STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215114	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Corsica Hills LLC	205 Armstrong Street Centreville, MD 21617

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 37296 Based on record review and interview it was determined that the facility staff failed to allow a resident the right to have a dignified existence by failing to be listening to the Resident during his/her care (Resident #911). This was evident for 1 of 73 residents reviewed during a complaint and recertification survey. The findings include: A review of the facility reported incident #MD00187781 on 7/10/24 at 10:30 AM revealed Resident #911 had reported an allegation of abuse on 1/14/23, because the GNA #148 turned me, and I yelled out in pain and asked her to stop and the GNA #148 continued working. An interview by the Director of Nursing on 1/14/23 revealed that Resident #911 felt that the GNA was not listening to me I instructed her how I like my care done and she would not listen. On 1/14/23 The roommate, Resident #929 called the manager to report that GNA #148 was mistreating my roommate, and he/she was not listening to him/her during his/her care. Resident #911 was no longer at the facility for an interview. On 7/10/24 at 12:30 PM, an interview with roommate Resident #929 revealed that he/she does not remember the incident. GNA #148 was placed on administrative leave on 1/14/23 and at the completion of the investigation GNA #148 was placed on a do not return list with the Agency. On 7/10/24 at 2:00 PM the Director of Nursing was made aware of the findings.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 40927 Based on record review and staff interview it was determined that the facility failed to ensure that residents and/or resident representatives were afforded the right to file a grievance and receive a response regarding the action taken by the facility (Resident #906). This was evident for 1 of 3 residents reviewed during a recertification and complaint survey. The findings include: The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. A review of the complaint #MD00186681 on 7/8/24 at 10:15 AM revealed that there were care concerns regarding Resident #908. The concerns included but were not limited to a nurse dispensing medications to four people at one time, staffing on the memory care unit was not consistent, the resident not being changed, wearing dirty clothing, and having body odor. An interview with the complainant on 7/8/24 at 10:31 AM revealed that the complainant had spoken to the Memory Support Program Director (MSPD), Director of Nursing (DON), and the Administrator on several occasions regarding the concerns. On 7/11/24 the DON was asked to provide any grievances that had been reported for Resident #908. The DON reported back on 7/12/24 that they did not have any records of grievance being filed. The Administrator was out of the facility at the time it was requested. A medical record review for Resident #906 on 7/12/24 at 8:32 AM revealed an MDS with an assessment reference date of 12/9/22 that documented the resident had severe cognitive impairment and relied on staff for activities of daily living (bathing, personal hygiene, toileting, getting in and out of bed). Review of the facility's Resident and Family Grievances policy revealed it had not been implemented until after these complaints on 4/5/23. An interview with the MSPD on 7/12/24 at 9:11 AM revealed that she had spoken with the resident's family frequently about care concerns. She stated that she had not completed a grievance form for the concerns. She stated that if she was able to address the issue immediately, she does not complete a grievance form. She reported that she remembered having a meeting with a family member and other administrative staff but could not recall who had attended. When asked if the family member's concerns required a meeting with administration would this not be considered a grievance, she replied that it would. The DON was made aware of the concerns on 7/12/24 at 11:18 AM and agreed that the grievance process should have been followed.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 35690 Based on interviews, record review, and facility policy review, the facility failed to ensure that grievances were promptly resolved and ensure all written grievance decisions included the date of the grievance, a summary of the resident's grievance, a summary of the findings, a statement as to whether the grievance was confirmed or not confirmed, corrective action taken as a result of the grievance, and the date the decision was issued. Specifically, the facility failed to ensure grievances voiced by residents during resident council were documented, investigated, resolved, and followed up on by the facility of 105 residents. This failure had the potential to cause further grievances to be unresolved for residents throughout the facility. Findings include: Review of the facility's policy titled, Resident Council Meetings, dated 04/25/23 and provided by the facility, revealed The facility shall act upon concerns and recommendations of the Council, make attempts to accommodate recommendations to the extent practicable, and communicate its decision to the Council. Review of the Resident Council Minutes provided by the facility, dated 11/27/23, revealed seven staff attended, including the Environmental Services Director and the Director of Nursing (DON). The Resident Council Minutes did not indicate the names of residents that attended. The concerns section of the Resident Council Minutes revealed aides have attitudes. In the Laundry section of the Resident Council Minutes revealed missing clothing, black clothing coming back brown. There was no indication in the Resident Council Minutes that these concerns were addressed or discussed. Review of the Resident Council Minutes provided by the facility, dated 01/18/24, revealed six staff attended, including the Environmental Services Director. The Resident Council Minutes did not indicate the names of residents that attended. The concerns section of the Resident Council Minutes revealed being put in bed with clothes on, showers not given. The Laundry section of the Resident Council Minutes revealed clothes coming out a different color. There was no indication on the Resident Council Minutes that this concern was addressed or discussed. Review of the Resident Council Minutes provided by the facility, dated 2/15/24, revealed staff did not attend the meeting. Resident Council Minutes did not indicate the names of residents that attended. The concerns section of the Resident Council Minutes revealed Showers, no name badge, call light not answered timely, not being changed. There was no indication on the Resident Council Minutes that these concerns were addressed or discussed. Review of the Resident Council Minutes provided by the facility, dated 5/23/24, revealed five staff attended, including the DON. The Resident Council Minutes did not indicate the names of residents that attended. The nursing concerns section of the Resident Council Minutes revealed Aides need to introduce themselves. There was no indication on the Resident Council Minutes that this concern was addressed or discussed. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident Council Minutes provided by the facility, dated 6/20/24, revealed two staff attended. The Resident Council Minutes did not indicate the names of the residents that attended. The concerns section of the Resident Council Minutes Showers not being offered, Aides need to introduce themselves were nursing concerns from residents. There was no indication on the Resident Council Minutes that these concerns were addressed or discussed. During a resident group meeting held on 07/09/24 at 10:59 AM, Resident (R) 30) stated she had multiple black pants go to laundry and when they were returned, they were brown. She stated staff have never talked with her about this. Other residents agreed they had reported concerns about their laundry and had not received follow-up. Residents who attended also stated they were often uncertain who the aides were during the weekends and wished they would introduce themselves when they entered their room. Residents stated they were uncertain how to file a grievance. During an interview on 07/09/24 at 3:15 PM, the DON stated she had completed training for aides regarding introducing themselves when they entered a resident's room, showers, call lights, and their attitudes. She stated she had not provided education to all staff. The DON stated if a resident had personal items missing or items that were ruined in the laundry, a search should have been completed by staff and the items should have been replaced. She stated there should be follow-up with residents for all concerns. During an interview on 07/11/24 at 9:43 AM, the Activities Director (AD) stated the current process was if a department manager attended the resident council meeting and a resident voiced a concern related to the specific department, the department manager would immediately address the concern. She stated she would document the concern in the Resident Council Minutes. The AD stated there was no follow-up documentation on whether the situation was addressed or if there was a resolution. She stated the Administrator would always receive a copy of the Resident Council Minutes. Neither the AD nor the DON provided any follow-up documentation for the voiced concerns documented in the Resident Council Minutes.