the resident hit another resident. On 8/26/24, the resident grabbed and scratched another resident. On 9/6/24, the resident slapped another resident. On 9/30/24, the resident slapped and pinched another resident while she called them names. On 10/20/24, the resident grabbed the arm of another resident. a. Resident #22 and Resident #77 The Minimum Data Set(MDS) assessment tool, dated 7/10/24, listed diagnoses for Resident #77 which included diabetes, non-Alzheimer's dementia, and chronic pain. The MDS listed his Brief Interview for Mental Status(BIMS) score as 0 out of 15, indicating severely impaired cognition. An 8/22/24 Resident to Resident Altercation report stated the resident approached another resident who sat in the lobby area watching TV and hit him in the head. An 8/22/24 Nursing Note stated Resident #77 sat in the TV room and Resident #22 walked over to him, began talking and hit him on the head several times. The CNA intervened and took Resident #22 to her room to lie down. b. Resident #22 and Resident #12 The MDS assessment tool, dated 6/13/24, listed diagnosis for Resident #12 which included arthritis, Alzheimer's, and non-Alzheimer's dementia. The MDS listed the resident's BIMS score as 5 out of 15, indicating severely impaired cognition. An 8/26/24 Resident to Resident Altercation report stated the Resident #22 had a hold of another resident's bilateral arms and scratched the resident. An 8/26/24 Progress Note stated another resident grabbed and scratched Resident #12's arms. c. Resident #22 and Resident #11 The MDS assessment tool, dated 8/28/24, listed diagnoses for Resident #11 which included non-Alzheimer's dementia, anxiety, and psychotic disorder. The MDS listed a BIMS score of 0 out of 15, indicating severely impaired cognition. A 9/6/24 Resident to Resident Altercation report stated a female resident told Resident #22 to shut up and Resident #22 slapped the female resident across the face to the left cheek. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 9/6/24 Nursing Note stated Resident #11 told another resident to shut up and the other resident slapped Resident #11. Staff separated the residents. d. Resident #22 and Resident #13 The MDS assessment tool, dated 8/21/24, listed diagnoses for Resident #13 which included non-Alzheimer's dementia, depression, and psychotic disorder. The MDS listed the resident's BIMS score as 4 out of 15, indicating severely impaired cognition. A 9/30/24 Physical Aggression Initiated report hit and pinched another resident. The other resident also hit Resident #22. A 9/30/24 Nursing Note stated the resident Resident #13 sat in the lobby next to another resident and started hitting and pinching her. The other resident also hit and pinched. e. Resident #22 and Resident #21 The MDS assessment tool, dated 9/13/24, listed diagnoses for Resident #21 which included diabetes, Parkinson's, and depression. The MDS listed the resident's BIMS score of 0 out of 15, indicating severely impaired cognition. A 10/20/24 Verbal Aggression Received report stated another resident yelled at Resident #22 and Resident #22 carried out a light grasp of the right upper arm(of the other resident). A 10/20/24 Incident Note stated a resident grabbed Resident #21's arm when Resident #21 asked her not to tap the couch. 2. The MDS assessment tool, dated 3/14/24, listed diagnoses for Resident #2 which included seizure disorder, anxiety disorder, and depression. The MDS stated the resident required partial to moderate assistance to transfer from chair to bed and listed his cognitive skills for daily decision making as moderately impaired. Care Plan entries, dated 5/17/13, stated the resident had the potential for uncontrolled seizures resulting in a safety hazards and falls and stated he would have no major injury related to his seizure disorder. An 8/1/19 Care Plan entry directed staff to keep a gait belt on the resident when he stood while dressing and to keep a hold of him by the gait belt so he could be assisted if he lost his balance. A 9/16/20 Care Plan entry directed staff to quickly assist the resident to lie down if he felt a seizure coming on. A 10/25/21 Care Plan entry stated the resident required the assistance of one staff member for transfers. Care Plan entries, dated 4/11/22, directed staff to not leave the resident alone during a seizure and protect from injury. The Care Plan directed staff to help the resident to the floor to prevent injury if the resident was not in bed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Care Plan entries, dated 6/24/24, stated the resident was at risk for falls related to impaired balance, poor safety awareness, neuromuscular/functional impairment, and the use of medications that may increase fall risks related to a diagnosis of seizure disorder. The entries directed staff to encourage him to ask for assistance when transferring, check on him frequently, and offer assistance with any activities of daily living(ADLs). A 6/22/24 6:22 p.m. Incident Note stated the resident placed his call light on during meal time and the nurse left to get assistance as when the resident requested to be laid down he was not always stable and also possibly requested to lie down when feeling the onset of seizures. The