STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185208	A. Building B. Wing	03/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Manor	100 Carmel Manor Road Fort Thomas, KY 41075

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46651 Based on interview, record review, and review of the facility's documents and policies, the facility failed to ensure that all alleged violations involving misappropriation of the residents' property were reported to the State Survey Agency (SSA) and local law enforcement within 24 hours of when the misappropriation was suspected. This affected 1 of 12 sample residents, Resident (R)25. The findings include: Review of the facility's policy titled, Prevention, Identification, Investigation and Reporting of Abuse, Neglect, Mistreatment or Exploitation of a Resident or Misappropriation of Resident Property, effective date 02/26/2025 and previously revised on 08/2017, revealed the facility, its employees, consultants, contractors, volunteers, and other caregivers would provide an environment for residents that was safe and free from abuse, neglect, exploitation, mistreatment, and misappropriation, treating each resident with respect, dignity, and provision of privacy. The policy stated that after ensuring the resident was protected, staff must immediately report any allegation or suspicion of the misappropriation of resident property to his or her supervisor or the Administrator. Per the policy, upon receipt of the report, the Administrator or his designee must report to state or federal agencies, as applicable, any suspected or alleged misappropriation within 24 hours of the report. Review of the facility's document Initial Report, dated 02/28/2025, revealed on 02/17/2025, Registered Nurse (RN)1 was notified by a written statement from STNA16, dated 02/16/2025, that during her shift on R25's ring went missing. The report documented that STNA16 stated that during her shift, she took R25's ring off to clean it, placed the ring on the sink, and then left the room to pass meal trays. Further review of the report revealed that STNA16 stated that when she returned to the [resident ' s] room, the ring was missing. The STNA16 looked multiple times but could not locate the ring. Per the report, STNA16 stated she asked STNA21 to look for the ring, but was unsure where the ring could have gone. Continued review of the initial report revealed local law enforcement was notified (no date specified) and STNA16 was suspended during the investigation. Review of the facility's document Final Report-Five Day Follow-Up, dated 03/07/2025, revealed local law enforcement had been notified on 02/27/2025, Police report #2025-03811, and as of 03/15/2025, the case remained opened. (continued on next page)

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

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of R25's Admission Record, found in R25's electronic medical record (EMR), revealed the facility admitted R25 on 08/31/2020 with diagnoses of Alzheimer's disease, unspecified dementia, and anxiety. Review of R25's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 02/02/2025, found in R25's EMR, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 10 out of 15, indicating R25 had moderate cognitive impairment. During an interview on 03/14/2025 at 4:30 PM with R25, she stated she felt safe at the facility and staff were very kind to her. She stated she was not aware anyone had ever taken anything from her and denied currently missing any belongings. During a telephone interview on 03/13/2025 at 7:30 PM with R25's Family Member (FM)1 and FM2 , they stated they had wished the facility would have notified local law enforcement sooner so the police could have checked with the local pawn shops so that they would have had more success in finding their loved one ' s ring. They also stated they understood the investigation was in the hands of law enforcement and neither law enforcement nor the facility had been able to reach the aide [STNA16] involved in the incident. FM1 and FM2 stated the ring had more sentimental value than monetary, but they still wished R25 had it back. The ring was described as gold and resembled a flower. Review of State Trained Nurse Assistant (STNA)16's written witness statement, undated, revealed she documented that she took R25's ring off to clean and laid it down on R25's sink. STNA16 then documented she asked STNA21 to help her lay R25 down, and then both STNAs went to pass meal trays. STNA16 documented when she returned to R25's room, the ring was gone, and both she and STNA21 looked for it, but did not find it. An interview by telephone was attempted with STNA16 on 03/13/2025 at 8:30 PM, but was unsuccessful. A second attempt was made on 03/15/2025 at 8:32 AM, but was also unsuccessful. Review of STNA21's written witness statement, dated 02/27/2025, revealed she documented that at approximately 5:00 PM she helped STNA16 change R25 and put her in bed, but did not notice whether R25's ring was on her finger or whether the ring was in R25's bathroom. STNA21 documented STNA16 approached her [on 02/16/2025] at approximately 5:30 PM and asked if she had seen R25's ring. Further review of the written statement revealed she had not seen the [resident's] ring but looked for R25's ring in the [resident's] room and bathroom without the help of STNA16. STNA21's written statement revealed she did not find the [resident's] ring. The State Survey Agency (SSA) surveyor attempted to reach STNA21 on 03/13/2025 at 8:30PM; however, was unsuccessful. Review of the Licensed Practical Nurse (LPN) 5's written witness statement, dated 02/18/2025, revealed she was not made aware of the missing property until 02/16/2025 at approximately 6:30 PM, the shift R25's ring was reported missing. LPN5 wrote she spoke with STNA16 and STNA21 and instructed STNA16 to fill out a statement detailing what happened. Further review revealed that the LPN then asked STNA16 to turn her written statement to her supervisor. LPN5 documented she did not follow up with the supervisor, but believed STNA16 had followed through as instructed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/15/2025 at 10:24 AM with LPN5, she stated she did not remember who the supervisor was the night R25's ring was reported missing but told STNA16 to write a statement and to turn it in to her supervisor. Review of the Social Services Director's (SSD) written witness statement, dated 02/27/2025, revealed she met with RN1 on 02/27/2025 to discuss R25's missing ring. According to the written statement, RN1 had just spoken with STNA16 regarding the written statement left on RN1's desk, on 02/16/2025. The SSD also documented RN1 interviewed STNA21 while the SSD was in the room, and STNA21 denied knowing R25's ring was taken off her hand and that she and STNA16 searched for the ring together. The SSD further documented that it was at this point, RN1 called local law enforcement to report the ring as missing . During an interview on 03/06/2025 at 3:38 PM with RN1, he stated he reported R25's missing ring to the previous Administrator, who was the Administrator and abuse coordinator at the time the resident's ring went missing. RN1 stated he became aware the incident had not been reported when the Interim Administrator made him aware. He stated he then assisted with the investigation by completing the paperwork and notified local law enforcement. During an interview on 03/05/2025 at 11:15 AM with the Interim Administrator, she stated her first day at the facility was 02/17/2025, and the previous Administrator was asked to leave not long after that. She stated she became aware there were several facility-reported incidents that were ongoing, and one involved a resident's ring which had not been reported to the State Survey Agency (SSA) or to the local law enforcement. She stated she then reported it as soon as she was made aware and made sure staff knew what a reportable incident was and what the regulatory time frames were. She stated it was her expectation that all reportable incidents be reported timely and as the regulation outlined.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46651 Based on interview, record review, and review of the facility's policy, the facility failed to develop and implement a comprehensive person-centered care plan for each resident consistent with resident rights and provide services required to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 12 sampled residents, Resident (R)1 and R24. 1. On 02/25/2025, R1, who resided on the facility's locked Memory Care Unit (MCU), and was care planned to wear a wanderguard (a monitoring device that triggers door alarms to alert staff when a resident was near a door or going out a door) was observed entering the facility through the main door which was equipped with an alarming device. However, the door did not alarm when R1 entered the facility. During interviews with the MCU staff, they stated they had last seen the resident at approximately 4:00 PM, and were unaware R1 left the building without staff's knowledge until they received a phone call from Receptionist 2, alerting them R1 was entering the facility. Receptionist 2 stated R1 was not wearing the wanderguard bracelet when he returned to the facility at approximately 5:15 PM, although the resident's Comprehensive Care Plan (CCP) dated 05/20/2024, revealed an intervention for the use of a wanderguard to the right wrist to prevent him from leaving the facility unattended. 2. R24 (hospice resident) was care planned with interventions for pain medication as ordered; and monitor for effectiveness of the pain medication. However, R24's family had a surveillance device in the resident's room that did not detect any staff members administering medication or providing care to her from 03/11/2025 at 6:03 PM, until 03/12/2025 at 5:41 AM, approximately 12 hours. The facility's failure to have an effective system in place to ensure the Comprehensive Care Plan is developed and implemented is likely to cause serious injury, impairment, or death, if immediate action is not taken. Immediate Jeopardy (IJ) was identified on 03/07/2025, was determined to exist on 02/25/2025 in the area of 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656. The facility provided an acceptable Immediate Jeopardy Removal Plan, on 03/12/2025, alleging removal of the IJ on 03/10/2025. The State Survey Agency (SSA) validated the IJ was removed on 03/15/2025, prior to exit. Remaining non-compliance continues at a Scope and Severity of a D while the facility develops and implements a Plan of Correction (PoC) and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. Refer to F658 and F689 The findings include: (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Comprehensive Care Plans (CCP), undated, revealed it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the resident's comprehensive assessment. Per policy, the CCP would describe the services to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The policy stated the CCP would include resident specific interventions that reflected the resident's needs and preferences. 1. Review of R1's Admission Record, located in the resident's electronic medical record (EMR), revealed the facility admitted the resident on 04/16/2024 with diagnoses which included mild cognitive impairment/severe vascular dementia with agitation, moderate malnutrition, and the need for assistance with personal care. On 09/05/2024, R1 was diagnosed with wandering. Review of R1's CCP, dated 05/20/2024, located in the resident's EMR, revealed the resident was an elopement risk/wanderer related to impaired safety awareness and wandered aimlessly. The goal stated the resident would not leave the facility unattended. Interventions included: distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: photography, and outdoor activities. There was also an intervention for wanderguard to the right wrist with the nurse to check placement each shift with an initiation date of 05/20/2024. Review of R1's Clinical Orders, dated 05/20/2024, revealed orders for R1 to wear a wanderguard bracelet to the right wrist and to check every shift. Review of R1's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 01/23/2025, located in the resident's EMR, revealed the facility assessed R1 to have a Brief Interview for Mental Status (BIMS) score of nine out of 15, which indicated moderate cognitive impairment. Additional review revealed the facility assessed the resident as wandering one to three days during the look back period. Review of R1's Clinical Orders, dated 01/31/2025, revealed orders for R1 to wear a wanderguard bracelet to the right wrist and to check every shift. Review of R1's Treatment Administration Record (TAR), dated 02/2025, revealed the placement of R1's wanderguard had been charted as checked and charted as present on 02/25/2025 by Licensed Practical Nurse (LPN)1. However, there was no intervention on the TAR to check functionality of the wanderguard and there was no documented evidence a check of functionality of the wanderguard had been completed. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R1's Progress Note, dated 02/25/2025 at 11:05 PM, signed by the MDS Nurse, located in the resident's EMR, revealed R1 followed visitors through the exit doors on the MCU. Per the note, R1 exited the facility for a short time, and then returned through the front doors. R1 told the receptionist he needed to sign back in, and he was out looking for his dog. According to the note, the receptionist recognized R1 and assisted the resident back to the locked MCU. Further review, revealed the nurse completed a head-to-toe assessment with no injuries noted at the time. Per the note, R1 had no complaints of pain with touch and vital signs were within normal range. The note further stated R1 was placed on one on one (1:1) observation for safety, and his family was in the facility and was given notification. During an interview, on 03/06/2025 at 4:11 PM, with Receptionist 2, she stated on the evening R1 eloped (02/25/2025), it was very busy with people going in and out with the phones ringing when she saw R1 walk in through the front facility door at approximately 5:15 PM. She stated she knew who he was because he had attempted to leave the facility before. Receptionist 2 stated R1's wanderguard was not visible, and no alarm sounded when he re-entered the facility. She stated she recalled R1 was wearing shorts and a t-shirt and it was warm that day. Receptionist 2 further stated she did not witness nor did she hear R1 go out the front door. She stated there was always 24/7 coverage in place at the main entrance reception desk, even before R1 eloped. During an interview, on 03/06/2025 at 2:35 PM, with State Trained Nurse Assistant (STNA)1, he stated he was assigned to R1 the day he eloped (02/25/2025). STNA1 stated the last time he remembered seeing R1 that day was about 3:45 PM to 4:00 PM when the resident was in the Common Room. After that, he was giving another resident a shower and did not hear any alarms sounding on the unit. STNA1 further stated he was made aware R1 was returning to the unit on the elevator. STNA1 stated he did not recall seeing the wanderguard on R1 at the beginning of the shift, but he was not looking for it specifically. He stated the nurses checked placement of the wanderguards. During an interview, on 03/06/2025 at 2:49 PM, with LPN1, she stated she was assigned to R1 on the day he eloped. LPN1 stated the last time she saw R1 was around 4:00 PM in the Common Room that day. LPN1 further stated she was caring for another resident, and did not hear an alarm. In continued interview, LPN1 stated there was an order to check the placement of R1's wanderguard every shift which she did that day prior to the elopement. She stated she observed it on his wrist, but she could not recall the exact time she checked the placement of the wanderguard. LPN1 stated after R1 returned she questioned the resident as to where his wanderguard was and he stated, I took it off and threw it. LPN1 stated staff searched R1's room, the MCU, and the garbage and did not find the wanderguard. During further interview with LPN1 on 03/06/2025 at 2:49 PM, she stated prior to R1's eloping, she checked the residents' wanderguard devices weekly by pushing the resident's wheelchair near to the door or walking the resident up near the door and making sure the alarm would sound. LPN1 further stated she did not have a wand or device to test the wanderguard alarm on the unit. In continued interview, she stated the charting for the alarm check for the wanderguards used to be a task on the resident's Medication/Treatment Administration Record (MAR/TAR), but at some point the intervention to test the wanderguard bracelets for function no longer showed up on the MAR/TAR, and therefore she did not document the checks anywhere. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview, on 03/07/2025 at 10:32 AM, with the MDS Nurse, she stated the floor nurses, the unit managers, and the Director of Nursing (DON) could update a resident's care plan, and then she reviewed the entire care plan with each MDS assessment. The MDS nurse stated the care plan should be developed with interventions to provide the best possible outcome for the resident and the care plan was to be person-centered. She stated the care plan was important as it provided staff information on how to care for the resident. Further, she stated information from the care plan flowed to the resident's Kardex (a nurse aide care plan which indicated a resident's specific care needs which was visible on the resident's EMR) so all staff would have access to the information on the resident's activities of daily living. The MDS Nurse stated this included information such as how the resident transferred and if the resident used an alarming device for wandering, etc. She further stated if the care plan was not followed, it could lead to harm for the resident, as the care plan was the main tool used for direction of resident care. During an interview, on 03/06/2025 at 5:30 PM, with the Interim Administrator and the Director of Nursing (DON), the Interim Administrator stated going forward, the function of the residents' wanderguards was to be checked every day instead of weekly, and placement of the residents' wanderguards was to be checked every shift and charted on the TAR and in the Progress Notes. They both stated if a resident had a wanderguard, the wanderguard should be marked on the resident's care plan and Kardex in order to alert all staff the resident had a wanderguard. Both stated the resident's care plan directed resident care, and it was important for the care plan to be followed to ensure the safety of the residents and to also ensure the resident's care needs would be met. They stated going forward, there would be an intervention to check placement and functionality on R1's care plan and that would flow to the STNA Kardex. 44001 2. Review of R24's Admission Record, located in R24's EMR, revealed the facility admitted R24 on 07/02/2024 with diagnoses to include Parkinson's disease, spondylosis (degeneration of the vertebral column), and spinal stenosis (narrowing of the spaces in the spine) with sciatica (pain along the sciatic nerve). Review of R24's quarterly MDS with an ARD of 01/28/2025, located in R24's EMR, revealed the resident's BIMS was not assessed. A staff assessment for mental status indicated R24 had short and long-term memory problems. Further review of the MDS revealed the facility assessed the resident as being a substantial/maximum assist (helper did more than half of the effort) for transfers, mobility, and activities of daily living (ADL). Review of R24's CCP, undated, revealed the resident was care planned for being at risk for alteration in comfort and pain. Goals included R24 would be free of any discomfort or adverse side effects from pain medication. Interventions included administer pain medication as ordered; monitor for effectiveness of the pain medication; document all interventions; and report any unrelieved pain or condition change to the primary care provider. Review of R24's Physician Orders, located in R24's EMR, revealed an order, dated 01/16/2025, for Hospice (end of life) Care due to her Parkinson's diagnosis. Further review revealed an order dated 01/25/2025, for tramadol HCl oral tablet 50 milligrams (mg), one tablet by mouth three times a day for pain/comfort (narcotic pain reliever). (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R24's Medication Administration Report (MAR), found in R24's EMR, dated March 2025, revealed Registered Nurse (RN) 6 documented in the MAR that she administered R24's 9:00 PM tramadol at 9:21 PM. During an interview with Family (F)2, on 03/14/2025 at 3:35 PM, he stated after reviewing video from the family's surveillance device in R24's room, it showed no person or staff member had entered R24's room from 03/11/2025 at approximately 6:03 PM to 03/12/2025 at 5:45 AM to provide essential care for R24. F2 stated he was concerned the resident was not observed for pain, repositioned to decrease pain, or administered her 9:00 PM pain medications (tramadol). Review of R24's family surveillance video, on 03/14/2024 at 3:35 PM, by the SSA Surveyor, provided by the family, revealed captured video of the resident's room, including the resident in the bed and a full view of the entrance door to the room. The video showed the resident's room, from 03/11/2025 at 5:45 PM to 03/12/2025 at 5:45 AM. The video confirmed the last staff person left R24's room on 03/11/2025 at 6:03 PM, and no facility staff returned to the room until 5:41 AM on 03/12/2025. During a telephone interview with STNA22, on 03/13/2024 at 2:39 PM, he stated he rounded on R24 every hour during the time from 11:00 PM on 03/11/2025 to 7:00 AM on 03/12/2025. When the SSA Surveyor questioned how he monitored R24 throughout the night, he stated every other hour he opened the door to her room enough to see her and make sure she was in bed. However, he verified during these checks, he did not always go into the room and did not turn on the room lights. During the next hour, he stated he entered the room and checked R24's brief for wetness, but the resident was not wet until last rounds. He stated R24 could not move around on her own but could move a little while in bed and often attempted to crawl out. He further stated he checked her and repositioned her every two hours. Additionally, STNA22 stated nurses rounded every other hour, checking on residents by opening doors to ensure everyone was sleeping well. During an interview, with SRNA23, on 03/13/2024 at 4:27 PM, she stated she worked the 7:00 PM to 11:00 PM shift on 03/11/2025. She stated she rounded on R24 in her room at around 6:45 PM, but did not provide care at that time. However, she stated she continued to round on the resident until end of shift at 11:00 PM. Telephone interview with RN6 was attempted by the SSA Surveyor on 03/13/2025 at 2:27 PM, 2:38 PM, and 3:14 PM. A voicemail was left each time to return the SSA Surveyor's call. No return call was received. During an interview with the DON, on 03/13/2025 at 11:30 AM, she stated F3 complained on the morning of 03/12/2025, that the resident had not been cared for during the night, and F3 had video surveillance showing R24 was left alone all night. The DON stated she notified the Administrator, and an investigation was initiated. She stated R24 should have been checked on at least every two hours. Further, R24 should have been monitored for pain. The DON stated it was her expectation that clinical staff rounded on residents throughout the night and that nursing staff provided care for residents as per the CCP. She further stated following the plan of care was important to provide appropriate, resident-specific care. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Interim Administrator, on 03/15/2025 at 11:46 AM, she stated she was notified of the staff's failure to round on R24 by the DON. The Interim Administrator stated F3 showed her the complete recording of video footage using the monitoring application on her iPhone. The Interim Administrator stated she initiated an investigation and suspended the staff members involved. She stated it was her expectation clinical staff rounded on residents and provided care as ordered and as per the CCP. During an interview with the Medical Director on 03/13/2025 at 3:08 PM, he stated he was notified about a video from R24's family, which revealed the resident was not monitored by clinical staff throughout the night. He further stated it appeared R24 did not receive any of her evening medications. He stated it was his expectation nursing staff implemented the CCP to ensure the facility maintained the resident's highest practicable level of functioning and well-being.