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40927 Based on medical record review and interview, and facility policy review, the facility staff failed to recognize abuse and take action to prevent abuse to residents (Resident #921, #919, #77, #905, #912, #916, #927, #2, #17, #66, #303) reviewed for abuse for 11 out of a total sample of 21 residents. These actions resulted in the finding of an Immediate Jeopardy which was identified on 7/10/24 at 4:30 PM. An IJ summary tool was provided to the facility on [DATE] at 4:48 PM. The facility submitted a draft of their plan to remove the immediacy on 7/10/24 at 6:30 PM and it was not accepted. The facility submitted a 2nd draft of their plan to remove the immediacy on 7/10/24 at 7:36 PM and it was not accepted. The facility submitted a 3rd plan on 7/10/24 at 8:30 PM and it was accepted by the state agency at 8:40 PM. After removal of the immediacy, the deficient practice remained with a scope and severity of H. The Immediate Jeopardy was removed on 7/12/24 at 9:30 AM after on-site confirmation of the completion of the facility's plan of removal. The findings include: The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. Brief Interview of Mental Status (BIMS) is a standardized test used to get a quick snapshot of the cognitive function and is a required screening tool used in nursing homes to assess cognition. A score of 13-15 points indicates an intact cognition, 8-12 points indicates moderately impaired cognition, and 0-7 points indicates severely impaired cognition. 1) A medical record review for Resident #921 on 7/10/24 at 6:51 PM revealed a MDS with an assessment reference date (ARD) of 2/4/24 that documented the resident had moderately impaired cognition, suffered from delusions, and exhibited physical and verbal behavior symptoms towards others. The resident wandered. Review of a physician's progress note dated 2/13/24 revealed the resident had the following, but not limited to diagnoses of dementia with behavioral disturbances. The resident had a care plan for aggressive behaviors which included an intervention to walk away and attempt care later if the resident becomes aggressive. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 7/10/24 at 7:15 PM a review of the facility's investigation file for self-reported incident #MD00203605 revealed a witness statement from geriatric nursing assistant (GNA) #130. The statement read that on 3/14/24 at approximately 6:00 AM, she and Registered Nurse (RN) #152 were attempting to move Resident #921 from one wheelchair to another. The resident was sitting in another resident's wheelchair. According to the statement, RN #152 was cussing at the resident telling him/her to sit down. The resident was agitated and became combative. The resident hit the nurse in the mouth. RN #152 responded by cursing and calling the resident names and slapped him/her on the head multiple times. GNA #130 wrote in her statement that she transferred Resident #921 to a regular chair, offered the resident something to eat and eventually the resident calmed down. A timeline of the events revealed that GNA #130 had not reported the incident to the Director of Nursing (DON) until 3/14/24 at 7:23 AM. This was 1 hour and 23 minutes that RN #152 continued to have access to vulnerable residents in the building. Further review revealed RN #152 was terminated and then referred to her state licensing board for review. A copy of Resident #921's order for a psychiatric consult was included. The Certified Registered Nurse Practitioner's (CRNP) note dated 3/18/24 was included, however it stated that the resident was being seen for hitting a nurse. There was no mention of the abuse endured by the resident. A review of RN #152's employee file revealed she last had dementia, behavioral health, and communication training in January of 2023. The training was required to be completed annually. An interview with Nurse Practice Educator on 7/11/24 at 11:54 AM revealed she had been hired in August of 2023. She reported that she was aware staff were due their annual trainings starting in January of 2023, and she was attempting to get staff to complete their required training. When asked the reason RN #152's training requirements were not up-to-date, she had no rationale to offer. An interview with the psychiatric CRNP on 7/11/24 at 2:44 PM revealed that she would have included in her note that the resident had been abused by a nurse had she been aware of the situation. Furthermore, she stated she has been seeing Resident #921 for quite a while and she would have seen the resident the same day of the incident of abuse if she had been aware. The DON was interviewed regarding the incident on 7/11/24 at 1:23 PM. She reported that she talked to the GNA about reporting to her immediately if she observed or received an allegation of abuse. When asked about the psychosocial/emotional support of the resident following abuse, she reported that the facility will refer them to psychiatric services. She reported that she and the Unit Managers will review the psychiatric notes. She stated that she was not aware that the visit psychiatric services had with Resident #921 on 7/18/24, had not addressed the abuse the resident endured. She reported that she was sure that the CRNP was aware of the incident for which she was seeing Resident #921. Furthermore, she was unable to provide a rationale for the resident waiting 4 days to be seen for psychosocial/emotional support. The concerns were reviewed 07/11/2024 3:33 PM with the Regional [NAME] President (RVP), Regional Clinical Consultant (RCC), and the DON. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2) A medical record review for Resident #919 on 7/9/24 at 11:50 AM revealed a physical therapy evaluation dated 1/17/24 that documented the resident needed partial/moderate assistance to go from a sitting position to a standing position and to transfer from one surface to another (such as the bed to the chair). However, to move around in bed the resident required substantial/maximal assistance. A physician progress note, dated 1/18/24, read that Resident #919 was admitted to the facility for rehabilitation services following an acute care admission. The resident was diagnosed with the following but not limited to: an acute upper right arm fracture and weakness in the upper and lower extremities. It was recommended that the resident remain NWB (non-weight bearing) with the right arm. Review of the MDS (minimum data set) with the assessment reference date of 1/22/24 revealed the resident had moderate impairment of cognition (the ability to think and process). Review of section J revealed the facility failed to do an assessment of the resident's pain. A review of the physician's orders revealed that the resident was non-weight-bearing for the right arm and was ordered to wear a sling upon admission. On 7/9/24 at 11:26 AM a review of the facility's investigation file revealed a written statement dated 2/26/24 from Registered Nurse (RN) #116 that read that at 7:45 PM on 2/26/24, Resident #919 reported to her that Geriatric Nursing Assistant (GNA) #140 had been rough with care and s/he was scared. RN #116 reported that the resident stated they had not been able to sleep for fear that GNA #140 was taking care of other residents. A handwritten interview (that had no date/time or who had conducted the interview, but later determined it was the Administrator) with GNA #81 revealed that she reported she had heard the resident yelling and went over to the resident's room. The resident stated that s/he wanted GNA #81 to stay with him/her because s/he thought GNA #140 was trying to kill him/her. A second handwritten interview that was in the same handwriting and green ink as the previous interview, however it had no name of the interviewee. The person being interviewed (which was later thought to be GNA #140 by the Director of Nursing) The interviewee had reported the resident had soiled themselves and the GNA was unable to change the bedding because the resident had difficulty moving. When asked if the resident told them to be careful with their arm, the interviewee confirmed that the resident had said that. The interviewee confirmed that the resident was yelling for help and that GNA #81 had responded. Facility staff failed to interview any other staff who may have had knowledge of the care provided by GNA #140 and to interview other residents who were within the GNA's care. A review of the final investigation report revealed that the facility determined that allegation of abuse was inconclusive. On 7/9/24 at 3:34 PM an interview with GNA #140, the accused GNA, she stated she could not recall the incident with Resident #919. An interview with RN #61 on 7/10/2024 at 10:19 AM, revealed that Resident #919 was a non-weight bearing status for the right arm. She stated that the resident should not be rolled onto his/her right side due to the broken arm because it would cause the resident pain. She reported that the resident wore the arm sling as ordered. When asked if a GNA came in to provide incontinence care would she expect them to roll the resident on the right side with a broken arm and she stated that she would not. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with GNA #81 on 7/10/2024 at 10:46 AM revealed she had been in the next room providing care to another resident on 2/26/24, when she heard Resident #919 yelling help me. She reported that she went over to the resident's room. When she walked in the resident was laying on his/her right side She stated the resident asked her to stay with her and asked that GNA #140 leave the room. She reported that she told GNA #140 that she would continue the care and GNA #140 left the room. When finished, GNA #81 reported the incident to the nurse assigned to the resident. During a subsequent interview with GNA #81 on 7/10/2024 at 11:15 AM she was asked how she provided care to the resident that day. She reported that the resident can stand and pivot, so she put the resident in a chair while she changed the bedding. Then she stood the resident to remove the brief and wash the resident. When asked again about how the resident had been lying in bed when she first walked in, she confirmed the resident was lying on their right side with the right arm under their body. An interview with RN #116 on 7/10/24 at 1:37 PM, via a phone call, revealed that the GNA #81 had told her that the resident wanted to see her. When she went in Resident #919 reported that GNA #140 had been rough with him/her during care. The resident reported fearing the GNA #140. RN #116 stated that she called the Director of Nursing (DON) to report the incident. She stated that she asked GNA #140 about the incident and the GNA reported that she had not meant to be rough with the resident, but the resident was hard to move so she had to push harder. RN #116 reported that after talking with GNA #140 the GNA was asked to leave the facility pending investigation. The concerns were reviewed 07/10/2024 4:30 PM with the Regional Clinical Consultant (RCC), and the DON. 36461 3) Review of a facility's policy titled, Compliance with Reporting Allegations of Abuse/ Neglect/ Exploitation, dated 03/22/23, indicated .It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment .Abuse .The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include .certain resident to resident altercations .Physical Abuse which includes hitting, slapping, pinching, kicking . 1. Review of R77's undated Admission Record, located in the resident's electronic medical record (EMR) under the profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Alzheimer's disease, anxiety, and depression. Review of R77's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/23/24 revealed a Brief Interview for Mental Status (BIMS) of three out of 15, which indicated the resident was severely cognitively impaired. Further review of the MDS with the ARD of 05/23/24 revealed R77 hallucinated and could be verbally aggressive during care but did not have refusals of care. Review of R77's EMR care plan, located under the care plan tab and dated 01/20/23, revealed the following focus area of .[R77] can be combative/resistant with hands on care . by pushing away at staff during care and with the intervention, .Make Resident [R77] aware of each step of the process of care before and during the care process. If resident resists with activities of daily living (ADLs), reassure resident, leave, and return 5-10 minutes later and try again . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a facility reported incident (FRI) with an incident dated 05/12/24 at 10:25 PM, Geriatric Nurse Aide (GNA) 139 reported .while caring for another resident, she heard this resident [R77] hollering out and went to check on [R77]. [GNA139] stated she heard [GNA138] reply to [R77] .shut up . in response to [R77's] non-sensical verbalizations. [GNA139] entered [R77's] room and [R77] was provided care by [GNA138]. [GNA139] educated [GNA138] on how to provide care while R77 is resistive to care. While in [R77's] room assisting [GNA138], [R77] stated to [GNA139] he [GNA138] is hurting me, (slapping his knee) and he punched me here (on his right thigh) . Continued review of the facility investigation revealed GNA139 failed to have GNA138 removed from providing care to R77, failed to report the allegation of physical abuse to the nurse on shift at the time of the incident and left a handwritten note for the Director of Nursing (DON) under her office door. The DON found the note on 05/13/24 at approximately 10:00 AM. During an interview on 07/10/24 at 1:00 PM, the DON stated GNA138 and GNA139 were both .agency staff . and they have not returned to the facility since the 05/12/24 incident. The DON also stated GNA138 was immediately placed on .administrative leave . while the investigation was in process. The DON stated GNA138's agency was notified of the allegation, and that he would not be allowed back to the facility. The DON further stated GNA139 was .educated . by the DON and Administrator regarding the facility policy and reporting any abuse concerns immediately to the DON or Administrator. During an interview on 07/10/24 at 1:30 PM, the DON verified that GNA138 worked .05/12/24 on the 3:00 PM to 11:00 PM shift on the memory care unit and then the 11:00 PM to 7:00 AM shift on the rehab unit . 30428 4) Documentation requested included any other change in conditions that occurred with Resident #913 after the reported incident on 11/6/22. Review on 7/12/24 at 9:28 AM revealed that on 12/22/22 Resident #913 was observed rubbing another resident's stomach in the common area. Resident #913 indicated I was pulling [resident's] shirt down. The DON at the time documented that the victim was moved to the nurse's station. The change in condition note however, was not completed until 12/30/22 and the interventions for Resident #913 that included placing him/her on a 1:1 was not implemented until 12/28/22 although the incident was reported to occur on 12/22/22 with the previous occurrence on 11/6/22 with no noted interventions. Resident #913 was seen by the facility psychiatrist on 12/30/22. The psychiatric note documented that s/he was evaluated 'again' for concerns with sexual impulse control after another patient reported concern though [Resident #913] reported no interactions with residents of the opposite sex and verbalized that s/he is supposed to be 6 feet away from the opposite sex. The only intervention recommended by the psychiatrist was for melatonin for sleep and to continue to monitor for worsening symptoms. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	According to physician orders and the medication administration record (MAR) Resident #913 remained on 1:1 from 12/30/22 through his/her discharge on 2/2024. This was verified on the physician orders and verified on the MAR for each shift according to a record review completed on 7/12/24 at 9:40 AM. However, on 7/21/23 Resident #913 was found in the room of Resident #912, alleged victim #3. According to this facility report Resident #912's diaper was down exposing the private area. Resident #913 was noted standing overtop of Resident #912 with [his/her] hands on Resident #912's incontinence product that was open. Resident #913 was seen looking in Resident #912's private area. A staff member interrupted and redirected Resident #913 out of the room. When Resident #913 was asked what s/he was doing, s/he stated that they were 'helping Resident #912' Resident #912 who had a BIMS of 4 assessed on 5/7/23 which indicated severe cognitive impairment and had a documented need for assistance with personal care. According to the facility reported incident related to the occurrence on 7/21/23 the facility interventions included to update the care plan for both residents. A review of the care plans on 7/12/24 revealed that there was no update or change for Resident #913. Intervention #2 included to move Resident #913 to a private room. A review of Resident #913's census report revealed that this did not occur. A concurrent review of Resident #913's MAR revealed that on the day of the 7/21/23 incident staff did sign off that 1:1 was in place. However, a closer review revealed that on the night shift of 7/22/22, 1 day later, staff signed off a '7, see nursing progress notes.' This was also on 7/13, 7/14, 7/15, 7/25. According to the corresponding progress notes the nurse stated, 'no one on one provided at night.' On 7/12/24 at 10:55 AM surveyor reviewed the concerns related to Resident #913 and the ongoing failed implementation of interventions related to his/her sexual preoccupation with residents of the opposite sex including the delay of the implementation of the 1:1 order from 12/28/22 and failure of the staff to follow through, monitor and implement the order to prevent additional occurrences. This was reviewed again with the facility Regional Clinical Consultant and Regional [NAME] President at exit on 7/12/24. At this time the Regional Clinical Consultant was asked again what happened and she stated that after the 7/21/23 incident they really 'buckled' down on the 1:1 monitoring with Resident #913 to ensure there were no more occurrences. 