nurse and CNA walked to the resident's room when they heard a loud band. The resident laid between the bed and the TV and a large amount of blood pooled on the floor. Staff called 911 and the resident transferred to the ER. A 6/22/24 9:40 p.m. Incident Note stated the resident returned to the facility and the hospital treated him for a scalp laceration and possible seizure. The resident returned to the facility with staples. On 11/13/24 at 8:38 a.m., Staff D Licensed Practical Nurse(LPN) stated (on 6/22/24) Resident #2 waved his hands when he wanted to lie down. She stated she left to get help because she did not want to help him by herself. She stated it was a busy time so she returned 10-15 minutes later. She stated she and other staff were outside the door when he fell . She stated there was enough staff but the CNAs were feeding residents at the time. Facility Daily Assignment sheets for the period of 10/1/24-11/15/24 documented one nurse and one CNA scheduled for the 6:00 p.m. to 6:00 a.m. shift: 10/5/24, 10/6/24, 10/11/24, 10/12/24, 10/13/24, 10/19/24, 10/20/24, 10/24/24, 10/25/24, 10/26/24, 10/27/24, 11/1/24, 11/2/24, 11/3/24, 11/8/24, 11/9/24, 11/10/24, 11/15/24. The Facility Assessment, dated 8/15/24, listed staff needs for the evening shift as 1-2 LPNs and 1-3 Certified Nursing Assistants(CNAs) and listed the needs for the night shift as 1 LPN and 1-2 CNAs. The assessment directed to adjust as needed. On 11/18/24 at 8:44 a.m., via phone, Staff I Certified Nursing Assistant(CNA) stated Resident #22 did act out against other residents. She stated if she thought people were in her bubble, she would point her finer at them, cuss at them, and sometimes she slapped them. She stated the keep an eye on her but there were not enough staff to monitor her and they were busy. She stated when she worked there were only 2 people on staff and this was not enough. She stated she had to prioritize and instead of changing residents every 2 hours, she completed this every 3 hours. On 11/19/24 at 1:59 via phone, the Director of Nursing(DON) of a sister facility stated if staff thought a resident was having a seizure, they would prioritize this even if they were busy. She would want staff to put them in bed and tell the nurse. On 11/18/24 at 11:31 a.m. via phone, Staff K CNA stated there were not enough staff to go around. She stated if there were 2 CNAs, it was enough, but sometimes there was just 1. She stated it was hard for her to change everyone every two hours and it was probably every 2.5 hours instead. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/19/24 at 1:48 p.m., the Business Office Manager(BOM) stated she tried to place 2 CNAs on days and evenings and 1-2 on nights. She stated having the extra person helped. On 11/19/24 at 1:57 p.m., the Administrator stated ideal staffing was 2 CNAs and a nurse. She stated after 6:00 p.m., residents were sleeping. She stated staffing was modeled by guidance from corporate. The facility policy Staffing, revised October 2017, stated the facility would provide sufficient numbers of staff to provide care and services for all residents in accordance with resident care plans and the facility assessment. 45338 On 11/13/24 at 12:55 PM, interview conducted with Staff G, Registered Nurse (RN). Staff G explained not having enough staff at the facility because they were all out on break instead of watching residents. Per Staff G, she had CNAs on break all the time not telling that they went on break.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 45338 Based on previous 2567 review, staff interview, and facility policy review the facility failed to ensure an effective QAPI (Quality Assurance Performance Improvement) process to address previously identified quality deficiencies, resulting in multiple repeat deficiencies identified on the facility's current recertification and complaint survey that were previously identified during surveys completed in the last twelve months. The facility reported a census of 26 residents. Findings include: Review of the facility's CMS-2567 form from a recertification and complaint survey dated 1/16/24 to 1/23/24 revealed, in part, deficient practices identified with advanced directives, care plan revision, activities of daily living related to incontinence care, lack of a qualified Infection Preventionist to attend Quality Assurance meetings, and lack of a qualified Infection Preventionist. During the facility's current recertification and complaint survey initiated 11/4/24 to 11/19/24, deficient practices were again identified with all of the above areas from the facility's previous recertification survey. On 11/19/24 at 3:35 PM, the facility's Administrator explained QA occurred the last Wednesday of the month, was done on a monthly basis, and ad hoc QAPI was done as well, whatever needed to do to fix processes. Review of the Facility Policy titled Quality Assurance Performance Improvement Plan [QAPI] for [Facility Name Redacted] revealed, in part, the following: IV. Feedback, Data Systems and Monitoring a. The facility will use a broad range of sources when monitoring and gathering data. b. Sources of this data may include but will not be limited to . iv. Survey findings (Annual and Complaint)