STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175334	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Liberal	2160 Zinnia Lane Liberal, KS 67901

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	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** 50659 The facility reported a census of 37 residents with 17 residents sampled, which included three residents reviewed for abuse and neglect. Based on observation, interview, and record review, the facility deprived Resident (R) 7 care when the facility failed to ensure call lights were working appropriately to address the care needs of all residents residing on one of the four halls. On 07/16/24, during initial screening, multiple residents reported issues with call light response times and the surveyor observed a 42-minute call light response time for R 7. The facility reported they had issues with the call light system for months and used staff at the nurses' station to watch the system; however, on 07/17/24 at 07:25 AM, no staff were at the nurses' station watching the call light system. This failure placed the residents in immediate jeopardy. In addition, the facility failed to ensure staff identified and responded appropriately to all allegations of abuse and reporting for R21 who had a large bruise across her chest. On 07/16/24, R21's family member stated the facility reported to her that R21 had a bruise located across her lower chest. Furthermore, the facility failed to respond appropriately to R17 allegations of sexual assault. This failure which placed the residents at risk for abuse and continued negative impact on their physical, mental, and psychosocial well-being. Findings Included: - Resident (R) 7's Electronic Health Record (EHR) revealed diagnoses, which included metabolic encephalopathy (condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), muscle weakness, anxiety disorder, and history of falling. The 12/07/23 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. R7 had a total mood severity score of two, indicating minimal depression. R7 was independent with eating. R7 required supervision assistance with activities of daily living (ADL), with dressing personal hygiene, transfer, and mobility. R7 required maximal assistance with bathing and toileting. R7 was occasionally incontinent of bladder. R7 had no falls. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The 06/07/24 Quarterly MDS documented a BIMS score of 15, indicating intact cognition. R7 was independent with eating, oral care, personal hygiene, and upper body dressing. R7 required supervision with toileting and bathing and required moderate assistance with transfers. R7 had no falls. The 12/07/23 Urinary Incontinence and Indwelling Catheter Care Area Assessment documented R7 had bladder incontinence related to his benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections) and weakness. The 07/18/24 Care Plan documented R7 had an ADL self-care performance deficit. The Care Plan instructed staff to provide R7 with required one staff assistance for transfers between surfaces and were instructed to use a walker and a gait belt dated 06/13/24. The Care Plan included the staff to provide a call light and place within R7's reach, dated 01/03/23. The 05/24/24 Physician Order included the staff were to ensure R7's tab alarm was working every day, due to frequent falls. Review of R7's Progress Notes from 01/01/24 to 07/18/24 lacked documentation regarding call lights. On 07/16/24 at 09:20 AM, R7 stated staff took a long time to answer his call light. R7 stated it could take the staff over 45 minutes to answer. On 07/16/24, observation revealed R7's call light was on at 09:18 AM, and staff failed to answer the call light until 10:00 AM, a total of 42 minutes. On 07/16/24 at 09:59 AM, Certified Nurse Aide (CNA) M stated she answered the call light for R7 a couple of minutes ago and had forgot to shut it off. CNA M entered R7's room and canceled the call light. Resident (R) 27's Electronic Health Record (EHR) revealed diagnoses, which included after care following a joint replacement surgery, presence of unspecified artificial knee joint, low back pain and migraines. The 05/20/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. R27 had a total mood severity score of 00, indicating no depression. R27 was independent with eating, oral care, toileting, dressing, personal hygiene and mobility. R27 required supervision assistance with activities of daily living (ADL) with bathing. R27 was frequently incontinent of bladder. R27 had pain occasionally with the worst pain level of 10. The 07/03/24 Entry MDS documented a BIMS of 15, and no depression. R27 required moderate assistance with her ADLs with lower dressing, footwear, transfers, and standing. The resident was non ambulatory and required maximal assistance with toileting and bathing. R27 was occasionally incontinent of bladder and documented frequently complained of pain with the worst pain level of nine. The 05/20/24 Functional Abilities Care Area Assessment documented R27 was awaiting knee surgery and was not ambulatory. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The 05/20/24 Pain CAA documented R27 had chronic pain related to her diagnosis. The Care Plan reviewed on 07/18/24, documented R27 had recent surgery on her right knee and instructed staff to provide the resident with required one staff assistance with dressing, toileting, transfers, and incontinent care, dated 07/01/24. The 07/13/24 Physician Orders included Hydrocodone-Acetaminophen Oral Tablet, 10-325 milligram (mg) tablet, one tablet, by mouth, five times a day scheduled at the following times, 12:00 AM, 06:00 AM, 12:00 PM, 04:00 PM and 08:00 PM for chronic pain. The Progress Notes reviewed from 06/27/24 to 07/19/24 documented the following: On 06/27/24 at 02:47 PM, R27 readmitted from the hospital after she received a right total knee replacement. On 06/29/24 at 04:42 PM, R27 complained of right knee pain rated at a 10. No medication had been delivered from pharmacy and no answer from the physician. R27 requested to go to emergency room and was transferred. On 06/29/24 at 06:36 PM, R27 returned from the hospital, she had received pain medications and returned with a script and stated her a pain level was five. On 07/03/24 at 06:12 PM, R27 rated her pain at 10, she stated she had scheduled pain medication and stated it worked for her. . On 07/06/24 at 10:56 AM, R27 noted to have redness, warm and pain to her left lower leg. R27's physician made aware waited on new orders. On 07/06/24 at 02:33 PM, Physician had not called facility back with new orders. R27 requested to go to the hospital if the facility did not hear back from the physician. On 07/06/24 at 03:28 PM, R27 was sent to hospital, evaluated in emergency room and was admitted with cellulitis (skin infection caused by bacteria). On 07/12/24 at 05:24 PM, R27 readmitted at 12:30 PM and rated her pain at a seven out of 10. On 07/13/24 AT 04:31 PM, received a new physician order to increase hydrocodone-acetaminophen 10-325 mg changed from four times a day to five times a day per physician. During an interview on 07/16/24 at 12:34 PM, R27 stated her call light did not always work, the light above the door in the hallway did not light up, and staff told her the call light did not activate their pager. R27 stated she had to yell loudly for staff to come assist her and stated this occurred on all three shifts and would at times, have to wait over 45 minutes for staff to answer her call light. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	On 07/16/24 at 04:00 PM, R27 yelled out the surveyor's name from her room when the surveyor walked by her room. R27 was in her bed. R27 had a frown on her face of discomfort and stated that her call light had been on for over 20 minutes, and no staff had answered it yet. R27 stated she was in pain and needed pain medication. During an interview on 07/16/24 at 04:01 PM, CNA N stated the C hall call lights did not alarm to all of the pagers and the call light system had not been working correctly for several months. During an interview on 07/16/24 at 04:05 PM, Licensed Nurse (LN) G and LN H both confirmed R 27's call light was activated 20 minutes prior when they observed the call light computer screen located in the nurses' station. LN G and LN H stated the call light system has not worked properly for months. During an interview on 07/16/24 at 04:35 PM, Administrative Nurse D stated the call light system had just been looked at recently by a company and had been working properly. Administrative Nurse D expected the aides to always have a working pager and walkie talkie on them when working. On 07/16/24 at 04:35 PM, Administrative Staff A, confirmed she would look into the call light system and update the surveyor. On 07/16/24 at 05:30 PM, CNA O stated she had a pager, but it was not on. CNA O then stated the pager battery was dead. On 07/16/24 at 05:30 PM, CNA P stated she had the float pager on her and had received alerts from A, B, and D hall call lights. Observation with CNA P of her pager history revealed no C hall call lights were received to her pager. On 07/16/24 at 05:30 PM, CNA N stated she always carried a call light pager. On 07/16/24 at 05:30 PM, CNA M stated she did not have a pager on her. CNA M stated she gave the C hall pager to another aide at 04:30 PM today. On 07/16/24 at 05:35 PM, CMA R stated she received the C hall pager at 04:30 PM and cleared the history off the pager. CMA R stated the call light system on C hall did not always work, but the nurses have the call light screen in the nurses' station and would call the staff on the walkie talkies to assist the residents when residents would activate their call light. Observation on 07/16/24 at 05:35 PM, revealed R27 activated her call light, the alert went to the C hall pager, but did not go to any other pager, including the float pager. During an observation on 07/16/24 at 05:40 PM, the call light computer screen in the nurses' station with a history of the longest call light activated time was 62 minutes. Administrative Staff A confirmed that was not an acceptable time for a resident's call light to go unanswered. Administrative Staff A stated the call light should also go to the float pager and confirmed R27's call light did not go to that pager at 05:35 PM. Review of the call light reports from 07/15/24 documented the following extended call light response times: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Room C-38, the call light was on for 43 minutes, 36.8 minutes, and 89.42 minutes. Room B-21, the call light was on for 51.17 minutes. Room B-26, the call light was on for 30 minutes. Room B-27, the call light was on for 65.58 minutes. Room A-7, the call light was on for 43 minutes, and Room B-19, the call light was on for 33 minutes. Review of the call light reports from 07/16/24 documented the following extended call light response times: Room A-7, the call light was on for 32 minutes, 36.15 minutes. Room B-23, the call light was on for 31 minutes. Room B-21, the call light was on for 61 minutes. Room B-27, the call light was on for 51 minutes. Room C-37, the call light was on for 47 minutes, 56 minutes, and 43 minutes. Room C-38, the call light was on for 42 minutes. Room D-23, the call light was on for 46 minutes, and Room A-8, the call light was on for 38 minutes. On 07/16/24 at 06:05 PM, Administrative Staff A stated the facility call light plan was the facility would have a staff member at the nurses' station to monitor the call light computer screen and notify staff members by walkie talkie when a call light had been activated. Administrative Staff A stated she contacted the call light company for instructions to re-program the float pager later in the evening as the company was not available to assist at the time of the call. On the morning of 07/17/24 at 07:25 AM, observation of the facility nurse's station revealed no staff were present at the nurse's station to monitor the computer screen for call lights. On 07/17/24 at 07:30 AM, CNA Q stated she did not have a pager but had a walkie talkie. CNA Q stated she was the bath aide and did not need to carry a pager. On 07/17/24 at 07:40 AM, LN I stated the Administrator re-programmed the float pager last night, and all staff were to have a pager and a walkie talkie. LN N stated no one educated or alerted them that a staff member was to watch the call light computer screen. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	On 07/17/24 at 08:05 AM, B hall CNA MM lacked a call light pager, however had a walkie talkie on her. On 07/17/24 at 08:05 AM, A hall CNA NN had her call light pager and walkie talkie on her, and the pager history showed the call lights activated on the A hall earlier in the morning. On 07/17/24 at 08:05 AM, C and D hall CNA M had both C and D hall call pagers and a walkie talkie on her. CNA M stated she had cleared the history on both the pagers that morning. On 07/17/24 at 08:05 AM, CNA Q stated she now had the float pager on her, and the float pager had no history on it. On 07/17/24 at 08:11 AM, R27 activated her call light. The call light did activate the pager for C hall and float pager, but it did not vibrate or sound when activated per CNA M and CNA Q. CNA M stated the pager should sound or vibrate. On 07/17/24 at 08:35 AM, Administrative Staff A stated she gave verbal education last night after the float pager was re-programmed and stated the aides were to carry the float pager so there would be two working pagers for the call lights being activated. Administrative Staff A stated she did not complete a written education. The facility Call Light policy, dated 08/01/23 documented staff were to ensure the resident always had a method of calling for assistance and would promptly answer resident's call lights. On 07/17/24 at 06:14 PM, Administrative Staff A was provided the Immediate Jeopardy (IJ) template for the failure to provide needed services to residents due to the lack of a functioning call system in place to address the care needs of all residents. The facility submitted an acceptable plan for removal of the immediate jeopardy on 07/18/24 at 07:54 AM which included the following: 1. All residents were immediately checked on to address any needs. Continual resident rounding was conducted to monitor and assess resident needs until all pagers were verified functioning appropriately. 2. All pagers were checked to ensure they were functioning properly, and all CNAs and CMAs were checked to ensure they were wearing their functioning pagers. 3. Immediate education was conducted with all CNAs, CMAs, and Charge nurses to ensure all CNAs, CMAs an assigned Charge nurse were wearing their pager during their shift. 4. Walkie talkies will be implemented for increased communication for resident care needs. Walkie talkies will be carried by all nursing staff during their shift to assist in call light response time. 5. Call light company contacted on 07/16/24 and corrected float pager, ensuring this pager received resident call lights from all hallways. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	What systematic changes were implemented to ensure deficient practice does not recur: 1. Walkie talkies will be carried by all nursing staff during their shift to assist in call light response time. 2. Order was placed for additional pagers. When additional pagers arrive to facility, all nursing staff will carry pagers including Nursing Leadership, during their shift to assist in call light responses. 3. At beginning of each shift, a huddle will be conducted by the charge nurse to ensure all CNAs & CMAs are carrying pagers on their person. 4. Nursing home leadership will implement Angel Rounding, a resident rounding interview and observation system to ensure resident care needs are addressed including call light response times The surveyor verified the facility implemented the above corrective measures on-site on 07/18/24 at 04:00 PM. The deficient practice remained at a scope and severity level of an E, following the implementation of the removal plan. - The Electronic Health Records (EHR) documented Resident (R)21 had the following diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following an intracranial hemorrhage (a type of stroke that causes bleeding in the head), lack of coordination and traumatic brain injury (TBI-an injury to the brain caused by external forces). The 02/15/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 99, indicating severely impaired cognition, the depression not scored and lacked staff interview. R21 had behaviors that included hitting and yelling. R21 required supervision for eating and oral care. Moderate assistance with activities of daily living (ADLs), with toileting hygiene, showering and dressing. R 21 required maximal assistance with transfers, personal hygiene, and bed mobility. R21 was dependent on staff for wheelchair mobility. R21 was always incontinent of bladder. The resident had no falls. The 02/15/24 Functional Abilities Care Area Assessment (CAA) documented R21 was dependent on staff with all ADLs. The 05/17/24 Quarterly MDS documented a BIMS score of 99, and the depression was not scored. R21 had behaviors of yelling and hitting. R21 required total dependence of staff for toileting, showering, dressing, hygiene, transfers, and dressing. R21 required maximal assistance for oral care and bed mobility. R21 required supervision for eating. R21 was frequently incontinent of bowel and bladder. On 07/17/24 the Care Plan documented R21 required a full lift with two persons assist, dated 03/21/24. Staff instructed to complete weekly skin assessment by licensed nurse, document the findings and report concerns to the physician, dated 08/03/22. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	On 07/17/24 the Physician Orders documented to complete weekly skin assessments, document the findings and report concerns to the physician, ordered on 06/29/23. The Progress Notes reviewed 01/01/24 to 07/18/24, documented the following: On 03/21/24 at 08:58 PM, R21 had an old bruise noted across her lower chest area, under arms and left shoulder area. Bruised areas were various colors of purple and yellow. The bruise determined to be from inappropriate gait belt (belt used to help transfer or stabilize during activity) used by staff. Review of the Skin Observation in EHR dated 03/18/24, documented R21's skin check was completed - no skin conditions observed/skin condition resolved. The Skin Observation in EHR dated 03/25/24, documented skin check was completed - no skin conditions observed/skin condition resolved. On 07/16/24 at 12:02 PM, R21 seated in her wheelchair in the main dining room eating her lunch. Noted a personal alarm on wheelchair attached to the handle of the wheelchair and clipped to R21's shirt. On 07/16/24 at 12:40 PM, R21 seated in her wheelchair yelling out come here a few times and waving her right arm. On 07/16/24 at 12:47 PM, a phone interview with R21's family member stated she received a phone call from the facility on 03/21/24 at 10:00 PM from a staff nurse and was notified that R21 had a bruise on her chest, and that it might have been caused by a gait belt. The family member stated they went to the facility the next day and observed a large bruise located on R21. The bruise was across the chest from armpit to armpit, with several different colors of healing. The family member stated they spoke to the Administrator that was no longer employed there and the SSD, and asked why she is just being notified of a bruise that looked to be healing. The family member stated that the Administrator would have the Director of Nurses call her about the bruise. The family member stated she talked to Administrative Nurse D on 03/25/24 and was informed the bruise was caused by a gait belt and that R21 was now a full body mechanical lift to avoid using a gait belt. On 07/17/24 at 05:30 PM, Administrative Staff A was requested to locate incident reports that was requested by a surveyor earlier in the morning from Administrative Nurse D. Administrative Staff A was notified that R21 had a bruise across her chest noted on 03/21/24. On 07/17/24 at 05:35 PM, Administrative Staff A stated that no investigation was completed, that the bruise occurred when family transferred R21 by themselves. Administrative Staff A stated there was a progress note in the EHR. The progress notes reviewed with Administrative Staff A and confirmed there was no progress note that mentioned the family caused the bruise. On 07/18/24 at 09:30 AM, no documentation received about the above concern from Administrative Staff A or Administrative Nurse D. On 07/18/24 at 04:00 PM, Social Service Staff X could not recall a conversation about a bruise on R21. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	On 07/22/24 at 02:40 PM, Administrative Nurse D stated there was no investigation or report completed about the bruise on R21 as the thought it was caused by a gait belt. Confirmed no staff education completed after the bruise was noted. Administrative Nurse D stated the skin observations should have included the bruise. The facility policy dated 07/06/23 Abuse and Neglect documented the following: The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The facility failed to ensure staff identified and responded appropriately to all allegations of abuse and reporting for this resident that had a large bruise across her chest. 36881 - Review of Resident (R) 17's undated Physician Orders, documentation included diagnoses of traumatic subdural hemorrhage (bleeding in the brain due to trauma), anxiety disorder, (mental or emotional reaction characterized by apprehension, uncertain and irrational fear) , need for assistance with personal care, lack of coordination, and problem related to care provider dependency. The Annual Minimum Data Set (MDS) dated [DATE], included a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The resident did not exhibit behaviors. She reported feeling down, depressed, or hopeless for two to six days of the look back period and noted the resident would isolate socially at times. The resident experienced hallucinations (sensing things while awake that appear to be real, but the mind created) and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) and rejected evaluation and/or cares one to three days of the look back period. She received antidepressant medication (class of medication used to treat depression). The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 06/12/24, included the resident had impaired cognitive function, impaired thought processes, experienced confusion, and behaviors. The Care Plan, (CP), dated 07/09/24, included interventions initiated on 04/17/24, which instructed staff to provide a translator as necessary to communicate with the resident and further documented the majority of facility staff spoke Spanish. An intervention initiated 04/17/24 instructed staff to monitor/record/report to R17's health care provider as needed when the resident had feelings such as labile mood or agitation, felt threatened by others or thoughts of harming someone. During an interview on 07/16/24 at 01:02 PM, R17 spoke in Spanish to Dietary Staff (DS) BB, who translated the interview to English on behalf of the resident. R17 stated two men sexually assaulted her in the facility. She said she had bruises and bite marks across her breast and abdomen when she made the report to the nurses (at the facility). Upon inquiry, she stated the nurses did not respond to her report of assault nor assess her for injury. She said she was in her room at the facility when the two men forced her on the bed and that was where it happened. The resident sat in her wheelchair, cried, and pointed towards her bed while describing the event. She was anxious, tearful, and her hands were trembling. She reported nobody did anything in response to her allegation. She confirmed law enforcement had not talked with her and she did not feel safe in the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 07/16/24 at 01:50 PM, DS BB stated she remembered hearing something about the resident (R17) reporting she was assaulted in the facility to someone at the local hospital, but that was a couple of months ago and she was not sure of the details. DS BB stated she did not recall any staff education (regarding resident abuse) provided by the facility at the time. Review of the Electronic Medical Record (EMR) Progress Notes (PN), dated 05/16/24 at 05:00 PM, revealed R17 complained of bilateral (both) breast pain due to a sexual assault that occurred at the facility a long time ago according to the resident. She did not recall when it happened. The resident had never reported any abuse since she admitted to the facility. She stated the people who assaulted her bit her at that time and she had several bruises on her breast and abdomen. The nurse performed a skin assessment, and the assessment was within normal limits. The nurse notified the Director of Nursing (DON), Social Services Designee (SSD), and Personal Care Physician (PCP) of the situation. The EMR PN dated 05/24/24 at 04:30 PM, documentation included the facility nurse spoke to the hospital nurse who reported the resident (R17) admitted from the emergency room (ER) on 05/22/24 for complaints of left sided chest pain. The hospital nurse informed the facility they made an adult protective service (APS) report due to the resident's complaint of sexual assault. The facility would follow up with the resident's PCP and to determine if a consult with cardiologist was required. The EMR PN dated 05/24/24 at 05:42 PM, documented upon return to the nursing facility, the resident was very aggressive and complained much of the night. She refused to have her call light turned off after cares. She banged on the door, yelled, and cried. The EMR PN dated 05/29/24 at 07:46 AM, revealed during a recent hospitalization , the resident (R17) reported to ER staff that she was being sexually abused at the nursing home. Review of the facility EMR documentation above revealed the resident (R17) reported sexual assault by two male perpetrators on 05/16/24. On 05/24/24, the resident went to the hospital for chest pain and reported to hospital staff she was sexually assaulted in the facility. On 05/29/24, the resident readmitted to the facility. The hospital notified the facility of the resident's report of sexual assault on 05/24/24 and on discharge on 05/29/24. The facility failed to respond to R17's allegation of abuse, investigate the allegation of abuse, and did not notify law enforcement until 07/16/24, when R17 reported the sexual assault to a state agency surveyor during a recertification survey. Review of the facility Grievance Log for 04/01/24 through 07/16/24 lacked identification of any allegation of abuse nor neglect regarding R17. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175334	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Liberal	2160 Zinnia Lane Liberal, KS 67901

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 07/17/24 at 02:44 PM Administrative Staff A confirmed the grievance logs did not include any report of sexual assault for the resident as noted in the 05/16/24 progress notes. The facility followed up on the reported sexual assault on 07/16/24 (approximately two months after the resident originally reported the allegation) when the surveyor brought it to her attention. Administrative Staff A reported she started at the facility as the Administrator on 06/10/24 and she was not aware of the report until 07/17/24. Administrative Staff A said she expected the Social Worker/SSD to track resident grievances, but the SSD informed her she did not maintain the grievance log as it was kept in the old Administrators office. She reported the SSD and the DON were employed during the time of the sexual assault allegation by R17 and the facility failed to respond to the resident's allegations of abuse on three different occasions. Administrative Staff A reported the facility should report, investigate, and notify law enforcement of allegations of sexual assault to ensure protection of the resident making the allegation, as well as the other residents of the facility. On 07/17/24 at 02:49 PM, Social Service Staff X stated she was just aware of the resident's allegation of abuse related to sexual assault. She stated the staff should protect the resident first then report any allegations of abuse to their supervisor and the state agency, initiate an investigation, and notify law enforcement. The nursing staff should assess the resident for injury, call the physician, family, and law enforcement. The facility should provide education for the staff and also question other residents and staff to get clarification on how they feel about their safety. Social Service Staff X confirmed the allegations of abuse were not reported or investigated when staff were made aware of the allegations on 05/16/24, 05/24/24, and 05/29/24. The facility failed to respond to the resident's allegation of abuse as they should. The facility policy Abuse and Neglect policy, dated 07/06/2023, documentation included the purpose of the policy was to ensure that residents are not subjected to abuse by anyone, including but not limited to, location employees, and/or other residents. Alleged or suspected violations involving any mistreatment, neglect, exploitation, or abuse including injuries of unknown origins will be reported immediately to the administrator. In the absence of the administrator from the location, the following individuals have the administrative authority of the administrator for purposes of immediate reporting of alleged violations: the director of nursing services or the supervisor of social services and both also have the authority to call law enforcement. The location will have evidence that all alleged or suspected violations are thoroughly investigated, and they will prevent further potential abuse while the investigation is in progress. Results of all investigations will be reported to the administrator or designated representative and to other officials in accordance with state law, including to the state survey and certification agency. The facility failed to ensure R17 remained free from sexual abuse when they failed to acknowledge an allegation, initiate an investigation, report the allegation to law enforcement and/or the state agency, and protect her from further abuse after she alleged, she was sexually assaulted by two men in her room at the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881 The facility reported a census of 37 residents with 17 sampled for review. The sample included one cognitively intact dependent Resident (R) 17 for reporting an allegation of abuse. Based on observation, interview, and record review, the facility failed to report an allegation of sexual assault when R17 reported a sexual assault by 2 male perpetrators on 05/16/24. On 05/24/24 the resident went to the hospital for chest pain and reported to hospital staff she was sexually assaulted in the facility. On 05/29/24 the resident readmitted to the facility. The hospital notified the facility of resident's report of sexual assault 05/24/24 and on discharge 5/29/24. The facility failed to respond to R17's allegation of abuse, investigate the allegation of abuse, did not report to the state agency, and did not notify law enforcement until 07/16/24, when R17 reported the sexual assault to the surveyor during survey. This failure placed the resident in immediate jeopardy and at risk for continued negative impact on her physical, mental, and psychosocial well-being. Findings included: - Review of Resident (R) 17's undated Physician Orders, documentation included diagnoses of traumatic subdural hemorrhage (bleeding in the brain due to trauma), anxiety disorder, (mental or emotional reaction characterized by apprehension, uncertain and irrational fear), need for assistance with personal care, lack of coordination, and problem related to care provider dependency. The Annual Minimum Data Set (MDS) dated [DATE], included a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The resident did not exhibit behaviors. She reported feeling down, depressed, or hopeless for two to six days of the look back period and noted the resident would isolate socially at times. The resident experienced hallucinations (sensing things while awake that appear to be real, but the mind created) and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) and rejected evaluation and/or cares one to three days of the look back period. She received antidepressant medication (class of medication used to treat depression). The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 06/12/24, included the resident had impaired cognitive function, impaired thought processes, experienced confusion, and behaviors. The Care Plan, (CP), dated 07/09/24, included interventions initiated on 04/17/24, which instructed staff to provide a translator as necessary to communicate with the resident and further documented the majority of facility staff spoke Spanish. An intervention initiated 04/17/24 instructed staff to monitor/record/report to R17's health care provider as needed when the resident had feelings such as labile mood or agitation, felt threatened by others or thoughts of harming someone. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 07/16/24 at 01:02 PM, R17 spoke in Spanish to Dietary Staff (DS) BB, who translated the interview to English on behalf of the resident. R17 stated two men sexually assaulted her in the facility. She said she had bruises and bite marks across her breast and abdomen when she made the report to the nurses (at the facility). Upon inquiry, she stated the nurses did not respond to her report of assault nor assess her for injury. She said she was in her room at the facility when the two men forced her on the bed and that was where it happened. The resident sat in her wheelchair, cried, and pointed towards her bed while describing the event. She was anxious, tearful, and her hands were trembling. She reported nobody did anything in response to her allegation. She confirmed law enforcement had not talked with her and she did not feel safe in the facility. During an interview on 07/16/24 at 01:50 PM, DS BB stated she remembered hearing something about the resident (R17) reporting she was assaulted in the facility to someone at the local hospital, but that was a couple of months ago and she was not sure of the details. DS BB stated she did not recall any staff education (regarding resident abuse) provided by the facility at the time. Review of the Electronic Medical Record (EMR) Progress Notes (PN), dated 05/16/24 at 05:00 PM, revealed R17 complained of bilateral (both) breast pain due to a sexual assault that occurred at the facility a long time ago according to the resident. She did not recall when it happened. The resident had never reported any abuse since she admitted to the facility. She stated the people who assaulted her bit her at that time and she had several bruises on her breast and abdomen. The nurse performed a skin assessment, and the assessment was within normal limits. The nurse notified the Director of Nursing (DON), Social Services Designee (SSD), and Personal Care Physician (PCP) of the situation. The EMR PN dated 05/24/24 at 04:30 PM, documentation included the facility nurse spoke to the hospital nurse who reported the resident (R17) admitted from the emergency room (ER) on 05/22/24 for complaints of left sided chest pain. The hospital nurse informed the facility they made an adult protective service (APS) report due to the resident's complaint of sexual assault. The facility would follow up with the resident's PCP and to determine if a consult with cardiologist was required. The EMR PN dated 05/24/24 at 05:42 PM, documented upon return to the nursing facility, the resident was very aggressive and complained much of the night. She refused to have her call light turned off after cares. She banged on the door, yelled, and cried. The EMR PN dated 05/29/24 at 07:46 AM, revealed during a recent hospitalization , the resident (R17) reported to ER staff that she was being sexually abused at the nursing home. Review of the facility EMR documentation above revealed the resident (R17) reported sexual assault by two male perpetrators on 05/16/24. On 05/24/24, the resident went to the hospital for chest pain and reported to hospital staff she was sexually assaulted in the facility. On 05/29/24, the resident readmitted to the facility. The hospital notified the facility of the resident's report of sexual assault on 05/24/24 and on discharge on 05/29/24. The facility failed to respond to R17's allegation of abuse, investigate the allegation of abuse, and did not notify law enforcement until 07/16/24, when R17 reported the sexual assault to a state agency surveyor during a recertification survey. Review of the facility Grievance Log for 04/01/24 through 07/16/24 lacked identification of any allegation of abuse nor neglect regarding R17. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 07/17/24 at 02:44 PM Administrative Staff A confirmed the grievance logs did not include any report of sexual assault for the resident as noted in the 05/16/24 progress notes. The facility followed up on the reported sexual assault on 07/16/24 (approximately two months after the resident originally reported the allegation) when the surveyor brought it to her attention. Administrative Staff A reported she started at the facility as the Administrator on 06/10/24 and she was not aware of the report until 07/17/24. Administrative Staff A said she expected the Social Worker/SSD to track resident grievances, but the SSD informed her she did not maintain the grievance log as it was kept in the old Administrators office. She reported the SSD and the DON were employed during the time of the sexual assault allegation by R17 and the facility failed to respond to the resident's allegations of abuse on three different occasions. Administrative Staff A reported the facility should report, investigate, and notify law enforcement of allegations of sexual assault to ensure protection of the resident making the allegation, as well as the other residents of the facility. On 07/17/24 at 02:49 PM, Social Service Staff X stated she was just aware of the resident's allegation of abuse related to sexual assault. She stated the staff should protect the resident first then report any allegations of abuse to their supervisor and the state agency, initiate an investigation, and notify law enforcement. The nursing staff should assess the resident for injury, call the physician, family, and law enforcement. The facility should provide education for the staff and also question other residents and staff to get clarification on how they feel about their safety. Social Service Staff X confirmed the allegations of abuse were not reported or investigated when staff were made aware of the allegations on 05/16/24, 05/24/24, and 05/29/24. The facility failed to respond to the resident's allegation of abuse as they should. The facility policy Abuse and Neglect policy, dated 07/06/2023, documentation included the purpose of the policy was to ensure that residents are not subjected to abuse by anyone, including but not limited to, location employees, and/or other residents. Alleged or suspected violations involving any mistreatment, neglect, exploitation, or abuse including injuries of unknown origins will be reported immediately to the administrator. In the absence of the administrator from the location, the following individuals have the administrative authority of the administrator for purposes of immediate reporting of alleged violations: the director of nursing services or the supervisor of social services and both also have the authority to call law enforcement. The location will have evidence that all alleged or suspected violations are thoroughly investigated, and they will prevent further potential abuse while the investigation is in progress. Results of all investigations will be reported to the administrator or designated representative and to other officials in accordance with state law, including to the state survey and certification agency. The facility failed to report, allegations of abuse/sexual assault to the appropriate state agency to ensure protection of the R17 as well as the other residents of the facility. This failure placed the resident in immediate jeopardy and at risk for continued negative impact on her physical, mental, and psychosocial well-being. On 07/18/24 at 03:30 PM, Administrative staff A was provided the Immediate Jeopardy (IJ) template for the failure to respond appropriately to R17's allegations of sexual assault. The IJ was first to exist on 05/16/24, and the facility submitted an acceptable plan for removal of the immediate jeopardy on 07/18/24 at which included the following: 1. On 07/16/24, R17 was assessed for any abuse, neglect, or trauma. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	2. All nursing staff education initiated on 07/16/24 for Recognizing and Reporting Abuse and Neglect Allegation by the Clinical Learning and Development Specialist. 3. Trauma Informed care assessment completed on 07/17/24 and R17's care plan was updated to reflect new trauma informed care interventions. 4. On 07/17/24, Law enforcement contacted and R17 interviewed. 5. Nursing Home Leadership were educated on Recognizing and Reporting Abuse and Neglect Allegation conducted by Regional Clinical Services Director on 7/18/24. 6. All above education will be completed by 7/18/24 or prior to next working shift. By 7/18/24, facility will review all residents at risk for Trauma informed care and address care plan interventions as needed. 7. Angel Rounding (leadership resident rounding touchpoint) will be initiated 7/18/24 to identify areas of concern and ensure resident safety. The surveyor verified the facility implemented the above corrective measures on -site on 07/22/24. The deficient practice remained at a scope and severity level of a D, following the implementation of the removal plan.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881 The facility reported a census of 37 residents with 17 sampled for review. The sample included one cognitively intact dependent Resident (R) 17 reviewed for investigating an allegation of abuse related to sexual assault. Based on observation, interview and record review, the facility failed to thoroughly investigate R17's allegations of sexual assault and failed to protect R17 from potential further sexual abuse. The resident reported sexual assault by 2 male perpetrators on 05/16/24. On 05/24/24 the resident went to the hospital for chest pain and reported to hospital staff she was sexually assaulted in the facility. On 05/29/24 the resident readmitted to the facility. The hospital notified the facility of resident's report of sexual assault 05/24/24 and on discharge 5/29/24. The facility failed to respond to R17's allegation of abuse, investigate the allegation of abuse, and did not notify law enforcement until 07/16/24 when R17 reported the sexual assault to the surveyor during survey. This failure placed the resident in immediate jeopardy and at risk for continued negative impact on her physical, mental, and psychosocial well-being. Findings included: - Review of Resident (R) 17's undated Physician Orders, documentation included diagnoses of traumatic subdural hemorrhage (bleeding in the brain due to trauma), anxiety disorder, (mental or emotional reaction characterized by apprehension, uncertain and irrational fear) , need for assistance with personal care, lack of coordination, and problem related to care provider dependency. The Annual Minimum Data Set (MDS) dated [DATE], included a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The resident did not exhibit behaviors. She reported feeling down, depressed, or hopeless for two to six days of the look back period and noted the resident would isolate socially at times. The resident experienced hallucinations (sensing things while awake that appear to be real, but the mind created) and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) and rejected evaluation and/or cares one to three days of the look back period. She received antidepressant medication (class of medication used to treat depression). The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 06/12/24, included the resident had impaired cognitive function, impaired thought processes, experienced confusion, and behaviors. The Care Plan, (CP), dated 07/09/24, included interventions initiated on 04/17/24, which instructed staff to provide a translator as necessary to communicate with the resident and further documented the majority of facility staff spoke Spanish. An intervention initiated 04/17/24 instructed staff to monitor/record/report to R17's health care provider as needed when the resident had feelings such as labile mood or agitation, felt threatened by others or thoughts of harming someone. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 07/16/24 at 01:02 PM, R17 spoke in Spanish to Dietary Staff (DS) BB, who translated the interview to English on behalf of the resident. R17 stated two men sexually assaulted her in the facility. She said she had bruises and bite marks across her breast and abdomen when she made the report to the nurses (at the facility). Upon inquiry, she stated the nurses did not respond to her report of assault nor assess her for injury. She said she was in her room at the facility when the two men forced her on the bed and that was where it happened. The resident sat in her wheelchair, cried, and pointed towards her bed while describing the event. She was anxious, tearful, and her hands were trembling. She reported nobody did anything in response to her allegation. She confirmed law enforcement had not talked with her and she did not feel safe in the facility. During an interview on 07/16/24 at 01:50 PM, DS BB stated she remembered hearing something about the resident (R17) reporting she was assaulted in the facility to someone at the local hospital, but that was a couple of months ago and she was not sure of the details. DS BB stated she did not recall any staff education (regarding resident abuse) provided by the facility at the time. Review of the Electronic Medical Record (EMR) Progress Notes (PN), dated 05/16/24 at 05:00 PM, revealed R17 complained of bilateral (both) breast pain due to a sexual assault that occurred at the facility a long time ago according to the resident. She did not recall when it happened. The resident had never reported any abuse since she admitted to the facility. She stated the people who assaulted her bit her at that time and she had several bruises on her breast and abdomen. The nurse performed a skin assessment, and the assessment was within normal limits. The nurse notified the Director of Nursing (DON), Social Services Designee (SSD), and Personal Care Physician (PCP) of the situation. The EMR PN dated 05/24/24 at 04:30 PM, documentation included the facility nurse spoke to the hospital nurse who reported the resident (R17) admitted from the emergency room (ER) on 05/22/24 for complaints of left sided chest pain. The hospital nurse informed the facility they made an adult protective service (APS) report due to the resident's complaint of sexual assault. The facility would follow up with the resident's PCP and to determine if a consult with cardiologist was required. The EMR PN dated 05/24/24 at 05:42 PM, documented upon return to the nursing facility, the resident was very aggressive and complained much of the night. She refused to have her call light turned off after cares. She banged on the door, yelled, and cried. The EMR PN dated 05/29/24 at 07:46 AM, revealed during a recent hospitalization , the resident (R17) reported to ER staff that she was being sexually abused at the nursing home. Review of the facility EMR documentation above revealed the resident (R17) reported sexual assault by two male perpetrators on 05/16/24. On 05/24/24, the resident went to the hospital for chest pain and reported to hospital staff she was sexually assaulted in the facility. On 05/29/24, the resident readmitted to the facility. The hospital notified the facility of the resident's report of sexual assault on 05/24/24 and on discharge on 05/29/24. The facility failed to respond to R17's allegation of abuse, investigate the allegation of abuse, and did not notify law enforcement until 07/16/24, when R17 reported the sexual assault to a state agency surveyor during a recertification survey. Review of the facility Grievance Log for 04/01/24 through 07/16/24 lacked identification of any allegation of abuse nor neglect regarding R17. (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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 07/17/24 at 02:44 PM Administrative Staff A confirmed the grievance logs did not include any report of sexual assault for the resident as noted in the 05/16/24 progress notes. The facility followed up on the reported sexual assault on 07/16/24 (approximately two months after the resident originally reported the allegation) when the surveyor brought it to her attention. Administrative Staff A reported she started at the facility as the Administrator on 06/10/24 and she was not aware of the report until 07/17/24. Administrative Staff A said she expected the Social Worker/SSD to track resident grievances, but the SSD informed her she did not maintain the grievance log as it was kept in the old Administrators office. She reported the SSD and the DON were employed during the time of the sexual assault allegation by R17 and the facility failed to respond to the resident's allegations of abuse on three different occasions. Administrative Staff A reported the facility should report, investigate, and notify law enforcement of allegations of sexual assault to ensure protection of the resident making the allegation, as well as the other residents of the facility. On 07/17/24 at 02:49 PM, Social Service Staff X stated she was just aware of the resident's allegation of abuse related to sexual assault. She stated the staff should protect the resident first then report any allegations of abuse to their supervisor and the state agency, initiate an investigation, and notify law enforcement. The nursing staff should assess the resident for injury, call the physician, family, and law enforcement. The facility should provide education for the staff and also question other residents and staff to get clarification on how they feel about their safety. Social Service Staff X confirmed the allegations of abuse were not reported or investigated when staff were made aware of the allegations on 05/16/24, 05/24/24, and 05/29/24. The facility failed to respond to the resident's allegation of abuse as they should. The facility policy Abuse and Neglect policy, dated 07/06/2023, documentation included the purpose of the policy was to ensure that residents are not subjected to abuse by anyone, including but not limited to, location employees, and/or other residents. Alleged or suspected violations involving any mistreatment, neglect, exploitation, or abuse including injuries of unknown origins will be reported immediately to the administrator. In the absence of the administrator from the location, the following individuals have the administrative authority of the administrator for purposes of immediate reporting of alleged violations: the director of nursing services or the supervisor of social services and both also have the authority to call law enforcement. The location will have evidence that all alleged or suspected violations are thoroughly investigated, and they will prevent further potential abuse while the investigation is in progress. Results of all investigations will be reported to the administrator or designated representative and to other officials in accordance with state law, including to the state survey and certification agency. The facility failed to ensure R17 remained free from sexual abuse when they failed to acknowledge an allegation, initiate an investigation, report the allegation to law enforcement and/or the state agency, and protect her from further abuse after she alleged, she was sexually assaulted by two men in her room at the facility. The facility failed to report and thoroughly investigate reported allegations of abuse/sexual assault to the appropriate state agency to ensure protection of the R17 as well as the other residents of the facility. The facility failed to thoroughly investigate R 17's allegations of abuse/sexual assault to ensure safety and protection of the R17 as well as the other residents of the facility. On 07/18/24 at 03:30 PM, Administrative staff A was provided the Immediate Jeopardy (IJ) template for the failure to respond appropriately to R17's allegations of sexual assault. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The IJ was first to exist on 05/16/24, and the facility submitted an acceptable plan for removal of the immediate jeopardy on 07/18/24 at which included the following: 1. On 07/16/24, R17 was assessed for any abuse, neglect, or trauma. 2. All nursing staff education initiated on 07/16/24 for Recognizing and Reporting Abuse and Neglect Allegation by the Clinical Learning and Development Specialist. 3. Trauma Informed care assessment completed on 07/17/24 and R17's care plan was updated to reflect new trauma informed care interventions. 4. On 07/17/24, Law enforcement contacted and R17 interviewed. 5. Nursing Home Leadership were educated on Recognizing and Reporting Abuse and Neglect Allegation conducted by Regional Clinical Services Director on 7/18/24. 6. All above education will be completed by 7/18/24 or prior to next working shift. By 7/18/24, facility will review all residents at risk for Trauma informed care and address care plan interventions as needed. 7. Angel Rounding (leadership resident rounding touchpoint) will be initiated 7/18/24 to identify areas of concern and ensure resident safety. The surveyor verified the facility implemented the above corrective measures on -site on 07/22/24. The deficient practice remained at a scope and severity level of a D, following the implementation of the removal plan.

