STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225723	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fall River Healthcare	1748 Highland Avenue Fall River, MA 02720

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 49424 Based on observations and interviews, for one resident unit out of a total sample of four resident units, the facility failed to ensure the physical environment met the residents' needs. Specifically, the facility failed to: 1. Accommodate residents who could not open the closed doors to the River 1 unit; and 2. Ensure the handicapped switches to and from the smoking area were functioning and in good repair. Findings include: On 1/30/25 the surveyor made the following observations on Unit 1: At 10:47 A.M., two closed doors to the River 1 Unit. At 10:48 A.M., a resident attempting to exit Unit 1 in a manual wheelchair. The resident was unable to open the doors, and staff observed the resident attempt and open the door. The resident was observed swearing in frustration. At 10:48 A.M., a second resident attempting to exit Unit 1 in a manual wheelchair. The resident was unable to open the doors and was swearing in frustration. A staff member observed the resident's attempts and eventually opened the door. At 10:57 A.M., one resident holding one door open and one resident in a wheelchair self-propelled through the door while another resident pushed another resident in a wheelchair through the door. The door was held open by a magnet at this time. At 10:57 A.M., a second resident holding a Unit 1 door open for another resident self-propelling in their wheelchair. The same resident also held the door for two additional residents, one resident pushing the other resident in a wheelchair. The resident holding the door left the door open, attached to the door magnet. At 10:59 A.M., the surveyor observed a Certified Nursing Assistant (CNA) close the doors. (continued on next page)

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 1/30/25 at 11:30 A.M., Resident #129 attempted to kick open one door to get through. The Resident said it was very difficult to go through the closed doors in a wheelchair and with a splint on his/her hand. He/She said they preferred the doors kept open for accessibility on and off the Unit. On 2/3/25 at 8:45 A.M., the surveyor observed a resident with an arm sling and in a wheelchair attempting to get through the door. The surveyor heard the resident grunt as he/she attempted to get a door open and hit his/her leg rests on one of the doors. The resident asked a passing staff member for help. The surveyor observed visible damage, such as scuff marks and indentations, to the bottom portion of the Unit 1 doors, equal to wheelchair level. On 2/4/25 at 10:35 A.M., the surveyor observed a staff member bringing a resident in a manual wheelchair backwards through the Unit 1 door because it was closed. During the Resident Group meeting on 1/30/25 at 10:00 A.M., residents said the doors to Unit 1 were always closed and they were unable to open the door independently and must ask for assistance each time. The residents said there was a sign on the door to keep the doors closed and they were unsure why, given multiple residents requested for the doors to stay open or for an accessible handicap door button to be installed. Members of the Resident Group also said, due to limited mobility, they have to kick the Unit 1 doors open and are fearful of the doors shutting on them if they don't move through fast enough. During an interview on 1/30/25 at 11:39 A.M., Unit Secretary #1, said she didn't know why the doors to Unit 1 were kept closed. She said there was no infection control rationale for the doors to be closed and she said that the residents should be able to enter and leave the Unit independently. During an interview on 2/4/25 at 10:20 A.M., Resident #129 said it can be tough to enter and exit Unit 1 when the doors are closed, so he/she kicks the door with his/her foot, and it swings to get him/her through. Not everyone can kick the door or get the door open without help though. During an interview on 2/4/25 at 10:51 A.M., the Director of Nurses and Corporate Nurse #1 said the Unit 1 doors should be kept open so the residents with disabilities/mobility issues can access the Unit with ease. They said they did not know why the Unit 1 door was kept closed or why the sign on the door said, Please Keep Door Closed. They said the doors were not closed for safety reasons. 2. On 1/30/25 at 10:15 A.M., Residents at the Resident Group Meeting said the handicapped access to and from the smoking area had been broken and they must rely on someone to hold the door for them. On 1/30/25 at 11:06 A.M., the surveyor attempted to push the handicapped buttons to open the doors to the smoking area but observed them not to be functioning. The handicapped button on the outside was on a pole that was loose from the ground and tilting at an angle. On 1/30/25 at 11:06 A.M., Unit Manager #4 said the outside button had been broken for months. She said that staff must hold the door for residents to enter the building from the smoking area. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/25 at 11:25 A.M., the Maintenance Director said he was aware the outdoor handicapped button had not worked for over a year. He said he wasn't sure how long the inside handicapped button had not been working as he just received a work order for it today after Unit Manager #4 told him the surveyor was asking about it. Review of an invoice, dated 1/30/25 at 1:45 P.M., indicated a work order was submitted for repair of the interior and exterior handicapped buttons. On 2/3/25 at 9:01 A.M., the surveyor observed Activities Staff #2 using the inside handicapped button twice to assist residents to the outside smoking area. The surveyor also observed a resident using the inside/outside handicapped button to open the door for two residents in wheelchairs. During an interview on 2/3/25 at 09:36 A.M., the Maintenance Director said he contacted a technician, and the handicapped buttons are working. He said he wasn't sure what prompted it to get fixed after over a year of being broken. He said he didn't think there had to be handicapped access to the smoking area for residents. He said there is always someone around to hold the door. During an interview on 2/4/25 at 10:51 A.M., the Director of Nurses and Corporate Nurse #1 said the handicapped buttons doors should be working so the residents with disabilities/mobility issues can access the smoking area in the courtyard. They said that they did not know the handicap buttons were not in good repair. They said there was no facility policy referencing resident accommodation of needs. During an interview on 2/4/25 at 10:20 A.M., Resident #129 said it was much easier to get out to the smoking area with functioning handicapped buttons that open the doors for residents. He/She said maintenance was aware they were not working but because the Department of Public Health asked about them was the reason they were repaired.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36542 Based on observations and interviews, the facility failed to ensure the residents' environment was safe, clean, comfortable, and homelike. Findings include: On the following dates and times, in the second-floor dayroom/dining room between R2 and H2 units, the surveyor observed: -1/29/25 at 11:25 A.M., a spill on the floor, a table with a book under the leg of the table balancing it, and heaters with missing top covers and with multiple rust spots -1/30/25 at 12:11 P.M., a spill on the floor and heaters with missing top covers and with multiple rust spots -1/31/25 at 11:15 A.M., a spill on the floor, a table with a book under the leg of the table balancing it, and residents present in the room watching a movie -2/3/25 at 9:05 A.M., a table with a book under the leg of the table balancing it On 1/31/25 at 11:10 A.M., on the H2 Unit, the surveyor observed an armoire door that was detached from the armoire and was next to the armoire in room [ROOM NUMBER]. On 2/3/25 at 8:43 A.M., on the H3 Unit, the surveyor observed: -the dark brown armoire doors in rooms [ROOM NUMBERS] were scratched with white scratch marks -room [ROOM NUMBER] with broken drawers on the armoire -room [ROOM NUMBER] with both the bathroom sink and room sinks clogged; Resident #22 said a facility staff person came a few weeks ago and snaked the sink, but the facility staff person said the sink was still draining slow at that time and nothing further had been done. -room [ROOM NUMBER] with the bathroom sink dripping and unable to be turned off completely, and the room sink with a missing faucet handle -room [ROOM NUMBER](A) with two bottom drawers of armoire broken During an interview on 1/30/25 at 8:36 A.M., Unit Manager #2 said maintenance requests were put in the TELS (a live cloud-based electronic building management communication system to schedule and track and request maintenance services and repairs) and there was no maintenance book for the unit. Review of the TELS indicated the following were reported and closed as fixed: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/8/25: both sinks in room [ROOM NUMBER] not draining. During an interview on 2/5/25 at 9:48 A.M., the Maintenance Director said the maintenance department did not conduct environmental rounds and relied on the unit staff to put information and requests in the TELS. The Maintenance Director said the water to the in-room sinks in rooms [ROOM NUMBERS], on the H3 Unit, had been shut off and that is why the sink in room [ROOM NUMBER] was clogged. The Maintenance Director said staff must have been pouring things down the sink and they should not have been. The Maintenance Director said he was not aware of the closets, sinks, and armoires, and if he did not know about them, he could not fix them.

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 36542 Based on observations, interviews, and record review, the facility failed to protect Resident #141's right to be free from verbal abuse by Resident #105. The total sample was 33 residents. Specifically, after the facility staff witnessed Resident #105 use racial slurs to verbally abuse Resident #141, the facility failed to develop and implement effective interventions to prevent further resident-to-resident verbal abuse, resulting in the verbal abuse continuing for three weeks and Resident #141 crying and verbalizing wanting to decrease their socialization. Findings include: Review of the facility's policy titled Abuse Investigating and Reporting, revised in February 2024, indicated the following: -Verbal abuse is defined as any use of oral, written, or gestured language that willfully include disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of a resident's age, ability to comprehend or mental and/or physical disability -alleged violations are reported to the Administrator and to other officials in accordance with state law -alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in process -the results of investigations must be reported in accordance with state/federal law within five business days of the incident -if the alleged violation is verified appropriate corrective actions must be taken -report to DPH (Department of Public Health) and local law enforcement any reasonable suspicion of a crime committed against an individual who is a resident of the facility -if the events that cause reasonable suspicion result in serious bodily injury, the report must be made immediately (but not later than two hours) after forming the suspicion; otherwise the report must not be made later than 24 hours after forming the suspicion. Crime is defined by local law jurisdiction. -any suspected allegation of abuse shall be reported to the Administrator or his/her designee -if the suspected perpetrator is another resident, the residents shall be separated so they do not have access to each other until the circumstances of the alleged incident can be determined -the staff member witnessing a potentially inappropriate treatment will report the event immediately to the nursing supervisor/management (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	-the nursing supervisor/designee will take appropriate steps to protect the resident from further mistreatment through: separating the accused/suspected resident from the alleged victim and other residents; provide emotional support to alleged victim if needed -interview appropriate individuals; which may include the alleged victim, employees working during the shift when the event was discovered/reported, as well as other residents who may have witnessed something -the Social Worker may interview other potential victims Resident #141 was admitted to the facility in January 2025 for short term rehabilitation and was receiving physical and occupational therapy services. Review of the Minimum Data Set (MDS) assessment, dated 1/13/25, indicated Resident #141 scored 14 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact, and was a smoker. Resident #105 was admitted to the facility in December 2024 for short term rehabilitation and was receiving physical therapy services. Review of the MDS assessment, dated 12/29/24, indicated Resident #105 scored 14 out of 15 on the BIMS indicating he/she was cognitively intact, and was a smoker. During an interview with observation on 1/30/25 at 2:10 P.M., the surveyor observed Resident #141 crying. The Resident said he/she was listening to his/her music earlier in the day when Resident #105, while on their way to Rehab, said, Why are you listening to that? I don't want to hear Nxxxxx music. Resident #141 said he/she did not know why Resident #105 did not like him/her. Resident #141 said there had been other negative encounters with Resident #105 saying he/she smelled and using racial slurs. Resident #141 said that Resident #105 could say whatever they wanted, but he/she couldn't. The Resident felt he/she needed to censor him/herself and couldn't allow him/herself to burst out in these situations in response to Resident #105. Resident #141 went on to say that he/she tries to stay in his/her room, as he/she had a TV and iPad he/she could use to pass time. Resident #141 said after today's incident, he/she will stay in his/her room and will not be going to communal places within the facility (such as the drop-in day room) as to avoid situations like today. Resident #141 said he/she was going to just sit in his/her bed in the current spot and that's where the surveyor will find him/her next week when the surveyor returned. Review of the medical record for Resident #105 indicated that on 1/7/25 Resident #105 was screaming racial slurs at new roommate (Resident #141) and the Resident became aggressive with redirection. Resident #105 was sent to the hospital for a change in mental status. Further review indicated Resident #105 had a room change on 1/7/25 so that he/she was not rooming with Resident #141. Resident #105 was moved two rooms down, diagonally across the hall from Resident #141. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of the emergency room After Visit Summary from 1/7/25 indicated Resident #105 presented with agitation and included an educational attachment for Intermittent Explosive Disorder which included treatment goals to stop outbursts through the use of cognitive behavioral therapy, group therapy, relaxation methods and medications. Review of the progress notes and care plans for Resident #105 failed to address behaviors and failed to identify interventions. Review of the medical record for Resident #141 failed to indicate any information regarding the Resident being called racial slurs and failed to indicate any follow-up was conducted with Resident #141 to determine the effectiveness of the room change across the hall. During an interview with the Administrator and the Director of Nurses (DON) on 1/30/25 at 2:42 P.M., the Administrator said he was unaware of the verbal altercation between Resident #141 and Resident #105 today. The DON said she was aware that Resident #105 had used racial slurs towards Resident #141 today on the way to attend physical therapy together and the staff were working on a plan to keep the residents separated. She said Resident #105 previously had a verbal altercation with Resident #141 when Resident #141 was admitted to the facility and a room change was initiated. She said she was unaware Resident #105 had used racial slurs during that altercation. During an interview on 1/30/25 at 2:40 P.M., Nurse #3 said she had been working on 1/7/25 when Resident #105 called Resident #141 a nxxxxx and said Resident #141 was making the room smell like a zoo. She said Resident #141 was so upset that he/she started crying because of the racial slurs that were hurled at him/her by Resident #105. Nurse #3 said she notified Nurse #1 who was the nursing supervisor. During an interview on 1/30/25 at 2:43 P.M., Certified Nursing Assistant (CNA) #1 said she was the assigned CNA for Resident #105 and Resident #141. She said about three weeks prior, Resident #105 had made racial comments to Resident #141, and they switched the room of Resident #105 to across the hall. She said she was not aware if there had been any additional plan to keep the residents separated. During an interview on 1/30/25 at 2:50 P.M., CNA #3 said on 1/7/25 Resident #105 had said he/she did not like black people and did not want Resident #141 in his/her room. She said Resident #105 was yelling that Resident #141 was nasty and smelled nasty and their room was going to smell nasty now and she felt this was directly related to race. The CNA said she immediately notified the nurse who notified the supervisor and the DON. During an interview on 1/30/25 at 2:55 P.M., Nurse #1 said she was the supervisor on 1/7/25 and was called down to the unit to assist as Resident #105 was yelling about Resident #141 saying that he/she smelled and was calling the Resident the N word. She said the plan at that time was to split up the two residents right way and moved Resident #105 across the hall. She said on 1/7/25, Resident #141 was very sensitive about this and was crying. She said another verbal altercation was bound to happen between the two residents. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	During an interview on 1/31/25 at 3:23 P.M., CNA #6 said on 1/7/25 she found Resident #141 in his/her room crying. CNA #6 said Resident #105 had called Resident #141 a nxxxxx. She said Resident #105 kept yelling and Resident #141 did not want to stay. The CNA said the Nurse Scheduler had come to assist separating the residents and the DON was contacted as well. In addition, CNA #6 said Resident #105 often uses profanities, and if smoking break is late, Resident #105 will call the staff bxxxxes and nxxxxxxs. During an interview on 1/30/25 at 2:40 P.M., CNA #5 said she was not aware there had been any altercations before today and normally works on the unit with both residents. During an interview on 1/30/25 at 2:40 P.M., CNA #4 said she was not aware there had been any altercations before today and normally works on the unit with both residents. During an interview on 1/31/25 at 9:45 A.M., Social Worker #1 said she was in the facility on 1/7/25 and went to the unit when Resident #105 was yelling. She said she heard Resident #105 yelling, This is gross, he/she smells like shit. She said Resident #141 was crying and said, This always happens to me. She said she did not directly hear any racist comments but had been told by staff that Resident #105 was saying racial slurs to Resident #141. She said the interdisciplinary team discussed this at morning meeting the next day and she thought the plan was to keep them separated. She said she would not have been involved in any staff education for this and it would have been completed by the Staff Development Coordinator (SDC). The Social Worker said at this facility the Social Service staff were not involved in documenting behaviors or implementing behavioral care plans or behavioral interventions. During an interview on 2/4/25 at 3:47 P.M., the SDC said she was at the facility on 1/7/25 when the altercation occurred. She said she was aware Resident #105 had used racial slurs towards Resident #141. She said the plan was to move the room of Resident #105 and there were no additional interventions. She said she did not provide any staff education on keeping the two residents separated. During an interview on 1/31/25 at 10:00 A.M., the Nurse Scheduler said he went to the unit when Resident #105 was yelling at Resident #141. He said he had not heard Resident #105 saying any racial slurs, but that Resident #141 had told him about the racial slurs. He said he offered Resident #141 support as the Resident was visibly very upset. During an interview on 2/4/25 at 8:48 A.M., the Activity Director said Resident #105 and Resident #141 attend the drop-in center (where residents can come and go at their leisure) and both residents attend the smoking breaks regularly. She said she was unaware there were any altercations between the two residents prior to 1/30/25. During an interview on 2/4/25 at 1:45 P.M., the DON confirmed there was no investigation to review for the verbal abuse that occurred between Resident #105 and Resident #141 on 1/7/25. During an interview on 1/30/25 at 5:15 P.M., the Administrator said the police had met with both Resident #105 and Resident #141 today. The Administrator said the plan was for Resident #105 to be checked on by staff every 15 minutes. He said both residents had refused to change rooms at this time. The Administrator said he had just discovered that both residents attend the smoking breaks and he would need to initiate a plan for this. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	During an interview on 1/31/25 at 9:25 A.M., Resident #141 said he/she did not understand why Resident #105 did not like him/her and when he/she asked Resident #105 a couple of days prior Resident #105 had responded with go f*** yourself. Resident #141 went on to talk about the racial slurs Resident #105 had used the previous day and Resident #141 said he/she had gotten so upset that he/she had started to lose their temper and raised their voice and was trying hard to control themselves and not retaliate. During an interview on 1/31/25 at 1:30 P.M., the Physical Therapy Assistant (PTA) said on 1/30/25 he went to the room of Resident #141 and asked the Resident to get ready to come down to the rehab gym. He said he then went to the room of Resident #105 to get this Resident to go down to the gym for rehab. He said he had never heard that there had been any issues between the two residents prior. He said Resident #141 had music playing and as they all approached the elevator Resident #105 started yelling and became verbally aggressive. The PTA said he was not sure exactly what was said and he had done his best to de-escalate the situation by having Resident #141 go back to his/her room while Resident #105 continued to yell. He said Resident #105 was aggressive, angry, and agitated. He said after Resident #105 went to his/her room he had Resident #141 come down to complete therapy in the Rehab gym. He said Resident #141 was very upset and told him how Resident #105 had been making racial comments and that smoking breaks had become an argumentative setting. During an interview on 1/31/25 at 9:30 A.M., the Director of Rehabilitation (Rehab) said she was not sure of the specifics from the previous day, which involved a Physical Therapy Assistant (PTA) and she would have to get back to the surveyor on what the plan was for Resident #105 and Resident #141 who were both receiving rehab services. She said that the residents should not be in rehab at the same time but that only the PTA needed to know this because he was the only staff who worked with both residents. During an interview on 1/31/25 at 9:35 A.M., the Certified Occupational Therapy Assistant (COTA) said he was working with Resident #141 and had already seen the Resident this morning. He said he was not at the facility the previous day (1/30/25) but had heard there was a verbal altercation between Resident #105 and the PTA. He said as far as he knew there had not been any altercations between Resident #105 and Resident #141 since Resident #141 was first admitted . The COTA said he had not heard anything since then and had never been told to keep the residents separated. During an interview on 1/31/25 at 9:45 A.M., Social Work Consultant #2 said she met with Resident #141 following the verbal abuse on 1/30/25 and Resident #141 told her the racial comments from Resident #105 had been occurring daily. During an interview with the Administrator and the DON on 2/5/25 at 12:00 P.M., the DON said she was not aware that Resident #105 had said racial slurs to Resident #141 on 1/7/25 until the surveyors brought it to her attention. The Administrator said he was also not aware and that the racial slurs were verbal abuse and should have been investigated and reported. The DON said the only intervention that occurred on 1/7/25 was to move Resident #105 diagonally across the hall. The Administrator and the DON said they did not recall discussing the racial slurs at morning meeting the following day. The Administrator said he had become aware this week that Resident #105 had been walking by the room of Resident #141, who would be visible from the door, and using it as a tool to continue to make comments towards Resident #141, including racial slurs. The Administrator said this could weigh a lot on someone psychosocially. (continued on next page)

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Fall River Healthcare	1748 Highland Avenue Fall River, MA 02720