5) Review on 7/10/24 of a facility reported incident revealed that on 9/5/23 there was an allegation that while on the dementia unit, in the dining room, during a visit with their respective family identified as Resident #70, the visiting family member yelled at Resident #926 while pointing in his/her face, stating I've already told you to stop it multiple times. If you keep reaching, I'm going to give you a hand smack. GNA #76 intervened and moved Resident #926 away from that visiting family member and then proceeded to escort Resident #70 out of the dining room to their respective room. Upon their arrival to the residents' room or soon thereafter, Resident #70's roommate, Resident #916, who resided in the 'A' bed, was there. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	According to the GNA statement in the investigation packet, provided to the survey team, that was read and verified with GNA #76 on 7/10/24 at 11:11 AM, she did take Resident #70 out of the dining room and hoped that the family would follow. She also did state when asked, that she did leave the room for an unknown amount of time to go and get supplies. This left the family member and both residents in the room alone for an unknown amount of time. Interview concurrently on 7/10/24 at 11:11AM with the Memory Support Program Director, staff # 142 who also confirmed her statements from the incident. She stated that she was alerted to the incident that occurred in the dining room by staff #76. As she went to the resident's room, she could then hear an argument occurring between the family member and Resident #916, who resides in bed 'A.' At this time there was another GNA in the room in addition to staff #76 and staff #142. The other GNA stated that the family accused Resident #916 of taking Resident #70's items and wanted to go through her family members [resident #70's] personal items to confirm. An argument ensued between the family member and Resident #916. The family member continued to rant and argue with the resident and staff #142 who asked the family to calm down and notified the family of her inappropriate behavior, tone and body language. Staff #142 stated that there was another aide that was with Resident #916 that stayed with him/her at this time attempting to keep him/her content. However, as in the statement the family refused to leave, was argumentative and ranting and arguing. It was not until the Administrator and the DON arrived that they were able to get the family member to leave who continued to yell through the facility. A care plan meeting was held 1 week later along with further dementia care education with the family member. The family member was eventually allowed to visit in a separate area with her family member, Resident #70 away from other residents, unsupervised. A care plan was implemented at that time regarding this intervention. The DON was interviewed on 7/10/24 at 11:42 AM and asked about that care plan and why it was no longer in place as it was discontinued on 3/8/24. She stated that it was not needed anymore, and she believed that there was a follow up care plan meeting about it and would follow up. The DON was also asked if there had been other incidents with this identified family member. There was no follow-up information provided prior to exit. It was reported to the survey team that the family member was ill and had not been in for a while. Further review on 7/10/24 of the care plans for Resident #70 revealed that there was a care plan initiated a month after admission that the resident had historical episodes related to suicidal ideations and verbal expressions when frustrated and or feelings of hopelessness. This was updated to note that it occurred when this identified family member visits. Staff #142 who was interviewed on 7/10/24 at 11:11 AM was questioned about this. She stated that they, the staff, know residents get teary when family leave and it's a process, however, they were noting that Resident #70 was more upset and seemed to have more concerns after that family member had visited. There were no interventions related to that family member to prevent Resident #70 from any further distress. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6) Review of the facility reported incident on 7/11/24 at 12:02 PM that occurred on 11/9/22 revealed an allegation that GNA #151 allegedly pushed Resident #905 during care, hurting and scaring him/her and their roommate, Resident #927. After the incident both residents reported to the DON the next day that they were scared but at that time felt safe in the facility. Interventions reported to have been implemented to the OHCQ were not completed, including psychiatric, social work or emotional support for either resident and neither care plan was updated related to the incident. Resident #927 was only referred to psychiatry on 11/15/22 after the facility staff became concerned of his/her change in behavior after they had witnessed the incident between Resident #905 and GNA #151. In addition, no final report of the investigation was submitted to the OHCQ. A review of the employee file on 7/11/24 for staff GNA # 151 revealed that just 3 weeks prior she was written up and placed on suspension for unprofessional conduct. This was written as a 'final warning.' Corrective measures included customer service training to ensure a more positive approach when providing care and speaking with residents and staff. She also had a write up on 1/9/22 related to unprofessional conduct, 'observed by a coworker using profanity, being disrespectful in an unprofessional conduct. GNA #151 at this time was to complete customer service training with the then DON and follow code of conduct per handbook. For this allegation of abuse GNA #151 was given a 'last final warning,' was suspended during the investigation and upon return continued to work at this facility through 4/2023 34484 7) The facility failed to remove Staff #137 after an allegation of abuse and continued to allow Staff #137 to participate in Resident #2&#39's care. Review of a facility reported incident on 7/09/24 revealed Resident #2 reported on 1/4/22 Staff #137 was rough with care. Review of Resident #2 ' s medical record on 7/10/24 revealed the Resident was admitted to the facility with a diagnosis of quadriplegia, complete. Complete quadriplegia is characterized by a complete loss of control over the arms and legs. This is a near-total form of paralysis where a person is wholly unable to move their extremities aside from their head. Interview of Resident #2 on 7/9/24 at 8:45 AM, Resident #2 stated in January 2022 he/she was in the shower room with Staff #137 and Staff #77 and asked the staff to stop showering him/her because of the pain. Resident #2 stated Staff #77 stopped but Staff #137 continued to wash his/her hair. Resident #2 states he/she has rods in his/her neck and Staff #137 was too rough and caused him/her pain. Resident #2 stated he/she spit on Staff #137 until they stopped. Resident #2 stated he/she started counseling because of the incident and is still upset about it to this day. Resident stated with other the traumas in his/her life of his/her friend being shot, his/her accident that caused the paralysis over [AGE] years ago and being admitted to a nursing home, this is the first time he/she felt like he/she needed to get counseling. Interview with Staff #77 on 7/9/24 at 4:28 PM, Staff #77 stated when Resident #2 began yelling you are hurting me, she stopped care immediately but Staff #137 continued to rinse Resident #2's hair with a shower nozzle until I told her to get out. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Further review of Resident #2 ' s medical record revealed Staff #137 ' s nurse note on 1/5/22 at 3:03 PM, Staff #137 stated at 2:00 PM this writer and A/B Unit manager (Staff #77) assisted resident to obtain a shower. This writer and Staff #77 transferred resident via hoyer lift to shower bed without complication. At no point did the resident verbally state he/she did not want this writer in his/her room or resident did not want this writer to assist resident in shower, this writer and Staff #77 entered the shower room and directed shower bed into the stall with feet first and head at the opening of the shower stall. This writer turned water on and allowed water to warm up. Resident asked this writer to place water on him so he/she could feel the temperature. This writer placed water on the resident ' s right leg. Resident stated, Of course you put it on my leg where I can ' t feel! This writer asked resident where resident would like water placed? Resident stated, Put it on my shoulder. This writer placed water on Resident ' s right shoulder. Resident stated, That ' s fine start with my head, one do my hair, and one wash my body. This writer wet resident hair and placed shampoo in hair, during this time Staff #77 wet washcloth on resident upper body, resident screamed I ' m hypersensitive! Staff #77 then removed all hands from resident. Staff #77 then lightly placed washcloth on resident abdomen. Resident then screamed get the f___ off of me! Staff #77 then put washcloth down and stepped away. This writer began to rinse shampoo out of resident hair. This writer never placed hands on resident during the rinsing process. Resident then began screaming get the f___ off me you b___h Resident then began to spit at this writer and Staff #77. This writer showed resident both hands and stated, my hands are right here, I am not touching you, I was only trying to rinse the shampoo out of your hair so it doesn ' t run in your eyes. Resident then began spitting again screaming I ' m calling the cops and filing charges get the F___ out of here you B___h! This writer turned off the water and stepped away leaving the shower room to go get help. Further review of Resident #2 ' s medical record on 7/10/24 revealed a nurse' s note on 1/4/22 at 4:25 PM that stated, Resident was heard by this RN yelling from the shower room on C wing. Staff #137 came out of the shower and reported the resident had spit in her face. Resident reports to this RN that Staff #137 was rough with him/her while washing his/her hair. This RN and a geriatric nursing assistant (GNA) assisted resident with the rest of his/her shower and put him/her back to bed. Resident wanted to call the police to report Staff #137 for being rough during his/her shower. Further review of Resident #2 ' s medical record revealed Staff #137 ' s nurse ' s note on 1/5/22 at 10:49 AM that stated, This writer informed Wound Nurse Practitioner (Staff #141) that I was not able to enter Resident room. This writer asked GNA to assist Staff #141 in holding resident over so Staff #141 could measure resident sacral wound. This writer never entered resident room and stood in the doorway still remaining in the hallway so this writer could document wound measurements as Staff #141 stated them verbally. As soon as resident heard my voice resident started yelling Get out of my F___ing room! This writer informed resident in fact was not in his/her room and was still standing in the hallway. Resident screamed again Get the F___ out of my room! Staff #141 stated calm down she is only documenting out in the hallway. Resident stated Then shut my f___ing door! This writer shut resident door and remained in hallway with Staff #141 and GNA in resident room. Review of the facility investigation on 7/10/24 revealed Staff #141 wrote, went to see patient today for wound rounds Staff #137 assisted by standing outside the room to write down measurements. Resident #2 heard Staff #137 outside the room and stated, "get her out of my room" Staff #137 proceeded to say that she was not in the room. Resident #2 shouted "get the f___ out of my room! and demanded that his/her door be shut. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Further review of Resident #2 ' s medical record on 7/10/24 revealed a nurse ' s note on 1/6/24 at 6:59 AM that stated, Resident proceeded to tell me his/her version of an event that he/she states occurred in the shower room yesterday. He/she stated the nurse manager (Staff #137) was very rough with him/her and kept jerking his/her head back and forth. He/she stated he/she asked her to stop about 15 times and panicked when she would not stop. That is when he/she stated he/she began spitting at her as a defense mechanism and admitted to calling her a b___h. During interview with the Director of Nursing (DON) on 7/10/24 at 1:50 PM, the DON was asked if Staff #137 was suspended pending the investigation of Resident #2 &#39's allegation of abuse on 1/4/22. The DON stated no. 12679 8) Review of R17's EMR Admission Record located under the Profile tab, indicated the resident was admitted to the facility on [DATE] with a diagnosis of schizoaffective disorder. Review of R17's EMR quarterly MDS with an ARD of 06/22/23 indicated the resident had a BIMS score of 15 out of 15 which revealed the resident was cognitively intact. The assessment indicated the resident had no physical/verbal behaviors directed to others. Review of R17's EMR Care Plan located under the Care Plan tab, dated 08/04/23, indicated the resident had the potential to be physically/verbally aggressive towards others. During an interview on 07/08/24 at 10:30 AM, R17 stated she slapped her previous roommate (R66). R17 stated she was unsure why she slapped R66 and had never done it prior or since. R17 stated the police were involved. Review of R66s' EMR Admission Record located under the Profile tab, indicated the resident was admitted to the facility on [DATE] with a diagnosis of cognitive communication deficit. Review of R66's EMR annual MDS with an ARD [TRUNCATED]

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36461 Based on interview, record review, and facility policy review the facility failed to report timely, within two hours and not later than 24 hours for initial notification of an allegation of staff to resident verbal and physical abuse, to the state survey agency (SSA) reviewed for facility reported incidents (FRIs) residents. This was evident for 4 of 26 residents (Resident #77, #303, #921, #928) reviewed for abuse during a recertification and complaint survey. Findings include: Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated 03/22/23, revealed . Reporting of all alleged violations to the Administrator within specified timeframes: immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse . 1) Review of R77's undated Admission Record, located in the resident's electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Alzheimer's disease, anxiety, and depression. Review of R77's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/23/24 revealed a Brief Interview for Mental Status (BIMS) of three out of 15 which indicated the resident was severely cognitively impaired. Review of a facility reported incident (FRI) with an incident dated 05/12/24 at 10:25 PM, Geriatric Nurse Aide (GNA) 139 reported .while caring for another resident, she heard this resident [R77] hollering out and went to check on [R77]. GNA139 stated she heard GNA138 reply to R77 .shut up . in response to R77's non-sensical verbalizations. GNA139 entered R77's room and R77 was provided care by GNA138. GNA139 educated GNA138 on how to provide care while R77 was resistive to care. While in R77's room assisting GNA138, .[R77] stated to [GNA139] he [GNA138] is hurting me, (slapping his knee) and he punched me here (on his right thigh) . Continued review of the facility investigation revealed GNA139 failed to report the allegation of physical and verbal abuse to the nurse on shift at the time of the incident and left a handwritten note for the Director of Nursing (DON) under her office door. The DON found the note on 05/13/24 at approximately 10:00 AM. During an interview on 07/10/24 at 1:00 PM, the DON stated GNA138 and GNA139 were both .agency staff . and they have not returned to the facility since the 05/12/24 incident. The DON further stated GNA139 was . educated . by the DON and Administrator regarding the facility policy and reporting any abuse concerns immediately to the DON or Administrator. DON further stated the initial allegation report was submitted to the SSA on 05/13/24 at 11:30 AM. 35690 2) Review of R303's Face Sheet, located in the electronic medical record (EMR) under the Profile tab, revealed R303 was admitted to the facility on [DATE] with a diagnosis of a rib fracture and adjustment disorder with anxiety. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R303's admission MDS with an ARD of 06/24/24 located in the EMR under the MDS tab, revealed R303 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Per the MDS, the resident did not exhibit any behavior during the assessment period. During an interview on 07/08/24 at 11:50 PM, R303 stated sometimes at night she was told by staff to go to the bathroom in her brief. She stated it felt awful and she did not like doing it. She stated sometimes she also had a bowel movement in her brief which felt very uncomfortable. She stated she would wiggle in the chair. She stated last night she was told this by a GNA who provided care. R303 stated she reported this to GNA148 this morning. During an interview on 07/11/24 at 2:26 PM, R303 stated she had told GNA148 about the overnight Certified Nurse Aide (CNA), when her shift started, at approximately 7:15 AM on 07/08/24. During an interview on 07/11/24 at 2:28 PM, DON said she had spoken with GNA148. She said GNA148 confirmed she had provided care with R303 in the morning of 07/08/24. She said GNA148 said R303 reported to her that overnight when R303 told her GNA she had to go to the bathroom. the GNA told her to pee in her diaper. The DON said GNA148 told the RN. The DON said that neither the nurse nor GNA148 reported the incident to the Administrator or the DON until after noon on 07/08/24. She said the report made by the surveyor and the report made by the nurse were made simultaneously. She said the report should have been made as soon as the RN heard about the incident so she (DON) or the Administrator could report the incident within the two-hour time frame. The incident was reported to the State Agency on 07/08/24 at 1:33 PM. 40927 3) A review of the facility's investigation file for the facility reported incident #MD00203605 on 7/10/24 at 7:15 PM revealed a witness statement from Geriatric Nursing Assistant (GNA) #130 stating that Resident #921 was observed being abused by RN #152 on 3/14/24 at approximately 6:00 AM. However, she waited until 7:23 AM to report the abuse to the Director of Nursing (DON). The DON documented in the self-report form that she sent it to the state agency (SA) on 3/14/24 at 9:18 AM. An interview with the DON on 7/11/24 at 3:33 PM revealed she was aware of the late reporting and had provided educated the GNA. 4) A review of the facility's investigation file for the facility reported incident #MD00205149 on 7/10/24 at 5:31 PM revealed that in response to an allegation of abuse the facility had interviewed Resident #928. The resident answered yes when asked if s/he had been abused and then elaborated that someone had been rough with him/her during care and didn't speak very nicely. There was no name of who interviewed the resident. On the back of the interview sheet was a handwritten note with no date or signature that stated, Resident interviewed - States I had the same aide today. I feel I may have made it up. This Indicated that this interview had been conducted the next day. However, there was no evidence that this allegation of abuse had been reported to the SA. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing on 7/11/24 at 1:11 PM revealed that she was unsure who had conducted the interviews. When asked if anyone reviewed the interviews conducted with residents, she stated that she and the Administrator reviewed them. She reported she wrote the note on the back of Resident #928's interview sheet and was unable to recall when the interview had been conducted. She stated that the resident had recanted the allegation, however it was uncertain when this interview was conducted and based on what was said it was the next day. Cross Reference: F600 and F610

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 40927 Based on record review and interview it was determined that the facility failed to have a process in place to ensure the resident's safety directly following an allegation of abuse and to conduct a thorough investigation of the allegation. Evident for 3 (#913, #921 and #928) and Evident for 4 (#905, #911, #919 and #924) of 26 residents reviewed for abuse allegations during a recertification and complaint survey. The findings include: 1) A review of the facility's investigation file for the self-reported incident #MD00203605 on 7/10/24 at 7:15 PM revealed witness statements written by Geriatric Nursing Assistant (GNA) #130 and GNA #23 that read they had witnessed Registered Nurse #152 cursing and hitting Resident #921 on 3/14/24 at approximately 6:00 AM. However, the abuse was not reported to the Director of Nursing (DON) until 7:23 AM that morning. Therefore, RN #152 continued to have access to vulnerable residents for 1 hour and 23 minutes after she abused Resident #921. An interview with the DON on 7/11/24 at 1:11 PM revealed she was aware of the delayed reporting and offered no rationale. She reported that she educated the GNAs when they spoke. 2) A review of the facility's investigation file for the self-reported incident #MD00205149 on 7/10/24 at 5:31 PM revealed a resident interview sheet for Resident #928. Review of the interview revealed that Resident #928 had reported that s/he was abused. Further explaining that a staff member had been rough with him/her during care and had not talked very nicely to them. The staff member conducting the interview failed to sign the interview sheet. On the back of the interview sheet was a handwritten note that had not been signed or dated, indicating an additional interview was conducted with the resident. However, further review of the record revealed the facility had failed to investigate the allegation of abuse. An interview with the Director of Nursing (DON) on 7/11/24 at 1:11 PM with the Regional [NAME] President (RVP) present. The DON reported she was not sure who had conducted the interview with Resident #928. She agreed that this was an allegation of abuse and reported she had interviewed the resident (the handwritten note on the back of the interview sheet) and the resident had recanted it. However, she could not recall the date of the interview. The note stated, I [resident #928] had the same aide today. Which indicated the interview had been conducted the day after the original interview. 3) A review of the facility's investigation report for the facility self-reported incident #MD00205149 on 7/10/24 at 5:31 PM revealed that Resident #924's representative had reported that she came in on two occasions and found the resident soiled. Further review of the file revealed the facility failed to interview other staff who may have had knowledge of the care provided by the accused geriatric nursing assistant. This concern was reviewed with the DON on 7/11/24 at 1:11 PM, she stated that she understood why it was important to interview other staff who may have had knowledge of the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) A review of the facility's investigation file for the self-reported incident #MD00203010 on 7/9/24 at 11:26 AM revealed an interview with GNA #81 that read she overheard Resident #919 yelling for help. She responded to the room and found GNA #140 was in the room providing care. She reported the resident asked her to stay with them as they thought GNA #140 was trying to kill them. Further review of the file revealed that staff interviewed GNA #140 (the accused GNA), GNA #81, and RN #116. However, they failed to interview other staff who may have had knowledge of care provided by GNA #140. In addition, they failed to interview other residents who had received care from the GNA. The facility determined the abuse was inconclusive. An interview with GNA #81 on 7/10/24 at 10:06 AM revealed that the resident had been rolled completely over on their right side. She reported the resident had a broken right upper arm and it was in the sling. The resident was yelling for help and GNA #140 allowed the resident to remain in that position. GNA #81, who reported she finished caring for the resident, stated she assisted Resident #919 to a chair, while she changed the bedding. She then stood the resident and provided incontinence care and changed the resident's clothing. She stated she put the resident back to bed. She stated she cared for the resident in this manner to avoid causing the resident pain. The concerns were reviewed with the DON, Regional Clinical Consultant, and Regional [NAME] President on 7/11/24 at 3:33 PM. Cross Reference: F600 and F609. 37296 5) Review of a facility reported incident MD00187781 on 7/10/24, revealed the facility reported to the Office of Health Care Quality (OHCQ) on 1/14/23, Resident #911 reported alleged abuse by facility staff GNA #148. On 7/10/24 at 12 PM a review of the facility investigation report revealed the facility staff has no record of a complete investigation to include interviews with other residents on the unit. On 7/10/24 at 1:30 PM the Director of Nursing confirmed that the investigation failed to include interviews of other residents that was cared for by Staff #148. 