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Good Samaritan Society - Liberal	2160 Zinnia Lane Liberal, KS 67901

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident when there is a significant change in condition 50659 The facility reported a census of 37 residents with 17 residents selected for review. Based on observation, interview, and record review, the facility failed to capture a significant change on Resident (R) 21 when the resident had two areas of decline in activities of daily living and increased behaviors. This deficient practice had the potential to lead negative impacts on the resident's physical, mental and psychosocial well-being. Findings included: - The Electronic Health Records (EHR) documented Resident (R)21 had the following diagnoses that included hemiplegia (paralysis of one side of the body) hemiparesis (muscular weakness of one half of the body) following an intracranial hemorrhage (a type of stroke that causes bleeding in the head), lack of coordination and traumatic brain injury (TBI-an injury to the brain caused by external forces). The 02/15/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 99, indicating severely impaired cognition, the depression not scored and lacked staff interview. R21 had behaviors that included hitting and yelling noted one to three days during the assessment look back period. R21 required supervision for eating and oral care. R21 required moderate assistance with activities of daily living (ADLs), toileting hygiene, showering, and dressing. R21 required maximal assistance with transfers, personal hygiene, and bed mobility. R21 was dependent on staff for wheelchair mobility. R21 was always incontinent of bladder. The 02/15/24 Functional Abilities Care Area Assessment (CAA) documented R21 was dependent on staff with all ADLs. The 05/17/24 Quarterly MDS documented a BIMS score of 99, and the depression was not scored. R21 had behaviors of yelling and hitting noted four to six days. R21 required total dependence of staff for toileting, showering, dressing, hygiene, transfers, and dressing. R21 required maximal assistance for oral care and bed mobility. R21 required supervision for eating. R21 was frequently incontinent of bowel and bladder. The Care Plan documented staff were to provide one person assistance with bathing, date revised 05/21/24. R7 was able to assist with dressing with cueing, staff provided one assist with dressing, revised date 08/20/22. Staff instructed to provide a full body mechanical lift for all transfers with two staff assistance date, revised 03/21/24. Review of the Progress Notes from 01/01/24 to 07/18/24 documented the following: On 04/30/24 at 04:03 PM, communication to physician related to the resident continued to yell and cuss. Resident attempted to spit at staff and the behavior had not improved in the past two weeks. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/20/24 at 01:49 PM, communication to physician related to the resident had experienced mood behaviors frequently. R21 yelled, grabbed, hit or scratched staff. Staff were unable to redirect the resident. Review of Functional Abilities - Current Performance assessments, dated 02/13/24 to 05/15/24 documented: On 02/13/24 at 10:17 AM, R21 required supervision for eating and oral care and moderate assistance with activities of daily living (ADLs), toileting hygiene, showering, and dressing. R 21 required maximal assistance with transfers, personal hygiene, and bed mobility. R21 was dependent on staff for wheelchair mobility. On 05/15/24 at 09:49 AM, R21 required total dependence of staff for toileting, showering, dressing, hygiene, transfers, and dressing. R21 required maximal assistance for oral care and bed mobility. R21 required supervision for eating. On 07/16/24 at 12:40 PM, R21 seated in her wheelchair in the main dining room, yelling loudly. On 07/17/24 at 12:45 PM, Licensed Nurse (LN) I assisted R21 from the dining room because R21 yelled out in the dining room. LN I propelled R21's wheelchair to the front lobby. On 07/18/24 at 05:20 PM, Licensed Nurse (LN) I stated that R21 yells out in the dining room at times, the staff will attempt to intervene with food and drinks. LN I stated that the intervention did not always work, so R21 would be escorted to a quieter place to watch the birds or listen to her country music. On 07/23/24 at 10:30 AM, Administrative Nurse E confirmed R21 had a decline in more than two of her ADLs and an increase in behaviors from her annual MDS completed on 02/15/24 to her quarterly MDS completed on 05/17/24. Additionally stated that the facility did not have a policy for MDS completion and used the Resident Assessment Instrument (RAI) manual as a guide. The facility failed to capture a significant change on (R) 21 had two areas of decline in activities of daily living and increased behaviors. This deficient practice had the potential to lead negative impacts on the resident's physical, mental and psychosocial well-being.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 37 residents with 17 residents selected for review. Based on observation, interview, and record review, the facility failed to accurately complete the Minimum Data Set (MDS) for five sampled residents, Resident (R)7 and R21 related to personal alarm use, R8 related to urinary catheter (tube inserted into the bladder to drain urine into a collection bag), R32 related to antiplatelet medication use and R23 for restraint use. This placed the residents at risk for uncommunicated care needs. Findings included: - Resident (R) 7's Electronic Health Record (EHR) revealed diagnoses included metabolic encephalopathy (condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), muscle weakness, anxiety disorder, and history of falling. The 12/07/23 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. R7's total severity score of two, indicating minimal depression. R7 was independent with eating. R7 required supervision assistance with activities of daily living (ADLs), with dressing, personal hygiene, transfer, and mobility. R7 required maximal assistance with bathing and toileting. R7 was occasionally incontinent of bladder. The 12/07/23 ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) documented R7 had actual self -care performance related to impaired balance. The 06/07/24 Quarterly MDS documented a BIMS score of 15, indicating intact cognition. R7 was independent with eating, oral care, personal hygiene, and upper body dressing. R7 required supervision with toileting and bathing and required moderate assistance with transfers. No alarm noted on MDS section P. The 07/18/24 Care Plan documented R7 had an ADL self-care performance deficit. Staff instructed to provide R7 with required assistance for transfers with assist of one staff between surfaces. Staff were instructed to use a walker and a gait belt. Staff were to provide a call light within R7's reach. Staff instructed to provide a chair alarm to alert movement of R7, dated 03/28/24. The 07/18/24 Physician Orders included staff were to ensure the tab alarm was working due to frequent falls daily, ordered 05/24/24. Review of the Progress Notes from 01/01/24 to 07/18/24 documented the following: On 03/28/24 at 05:01 AM, the resident was found on the floor in his room. R7 stated he fell when he transferred himself. Intervention of a chair alarm placed on R7's recliner. On 07/16/24 at 03:32 PM, R7 stated he had some falls but was not sure how many and stated that he would get up by himself. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/22/24 at 04:45 PM, R7 seated in his recliner, with a personal alarm attached to a recliner and to the resident. R7 stated he had the alarm for several months and it did not bother him. On 07/23/24 at 09:05 AM, Certified Medication Aide (CMA) R stated R7 has had a chair alarm on his recliner for a few months. On 07/23/24 at 09:10 AM, Certified Nurse Aide (CNA) M stated R7 has had a personal alarm since last year. On 07/23/24 at 10:00 AM, Licensed Nurse (LN) I stated if a resident had an alarm, the resident should have a physician order, as the nurse had to verify three times a day if the alarm worked. On 07/23/24 at 10:30 AM, Administrative Nurse E confirmed R7 had a chair alarm added to his care plan on 03/28/24 and the Quarterly MDS dated [DATE] section P alarm was not checked off as yes. Additionally stated that the facility did not have a policy for MDS completion and used the Resident Assessment Instrument (RAI) manual as a guide. On 07/23/24 at 03:41 PM, Administrative Nurse D expected the MDS to be completed accurately. The facility policy Alarms Bed, Chair and Door dated 08/22/23 revealed the following: To Ensure that use of alarms was appropriate based on resident's condition. Nursing staff would be responsible to check placement and alarm is functional daily. The use of alarms would be reviewed on a regular basis but not less than quarterly by the interdisciplinary team. The facility failed to accurately complete the MDS for R7 related to chair alarm use. This placed the resident at risk for uncommunicated care needs. - The Electronic Health Records (EHR) documented Resident (R)21 had the following diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following an intracranial hemorrhage (a type of stroke that causes bleeding in the head), lack of coordination and traumatic brain injury (TBI-an injury to the brain caused by external forces). The 02/15/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 99, indicating severely impaired cognition, the depression not scored and lacked staff interview. R21 had behaviors that included hitting and yelling. R21 required supervision for eating and oral care. Moderate assistance with activities of daily living (ADLs), with toileting hygiene, showering and dressing. R21 required maximal assistance with transfers, personal hygiene, and bed mobility. R21 was dependent on staff for wheelchair mobility. R21 was always incontinent of bladder. The resident had no falls and no alarm. The 02/15/24 Functional Abilities Care Area Assessment (CAA) documented R21 was dependent on staff with all ADLs. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 05/17/24 Quarterly MDS documented a BIMS score of 99, and the depression was not scored. R21 had behaviors of yelling and hitting. R21 required total dependence of staff for toileting, showering, dressing, hygiene, transfers, and dressing. R21 required maximal assistance for oral care and bed mobility. R21 required supervision for eating. R21 was frequently incontinent of bowel and bladder. R21 had no alarm. On 07/17/24 the Care Plan lacked any documentation of a personal alarm. On 07/17/24 the Physician Orders lacked any documentation of a personal alarm. The Progress Notes reviewed 01/01/24 to 07/18/24, lacked any documentation for a personal alarm. On 07/16/24 at 12:02 PM, revealed R21 seated in her wheelchair in the main dining room eating her lunch. R21 had a personal alarm on her wheelchair attached to the handle of the wheelchair and clipped to R21's shirt. On 07/18/24 at 12:15 PM, R21 seated in her wheelchair in the main dining room with a personal alarm on her wheelchair attached to the handle of the wheelchair and clipped on the back of R21's shirt. On 07/18/24 at 12:15 PM, Certified Nurse Aide (CNA) Q stated R21 had worn the persona alarm for months. On 07/18/24 at 05:15 PM, Certified Medication Aide (CMA) R stated R21 had worn the personal alarm for at least the six months she has been employed. On 07/18/24 at 05:20 PM, Licensed Nurse (LN) I stated she was unaware that R21 had a personal alarm and verified there was no physician order on R21's EHR. On 07/18/24 at 05:20 PM, LN H confirmed R21's care plan, Kardex (nursing tool that gives a brief overview of the care needs of each resident) and physician orders in EHR lacked any documentation of any alarm. On 07/23/24 at 10:30 AM, Administrative Nurse E confirmed that R21's annual MDS dated [DATE] and quarterly MDS dated [DATE] lacked alarm being checked off as yes. She also confirmed that R21 had a personal alarm being used for the past several months. Additionally stated that the facility did not have a policy for MDS completion and used the Resident Assessment Instrument (RAI) manual as a guide. On 07/23/24 at 03:41 PM, Administrative Nurse D expected the MDSs to be completed accurately. The facility failed to accurately complete the MDS for R21 related to personal alarm use. This placed the resident at risk for uncommunicated care needs. - Resident (R) 8's Electronic Health Record (EHR) revealed diagnoses included obstructive and reflux uropathy (is a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional) and dementia (progressive mental disorder characterized by failing memory, confusion). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 05/06/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. R8's total severity score of 00, indicating no depression. R8 was independent with eating and wheelchair mobility. R8 required total assistance with activities of daily living (ADLs), with toileting and transfers. R8 required moderate assistance with dressing and personal hygiene. Occasionally incontinent of bladder, however resident had a supra-pubic catheter (urinary bladder catheter inserted through the abdomen into bladder). Section H had indwelling foley catheter (tube inserted into the bladder to drain urine into a collection bag), external foley opening from an area inside the body to the outside) all three were checked off yes. The 05/06/24 ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) documented R8 had a self -care performance deficit related to weakness and contractures (abnormal permanent fixation of a joint or muscle) of both lower extremities. The 05/06/24 Urinary Incontinence and Indwelling Catheter CAA documented R21 has a supra-pubic catheter and lacked any analysis of findings. The 02/07/24 Quarterly MDS documented a BIMS score of 11, indicating moderately impaired cognition. R8 was independent with eating and wheelchair mobility. R8 required total assistance with ADL's, including toileting and transferring. R21 not rated for incontinence of bladder. Section H had indwelling foley catheter, external catheter and ostomy checked off as yes. The 07/18/24 Care Plan documented R8 had a 24 French suprapubic catheter to be changed monthly or as needed. Staff instructed to provide catheter care every shift. The 07/18/24 Physician Orders included change suprapubic catheter monthly, 24 French catheter, ordered 07/22/22. May flush suprapubic catheter as needed, ordered 08/17/22. Review of the Progress Notes from 01/01/24 to 07/18/24 lacked any documentation of suprapubic catheter. Review of the Treatment Record dated 07/01/24 to 07/31/24 documented R8's suprapubic catheter changed on 07/03/24. On 07/16/24 at 10:42 AM, R8 was in bed with his eyes closed. A urinary catheter drainage bag in a dignity bag was in a wash basin on the floor next to the bed. On 07/16/24 at 12:07 PM, R8 seated in his wheelchair in the main dining room. A urinary catheter drainage bag was covered with dignity bag. On 07/18/24 at 12:27 PM, Administrative Nurse D stated R8 had only a suprapubic catheter and no other ostomies. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/23/24 at 10:30 AM, Administrative Nurse E confirmed she checked off all three areas in section H for the catheter and she stated R8 only has a suprapubic catheter. Also confirmed that not rated should have been answered on the Annual MDS dated [DATE] for incontinence. Additionally stated that the facility did not have a policy for MDS completion and used the Resident Assessment Instrument (RAI) manual as a guide. The facility failed to accurately complete the MDS for R8 related to urinary catheter use. This placed the resident at risk for uncommunicated care needs. 36881 - Review of Resident (R)23's undated Physician Orders, documentation included diagnoses of acute kidney failure, hypertension (high blood pressure), restlessness and agitation, and personal history of transient ischemic attack (TIA-mini-stroke). The Annual Minimum data Set (MDS), dated [DATE], documentation included Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. The resident did not use restraints. The Quarterly MDS dated [DATE] documentation included a BIMS score of 15, indicating the resident cognitively intact. The resident used a trunk restraint less than daily. On 07/17/24 at 08:59 AM, the resident sat in his wheelchair at his bedside. He moved around the room independently self-propelling his wheelchair, without restraints present. The resident exhibited no limitations in access to his body. The resident was alert and oriented and responded to direct questions appropriately. Upon inquiry, the resident denied the use of restraints while a resident at the facility and reported having full access to his body. The environment in the resident's room lacked any evidence of devices used to restrict the resident's voluntary movement or access to his body. On 07/23/24 at 11:21 AM, Administrative Nurse E confirmed the resident had not used physical restraints while a resident in the facility. She reported the MDS was not accurate related to the coding for restraint use. Administrative Nurse E stated they used the Resident Assessment Instrument Manual for guidance to code the MDS accurately. The RAI manual, dated 10/2023, defined physical restraints as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. The documented guidance included the intent of this section of the MDS was to record the frequency that the resident was restrained by any of the listed devices. Assessors should evaluate whether a device meets the definition of a physical restraint and code only the devices that meet the definitions in the appropriate categories. The facility failed to complete an accurate assessment/Minimum Data Set (MDS) for the resident related to the use of physical restraints. - Review of Resident (R) 32's electronic medical record (EMR) revealed the following diagnoses that included heart failure (failure for the heart to pump effectively) and major depressive disorder with psychotic symptoms (MDD which includes a gross impairment in reality perception). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment. He received antipsychotic medication (medication used to treat psychosis) on a routine basis during the assessment period. The Psychoactive Drug Use Care Area Assessment (CAA), dated 02/05/24, documented the resident received an antipsychotic medication. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of six, indicating severe cognitive impairment. He received anticoagulant medication (medications which prevents blood from clotting) during the assessment period. The MDS inaccurately documented the resident had not received antipsychotic medication during the assessment period. The care plan, revised 05/14/24, instructed staff the resident used an antipsychotic medication. Review of the resident's EMR revealed the following physician's orders: Seroquel (an antipsychotic medication), 50 milligrams (mg), by mouth (po) every (Q) morning (AM), for MDD with severe psychotic symptoms, ordered 04/26/24. Seroquel, 50 mg, two tablets (tabs) po, Q bedtime (HS), for MDD with psychotic symptoms, ordered 04/25/24. Aspirin (ASA), 81 mg, po Q AM, for blood thinner, ordered 01/31/24. Review of the resident's Medication Administration Record (MAR) for April and May 2024, revealed the resident received Seroquel and ASA, as ordered. On 07/23/24 at 10:49 AM, Administrative Nurse E stated the quarterly MDS, completed 05/06/24, was inaccurate. The resident did receive antipsychotic medication during the assessment period and ASA should not be documented as a blood thinner. The facility utilized the Resident Assessment Instrument (RAI) manual for completion of the MDSs. The facility failed to complete an accurate MDS for this resident who received ASA and an antipsychotic medication.