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Refer to F607, F609, F610, F656, F740, and F745

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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 0607 Level of Harm - Actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 36542 Based on observation, interview, and record review, the facility failed to implement their abuse policy and procedures to prevent further verbal abuse for one Resident (#141), in a total sample of 33 residents. Specifically, after the facility staff witnessed Resident #105 use racial slurs to verbally abuse Resident #141, the facility failed to implement their policy to initiate effective interventions to prevent further resident-to-resident verbal abuse, resulting in the verbal abuse continuing for three weeks and Resident #141 crying and verbalizing wanting to decrease their socialization. Findings include: Review of the facility's policy titled Abuse Investigating and Reporting, revised in February 2024, indicated the following: -Verbal abuse is defined as any use of oral, written, or gestured language that willfully include disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of a resident's age, ability to comprehend or mental and/or physical disability -alleged violations are reported to the Administrator and to other officials in accordance with state law -alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in process -the results of investigations must be reported in accordance with state/federal law within five business days of the incident -if the alleged violation is verified appropriate corrective actions must be taken -report to DPH (Department of Public Health) and local law enforcement any reasonable suspicion of a crime committed against an individual who is a resident of the facility -if the events that cause reasonable suspicion result in serious bodily injury, the report must be made immediately (but not later than two hours) after forming the suspicion; otherwise the report must not be made later than 24 hours after forming the suspicion. Crime is defined by local law jurisdiction. -any suspected allegation of abuse shall be reported to the Administrator or his/her designee -if the suspected perpetrator is another resident, the residents shall be separated so they do not have access to each other until the circumstances of the alleged incident can be determined -the staff member witnessing a potentially inappropriate treatment will report the event immediately to the nursing supervisor/management (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 0607 Level of Harm - Actual harm Residents Affected - Some	-the nursing supervisor/designee will take appropriate steps to protect the resident from further mistreatment through: separating the accused/suspected resident from the alleged victim and other residents; provide emotional support to alleged victim if needed -interview appropriate individuals; which may include the alleged victim, employees working during the shift when the event was discovered/reported, as well as other residents who may have witnessed something -the Social Worker may interview other potential victims Resident #141 was admitted to the facility in January 2025 for short term rehabilitation and was receiving physical and occupational therapy services. Review of the Minimum Data Set (MDS) assessment, dated 1/13/25, indicated Resident #141 scored 14 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact and was a smoker. Resident #105 was admitted to the facility in December 2024 for short term rehabilitation and was receiving physical therapy services. Review of the MDS assessment, dated 12/29/24, indicated Resident #105 scored 14 out of 15 on the BIMS indicating he/she was cognitively intact and was a smoker. During an observation with interview on 1/30/25 at 2:10 P.M., the surveyor observed Resident #141 from their doorway. The Resident did not wave or smile to the surveyor and was visibly upset. The surveyor entered the Resident's room and observed Resident #141 crying. During an interview at this time, the Resident said he/she was listening to his/her music earlier in the day when Resident #105, on the way to Rehab, said, Why are you listening to that? I don't want to hear Nxxxxx music. Resident #141 said he/she did not know why Resident #105 did not like him/her. Resident #141 said there had been other negative encounters with Resident #105 saying he/she smelled and using racial slurs. Resident #141 said he/she tries to stay in his/her room, as he/she had a TV and iPad he/she could use to pass time. Resident #141 said after today's incident, he/she will stay in his/her room and will not be going to communal places within the facility (such as the drop-in day room) as to avoid situations like today. Resident #141 said he/she was going to just sit in his/her bed in the current spot and that's where the surveyor will find him/her next week when the surveyor returned. Review of the medical record for Resident #105 indicated on 1/7/25 Resident #105 was screaming racial slurs at new roommate (Resident #141) and the Resident became aggressive with redirection. Resident #105 was sent to the hospital for change in mental status. Further review indicated Resident #105 had a room change on 1/7/25 so that he/she was not rooming with Resident #141. Resident #105 was moved two rooms down, diagonally across the hall from Resident #141. Review of the medical record for Resident #141 failed to indicate any information regarding the Resident being called racial slurs and failed to indicate any follow-up was conducted with Resident #141 to determine the effectiveness of the room change across the hall. (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 0607 Level of Harm - Actual harm Residents Affected - Some	During an interview on 1/30/25 at 2:42 P.M., the Director of Nurses (DON) said Resident #105 had previously had a verbal altercation with Resident #141 when Resident #141 was admitted to the facility and a room change was initiated and she was unaware Resident #105 had used racial slurs during that altercation. During an interview on 1/30/25 at 2:40 P.M., Nurse #3 said she had been working on 1/7/25 when Resident #105 called Resident #141 a nxxxxx and said Resident #141 was making the room smell like a zoo. She said Resident #141 was so upset that he/she started crying because of the racial slurs that were hurled at him/her by Resident #105. Nurse #3 said she notified Nurse #1 who was the nursing supervisor. During an interview on 1/30/25 at 2:43 P.M., Certified Nursing Assistant (CNA) #1 said she was the assigned CNA for Resident #105 and Resident #141. She said about three weeks prior Resident #105 had made racial comments to Resident #141, and they switched the room of Resident #105 to across the hall. She said she was not aware if there had been any additional plan to keep the residents separated. During an interview on 1/30/25 at 2:50 P.M., CNA #3 said on 1/7/25 Resident #105 had said he/she did not like black people and did not want Resident #141 in his/her room. She said Resident #105 was yelling that Resident #141 was nasty and smelled nasty and their room was going to smell nasty now and she felt this was directly related to race. The CNA said she immediately notified the nurse who notified the supervisor and the DON. During an interview on 1/30/25 at 2:55 P.M., Nurse #1 said she was the supervisor on 1/7/25 and was called down to the unit to assist as Resident #105 was yelling about Resident #141 saying that he/she smelled and was calling the Resident the N word. She said the plan at that time was to split up the two residents right way and moved Resident #105 across the hall. She said on 1/7/25 Resident #141 was very sensitive about this and was crying. She said another verbal altercation was bound to happen between the two residents. During an interview on 1/31/25 at 3:23 P.M., CNA #6 said on 1/7/25 she found Resident #141 in his/her room crying. CNA #6 said Resident #105 had called Resident #141 a nxxxxx. She said Resident #105 kept yelling and Resident #141 did not want to stay. The CNA said the Nurse Scheduler had come to assist separating the residents and the DON was contacted as well. In addition, CNA #6 said Resident #105 often uses profanities, and if smoking break is late, Resident #105 will call the staff bxxxxxs and nxxxxxs. During an interview on 1/31/25 at 9:45 A.M., Social Worker #1 said she was in the facility on 1/7/25 and went to the unit when Resident #105 was yelling. She said she heard Resident #105 yelling, this is gross, he/she smells like shit. She said Resident #141 was crying and said, this always happens to me. She said she did not directly hear any racist comments but had been told by staff that Resident #105 was saying racial slurs to Resident #141. She said the interdisciplinary team discussed this at morning meeting the next day and she thought the plan was to keep them separated. She said she would not have been involved in any staff education for this and it would have been completed by the Staff Development Coordinator (SDC). (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Some	During an interview on 2/4/25 at 3:47 P.M., the SDC said she was at the facility on 1/7/25 when the altercation occurred. She said she was aware Resident #105 had used racial slurs towards Resident #141. She said the plan was to move the room of Resident #105 and there were no additional interventions. She said she did not provide any staff education on keeping the two residents separated. During an interview on 2/4/25 at 8:48 A.M., the Activity Director said Resident #105 and Resident #141 attend the drop-in center (where residents can come and go at their leisure) and both residents attend the smoking breaks regularly. She said she was unaware there were any altercations between the two residents prior to 1/30/25. During an interview on 2/4/25 at 1:45 P.M., the DON confirmed there was no investigation to review for the verbal abuse that occurred between Resident #105 and Resident #141 on 1/7/25. During an interview on 1/31/25 at 9:25 A.M., Resident #141 said he/she did not understand why Resident #105 did not like him/her and when he/she asked Resident #105 a couple of days prior Resident #105 had responded with go f*** yourself. Resident #141 went on to talk about the racial slurs Resident #105 had used the previous day and Resident #141 said he/she had gotten so upset that he/she had started to lose their temper and raised their voice and was trying hard to control themselves and not retaliate. During an interview on 1/31/25 at 1:30 P.M., the Physical Therapy Assistant (PTA) said on 1/30/25 he went to the room of Resident #141 and asked the Resident to get ready to come down to the rehab gym. He said he then went to the room of Resident #105 to get this Resident to go down to the gym for rehab. He said he had never heard that there had been any issues between the two residents prior. He said Resident #141 had music playing and as they all approached the elevator Resident #105 started yelling and became verbally aggressive. The PTA said he was not sure exactly what was said and he had done his best to de-escalate the situation by having Resident #141 go back to his/her room while Resident #105 continued to yell. He said Resident #105 was aggressive, angry and agitated. He said after Resident #105 went to his/her room he had Resident #141 come down to complete therapy in the Rehab gym. He said Resident #141 was very upset and told him how Resident #105 had been making racial comments and that smoking breaks had become an argumentative setting. During an interview on 1/31/25 at 9:35 A.M., the Certified Occupational Therapy Assistant (COTA) said he was working with Resident #141 and had already seen the Resident this morning. He said he was not at the facility the previous day, 1/30/25 but had heard there was a verbal altercation between Resident #105 and the PTA. He said as far as he knew there had not been any altercations between Resident #105 and Resident #141 since Resident #141 was first admitted . The COTA said he had not heard anything since then and had never been told to keep the residents separated. (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 0607 Level of Harm - Actual harm Residents Affected - Some	During an interview with the Administrator and the DON on 2/5/25 at 12:00 P.M., the DON said she was not aware that Resident #105 had said racial slurs to Resident #141 on 1/7/25 until the surveyors brought it to her attention. The Administrator said he was also not aware and that the racial slurs were verbal abuse and should have been investigated and reported. The DON said the only intervention that occurred on 1/7/25 was to move Resident #105 diagonally across the hall. The Administrator and the DON said they did not recall discussing the racial slurs at morning meeting the following day. The Administrator said he had become aware this week that Resident #105 had been walking by the room of Resident #141, who would be visible from the door, and using it as a tool to continue to make comments towards Resident #141, including racial slurs. The Administrator said this could weigh a lot on someone psychosocially. Refer to F609 and F610

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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	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 36542 Based on interview and record review, the facility failed to report verbal abuse for one Resident (#141), in a total sample of 33 residents. Specifically, after the facility staff witnessed Resident #105 use racial slurs to verbally abuse Resident #141, the facility failed to report the verbal abuse to the State Survey Agency. Findings include: Review of the facility's policy titled Abuse Investigating and Reporting, revised in February 2024 indicated the following: -Verbal abuse is defined as any use of oral, written, or gestured language that willfully include disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of a resident's age, ability to comprehend or mental and/or physical disability -any suspected allegation of abuse shall be reported to the Administrator or his/her designee -alleged violations are reported to the Administrator and to other officials in accordance with state law -the results of investigations must be reported in accordance with state/federal law within five business days of the incident -report to DPH (Department of Public Health) and local law enforcement any reasonable suspicion of a crime committed against an individual who is a resident of the facility -if the events that cause reasonable suspicion result in serious bodily injury, the report must be made immediately (but not later than two hours) after forming the suspicion; otherwise, the report must not be made later than 24 hours after forming the suspicion. Crime is defined by local law jurisdiction. Resident #141 was admitted to the facility in January 2025. Review of the Minimum Data Set (MDS) assessment, dated 1/13/25, indicated Resident #141 scored 14 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. Resident #105 was admitted to the facility in December 2024. Review of the MDS assessment, dated 12/29/24, indicated Resident #105 scored 14 out of 15 on the BIMS indicating he/she was cognitively intact. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/30/25 at 2:10 P.M., Resident #141 was crying and said he/she was listening to music earlier in the day on the way to Rehab when Resident #105 said, Why are you listening to that? I don't want to hear Nxxxxx music. Resident #141 said he/she did not know why Resident #105 did not like him/her. Resident #141 said there had been other negative encounters with Resident #105 saying he/she smelled and using racial slurs. Review of the medical record for Resident #105 indicated on 1/7/25 Resident #105 was screaming racial slurs at a new roommate (Resident #141) and the Resident became aggressive with redirection. Resident #105 was sent to the hospital for a change in mental status. Further review indicated Resident #105 had a room change on 1/7/25 so that he/she was not rooming with Resident #141. Resident #105 was moved two rooms down, diagonally across the hall from Resident #141. Review of the Health Care Facility Reporting System (HCFRS) from 1/1/25 through 1/31/25 failed to indicate any incidents of verbal abuse of Resident #141 by Resident #105 were reported by the facility. During an interview on 1/30/25 at 2:42 P.M., the Director of Nurses (DON) said Resident #105 previously had a verbal altercation with Resident #141 when Resident #141 was admitted to the facility and a room change was initiated. She was unaware Resident #105 had used racial slurs during that altercation and the incident had not been reported to DPH. During an interview on 2/5/25 at 12:00 P.M., the Administrator said he was not aware racial slurs were said to Resident #141 on 1/7/25, that the racial slurs were verbal abuse and should have been reported. Refer to F610