30428 6) Review of the facility reported incidents regarding Resident #913 on 7/11/24 at 12:02 through exit on 7/12/24 failed to reveal documentation that the facility effectively implemented ordered interventions to prevent Resident #913 from being alone with residents of the opposite sex. This was identified as occurring on 11/6/22 with no interventions implemented and again on 7/21/23 after Resident #913 was already ordered to be on a 1:1 from 12/28/23. cross reference F600 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7) Review of the facility reported incident occurring on 11/9/22 revealed an allegation of physical abuse between GNA #151 and Resident #905 where GNA #151 pushed Resident #905 during care, scaring him/her and the roommate, so much so the roommate got up and stayed in the bathroom. Further review of this facility report on 7/12/24 with the facility DON failed to reveal that a 5-day report was submitted showing the facilities findings. Additionally, there were no additional interviews with other residents or staff included in the investigation. The alleged perpetrator, GNA #151, had 2 writeups previously regarding unprofessional conduct including one 3 weeks prior that was a 'final' warning and given the same write up for this allegation and noted as a 'last final' warning. This employee continued to work in the facility as a GNA through 4/2023 when she was terminated for 'not fulfilling PRN (as needed) contract).' However was marked as eligible for re-hire. cross reference F600

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. 30428 Based on medical record review and interview with facility staff, it was determined that the facility failed to review and implement a care plan when there were noted changes in condition requiring further facility services and follow-up (Resident #905). This was evident for 1 of 73 residents reviewed during a complaint and recertification survey. A care plan is a comprehensive and personalized document that outlines the specific needs, goals, and preferences of a patient. Care plans also address the specific services needed to attain and maintain a resident's highest practicable well-being through focus, goals and interventions. The findings include: Review of the electronic health record for Resident # 905 on 7/11/24 at 2:00 PM failed to reveal updated care plans related to 2 allegations of abuse occurring on 11/6/22 and on 11/9/22 respectively involving Resident #905. Resident #905's care plans in place were noted to address depression and cognitive decline, however, nothing related to having been exposed to 2 incidents of abuse 4 days apart. This concern was reviewed with the DON and Regional [NAME] President at exit on 7/12/24. cross reference F600, F744

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35690 Based on interviews, record review, and review of facility policy, the facility failed to revise the care plan to include recommendations from the dental consult on 05/11/24 for one of 21 sample residents (Resident (R) 73) reviewed for care plan revision. This failure caused staff to be unaware of recommendations from the dentist or possible tooth pain for R73. Findings include: Review of the facility's policy titled, Care Planning - Comprehensive Person-Centered, dated 10/19, revealed A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .The comprehensive, person-centered care plan will: . Describe services that would otherwise be provided . but are not provided due to the resident exercising his or her rights, including the right to refuse treatment . Review of R73's Face Sheet located in the electronic medical record (EMR) under the Profile tab, revealed an admitted [DATE] with medical diagnoses that included congestive heart failure, kidney disease and type two diabetes. Review of R73's annual Minimum Data Set (MDS) located in the EMR under the Resident Assessment Instrument (RAI) tab with an Assessment Reference Date (ARD) of 05/05/24 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R73 was cognitively intact. The MDS revealed R73 was dependent on staff for all activities of daily living. The MDS revealed she had no mouth or facial pain, discomfort, or difficulty with chewing. Review of R73's Health Drive Dental Group note, located in the EMR under the Misc[ellaneous] tab, dated 05/11/24 revealed Request to be seen by Hygienist to address patient concern over food impaction in tooth #20. Tooth #20 has a fracture. Patient informed tooth would need to be extracted to remedy food impaction. Patient does not want tooth #20 extracted. Review of R73's Care Plan located in the EMR under the Care Plan tab, last updated 11/06/23, read Resident has oral/dental health problems related to poor oral hygiene .the resident will comply with mouth care daily . coordinate arrangements for dental care, transportation as needed/as ordered. There was no indication of fractured tooth #20, recommendations of extraction for tooth #20, tooth pain, or R73 refusal for extraction. During an interview on 07/08/24 at 11:36 AM, R73 stated she had a broken tooth which caused her pain. She stated she only chewed on the right side. During an interview on 07/10/24 at 9:40 AM, Medical Records Director (MRD) stated she would notify the dentist if a resident needed an appointment. She stated if there was follow-up from the appointment, she would provide documentation to the Unit Manager (UM). She stated she would notify the UM if a problem was identified for the resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/10/24 at 10:03 AM, the UM stated after a resident saw the dentist, the consult notes would be reviewed by the UM and given to the unit clerk. She stated the recommendations from the dentist from the appointment on 05/11/24 and the refusal by R73 should have been care planned to indicate ongoing tooth pain, refusal of the dentists' recommendations and recommended follow-up interventions. During an interview on 07/10/24 at 1:26 PM, R73 stated she felt pain in her tooth approximately once per week. She stated she was okay with chewing on the right side of her mouth and did not want the tooth pulled. During an interview on 07/10/24 at 2:22 PM, Resource Nurse said the Care Plan had not been revised timely and did not include anything about R73's tooth pain, recommendation for extraction from the dentist, or R73's refusal to have tooth #20 extracted. She stated the Care Plan should have been updated timely and should have included specific information about tooth #20 as this was important to R73's care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 40927 Based on record review and interview it was determined that facility staff failed to provide activities of daily living (ADLs: bathing, personal hygiene, toileting, getting in and out of bed) for a resident who was dependent on them for care (Resident #906). This was evident for 1 (MD00186681) of 11 complaints reviewed during a recertification and complaint survey. The findings include: The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. A medical record review for Resident #906 on 7/12/24 at 8:32 AM revealed the attending physicians' progress note for a visit on 11/29/22 that read the resident had Alzheimer's dementia with anxiety. Review of an MDS (minimum data set) with an assessment reference date of 12/9/24 which documented that the resident was dependent on staff for most ADLs. According to the MDS the resident was severely cognitively impaired. Review of the geriatric nursing assistant (GNA) documentation for 12/1/22 through 12/31/22 revealed the resident was scheduled for showers on Wednesday and Saturday of each week, yet staff failed to give the resident a shower except on 12/9/22. They attempted to give the resident a shower on 12/27/22, but the resident refused, and all other days were marked N/A (not applicable). The resident was to receive mouth care on each shift, however 10 days on evening shift were marked as N/A. The resident required assistance with incontinence care this was marked as N/A or left blank 4 days on evening shift. Review of the GNA documentation for 2/1/23 - 2/14/23 revealed that the resident was not given a shower the entire 14 days. The resident was on a toileting schedule (which means staff take them to the toilet on a set schedule to increase continence) on 4 days it was marked N/A on evening shift and on 6 days it was marked N/A on night shift. An interview on 7/12/24 at 9:11 AM with the Memory Support Program Director (MSPD) revealed that she was unaware of this documentation although she had reported she spoke with Resident #906's family frequently about care concerns. She agreed that marking N/A for these categories was not acceptable. The concerns were reported to the Director of Nursing (DON), Regional [NAME] President, and Regional Clinical Consultant on 7/12/24 at 11:18 AM. The DON agreed that the GNAs should not have documented N/A for those categories.