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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. 50659 The facility reported a census of 37 residents with 17 residents selected for review. Based on observation, interview, and record review, the facility failed to accurately update Resident (R)7's care plan for fall interventions. This placed the residents at risk for uncommunicated care needs. Findings included: - Resident (R) 7's Electronic Health Record (EHR) revealed diagnoses included metabolic encephalopathy (condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), muscle weakness, anxiety disorder, and history of falling. The 12/07/23 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. R7's total severity score of two, indicating minimal depression. R7 was independent with eating. R7 required supervision assistance with activities of daily living (ADLs), with dressing, personal hygiene, transfer, and mobility. R7 required maximal assistance with bathing and toileting. R7 was occasionally incontinent of bladder. The 12/07/23 ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) documented R7 had actual self -care performance related to impaired balance. The 06/07/24 Quarterly MDS documented a BIMS score of 15, indicating intact cognition. R7 was independent with eating, oral care, personal hygiene, and upper body dressing. R7 required supervision with toileting and bathing and required moderate assistance with transfers. No alarm noted on MDS section P. The 07/18/24 Care Plan documented R7 had an ADL self-care performance deficit. Staff instructed to provide R7 with required assistance for transfers with assist of one staff between surfaces. Staff were instructed to use a walker and a gait belt. Staff were to provide a call light within R7's reach. Staff instructed to provide a chair alarm to alert movement of R7, dated 03/28/24. For fall that occurred on 05/17/24 fall intervention physical therapy consults for strength and mobility dated 05/18/24. Staff instructed to monitor R7 for significant changes in gait, mobility, positioning device, standing /sitting balance and lower extremity function dated on 05/12/24. On 06/15/24 staff instructed ensure safety when transferring surfaces appropriate positioning. Staff instructed to not leave R7 unattended in bathroom, dated 07/01/24. Ensure that R7 is provided with appropriate footwear when ambulated, dated 07/01/24. Staff instructed to provide clothing that is not loose fitting to prevent falls dated 12/13/23. However, the care plan lacked interventions after R7's fall on 01/26/24 and 04/15/24. The Physician Orders included staff were to ensure the tab alarm was working due to frequent falls daily, ordered 05/24/24. Review of the Progress Notes from 01/01/24 to 07/18/24 documented the following. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/26/24 at 09:48 PM, R7 was found on the floor in his bathroom. No injury noted, R7 encouraged to call staff for assistance. On 03/28/24 at 05:01 AM, the resident was found on the floor in his room. R7 stated he fell when he transferred himself. Intervention of a chair alarm placed on R7's recliner. On 04/15/24 at 05:22 PM, R7 was found on his hands and knees at his doorway of his room, R7 stated he was trying to go to the dining room for lunch and fell . On 05/12/24 at 12:00 AM, R7 was found on his floor in room, noted that R7 was bleeding from his scalp. R7 stated he was going to the bathroom when he fell and hit his head on the television stand. R7 was transported to local ER to be evaluated. On 05/17/24 at 06:15 PM, R7 was found on his floor on his hands and knees, no injury noted. On 06/15/24 at 03:00 PM, R7 had a witnessed fall in the whirlpool room. R7 had been transferred into the bath chair and slid off the chair onto the floor on his left side. R7 stated he was trying to adjust himself in the chair. On 07/01/24 at 05:28 PM, R7 was found seated on his floor, stated he had tried to pull his pants back up and fell backwards. On 07/16/24 at 03:32 PM, Interview with R7 stated he had some falls but was not sure how many and stated that he would get up by himself. On 07/22/24 at 04:45 PM, R7 seated in his recliner, with a personal alarm attached to recliner and the resident. R7 stated he had the alarm for several months and it did not bother him. On 07/23/24 at 10:00 AM, Licensed Nurse (LN) I stated that when a resident fell , the nurse on duty was to complete a fall investigation to determine why the resident fell . LN I stated the Director of Nursing, Administrator, Physician, and family member should be notified of a fall. LN I stated an intervention was to be completed immediately to prevent further falls and that the care plan should be updated by the MDS nurse or the Director of Nursing. On 07/23/24 at 03:30 PM, Administrative Nurse D confirmed R7 lacked a care plan intervention for the falls that occurred on 01/26/24 and 04/15/24. The facility policy Individual Care Plan dated 06/10/24 documented the following: To comply with state regulations concerning care delivered. Documentation must be completed for subsequent additions or any necessary updates to the plan. The facility failed to accurately update R7's care plan with fall interventions. This placed the resident at risk for uncommunicated care needs.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881 The facility reported a census of 37 residents with 17 residents sampled, which included five residents identified for restorative nursing services (care provided to maintain a person's highest level of physical, mental, and psychosocial function in order to prevent declines that impact quality of life). Based on observation, interview, and record review, the facility failed to provide treatment and services for four of the five sampled residents (R)4, R 11 R 29, and R 8, related to the lack of restorative nursing programs. Findings included: - Review of Resident (R) 4's undated physician Orders, revealed diagnoses which included hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one half of the body) following cerebrovascular disease (impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting right dominant side, and osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk). The Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of eight, indicating severe cognitive impairment. The resident had functional limitation in range of motion on both sides of his upper and lower extremities. He did not receive therapy or restorative nursing programs (RNP). The Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 06/04/24, documentation included the resident has an ADL self-care performance deficit related to history of cerebral vascular disease (CVA--stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and inability to independently bathe, dress, and groom. Goals included for the resident to maintain current level of functioning. The Care Plan (CP), dated 07/20/24, documented an intervention initiated on 04/08/2020 and revised on 02/03/2023, advised staff the resident had potential for developing contractures (abnormal permanent fixation of a joint or muscle) of the right hand. The resident should wear a resting hand splint at night and palm protector to the right hand during the day. The electronic records lacked documentation of a restorative nursing program. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/16/24 at 12:52 PM, R 4 sat in the wheelchair (w/c) at the dining room table for residents that required staff assistance with their meals. His arms crossed over his lap, with his left arm bent at the elbow with his left wrist flexed in a dropped fixed position, and his fingers and left hand rolled into his left hand. He lacked a palm protector in either hand. His hands and arms were under the edge of the dining room table. He coughed sporadically and banged his arms beneath the table. The resident noted to have several discolored areas on his bilateral (both) arms in the same areas noted to have contact with the dining room table when he coughed. Staff assisted the resident to eat, however the resident did not participate in feeding himself nor did he receive verbal cues or physical guidance from the staff to feed himself throughout the meal. The staff did not provide the resident with passive range of motion (when someone else moves or stretches a part of the body) during the observation period. On 07/16/24 at 03:15 PM, Certified Nurse Aide (CNA)/Restorative Aide (RCNA) L, reported she was the restorative aide, but she currently did not provide routine restorative nursing programs to any of the residents of the facility. She stated she was responsible for transportation for appointments in addition to other duties in the facility and did not have the time available to provide restorative programs. Additionally, she reported that the therapist would provide Administrative Nurse D, Administrative Nurse E, and her with recommendations for residents when they transitioned from therapy to maintain their functioning and prevent decline. RCNA L stated Administrative Nurse D and/or Administrative Nurse E were responsible for assessing the residents for Restorative Nursing Programs, but she was not aware of any assessments that had ben done for the residents of the facility. She reported she tried to do range of motion for residents that needed it when she worked the floor as a CNA but did not provide treatment for 15 minutes at any given time and could not confirm that the residents received the needed care and treatment related to restorative nursing services to prevent decline or maintain functioning. RCNA L confirmed that R4 was on her list as a resident who would benefit from passive range of motion to all extremities to prevent decline. She was not aware if he had been assessed for any nursing restorative programs, she reported he could still hold his cup to drink but could not feed himself. He needed passive range of motion to his upper and lower extremities. The resident should wear a splint to the right hand at night, but reported she did not know if the staff applied the splint at night as they should. On 07/23/24 at 11:32 AM, Consultant GG reported the facility therapist provides the administrative nursing staff recommendations when coming off of therapy to maintain functioning and prevent decline, however they were not involved in a routine screening process and their communication with nursing is limited to receiving orders for residents and when they are discharged from therapy services. Consultant GG stated the facility did not involve the therapy department in routine screening to identify residents who may have a decline in functioning or would benefit from restorative nursing. She stated the therapy department receives referrals from direct care staff if they see a decline which often are residents that have received therapy in the past and were not provided with restorative nursing programs as recommended by therapy. Consultant GG verified there were at least seven residents that therapy had recommended continued restorative nursing services to prevent decline and maintain functioning over the past several months. She confirmed R4 received therapy in the past and would benefit from restorative nursing program such as passive range of motion to prevent further decline. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/23/24 at 03:36 PM, Administrative Nurse E confirmed the therapy department would provide recommendations to nursing to maintain functioning and prevent decline when residents transitioned off of therapy. However, the facility did not provide restorative nursing programs for residents. Administrative Nurse E reported the facility lacked a system for routine screening process to identify residents who had experienced decline in functioning or would benefit from RNP to maintain functioning. She reported nursing had not assessed or provided restorative nursing programs for residents of the facility for over a year. She verified R4 would benefit from RNP to include range of motion and splint application to maintain his functioning and prevent decline. The facility policy Restorative -Nursing Care Implementation and Screening, dated 11/08/2023, documentation included the purpose of Restorative-Nursing Care to provide appropriate restorative nursing care to each resident and to assist in the implementation of a restorative nursing program. Each resident will receive restorative nursing care based on individual strengths, needs and problems as defined in the nursing assessment. The facility failed to provide treatment and services related to the lack of restorative nursing programs for this resident with contractures. - Review of Resident (R) 11's undated physician Orders, revealed diagnoses which included hypertension (high blood pressure), congestive heart failure (fluid around the heart which impedes the ability of the heart to pump) and stage four pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). The Annual Minimum Data Set (MDS), dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 99, indicating severe cognitively impairment. The resident had no functional limitation in range of motion on both sides of her upper and lower extremities. She used a wheelchair for a mobility device. She did not receive therapy or restorative nursing programs (RNP). The Pressure Ulcer/Injury (CAA) dated 12/28/24 documented the resident has pressure ulcer development related to mobility. Stage 4 (a deep pressure wound that reaches the muscles, ligaments, or even bone) sacral (large triangular bone/area between the two hip bones) wound. Staff should educate the resident/family as to causes of skin breakdown including transfer/positioning requirements, good nutrition, and frequent repositioning. The Care Plan (CP), dated 06/26/24, documented an intervention initiated on 01/12/21, advised staff the resident has activities of daily living (ADL) self-care performance deficit related to Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure) and required extensive to total assistance of staff with all cares. She required repetitive cueing and assistance with one to two staff. The resident had contractures (abnormal permanent fixation of a joint or muscle) of the right hand. Staff were to provide skin care on both right and left hands, each shift. Staff were to place a rolled wash rag in the resident's right hand to protect the palm and to keep clean and prevent skin breakdown. Inspect fingernails weekly and trim regularly to keep the resident's nails short and prevent injury to her palm. On 07/17/24 at 08:18 AM, R11 was in the bed, speaking out loudly and not able to discern request. Her right hand and fingers contracted and lacked splints or rolls in her hands. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/17/24 at 08:23 AM, Licensed Nurse (LN) I and LN J entered R11's room to provide a dressing change to the resident's sacral pressure ulcer and brief changed with peri care. No range of motion or splints were applied or provided for the resident by during care. LN I and LN J reported they were not aware of any nursing restorative programs provided by the facility. They agreed the resident would benefit from passive range of motion (movement of a joint by an external force, such as a person or device) to prevent worsening contractures. On 07/16/24 at 03:15 PM, Certified Nurse Aide (CNA)/Restorative Aide (RCNA) L, reported she was the restorative aide, but she currently did not provide routine restorative nursing programs to any of the residents of the facility. She stated she was responsible for transportation for appointments in addition to other duties in the facility and did not have the time available to provide restorative programs. Additionally, she reported that the therapist would provide Administrative Nurse D, Administrative Nurse E, and her with recommendations for residents when they transitioned from therapy to maintain their functioning and prevent decline. RCNA L stated Administrative Nurse D and/or Administrative Nurse E were responsible for assessing the residents for Restorative Nursing Programs, but she was not aware of any assessments that had been done for the residents of the facility. She reported she tried to do range of motion for residents that needed it when she worked the floor as a CNA but did not provide treatment for 15 minutes at any given time and could not confirm that the residents received the needed care and treatment related to restorative nursing services to prevent decline or maintain functioning. RCNA L confirmed that R11 as a resident who would benefit from passive range of motion to all extremities to prevent decline. On 07/23/24 at 11:32 AM, Consultant GG reported the facility therapist provided the administrative nursing staff recommendations when coming off of therapy to maintain functioning and prevent decline, however they were not involved in a routine screening process and their communication with nursing was limited to receiving orders for residents and when they are discharged from therapy services. Consultant GG stated the facility did not involve the therapy department in routine screening to identify residents who may have a decline in functioning or would benefit from restorative nursing. She stated the therapy department receives referrals from direct care staff if they see a decline which often are residents that have received therapy in the past and were not provided with restorative nursing programs as recommended by therapy. Consultant GG verified there were at least seven residents that therapy had recommended continued restorative nursing services to prevent decline and maintain functioning over the past several months. On 07/23/24 at 03:36 PM, Administrative Nurse E confirmed the therapy department would provide recommendations to nursing to maintain functioning and prevent decline when residents transitioned off therapy. However, the facility did not provide restorative nursing programs for residents. Administrative Nurse E reported the facility lacked a system for routine screening process to identify residents who had experienced decline in functioning or would benefit from RNP to maintain functioning. She reported nursing had not assessed or provided restorative nursing programs for residents of the facility for over a year. She verified R11 would benefit from RNP to include range of motion to maintain, functioning, prevent worsening contractures and decline. The facility policy Restorative -Nursing Care Implementation and Screening, dated 11/08/2023, documentation included the purpose of Restorative-Nursing Care to provide appropriate restorative nursing care to each resident and to assist in the implementation of a restorative nursing program. Each resident will receive restorative nursing care based on individual strengths, needs and problems as defined in the nursing assessment. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to provide treatment and services related to the lack of restorative nursing programs for this resident with contractures. - Review of Resident (R) 29's undated physician Orders, revealed diagnoses which included cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hypertension (high blood pressure), and traumatic brain injury (TBI-an injury to the brain caused by external forces). The Admission Minimum Data Set (MDS), dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact. The resident had functional limitation in range of motion on both sides of her upper extremities. She required extensive assistance of staff for bed mobility, dressing, personal hygiene and used a wheelchair for as a mobility device. She received physical therapy for 63 minutes over two days of the look back period. R29 did not receive therapy or restorative nursing programs (RNP). The Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 07/06/23, documented the resident was dependent on staff with all ADL's. Resident was usually able to ask for assistance and make her needs known. The Care Plan (CP), dated 07/10/24, documented an intervention initiated on 07/06/23, advised staff the resident had activities of daily living (ADL) self-care performance deficit related to disease process related to cerebral infarction (stroke) and contractures (abnormal permanent fixation of a joint or muscle) to hands. The resident was able to hold a cup with a lid and a straw and required staff assistance to eat. On 07/16/24 at 03:32 PM, R29 sat in a high back wheelchair (w/c) the dining room, her arms crossed over her abdomen hands and curled inward. She did not have any handrolls or rolled cloth in place. Throughout her meal, staff did not provide range of motion or movement with her arms or hand. She was dependent on staff for her food intake. Upon inquire, she stated she did not receive exercises by the staff. On 07/16/24 at 03:15 PM, Certified Nurse Aide (CNA)/Restorative Aide (RCNA) L, reported she was the restorative aide, but she currently did not provide routine restorative nursing programs to any of the residents of the facility. She stated she was responsible for transportation for appointments in addition to other duties in the facility and did not have the time available to provide restorative programs. Additionally, she reported that the therapist would provide Administrative Nurse D, Administrative Nurse E, and her with recommendations for residents when they transitioned from therapy to maintain their functioning and prevent decline. RCNA L stated Administrative Nurse D and/or Administrative Nurse E were responsible for assessing the residents for Restorative Nursing Programs, but she was not aware of any assessments that had been done for the residents of the facility. She reported she tried to do range of motion for residents that needed it when she worked the floor as a CNA but did not provide treatment for 15 minutes at any given time and could not confirm that the residents received the needed care and treatment related to restorative nursing services to prevent decline or maintain functioning. RCNA L confirmed that R29 as a resident who would benefit from passive range of motion to her upper extremities to prevent decline. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/23/24 at 11:32 AM, Consultant GG reported the facility therapist provided the administrative nursing staff recommendations when coming off therapy to maintain functioning and prevent decline, however they were not involved in a routine screening process and their communication with nursing was limited to receiving orders for residents and when they are discharged from therapy services. Consultant GG stated the facility did not involve the therapy department in routine screening to identify residents who may have a decline in functioning or would benefit from restorative nursing. She stated the therapy department received referrals from direct care staff if they see a decline which often are residents that have received therapy in the past and were not provided with restorative nursing programs as recommended by therapy. Consultant GG verified there were at least seven residents that therapy had recommended continued restorative nursing services to prevent decline and maintain functioning over the past several months. On 07/23/24 at 03:36 PM, Administrative Nurse E confirmed the therapy department would provide recommendations to nursing to maintain functioning and prevent decline when residents transitioned off therapy. However, the facility did not provide restorative nursing programs for residents. Administrative Nurse E reported the facility lacked a system for routine screening process to identify residents who had experienced decline in functioning or would benefit from RNP to maintain functioning. She reported nursing had not assessed or provided restorative nursing programs for residents of the facility for over a year. She verified R 29 would benefit from RNP to include range of motion to maintain, functioning, prevent worsening contractures and decline. The facility policy Restorative -Nursing Care Implementation and Screening, dated 11/08/2023, documentation included the purpose of Restorative-Nursing Care to provide appropriate restorative nursing care to each resident and to assist in the implementation of a restorative nursing program. Each resident will receive restorative nursing care based on individual strengths, needs and problems as defined in the nursing assessment. The facility failed to provide treatment and services related to the lack of restorative nursing programs for this resident with contractures. 50659 - Resident (R) 8's Electronic Health Record (EHR) revealed diagnoses included dementia (progressive mental disorder characterized by failing memory, confusion), weakness, and unspecified osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). The 05/06/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. R8's total severity score of 00, indicating no depression. R8 was independent with eating and wheelchair mobility. R8 required total assistance with activities of daily living (ADLs), with toileting and transfers. R8 required moderate assistance with dressing and personal hygiene. Lower extremity impairment of both sides. R8 stated he had severe pain occasionally. The 05/06/24 ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) documented R8 had a self -care performance deficit related to weakness and contractures (abnormal permanent fixation of a joint or muscle) of both lower extremities. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 05/06/24 Pain CAA documented R8 had chronic pain/discomfort related to contractures in both lower extremities. The 02/07/24 Quarterly MDS documented a BIMS score of 11, indicating moderately impaired cognition. R8 was independent with eating and wheelchair mobility. R8 required total assistance with ADL's, including toileting and transferring. R8 had frequent mild pain. The 07/18/24 Care Plan documented R8 had contractures of lower extremities, staff instructed to provide assistance with bed mobility, transfers, dressing, toileting and bathing. The care plan lacked any interventions or exercises for both lower leg contractures. The 07/18/24 Physician Orders included meloxicam (is a nonsteroidal anti-inflammatory drug (NSAID) used to relieve the symptoms of arthritis), 7.5 milligram (mg) tablet, give one tablet by mouth, one time a day for osteoarthritis, chronic pain, take with food, ordered 05/26/22. Tramadol (is an opioid medicine used for the short-term relief of moderate to severe pain), 50 mg tablet, give one tablet, by mouth, three times a day, for pain, ordered on 05/30/24. Acetaminophen, 650 mg, every four hours, as needed for pain, do not exceed more than 3,000 mg per day. Ordered on 01/29/23. The review of Therapy Discharge Note dated 10/19/23, documented the resident did not want to attend therapy anymore. Therapist recommended Restorative Nursing Program (care provided to maintain a person's highest level of physical, mental, and psychosocial function in order to prevent declines that impact quality of life). On 07/16/24 at 10:42 AM, R8 was in bed with his eyes closed. Both of his legs were noted to be bent at the knees. On 07/16/24 at 12:07 PM, R8 seated in his wheelchair in the main dining room, waiting on his lunch to be delivered. On 07/23/24 at 07:55 AM, Certified Nurse Aide (CNA)M and Certified Medication Aide (CMA)R assisted R8 out of his bed to his wheelchair with a full body mechanical lift. R8 was unable to fully extend his legs when he was asked to do that. R8 stated that was a far as he could do by himself. Both of his knees remained bent when he tried to extend both legs. On 07/16/24 at 02:50 PM, Certified Nurse Aide (CNA) L stated there was not a restorative program. Therapy would be involved if a need for a resident would be identified, and a screen should be completed. CNA L stated she had not completed a progress note and stated she reports verbally to the care team. On 07/23/24 at 08:00 AM, CNA M stated R8 was unable to extend either one of his legs completely straight and his knees were always bent. CNA M stated that the resident was able to extend his legs as far as he can himself staff dress and transfer him. CNA M stated she had not been instructed to complete leg exercises with R8. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/23/24 at 10:30 AM, Administrative Nurse E confirmed the therapy note recommended restorative nursing program and stated the facility had not had a restorative nursing program since she was employed almost two years ago. The facility policy Restorative - Nursing Care Implementation and Screening dated 11/08/23 documented: To provide appropriate restorative nursing care to each resident. Each resident will receive restorative nursing care to the extent of possible, based on individual strengths, needs, problems as identified in nursing assessments. The facility failed to provide a restorative nursing program for R8 to prevent further decline of contractures. This deficient practice had the potential to place R8 at an increased risk for development of additional medical problems and discomfort.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50659 The facility reported a census of 37 residents with 17 residents selected for review. Based on observation, interview, and record review, the facility failed to provide an environment that remained free from accident hazards for two residents when the facility failed to appropriately place a fall mat on the floor next to Resident (R)21's bed. This deficient practice could potentially result in an injury. R36 the facility failed to ensure a safe transfer for R36, when staff utilized a full body mechanical lift, without a second staff member present. This deficient practice could potentially result in a mechanical lift transfer accident. Findings included: - The Electronic Health Records (EHR) documented Resident (R)21 had the following diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following an intracranial hemorrhage (a type of stroke that causes bleeding in the head), lack of coordination and traumatic brain injury (TBI-an injury to the brain caused by external forces). The 02/15/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 99, indicating severely impaired cognition, the depression not scored and lacked staff interview. R21 had behaviors that included hitting and yelling. R21 required supervision for eating and oral care. Moderate assistance with activities of daily living (ADLs), with toileting hygiene, showering, and dressing. R 21 required maximal assistance with transfers, personal hygiene, and bed mobility. R21 was dependent on staff for wheelchair mobility. R21 was always incontinent of bladder. The resident had no falls. The 02/15/24 Functional Abilities Care Area Assessment (CAA) documented R21 was dependent on staff with all ADLs. The 05/17/24 Quarterly MDS documented a BIMS score of 99, and the depression was not scored. R21 had behaviors of yelling and hitting. R21 required total dependence of staff for toileting, showering, dressing, hygiene, transfers, and dressing. R21 required maximal assistance for oral care and bed mobility. R21 required supervision for eating. R21 was frequently incontinent of bowel and bladder. On 07/17/24 the Care Plan documented R21 staff instructed to place a fall mat at bedside when in R21 was in bed. R21's bed was placed in low position. The care plan initiated a fall mat on 01/30/24 and was revised care plan on 02/24/24. On 07/17/24, review of the Physician Orders lacked any documentation for a fall mat. On 02/24/24 at 09:21 PM, R21 was found on her floor next to her bed. The bed was in the lowest position and the fall mat was in place. R21's bed alarm did not alarm at the time when R21 was found on the floor. Intervention of a new bed alarm placed on R21's bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/16/24 at 01:18 PM, R21 observed laying in her bed, country music was playing on the television. No fall mat was on the floor next to R21's bed. The fall mat was folded up and placed by the window. On 07/16/24 at 01:35 PM, Certified Nurse Aide (CNA) M stated she had forgot to place the fall mat on the floor next to R21's bed when she assisted her to bed about 15 to 20 minutes ago. On 07/23/24 at 02:40 PM, Administrative Nurse D expected the staff to follow the care plan and make sure all the safety interventions were being utilized at all times. The facility policy Individual Care Plan dated 06/10/24 documented the following: To comply with state regulations concerning care delivered. Planned interventions should be executed by the direct care staff as specified on the care plan. The facility failed to provide an environment that remained free from accident hazards for this resident when the facility failed to appropriately place a fall mat on the floor next to R21's bed. This deficient practice could potentially result in an injury. 36881 - Resident (R)36's electronic medical record (EMR) included the following diagnosis that included cerebral aneurysm (a bulge in a blood vessel in the brain that can rupture and cause bleeding in the brain). The Admission Minimum Data Set (MDS), dated [DATE], revealed R36 had a Brief Interview for Mental Status (BIMS) score of 99, indicating severe cognitive impairment. The resident was dependent on staff for chair/bed-to-chair transfers and used a wheelchair/scooter for mobility. The Cognitive loss/dementia Care Area Assessment (CAA), dated 05/20/24, revealed R36 had impaired cognitive function/dementia or impaired thought processes and had difficulty making decisions. R36 had long-term memory loss. R36's activity of daily living (ADL) care plan, revised 07/20/24, revealed the resident required a total lift transfer with two-person assistance and required an extra-large sling. Review of the EMR from 07/18/24 through 07/23/24 lacked documentation related to one staff transfer with a mechanical full body lift. Review of the facility's investigation notes, revealed on 07/20/24 at 04:59 PM, documented certified Nurse Aide (CNA) PP transferred the resident by herself with a (full body) mechanical lift. On 07/23/24 at 08:30 AM, R36 propelled her wheelchair from the dining room to the lobby/indoor fishpond area. R36 reported several times to staff as they passed by and her roommate that she was unable to lay down and nap because they (staff) were making beds today. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/24 at 10:23 AM, CNA OO and CNA Q transferred R36 from her wheelchair to her bed with a full body mechanical lift. On 07/22/24 at 04:45 PM, Administrative Nurse D reported on 07/20/24, CNA PP transferred R36 by herself with a full body mechanical lift. Licensed Nurse (LN) J walked into the resident's room when CNA PP requested to help reposition her in the wheelchair and realized CNA PP transferred the resident without a second staff member. It was Administrative Nurse D's expectation that two staff required to transfer residents when utilizing a mechanical lift. On 07/22/24 at 05:49 PM, Administrative Staff A reported she was informed CNA PP transferred the resident by herself on 07/20/24. It was her expectation for two staff to transfer residents that required a full body mechanical lift. On 7/23/24 at 07:46 AM, LN J reported R36's call light was on and when she went to the room, CNA PP stood at R26's doorway and asked for assistance to reposition the resident. R36 was in her wheelchair with the lift sheet underneath her. LN J assisted CNA PP to reposition the resident in her wheelchair. LN J reported she educated CNA PP that she should call for assistance with mechanical lift transfers, because two staff were required to transfer a resident with a mechanical lift. LN J informed administrative staff A and Administrative nursing staff D and was instructed to send CNA PP home immediately. On 7/23/24 at 10:04 AM, Administrative Nurse D reported CNA PP had been suspended due to transferring R36 by herself with a mechanical lift and would require transfer training when she returned. On 7/23/24 at 10:23 AM, CNA Q reported two staff required to transfer residents with a full body mechanical lift. On 07/23/24 at 11:52 AM, CNA PP, per phone conversation, reported she went into the resident's room with the full body mechanical lift and informed R36 to bear with me because it was the first time working with R36. CNA P verified she transferred the resident from her bed to the wheelchair by herself, but required additional assistance after R36 was not properly positioned in her wheelchair and she was unable to get the resident positioned, so she turned on the resident's call light and waited for assistance to reposition the resident. She reported she was aware that two staff were to transfer the resident, but the other aides were working other halls. The facility's policy for Mobility Support and Positioning, dated 03/29/24, documented the facility requires two or more employees to use the total lift to transfer the resident from surface to surface. The facility failed to ensure a safe transfer for R36, when staff utilized a full body mechanical lift, without a second staff member present. This deficient practice could potentially result in a mechanical lift transfer accident.