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F 0657 Level of Harm - 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. 44001 Based on interview, record review, and review of the facility's policy, the facility failed to ensure the Comprehensive Care Plan (CCP) was reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs for 2 of 12 sampled residents, Resident (R)12 and R13. 1. On 06/07/2024, R12 was transferred without the use of a gait belt, as per policy. The resident sustained wounds to the left knee, and left arm, and bruising with scratches on the left ribcage. Additionally, a CT of the Chest performed on 06/08/2024, revealed an age-indeterminate nondisplaced left 8th rib fracture. R12's care plan was updated on 06/08/2024 to state the resident required extensive assistance by two staff to move between surfaces; however, the CCP was not revised to include an intervention for the use of a gait belt during transfers. 2. R13 sustained 6 falls from 03/04/2024 through 03/09/2025. However, there was no documented evidence the CCP was revised with new interventions to prevent recurrence. On 06/06/2024, R13 sustained an unwitnessed fall, resulting in a hematoma and 3 lacerations on the right side of the resident's forehead requiring 7 sutures. Again, there was no documented evidence the CCP was revised with new interventions to prevent recurrence. Refer to F689 The findings include: Review of the facility's policy titled, Interdisciplinary: Comprehensive Care Plan, dated 01/01/2023, revealed the comprehensive care plan would be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. The objectives would be utilized to monitor the resident's progress. Per the policy, alternative interventions would be documented, as needed. Review of the facility's Fall Prevention Program policy, undated, revealed each resident would be assessed for fall risk, and care and services would be provided according to each resident's individualized level of risk to minimize the likelihood of falls. Per policy, fall risk protocols included to complete a fall risk assessment after each fall and to provide interventions that addressed risk factors as directed by the resident's assessment. 1. Review of the facility's Use of Gait Belts policy, undated, revealed gait belts were to be used for any resident who could not independently walk or transfer, ensuring their safety. Review of R12's Admission Record, located in the resident's Electronic Medical Record (EMR), revealed the facility admitted R12 on 10/23/2023 with diagnoses including myasthenia gravis (neuromuscular disorder causing muscle weakness), transient cerebral ischemic attack (mini stroke) and type 2 diabetes. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS), located in R12's EMR, with an Assessment Reference Date (ARD) of 04/09/2024, revealed the facility assessed R12 to have a Brief Interview for Mental Status (BIMS) score of nine out of 15, which indicated moderate cognitive impairment. Further review of the MDS revealed the facility assessed the resident as requiring substantial/maximum assist (helper did more than half of the effort) for transfers; and as having no falls during the look back period. Review of R12's CCP, dated 10/24/2023, located in R12's EMR, revealed the resident was care planned for being at increased risk for falls related to impaired mobility and self-care performance deficit. Interventions included keeping the resident's call light placed within reach and to follow fall protocols. However, the CCP did not include an intervention for the use of a gait belt during transfers. Review of R12's Health Status Note, dated 06/07/2024 at 10:46 PM, located in the resident's EMR, revealed at approximately 8:00 PM, R12 was sitting in the living room recliner when State Trained Nurse Assistant (STNA)12 assisted her into a wheelchair. During the transfer, R12 fell , landing on top of STNA12. According to the note, the resident sustained three injuries: a wound on the left knee, a wound on the left arm, and bruising with scratches on the left ribcage. The note further stated R12 reported pain at an intensity of eight out of 10 on a pain scale with 10 being the worst, and was transported to the local hospital. Review of R12's Incident Report, dated 06/07/2024 at 8:47 PM, revealed STNA12 stated he failed to use a gait belt while transferring R12 from a recliner to her wheelchair. STNA12 described the incident as an accidental fall. Review of R12's Emergency Department (ED) Provider Notes, dated 06/08/2024 at 7:52 AM, located in the resident's EMR, revealed the resident presented to the local ED after sustaining a fall. According to the note, R12 complained of chest wall and back pain and a skin tear to the right arm. Review of R12's Computed Tomography (CT) (x-ray imaging) of the Chest, dated 06/08/2024 at 7:11 AM, located in R12's EMR, revealed an age-indeterminate nondisplaced left 8th rib fracture. Additional review of R12's CCP, dated 10/24/2023, located in the EMR, revealed R12's care plan was updated on 06/08/2024 to state the resident required extensive assistance by two staff to move between surfaces; however, the CCP was not developed to include transfer using a gait belt. During an interview with the MDS Nurse, on 03/11/2025 at 3:41 PM, she stated R12's CCP should have been revised to include the use of a gait belt with all transfers. 2. Review of the Admission Record, located in R13's EMR, indicated the facility admitted the resident on 06/29/2023 with diagnoses to include Alzheimer's disease, muscle weakness, and reduced mobility. Review of R13's CCP, dated 06/29/2023, located in the resident's EMR, revealed R13 was care planned for being at increased risk for falls related to a history of falls. Listed interventions included to keep the resident's call light in reach, encourage the resident to participate in activities, ensure the resident was wearing appropriate footwear, and follow fall protocol. All the above interventions were dated 06/29/2023. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Review of an Occurrence History report for R13, provided by the facility, revealed she had one fall on 06/09/2024 resulting in a minor injury, and four non-injury falls on 07/17/2024, 09/06/2024, 02/25/2025, and 03/09/2025. Additionally, a witnessed non-injury fall, on 03/04/2024, was not noted on this report. Review of a Fall Checklist, provided by the facility and dated 02/25/2025 at 4:02 AM, revealed an intervention to initiate an exercise program for gait training was documented; however, the CCP was not revised with this intervention. Review of a Fall Checklist, provided by the facility and dated 03/04/2025 at 6:10 PM, revealed the CCP was not revised with a new intervention after R13 experienced a non-injury fall. Further review of R13's EMR, revealed no documented evidence the facility's Interdisciplinary Team (IDT) reviewed the above six falls or verified that previous care planned interventions were in place at the time of the resident's falls. Furthermore, there was no documented evidence the facility revised the CCP in an attempt to prevent recurrence. Review of R13's Health Status Note, dated 06/06/2024 at 10:27 PM, located in the resident's EMR, revealed LPN6 reported she found R13 on the side of the bed in a sitting position and blood was streaming down her face. According to the note, R13 was unable to explain how the fall occurred or what she was attempting to do at the time of the incident. Additional review revealed LPN6 notified the House Supervisor, Provider, Resident Representative (RR), and Emergency Medical Services (EMS). R13 was transferred to the local hospital for assessment. Review of R13's Emergency Department (ED) Provider Notes, dated 06/07/2024 at 1:12 AM, located in R13's EMR, revealed the resident presented to the local ED due to a head injury sustained from a fall. According to the ED notes, the examination revealed three lacerations on the right side of the resident's forehead, accompanied by an underlying hematoma. Per the ED note, R13 received a total of seven sutures to close the lacerations, and a CT scan of the head was conducted, which showed no intracranial processes. Further review revealed the resident was alert and neurologically intact at the time of discharge. Review of R13's Health Status Note, dated 06/07/2024 at 12:00 AM, located in the resident's EMR, revealed Nurse Practitioner (NP)1 reported R13 returned from the hospital with 6-9 sutures in head per nursing and complained of right lower rib pain. A chest radiograph (x-ray) was ordered. Review of R13's X-ray Rib Right Chest, dated 06/07/2024 at 11:49 AM, located in the resident's EMR, revealed no definite rib fracture. Although R13's EMR revealed the resident suffered injury related to the 06/06/2025 fall, there was no documented evidence the facility's Interdisciplinary Team (IDT) reviewed R13's falls or verified previous care planned interventions were in place at the time of the resident's falls. Nor did the facility revise the CCP in an attempt to prevent recurrence. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Review of R13's quarterly MDS, with an ARD of 02/16/2025, located in R13's EMR, revealed the facility assessed R13 to have a BIMS score of five out of 15, which indicated severe cognitive impairment. Further review revealed the resident was not assessed for having falls during the look back period. Continued review revealed the facility assessed the resident as requiring substantial/maximum assist (helpers did more than half the effort) for transfers and once seated was able to wheel self short distances in a wheelchair. During an interview with LPN1, on 03/15/2025 at 10:22 AM, she stated she was familiar with R13 and due to the resident's diagnosis of Alzheimer's, R13 was forgetful and attempted to self-transfer without staff assistance. LPN1 stated R13 was care planned as a fall risk. She stated staff provided increased checks on the resident and provided activities if she was restless. During additional interview with the MDS Nurse, on 03/11/2025 at 3:55 PM, she stated the CCP should address the resident's needs based on diagnoses and assessments. The MDS Nurse further stated, every resident is at risk for falls, and residents with a history of falls required careful monitoring. She stated the care plan should be revised with new interventions to be implemented after a fall in an attempt to prevent further falls. The MDS Nurse further stated she was unsure why no new interventions were implemented after R13's fall on 06/06/2024. During an interview, on 03/13/2025 at 11:30 AM, with the Director of Nursing (DON), she stated staff was to follow the facility's fall protocol which included completing the Fall Checklist, which listed each step to complete when a fall occurred. She stated the checklist was to be completed by the nurse on duty and given to the DON for review at the Interdisciplinary Team (IDT) meeting. She further stated the IDT would then review the incident and add/revise interventions to prevent future falls. In further interview, she stated she could not find a Fall Checklist for R13's 06/06/2024 fall. The DON stated she currently kept IDT notes in a binder as they were not part of the EMR. During an interview with the Interim Administrator, on 03/15/2025 at 11:46 AM, she stated it was her expectation that staff would follow the facility's policies related to falls, and development/revision of care plans for the safety of the residents.