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F 0610 Level of Harm - Actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 36542 Based on observation, interview, and record review, the facility failed to implement their policy and procedures to investigate and prevent further verbal abuse for one Resident (#141), in a total sample of 33 residents. Specifically, after the facility staff witnessed Resident #105 use racial slurs to verbally abuse Resident #141, the facility failed to implement their policy to conduct a thorough investigation and initiate effective interventions to prevent further resident-to-resident verbal abuse, resulting in the verbal abuse continuing for three weeks and Resident #141 crying and verbalizing wanting to decrease socialization. Findings include: Review of the facility policy titled Abuse Investigating and Reporting, revised in February 2024 indicated the following: -Verbal abuse is defined as any use of oral, written, or gestured language that willfully include disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of a resident's age, ability to comprehend or mental and/or physical disability -alleged violations are reported to the Administrator and to other officials in accordance with state law. -alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in process -the results of investigations must be reported in accordance with state/federal law within five business days of the incident - if the alleged violation is verified appropriate corrective actions must be taken -any suspected allegation of abuse shall be reported to the Administrator or his/her designee -if the suspected perpetrator is another resident, the residents shall be separated so they do not have access to each other until the circumstances of the alleged incident can be determined -the staff member witnessing a potentially inappropriate treatment will report the event immediately to the nursing supervisor/management -the nursing supervisor/designee will take appropriate steps to protect the resident from further mistreatment through: separating the accused/suspected resident from the alleged victim and other residents; provide emotional support to alleged victim if needed -interview appropriate individuals; which may include the alleged victim, employees working during the shift when the event was discovered/reported, as well as other residents who may have witnessed something (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Some	-the Social Worker may interview other potential victims Resident #141 was admitted to the facility in January 2025 for short term rehabilitation and was receiving physical and occupational therapy services. Review of the Minimum Data Set (MDS) assessment, dated 1/13/25, indicated Resident #141 scored 14 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact and was a smoker. Resident #105 was admitted to the facility in December 2024 for short term rehabilitation and was receiving physical therapy services. Review of the MDS assessment, dated 12/29/24, indicated Resident #105 scored 14 out of 15 on the BIMS indicating he/she was cognitively intact and was a smoker. On 1/30/25 at 2:10 P.M., the surveyor observed Resident #141 from their doorway. The Resident did not wave or smile to the surveyor and was visibly upset. The surveyor entered the Resident's room and observed Resident #141 crying. During an interview at this time, the Resident said he/she was listening to his/her music earlier in the day on the way to Rehab when Resident #105 said Why are you listening to that? I don't want to hear Nxxxxx music. Resident #141 said he/she did not know why Resident #105 did not like him/her. Resident #141 said there had been other negative encounters with Resident #105 saying he/she smelled and using racial slurs. Resident #141 said he/she tries to stay in his/her room, as he/she had a TV and iPad he/she could use to pass time. Resident #141 said after today's incident, he/she will stay in his/her room and will not be going to communal places within the facility (such as the drop-in day room) as to avoid situations like today. Resident #141 said he/she was going to just sit in his/her bed in the current spot and that's where the surveyor will find him/her next week when the surveyor returned. Review of the medical record for Resident #105 indicated on 1/7/25 Resident #105 was screaming racial slurs at roommate (Resident #141) and the Resident became aggressive with redirection. Resident #105 was sent to the hospital for a change in mental status. Further review indicated Resident #105 had a room change on 1/7/25 so that he/she was not rooming with Resident #141. Resident #105 was moved two rooms down, diagonally across the hall from Resident #141. Review of the emergency room After Visit Summary from 1/7/25 indicated Resident #105 presented with agitation and included an educational attachment for Intermittent Explosive Disorder which included treatment goals to stop outbursts through the use of cognitive behavioral therapy, group therapy, relaxation methods and medications. Review of the progress notes and care plans for Resident #105 failed to address behaviors and failed to identify interventions. Review of the medical record for Resident #141 failed to indicate any information regarding the Resident being called racial slurs and failed to indicate any follow-up was conducted with Resident #141 to determine the effectiveness of the room change across the hall. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Some	During an interview on 1/30/25 at 2:42 P.M., the Director of Nurses (DON) said Resident #105 had previously had a verbal altercation with Resident #141 when Resident #141 was admitted to the facility and a room change was initiated. She was unaware Resident #105 had used racial slurs during that altercation. During an interview on 1/30/25 at 2:40 P.M., Nurse #3 said she had been working on 1/7/25 when Resident #105 called Resident #141 a nxxxxx and said Resident #141 was making the room smell like a zoo. She said Resident #141 was so upset that he/she started crying because of the racial slurs that were hurled at him/her by Resident #105. Nurse #3 said she notified Nurse #1 who was the nursing supervisor. During an interview on 1/30/25 at 2:43 P.M., Certified Nursing Assistant (CNA) #1 said she was the assigned CNA for Resident #105 and Resident #141. She said about three weeks prior Resident #105 had made racial comments to Resident #141, and they switched the room of Resident #105 to across the hall. She said she was not aware if there had been any additional plan to keep the residents separated. During an interview on 1/30/25 at 2:50 P.M., CNA #3 said on 1/7/25 Resident #105 had said he/she did not like black people and did not want Resident #141 in his/her room. She said Resident #105 was yelling that Resident #141 was nasty and smelled nasty and their room was going to smell nasty now and she felt this was directly related to race. The CNA said she immediately notified the nurse who notified the supervisor and the DON. During an interview on 1/30/25 at 2:55 P.M., Nurse #1 said she was the supervisor on 1/7/25 and was called down to the unit to assist as Resident #105 was yelling about Resident #141 saying that he/she smelled and was calling the Resident the N word. She said the plan at that time was to split up the two residents right way and moved Resident #105 across the hall. She said on 1/7/25 Resident #141 was very sensitive about this and was crying. She said another verbal altercation was bound to happen between the two residents. During an interview on 1/31/25 at 3:23 P.M., CNA #6 said on 1/7/25 she found Resident #141 in his/her room crying. CNA #6 said Resident #105 had called Resident #141 a nxxxxx. She said Resident #105 kept yelling and Resident #141 did not want to stay. The CNA said the Nurse Scheduler had come to assist separating the residents and the DON was contacted as well. In addition, CNA #6 said Resident #105 often uses profanities and if smoking break is late Resident #105 will call the staff bxxxxxs and nxxxxxs. During an interview on 1/31/25 at 9:45 A.M., Social Worker #1 said she was in the facility on 1/7/25 and went to the unit when Resident #105 was yelling. She said she heard Resident #105 yelling this is gross, he/she smells like shit. She said Resident #141 was crying and said this always happens to me. She said she did not directly hear any racist comments but had been told by staff that Resident #105 was saying racial slurs to Resident #141. She said the interdisciplinary team discussed this at morning meeting the next day and she thought the plan was to keep them separated. She said she would not have been involved in any staff education for this and it would have been completed by the Staff Development Coordinator (SDC). (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Some	During an interview on 2/4/25 at 3:47 P.M., the SDC said she was at the facility on 1/7/25 when the altercation occurred. She said she was aware Resident #105 had used racial slurs towards Resident #141. She said the plan was to move the room of Resident #105 and there were no additional interventions. She said she did not provide any staff education on keeping the two residents separated. During an interview on 2/4/25 at 8:48 A.M., the Activity Director said Resident #105 and Resident #141 attend the drop-in center (where residents can come and go at their leisure) and both residents attend the smoking breaks regularly. She said she was unaware there were any altercations between the two residents prior to 1/30/25. During an interview on 2/4/25 at 1:45 P.M., the DON confirmed there was no investigation to review for the verbal abuse that occurred between Resident #105 and Resident #141 on 1/7/25. During an interview on 1/31/25 at 9:25 A.M., Resident #141 said he/she did not understand why Resident #105 did not like him/her and when he/she asked Resident #105 a couple of days prior Resident #105 had responded with go f*** yourself. Resident #141 went on to talk about the racial slurs Resident #105 had used the previous day and Resident #141 said he/she had gotten so upset that he/she had started to lose their temper and raised their voice and was trying hard to control themselves and not retaliate. During an interview on 1/31/25 at 1:30 P.M., the Physical Therapy Assistant (PTA) said on 1/30/25 he went to the room of Resident #141 and asked the Resident to get ready to come down to the rehab gym. He said he then went to the room of Resident #105 to get this Resident to go down to the gym for rehab. He said he had never heard that there had been any issues between the two residents prior. He said Resident #141 had music playing and as they all approached the elevator Resident #105 started yelling and became verbally aggressive. The PTA said he was not sure exactly what was said and he had done his best to de-escalate the situation by having Resident #141 go back to his/her room while Resident #105 continued to yell. He said Resident #105 was aggressive, angry and agitated. He said after Resident #105 went to his/her room he had Resident #141 come down to complete therapy in the Rehab gym. He said Resident #141 was very upset and told him how Resident #105 had been making racial comments and that smoking breaks had become an argumentative setting. During an interview on 1/31/25 at 9:35 A.M., the Certified Occupational Therapy Assistant (COTA) said he was working with Resident #141 and had already seen the Resident this morning. He said he was not at the facility the previous day, 1/30/25 but had heard there was a verbal altercation between Resident #105 and the PTA. He said as far as he knew there had not been any altercations between Resident #105 and Resident #141 since Resident #141 was first admitted . The COTA said he had not heard anything since then and had never been told to keep the residents separated. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Some	During an interview with the Administrator and the DON on 2/5/25 at 12:00 P.M., the DON said she was not aware that Resident #105 had said racial slurs to Resident #141 on 1/7/25 until the surveyors brought it to her attention. The Administrator said he was also not aware and that the racial slurs were verbal abuse and should have been investigated. The DON said the only intervention that occurred on 1/7/25 was to move Resident #105 diagonally across the hall. The Administrator and the DON said they did not recall discussing the racial slurs at morning meeting the following day. The Administrator said he had become aware this week that Resident #105 had been walking by the room of Resident #141, who would be visible from the door, and using it as a tool to continue to make comments towards Resident #141, including racial slurs. The Administrator said this could weigh a lot on someone psychosocially.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 50740 Based on record review and interview, the facility failed to ensure a Notice of Intent to Transfer Resident with Less than 30 Days' Notice was issued to two Residents (#22 and #46), out of a sample of 33 residents and three discharge records reviewed. Specifically, the facility failed to send a copy of the Notice of Intent to Transfer Resident with Less than 30 Days' Notice to the Ombudsman's office when the Residents were transferred to the hospital. Findings include: Review of the facility's policy titled Bed Holds/Returns, dated 11/2024, indicated but was not limited to the following: -Prior to transfer, written information will be given to the residents and/or the resident representatives that explains in detail: a. The rights and limitations of the resident regarding the bed holds; b. The reserve bed payment policy established by the state plan (Medicaid residents); c. The facility per diem rate required to hold a bed (non-Medicaid residents), or hold a bed beyond the state bed-hold period (Medicaid residents); and d. The details of the transfer (per the Notice of the Transfer). 1. Resident #22 was admitted to the facility in July 2023 with diagnoses including heart failure (a condition where the heart does not pump blood as effectively as it should) and rheumatoid arthritis (a chronic inflammatory disorder primarily affecting the joints). Review of the Minimum Data Set (MDS) assessment, dated 1/10/25, indicated Resident #22 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact. Review of Resident #22's medical record indicated he/she was transferred to the hospital three times in the month of 6/2024, and one time in the months of 8/2024 and 1/2025. The facility failed to provide documentation indicating the Ombudsman was notified of any of the Resident's transfers. During an interview on 2/4/25 at 9:07 A.M., Social Worker #1 said that she did not send any Notices of Transfer/Discharge to the Ombudsman. 49424 2. Resident #46 was admitted to the facility in April 2022 with diagnoses including dementia, Parkinson's disease, and epilepsy (seizure disorder). (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Review of the MDS assessment, dated 1/17/25, indicated the Resident scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment indicating the Resident was cognitively intact. Review of Resident #46's medical record indicated the Resident was transferred to the hospital once in each of the following months: 2/2025, 1/2025, 9/2024, 8/2024, and 7/2024. During an interview on 1/28/25 at 4:30 P.M., the Ombudsman said she had not received any transfer/discharge notices since July 2024. She said she was not sure if the facility was issuing notices to the residents and their responsible party. The Ombudsman also said the facility did not inform her when a resident received a 30-day discharge notice. During an interview on 2/4/25 at 9:07 A.M., Social Worker #1 said nurses complete the transfer/discharge notices and send them with the resident to the hospital. She said Resident #46 is not his/her own responsible party, and the transfer notices should have been provided to Resident #46's Health Care Proxy (HCP). Social Worker #1 said she should have mailed these notices to the Resident #46's HCP but did not. She said she had not been sending transfer notices when residents go to the hospital. She said she was not sure exactly what the process should be for completing transfer/discharge notices and ensuring the resident, resident representative, and ombudsman receive copies. During an interview on 2/4/25 at 9:25 A.M., the Director of Nurses (DON) said she was not aware the transfer/discharge notices were not being sent to the ombudsman. The DON said she expected a resident or their responsible party and the Ombudsman to receive transfer/discharge notices.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 50740 Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was complete and accurate to reflect the status of five Residents (#22, #30, #107, #47, #154), out of a sample of 33 residents. Specifically, the facility failed: 1. For Resident #22, to complete MDS Section J0200, Pain Assessment Interview; 2. For Residents #30, #107, #47, and #154, to complete MDS Section C0200, Brief Interview for Mental Status (BIMS), and D0150, Resident Mood Interview. Findings include: 1. Resident #22 was admitted to the facility in July 2023 with diagnoses including chronic pain syndrome and rheumatoid arthritis (a chronic inflammatory disorder primarily affecting the joints). Review of the Minimum Data Set (MDS) assessment, dated 1/10/25, Section J indicated, but was not limited to, the following: J0200: Should Pain Assessment Interview be Conducted?: Yes Further review indicated questions J0300 through J0600 were not answered and there was no assessment of the Resident's pain presence, pain frequency, pain effect on sleep, pain interference with therapy activities, pain interference with day-to-day activities, and pain intensity. During an interview on 2/5/25 at 9:08 A.M., the Director of Nurses (DON) said the facility does not have an MDS policy and staff completing the MDS follow the instructions in the Long-Term Care Facility Resident Assessment Instrument user's manual. During an interview on 2/5/25 at 11:22 A.M., the MDS nurse said the pain interview should have been completed, but there was not adequate information in the Resident's record and the interview was not completed. 49424 2. Review of resident records for Residents #30, #107, #47, #154 indicated inaccurate and incomplete MDS assessments for section C (BIMS) and section D (Mood Assessment). Review of Resident #30's MDS assessment, dated 1/8/25, indicated the BIMS and Resident Mood Interview should be conducted. Further review of the questions indicated that they were marked with a dash indicating an incomplete assessment. Review of Resident #107's MDS assessment, dated 1/8/25, indicated the BIMS and Resident Mood Interview should be conducted. Further review of the questions indicated that they were marked with a dash indicating an incomplete assessment. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident #47's MDS assessment, dated 1/8/25, indicated the BIMS and Resident Mood Interview should be conducted. Further review of the questions indicated that they were marked with a dash indicating an incomplete assessment. Review of Resident #154's MDS assessment, dated 1/15/25, indicated the BIMS and Resident Mood Interview should be conducted. Further review of the questions indicated that they were marked with a dash indicating an incomplete assessment. During an interview on 2/4/25 at 3:20 P.M., the MDS nurse said the BIMS assessment and the Resident Mood Interview should be completed by social services. She said if the resident is not able to participate, then the staff interviews should be completed. She said if the social service evaluations are not complete then the MDS fields are marked with a line to show no data was collected. She said that Residents #30, #107, #47, and #154 should have had data entered from the interviews but were not completed prior to the assessment review date (ARD). During an interview on 2/4/25 at 3:30 P.M., Social Work Consultant #1 said the BIMS and Mood assessments should have been completed for the residents and does not know why they were not. He said if the social service assessment weren't complete, then often the other assessments were not as well. He said the residents should have completed assessments either through resident interview or staff interview. During an interview on 2/5/25 9:08 A.M., the DON said there is no specific facility policy related to MDS completion but the facility follows the Resident Assessment Instrument (RAI) manual. She said she expects that the assessments are being completed accurately and reflective of the residents' current cognition and mood.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 46562 Based on record review and interview, the facility failed, for one Resident (#43), out of 33 sampled residents, to complete Preadmission Screening and Resident Review (PASARR- screen to determine if a resident had an intellectual or developmental disability and/or serious mental illness (ID/DD/SMI) and needed further evaluation) prior to his/her admission. Findings include: Resident #43 was admitted to the facility in December 2023. Review of the medical record indicated a PASARR had not been completed until one day after his/her admission to the facility. During an interview on 1/30/25 at 12:27 P.M., Social Worker #1 reviewed Resident #43's medical record and said Resident #43's PASARR was not completed prior to admission. Social Worker #1 said the PASARR should have been completed before the Resident was admitted . During an interview on 1/30/25 at 2:23 P.M., Corporate Nurse #2 said the facility did not have a PASARR policy.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 49424 Based on observation, interview, and document review, the facility failed to ensure one Resident (#144) was informed of and actively participated in his/her baseline plan of care within the first 48 hours following admission, out of a total sample of 33 residents. Findings include: Review of the facility's policy titled Baseline Care Plan, dated as revised 11/2017, indicated but was not limited to: -To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within 48 hours of the resident's admission -The resident and their representative will be provided a summary of the baseline care plan that includes but is not limited to: a. The initial goals of the resident; b. A summary of the resident's medications and dietary instructions; c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. Resident #144 was admitted to the facility in September 2024 with diagnoses of Parkinson's disease, Type II diabetes, and delusional disorders. Review of the Minimum Data Set (MDS) assessment, dated 11/7/24, indicated the Resident scored 2 out of 15 on the Brief Interview for Mental Status (BIMS) assessment indicating severe cognitive impairment. Review of Physician's orders, dated 11/19/24, indicated Resident #144's Health Care Proxy was activated. During an interview on 2/3/25 at 1:58 P.M., Social Worker #1 said the process is supposed to include the initiation and completion of the baseline care plan under the evaluation tab in the electronic health record (EHR). She said there was a lapse in consistent social service coverage and Resident #144's baseline care plan did not get completed. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/25 at 3:20 P.M., Social Work Consultant #1 said the contract for the consulting company was initiated on 1/6/25 and he cannot speak to previous missed baseline care plan meetings. He said he was aware that meetings were not being conducted regularly and the meeting is where the resident and resident representative would receive a copy of the initiated baseline care plan. He said because the meetings were not occurring it is possible that the baseline care plans were not being completed previously. He said Resident #144 did not have a baseline care plan and the representative did not receive a copy.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 36542 Based on record review and interview, the facility failed to develop and implement a person-centered plan of care for two Residents (#105, #141), out of a total of 33 sampled residents. Specifically, the facility failed: 1. For Resident #105, to implement a care plan and interventions related to exhibited behaviors of yelling, swearing, throwing furniture, exposing themselves, alcohol intoxication and using racial slurs; and 2. For Resident #141, to have a person-centered care plan by implementing a behavior care plan that was not individualized and failed to initiate a care plan related to the trauma of military combat. Findings include: Review of the facility's policy titled Behavioral Assessment, Intervention and Monitoring, revised in November 2017 indicated but was not limited to the following: -behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment. -the interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. -safety strategies will be implemented immediately if necessary to protect the resident and others from harm -the resident will be involved in the development and implementation of the care plan. -interventions will be individualized and part of an overall care environment that supports physical functional and psychosocial needs and strives to understand, prevent or relieve the resident's distress or loss of abilities. -interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. -the care plan will include, as a minimum: a description of the behavioral symptoms (frequency, intensity, duration, outcomes, location, environment, and precipitating factors or situations), targeted and individualized interventions for behavioral and/or psychosocial symptoms, rational for the interventions and approaches, specific and measurable goals for targeted behaviors, and how staff will monitor for the effectiveness of the interventions. 1. Resident #105 was admitted to the facility in December 2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS) assessment, dated 12/29/24, indicated Resident #105 scored 14 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. Review of the Nursing Progress Notes indicated on 12/31/24 Resident #105 returned to the facility at 7:00 P. M. following a personal leave with family. When the Resident returned he/she was verbally loud and noisy, making inappropriate statements to staff and slurring his/her speech. The note indicated Resident #105 became very agitated, threatening to punch someone if he/she did not get their medication. The Resident then went to their room and started throwing around furniture, came back into the hallway swearing and exposing him/herself to the nurse, while yelling with slurred speech. 911 was called and Resident #105 was sent to the hospital. During an interview on 1/30/25 at 2:55 P.M., Nurse #1 said she was working on 12/31/24 when Resident #105 returned and was intoxicated. She said the Resident was yelling and swearing and there were family members of other residents around. Review of the Nurse Practitioner's (NP) Progress Note, dated 1/3/25, indicated Resident #105 was sent to the emergency room for aggressive behavior and alcohol intoxication with the following plan: -behavior: nursing to provide ongoing support to monitor for any signs of recurrent aggression or agitation and collaborate with behavioral health services if necessary -alcohol intoxication: reinforce strategies to prevent further episodes and consider behavioral counseling or substance use treatment referrals if patient agrees Review of the care plans failed to indicate a care plan with behavioral interventions was implemented following Resident #105 being intoxicated, yelling, swearing, throwing furniture and exposing him/herself. Review of the Nursing Progress Note indicated on 1/7/25 Resident #105 was yelling and screaming racial slurs at a new resident and when staff attempted to redirect the Resident he/she became very aggressive and the Resident was sent to the hospital. Review of the emergency room After Visit Summary from 1/7/25 indicated Resident #105 presented with agitation and included an educational attachment for Intermittent Explosive Disorder (recurrent aggressive behavior; disordered aggression) which included treatment goals to stop outbursts through the use of cognitive behavioral therapy, group therapy, relaxation methods and medications. During an interview on 1/30/25 at 2:55 P.M., Nurse #1 said she was the supervisor on 1/7/25 and was called when Resident #105 was yelling racial slurs. She said the Resident was screaming, would not take Ativan (an antianxiety medication) and was sent out the hospital. During an interview on 1/30/25 at 2:43 P.M., Certified Nursing Assistant (CNA) #1 said she was the primary CNA for Resident #105. She said the Resident gets upset and yells and she gives the Resident space. She said she did not know any other ways to manage the behaviors. During an interview on 1/30/25 at 2:42 P.M., the Director of Nurses (DON) said on this day Resident #105 was yelling, swearing, and using a racial slur. She said there had been a few issues with Resident #105 since admission and Resident #105 had a history of drug and alcohol abuse. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the January 2025 Behavior Monitoring, completed by the CNAs, indicated Resident #105 had the following behaviors: 1/4/25: accusing of others, expressing frustration/anger at others, cursing at others, screaming at others 1/17/25: expressing frustration/anger at others 1/22/25: expressing frustration/anger at others 1/26/25: expressing frustration/anger at others Review of the care plans for Resident #105 on 1/30/25 failed to address behaviors of yelling, swearing, being aggressive, saying racial slurs, or substance abuse and failed to identify interventions. During an interview on 1/31/25 at 9:40 A.M., Social Worker #1 said the facility Social Workers do not create or participate in care plans related to behavioral concerns. She said the nursing staff were responsible for behavioral care plans. She said Resident #105 has had behaviors of yelling, screaming, using racial slurs and had been sent out to the hospital for being intoxicated. During an interview on 1/31/25 at 9:40 A.M., Social Work Consultant #2 said the Social Workers do not create or participate in care plans related to behavioral concerns. She said Resident #105 has had behaviors of yelling, swearing and being verbally aggressive. She said the Resident can be combative in discussions and was screaming and swearing at her on 1/30/25 when she inquired if the Resident would change his/her room. During an interview on 2/4/25 at 12:11 P.M., Unit Manager #1 said she was a nurse on the unit prior to becoming the Unit Manager last week. She said the behavioral care plans were usually a collaboration between the Social Workers and the Unit Manager. She said she was not sure if behavioral interventions were implemented for Resident #105 and she had not initiated a care plan for this Resident. During an interview on 2/4/25 at 3:10 P.M., Social Work Consultant #1 said Resident #105 had been exhibiting behaviors and a care plan should have been initiated for the Resident with personalized interventions. During an interview on 2/4/25 at 4:15 P.M., Nurse #11 said she was previously the Unit Manager until mid-January 2025. She said Resident #105 had behaviors of making racial comments, yelling, and throwing things. She said the Social Workers create care plans related to behavioral concerns of verbal altercations, throwing things, and substance use. During an interview on 2/5/25 at 12:00 P.M., the Administrator said the Social Workers should have evaluated/assessed the behaviors of Resident #105 and implemented care plans following a face-to-face assessment with resident specific interventions. He said he was unaware that the Social Workers were not initiating behavioral care plans and they should be involved from a psychosocial standpoint. 2. Resident #141 was admitted to the facility in January 2025. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment, dated 1/13/25, indicated Resident #141 scored 14 out of 15 on the BIMS indicating he/she was cognitively intact. During an interview on 1/29/25 at 10:20 A.M., Resident#141 said he/she was a veteran and had experienced combat. Review of the care plans failed to indicate Resident #141 was a veteran who experienced combat and was wounded in combat. Review of the care plans for Resident #141 indicated the following: -Focus: Behavior: potential concern related to verbally abusive as evidenced by verbal outbursts due to frustrations with others, current health status and inpatient admission status -Goal: behavior will not interfere with daily care needs, will not harm themselves or others secondary to their behaviors -Interventions: administer and monitor effectiveness of medications -anticipate care needs and provide before resident becomes overly stressed -invite and encourage activity programs -provide non-confrontational environment -share options of dealing with feelings -when agitated reapproach at a later time Review of the medical record, including all progress notes, failed to indicate Resident #141 had exhibited any verbal outbursts or had been verbally abusive. During an interview on 1/30/25 at 4:52 P.M., the MDS Coordinator said she had created the behavioral care plan of being verbally abusive for Resident #141. She said the care plan was created based on the MDS assessment which indicated the Resident had verbal behaviors towards others (threatening, screaming, cursing). She said the information came from the Certified Nursing Assistant (CNA) Behavior Monitoring. Review of the Behavior Monitoring with the MDS Coordinator indicated CNA #2 was the only CNA who had documented the behavior of expressing frustration/anger at others. for Resident #141. The MDS Coordinator said she did not know the specifics of the behaviors for Resident #141. During an interview on 1/31/25 at 9:39 A.M., Social Worker #1 said the Social Workers were not involved in behavioral care plans, but that Resident #141 had not exhibited any behaviors and was very polite. In addition, she reviewed the Social Service Evaluation and said Resident #141 was a veteran who had experienced combat and had been wounded in combat. She said being in combat would be traumatic and a care plan should have been implemented. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/31/25 at 9:45 A.M., Social Worker Consultant #2 confirmed the Social Workers were not involved in behavioral care plans. She said Resident #141 had not exhibited any behaviors. During an interview on 1/31/25 at 11:45 A.M., CNA #2 said Resident #141 had gotten frustrated when he/she did not get the food they ordered on the selected menu and would be on the telephone yelling about it. She said the Resident was very pleasant to her and had never yelled at her, other staff or other residents. During an interview on 1/31/25 at 1:30 P.M., the Physical Therapy Assistant who works with Resident #141 said the Resident had not had any behaviors and enjoyed the facility food and would often order a second tray of food. During an interview on 2/4/25 at 8:48 A.M., the Activity Director said Resident #141 had not had any behaviors. During an interview on 2/4/25 at 9:34 A.M., CNA #7 said she worked on the unit of Resident #141 and the Resident had not exhibited any behaviors. During an interview on 2/4/25 at 10:00 A.M., CNA #8 said she was the assigned CNA for Resident #141 and the Resident had not had any behaviors of yelling or verbal outbursts. During an interview on 2/4/25 at 3:05 P.M., Social Work Consultant #1 said the reaction of being frustrated with getting the wrong meal was reasonable and a behavioral care plan for verbal abuse was not warranted for Resident #141.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 49428 Based on interview and record review, the facility failed to provide care and services consistent with professional standards of practice for one out of four units, and for five Residents (#136, #105, #210, #457, and #110) out of a total sample of 33 residents. Specifically, the facility failed to: 1. Administer morning medications per physician's orders on one of four units; 2. For Resident #136, administer medications timely including diabetic and seizure medications; 3. For Resident #105, administer an opioid as ordered and document in the medical record when it was administered; 4. For Resident #210, administer an IV (intravenous) antibiotic timely; 5. For Resident #457, provide urostomy and colostomy care per physician's orders; and 6. For Resident #110, obtain a physician's order for an air mattress. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. Review of the facility's policy titled Administering Medications, dated as revised in September 2024 indicated but was not limited to the following: -medications are administered in accordance with prescriber orders, including any required time frame -medications may be administered one (1) hour before or after the prescribed time, unless otherwise specified -the individual administering medications records the administration on the resident's Medication Administration Record (MAR) 1. During an interview on 2/3/25 at 1:45 P.M., Residents #47 and #458 on Unit 1 said they had not received today's morning medications at the scheduled times. Residents #47 and #458 said they were given their morning medications around 1:15 to 1:30 P.M. Both Residents also said a Resident across the hall was upset and yelling about not getting his/her morning medications that day. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/3/25 at 1:54 P.M., Nurse #8 said she was asked to work the unit around 12:15 P.M. at which time she was told morning medications were not passed. During an interview on 2/3/25 at 2:05 P.M., Unit Manager (UM) #1 said Nurse #1 was pulled from her assignment around 12:00 to 12:30 P.M. today. UM #1 said she was unsure why the nurse was pulled, but morning medications were not given. During an interview on 2/3/25 at 2:19 P.M., the Director of Nursing (DON) said if the Medication Administration Record indicated nursing administered a medication, then she believed the nurse administered it. The DON said the plan was to monitor residents and call the physician if needed. The DON said Nurse #8 is now covering the unit. During an interview on 2/3/25 at 3:25 P.M., the DON said Nurse #1 did not administer all the morning medications on Unit 1. The DON said the physicians had been called and instructed the facility to skip morning medications. Review of the Medication Administration Audit Report (MAAR), dated 2/3/25 at 3:28 P.M., indicated but was not limited to the following: -Resident name, Unit, Order Summary, Schedule Date (which included the scheduled administration time), Administration Time, Documented Time, Documented By; -List of Residents on Unit 1 with medication and/or treatment orders with no documentation of completion; -18 Residents with blank documentation for physician's orders that were scheduled between 7:00 A.M. and 12:00 P.M. Review of the MAAR, dated 2/3/25 at 3:44 P.M., indicated but was not limited to the following: -Resident name, Unit, Order Summary, Schedule Date (which included the scheduled administration time), Administration Time, Documented Time, Documented By; -39 Residents on Unit 1 were scheduled for medication and/or treatment orders; -39 Residents on Unit 1 had at least one physician's medication/treatment order with Administration Time and Documented Time completed two or more hours after the Schedule Date and scheduled administration time. -Administration Times and Documented Times ranged from more than two hours to eight and a half hours past the Schedule Date and scheduled administration times. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/4/25 at 1:52 P.M., Resident #93 said on 2/3/25 he/she did not get his/her morning medications until 2:30 P.M. The Resident said Nurse #1 was outside his/her door twice that day, once at 9:15 A.M., telling the Resident she had his/her medications. The Resident said Nurse #1 evidently gave residents their medications and didn't write it down in the book. The Resident said if that was the case, double medicating could be dangerous. Resident #93 said the situation makes him/her angry and upset. The Resident said he/she is flexible when it comes to receiving medication, but he/she cannot wait to take his/her blood pressure and diuretic medication. The Resident said his/her roommate did not get their morning medications on 2/3/25 either. During an interview on 2/4/25 at 3:26 P.M., Nurse #8 said she had taken over the medication cart around noon on 2/3/25. She said she could not tell which residents received their medications and which residents did not because not all of the medications were documented as administered in the electronic medical record. She said the most she could do was start with the noon medications and move forward adding It was just chaos. During an interview on 2/5/25 at 12:00 P.M., the Director of Nurses (DON) said the nurses should be documenting on the MAR as medications were administered and medications should be administered between one hour before and one hour after the scheduled time. 36542 2. Resident #136 was admitted to the facility in December 2024 with diagnoses of epilepsy, hypothyroidism, and diabetes. Review of the MDS assessment, dated 1/1/25, indicated a BIMS should be conducted with Resident #136, but was not completed. The staff assessment indicated Resident #136 had moderately impaired cognitive skills for daily decision making. During an interview on 1/29/25 at 8:40 A.M., Resident #136 said he/she takes seizure medication around 8:00 P.M. or 9:00 P.M. and that the previous night (1/28/25) he/she had to leave their room to ask for their seizure medication around midnight. He/she said they also take a medication for their thyroid which was not given on time the previous day. The Resident said the hospital staff had told him/her that they needed to take their medication on time in order to avoid complications. Resident #136 became tearful and said, It's my life. Review of the Physician's Progress Note, dated 1/2/25, indicated Resident #136 had multiple issues related to the underlying history of seizure disorder during the hospitalization , was followed by neurology, and medications had been adjusted. Review of the January 2025 Medication Administration Audit Report (MAAR) which included time of administration indicated that on 1/28/25 the following medications were scheduled to be administered at 8:00 P.M. -Levetiracetam tablet 1000 milligrams (mg) for seizures was administered at 10:32 P.M. -Amitriptyline 50 mg for seizures was administered at 10:32 P.M. -Lacosamide 150 mg for seizures was administered at 12:12 A.M. on 1/29/25 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cenobamate 200 mg for seizures was administered on 12:12 A.M. on 1/29/25 Further review of the January 2025 MAAR indicated the following medications were administered over an hour after the scheduled time of administered: -Repaglinide (regulates the amount of sugar in blood) 0.5 mg to be given for diabetes before lunch at 11:00 A.M.: 9 out of 30 times -Repaglinide 0.5 mg at 4:00 P.M.: 5 out of 29 times -Humalog injection (insulin), 12 units at 8:00 A.M.: 16 out of 30 times -Humalog insulin: inject based on sliding scale of blood sugars at 6:30 A.M.: 2 out of 30 times -Humalog insulin: inject based on sliding scale of blood sugars at 4:00 P.M.: 2 out of 29 times -Lacosamide 150 mg give twice per day for seizure disorder at 8:00 A.M.: 16 out of 30 times -Lacosamide 150 mg give twice per day for seizure disorder at 8:00 P.M.: 2 out of 29 times -Levetiracetam tablet 1000 mg twice per day for seizures at 8:00 A.M.: 16 out of 30 times -Levetiracetam tablet 1000 mg twice per day for seizures at 8:00 P.M.: 2 out of 29 times -Amitriptyline 50 mg one time per day for seizures at 8:00 P.M.: 2 out of 29 times -Cenobernate 200 mg tablet for seizures at 8:00 P.M.: 2 out of 29 times -Enoxaparin (anticoagulant) 30 mg injected one time per day at 8:00 A.M.: 16 out of 30 times -Magnesium Oxide 800 mg twice per day 8:00 A.M.: 16 out of 30 times -Magnesium Oxide 800 mg twice per day at 8:00 P.M.: 2 out of 29 times -Lidocaine pain relief patch to bilateral knees at 8:00 A.M.: 16 out of 30 times -Cyanocobalamin (Vitamin B12) 500 micrograms (mcg): 16 out of 30 times -Cholecalciferol (Vitamin D) tablet 1000 unit twice per day 8:00 A.M.: 16 out of 30 times -Cholecalciferol tablet 1000 unit twice per day at 8:00 P.M.: 2 out of 29 times -Prilosec (decreases stomach acid) 20 mg at 8:00 A.M.: 16 out of 30 times -Calcium Carbonate 600 mg at 8:00 A.M.: 16 out of 30 times -Acetaminophen 650 mg for arthritic pain at 8:00 A.M.: 16 out of 30 times (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Lisinopril 10 mg for hypertension at 8:00 P.M.: 2 out of 29 times -Atorvastatin 40 mg for hyperlipidemia at 8:00 P.M.: 2 out of 29 times -Ezetimibe 10 mg for cholesterol control at 9:00 P.M.: 2 out of 29 times -Levothyroxine 100 mcg for thyroid at 6:30 A.M.: 2 out of 30 times During an interview on 1/31/25 at 2:22 P.M., the DON said all medications should be given within one hour before or one hour after the scheduled time. She said she had not heard there were any issues with administering medications late from staff or residents and could not say why medications were not being administered on time. She said her expectation was that medications get administered on time. During an interview on 2/3/25 at 12:00 P.M., Nurse #13 said he regularly worked on the unit of Resident #136 and was his/her nurse during the day shift. He said he was not sure why medications were not administered on time. He said the network made the electronic medical record system very slow and that it would take multiple seconds (up to 30) while waiting between clicking one button and it was difficult to wait for the system to process the information. 3. Resident #105 was admitted to the facility in December 2024 following a new above the knee amputation of the left leg. Review of the MDS assessment, dated 12/29/24, indicated Resident #105 had pain almost constantly which frequently interfered with therapeutic activities and day to day activities. During an interview on 2/3/25 at 2:18 P.M., the DON said there had been a change in the nurse on the River 1 unit around 12:00 P.M. today. She said she was not sure which residents had gotten their morning medications and which had not. She said Resident #105 had been sent out during this time related to stroke-like symptoms. Review of the February 2025 MAAR indicated Resident #105 received the following medication from Nurse #8 on 2/3/25 at 2:35 P.M. (after they had left the facility): -Oxycodone (an opioid used for pain management) 5 milligrams (mg), scheduled for 8:00 A.M. During an interview on 2/4/25 at 3:26 P.M., Nurse #8 said she completed report on the residents on River 1 with Nurse #1 around noon on 2/3/25. She said the medication cart was located outside of the room of Resident #105 and Nurse #1 had said they had just administered medications to Resident #105 but had not signed them off in the electronic medical record. She said Nurse #1 had administered the Oxycodone to Resident #105 and had signed the Oxycodone out in the Controlled Substance Log. Nurse #8 said she should not have marked the medication as administered on the MAR. Review of the Physician's Orders indicated Resident #105 had the following orders: -Oxycodone 5 mg twice per day at 8:00 A.M. and 8:00 P.M. (started 1/6/25) and -Oxycodone 5 mg as needed for moderate to severe pain twice per day (started 1/24/25) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Controlled Substance Log versus the MAR for 2/1/25 through 2/3/25 indicated the following for Oxycodone scheduled and as needed: 2/1/25 administered at 9:00 A.M. (as scheduled) 2/1/25 administered at 2:45 P.M. (an as needed dose which was not on the MAR) 2/1/25 administered at 8:00 P.M. (as scheduled) 2/2/25 administered at 2:00 A.M. (an as needed dose which was not on the MAR) 2/2/25 administered at 2:45 A.M. (an as needed dose which was not on the MAR and which was administered 45 minutes after the previous as needed dose) 2/2/25 administered at 7:00 P.M. (as scheduled) 2/2/25 administered at 11:00 P.M. (an as needed dose which was not on the MAR) 2/3/25 administered at 9:00 A.M. (as scheduled) Review of the Controlled Substance Log indicated Nurse #1 had signed out all of the administered doses of Oxycodone from 2/1/25 through 2/3/25. During an interview on 2/4/25 at 5:00 P.M., the DON said she would have to review the information to determine why the nurse had not documented on the MAR and the administration of an Oxycodone 45 minutes after the previous administration. During an interview on 2/5/25 at 12:00 P.M., the DON said they were still reviewing the administration of the Oxycodone for Resident #105 and had not spoken with Nurse #1. She said the nurses should be documenting on the MAR when medications were administered. 15214 4. Resident #210 was admitted in January 2025 with diagnoses which included osteomyelitis (bone infection) and sepsis (infection in bloodstream). On 1/31/25 at 2:19 P.M., the surveyor observed Resident #210's Intravenous Vancomycin (antibiotic) 1250 milligrams (mg) infusing via an IV pump at 166 milliliters(ml)/hour. The IV Vancomycin was ordered to be administered at 9:00 A.M. During an interview on 1/31/25 at 2:34 P.M., Nurse #5 said that she didn't start to administer the Resident's Vancomycin until approximately 12:15 P.M. She said she administered it late because she is new and not familiar with the residents and the medications. She said that she understood the importance of administering medications like Vancomycin (a potent antibiotic) on time. During an interview on 1/31/25 at 2:38 P.M., Unit Manager #1 (UM) #1 said that the IV Vancomycin should have been administered at 9:00 A.M. and was late, as Nurse #5 did not administer it until 12:15 P.M. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/31/25 at 3:01 P.M., the DON said that she shared the same concern regarding the late administration of the Resident's Vancomycin. 5. Resident #457 was admitted to the facility in January 2025 with diagnoses that included acute polynephritis (kidney infection), severe sepsis (a life-threatening blood infection) with septic shock (organ failure and dangerously low blood pressure), cancer status post total pelvic exenteration (removal of pelvic organs) and chemo and radiation therapies, postprocedural pain, and colostomy (a procedure that diverts the colon to the abdominal wall) status. Review of Resident #457's Physician Orders included but was not limited to the following: -1/30/25, Change colostomy appliances; Coloplast 1 3/4 inch (in) every day shift every 3 day(s) for colostomy; -1/22/25, Change urostomy appliances every day shift every 3 day(s) for urostomy; -1/22/25, Colostomy care every shift; -1/22/25, Urostomy care every shift. Review of Resident #457's January and February 2025 Treatment Administration Record (TAR) indicated that care was not performed and not completed on: -Change colostomy appliances; Coloplast 1 3/4 inch (in) every day shift every 3 day(s) for colostomy not completed on 2/2/25. -Change urostomy appliances every day shift every 3 day(s) for urostomy not completed on 2/2/25. -Colostomy care every shift not completed on the following shifts: 1/23/25 (day); 1/26/25 (evening); 1/29/25 (evening); 2/1/25 (evening); 2/2/25 (day and evening). -Urostomy care every shift not completed on the following shifts: 1/23/25 (day); 1/26/25 (evening); 1/29/25 (evening); (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/1/25 (evening); 2/2/25 (day and evening). Review of Resident #457's care plan indicated but was not limited to the following: -Bowel incontinence/ostomy characterized by inability to control bowel movements related to recent surgical creation of ostomy; -Change appliance as ordered and as needed, 1/22/25; -The resident has ileal conduit/urostomy in place status post-surgical creation; During an interview on 2/5/25 at 3:02 P.M., Nurse #12 said when treatment is completed or a medication is administered, staff will check off the corresponding order in the resident's Medication Administration Record (MAR) or TAR. Nurse #12 said blank entries indicate a treatment was not performed or a medication was not administered. Nurse #12 said any blank entries for urostomy and colostomy care in Resident #457's TAR indicated the care was not provided. During an interview on 2/5/25 at 1:05 P.M., the DON said a check mark on the MAR or TAR indicates a treatment was provided or a medication was administered. The DON said any blank entries for Resident #457's urostomy and colostomy care indicated the treatment was not performed per physician's orders. During an interview on 2/5/25 at 12:00 P.M., the Director of Nurses (DON) said the nurses should be documenting on the MAR as medications were administered and medications should be administered between one hour before and one hour after the scheduled time. 6. Resident #110 was admitted to the facility in May 2023 with diagnoses that included venous thrombosis and embolism and type 2 diabetes. Review of Resident #110's MDS assessment, dated 11/27/24, indicated Resident #110 scored 12 out of 15 on the BIMS indicating he/she had moderate cognitive impairment. The MDS also indicated but was not limited to the following: -Resident #110 had not been on a scheduled pain medication regimen and did not receive pain medication on an as-needed basis and did not receive non-medication intervention for pain; -Resident #110's skin was intact; -Skin and ulcer treatments included applications of ointments/medications other than to feet; pressure reducing device for bed was not selected. The surveyor observed Resident #110 lying on his/her air mattress on 1/29/25, 1/30/25, 2/3/25, 2/4/25, and 2/5/25. Review of Resident #110's Physician's Orders did not indicate an order for an air mattress. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/5/25 at 11:42 A.M., Nurse #12 said Resident #110 used an air mattress but did not know why the Resident had one or what the settings were to be. Nurse #12 said the air mattress indication and settings were in the physician's order. Nurse #12 reviewed the Resident's physician's orders and said there was no physician's order for an air mattress. Nurse #12 reviewed the Resident's care plan and said there was no care plan for the Resident's air mattress. Nurse #12 said Resident #110's air mattress should have a physician's order and be documented in the Resident's care plan. During an interview on 2/5/25 at 1:05 P.M., the DON said Resident #110 should have a physician's order for his/her air mattress and the air mattress should be included in the Resident's care plan.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 49428 Based on record review and interviews, the facility failed to provide the necessary care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being for one Resident (#457), out of a total sample of 33 residents. Specifically, the facility failed to fully develop and implement interdisciplinary care plans related to his/her primary language of Spanish and failed to ensure staff provided person-centered care and services to determine and support the Resident's communication needs. Findings include: Review of the facility's policy titled Translation and Interpretation Policy, dated January 2018, indicated but was not limited to: Policy: The facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility. Guidelines: -All LEP persons shall receive a written notice in their primary language of their rights to obtain competent oral translation services free of charge. If written notice is not possible, such notice shall be given orally. -Competent oral translation of vital information and non-vital information shall be provided in a timely manner and at no cost to the resident through the following means (as available to the facility): a. A staff member who is trained and competent in the skill of interpreting; b. A staff interpreter who is trained and competent in the skill of interpreting; c. Contracted interpreter service; d. Voluntary community interpreters who are trained and competent in the skill of interpreting; e. Telephone interpretation services. -Interpreters and translators must be appropriately trained in medical terminology, confidentiality of protected health information, and ethical issues that may arise in communicating health-related information. -Family members and friends shall not be relied upon to provide interpretation services for the resident, unless explicitly requested by the resident. If family or friends are used to interpret, the resident must provide written consent for disclosure of protected health information. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-It is understood that providing meaningful access to services provided by this facility requires also that the LEP resident's needs and questions are accurately communicated to the staff. Oral interpretation services therefore include interpretation from the LEP resident's primary language back to English. -Staff should be trained upon hire and at least annually on how to provide language access services to LEP residents. Review of Resident #457's Admission Packet indicated but was not limited to the following: Long Term Care Resident Rights Notice of Rights and Services: -You will be informed of your rights and of all rules and regulations governing resident conduct and responsibilities, both orally and in writing, in a language you understand; -You have the right to be fully informed of your total health status; -You will be informed of facility services and charges. Free Choice: -You will be informed of and may participate in the development and implementation of your person-centered care plan and treatment, and any resulting changes. Staff Treatment: -The facility must implement procedures that protect you from abuse, neglect, or mistreatment, and misappropriation of your property. Dignity: -The facility will treat you with dignity and respect in the full recognition of your individuality. Quality of Life: -The facility must care for you in a manner that enhances your quality of life. Accommodation of Needs: -You have the right as a resident to receive services with reasonable accommodations to individual needs and preferences except when to do so would endanger the health or safety of other residents; -You have the right to make choices about specific aspects of your life that are important to you, while staying in the facility. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #457 was admitted to the facility in January 2025 with diagnoses that included acute polynephritis (kidney infection), severe sepsis (a life-threatening blood infection) with septic shock (organ failure and dangerously low blood pressure), cancer status post total pelvic exenteration (removal of pelvic organs) and chemo and radiation therapies, postprocedural pain, and colostomy (a procedure that diverts the colon to the abdominal wall) status. Review of Resident #457's medical record included but was not limited to the following: 1/24/25 Recreation Assessment: Highest level of education = 8th grade or less; Primary language = Spanish; Resident #457 is Spanish, and the interview was done with the help from his/her son. 1/23/25 Social Determinants of Health Progress Note: -Language: Spanish Resident does need or want an interpreter to communicate with a doctor or health care staff. 1/23/25 Evaluation Summary: Social Service Evaluation Completed. Interpreter needed: Yes. 2/3/25 Nurse's Note: Resident alert/verbal, Spanish speaking. This nurse understands some Spanish. 2/3/25 Occupational Therapy (OT) Note: Education provided on benefits in skilled OT, patient declined due to pain, unable to describe due to language barrier. Pain at rest = 5/10; Frequency = constant; Location = generalized; Pain description/Type = unable to describe; Pain with movement = 6/10. Review of Resident #457's care plan indicated but was not limited to the following: Communication Care Plan, dated 1/22/25: -The resident prefers to communicate in (SPECIFY: language); -The resident requires (SPECIFY assistance) with communication. Psychosocial Care Plan, dated 1/22/25: -Encourage alternative communication with visitors; -Honor resident preferences and choices whenever possible; -Provide opportunities for expression of feelings related to situational stressor. During an interview on 1/29/25 at 9:03 A.M., Resident #457's son, who was fluent in English and Spanish, said the Resident and their spouse were mostly Spanish speaking and that the spouse understood some English. The Resident's son said, upon admission, he asked the facility about the potential communication barrier and how the facility handles Spanish translating. The Resident's son said he was told that some staff speak some Spanish, fluent Spanish, or Portuguese. The Resident's son said professional interpreting services were never discussed or offered upon admission. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/25 at 9:05 A.M., Resident #457's son translated for the Resident's spouse who said there were one or two instances in which the Resident's spouse loosely understood information the staff was communicating to them about the Resident. The Resident's spouse said translation services should have been offered. During a telephone interview on 2/4/25 at 9:30 A.M., Resident #457's son said the communication barrier makes the Resident feel uneasy, especially at night when the Resident's spouse can't stay. The Resident's son said there had been times with the Resident pressed his/her call button, staff would come by and say something, but the Resident did not understand. The Resident's son said, one night, Resident #457 asked the nurse if it was time for pain medication but did not understand the nurse's response. Resident #457's son said he asked upon admission if the facility had an interpreter but was told the facility only had some staff that spoke Spanish. During an interview on 2/4/25 at 9:30 A.M., Resident #457's spouse said the Resident asked nursing for pain medication during the night. The Resident's spouse said the Resident was unsure if the nurse did not understand him/her, or if it wasn't time to administer the medication. The Resident's spouse said it makes the Resident uncomfortable when staff does not understand the Resident or the Resident does not understand the staff. During an interview on 2/4/25 at 9:30 A.M., Resident #457's spouse said the Resident's colostomy bag was leaking on a previous day. The Resident's spouse said it appeared staff members were having a conversation back and forth about who would change the colostomy bag but the Resident's spouse could not understand the conversation. The Resident's spouse said staff tried to fix the leaking colostomy but could not resolve the leaking. The Resident's spouse said they felt like they couldn't communicate and would have preferred a translator in this situation. During an interview on 2/4/25 at 1:27 P.M., Nurse #7 said they are not fluent in Spanish. Nurse #7 said they use gestures to communicate with Resident #457. Nurse #7 said there was no communication book with simple pictures, words, or phrases in the Resident's room. Nurse #7 said when asking the Resident about pain, Nurse #7 would hold their stomach and say pain. Nurse #7 said they had never used the telephonic translator services with residents in the few months they'd been working at the facility. Nurse #7 said they were unsure of how to use the telephonic translator services. Nurse #7 said they and Resident #457 have gotten good at gestures. During an interview on 2/4/25 at 2:03 P.M., Unit Manager (UM) #1 said the facility has professional interpreter services via telephone. UM #1 said there was a paper at the nursing station with contact information for the interpreter services. UM #1 said she never had to use the telephonic interpreter services in the years she had worked at the facility. UM #1 said family or facility staff are utilized as interpreters for residents. During an interview on 2/5/25 at 9:52 A.M., Nurse #12 said Resident #457 and their spouse speak little English. Nurse #12 said the Resident's son was called that morning to help translate that the Resident was experiencing nausea. Nurse #12 said there are some Spanish-speaking staff on the floors that the facility uses to help translate. Nurse #12 said she works in the facility quite a lot on the different units and was unaware of any telephonic translating services. Nurse #12 said she had not utilized a telephonic translation service since she started working at the facility. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/25 at 10:01 A.M., Certified Nursing Assistant (CNA) #3 said she speaks Portuguese and some Spanish and helps translate for residents and staff. CNA #3 said she had no formal training or competencies in translating. During an interview on 2/5/25 at 12:32 P.M., Social Worker #1 said she was aware the contracted on-demand phone interpreting service was available for languages that staff do not speak in the facility. Social Worker #1 said she never had to use the phone service in the four months she has been at the facility. Social Worker #1 said the facility has a lot of residents who speak Spanish or Portuguese. Social Worker #1 said no staff on Resident #457's unit speaks fluent Spanish. During an interview on 2/5/25 at 12:32 P.M., Social Worker #1 said she believed admissions would provide residents paperwork with information about those translation services. Social Worker #1 said the front desk receptionist performed admissions. During an interview on 2/5/25 at 1:00 P.M., the Receptionist said she goes over the admission packet with English-speaking residents, and non-English speaking residents' admission would be handled by the appropriate staff who were better able to communicate with the residents. The Receptionist said she was not aware if information on translation services were included in the admission packet. During an interview on 2/5/25 at 1:05 P.M., the Director of Nursing (DON) said the facility utilizes Spanish speaking employees for general questions to residents, but not for detailed interviews. The DON said she was unaware if staff had translating competencies on file. The DON said the facility has a contracted on-demand phone interpreting service which should be used with non-English speaking residents, and she expected staff to be aware of and know how to use the translating service. During an interview on 2/5/25 at 3:21 P.M., Corporate Nurse #2 said there was no documentation of staff training/competency on translating on file and no written consent to disclose Patient Health Information to family members per the facility's policy.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 36542 Based on observations, interviews, and record review, the facility failed to ensure foot care, including toenail care, was provided to one Resident (#122), in a total sample of 33 residents. Specifically, for Resident #122, the facility failed to ensure toenails were cut to prevent thickened elongated nails and ensure treatment to dry flaky skin on the feet. Findings include: Resident #122 was admitted to the facility in December 2023 with a diagnosis of hemiplegia following a stroke. Review of the Minimum Data Set (MDS) assessment, dated 12/18/24, indicated Resident #122 scored 11 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident had a moderate cognitive impairment. The MDS also indicated Resident #122 was their own responsible person. During an interview with observation on 1/29/25 at 10:47 A.M., Resident #122 said they had not seen a podiatrist and would like their toenails and feet looked at. The surveyor observed Resident #122's feet to have long, overgrown toenails which curled off of the toes and dry flaky skin on the toes and bottoms of the feet. Review of the Physician's Orders included an order to consult with a podiatrist as needed. During an interview on 1/30/25 at 9:00 A.M., Unit Manager #2 said the facility utilized a contracted provider for podiatry services including toenail care. She said the consent forms were uploaded into the electronic medical record. Review of the electronic and paper medical record failed to indicate Resident #122 had been offered to see a podiatrist since their admission one year prior. Review of the Weekly Skin Evaluation failed to indicate Resident #122 had elongated toenails or scaly skin on the feet. During an interview on 1/30/25 at 12:47 P.M., Unit Manager #2 said feet should be checked as part of the weekly skin assessment and the Resident's toenails or flaky skin should have been noted. She said Resident #122 definitely needed to be seen by a podiatrist and the podiatrist was coming to the facility on the following day. Review of the Podiatry Group visit from 1/31/25 indicated Resident #122 was being seen for elongated toenails and onychomycosis (a fungal infection of the nails). Review of the visit indicated all toenails were elongated, discolored, yellow, 6 millimeters thick (the height of 3 stacked nickels). The visit indicated the Resident had dry flaky skin on the bilateral feet/digits. During an interview on 1/31/25 at 2:01 P.M., Resident #122 said they were very happy their toenails were cut. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/31/25 at 2:22 P.M., the Director of Nurses said the nurses or the Certified Nursing Assistants should have noticed the Resident's toenails and skin on the feet and reported it to the Unit Manager so that the Resident could have been seen by the Podiatrist.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 50740 Based on observation, record review, and interview, the facility failed to ensure it provided an environment free of potential safety hazards. Specifically, the facility failed: 1. For Resident #138, to ensure that the Resident's safety device was in place at all times when unsupervised per physician's orders; 2. For Resident #123, to safely secure his/her cigarette lighter; and 3. To ensure resident areas were free from portable space heaters. Findings include: 1. Resident #138 was admitted to the facility in March 2024 with diagnoses including cerebral infarction (also known as an ischemic stroke, occurs when blood flow to the brain is disrupted due to issues with the arteries that supply it) and decompressive hemicraniectomy (a surgical procedure in which a significant proportion of the skull is removed). Review of the Minimum Data Set (MDS) assessment for Resident #138, dated 1/1/25, indicated the Resident was rarely/never understood and Brief Interview for Mental Status (BIMS) should not be completed. Further review of the MDS assessment indicated Resident #138 had short-term and long-term memory impairments. Review of Resident #138's current Physician's Orders indicated but was not limited to the following: -Helmet on at all times when unattended (order date: 11/8/24) Review of Resident #138's Impaired Cognition Care Plan included but was not limited to the following intervention: -Resident is to wear helmet at all times when not attended including while in bed (date initiated 11/11/24) Review of Resident #138's Report of Consultation from a vascular neurology appointment, dated 11/8/24, indicated Resident #138 should be wearing a helmet when unattended. Review of Resident #138's Progress Notes, dated 11/1/24 through 2/2/25, failed to indicate that Resident #138 declined to wear the helmet or removed the helmet after it was applied. Review of the Progress Note, dated 11/8/24, indicated Resident #138 returned from a neurology appointment with a recommendation that the Resident should wear a helmet at all times when not attended. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #138's Treatment Administration Record for January 2025 and February 2025 indicated the Resident's helmet was on at all times when unattended as ordered. The surveyor made the following observations during the course of the survey: -On 1/29/25 at 9:40 A.M., Resident #138 was lying in bed without the helmet on. The helmet was noted to be across the room on top of the Resident's dresser. -On 2/3/25 at 8:49 A.M., Resident #138 was sitting up in bed eating breakfast. The Resident was not wearing the helmet. The helmet was across the room on top of the Resident's dresser. -On 2/4/25 at 8:26 A.M., Resident #138 was lying in bed without the helmet on. The helmet was on top of the Resident's nightstand. During an interview on 2/4/25 at 8:33 A.M., Unit Manager #3 said Resident #138 should have the helmet on when he/she is alone. Unit Manager #3 said sometimes Resident #138 removes the helmet himself/herself and will not put it back on. During an interview on 2/4/25 at 9:35 A.M., the Director of Nurses (DON) said that Resident #138 should be wearing the helmet as ordered by the physician. 49424 2. Resident #123 was admitted to the facility in July 2023 with diagnoses including dementia, frontal lobe and executive function deficit (lack of cognitive skills that allow the brain to absorb, remember, and manipulate new information). Review of the MDS assessment, dated 1/24/25, indicated the Resident scored 4 out of 15 on the BIMS assessment, indicating severe cognitive impairment. Review of Resident #123's medical record indicated that he/she has a permanent court appointed legal guardian due to incapacitation, dated 7/13/23. Review of Resident #123's Care Plan, dated 7/30/23, indicated: Focus: Resident wishes to smoke and is assessed for supervision level. Goal: Resident will be free from smoking related injuries. Intervention: Smoking policy is reviewed with resident and/or responsible party. Review of smoking policy indicated that Resident #123's resident representative/legal guardian's signature was not obtained. On 1/30/25 at 8:25 A.M., the surveyor observed, on top of the Resident's television stand across from his/her bed at about waist height, a package of cigarettes and a blue cigarette lighter. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/25 at 8:45 A.M., the surveyor observed Certified Nursing Assistant (CNA) #1 pick up the Resident's breakfast tray and talk with the Resident in his/her room. On 1/30/25 at 11:34 A.M., the surveyor observed the cigarettes and the blue lighter in the same spot as previously observed. On 1/30/25 at 2:14 P.M., the surveyor observed the cigarettes and the blue lighter in the same spot as previously observed. During an interview on 1/30/25 at 8:47 A.M., CNA #1 said residents are not supposed to have their cigarettes or lighters stored in their room, but she said some residents prefer to hold on to them and there isn't anything that can be done if the resident does not want to give staff their lighter or cigarettes. During an interview on 1/30/25 at 8:25 A.M., Resident #123 said he/she has not been out to smoke yet this morning and the first smoke time is at 9:00 A.M. He/she said staff delivered his/her breakfast tray and didn't say anything about having cigarettes and a lighter out. He/She said everyone knows that he/she smokes. He/She has been here two and a half years, and he/she always keeps their cigarette and lighter in the same spot. During an interview on 2/3/25 at 1:24 P.M., CNA #12 said she collects cigarette lighters at the end of the cigarette break. She said there isn't a list of residents who have their own lighters. She said she wasn't sure if there was a formal process for smoking. She said she knows some residents keep their own cigarettes and lighters because she doesn't have to light their cigarettes. During an interview on 2/3/25 at 1:52 P.M., the DON said the expectation is for the Resident's smoking materials to be safely secured. She said the Resident should not have a lighter on their television stand because it shouldn't be accessible to any resident, particularly since his roommate uses oxygen. She said the Resident signed a smoking agreement indicating he/she understands the smoking policy. She said the Resident's Legal guardian should have signed the form, not the Resident if he/she is not his/her own responsible person. 36542 3. On 1/29/25 at 9:30 A.M., the surveyor observed a black portable radiator in the River 2 Sitting Room, where residents were observed finishing breakfast. The black portable radiator was hot to the touch. During an interview on 1/30/25 at 1:08 P.M., CNA #11 said there were two wall unit heaters in the River 2 Sitting Room and there was a period of time where both units did not work so the staff had been utilizing a portable radiator. She said someone took the portable radiator out the previous day because it was a fire hazard. She said currently, only one of the wall unit heaters had been working and the other continued to not work. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/3/25 at 9:30 A.M., the Maintenance Director said one of the wall unit heaters in the River 2 Sitting Room was not working. He said the staff had been using a portable heater and he was not sure where they got it. He said the staff should not have been using a portable heater and he had taken it away. He said the facility was not supposed to use portable heaters. He said the wall unit heater had been leaking and needed a plumber and he would have to check to see if one had been called to fix the unit. On 1/29/25 at 11:20 A.M., the surveyor observed a tan portable radiator, on a medium setting and hot to the touch between the beds of Resident #53 and Resident #76. During an interview at this time, Resident #53 said they had the portable radiator because the wall unit heater only put out cold air and that it did not work. On 1/30/25 at 1:05 P.M., the surveyor did not observe the tan portable radiator in the room of Resident #53 and Resident #76. During an interview at this time, Resident #76 said the staff had removed the portable radiator and the staff had said something about a fire hazard. She said the wall unit heater still was not working. The surveyor observed the wall unit heater to be on, set at 85, and blowing cool air. During an interview on 1/31/25 at 11:20 A.M., Resident #53 said he/she was wearing gloves because it was cold in their room. He/she said the staff had taken their portable radiator and put it in their closet. The surveyor observed the portable radiator in the Resident's closet. She said the wall unit heater continued to blow cold air. During an interview on 2/3/25 at 9:30 A.M., the Maintenance Director said the wall unit heater for Resident #53 and #76 was not working and that a replacement had been ordered, but it was back ordered. He said the Residents should not have had a portable heater as they could be hot to the touch. During an interview on 2/5/25 at 3:10 P.M., the Maintenance Director said there should not be any portable heaters as they are fire hazards and he would look for any policies regarding electrical devices or fire safety. During an interview on 2/5/25 at 4:00 P.M., the Maintenance Director said he was unable to locate any policies on electrical devices or fire safety. He said the process for an electrical device brought in to the facility was to have it checked by maintenance first to ensure the device was UL- listed (Underwriters Laboratory- ensure that electrical products are capable of transmitting or insulating currents without exposing people to hazards) and grounded (provides a path for excess electricity to escape in case of a fault, preventing potential electric shock). He said he had not checked either of these portable heaters.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36542 Based on record review and interview, the facility failed to ensure a person-centered plan of care with individualized interventions for trauma-informed care was developed for four Residents (#145, #141, #105, and #77), out of a total of 33 sampled residents. Specifically, the facility failed to assess and implement care plan interventions for: 1. Resident #145 with a history of a traumatic and violent event, 2. Resident #141 with a history of military combat and war injuries, 3. Resident #105 with a new above the knee amputation, and 4. Resident #77 with a diagnosis of post-traumatic stress disorder (PTSD). Findings include: Review of the facility's policy titled Trauma Informed Care, revised in October 2019, indicated the following: -trauma-informed care is culturally sensitive and person-centered -care givers are taught strategies to help eliminate, mitigate or sensitively address a resident's triggers -use trauma-informed principles in strategic planning -implement universal screening of residents with trauma -as part of the comprehensive assessment, identify history of trauma or interpersonal violence when such information is provided to the facility. -identifying past trauma or adverse experiences may involve record review or the use of screening tools 1. Resident #145 was admitted to the facility in August 2024 with a diagnosis of dementia. Review of the Minimum Data Set (MDS) assessment, dated 12/4/24, indicated Resident #145 scored 7 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she had a severe cognitive impairment and had a permanent legal guardian. Review of the admitting paperwork indicated Resident #145 had experienced a traumatic and violent event [AGE] years prior and had not returned to a community setting until being discharged to the facility in August 2024. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record failed to indicate that a care plan had been developed for past trauma. Review of the Trauma Informed Care section of the Social Service Evaluation, dated 12/4/24, indicated the Resident had never experienced anything upsetting that could have changed him/her emotionally, spiritually, physically, or behaviorally. The Trauma Informed Care assessment further indicated the following experiences were not applicable: sudden or violent death, unexpected death of someone close to you, serious injury you caused to someone. During an interview on 1/31/25 at 11:30 A.M., Unit Manager #2 said Resident #145 had not wanted to come out of his/her room when they were first admitted but had started to bond with some residents on the unit and was now attending activities. Review of the progress notes indicated that on 2/2/25 Resident #145 was seen by Social Work Consultant #3 for a supportive visit to discuss any history of SUD (substance use disorder), trauma, behaviors, psychosocial well-being and the Social Worker would proceed to care plan. During an interview on 2/3/25 at 2:00 P.M., Social Work Consultant #3 said she had been at the facility over the weekend assessing residents for psychosocial history including SUD and trauma. She said she had visited a lot of residents and called a lot of family/guardians, and she was unable to recall Resident #145. She said if she had identified any history of trauma it was noted in the progress note and on the care plans. Review of the care plans and assessments for Resident #145 on 2/3/25 failed to include any information regarding the history of the traumatic and violent event. During an interview on 2/3/25 at 1:03 P.M., Social Worker #1 said she had started working at the facility shortly after Resident #145 was admitted . She reviewed the medical record for Resident #145 and said a Social Service Evaluation and Trauma Informed Care assessment had not been completed when the Resident was admitted . The Social Worker said she had completed the quarterly assessment for the Resident in December 2024. She said Resident #145 did not have any trauma. The Social Worker reviewed the quarterly assessment and said the information was not available in the assessment, but she thought the Resident had previously resided with family and the house was not in good order. The surveyor requested a follow up on the social history of Resident #145. During an interview on 2/3/25 at 1:40 P.M., Social Worker #1 said she spoke with additional staff members and Resident #145 had not been residing in the community prior to admission and she was not sure how long the Resident had not been part of the community. The Social Worker said she knew of the traumatic and violent event and that he/she absolutely went through a trauma. The Social Worker said she had asked the Resident about a history of trauma and took the information at face value, regardless of a diagnosis of dementia. She said she could not recall if the guardian had returned any phone calls regarding a history of trauma. She said a trauma assessment should have been conducted to indicate the history and a care plan should have been developed. 2. Resident #141 was admitted to the facility in January 2025. Review of the MDS assessment, dated 1/13/25, indicated Resident #141 scored 14 out of 15 on the BIMS indicating he/she was cognitively intact. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Psychiatric Evaluation and Consultation, dated 1/7/25, indicated Resident #141 took medication for the management of nightmares. During an interview on 1/29/25 at 10:20 A.M., Resident#141 said he/she was a veteran, had experienced combat and had parts of their fingers blown off. Resident #141 showed the surveyor his/her hand with missing parts of his/her fingers. Resident #141 said he/she told his/her children they could not go into the military based on the Resident's experience. Review of the Social Service Evaluation, dated 1/13/25, indicated Resident #141 was a veteran who had served eight years in combat and was wounded four times. Review of the Trauma Informed Care section of the Evaluation indicated the Resident had never experienced anything upsetting that could have changed him/her emotionally, spiritually, physically or behaviorally. The Trauma Informed Care assessment further indicated the following were not applicable: fire/explosion, assault with a weapon, combat or exposure to war-zone, bullying. Review of the care plans failed to indicate Resident #141 was a veteran who experienced combat and was wounded in combat. During an interview on 1/31/25 at 9:39 A.M., Social Worker #1 said she reviewed the Social Service Evaluation and could see that Resident #141 was a veteran who had experienced combat. She said being in combat would be traumatic and the Social Workers should still assess the history they know about for triggers, even if the Resident wasn't willing to talk about them. She said she was not sure why the Trauma Informed Care section did not indicate this or why a care plan had not been implemented. She said Social Work Consultant #1 had completed this evaluation. During an interview on 2/3/25 at 11:16 A.M., Social Work Consultant #1 said when the Social Service Evaluation was completed for Resident #141 it was completed by Social Worker #1 and signed off by Social Work Consultant #1. He said he had not met with Resident #141 and Social Worker #1 had noted the history of military experience and he had asked Social Worker #1 about initiating a care plan for a history of trauma but had not checked that one had been initiated. During an interview on 2/3/25 at 1:31 P.M., Social Worker #1 said there are common triggers from military trauma and the social workers should have assessed for the triggers and implemented a care plan for Resident #141. 3. Resident #105 was admitted to the facility in December 2024 with a new above the knee amputation on the left leg with phantom limb syndrome. Review of the MDS assessment, dated 12/29/24, indicated Resident #105 scored 14 out of 15 on the BIMS indicating he/she was cognitively intact. Review of the nursing and social service progress notes indicated that since admission Resident #105 had exhibited behaviors of yelling, swearing, throwing furniture, and making comments regarding race. Review of the medical record failed to indicate Resident #105 had been assessed for a history of trauma. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/31/25 at 9:40 A.M., Social Worker #1 said the process was for all new admissions to have a social history assessment completed by a Social Worker. She said the social history assessment included a trauma assessment. The Social Worker reviewed the medical record and confirmed that neither a social history nor a trauma assessment had ever been completed for Resident #105. She said a recent amputation could be traumatic and a trauma assessment should have been completed with the Resident. Resident #105 went out to the hospital during the survey process and was unavailable for interview. 46562 4. Resident #77 was admitted to the facility in September 2024 with diagnoses including PTSD. Review of the Minimum Data Set (MDS) assessments, dated 9/12/24 and 12/11/24, indicated Resident #77 had a history of PTSD. Review of the medical record indicated his/her Social Service Evaluation was completed on 12/11/24, three months after his/her admission. Review of the Social Service Evaluation, dated 12/11/24, section E, failed to identify his/her history of trauma. Further review of the Social Service Evaluation, Plan of Care/Comments section, indicated his/her diagnoses included PTSD. Review of Resident #77's medical record failed to indicate a care plan for Trauma Informed Care/PTSD had been formulated and failed to identify any potential triggers or interventions to prevent re-traumatization. During an interview on 1/30/25 at 1:34 P.M., Unit Manager #4 said the Social Service department completed trauma informed care and PTSD assessments. The surveyor and Unit Manager #4 reviewed Resident #77's medical record and Unit Manager #4 said he/she had a history of PTSD but there was no care plan. Unit Manager #4 said she was not aware of potential triggers or interventions to prevent re-traumatization. During an interview on 2/4/25 at 12:10 P.M., Social Worker #1 said Resident #77's Social Service Evaluation was not completed with his/her admission in September; it was not completed until three months later. Social Worker #1 said Resident #77 did have a history of PTSD and a care plan should have been developed.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 46562 Based on record reviews and interviews, for seven Residents (#139, #55, #43,#9, #138, #17, and #88), out of 33 sampled residents, the facility failed to ensure the Resident was seen by the Physician at least every 30 days for the first 90 days after admission and at least every 60 days thereafter, with alternate visits by a Nurse Practitioner (NP) as indicated. Findings include: Review of the facility's policy titled Physician Services, dated as revised February 2020, indicated but was not limited to: - The medical care of each resident is under the supervision of a Licensed Physician. - The Physician will perform pertinent, timely medical assessments; prescribe an appropriate medical regimen; provide adequate, timely information about the resident's condition and medical needs; visit the resident at appropriate intervals; and ensure adequate alternative coverage. - Physician visits, frequency of visits, emergency care of residents, etc., are provided in accordance with current regulations and facility policy. 1. Resident #139 was admitted to the facility in April 2024. Review of Resident #139's medical record indicated he/she had no documented evidence of a physician visit since her/her admission to the facility. Further review of the medical record failed to include documented evidence that a physician completed an admission assessment. During an interview on 1/30/25 at 1:34 P.M., Unit Manager #4 said the Physicians walk around and check on things but the Nurse Practitioners do the actual visits. Unit Manager #4 reviewed Resident #139's medical record and said there was no evidence that the facility physician saw the Resident. During an interview on 1/30/25 at 2:10 P.M., Medical Record Staff #1 said she had contacted the physician office for Resident #139 and there were no visits from the physician. 2. Resident #55 was admitted to the facility in August 2023. Review of Resident #55's medical record, on 1/30/25, indicated it had been 196 days since his/her last documented physician visit on 7/18/24. During an interview on 1/30/25 at 1:34 P.M., Unit Manager #4 reviewed Resident #55's medical record and said there was no evidence that the Resident had been seen by the physician since July 2024. During an interview on 1/30/25 at 2:10 P.M., Medical Record Staff #1 said she had contacted the physician's office for Resident #55 and there had been no additional visits from the physician since July. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #43 was admitted to the facility in December 2023. Review of Resident #43's medical record, on 1/30/25, indicated it had been 196 days since his/her last documented physician visit on 7/18/24. During an interview on 1/30/25 at 1:34 P.M., Unit Manager #4 reviewed Resident #43's medical record and said there was no evidence that Resident #43 had been seen by the physician since July 2024. During an interview on 1/30/25 at 2:10 P.M., Medical Record Staff #1 said she had contacted the physician office for Resident #43 and there had been no additional visits from the physician since July. 50740 4. Resident #138 was admitted to the facility in March 2024. Review of the medical record indicated he/she was seen by the physician on 4/1/24. Resident #138 was not seen by the physician again until 1/7/25, 281 days after the last physician visit. 5. Resident #17 was admitted to the facility in July 2020. Review of the medical record indicated his/her last documented visit from the physician occurred on 7/11/24. 6. Resident #9 was admitted to the facility in December 2017. Review of the medical record indicated his/her last documented visit from the physician occurred on 7/18/24. 36542 7. Resident #88 was admitted to the facility in April 2020. Review of the Physician's Progress Notes indicated Resident #88 was seen by the MD (Doctor of Medicine) on 4/18/24. The next visit from the MD occurred on 10/29/24, 194 days since the previous MD visit. Resident #88 was only seen by the Nurse Practitioner between 4/18/24 and 10/29/24. During an interview on 1/30/25 at 2:10 P.M., Medical Record Staff #1 said she had contacted the physician office for Resident #88 and there were no additional visits from the MD between April and October 2024. During an interview on 2/4/25 at 2:23 P.M., Physician #1 said residents should be every two to four months and visits could alternate with the Nurse Practitioners. Physician #1 said he was not sure why some residents had not been seen. During an interview on 1/31/25 at 2:14 P.M., the Director of Nurses said she was unaware there was a lapse in visits from the MD and the physicians should be alternating visits with the Nurse Practitioners every 60 days. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/5/25 at 9:35 A.M., the Director of Nurses said that the physician keeps his own list of when each resident should be seen and is present in the building multiple times per week. The Director of Nurses said Residents should be seen by the physician as required by the CMS regulation. During an interview on 2/4/25 at 4:22 P.M., Corporate Nurse #1 said that physician visits should occur as required by the Centers for Medicare and Medicaid Services (CMS) regulation; once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. The subsequent physician visits may alternate with Nurse Practitioner visits, so the Resident may be seen every 120 days by the physician.