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 35690 Based on observation and interview, the facility failed to ensure staffing information was posted daily and readily accessible to residents and visitors, during the first three days of the survey for 105 census residents. Findings include: During an observation on 07/08/24 at 8:35 AM, nurse staffing was not posted or available to residents or visitors. During an observation on 07/09/24 at 8:35 AM, nurse staffing was not posted or available to residents or visitors. During an observation on 07/10/24 at 8:35 AM, nurse staffing was not posted or available to residents or visitors. During an interview on 07/10/24 at 2:42 PM, the Director of Nursing (DON) stated they did not have nurse staffing posted in the facility and was unaware of the regulatory requirement. She stated they were currently completing the document so it could be posted.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30428 Based on observation, medical record review and interview it was determined that the facility failed to 1) complete an admission nursing assessment thoroughly and therefore implement the correct interventions for a resident with known dementia history (Resident #917) This was evident for 1 of 1 resident reviewed for elopement and 2) ensure that residents residing on their dementia care unit had activities to help them achieve their highest practicable physical, mental, and psychosocial well-being. This was evident for 1 (#906) of 4 residents reviewed for dementia care. The findings include: 1) Review of the medical record for Resident # 917 on 7/9/24 at 12:08 PM revealed admission to the facility the end of November 2023, post hospitalization for change in vital signs, dementia and Alzheimer's behaviors including a recent hip fracture with continued falls. Review at this time of a facility incident report completed on 12/10/23 revealed that Resident #917 was able to exit the facility out a side door of the rehabilitation unit alone. According to the facility report a geriatric nursing assistant happened by and saw a wheelchair by the exit door and then saw the resident walking outside. The resident was brought back in, assessed and then placed in the memory care unit for safety. Surveyor interviewed the Director of Nursing on 7/9/24 at 3:56 PM regarding what assessments are completed on admission. She stated along with the Regional Clinical Consultant that certain assessments, such as the elopement assessment is imbedded in the nursing assessment completed on admission. This can be found under section 'M' under mobility. An elopement assessment can be used as a tool to determine what interventions would be needed such as increased observations and supervision for a resident that is identified as a wanderer or at risk for eloping from the facility. Review of the nursing admission assessment under section 'M' for mobility revealed that the elopement assessment for Resident #917 was incomplete and failed to identify any issues such as medical diagnosis or other medical conditions that could cause increased confusion or exit seeking behaviors. Resident #917 was admitted and already identified as having the diagnosis of dementia with behavioral disturbances and Alzheimer's. These identified concerns were reviewed with the DON and the Regional Clinical Consultant on 7/9/24 at 4:00 PM and again during exit on 7/12/24. 40927 2) The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Multiple observations were made of the memory care unit in which the residents were in the dining room with no activities being done. These observations were on the following dates: 7/8/24 at 8:58; 7/10/24 7:20 PM; and 7/11/24 at 9:10 AM through 9:28 AM and again at 2:45 PM. A medical record review for Resident #906 on 7/12/24 at 8:32 AM, in response to complaint #MD00186681 and #MD00188923, revealed a physician's progress note 11/29/22 for a monthly visit. The physician documented that the resident had Alzheimer's dementia with anxiety, diabetes type 2, and neuropathy. Review of the MDS with ARD of 12/9/22 revealed the resident had been in the facility since 2017. In section C the resident was noted to have severe cognitive impairment. Further review revealed a care plan for activities which noted that while in the facility the resident stated it was important to him/her to have the opportunity to engage in daily routines that were meaningful and relative to the resident's preferences. The goal was that the resident will plan and choose to engage in preferred activities throughout this review period. A resident with severe cognitive impairment would not be able to plan and choose activities. This care plan was initiated on 5/1/17 and not been updated until the resident was discharged on [DATE]. A review of the GNA documentation for activities offered to the resident 12/1/22 - 12/31/22 showed the resident had no activities documented on 10 days of month. Staff had the ability to mark if the resident was unavailable or refused, however these days were left blank. A review of the activities documented for 2/1/23 - 2/14/23 revealed that 7 days (50% of the time) were blank. An interview with the Memory Support Program Manager (MSPM) on 7/12/24 at 9:11 AM revealed that she was responsible for setting up activity programs for the residents on the unit. She stated that she maintains a calendar for the activities. They have a full-time recreation assistant to provide group and 1:1 activity for the residents. The activities included: exercising, cooking, crafts, religious programs, entertainers, and cognitive activities. When made aware of the surveyor's observations of the lack of activities, she offered no rationale. She stated that the geriatric nursing assistants were responsible for providing activities in the evenings. Reviewed the activity documentation for Resident #906 with the MSPM and she reported she had not been in her current role in December 2022 as she was the facility's Activity Director. However, she had been in the role in February of 2023. She stated she was still setting up the activity programming at that time.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 12679 Based on interviews, review of the facility documentation, and review of the facility policy, the facility failed to ensure policies and procedures were implemented to address the facility's Quality Assessment and Performance Improvement (QAPI) plan and program, in which data was gathered, analyzed, developed, implemented, and re-evaluated to address adverse events related to potential deficient practice of abuse. This had the potential to affect all 105 residents residing in the facility at the time of the survey. Findings include: Review of the facility's policy titled, [Facility Name] Quality Assurance and Performance Improvement (QAPI), dated 2020, indicated .To provide continuous evaluation of [Name of facility] systems with the objectives of keeping systems functioning satisfactorily, preventing points of accountability for ensuring quality of care and quality of life . A request was made for any Performance Improvement Plan (PIP) regarding the prevention of abuse from 01/01/22 to 07/11/24. The facility provided documents from 09/19/22, which indicated the facility had an action plan for timely reporting of abuse allegations and revealed there were no current issues. The action plan directed staff to provide training to the facility staff by 09/26/22. In addition, a review of multiple sign-in sheets, provided by the facility, revealed staff who attended abuse prevention training on 09/19/22, 09/20/22, and 06/14/23. There was no evidence the facility tracked, trended, and provided additional abuse prevention training as part of an effective QAPI program to sustain compliance. During an interview on 07/11/24 at 2:33 PM, the Regional Clinical Consultant (RCC) and the Director of Nursing (DON) were specifically asked if they had taken any abuse allegations through the QAPI process. The RCC stated the facility provided lots of abuse prevention training but there was no focus on sustaining compliance with abuse prevention through QAPI. The RCC stated there was no data, monitoring, or evaluation of data collected as part of their QAPI program which would show they were able to sustain compliance. The DON stated the QAPI meetings were held on a monthly basis and the facility had no additional information to provide on abuse prevention which would have been tracked, trended, monitored with an action plan developed as a result.