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 44001 Based on interview, record review, review of a surveillance video recording, review of the facility's job descriptions, and review of the facility's policies, the facility failed to ensure that services provided met professional nursing standards for 1 of 33 sampled residents, Residents (R) 24. Review, on 03/14/2025 at 3:35 PM, of a surveillance video of R24, provided by the resident's family, revealed video footage of the resident and her room. The video revealed the last staff member left R24's room at 6:03 PM on 03/11/2025. Following this departure, no facility personnel re-entered the room until 5:41 AM on 03/12/2025, approximately 11 hours and 38 minutes. During this time, R24 did not receive monitoring or physician-ordered care, including assessments and administration of pain medications. The findings include: Review of the facility's policy titled, Rounding, undated, revealed the facility must ensure that staff routinely rounded on each resident to provide necessary care and services as needed. Review of the facility's policy titled, Administration of Medication, undated, revealed medications were administered as ordered by the physician, in accordance with professional standards of practice. Review of the facility's Nursing Assistant Job Description and Performance Appraisal, revised 07/2023, revealed the State Trained Nurse Aide (STNA) carried out delegated activities in accordance with current standards of practice that governed long term care facilities to ensure compliance. Furthermore, the job description stated the STNA was to make multiple rounds on the assigned unit to ensure residents were safe and accounted for, addressing the emergent issues. Review of the facility's Registered Nurse Job Description and Performance Appraisal, revised 06/2023, revealed the Registered Nurse (RN) carried out delegated activities in accordance with current standards of practice that governed long term care facilities to ensure compliance. Furthermore, the job description stated the RN ensured that medical nursing care was administered, medications were given as ordered, nursing documentation were complete and accurate to reflect the care provided and the resident's response to that care, and medication was administered in accordance with policy. Review of R24's Admission Record, found in R24's electronic medical record (EMR), revealed the facility admitted R24 on 07/02/2024 with diagnoses to include Parkinson's disease, spondylosis (degeneration of the vertebral column), and spinal stenosis (narrowing of the spaces in the spine) with sciatica (pain along the sciatic nerve). Review of R24's Quarterly Minimum Data Set [MDS], found in R24's EMR, with an Assessment Reference Date (ARD) of 01/28/2025, revealed R24's Brief Interview for Mental Status [BIMS] was not assessed. A staff assessment for mental status indicated R24 had short and long-term memory problems. Further review of the MDS revealed the facility assessed the resident as being a substantial/maximum assist (helper did more than half of the effort) for transfers, mobility, and activities of daily living (ADL). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R24's Comprehensive Care Plan [CCP], undated, revealed the facility care planned the resident for being at risk for alteration in comfort and pain. Goals included R24 would be free of any discomfort or adverse side effects from pain medication. R24 would be given the pain medication as ordered, would be monitored, and the effectiveness of the pain medication and all interventions would be documented; and any unrelieved pain or condition change would be reported to the primary care provider. Review of R24's Physician Orders Summary, found in R24's EMR, revealed an order, dated 01/25/2025, for tramadol HCl oral tablet 50 milligrams (mg), one tablet by mouth three times a day for pain/comfort. Further review of the orders revealed R24 was admitted to Hospice (end of life) care on 01/16/2025. Review of R24's Medication Administration Report [MAR], found in R24's EMR, dated March 2025, revealed Registered Nurse (RN) 6 documented in the MAR that she administered R24's 9:00 PM tramadol at 9:21 PM. Review of the video surveillance footage of R24's room, on 03/14/2025 at 3:35 PM revealed it was started on 03/11/2025 at 5:45 PM and ended on 03/12/2025 at 6:07 AM. The video footage was provided by R24's family member (F2) via his cell phone's Ring monitoring application. The video showed that at 5:45 PM, R24 and a family member were in the room. A dayshift STNA entered R24's room and assisted her into bed, then left the room and closed the door at 6:03 PM. The family member remained with R24 until 6:25 PM, when she left the room, leaving the door open. Per the video, at 7:15 PM, another resident, who was assigned to close doors, shut R24's door. The resident moved around in bed at 3:33 AM. At 4:47 AM, R24 awoke and looked under her bed covers. She changed positions slightly, and then laid back down. From that time until 5:41 AM, no one was seen opening the door or entering R24's room to provide care during that timeframe. The door remained fully closed all night. At 5:41 AM, STNA22 entered the room, changed R24, and then transferred her to a wheelchair. He exited the room with R24 at 5:56 AM. During a telephone interview with Family Member 3 (F3) on 03/13/2025 at 9:37 AM, she identified herself as R24's Power of Attorney (POA). F3 expressed concerns regarding R24's care. She stated that, until now, the staff had generally been good, although her interactions had primarily been with the day shift staff, and she was unfamiliar with the night shift staff. F3 stated she had sent a 10-hour recording from a surveillance camera located in R24's room to the facility's Administrator. She stated that she and her siblings reviewed the video footage daily and noted there had not been any instances where the staff failed to check on their mother. However, F3 stated she had a specific concern regarding the evening shift on 03/11/2025. She stated R24 was not checked on after being put to bed by the day shift staff until the following morning when an aide woke her at 5:41 AM. During that time, F3 stated R24 was not observed by staff, was not changed, did not receive care, and was not given her evening medications. F3 stated she was very concerned about the inadequate care provided to R24, who was admitted to Hospice for end-of-life treatment and pain management due to Parkinson's disease and severe spinal pain. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with F2 on 03/14/2025 at 3:35 PM, he stated after reviewing the video it showed that no one entered R24's room from 03/11/2025 at approximately 6:03 PM to 03/12/2025 at 5:45 AM. He stated he was concerned that his mother was not observed, provided care, or administered her 9:00 PM pain medication. Furthermore, F2 stated the camera would follow and maintain focus on any activity occurring throughout the room, including R24's movements in bed. He stated the camera operated 24 hours a day, seven days a week, to ensure comprehensive monitoring at all times. During a telephone interview with STNA22 on 03/13/2024 at 2:39 PM, he stated he rounded on R24 every hour during the time from 11:00 PM to 7:00 AM. The STNA stated, I opened the door to check on her to make sure she was asleep when I first arrived. He stated he did not change R24 at his start of shift because the STNA who gave him report told him R24 had just been changed. He stated, She was asleep, and I checked on her probably every hour until she woke her up at about 5:15 AM. When asked by the SSA Surveyor how he monitored R24 throughout the night, he stated that every other hour he opened the door to her room enough to see her and make sure she was in bed. However, he stated during these checks, he did not always go into the room and did not turn on the room lights. During the next hour, he stated he entered the room and checked R24's brief for wetness. He stated he was uncertain when R24 went to bed on 03/11/2025 because he did not start his shift until 11:00 PM. Additionally, STNA22 stated nurses rounded every other hour, checking on residents by opening the doors to ensure everyone was sleeping well. He stated staff members were aware of which residents required more frequent changes, so they were checked on more often. He stated, when he woke R24, he found her wet but not soaked. He stated staff should follow the facility's policy to round once every hour, and then check and reposition the resident every two hours. During an interview with SRNA23 on 03/13/2024 at 4:27 PM, she stated she worked the 7:00 PM to 11:00 PM shift on 03/11/2025. She stated she rounded on R24 in her room around 6:45 PM, but she did not provide care at that time. However, she stated she continued to round on the resident until the end of her shift at 11:00 PM. A telephone interview with RN6 was attempted by the SSA Surveyor on 03/13/2025 at 2:27 PM, 2:38 PM, and 3:14 PM. A voicemail was left each time to return the SSA Surveyor's call. No return call was received. During an interview with the Director of Nursing (DON) on 03/13/2025 at 11:30 AM, she stated F3 made a complaint to her on 03/12/2025 in the morning, that her mother had not been cared for during the night. The DON stated F3 told her that she had video surveillance showing R24 was left alone all night. The DON stated she notified the Administrator, and an investigation began. The DON stated it was her expectation that clinical staff rounded on residents throughout the night and that nursing staff provided care for residents as directed to support their highest level of functioning and well-being. During an interview with the Interim Administrator on 03/15/2025 at 11:46 AM, she stated she was made aware of the staff's failure to round on R24 by the DON. She stated that she, the DON, and the Nurse Consultant met with R24's family to address their concerns. The Interim Administrator stated she requested to review the video footage, and F3 showed her the complete recording. She stated she initiated an investigation and suspended the staff members involved. She stated that routine rounding was essential for ensuring the well-being and safety of residents, and it was her expectation that clinical staff rounded on residents and provided care as ordered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Medical Director on 03/13/2025 at 3:08 PM, he stated he was informed about a video from R24's family,which revealed the resident was not monitored by clinical staff throughout the night. He further stated it appeared R24 did not receive any of her evening medications. The Medical Director stated it was his expectation that such occurrences did not happen in the future. He stated, Missing a dose or two is not ideal. I don't believe she was harmed in any way, but it's still not an acceptable situation. I would like to prevent this from happening again. Additionally, he stated it was his expectation that nursing staff provided resident care as ordered to ensure the facility maintained the resident's highest practicable level of functioning and well-being.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 46651 Based on observation, interview, record review, review of the RoamAlert Resident Safety User Guide, and review of the facility's documents and policies, the facility failed to have an effective system in place to ensure each resident received adequate supervision and properly functioning assistance devices to prevent unsafe wandering, elopement, and falls for 3 of 11 sampled residents, Resident (R)1, R12, and R13. 1. R1's Clinical orders, initiated 05/20/2024, revealed orders for the resident to wear a wanderguard bracelet (an electronic device that caused an alarm to sound when the resident tried to exit a door that had an accompanying device installed) to his right wrist and to check every shift. Per R1's Progress Note, dated 06/25/2024, R1 was exit-seeking, went outside the exit door, and was brought back into the facility immediately. However, per the 06/25/2024 note, the wanderguard was not on R1's right wrist upon staff bringing the resident back inside. Subsequently, on 02/25/2025, R1 who resided on the locked Memory Care Unit (MCU) was observed entering the facility through the main door which was equipped with an alarming device, but the door did not alarm when the resident entered the building as R1 was again not wearing the wanderguard bracelet upon return to the facility. Interviews were conducted with MCU staff who were on duty during the time of the 02/25/2025 elopement, and they stated they had last seen the resident at approximately 4:00 PM, and were unaware R1 left the building unsupervised until they received a phone call from Receptionist 2, alerting them R1 was entering the facility. Also, there was no documented evidence the facility had checked R1's wanderguard for functionality, and on 02/28/2025, the vendor for the alarm system found it was not working properly. 