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F 0740 Level of Harm - Actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 36542 Based on observation, interviews, and record review, the facility failed to provide effective and appropriate treatment and services to attain the highest practicable mental and psychological well-being for one Resident (#105) with anxiety, demonstrated behaviors, and active substance use, out of a total sample of 33 residents. Specifically, the facility failed to develop, implement, and update the plan of care to meet the Resident's behavioral needs, including interventions for verbal abuse to Resident #141, interventions for intermittent explosive disorder, and interventions for active substance use resulting in emergency room visits. Findings include: Review of the facility's policy titled Behavioral Assessment, Intervention and Monitoring, revised in November 2017, indicated but was not limited to the following: -behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment. -the interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. -safety strategies will be implemented immediately if necessary to protect the resident and others from harm. -the resident will be involved in the development and implementation of the care plan. -interventions will be individualized and part of an overall care environment that supports physical functional and psychosocial needs and strives to understand, prevent or relieve the resident's distress or loss of abilities. -interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. -the care plan will include, as a minimum: a description of the behavioral symptoms (frequency, intensity, duration, outcomes, location, environment, and precipitating factors or situations), targeted and individualized interventions for behavioral and/or psychosocial symptoms, rational for the interventions and approaches, specific and measurable goals for targeted behaviors, and how staff will monitor for the effectiveness of the interventions. Review of the facility's policy titled Substance Use Disorder Policy, revised February 2024, indicated but was not limited to the following: (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Some	-if residents with a history of Substance Use Disorder are admitted to the facility the nursing staff will be alerted of the resident's history to ensure appropriate measures are taken if warranted. -social services will refer the resident to mental health services/Licensed Drug Addiction Counselor as warranted with a focus on management of relapse risk and maintenance of sobriety. -the interdisciplinary team will evaluate the resident substance use history, risk of relapse, and develop a person-centered plan of care. -residents will be offered counseling from a Licensed Drug Addiction Counselor. -should residents show signs of relapse, the provider will be made aware and the resident's plan of care will be revised as warranted. Resident #105 was admitted to the facility in December 2024 with a new above the knee amputation of the left leg, anxiety, and cannabis dependence. Review of the Minimum Data Set (MDS) assessment, dated 12/29/24, indicated Resident #105 scored 14 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. Review of the nursing progress notes indicated on 12/31/24 Resident #105 returned to the facility at 7:00 P. M. following a personal leave with family. When the Resident returned, he/she was verbally loud and noisy, making inappropriate statements to staff and slurring his/her speech. The nursing progress note indicated the Nurse Practitioner (NP) was contacted with a new order to hold medication and send to the emergency room . The note indicated when Resident #105 was informed of the new orders the Resident became very agitated, threatening to punch someone if he/she did not get their medication. The Resident then went to their room and started throwing around furniture, came back into the hallway swearing, and exposing him/herself to the nurse, while yelling with slurred speech. 911 was called and Resident #105 was sent to the hospital. Review of the Hospital Discharge Summary, dated 1/1/25, indicated Resident #105 was seen in the emergency room for alcohol intoxication where the Resident was restrained related to violence. In the emergency room , the Resident was administered the following injections: Haldol 5 milligrams (mg), Ativan 2 mg, and Benadryl 25 mg. During an interview on 1/30/25 at 2:55 P.M., Nurse #1 said she was working on 12/31/24 when Resident #105 returned and was intoxicated. She said the Resident was yelling and swearing and there were family members of other residents around. Review of the NP's Progress Note, dated 1/3/25, indicated Resident #105 was sent to the emergency room for aggressive behavior and alcohol intoxication with the following plan: -behavior: nursing to provide ongoing support to monitor for any signs of recurrent aggression or agitation and collaborate with behavioral health services if necessary -alcohol intoxication: reinforce strategies to prevent further episodes and consider behavioral counseling or substance use treatment referrals if patient agrees (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Some	Review of the medical record including assessments, care plans, and progress notes failed to indicate any behavioral interventions were implemented following Resident #105 being intoxicated, yelling, swearing, throwing furniture, and exposing him/herself. Review of the Nursing Progress note, dated 1/3/25, indicated Resident #105 became extremely agitated during a change of the bandage to the amputation, threw the bandage at the nurse, and refused a new dressing. Review of the Nursing Progress note, dated 1/7/25, indicated Resident #105 was yelling and screaming racial slurs at a new Resident (#141) and when staff attempted to redirect the Resident he/she became very aggressive and the Resident was sent to the hospital. Further review indicated Resident #105 had a room change on 1/7/25 so that he/she was not rooming with Resident #141. Resident #105 was moved two rooms down, diagonally across the hall from Resident #141. Review of the emergency room After Visit Summary from 1/7/25 indicated Resident #105 presented with agitation and included an educational attachment for Intermittent Explosive Disorder (recurrent aggressive behavior; disordered aggression) which included treatment goals to stop outbursts through the use of cognitive behavioral therapy, group therapy, relaxation methods, and medications. During an interview on 1/30/25 at 2:55 P.M., Nurse #1 said she was the supervisor on 1/7/25 and was called when Resident #105 was yelling racial slurs. She said the Resident was screaming, would not take Ativan (an antianxiety medication) and was sent out the hospital. Review of the medical record, including assessments, progress notes, and care plans, failed to address behaviors of yelling, swearing, being aggressive and saying racial slurs and failed to identify interventions. Review of the Physician's Progress Note, dated 1/8/25, failed to indicate the behaviors and emergency room visit were reviewed. During an interview on 1/30/25 at 2:43 P.M., Certified Nursing Assistant (CNA) #1 said she was the primary CNA for Resident #105. She said the Resident gets upset and yells and she gives the Resident space. She said she did not know any other ways to manage the Resident's behavior. During an interview on 1/30/25 at 2:10 P.M., Resident #141, who was crying, said when he/she was on their way to Rehab today Resident #105 started yelling at him/her about their music and said why are you listening to that? I don't want to hear N***** music. Resident #141 said he/she had previous encounters with Resident #105 using racial slurs. During an interview on 1/30/25 at 2:42 P.M., the Director of Nurses (DON) said on 1/7/25 Resident #105 was yelling and did not want a roommate. Resident #105's room was changed to diagonally across the hall. She said she did not think there were any further concerns between the two residents until today. She said Social Services would have done the follow up with Resident #141. She said there had been a few issues with Resident #105 since admission and Resident #105 had a history of drug and alcohol abuse. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Some	Review of the Medication Administration Record (MAR) for January 2025 for Resident #105 included an order to monitor behaviors. Further review of the MAR indicated Resident #105 did not have any behaviors in January 2025. Review of the January 2025 Behavior Monitoring, completed by the CNAs, indicated Resident #105 had the following behaviors: 1/4/25: accusing others, expressing frustration/anger at others, cursing at others, screaming at others 1/17/25: expressing frustration/anger at others 1/22/25: expressing frustration/anger at others 1/26/25: expressing frustration/anger at others Review of the care plans for Resident #105 on 1/30/25 failed to address behaviors of yelling, swearing, being aggressive, saying racial slurs, or substance abuse and failed to identify interventions. During an interview on 1/31/25 at 9:40 A.M., Social Worker #1 said the facility Social Workers do not create or participate in care plans related to behavioral concerns. She said the nursing staff were responsible for behavioral care plans. She said Resident #105 has had behaviors of yelling, screaming, using racial slurs and had been sent out to the hospital for being intoxicated. She said she did not know the Resident was also sent to the hospital on 1/7/25 related to behaviors. She said the contracted psychiatric serivces had a therapist at the facility on Tuesdays and a psychiatric NP at the facility on Fridays. She said she verbally referred residents to the psychiatric clinicians and she could not recall if she ever referred Resident #105. She said the facility had recently contracted with a Substance Use Disorder (SUD) Counselor and she was not sure how the residents were referred to the SUD counselor. She said the interdisciplinary team discussed Resident #105 at morning meeting on Monday 1/27/25, possibly related to smoking and the nursing staff was going to refer the Resident to the psychiatric services. Review of the paper record indicated Resident #105 had consented to be seen by the contracted psychiatric services on 12/24/24. Review of the contracted psychiatric services referral book on 1/31/25 failed to indicate Resident #105 had been referred for services. Review of the medical record failed to indicate Resident #105 had been seen by psychiatric services. During an interview on 1/31/25 at 9:40 A.M., Social Work Consultant #2 said the Social Workers do not create or participate in care plans related to behavioral concerns. She said Resident #105 has had behaviors of yelling, swearing and being verbally aggressive. She said the Resident can be combative in discussions and was screaming and swearing at her on 1/30/25 when she inquired if the Resident would change his/her room. She said she was not sure how the residents were referred to the SUD Counselor and would follow up with the surveyor. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Some	During an interview on 2/4/25 at 12:11 P.M., Unit Manager #1 said she was a nurse on the unit prior to becoming the Unit Manager last week. She said the process was for the Unit Manager to enter care plans in the electronic medical record. She said the behavioral care plans were usually a collaboration between the Social Workers and the Unit Manager. She said she was not sure if behavioral interventions were implemented for Resident #105 and she had not initiated a care plan for this Resident. She said the NP had seen Resident #105 following one of the emergency room visits and the NP had come up with the plan and the staff would have followed that. She said she was not sure what that plan was. The Unit Manager reviewed the psychiatric services referral book and said Resident #105 was referred to psychiatric services on 1/31/25 and she did not see that the Resident had been referred prior to that. During an interview on 2/4/25 at 3:10 P.M., Social Work Consultant #1 said Resident #105 had been exhibiting behaviors and a care plan should have been initiated for the Resident with personalized interventions. During an interview on 2/4/25 at 4:15 P.M., Nurse #11 said she was previously the Unit Manager until mid-January 2025. She said Resident #105 had behaviors of making a racial comment to Resident #141 on 1/7/25, of yelling and throwing things. She said the Social Workers create care plans related to behavioral concerns of verbal altercations, throwing things, and substance use. During a follow up interview on 1/31/25 at 10:22 A.M., Social Work Consultant #2 said the process for the SUD counselor was for the Social Workers to tell the Administrator which residents would be seen, and the Administrator would tell the SUD Counselor. During an interview on 1/31/25 at 10:42 A.M., the Administrator said the MDS Coordinator tells the SUD Counselor which residents to see. During an interview on 1/31/25 at 10:43 A.M., the MDS Coordinator said they did not provide a list of residents to the SUD Counselor. During an interview on 1/31/25 at 10:44 A.M., the Administrator said the Assistant Administrator tells the SUD Counselor who to see and thought the list had come from the MDS Coordinator. During an interview on 1/31/25 at 10:50 A.M., the Assistant Administrator said she did not provide a list of residents to the SUD Counselor and thought the resident referrals came from the nurses or the Social Workers. During an interview on 1/31/25 at 11:34 A.M., the Assistant Administrator said she wanted to clarify that she previously had a list of residents in the facility with a history of SUD and that was why the Administrator thought she had it. She said the MDS Coordinator had run a report of residents with diagnoses related to SUD and that had been provided to the SUD Counselor the first time they had come to the facility the previous month. She said she was not sure how newly identified residents were identified for the SUD Counselor and thought maybe the Social Workers would tell the SUD Counselor. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Some	During an interview on 1/31/25 at 1:11 P.M., the SUD Counselor said he had started a contract with the facility in mid-December and had been to the facility twice, the last time about two weeks ago. He said he had been provided with a list of residents with a diagnosis of SUD in mid-December (prior to the admission of Resident #105) and had not been provided a new one. He said Resident #105 had not been referred to him for services. During an interview on 2/3/25 at 2:18 P.M., the DON said Resident #105 was sent to the hospital for a change in condition. She said the Resident had presented with stroke-like symptoms and another Resident had indicated Resident #105 had taken a controlled substance from a visitor and they were investigating this. During an interview on 2/4/25 at 4:15 P.M., Nurse #11 said she was the daytime supervisor on 2/3/25 and assisted in sending Resident #105 out to the hospital. She said the staff had found Resident #105 on 2/3/25 to be lethargic, had uneven pupils and a slight facial droop, but was still responsive. She said when emergency medical services (EMS) arrived to transport the Resident to the hospital, another Resident (#151) had said Resident #105 had taken pills from a visitor. During an interview on 2/4/25 at 2:48 P.M., Social Work Consultant #1 said he spoke with Resident #151 who said Resident #105 had taken Xanax (a Benzodiazepines that produces sedation) from a visitor on 2/3/25. He said Resident #105 had not had a Social Service Evaluation upon admission and that evaluation contained the assessment for SUD and one was never completed. He said the SUD Counselor had been at the facility on 2/3/25 and had not seen Resident #105. He said the process for the SUD Counselor was being worked on and the SUD Counselor had been provided a list of residents with a diagnosis of SUD. He said the SUD Counselor had not been provided with any additional information to indicate which residents to prioritize based on most recent use or most at risk for relapse. During an interview on 2/5/25 at 12:00 P.M., the DON said she was at the facility on 1/7/25 when Resident #105 was yelling at Resident #141. She said she was not aware that Resident #105 had used racial slurs. She said the Resident was moved diagonally across the hall and when the Resident was not de-escalating and would not take Ativan the Resident was sent to the hospital. She said no additional interventions were implemented to keep Resident #105 and Resident #141 separated and there were more interventions they could have done. During an interview on 2/5/25 at 12:00 P.M., the Administrator said facility staff did not know Resident #105 had continued to walk by the room of Resident #141 (in the same hallway) and continued to use racial slurs. He said the Social Workers should have evaluated/assessed the behaviors of Resident #105 and implemented care plans following a face-to-face assessment with resident specific interventions. He said he was unaware the Social Workers were not initiating behavioral care plans and they should be involved from a psychosocial standpoint. He said the SUD Counselor had started services at the facility approximately a month and a half prior and there had not been a system in place for the SUD Counselor referral or to prioritize the residents who were at risk or currently using substances. Refer to F745