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881 The facility reported a census of 37 residents, with 17 residents sampled, which included four residents reviewed for Trauma Informed Care. Based on observation, interview, and record review, the facility failed to acknowledge and respond appropriately to R17's allegations of sexual assault and her display of behaviors, which align to a trauma response, based on reasonable person concept, when the resident expressed feelings of fear, anger, and aggressiveness associated with her reported allegation of sexual assault while a resident of the facility. This failure placed R17 in Immediate Jeopardy (IJ) and at risk for untreated trauma and the negative impact to her mental, physical, and psychosocial well-being. Findings included: - Review of Resident (R) 17's undated Physician Orders, documentation included diagnoses of traumatic subdural hemorrhage (bleeding in the brain due to trauma), anxiety disorder, (mental or emotional reaction characterized by apprehension, uncertain and irrational fear), need for assistance with personal care, lack of coordination, and problem related to care provider dependency. The Annual Minimum Data Set (MDS) dated [DATE], included a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The resident did not exhibit behaviors. She reported feeling down, depressed, or hopeless for two to six days of the look back period and noted the resident would isolate socially at times. The resident experienced hallucinations (sensing things while awake that appear to be real, but the mind created) and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) and rejected evaluation and/or cares one to three days of the look back period. She received antidepressant medication (class of medication used to treat depression). The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 06/12/24, included the resident had impaired cognitive function, impaired thought processes, experienced confusion, and behaviors. The Care Plan, (CP), dated 07/09/24, included interventions initiated on 04/17/24, which instructed staff to provide a translator as necessary to communicate with the resident and further documented the majority of facility staff spoke Spanish. An intervention initiated 04/17/24 instructed staff to monitor/record/report to R17's health care provider as needed when the resident had feelings such as labile mood or agitation, felt threatened by others or thoughts of harming someone. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 07/16/24 at 01:02 PM, R17 spoke in Spanish to Dietary Staff (DS) BB, who translated the interview to English on behalf of the resident. R17 stated two men sexually assaulted her in the facility. She said she had bruises and bite marks across her breast and abdomen when she made the report to the nurses (at the facility). Upon inquiry, she stated the nurses did not respond to her report of assault nor assess her for injury. She said she was in her room at the facility when the two men forced her on the bed and that was where it happened. The resident sat in her wheelchair, cried, and pointed towards her bed while describing the event. She was anxious, tearful, and her hands were trembling. She reported nobody did anything in response to her allegation. She confirmed law enforcement had not talked with her and she did not feel safe in the facility. During an interview on 07/16/24 at 01:50 PM, DS BB stated she remembered hearing something about the resident (R17) reporting she was assaulted in the facility to someone at the local hospital, but that was a couple of months ago and she was not sure of the details. DS BB stated she did not recall any staff education (regarding resident abuse) provided by the facility at the time. Review of the Electronic Medical Record (EMR) Progress Notes (PN), dated 05/16/24 at 05:00 PM, revealed R17 complained of bilateral (both) breast pain due to a sexual assault that occurred at the facility a long time ago according to the resident. She did not recall when it happened. The resident had never reported any abuse since she admitted to the facility. She stated the people who assaulted her bit her at that time and she had several bruises on her breast and abdomen. The nurse performed a skin assessment, and the assessment was within normal limits. The nurse notified the Director of Nursing (DON), Social Services Designee (SSD), and Personal Care Physician (PCP) of the situation. The EMR PN dated 05/24/24 at 04:30 PM, documentation included the facility nurse spoke to the hospital nurse who reported the resident (R17) admitted from the emergency room (ER) on 05/22/24 for complaints of left sided chest pain. The hospital nurse informed the facility they made an adult protective service (APS) report due to the resident's complaint of sexual assault. The facility would follow up with the resident's PCP and to determine if a consult with cardiologist was required. The EMR PN dated 05/24/24 at 05:42 PM, documented upon return to the nursing facility, the resident was very aggressive and complained much of the night. She refused to have her call light turned off after cares. She banged on the door, yelled, and cried. The EMR PN dated 05/29/24 at 07:46 AM, revealed during a recent hospitalization , the resident (R17) reported to ER staff that she was being sexually abused at the nursing home. Review of the facility EMR documentation above revealed the resident (R17) reported sexual assault by two male perpetrators on 05/16/24. On 05/24/24, the resident went to the hospital for chest pain and reported to hospital staff she was sexually assaulted in the facility. On 05/29/24, the resident readmitted to the facility. The hospital notified the facility of the resident's report of sexual assault on 05/24/24 and on discharge on 05/29/24. The facility failed to respond to R17's allegation of abuse, investigate the allegation of abuse, and did not notify law enforcement until 07/16/24, when R17 reported the sexual assault to a state agency surveyor during a recertification survey. Review of the facility Grievance Log for 04/01/24 through 07/16/24 lacked identification of any allegation of abuse or neglect regarding R17. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 07/17/24 at 02:44 PM Administrative Staff A confirmed the grievance logs did not include any report of sexual assault for the resident as noted in the 05/16/24 progress notes. The facility followed up on the reported sexual assault on 07/16/24 (approximately two months after the resident originally reported the allegation) when the surveyor brought it to her attention. Administrative Staff A reported she started at the facility as the Administrator on 06/10/24 and she was not aware of the report until 07/17/24. Administrative Staff A said she expected the Social Worker/SSD to track resident grievances, but the SSD informed her she did not maintain the grievance log as it was kept in the old Administrators office. She reported the SSD, and the DON were employed during the time of the sexual assault allegation by R17, and the facility failed to respond to the resident's allegations of abuse on three different occasions. Administrative Staff A reported the facility should report, investigate, and notify law enforcement of allegations of sexual assault to ensure protection of the resident making the allegation, as well as the other residents of the facility. On 07/17/24 at 02:49 PM, Social Service Staff X stated she was just aware of the resident's allegation of abuse related to sexual assault. She stated the staff should protect the resident first then report any allegations of abuse to their supervisor and the state agency, initiate an investigation, and notify law enforcement. The nursing staff should assess the resident for injury, call the physician, family, and law enforcement. The facility should provide education for the staff and also question other residents and staff to get clarification on how they feel about their safety. Social Service Staff X confirmed the allegations of abuse were not reported or investigated when staff were made aware of the allegations on 05/16/24, 05/24/24, and 05/29/24. The facility failed to respond to the resident's allegation of abuse. The facility policy Abuse and Neglect policy, dated 07/06/2023, documentation included the purpose of the policy was to ensure that residents are not subjected to abuse by anyone, including but not limited to, location employees, and/or other residents. Alleged or suspected violations involving any mistreatment, neglect, exploitation, or abuse including injuries of unknown origins will be reported immediately to the administrator. In the absence of the administrator from the location, the following individuals have the administrative authority of the administrator for purposes of immediate reporting of alleged violations: the director of nursing services or the supervisor of social services and both also have the authority to call law enforcement. The location will have evidence that all alleged or suspected violations are thoroughly investigated, and they will prevent further potential abuse while the investigation is in progress. Results of all investigations will be reported to the administrator or designated representative and to other officials in accordance with state law, including to the state survey and certification agency. The facility failed to acknowledge and respond appropriately to R17's allegations of sexual assault and her display of behaviors, which align to trauma response, based on reasonable person concept, when the resident expressed feelings of fear, anger, and aggressiveness associated with her reported allegation of sexual assault while a resident of the facility. On 07/18/24 at 03:30 PM, Administrative staff A was provided the Immediate Jeopardy (IJ) template and were notified the facility failed to acknowledge and respond appropriately to R17's allegations of sexual assault and her display of behaviors, which align to trauma response, based on reasonable person concept, when the resident expressed feelings of fear, anger, and aggressiveness associated with her reported allegation of sexual assault while a resident of the facility. This failure placed R17 in immediate jeopardy and at risk for untreated trauma and the negative impact to her mental, physical, and psychosocial well-being. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The IJ was first to exist on 05/16/24, and the facility submitted an acceptable plan for removal of the immediate jeopardy on 07/18/24 at which included the following: 1. On 07/16/24, R17 was assessed for any abuse, neglect, or trauma. 2. All nursing staff education initiated on 07/16/24 for Recognizing and Reporting Abuse and Neglect Allegation by the Clinical Learning and Development Specialist. 3. Trauma Informed care assessment completed on 07/17/24 and R17's care plan was updated to reflect new trauma informed care interventions. 4. On 07/17/24, Law enforcement contacted and R17 interviewed. 5. Nursing Home Leadership were educated on Recognizing and Reporting Abuse and Neglect Allegation conducted by Regional Clinical Services Director on 7/18/24. 6. All above education will be completed by 7/18/24 or prior to next working shift. By 7/18/24, facility will review all residents at risk for Trauma informed care and address care plan interventions as needed. 7. Angel Rounding (leadership resident rounding touchpoint) will be initiated 7/18/24 to identify areas of concern and ensure resident safety. The surveyor verified the facility implemented the above corrective measures on -site on 07/22/24. The deficient practice remained at a scope and severity level of a D, following the implementation of the removal plan.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50659 The facility reported a census of 37 residents with 17 residents selected for review. Based on observation, interview, and record review, the facility failed to ensure two resident's medications received and documented as ordered by the physician. The facility failed to administer scheduled Tramadol to Resident (R)8 for seven days. Furthermore, the facility failed to administer R16's insulin on one day per sliding scale orders. Findings included: - Resident (R) 8's Electronic Health Record (EHR) revealed diagnoses included dementia (progressive mental disorder characterized by failing memory, confusion), weakness, and unspecified osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). The 05/06/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. R8's total severity score of 00, indicating no depression. R8 was independent with eating and wheelchair mobility. R8 required total assistance with activities of daily living (ADLs), with toileting and transfers. R8 required moderate assistance with dressing and personal hygiene. Lower extremity impairment of both sides. R8 stated he had severe pain occasionally. The 05/06/24 ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) documented R8 had a self -care performance deficit related to weakness and contractures (abnormal permanent fixation of a joint or muscle) of both lower extremities. The 02/07/24 Quarterly MDS documented a BIMS score of 11, indicating moderately impaired cognition. R8 was independent with eating and wheelchair mobility. R8 required total assistance with ADL's, including toileting and transferring. R8 stated her had mild pain frequently. The 07/18/24 Care Plan instructed staff to attempt non-pharmacological interventions of repositioning, offer fluids or food, and assess basic care needs. Staff instructed to report to the nurse of any signs or symptoms of non-verbal pain. The 07/18/24 Physician Orders included meloxicam (is a nonsteroidal anti-inflammatory drug (NSAID) used to relieve the symptoms of arthritis), 7.5 milligram (mg) tablet, give one tablet by mouth, one time a day for osteoarthritis, chronic pain, take with food, ordered 05/26/22. Tramadol (an opioid medicine used for the short-term relief of moderate to severe pain), 50 mg tablet, give one tablet, by mouth, three times a day, for pain, ordered on 05/30/24. Acetaminophen, 650 mg, every four hours, as needed for pain, do not exceed more than 3,000 mg per day. Ordered on 01/29/23. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress Notes from 01/01/24 to 07/18/24 documented the following: On 06/23/24 at 03:55 PM, communication to physician, R8 ran out of Tramadol 50 mg tablets. R8 complained of pain and being unable to sleep. Review of the Medication Administration Record from 06/17/24 to 06/24/24 revealed the following: On 06/17/24 through 06/23/24 at 04:00 PM documented code four, which was identified as the medication was not available on 06/17/24, 06/18/24, 06/21/24 and 06/22/24. On 06/19/24 and 06/20/24 at 04:00 PM, staff documented code 8, which identified to see nurse notes. On 06/18/24 through 06/24/24 at 08:00 AM scheduled dose, staff documented on 06/18/24, 06/19/24 and 06/20/24 code 8 (identified to see nurse notes). On 06/21/24, 06/22/24, /06/23/24 and 06/24/24, staff documented code four (medication was not available). On 06/18/24 through 06/24/24 at 12:00 AM scheduled dose, staff documented 06/18/24, 06/23/24 and 06/24/24 code 10 (identified as resident sleeping). On 06/19/24, 06/20/24, 06/21/24 and 06/22/24, staff documented code four (medication was not available). On 07/18/24 at 04:30 PM, Certified Medication Aide (CMA) T reported when there is no medication available for a resident, she would update the charge nurse. CMA T stated that the charge nurse should call the pharmacy for medication refills. On 0718/24 at 01:40 PM, Licensed Nurse (LN) I reviewed June 2024 and July 2024 Narcotic sign off record for R8's Tramadol. The facility was unable to locate R8's Narcotic sheet for the dates from 06/17/24 after 08:00 AM to 06/24/24 at 04:44 PM. LN I stated that CMA's do not always update the Nurses when a medication was not available. On 07/18/24 at 04:15 PM, Administrative Nurse D confirmed R8 did not receive the Tramadol as per physician orders. She stated that was not acceptable for any resident to miss scheduled or as needed medications ordered by the physician. Administrative D stated the medication was not removed from the emergency kit to administer tot resident. The facility policy Medication: Administration Including Scheduling and Medication Aides dated 05/21/24 documented the following: To administer medications correctly and in a timely manner. A provider's order for any medication is required. If a medication is not available for 24 hours, the physician must be notified. The facility policy Local Pharmacy Medication Ordering dated 08/29/23 documented the following: To assist the revolving issues in received medications from pharmacy when an automatic dispensing cabinet is not on site. If a medication is not available, notify the ordering physician immediately to determine whether the order could be changed or start the medication when it becomes available. The facility failed to administer scheduled Tramadol to Resident (R)8 for seven days, as ordered by the physician. This placed the resident at risk for development of additional medical problems and discomfort. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident (R) 16's Electronic Health Record (EHR) revealed diagnoses included diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and altered mental status. The 01/18/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 99, indicating severely impaired cognition. R16's total severity score of 00, indicating no depression. R16 received insulin (hormone that lowers the level of glucose in the blood) for the seven days look back with no order changes. The 05/20/24 Quarterly MDS documented a BIMS score of 09, indicating moderately impaired cognition. R16 received insulin for the seven days look back with no order changes. The 07/17/24 Care Plan lacked any staff guidance related to insulin. The 07/17/24 Physician Orders documented the following: Fasting blood sugars, three times a day, for diabetes, notify physician if blood sugar is less than 60 or greater than 450, ordered on 06/29/24. Aspart insulin, 100 units in one ml, subcutaneous (beneath the skin) injector pen. Inject as per sliding scale: If blood sugar is 200 -250, administer two units; if 251 -300, administer four units; if 301-350, administer six units; if 351-400, administer eight units, subcutaneously three times a day for DM, ordered on 06/29/24. Basaglar insulin, administer 30 units, subcutaneously at bedtime, for DM, ordered on 06/29/24. Review of the Progress Notes from 01/01/24 to 07/18/24 documented the following: On 07/16/24 at 04:16 PM, the facility staff called the pharmacy and new script required. Called physician office for a refill script, left a voicemail. Review of the Medication Administration Record from 07/01/24 to 07/17/24 revealed the following: On 07/16/24 at 04:00 PM, staff documented blood sugar of 248 and documented a code four (medication was not available). On 07/17/24 at 11:16 AM, Licensed Nurse (LN) I reported that R16 had run out of Aspart insulin last evening and would have to pull the Aspart insulin from the emergency kit. LN I confirmed that the 07/16/24. 04:00 PM dose of Aspart insulin had not been administered. On 07/17/24 at 11:20 AM, RN Consultant HH stated that was unacceptable to not administer the insulin per physician orders and insulin should have been removed from emergency kit to administer. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Medication: Administration Including Scheduling and Medication Aides dated 05/21/24 documented the following: To administer medications correctly and in a timely manner. A provider's order for any medication is required. If a medication is not available for 24 hours, the physician must be notified. The facility policy Local Pharmacy Medication Ordering dated 08/29/23 documented the following: To assist the revolving issues in received medications from pharmacy when an automatic dispensing cabinet is not on site. If a medication is not available, notify the ordering physician immediately to determine whether the order could be changed or start the medication when it becomes available. The facility failed to administer ordered insulin to Resident (R)16 as ordered by the physician. This placed the resident at risk for development of additional medical problems.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 50659 The facility reported a census of 37 residents with 17 residents selected for review. Based on observation, interview, and record review, the facility failed to follow the Consultant Pharmacist recommendation to complete an Abnormal Involuntary Movement Scale (AIMS) (a rating scale to measure involuntary movements known as tardive dyskinesia [TD is abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs and trunk]) for one of the five residents reviewed for unnecessary medications. Resident (R)21 who received risperidone, an antipsychotic (class of medications used to treat major mental conditions which cause a break from reality). Findings included: - The Electronic Health Records (EHR) documented Resident (R)21 had the following diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following an intracranial hemorrhage (a type of stroke that causes bleeding in the head), lack of coordination and traumatic brain injury (TBI-an injury to the brain caused by external forces). The 02/15/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 99, indicating severely impaired cognition, the depression not scored and lacked staff interview. R21 had behaviors that included hitting and yelling. R21 received an antipsychotic. The 02/15/24 Psychotropic Drug Use Care Area Assessment (CAA) documented R21 is on Risperidone. She had behaviors like hollering, combativeness, and irritation. The 05/17/24 Quarterly MDS documented a BIMS score of 99, and the depression was not scored. R21 had behaviors of yelling and hitting. R21 received an antipsychotic. On 07/17/24 the Care Plan documented R21 staff instructed to consult with pharmacy, health care provider to consider dosage reduction when clinically appropriate. Black box warning increased risk of mortality in elderly patients. On 07/17/24, review of the Physician Orders documented the following: Risperdal, oral tablet 0.25 milligram, give one tablet, by mouth, two times a day, for behaviors, ordered 06/21/23. Updated on 10/18/23 to include related to personal history of traumatic brain injury. On 07/26/23, Consultant Pharmacist recommended an AIMS or other appropriate assessment to assess for TD related to R21's Risperidone use. On 08/22/23, Consultant Pharmacist recommended an AIMS or other appropriate assessment to assess for TD as R 21 received Risperidone and no assessment was documented in the EHR for the past six months. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/20/23 Consultant Pharmacist documented on recommendations, facility has not acted upon the 07/26/23 and 08/22/23 recommendations in accordance with regulation or facility policy, recommended AIMS for R21 as she received risperidone which may cause TD. On 09/25/23, the facility completed an AIMS assessment, and had a score of zero. (no abnormal movements) On 03/25/24, the facility completed an AIMS assessment and score of zero. On 07/22/24 at 02:40 PM, Administrative Nurse D stated that an AIMS was to be completed every six months and it was scheduled on the User - Defined Assessment on the EHR. Administrative Nurse D confirmed the 07/26/23 and 08/22/23 AIMS recommendation was not completed, and reported the assessment must have been overlooked and that was unacceptable. The facility policy Psychotropic Medications Rehab/Skilled dated 12/09/22 documented the following: The resident will be free from any chemical restraint imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms. If a physician prescribes an antipsychotic for a resident, a Registered Nurse must complete the Initial AIMS in EHR and every six months. The facility failed to follow Consultant Pharmacist recommendation to complete an AIMS for R21 who received Risperidone. This deficient practice had the potential to lead to uncommunicated needs which could lead to negative impacts on the resident's physical, mental and psychosocial well-being.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50659 The facility reported a census of 37 residents. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in a sanitary manner to prevent possible food-borne illness to the residents of the facility. Findings included: - Observation of the kitchen and food storage areas on 07/16/24 at 08:27 AM revealed the following areas of concern: One sealed 5-pound bag of cake mix, approximately half used, without an open date. One bag of un-sealed corn bread mix. The refrigerator outside of the kitchen contained an opened orange juice container, one opened gallon of milk and a half gallon of chocolate milk without open date. Observation of the kitchen and food storage areas on 07/17/24 at 04:30 PM revealed the following: Three coated frying pans with several scratch marks. Six cutting boards that had several scratches. Both kitchen ovens had a burnt substance on the bottom. The chest freezer had ice cream with the lids removed and six of the cups had freezer burn. An open bag of barbecued pork which was undated. An open ten-pound bag of frozen vegetables that was undated. Interview on 07/16/24 at 08:27 AM with Dietary Staff BB revealed that she expected staff to label the date on opened food items. Interview on 07/17/24 at 04:30 PM with Dietary Staff BB confirmed the above concerns of kitchen and freezer storage undated items was unacceptable. The Food-Supply Storage-Food and Nutrition Services Policy dated 07/09/20 revealed food that had been opened or prepared, were to be placed in an enclosed container, dated, labeled, and stored properly. The facility failed to store, prepare, and serve food in a sanitary manner to prevent possible food-borne illness to the residents of the facility.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 36881 The facility identified a census of 37 residents. Based on observations, record reviews, and interviews the facility failed to put in place an effective administration who ensured the facility was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident who resided at the facility. This deficient practice placed the residents at risk for decreased quality of care, quality of treatment, and sense of well-being. Findings included: - The facility failed to ensure an effective quality assessment and performance improvement (QAPI) program as evidenced by the number of deficient practices, elevated scope and severity, and substandard quality of care found onsite as followed. The facility failed to ensure staff identified and responded appropriately to all allegations of abuse, which included Resident 17's allegation of sexual assault. The facility failed to ensure the timely reporting of alleged abuse to the State Agency (SA - a state governmental agency that provides oversight for the Centers for Medicare & Medicaid Services [CMS - the federal government agency that administers the nation's major healthcare programs]) or local law enforcement, as required by federal regulations. The facility failed to investigate all allegations of resident-to-resident abuse, failed to protect residents from further incidents of abuse. The facility failed to recognize a significant change in a resident's physical condition and perform a Comprehensive Minimum Data Set (MDS) assessment within the required 14-day period of the resident's change in condition. This deficient practice had the potential to lead to uncommunicated needs and placed the resident at risk for further deterioration of his physical, mental, and psychosocial well-being. The facility failed to accurately complete the Minimum Data Set (MDS) for five sampled residents, as required by the federal regulations. The facility failed to develop a comprehensive person-centered care plan for one of the 17 residents sampled. The facility failed to revise fall care plans with interventions for three residents for one of the 17 residents sampled. The facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for five of 17 sampled residents related to Restorative Nursing Program to ensure his quality of life. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to ensure an environment as free from accident hazards as possible when facility failed to thoroughly document and place fall mat for R 21 as directed in the care plan. The facility failed to ensure a safe transfer for R36, when staff utilized a full body mechanical lift, without a second staff member present. This deficient practice could potentially result in a mechanical lift transfer accident. The facility failed to acknowledge and respond appropriately to R17's allegations of sexual assault and her display of behaviors, which align to a trauma response, based on reasonable person concept, when the resident expressed feelings of fear, anger, and aggressiveness associated with her reported allegation of sexual assault while a resident of the facility. This failure placed R17 in Immediate Jeopardy (IJ) and at risk for untreated trauma and the negative impact to her mental, physical, and psychosocial well-being. The facility failed to provide scheduled pain medication for R 8 as ordered by the physician. The facility failed to respond to pharmacist's recommendation to complete an Abnormal Involuntary Movement Score to evaluate the effects of the R 21's psychotropic medications. The facility failed to serve the residents of the facility food, which was palatable, attractive, and served at the appropriate temperature. The facility failed to prepare and serve food under sanitary conditions, to the residents of the facility appropriately to prevent the potential for food borne illness. The facility failed to electronically submit to Centers for Medicare and Medicaid Services (CMS) with complete and accurate direct staffing information, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e. Payroll Base Journal (PBJ), related to licensed nursing staffing information, when the facility failed to accurately report Registered Nurse (RN) coverage on 29 dates between January 1, 2023 and 09/30/23. The facility failed to have an effective administration to identify and develop corrective action plans for potential quality deficiencies as found on the current survey. This deficient practice placed the residents at risk for decreased quality of care, quality of treatment, and sense of well-being.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 36881 The facility reported a census of 37 residents. Based on record review and interview, the facility failed to electronically submit to Centers for Medicare and Medicaid Services (CMS) complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e. Payroll Base Journal [PBJ], related to licensed nursing coverage 24 hours/day and excessively low weekend staffing. Findings included: - Review of the Payroll Base Journal (PBJ) Staffing Data Report for fiscal year (FY), Quarter 3, 2023 (April 01-June 30), revealed a lack of License Nurse (ON) for 24 hours/seven days a week, 24 hour/day on the following dates: On 05/06/23 Saturday (SA), On 05/07/23 Sunday (SU), On 05/14/23 (SU), On 05/27/23 (SA), On 06/03/23 (SA), On 06/04/23 (SU), On 06/11/23 (SU), and On 06/18/23 (SU). Review of the PBJ Staffing Data report for FY Quarter 4 (July 01-September 30,2023), FY Quarter 01 (October 01-December 31,2024, and FY Quarter 2 (January 01-March 31, 2024, revealed excessively low weekend staffing. Review of the daily staffing sheets from May 2023 through March 2024, revealed equal staffing on the weekends as during the week. On 07/23/24 at 08:57 AM, Administrative Nurse D reported the Administrator compiles the staff hours for the PBJ and transmits the data to CMS. Administrative Nurse D confirmed the inaccurate staff hours reported on the PBJ for the Quarter 3, 2023 and the inaccurate excessive low weekend staffing reported on the PBJ. The facility lacked a policy for accuracy of the PBJ. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility reported a census of 37 residents. Based on record review and interview, the facility failed to electronically submit to Centers for Medicare and Medicaid Services (CMS) complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e. Payroll Base Journal [PBJ], related to licensed nursing coverage 24 hours/day and excessively low weekend staffing.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 36881 The facility reported a census of 37 residents. Based on the observations, interview, and record review obtained on the current survey and its numerous findings of deficient practice including 4 Immediate Jeopardy citations which constituted Substandard Quality of Care, and with several of the deficient practice areas noted as repeat citations from the prior survey, the facility failed to demonstrate an effective Quality Assurance and Performance Improvement (QAPI) program. This failure affected all 37 residents of the facility and placed them at risk for a decreased quality of life, decreased quality of care, and continued resident abuse. (See all citations associated with (HEJK11). Findings Included: - During the second day of the onsite recertification survey, the surveyors discovered one Immediate Jeopardy (IJ) concerns which were not identified by the facility. The third day of the survey ,the surveyors discovered three additional IJ concerns. The surveyors issued IJ templates to the facility for abuse (See finding at F600), for lack of reporting all allegations of abuse (See finding at F609), for lack of protecting residents from further abuse and lack of investigating all allegations of abuse (See finding at F610), and F742 Trauma Informed Care. The IJs further constituted Substandard Quality of Care and changed the recertification survey to an Extended Recertification Survey. Review of the prior annual recertification survey dated 10/27/2022 revealed areas of care were identified as deficient practice to include Care Plan timing and revision (F657), prevent range of motion decline (F688), and Drug Regimen Review (F756). The Current survey also found deficient practice in three of the same areas, as evidence the facility had not maintained corrective measures in known areas of concern. The current survey HEJK11found deficient practice with the following failures: - The facility failed to ensure an effective quality assessment and performance improvement (QAPI) program as evidenced by the number of deficient practices, elevated scope and severity, and substandard quality of care found onsite as followed. The facility failed to ensure staff identified and responded appropriately to all allegations of abuse, which included Resident 17's allegation of sexual assault. The facility failed to ensure the timely reporting of alleged abuse to the State Agency (SA - a state governmental agency that provides oversight for the Centers for Medicare & Medicaid Services [CMS - the federal government agency that administers the nation's major healthcare programs]) or local law enforcement, as required by federal regulations. The facility failed to investigate all allegations of resident-to-resident abuse, failed to protect residents from further incidents of abuse. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to recognize a significant change in a resident's physical condition and perform a Comprehensive Minimum Data Set (MDS) assessment within the required 14-day period of the resident's change in condition. This deficient practice had the potential to lead to uncommunicated needs and placed the resident at risk for further deterioration of his physical, mental, and psychosocial well-being. The facility failed to accurately complete the Minimum Data Set (MDS) for five sampled residents, as required by the federal regulations. The facility failed to develop a comprehensive person-centered care plan for one of the 17 residents sampled. The facility failed to revise fall care plans with interventions for three residents for one of the 17 residents sampled. The facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for five of 17 sampled residents related to Restorative Nursing Program to ensure his quality of life. The facility failed to ensure an environment as free from accident hazards as possible when facility failed to thoroughly document and place fall mat for R 21 as directed in the care plan. The facility failed to ensure a safe transfer for R36, when staff utilized a full body mechanical lift, without a second staff member present. This deficient practice could potentially result in a mechanical lift transfer accident. The facility failed to acknowledge and respond appropriately to R17's allegations of sexual assault and her display of behaviors, which align to a trauma response, based on reasonable person concept, when the resident expressed feelings of fear, anger, and aggressiveness associated with her reported allegation of sexual assault while a resident of the facility. This failure placed R17 in Immediate Jeopardy (IJ) and at risk for untreated trauma and the negative impact to her mental, physical, and psychosocial well-being. The facility failed to provide scheduled pain medication for R 8 as ordered by the physician. The facility failed to respond to pharmacist's recommendation to complete an Abnormal Involuntary Movement Score to evaluate the effects of the R 21's psychotropic medications. The facility failed to serve the residents of the facility food, which was palatable, attractive, and served at the appropriate temperature. The facility failed to prepare and serve food under sanitary conditions, to the residents of the facility appropriately to prevent the potential for food borne illness. The facility failed to electronically submit to Centers for Medicare and Medicaid Services (CMS) with complete and accurate direct staffing information, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e. Payroll Base Journal (PBJ), related to licensed nursing staffing information, when the facility failed to accurately report Registered Nurse (RN) coverage on 29 dates between January 1, 2023 and 09/30/23. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to have an effective administration to identify and develop corrective action plans for potential quality deficiencies as found on the current survey. This deficient practice placed the residents at risk for decreased quality of care, quality of treatment, and sense of well-being. The facility failed to have an effective QAPI program to identify the quality issues in the facility and implement and maintain corrective actions to ensure the highest mental, physical, and psychosocial wellbeing of each resident. This deficient practice affected all 43 residents of the facility and placed them at risk for substandard quality of care.