2. On 06/07/2024, R12 was transferred without the use of a gait belt, as per policy. The resident sustained a wound to the left knee, a wound to the left arm, and bruising with scratches on the left ribcage. Additionally, a CT of the Chest was performed on 06/08/2024, which revealed an age-indeterminate nondisplaced left 8th rib fracture. There was no documented evidence of a root cause analysis or investigation related to the fall. 3. On 06/06/2024, R13 sustained an unwitnessed fall, resulting in a hematoma and three lacerations on the right side of the resident's forehead requiring seven sutures to close the lacerations. There was no documented evidence of a root cause analysis or investigation related to the fall. Additionally, there was no documented evidence the CCP was updated in an attempt to prevent future potential falls. The facility's failure to have an effective system in place to ensure residents' safety is likely to cause serious injury, impairment, or death, if immediate action is not taken. Immediate Jeopardy (IJ) was identified on 03/07/2025, was determined to exist on 02/25/2025 in the area of 42 CFR 483.25 Quality of Care, F689, and Substandard Quality of Care (SQC) at 42 CFR 483.25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility provided an acceptable Immediate Jeopardy Removal Plan, on 03/12/2025, alleging removal of the IJ on 03/10/2025. The State Survey Agency (SSA) validated the IJ was removed on 03/15/2025, prior to exit. Remaining non-compliance continues at a Scope and Severity of a G while the facility develops and implements a Plan of Correction (PoC) and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. Refer to F656 and F657 The findings include: 1. Review of the facility's policy titled, Elopements and Wandering Residents, dated 04/18/2024, revealed the facility ensured residents who exhibited wandering behavior and/or were at risk for elopement received adequate supervision to prevent accidents. The policy further stated residents received care in accordance with their person-centered care plan of addressing their unique factors contributing to wandering or elopement risk. Per policy, the facility was equipped with door locks/alarms to help avoid resident elopements, but alarms were not a replacement for necessary supervision. Further review revealed devices used to prevent elopement were checked for functionality and placement, and this would be documented every shift on the Treatment Administration Record (TAR). The policy stated a system would be in place for systematic and frequent checks of all critical components of the electronic alarm system with clear designation of responsibility for monitoring and maintaining the system. Per policy, a basic check of the system was to be done every 24 hours to assure proper functioning. Additionally, the policy stated maintenance of the system must be consistent with the manufacturer's guidelines, and a complete systems check must be performed at least annually. Review of the website's manual (found at https://jmacfiles.s3.amazonaws.com/docs_Roam_Alert_User_Guide.pdf) RoamAlert Resident Safety User Guide, dated 01/2010, revealed monthly testing and maintenance was essential to ensure the program was operating correctly. It also stated the failure to do regular testing and maintenance would increase the risk of system failure and the failure to detect resident wandering. The State Survey Agency (SSA) Surveyor requested the log of the wanderguard system/electronic alarm system checks from the Maintenance Director on 03/05/2025 at 3:28 PM and from the Interim Administrator on 03/06/2025 at 9:07 AM and 03/07/2025 at 8:30 AM. However, the log was not provided. Review of the facility's document titled, Service Orders for [Facility Name] Nursing Home, dated 02/26/2025 to 03/07/2025, revealed the vendor for the wanderguard system had serviced the facility on 02/26/2025 to reprogram the RoamAlert/wanderguard keypad passcode; on 02/28/2025 for wanderguard not recognizing when someone went through the door; on 03/06/2025 for wanderguard alarming on its own; and on 03/10/2025 to confirm the order for two new door controllers. Review of the Weather underground.com temperature history for the facility area on 02/25/2025, revealed a temperature of 65 degrees Fahrenheit from 3:30 PM until 5:30 PM. Review of R1's Admission Record, located in the resident's electronic medical record (EMR), revealed the facility admitted R1 on 04/16/2024 with diagnoses including mild cognitive impairment/severe vascular dementia with agitation, moderate malnutrition, and need for assistance with personal care. On 09/05/2024, R1 was diagnosed with wandering. Per the EMR, the resident resided on the locked MCU. (continued on next page)

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	185208	A. Building B. Wing	03/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Manor	100 Carmel Manor Road Fort Thomas, KY 41075

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R1's Comprehensive Care Plan (CCP), dated 05/20/2024, located in the resident's EMR, revealed R1 was an elopement risk/wanderer related to impaired safety awareness and wandered aimlessly. The goal stated R1 would not leave the facility unattended. Interventions included resident to wear wanderguard to his right wrist and for the nurse to check placement each shift. Review of R1's Clinical Orders, dated 05/20/2024 and 01/31/2025, located in the resident's EMR, revealed orders for R1 to wear a wanderguard bracelet to his right wrist and to check every shift. Review of R1's Progress Notes, from 04/16/2024 to 02/25/2025, revealed instances where R1 had been noted to be wandering and required redirection. These dates included: 04/19/2024, 04/26/2024, 06/25/2024, 06/30/2024, 09/04/2024, 09/05/2024, 09/06/2024, 09/09/2024, 09/16/2024, 11/13/2024, and 01/21/ 2025. Review of R1's Progress Note, dated 06/25/2024 at 3:44 PM, revealed R1 was exit-seeking, went outside the exit door, and was brought back into the facility immediately. However, per the note, the wanderguard was not on his right wrist, and R1 stated he lost it at some point during the night. The note stated a new wanderguard was applied to R1's right wrist and checked to ensure it was working properly. Further review revealed an order was in place to ensure the wanderguard was checked each shift. Review of R1's Elopement Risk Assessment, dated 01/23/2025, revealed a score of seven which indicated he was at high risk for elopement. Per the legend, any score above three was considered high risk. Review of R1's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/23/2025, located in the resident's EMR, revealed the facility assessed R1 to have a Brief Interview for Mental Status [BIMS] score of nine out of 15, indicating moderate cognitive impairment. Further review revealed the facility assessed the resident to have wandered one to three days during the look back period. Review of R1's Treatment Administration Record (TAR), dated 02/2025, located in the resident's EMR, revealed the placement of R1's wanderguard had been charted as checked and charted as present on 02/25/2025 on day shift by Licensed Practical Nurse (LPN) 1. However, there was no documented evidence a check of functionality had been completed. Review of R1's Progress Note, dated 02/25/2025 at 11:05 PM, signed by the MDS Nurse, located in the resident's EMR, revealed R1 had followed visitors through the exit doors on the MCU, exited the facility for a short time, and returned through the front doors. Per the note, R1 told the receptionist he needed to sign back in, and he was out looking for his dog. The receptionist recognized the resident and assisted the resident back to the locked MCU. The note stated the nurse completed a head-to-toe assessment with no injuries noted. Per the note, R1 had no complaints of pain with touch and vital signs were within normal range. The note stated R1 was placed on one on one (1:1) observation for safety, and R1's family was in the facility and was given notification. Observation on 03/05/2025 at 12:10 PM, revealed R1 was ambulating independently with his son and entered the facility through the main doors. R1's wanderguard was visible on his right wrist, and the alarm was sounding as he entered. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 03/05/2025 at 12:13 PM, revealed R1 was in his room, in bed. R1 stated he wore a wristwatch and this other one, while pointing at the wanderguard. R1 denied knowing the purpose of the wanderguard bracelet. During an interview, on 03/05/2025 at 12:19 PM, with R1's Power of Attorney (POA), he stated the facility notified him of the resident leaving the facility unaccompanied on 02/25/2025, within 30 minutes of the resident returning to the facility. He further stated he understood R1 had returned on his own, walked through the facility's front door, and signed himself in as Me. R1's POA stated no harm had come to R1, and he was not sure if R1's wanderguard was in place the last time he visited. He further stated, It was like a wristwatch, and I just got used to seeing it on him. In continued interview, R1's POA stated the facility told him R1 was not wearing the wanderguard when he returned to the facility, and to his knowledge, the facility had not been able to locate it. He stated he asked R1 what happened to it, and R1 told him he was in the field and a girl had cut it off. R1's POA stated he observed staff replacing the wanderguard while he was visiting R1. During an interview, on 03/06/2025 at 2:35 PM, with State Trained Nurse Assistant (STNA) 1, he stated he had worked at the facility since 04/02/2024 and was assigned to R1 the day he eloped. STNA1 stated the last time he remembered seeing R1 was about 3:45 PM to 4:00 PM that day in the Common Room, and after that, he was giving another resident a shower and did not hear any alarms sounding on the unit. STNA1 stated he was made aware R1 was returning to the unit on the elevator and did not recall specifically seeing a wanderguard on R1, but if R1 had come within about six feet of the door, it would have alarmed. STNA1 stated the alarm was loud and audible over the whole unit, but since he was in the shower room with another resident he might not have heard it sound. STNA1 also stated the alarm for the side fire door off the unit and next to the elevators was also very loud, and he was able to hear it on the memory care unit if it sounded. During an interview, on 03/06/2025 at 2:49 PM, with Licensed Practical Nurse (LPN)1, she stated she had worked at the facility since 03/13/2006 and was assigned to R1 on the day he eloped. LPN1 stated the last time she saw R1 was around 4:00 PM in the Common Room where the residents were listening to music and watching television. LPN1 stated she received a readmission from the hospital at about 4:15 PM and was providing care for that resident in the resident's room, and did not hear any alarms sound on the unit during that time. LPN1 stated she received a call from Receptionist 2 and was told R1 was returning to the facility alone through the front entrance, and she would assist him to the elevator and send him down to the MCU. LPN1 stated that happened around 5:00 PM to 5:15 PM, and she knew that because supper meal trays were out. In continued interview, LPN1 stated there was an order to check the placement of R1's wanderguard every shift. She stated she checked the placement of R1's wanderguard on 02/25/2025, and it was on his wrist, but she could not remember the exact time she checked the wanderguard for placement. LPN1 stated when a resident with a wanderguard got close to the door, it would alarm, but not too loud, then it would beep for about 30 seconds, and then would turn off by itself. LPN1 stated there was no code for staff to shut the alarm off. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During continued interview with LPN1, on 03/06/2025 at 2:49 PM, she stated R1 had previously complained his wanderguard was too tight, but he had not complained about it on 02/25/2025 or the day before and she had never cut his wanderguard off. LPN1 stated a new one had been placed on R1 when he returned to the unit on 02/25/2025. LPN1 stated she asked R1 where his wanderguard was when he returned and he stated, I took it off and threw it. LPN1 stated the staff searched the unit, R1's room, and the garbage, but could not find the missing device. She stated prior to R1 eloping, she checked the function of the residents' wanderguard devices weekly by pushing the resident's wheelchair near to or walking the resident up near the door and making sure the alarm would sound. LPN1 stated she did not have a wand or device to test the wanderguard alarm on the unit. Further, she stated she did not document checking the function of the residents' wanderguard. LPN1 stated the day R1 eloped, it was supper time, the television was on, the music was loud, and since she was in a room with another resident, she did not hear any alarms go off. LPN1 further stated the double doors to the MCU had a delay in closing. During an interview, on 03/05/2025 at 3:28 PM, with the Maintenance Director, he stated he had been at the facility for [AGE] years and had reviewed the facility's video footage of the front door. He stated he observed R1 coming back to the facility through the front door but was not able to identify him leaving the facility through the front door. He further stated the camera was situated to record the main entrance between the outside door and the locked facility door in the vestibule. He also stated it was difficult to tell R1 from other visitors, and he might have been able to follow a group of visitors out the front door. The Maintenance Director stated none of the staff heard an alarm go off around the time R1 left the facility, and therefore thought R1 must have tailgated with the visitors out the double doors of the MCU, rode the elevator up to the main floor, and then exited out the front door. The Maintenance Director stated prior to R1 leaving the facility unattended, family members were given the code to the locked double doors to the MCU and could come and go without staff assistance. Further, he stated that since the incident, the codes to the doors had been changed and were given to staff only. During an interview, on 03/05/2025 at 3:52 PM, the Interim Administrator stated she had been at the facility since 02/17/2025, and the Director of Nursing (DON) stated she had been at the facility for eight weeks. They both stated they felt R1 had followed visitors out the locked double doors to the MCU and then exited out the side fire door next to the gated garden area near Elevators 6 and 7. The Interim Administrator stated she was new to the facility and had only been in the facility for a week when R1 eloped. She stated if she had been aware family members and visitors had the code to the locked MCU doors, she would have had the codes changed sooner. The Interim Administrator further stated the facility's investigation revealed R1's elopement happened right before supper service, during a time when a resident activity was happening which often included a movie or music, and staff did not hear the side fire door alarm when R1 left. Additionally, the Interim Administrator stated Emergency Medical Services (EMS) was in the building at the time R1 eloped which added to the traffic/activity on and off the unit. The Interim Administrator stated the codes to all the locked doors had been changed, and a letter went out to the residents' families explaining the need for the doors to stay locked and the need for the codes to be changed. The Interim Administrator stated going forward, staff would have to assist visitors in and out of the facility. The Interim Administrator further stated her plan was to have a telephone/intercom system installed outside the MCU double doors to replace the push pad so visitors would have to call into the unit for entry. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In additional interview, with the Interim Administrator, on 03/06/2025 at 9:07 AM, she stated the contractor/vendor for the wanderguard sensors was contacted on 02/26/2025, for a system check, to evaluate the alarm and how it responded when the wanderguard bracelet was near it. She stated, on 02/28/2025, the contractor/vendor found the main wanderguard unit, which was housed in the ceiling just inside the double doors to the MCU near the nurses' station, was not receiving information from the exciter sensors. The Interim Administrator stated the other control boxes for the other facility doors were functioning, but not the one for MCU, and the unit would need to be replaced. In further interview, on 03/06/2025 at 5:30 PM, with the Interim Administrator and the DON, they stated the MCU was a very busy unit, especially at the time of day R1 eloped. They stated often the Common area was full of residents and staff engaged in activities, music and/or watching television, and it could be loud. The Interim Administrator stated depending on the time of day and the environment, alarm audibility could vary. The Interim Administrator stated going forward, the function of the residents' wanderguards was to be checked every day, and placement of the residents' wanderguards was to be checked every shift and charted on the MAR/TAR and in the Progress Notes. Observation on 03/13/2025 at 9:57 AM, revealed R1 was sitting at a table in the MCU Common area with staff in the general area. STNA14, the staff person assigned to R1 as his 1:1 monitor for today, was observed in R1's room sitting in the recliner on her phone (at the opposite corner of the unit and out of eyesight/earshot of R1) The Interim Administrator was rounding on the MCU and was made aware by the SSA Surveyor. During an interview, on 03/13/2025 at 10:05 AM, with STNA14, she stated she had been educated related to elopement and 1:1 observation and was expected to have eyes on R1 at all times. STNA14 further stated she had just gone back to R1's room to get her phone, and she had told RN4 and STNA15 she was going there and asked them to keep eyes on R1. During an interview, on 03/13/2025 at 10:09 AM, with RN4, she denied STNA14 telling her she was going to R1's room or asking her to keep eyes on R1. During an interview, on 03/13/2025 at 10:15 AM, with STNA15, she stated she had not been told to watch R1 while STNA14 went to R1's room. She further stated she had told STNA14 not to leave R1 unattended on two other occasions and had made LPN1 and the Weekend Supervisor aware. During a telephone interview, on 03/14/2024 at 4:20 PM, with the Weekend Supervisor, she denied being made aware by any staff that STNA14 was observed leaving R1 unattended while she was responsible for his 1:1 observation. During an interview, on 03/15/2024 at 1:05 PM, with LPN1, she stated to be a 1:1 sitter meant the staff person had eyes on the resident at all times, and if they needed a break, she would have the resident sit with her in the Common area. LPN1 denied any staff ever told her STNA14 left R1 unsupervised. During an interview with RN1, on 03/13/2025 at 10:25 AM, he stated STNA14 was being escorted out of the building at this time, and RN4 had been told to keep eyes on R1 while R1 was in the Common area. RN1 stated he was told if R1 got up to leave the Common area, either RN4 or STNA15 were to accompany R1. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/14/2025 at 12:09 PM, RN1 accompanied the SSA Surveyor to the second floor unit, on the [NAME] Unit, and activated the wanderguard alarm on the second floor near the entrance/exit to the unit. An audible alarm sounded for 41 seconds with no staff response. The alarm silenced with no staff entry of a code. After a second immediate activation and after the alarm sounded for 10 seconds, a staff member was overheard to ask, What is that sound? Then, per observation, a second staff person answered, That's the door. The audible alarm sounded for an additional 67 seconds, with no staff response. The total alarm time was 77 seconds, with no staff [LPN4 or STNA19] response. Interview was conducted, on 03/14/2025 at 2:15 PM, with LPN4, who had been employed by the facility for [AGE] years and STNA19, who had been employed by the facility for two years, and they both stated they only had one resident on the unit that used a wanderguard on the [NAME] unit. They stated, if the alarm went off and they had eyes on her, they did not worry about the alarm. LPN4 and STNA19 also stated it was not always easy to hear alarms in the back hall. Observation and interview with STNA17, on 03/15/2025 at 10:00 AM, on the MCU, revealed STNA17 was assigned 1:1 monitoring for R1 and was posted outside R1's room with eyes on him. STNA17 stated she had received continued education on elopement, missing resident, and additional information on the response to alarms yesterday and this morning. During interview on 03/15/2025 at 10:05 AM, with STNA18, who was monitoring the entry doors to the MCU, he stated he had received education on elopement, a missing resident, and response to alarms. During interview on 03/15/2025 at 10:24 AM, with LPN5, on the [NAME] Unit, located on the second floor, she stated she received education on elopement and new education During interview on 03/15/2025 at 10:26 AM, with RN1, he stated there was a whole house test yesterday on door alarms and wanderguards, and the policy was reviewed. RN1 also stated all the alarms on all the units had been made louder. During interview on 03/15/2025 at 12:00 PM, with the Interim Administrator and the DON, they stated it was their expectation the facility would have an elopement and wandering system in place with immediate staff response, a head count of residents completed, and for staff to report to a manager/supervisor on duty when concerns occur, to ensure resident safety. Further, the DON stated the facility should have been checking placement and functionality of the resident's wanderguards and documenting both in the resident record and the system functionality should have also been checked regularly and documented. 44001 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Fall Prevention Program policy, undated, revealed each resident would be assessed for fall risk, and care and services would be provided according to each resident's individualized level of risk to minimize the likelihood of falls. Per policy, fall risk protocols included to implement environmental interventions that decreased the risk of falling; provide routine rounding; wear footwear with non-slip soles while ambulating (residents); complete a fall risk assessment upon admission, quarterly, and as indicated for significant condition changes or after each fall; and provide interventions that addressed risk factors as directed by the resident's assessment. Further review revealed when a resident fell , the facility would assess them, complete a post-fall assessment, and generate an incident report. The policy stated the physician and family would be notified, and the care plan would be updated as needed. Per policy, all actions would be documented, witness statements collected if there was an injury, and the interdisciplinary team (IDT) would review the interventions and conduct a complete investigation. 2. Review of the facility's Use of Gait Belts policy, undated, revealed gait belts were to be used for any resident who could not independently walk or transfer, ensuring their safety. Additionally, per policy, all employees received training on the proper use of gait belts during their orientation and annually. Review of R12's Admission Record, located in the resident's EMR, revealed the facility admitted the resident on 10/23/2023 with diagnoses to include myasthenia gravis (neuromuscular disorder causing muscle weakness), transient cerebral ischemic attack (mini stroke) and type 2 diabetes. Review of R12's CCP, dated 10/24/2023, located in the resident's EMR, revealed R12 was care planned for being at increased risk for falls related to impaired mobility and a self-care performance deficit. Interventions included keeping the resident's call light within reach and follow fall protocols. Review of R12's quarterly MDS with an ARD of 04/09/2024, located in the resident's EMR, revealed the facility assessed R12 to have a BIMS score of nine out of 15, which indicated moderate cognitive impairment. Further review revealed the resident was assessed as not having any falls during the look back period. Continued review revealed the facility assessed R12 as requiring substantial/maximum assist (helper did more than half of the effort) for transfers. Review of R12's Health Status Note, dated 06/07/2024 at 10:46 PM, located in the resident's EMR, revealed at approximately 8:00 PM, R12 was sitting in the living room recliner when STNA12 assisted her into a wheelchair. During the transfer, R12 fell , landing on top of STNA12. Per the note, the resident sustained three injuries: a wound on the left knee, a wound on the left arm, and bruising with scratches on the left ribcage. The note further stated R12 reported pain at an intensity of eight out of 10 on a pain scale with 10 being the worst. R12 was transported to the local hospital. Review of R12's Incident Report, dated 06/07/2024 at 8:47 PM, revealed STNA12 acknowledged he did not use a gait belt when transferring R12 from the recliner to her wheelchair. Per the report, STNA12 stated it was an accidental fall, and he attempted to break the fall with his own body. According to the report, R12 leaned back into him, causing him to lose his balance and fall backward, with the resident landing on top of him. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R12's ED Provider Notes, dated 06/08/2024 at 7:52 AM, located in the resident's EMR, revealed R12 presented to the local ED after a fall. Per the note, R12 complained of chest wall and back pain and a skin tear to the right arm. Review of R12's Computed Tomography (CT) (x-ray imaging) of the Chest, dated 06/08/2024 at 7:11 AM, located in R12's EMR, revealed an age-indeterminate nondisplaced left 8th rib fracture. Additional review of R12's CCP, dated 10/24/2023, located in the EMR, revealed R12's care plan was updated on 06/08/2024 to state the resident required extensive assistance by two staff to move between surfaces; however, the CCP was not revised to include transfer using a gait belt. Review of the facility's Schedule, for 06/07/2024, at the time of R12's fall, revealed the unit where R12 resided was fully staffed with one nurse and two STNAs, and STNA13 was orienting STNA12 The nurse on duty the evening of R12's fall was no longer an employee at the facility. During an interview with Human Resources (HR), on 03/12/2024 at 8:35 AM, she stated on 06/07/2024, STNA12 was on orientation in the facility and was shadowing STNA13. She stated STNA12 should not have been left alone to provide care. The State Survey Agency (SSA) Surveyor attempted a telephone interview with STNA13, on 03/12/2025 at 9:04 AM and 9:07 AM, with no success, and a voicemail could not be left. The SSA Surveyor attempted a telephone interview with STNA12, on 03/12/2025 at 9:05 AM, with no success, and a message stated the phone number dialed did not have voicemail set up. During an interview with STNA11 (agency), on 03/11/2024 at 10:55 AM, she stated it was the facility's policy to use a gait belt with all residents who required assistance with transfers. During an interview with STNA20, on 03/13/2025 at 2:35 PM, she stated she used a gait belt for all resident transfers. During an interview with the Infection Prevention and Staff Development Coordinator (IP/SDC), on 03/12/2024 at 10:30 AM, she stated employees received education upon hire, which included training for safe resident transfers. She stated STNAs did not receive gait belt training during the facility's orientation, as this training was part of their nursing aide course curriculum. Additionally, the IP/SDC stated staff members received orientation on the floor and were paired with a senior staff member for preceptorship. She stated new employees completed a checklist during that orientation, which the preceptor and employee were required to sign. She further stated it typically took three to four days to finish the checklist. Further, while being oriented on the floor, new hires were not allowed to perform resident care independently. She stated she did not know why STNA12 independently transferred R12. The IP/SDC stated it was her expectation that staff followed facility policy in an attempt to prevent falls and used gait belts for all assisted transfers to ensure resident and staff safety. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the DON on 03/13/2025 at 11:30 AM, she stated gait belts were to be used for all transfers with residents who were not independent. She stated it was her expectation that staff followed the facility's policy and use gait belts on all residents requiring transfer assistance. The DON stated this was important for the safety and well-being of the residents. In further interview, the DON stated she was unable to locate IDT notes nor was she able to find an investigation related to R12's 06/07/2024 fall. 3. Review of R13's Admission Record, located in the resident's EMR, revealed the facility admitted R13 on 06/29/2023 with diagnoses to include Alzheimer's disease, muscle weakness, and reduced mobility. Review of R13's CCP, dated 06/29/2023, located in the resident's EMR, revealed R13 was care planned for being at increased risk for falls related to a history of falls. Interventions included keeping the resident's call light in reach, encouraging the resident to participate in activities, ensuring the resident was wearing appropriate footwear, and following fall protocol. Review of R13's Occurrence History report provided by the facility, revealed she had one fall on 06/09/2024 resulting in a minor injury, and four non-injury falls on 07/17/2024, 09/06/2024, 02/25/2025, and 03/09/2025. Furthermore, a witnessed non-injury fall, on 03/04/2024, was not noted on this report. Review of R13's Fall Checklist, provided by the facility and dated 02/25/2025 at 4:02 AM, revealed an intervention to initiate an exercise program for gait training was documented; however, the intervention was not added to the CCP. Review of R13's Fall Checklist, provided by the facility and dated 03/04/2025 at 6:10 PM, revealed there was no initiated intervention added to the CCP after R13 experienced a non-injury fall. Further review of R13's EMR revealed no documented evidence th [TRUNCATED]

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 44001 Based on interview, record review, and review of the facility's policies, the facility failed to ensure that residents who required pain management were provided such services, for 1 of 33 sampled residents, Resident (R) 24. Review, on 03/14/2025 at 3:35 PM, of a surveillance video of R24, provided by the family, revealed the resident in her room. The video confirmed the last staff member left R24's room at 6:03 PM on 03/11/2025 and re-entered the resident's room at 5:14 AM on 03/12/2025. During this time, R24 was not administered her scheduled pain medication or assessed for signs and symptoms of pain. The findings include: Review of the facility's policy titled, Pain Management, undated, revealed the facility must ensure that pain management was provided to residents who required such services consistent with professional standards of practice and the comprehensive person-centered care plan (CCP). Furthermore, the facility must ensure that residents' pain was regularly assessed. Review of the facility's policy titled, Administration of Medication, undated, revealed medications were administered as ordered by the physician in accordance with professional standards of practice. Review of R24's Admission Record, found in the electronic medical record (EMR), revealed the facility admitted R24 on 07/02/2024 with diagnoses that included Parkinson's disease, spondylosis (degeneration of the vertebral column), and spinal stenosis (narrowing of the spaces in the spine) with sciatica (pain along the sciatic nerve). Review of R24's Quarterly Minimum Data Set [MDS], found in R24's EMR, with an Assessment Reference Date (ARD) of 01/28/2025, revealed R24's Brief Interview for Mental Status [BIMS] was not assessed. However, the facility assessed R24's mental status as short and long-term memory problems. Review of R24's Physician Orders, found in R24's EMR, revealed the facility admitted R24 to Hospice (end-of-life) care on 01/16/2025. The physician ordered several pain medications that included: tramadol HCl 50 milligrams (mg), one tablet by mouth, scheduled three times a day for pain/comfort; tramadol HCl 50 mg, one tablet by mouth, every six hours as needed for signs and symptoms of pain; acetaminophen 500 mg, two tablets by mouth at bedtime for chronic pain; Salonpas external pain relief patch 3-10%, apply to lower back topically one time a day for intervertebral disc degeneration and back pain, and diclofenac sodium external gel 1% topically for right hip and sacral pain. Further review revealed nursing staff were required to perform and document monitoring and assessments for R24. This included interviewing and observing for signs and symptoms of pain every shift, monitoring behavior every shift, and checking for non-purposeful facial movements (such as lip puckering, frowning, or irregular eyebrow movement) and non-purposeful irregular body movements. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R24's Comprehensive Care Plan [CCP], undated, revealed the facility care planned the resident as at risk for alteration in comfort and pain. Goals included R24 would be free of any discomfort or adverse side effects from pain medication; R24 would be given the pain medication as ordered, would be monitored, and the effectiveness of the pain medication and all interventions would be documented; and any unrelieved pain or condition change would be reported to the primary care provider. Review of R24's Medication Administration Record [MAR], dated 03/2025, revealed Registered Nurse (RN) 6 documented she administered R24's 9:00 PM medications at 9:21 PM. Scheduled 9:00 PM medications included: acetaminophen 500 mg for pain; Carbidopa-Levodopa 25-100 mg for Parkinson's; trazodone HCl 50 mg for primary insomnia; Depakote sprinkles 125 mg for anxiety and restlessness related to dementia; Salonpas external pain relief patch 3-10% for intervertebral disc degeneration and back pain; diclofenac sodium external gel 1% for right hip and sacral pain; tramadol HCl 50 mg for pain/comfort; and Calmoseptine external ointment 0.44-20.6 % for buttocks/coccyx redness. Continued review of the MAR revealed RN6 documented R24's pain level at 0 (having no pain), during the shift. During a telephone interview with Family (F) 3 on 03/13/2025 at 9:37 AM, she stated she was R24's Power of Attorney (POA). She stated she had some concerns regarding R24's care. F3 stated, up until this point, the staff had generally been good, but her interactions were mostly with the dayshift staff, and she was not familiar with any night shift staff. F3 stated her family reviewed the surveillance camera's video footage every day, and there had not been any instances where the staff did not check on her mother. She stated usually, her mother was checked on regularly throughout the night. F3 expressed concern that no one checked on her mother at all the night before last, and R24 was not given her pain medications. F3 stated R24 was admitted to Hospice to provide end of life care and manage her pain due to Parkinson's disease and severe spinal pain. During an interview with F2 on 03/14/2025 at 3:35 PM, he stated the family placed a surveillance camera in R24's room to monitor her. F2 stated the surveillance camera was designed to record video footage the moment it detected any movement in the room. Furthermore, F2 stated the camera would follow and maintain focus on any activity occurring throughout the room, including R24's movements in bed. F2 stated the surveillance camera operated 24 hours a day, seven days a week, to ensure comprehensive monitoring at all times. He stated staff was aware of the camera as there was a sign located outside of R24's room, which announced video surveillance was in progress. F2 stated, after reviewing the video he discovered that no staff member had entered R24's room from 03/11/2025 at approximately 6:03 PM to 03/12/2025 at 5:45 AM. He stated he was concerned that his mother was not observed, provided care, or administered her 9:00 PM pain medications. The SSA Surveyor attempted a telephone interview with RN6 on 03/13/2025 at 2:27 PM, 2:38 PM and 3:14 PM. A voicemail was left each time to return the SSA Surveyor's call. However, no return call was received. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 03/13/2025 at 11:30 AM, she stated F3 made a compliant to her, on 03/12/2025 in the morning, that her mother had not received care during the night. The DON stated F3 told her she had video surveillance showing R24 was left alone all night. The DON stated she notified the Administrator, and an investigation began. According to the DON, she reviewed R24's MAR and noted that RN6 had documented she had administered R24's 9:00 PM medications, which were given at 9:21 PM. The medications included a scheduled pain medication and an external pain patch. The DON stated when she interviewed RN6, the nurse told her that she had provided the care and medication as documented in the resident's record. The DON stated, upon assessing resident R24, she discovered R24 was not wearing an external pain patch. She stated this was when she realized that RN6 had not provided care to R24 during the evening shift. The DON stated it was her expectation that nursing staff rounded on residents regularly and provided ordered care. She stated nursing staff was required to administer prescribed medication as directed to ensure residents achieved their highest level of functioning, received adequate pain control, and maintained their overall well-being. During an interview with the Interim Administrator on 03/15/2025 at 11:46 AM, she stated she was made aware of the staff's failure to round on R24 by the DON. She stated that she, the DON, and the Nurse Consultant met with R24's family to address their concerns. The Interim Administrator requested to review the video footage, and F3 showed her the complete recording using the monitoring application on her iPhone. She stated she (the Interim Administrator) and Social Services reviewed the video footage with the family present. The Interim Administrator stated the video revealed R24 did not receive medicine or bedside care as documented. The Interim Administrator stated she initiated an investigation and suspended the staff members involved. She stated it was her expectation that clinical staff provided care as ordered to include administration of pain medications. She stated it was important to maintain adequate pain control to promote the residents' well-being. During an interview with the Medical Director on 03/13/2025 at 3:08 PM, he stated he was informed about a video from R24's family, which revealed R24 was not monitored by clinical staff throughout the night. He stated it appeared R24 did not receive any of her evening medications. The Medical Director stated it was his expectation that such occurrences did not happen in the future. He stated, Missing a dose or two is not ideal. I don't believe she was harmed in any way, but it's still not an acceptable situation. I would like to prevent this from happening again. Additionally, he stated it was his expectation that nursing staff provide resident care as ordered to ensure the facility maintained the resident's highest practicable level of functioning and well-being.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001 Based on observation, interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, and review of the facility's policies, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 33 sampled Residents (R) 8, R18, and R20. 1. Observation and interview on 03/11/2025 revealed State Trained Nurse Aide (STNA) 11 did not put on personal protective equipment (PPE) before providing care for R20's who was under contact isolation precautions. Additionally, STNA11 failed to perform hand hygiene before entering or after exiting the room. 2. Observation and interview on 03/11/2025 revealed that a Hospice Certified Nursing Assistant (CNA) failed to remove her gloves after providing care for R18, who was under enhanced barrier precautions, before exiting the room. The CNA removed her contaminated gloves in the hallway and placed them on top of the PPE container. The CNA failed to perform hand hygiene before opening the drawers to the PPE container. 3. Observation and interview on 03/12/2025 revealed Licensed Practical Nurse (LPN) 3 failed to implement infection control practices during R24's medication administration preparation, including the use of gloves when touching medication. Additionally, LPN3 placed R8's hydroxyzine oral tablet directly on top of the medication cart without a barrier. The findings include: Review of the facility's policy titled, Infection Prevention and Control Program [IPCP], undated, revealed the facility maintained an infection prevention and control program designed to provide a safe sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections per accepted national standards and guidelines. All staff are responsible for adhering to IPCP policies, including the use of PPE and hand hygiene according to established procedures. Review of the Centers' for Disease Control and Prevention (CDC) Guidelines, titled, Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated 04/12/2024, revealed hand hygiene should be performed immediately before providing resident care and after care is completed. Ensure proper selection and use of PPE based on the nature of the patient interaction and potential for exposure to blood, body fluids and/or infectious materials. Review of the facility's policy titled Transmission-Based Precautions [TBP], undated, revealed staff will implement TBP precautions alongside standard precautions for residents known or suspected to be infected with certain agents to prevent transmission. Review of the facility's policy titled Enhanced Barrier Precautions [EBP], undated, revealed staff will implement EBP precautions to include targeted gown and glove use during high contact care activities for residents known or suspected to be infected with multi drug-resistant organisms (MDRO). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Medication Administration, undated, revealed while preparing medication for administration, nursing staff should not touch the medication with bare hands. 1. Review of an Admission Record, found in R20's EMR, revealed the facility admitted R20 on 05/02/2023 with diagnoses that included Parkinson's disease, spondylosis (degeneration of the vertebral column) and urinary tract infections (UTI) related to Escherichia coli (E. coli, a bacterial infection). Review of R20's Quarterly Minimum Data Set (MDS), found in the electronic medical records (EMR), with an Assessment Reference Date (ARD) of 12/31/2024, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated the resident was cognitively intact. Review of the CCP, dated 01/07/2025, revealed the facility care planned R20 for a history of recurrent UTIs related to E coli. Goals included R20's infection would be resolved without complications. Interventions included placing R20 in contact precautions. Review of the Physician's Order Summary Report, found in R20's EMR, revealed the facility placed R20 on contact isolation precautions on 02/28/2025 for an urinary tract infection caused by Escherichia coli (bacteria). During an observation on the St. [NAME] Unit on 03/11/2025 at 11:45 AM, STNA11 was observed taking a lunch tray into R20's room, a contact isolation room. STNA11 transferred R20 from her bed to her recliner and set up her lunch tray. The STNA left the room and did not perform hand hygiene. During an interview with STNA11 on 03/11/2025 at 12:05 PM, she stated that she was unaware that R20 was under contact precautions and did not notice the CDC signage on the door. She stated that she forgot to perform hand hygiene. STNA11 stated that she had received education on infection control through her staffing agency prior to her assignment at the facility. She stated that the facility's policy required staff to wear a gown and gloves at all times while in a contact precaution room and to perform hand hygiene both before and after providing care to protect both the resident and staff from the spread of infection. 2. Review of the Admission Record, found in R18's EMR, revealed the facility admitted R18 on 01/07/2025 with diagnoses that included end-stage renal disease (ESRD), anemia, and malnutrition. Review of a Quarterly MDS found in R18's EMR, with an ARD of 01/13/2025, revealed a BIMS score of 07 out of 15, which indicated the resident was severely cognitively impaired. During an observation of the St. [NAME] Unit on 03/11/2025 at 12:46 PM, a Hospice CNA was observed to exit R18's room, an EBP room, wearing gloves. Further observation revealed the CNA removed her contaminated gloves in the hallway and placed them on top of the PPE container. She did not perform hand hygiene before opening the drawers to the PPE container to pull additional PPE out of the drawers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Hospice CNA on 03/11/2025 at 12:46 PM, she stated that she was not an employee of the facility. She stated she worked for Hospice and was visiting R18. She stated she provided care to R18 and was coming out of the room to get a gown. She stated she forgot to remove her gloves and perform hand hygiene before exiting the room. She stated she had received infection control training as part of her CNA curriculum. The CNA stated it was important to follow infection control procedures to prevent the spread of disease. 3. Review of the Admission Record, found in R8's EMR, revealed the facility admitted R8 on 08/01/2022 with diagnoses that included dementia, anxiety, and atherosclerotic heart disease. Review of the Quarterly MDS found in R8's EMR, with an ARD of 02/11/2025, revealed a BIMS score of 11 out of 15, which indicated the resident was moderately impaired. Review of the CCP, dated 03/03/2025, revealed the facility care planned R8 as at risk for behaviors associated with cognitive decline. Interventions initiated on 08/03/2022, included to give medications as ordered. Review of Physician Orders, found in R8's EMR, dated 02/25/2025, revealed the physician ordered hydroxyzine HCL, 25 milligram (mg) oral tablet, one tablet by mouth every six hours as needed for anxiety. Observation on the St. [NAME] Unit on 03/12/2025 at 1:00 PM, revealed LPN3 touching R8's hydroxyzine 25 mg capsule with ungloved hands. She took the capsule out of the medication pack and placed it directly on top of the medication cart without first placing the pill in a cup. During an interview with LPN3 on 03/12/2025 at 1:00 PM, she stated that R8's medications were to be administered in crushed form, and she was in the process of preparing the medications. She stated she should not have placed the pill on the medication cart as it could have been contaminated. LPN3 stated that following infection control procedures was important to prevent the spread of infection and cross-contamination. Further interview revealed that LPN3 was unaware of the requirement to wear gloves when handling medications. She stated she had received training on infection control and medication administration upon hiring; however, she had not been instructed to use gloves when touching medications with her bare hands. During an interview with the Infection Preventionist/Staff Development Coordinator (IP/SDC) on 03/11/2025 at 1:50 PM, she stated that the facility adhered to the CDC's guidelines and followed the facility's infection prevention and control policies (IPCP). According to the IP/SDC, all staff members, including those from the agency, received education related to IPCP. She stated all staff were trained upon hire in the use of PPE and isolation precautions, including contact precautions and EBP. The IP/SDC stated the facility's vendors, including Hospice staff should follow the CDC guidelines for infection control. She stated if they were unsure, they have been advised to consult with a staff member. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During continued interview, on 03/11/2025 at 1:50 PM, the IP/SDC stated she was unsure why some staff did not follow isolation precautions despite having been educated on the importance of observing the signs posted on doors. She stated each TBP/EBP room was equipped with a CDC sign and a yellow stop sign to indicate that PPE was required. Additionally, each precaution room has an individual PPE cart located outside the door. She stated gowns and gloves must be worn whenever staff entered a contact precaution room, or an EBP room if they were providing high-level care. She stated it was her expectation that all staff adhere to the facility's policies and procedures to help prevent the spread of infections. She stated it was important for the health and safety of the residents. During an interview with the Director of Nursing (DON) on 03/13/2025 at 11:30 AM, she stated all staff received infection control training upon hire and periodically throughout the year. The DON stated staff was updated on current CDC guidelines when they changed. She stated it was her expectation that all staff maintained IPCP guidelines at all times to decrease the potential spread of infection. During an interview with the Interim Administrator on 03/15/2025 at 11:46 AM, she stated it was her expectation that staff followed the facility's infection control policies to prevent the spread of infection to residents and staff. During a telephone interview with the Medical Director on 03/13/2025 at 3:08 PM, he stated it was his expectation for staff to follow the facility's policy to help prevent the spread of infections. The Medical Director stated it was important to prevent the spread of disease and infection and for the health and safety of the residents.