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F 0745 Level of Harm - Actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. 36542 Based on observation, interviews, and record review, the facility failed to provide social services to attain the highest practicable mental and psychological well-being for two Residents (#105 and #141), out of a total sample of 33 residents. Specifically, the facility failed 1. For Resident #105, to assess, develop, implement, and update the plan of care to meet the Resident's behavioral needs, including interventions for verbal abuse to Resident #141, interventions for intermittent explosive disorder and interventions for active substance use resulting in emergency room visits; and 2. For Resident #141, to follow up after being verbally abused by Resident #105 to ensure effective interventions were implemented to prevent additional incidents of verbal abuse resulting in Resident #141 crying and verbalizing wanting to decrease socialization. Findings include: Review of the facility's policy titled Behavioral Assessment, Intervention and Monitoring, revised in November 2017, indicated but was not limited to the following: -the interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. -safety strategies will be implemented immediately if necessary to protect the resident and others from harm -the resident will be involved in the development and implementation of the care plan -interventions will be individualized and part of an overall care environment that supports physical functional and psychosocial needs and strives to understand, prevent or relieve the resident's distress or loss of abilities -interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. -the care plan will include, as a minimum: a description of the behavioral symptoms (frequency, intensity, duration, outcomes, location, environment, and precipitating factors or situations), targeted and individualized interventions for behavioral and/or psychosocial symptoms, rational for the interventions and approaches, specific and measurable goals for targeted behaviors, and how staff will monitor for the effectiveness of the interventions Review of the facility's policy titled Substance Use Disorder (SUD) Policy, revised February 2024, indicated but was not limited to the following: (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 0745 Level of Harm - Actual harm Residents Affected - Some	-if residents with a history of Substance Use Disorder are admitted to the facility the nursing staff will be alerted of the resident's history to ensure appropriate measures are taken if warranted -social services will refer the resident to mental health services/Licensed Drug Addiction Counselor as warranted with a focus on management of relapse risk and maintenance of sobriety -the interdisciplinary team will evaluate the resident substance use history, risk of relapse, and develop a person-centered plan of care -residents will be offered counseling from a Licensed Drug Addiction Counselor -should residents show signs of relapse, the provider will be made aware and the resident's plan of care will be revised as warranted. Review of the facility's Social Service Job Description indicated the Social Work employees had the following functions: -work with the interdisciplinary team and administration to promote and protect resident rights and the psychosocial well-being of each resident. Prevent and address abuse as mandated by law and professional licensure -complete a social history and psychosocial assessment for each resident that identifies social, emotional, and psychosocial needs -participate in the development of written, interdisciplinary plan of care for each resident that identifies the psychosocial needs/issues of the resident, the goals to accomplish those needs/issues, and the appropriate social worker interventions -ensure or provide therapeutic interventions to assist residents in coping with their transition and adjustment to a long term care facility, including their social, emotional, and psychological needs 1. Resident #105 was admitted to the facility in December 2024 with a new above the knee amputation of the left leg, anxiety and cannabis dependence. Review of the Minimum Data Set (MDS) assessment, dated 12/29/24, indicated Resident #105 scored 14 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. Review of the medical record on 1/30/25 failed to indicate a social service evaluation had been completed with Resident #105, over a month after he/she was admitted . Review of the nursing progress notes indicated on 12/31/24 Resident #105 returned to the facility at 7:00 P. M. following a personal leave with family. When the Resident returned he/she was verbally loud and noisy, making inappropriate statements to staff and slurring his/her speech. The note indicated the Resident became very agitated, threatening to punch someone if he/she did not get their medication. The Resident went to their room and started throwing around furniture, came back into the hallway swearing and exposing him/herself to the nurse, while yelling with slurred speech. 911 was called and Resident #105 was sent to the hospital. (continued on next page)

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F 0745 Level of Harm - Actual harm Residents Affected - Some	During an interview on 1/30/25 at 2:55 P.M., Nurse #1 said she was working on 12/31/24 when Resident #105 returned and was intoxicated. She said the Resident was yelling and swearing and there were family members of other residents around. Review of the Nurse Practitioner's (NP) Progress Note, dated 1/3/25, indicated Resident #105 was sent to the emergency room for aggressive behavior and alcohol intoxication with the following plan: -behavior: nursing to provide ongoing support to monitor for any signs of recurrent aggression or agitation and collaborate with behavioral health services if necessary -alcohol intoxication: reinforce strategies to prevent further episodes and consider behavioral counseling or substance use treatment referrals if patient agrees Review of the Social Service Note, dated 1/3/25, indicated Resident #105 was issued a 30-day discharge notice by the Social Worker, the Resident had refused to sign it and swore at the Social Worker. There were no additional notes from a Social Worker regarding the Resident being sent to the hospital on 12/31/24 related to intoxication and behaviors. Review of the nursing progress note, dated 1/7/25, indicated Resident #105 was yelling and screaming racial slurs at a new Resident (#141) and when staff attempted to redirect the Resident he/she became very aggressive and the Resident was sent to the hospital. Review of the emergency room After Visit Summary from 1/7/25 indicated Resident #105 presented with agitation and included an educational attachment for Intermittent Explosive Disorder (recurrent aggressive behavior; disordered aggression) which included treatment goals to stop outbursts through the use of cognitive behavioral therapy, group therapy, relaxation methods and medications. During an interview on 1/30/25 at 2:55 P.M., Nurse #1 said she was the supervisor on 1/7/25 and was called when Resident #105 was yelling racial slurs. She said the Resident was screaming, would not take Ativan (an antianxiety medication) and was sent out the hospital. During an interview on 1/30/25 at 2:10 P.M., Resident #141, who was crying, said when he/she was on their way to Rehab today Resident #105 started yelling at him/her about their music and said why are you listening to that? I don't want to hear N***** music. Resident #141 said he/she had previous encounters with Resident #105 using racial slurs. During an interview on 1/30/25 at 2:42 P.M., the Director of Nurses (DON) said on 1/7/25 Resident #105 was yelling and did not want a roommate and Resident #105's room was changed to diagonally across the hall. She said there had been a few issues with Resident #105 since admission and Resident #105 had a history of drug and alcohol abuse. Review of the medical record for Resident #105 on 1/30/25 failed to address behaviors of yelling, swearing, being aggressive, saying racial slurs, or substance abuse and failed to identify interventions. The record review indicated the only Social Service progress note was written on 1/3/25 when the 30-day discharge notice was given. There were no additional notes or assessments from a Social Worker. (continued on next page)

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F 0745 Level of Harm - Actual harm Residents Affected - Some	During an interview on 1/31/25 at 9:40 A.M., Social Worker #1 said when residents were first admitted the process was for a Social Worker to complete the Social Service Evaluation which included but was not limited to a social history, a trauma assessment, and a SUD assessment. She said assessments were usually completed within one week of admission. She reviewed the medical record for Resident #105 and said a Social Service Evaluation had not been completed. She said Resident #105 has had behaviors of yelling, screaming, using racial slurs and had been sent out to the hospital for being intoxicated. She said she did not know the Resident was also sent to the hospital on 1/7/25 related to behaviors. Social Worker #1 said the facility Social Workers do not create or participate in care plans related to behavioral concerns. She said she verbally referred residents to the psychiatric clinicians and she could not recall if she ever referred Resident #105. She said the facility had recently contracted with a Substance Use Disorder (SUD) Counselor and she was not sure how the residents were referred to the SUD counselor. She said the interdisciplinary team discussed Resident #105 at morning meeting on Monday 1/27/25, possibly related to smoking and the nursing staff was going to refer the Resident to the psychiatric services. Review of the paper record indicated Resident #105 had consented to be seen by the contracted psychiatric services on 12/24/24. Review of the contracted psychiatric services referral book on 1/31/25 failed to indicate Resident #105 had been referred for services. Review of the medical record failed to indicate Resident #105 had been seen by psychiatric services. During an interview on 1/31/25 at 9:40 A.M., Social Work Consultant #2 said the Social Workers do not create or participate in care plans or interventions related to behavioral concerns. She said Resident #105 has had behaviors of yelling, swearing and being verbally aggressive. She said the Resident can be combative in discussions and was screaming and swearing at her on 1/30/25 when she inquired if the Resident would change his/her room. She said she was not sure how the residents were referred to the SUD Counselor and would follow up with the surveyor. During an interview on 2/4/25 at 12:11 P.M., Unit Manager #1 said she was a nurse on the unit prior to becoming the Unit Manager last week. She said the behavioral care plans were usually a collaboration between the Social Workers and the Unit Manager. She said she was not sure if behavioral interventions were implemented for Resident #105. During an interview on 2/4/25 3:10 P.M., Social Work Consultant #1 said Resident #105 had been exhibiting behaviors and personalized interventions should have been initiated. During an interview on 2/4/25 at 4:15 P.M., Nurse #11 said she was previously the Unit Manager until mid-January 2025. She said Resident #105 had behaviors of making a racial comment to Resident #141 on 1/7/25, of yelling and throwing things. She said the Social Workers create care plans related to behavioral concerns of verbal altercations, throwing things and substance use. During an interview on 1/31/25 at 11:34 A.M., the Assistant Administrator said the MDS Coordinator had run a report of residents with diagnoses related to SUD and that had been provided to the SUD Counselor the first time they had come to the facility the previous month. She said she was not sure how newly identified residents were identified for the SUD Counselor and thought maybe the Social Workers would tell the SUD Counselor. (continued on next page)

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F 0745 Level of Harm - Actual harm Residents Affected - Some	During an interview on 1/31/25 at 1:11 P.M., the SUD Counselor said he had started a contract with the facility in mid-December and had been to the facility twice, the last time about two weeks ago. He said he had been provided a list of residents with a diagnosis of SUD in mid-December (prior to the admission of Resident #105) and had not been provided a new one. He said Resident #105 had not been referred to him for services. During an interview on 2/3/25 at 2:18 P.M., the DON said Resident #105 was sent to the hospital for a change in condition. She said the Resident had presented with stroke-like symptoms and another Resident had indicated Resident #105 had taken a controlled substance from a visitor and they were investigating this. During an interview on 2/4/25 at 4:15 P.M., Nurse #11 said she was the daytime supervisor on 2/3/25 and assisted in sending Resident #105 out to the hospital. She said the staff had found Resident #105 on 2/3/25 to be lethargic, had uneven pupils and a slight facial droop, but was still responsive. She said when emergency medical services (EMS) arrived to transport the Resident to the hospital, another Resident (#151) had said Resident #105 had taken pills from a visitor. During an interview on 2/4/25 at 2:48 P.M., Social Work Consultant #1 said he spoke with Resident #151 who said the Resident #105 had taken Xanax (a Benzodiazepines that produces sedation) from a visitor on 2/3/25. He said Resident #105 had not had a Social Service Evaluation upon admission and that evaluation contained the assessment for Substance Use Disorder and one was never completed. He said the SUD Counselor had been at the facility on 2/3/25 and had not seen Resident #105. He said the process for the SUD Counselor was being worked on and the SUD had been provided a list of residents with a diagnosis of SUD. He said the SUD had not been provided with any additional information to indicate which residents to prioritize based on most recent use or most at risk for relapse. During an interview on 2/5/25 at 12:00 P.M., the Administrator said the Social Workers should have evaluated/assessed the behaviors of Resident #10 with a face-to-face assessment to obtain resident specific interventions. He said he was unaware the Social Workers were not initiating behavioral care plans and they should be involved from a psychosocial stand point. He said the SUD Counselor had started services at the facility approximately a month and a half prior and there had not been a system in place for the SUD Counselor referral or to prioritize the residents who were at risk or currently using substances. 2. Resident #141 was admitted to the facility in January 2025 for short term rehabilitation and was receiving physical and occupational therapy services. Review of the MDS assessment, dated 1/13/25, indicated Resident #141 scored 14 out of 15 on the BIMS indicating he/she was cognitively intact. During an interview on 1/30/25 at 2:10 P.M., Resident #141, who was crying, said when he/she was on their way to Rehab today Resident #105 started yelling at him/her about their music and said why are you listening to that? I don't want to hear N***** music. Resident #141 said he/she had previous encounters with Resident #105 using racial slurs. Review of the medical record for Resident #141 failed to indicate any information regarding the Resident being called racial slurs. (continued on next page)

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F 0745 Level of Harm - Actual harm Residents Affected - Some	During an interview on 1/30/25 at 2:40 P.M., Nurse #3 said she had been working on 1/7/25 when Resident #105 called Resident #141 a nxxxxx and said Resident #141 was making the room smell like a zoo. She said Resident #141 was so upset that he/she started crying because of the racial slurs that were hurled at him/her by Resident #105. Nurse #3 said she notified Nurse #1 who was the nursing supervisor. During an interview on 1/30/25 at 2:55 P.M., Nurse #1 said she was the supervisor on 1/7/25 and was called down to the unit to assist as Resident #105 was yelling about Resident #141 saying that he/she smelled and was calling the Resident the N word. She said the plan at that time was to split up the two residents right way and moved Resident #105 across the hall. She said on 1/7/25, Resident #141 was very sensitive about this and was crying. She said another verbal altercation was bound to happen between the two residents. During an interview on 1/30/25 at 2:42 P.M., the DON said she was aware Resident #105 had used racial slurs towards Resident #141 today on the way to attend physical therapy together and the staff were working on a plan to keep the residents separated. She said Resident #105 previously had a verbal altercation with Resident #141 when Resident #141 was admitted to the facility and a room change was initiated. Review of the medical record for Resident #141 failed to indicate any information regarding the Resident being called racial slurs and failed to indicate any follow-up was conducted with Resident #141 to determine the effectiveness of the room change across the hall. During an interview on 1/31/25 at 9:40 A.M., Social Worker #1 said she was at the facility on 1/7/25 when Resident #105 was yelling at Resident #141. She said she had not directly heard the racial slurs, but staff had told her. She said she met with Resident #141 at that time and the Resident was crying. She said she invited Resident #141 to sit in her office the next day as the Resident was walking by and the Resident talked about how sad he/she was about the racial slur. She said she had not checked with Resident #141 on the effectiveness of the intervention of moving Resident #105 diagonally across the hall. During an interview on 1/31/25 at 9:45 A.M., Social Work Consultant #2 said she met with Resident #141 following the verbal abuse on 1/30/25 and Resident #141 told her the racial comments had been happening every day. During an interview on 2/3/25 at 1:30 P.M., Social Worker #1 said the facility staff did not pay enough attention to Resident #141 and Resident #105 following the verbal altercation on 1/7/25. During an interview on 2/5/25 at 12:00 P.M., the DON said no additional interventions were implemented following the verbal abuse on 1/7/25 to keep Resident #105 and Resident #141 separated and there were more interventions they could have done. During an interview on 2/5/25 at 12:00 P.M., the Administrator said facility staff did not know Resident #105 had continued to walk by the room of Resident #141 (in the same hallway) and continued to use racial slurs. He said the Social Workers should have followed up with Resident #141 to determine if there had been any further interactions with Resident #105.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50740 Based on observation, record review, and interview, the facility failed to ensure that all drug records were in order and that an account of all controlled drugs was maintained. Specifically, the facility failed to ensure for two Residents (#117, and #118), information was entered on the narcotic accountability record immediately after a schedule-IV controlled substance (low potential for abuse and a low risk of dependence) and schedule-V controlled substance (lowest potential for abuse) were removed from the medication cart. Findings include: Review of the facility's policy titled Administration Procedures for All Medications, revised 8/2020, indicated but was not limited to the following: -After administration, return to cart, replace medication container (if multi-dose and doses remain), and document administration in the MAR (medication administration record) or TAR (treatment administration record) and the controlled substance sign out record, if necessary. Review of the facility's policy titled Narcotic Count, revised 7/2023, indicated but was not limited to the following: -Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling and record keeping in the facility, in accordance with Federal and State laws and regulations and require narcotic book documentation. 1. Resident #117 was admitted to the facility in January 2025 with diagnoses including chronic venous hypertension (a condition where blood pressure in the veins is high due to damaged valves) with ulcer of right lower extremity and diabetes. Review of Resident #117's current Physician's Orders included but was not limited to the following: -Tramadol 25 milligrams (mg) 1 tablet twice daily as needed for left shoulder/right leg wound During inspection of the Medication Cart on the Riverside 1 Unit (high side) on 1/30/25 at 2:24 P.M. with Nurse #6, the surveyor observed the following: -The Narcotic Medication Card in the Medication Cart for Resident #117's Tramadol 25mg tablets (schedule-IV controlled substance medication) contained 16 tablets. -The Narcotic Book documentation log for Resident #117's Tramadol 25mg tablets had 17 tablets on the register. Review of Resident #117's MAR indicated Tramadol 25 mg was administered by Nurse #6 on 1/30/25 at 12:46 P.M. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/30/25 at 2:30 P.M., Nurse #6 said she administered an as needed dose of Tramadol 25 mg to Resident #117 earlier in her shift and should have signed the medication out of the Narcotic Book at the time of administration but did not. Nurse #6 showed the surveyor her documentation in the Resident's electronic medical record indicating that the dose had been administered. 2. Resident #118 was admitted to the facility in December 2024 with diagnoses including low back injury and polyneuropathy (a nerve disease affecting many nerves that often causes pain). Review of Resident #118's current Physician's Orders included but was not limited to the following: -Pregabalin 25 mg Give 1 capsule by mouth two times a day for chronic pain During inspection of the Medication Cart on the Riverside 1 Unit (high side) on 1/30/25 at 2:24 P.M. with Nurse #6, the surveyor observed the following: -The Narcotic Medication Card in the Medication Cart for Resident #117's Pregabalin 25 mg capsules (schedule-V controlled substance medication) contained 30 capsules. -The Narcotic Book documentation log for Resident #118's Pregabalin 25mg capsules had 31 capsules on the register. Review of Resident #118's MAR indicated Pregabalin 25 mg was administered by Nurse #6 on 1/30/25 at 9:36 A.M. During an interview on 1/30/25 at 2:30 P.M., Nurse #6 said she administered Resident #118's Pregabalin dose as ordered earlier in her shift. Nurse #6 said she should have signed the medication out of the Narcotic Book at the time of administration but did not. Nurse #6 showed the surveyor her documentation in the Resident's electronic medical record indicating that the dose had been administered during the morning medication pass. During an interview on 2/5/25 at 9:35 A.M., the Director of Nurses said all narcotics should be signed out of the Narcotic Book when they are removed from the medication cart and administered, not later in the day.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49428 Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to ensure the main kitchen floor and ceiling were maintained in a sanitary and safe condition. Findings include: Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: 1-2 Definitions 1-201 Applicability and Terms Defined 1-201.10 Statement of Application and Listing of Terms. Easily Cleanable. (1) Easily cleanable means a characteristic of a surface that: (a) Allows effective removal of soil by normal cleaning methods; (b) Is dependent on the material, design, construction, and installation of the surface; and (c) Varies with the likelihood of the surface's role in introducing pathogenic or toxigenic agents or other contaminants into food based on the surface's approved placement, purpose, and use. Smooth means: (3) A floor, wall, or ceiling having an even or level surface with no roughness or projections that render it difficult to clean. 6-201.12 Floors, Walls, and Ceilings, Utility Lines. Floors that are of smooth, durable construction and that are nonabsorbent are more easily cleaned. Requirements and restrictions regarding floor coverings, utility lines, and floor/wall junctures are intended to ensure that regular and effective cleaning is possible and that insect and rodent harborage is minimized. 6-201.13 Floor and Wall Junctures, Coved, and Enclosed or Sealed. (A) In FOOD ESTABLISHMENTS in which cleaning methods other than water flushing are used for cleaning floors, the floor and wall junctures shall be coved and closed to no larger than 1 mm (one thirty-second inch). When cleaning is accomplished by spraying or flushing, coving and sealing of the floor/wall junctures is required to provide a surface that is conducive to water flushing. Grading of the floor to drain allows liquid wastes to be quickly carried away, thereby preventing pooling which could attract pests such as insects and rodents or contribute to problems with certain pathogens such as Listeria monocytogenes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6-201.17 Walls and Ceilings, Attachments. (A) Except as specified in (B) of this section, attachments to walls and ceilings such as light fixtures, mechanical room ventilation system components, vent covers, wall mounted fans, decorative items, and other attachments shall be EASILY CLEANABLE. On 1/29/25 at 8:00 A.M. and on 2/4/25 at 11:20 A.M., the surveyor observed in the main kitchen, several areas of compromised and recessed floor grout. Specifically, the surveyor observed: -uneven grout levels throughout the main kitchen; specifically, areas where grout and tile were almost even to each other and other areas where tiles were noticeably protruding up from the surrounding grout; -areas of crumbling grout; -crumbs, debris, and standing water in some areas of the recessed and/or crumbling grout; -noticeably recessed grout were, but not limited to, areas around the steam table, food prep table, ice machine, and in the dish room. On 1/29/25 at 8:00 A.M. and on 2/4/25 at 11:20 A.M., the surveyor observed the following of the main kitchen ceiling: -several ceiling tiles that did not snugly fit within the metal ceiling grid; -ceiling tiles with peeled layers protruding; -ceiling tiles with broken corners; -metal ceiling grid with surface areas that contained black, clustered splotches and/or peeling. During an interview on 1/29/25 at 8:20 A.M., the surveyor and Food Service Director (FSD) observed areas of the main kitchen's floor grout and ceiling. The FSD said the grout was recessed and the floor could use regrouting. The FSD said steam causes ceiling tiles to [NAME] and sag as well as black splotchy growth on the metal ceiling grids. The FSD said any compromised ceiling tiles or metal ceiling grid should be replaced to prevent potential contamination. During an interview on 2/5/25 at 3:04 P.M., the Director of Nursing (DON) said the floor grout and ceiling tiles and gridding in the main kitchen should be in good repair and easy to clean.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 46562 Based on document review and interview, the facility failed to develop and implement their facility assessment (a document assessing the capability of the facility and its resources to provide both emergency and day to day care of the population the facility currently serves). Specifically, the facility failed to: 1. Implement and utilize the identified resources in the facility assessment to provide care to the resident population; and 2. Ensure active involvement of all required members when conducting the facility assessment. Findings include: Review of the facility's policy titled Facility Assessment, dated as revised September 2024, indicated but was not limited to: -The team responsible for conducting, reviewing and updating the facility assessment includes the following: a. the administrator; b. a representative of the governing body; c. the medical director; d. the director of nursing services; and e. the director (or designee) from the following departments as warranted: environmental services, physical operations, dietary services, social services, activity services, rehabilitative services, staff on the unit and residents -The facility assessment includes a detailed review of the resident population. -The facility assessment also includes a detailed review of the resources available to meet the needs of the resident population. -The facility assessment is intended to help our facility plan for and respond to changes in the needs of our resident population. Review of the Centers for Medicare and Medicaid Services (CMS) guidance, dated 6/18/24, indicated but was not limited to: (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-In conducting the facility assessment, the facility must ensure active involvement of the following participants in the process: a. Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and b. Direct care staff, including but not limited to, Registered Nurses, Licensed Practical Nurses/Licensed Vocational Nurses, Nursing Assistants, and representatives of the direct care staff, if applicable c. The facility must also solicit and consider input received from residents, resident representatives, and family members 1. Review of the Facility Assessment, dated December 2024, indicated but was not limited to: -Section 2.0 Resident Profile: the average daily census (range) was 158 -Section 3.0 Common Diagnoses/Conditions: common diagnoses/conditions the facility may accept residents with or residents may develop included mental disorder, post-traumatic stress disorder (PTSD), and behavior that needs intervention -Section 5.0 Special Treatments and Conditions: the facility had 145-155 residents who required behavioral health needs, and 50-70 residents with active or current substance use disorders -Section 8.0 Services Provided Based on Resident Assessments and Care Plans: Mental health and behavior: Identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of individuals with depression, trauma/PTSD During an interview on 1/31/25 at 9:40 A.M., Social Worker #1 said when residents were first admitted the process was for a Social Worker to complete the Social Service Evaluation which included but was not limited to a social history, a trauma assessment, and a substance use disorder (SUD) assessment. She said the facility had a younger population of residents with psychosocial concerns including but not limited to: history of trauma, history of SUD, justice involved residents with and without a history of violence, and history of psychiatric conditions. Social Worker #1 said the facility Social Workers do not create or participate in care plans related to behavioral concerns (yelling, threatening, swearing, verbal abuse, physical abuse, refusing care, resident to resident altercations.) She said the Social Workers will create care plans related to the use of psychotropic medications, SUD and/or trauma. During an interview on 1/31/25 at 9:40 A.M., Social Work Consultant #2 said the Social Workers do not create or participate in care plans related to behavioral concerns and do not initiate behavioral interventions. During an interview on 2/4/25 at 12:11 P.M., Unit Manager #1 said she was a nurse on the unit prior to becoming the Unit Manager last week. She said the behavioral care plans were usually a collaboration between the Social Workers and the Unit Manager but she had not created any behavioral care plans in the previous week. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/4/25 at 4:15 P.M., Nurse #11 said she was previously the Unit Manager until mid-January 2025. She said the Social Workers create care plans related to behavioral concerns of verbal altercations, throwing things, and substance use. During an interview on 2/5/25 at 12:02 P.M., the Director of Nurses said she believed social services was dealing with psychosocial issues and she did not know that the social service department was not developing behavior care plans and was not implementing interventions related to behaviors. The Director of Nurses said the social service department should have been meeting with the resident's face to face to determine specific interventions and needs. During an interview on 2/5/25 at 1:45 P.M., with the Administrator and Assistant Administrator, the Administrator said trauma-informed care/behavioral issues were not on his radar, and he thought the social service department was doing what was expected of them. 2. Review of the Facility Assessment, dated December 2024, indicated the following participant sections were left blank: -Direct Care Staff Member (RN, LPN, CNA, etc.) -Resident -Family Member -Resident Representative -Staff Representative During an interview on 2/5/25 at 1:45 P.M., the Assistant Administrator said the facility assessment was completed with help from the Administration team including the Administrator, Director of Nurses, Infection Control Nurse, the Governing Body, and Department Heads. As of the end of the survey, on 2/5/25, the survey team did not receive any additional documentation to support the involvement of required members in completing the Facility Assessment.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 49424 Based on interview and document review, the facility failed to ensure the binding Arbitration Agreement presented to residents as part of the admission packet was explained to the resident and/or his/her representative in a form and manner that he/she understands for three Residents (#146, #209, and #151), out of three sampled residents, that had signed arbitration agreements in the facility. Findings include: During the Resident Group Meeting on 1/30/25 at 10:00 A.M., Residents in attendance said they do not understand what arbitration is. They said they were asked to sign papers after they were admitted and never received a copy of what they signed. During an interview on 1/30/25 at 12:18 P.M., the Administrator said he was not sure who was responsible for having residents sign the arbitration agreement. He said either the Receptionist or nursing would have residents sign the agreement. He said the business office reported that nursing staff have residents sign the agreement upon admission. During an interview on 1/30/25 at 12:20 P.M., the Receptionist said she has residents sign admission paperwork in four spots, she said she puts a sticky note where the resident needs to sign. She said she does not know what arbitration is and cannot explain it to the residents. She said she has them sign the paperwork because she is responsible for getting these signatures but doesn't have knowledge of what the documents are. She said she has not been trained on arbitration agreements. During an interview on 1/30/25 at 12:39 P.M., Resident #146 said he/she signed a bunch of papers on the day they arrived, but he/she doesn't recall anything being explained about an arbitration process. The Resident said he/she does not know what arbitration is. During an interview on 1/30/25 at 12:48 P.M., Resident #209 said he/she did not know if he/she signed an arbitration agreement. The Resident said he/she was told to sign a lot of papers and shown where to sign but it was not explained. During an interview on 1/30/25 at 01:43 P.M., Resident #151 said he/she was handed a pile of papers with sticky notes of where to sign. The Resident said he/she did not know what arbitration was and wouldn't have signed it if he/she understood what it was. The Resident said the arbitration process and agreement were not explained to him/her. During an interview on 1/30/25 at 2:35 P.M., the Administrator said he expects that the residents are educated on what they are asked to sign. He said there should be someone who can explain the arbitration agreement and their current process needs to be revised because it isn't working.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 46562 Based on interview and document review, the facility failed to maintain a Quality Assurance and Performance Improvement (QAPI) Committee which included the required members at their meetings. Specifically, the facility Medical Director failed to attend the last two quarterly QAPI meetings and the Director of Nurses (DON) the last QAPI meeting. Findings include: Review of the facility's policy titled Quality Assurance Performance Improvement (QAPI), dated as revised 6/2019, indicated but was not limited to: -the facility will form a QAPI Steering Committee designed to meet quarterly. The Steering Committee must include the Medical Director (attendance required quarterly), Administrator, DON, Pharmacist, Staff Development Coordinator (ADON), and Social Services. Review of the facility's QAPI Attendee sign-in sheets for October 2024 indicated the line for the Medical Director signature was blank. Review of the facility's QAPI Attendee sign-in sheets for January 2025 indicated the line for the Medical Director and Director of Nurses signature was blank. During an interview on 2/5/25 at 1:45 P.M., with the Administrator and Assistant Administrator, the Assistant Administrator said the facility completed monthly QAPI meetings and conducts a larger Quarterly QAPI meeting. The Administrator said the last quarterly QAPI meetings were held in January 2025 and October 2024. The Administrator said the Medical Director attended the Quarterly QAPI meetings. During an interview on 2/5/25 at 1:46 P.M., with the Administrator and Assistant Administrator, the surveyor reviewed the QAPI Attendee sign-in sheets and the Assistant Administrator said sometimes the Medical Director attended telephonically and when that was the case he/she would fax over a copy of the signed attendance sheet. The Assistant Administrator said the DON may have been on vacation at the last QAPI meeting. The Assistant Administrator said she would provide the survey team with the updated attendance sheets. During an interview on 2/5/25 at 2:01 P.M., the Medical Director (Physician #1) said the facility usually reports any issues they have to him but he did not attend the QAPI meetings. At the time of survey completion, on 2/5/25, the facility failed to provide any additional documentation to the survey team.

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	225723	A. Building B. Wing	02/05/2025

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Fall River Healthcare	1748 Highland Avenue Fall River, MA 02720

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 46562 Based on observation, interview, and document review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed to: 1. For Resident #118, ensure his/her respiratory equipment was stored in clean and sanitary condition when not in use; 2. For Resident #139, who has chronic wounds and indwelling devices, putting him/her at increased risk for infection, to ensure staff implemented Enhanced Barrier Precautions (EBP-an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities; and 3. For Resident #210, ensure staff implemented contact precautions (an infection control intervention to prevent the spread of infection) while being treated for an infection with an multi-drug resistant organism. Findings include: Review of the facility's policy titled Infection Control Guidelines for Nursing Procedures, dated as revised 7/2024, indicated but was not limited to: -Transmission-Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent the spread of infection. Transmission-Based Precautions will be initiated when there is reason to believe that a resident has a communicable infectious disease. Transmission- Based Precautions may include Contact Precautions, Droplet Precautions, Airborne Precautions, or Enhanced Barrier Precautions. -Contact Precautions: a. in addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. b. examples of infections requiring Contact Precautions include but are not limited to: infections with multi-drug resistant organisms. c. Personal Protective Equipment 1. in addition to wearing gloves as outlined under Standard Precautions, don (put on) disposable gown when entering the room 2. while caring for a resident, change gloves after having contact with infective material (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Enhanced Barrier Precautions (EBP): a. EBP is indicated in nursing home residents with any of the following: infection or colonization with an MDRO when Contact Precautions do not otherwise apply, chronic wounds, and indwelling devices including feeding tubes, trach, and urinary catheters b. Personal Protective Equipment 1. use of gown and gloves during high-contact care resident care activities that may provide opportunities for transmission of MDROs via staff hands and clothing, examples of high contact resident activities are dressing, bathing, shower, transferring, changing linen, personal hygiene, toileting/brief change, device care, PICC/central line 2. while caring for a resident change gloves after having contact with infective material 1. On 1/30/25 at 1:04 P.M., the surveyor observed Resident #118's nasal canula hanging from a door handle with the nasal prongs touching the handle. On 2/3/25 at 11:18 A.M., the surveyor observed Resident #118's nasal canula hanging from a hook with the nasal prongs touching the hook and other items hanging from the hook. During an interview on 2/3/25 at 4:48 P.M., Resident #118 said during a smoke break he/she removed their oxygen and left it inside the building. Resident #118 said the facility never instructed him/her to store the tubing in a respiratory bag when he/she was smoking so he/she just stuck it on a hook or a handle before going outside. During an interview on 2/3/25 at 4:10 P.M., Certified Nursing Assistant (CNA) #10 said when oxygen was not being utilized the tubing should be stored in a bag. During an interview on 2/3/25 at 4:13 P.M., Nurse #4 said oxygen tubing should be stored in a respiratory bag and not exposed to the environment when not in use. During an interview on 2/4/25 at 9:14 A.M., Unit Manager #4 said oxygen tubing should be stored in a respiratory bag when it was not being utilized. Unit Manager #4 said during smoking breaks residents should keep the nasal cannula in a bag inside the building. During an interview on 2/4/25 at 8:23 A.M., the Infection Control Nurse said any time the oxygen was not in use the tubing should be stored in a respiratory bag. The Infection Control Nurse said if needed staff should assist residents with storing their oxygen in a bag during smoke breaks. During an interview on 2/4/25 at 9:15 A.M., the Director of Nurses said the facility did not have a policy for care of respiratory equipment. 2. Review of the Centers for Medicare and Medicaid Services (CMS) guidance titled Enhanced Barrier Precautions in Nursing Homes, dated 3/20/24, indicated but was not limited to: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities. -EBP are used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing -EBP are indicated for residents with any of the following: a. Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or b. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO -EBP should be used for any residents who meet the above criteria, wherever they reside in the Facility Review of the Centers for Disease Control and Prevention (CDC) Enhanced Barrier Precaution sign indicated but was not limited to: -In addition to standard precautions Staff and Providers must: -Clean hands prior to entering and when exiting the room -Wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use, and wound care. Review of Resident #139's medical record indicated he/she had a tracheostomy (an opening surgically created through the neck into the trachea (windpipe) to allow direct access to the breathing tube), gastrostomy (a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications), a chronic wound, and an indwelling urinary catheter. On 2/3/25 at 10:57 A.M., the surveyor observed Nurse #4 performing tracheostomy care to Resident #139 with only gloves donned. There was a PPE bin outside of the room and an EBP sign posted at the entrance of the room. On 2/3/25 at 1:45 P.M., the surveyor observed Nurse #4 repositioning Resident #139 in bed with only gloves donned. There was a PPE bin outside of the room and an EBP sign posted at the entrance of the room. During an interview on 2/3/25 at 4:10 P.M, CNA #10 said when a resident has a sign for EBP the staff should wear a gown and gloves when they are providing direct care to the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/3/25 at 4:13 P.M., Nurse #4 said the EBP signs posted at the entrance to residents rooms told the staff what to wear for PPE. Nurse #4 said Resident # 139 required a gown and gloves for wound care because his/her wound used to have an infection in it. During an interview on 2/3/25 at 4:16 P.M., Unit Manager #4 said Resident #139 required EBP because he/she had a tracheostomy, a gastrostomy, a catheter and a chronic wound. Unit Manager #4 said anytime staff was performing care and/or touching the resident a gown and gloves should be worn. During an interview on 2/3/25 at 4:44 P.M., the Infection Control Nurse said EBP should be followed according to the signs posted outside of the rooms. The Infection Control Nurse said EBP are required for residents with a colonized MDRO, an indwelling device, and/or a chronic wound. The Infection Control Nurse said EBP would require gowns and gloves for positioning a resident in bed and performing tracheostomy care. 15214 3. Resident #220 was admitted in January 2025 with diagnoses which included osteomyelitis, ankle and foot, other specified sepsis, and encounter for orthopedic aftercare following surgical amputation, and Methicillin-resistant Staphylococcus aureus (MRSA) sepsis (blood infection). Review of Resident #220's medical record indicated that the Resident was being treated for a blood infection with the MDRO, MRSA. Review of the January 2025 Medication Administration Record indicated a physician's order to Maintain Contact Precautions/MRSA blood, dated 1/29/25 at 7:00 A.M. On 1/31/25 at 12:15 P.M., 1/31/25 at 2:19 P.M., and 2/4/25 at 8:45 A.M., the surveyor observed the sign posted on the entrance to the Resident's room was for Enhanced Barrier Precautions, not Contact Precautions, as required. On 1/31/25 at 12:15 P.M., the surveyor observed Nurse #5 preparing to administer the Resident's IV (intravenous) antibiotic (Vancomycin). The surveyor did not observe Nurse #5 wearing a gown as required. On 1/31/25, between 12:15 P.M. and 2:30 P.M., the surveyor observed Nurse #5 enter Resident #220's room without donning a gown, as required for a resident on Contact Precautions. During an interview on 2/5/25 at 12:35 P.M., Unit Manager (UM) #1 said that from 1/29/25 through 2/5/25, the precaution sign on the Resident's doorway was not the correct one; the Enhanced Barrier Precaution sign should have been a Contact Precaution sign for the Resident's MRSA infection. She said that nursing staff should have been donning gown and gloves, when providing care to any resident with a MRSA infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 2/4/25 at 11:24 A.M., the Infection Preventionist (IP) and the surveyor observed the signage posted outside of Resident #220's room. The IP said that the Enhanced Barrier Precaution sign was the wrong sign. The IP said the Resident has a MRSA infection in his/her blood and should have a Contact Precaution sign posted at the entrance to the room. The IP said that the unit managers are typically the ones to ensure the proper precaution signs are posted. The IP did not know why the proper precaution sign was not posted.