STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265140	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46104 Based on interview and record review, the facility staff failed to follow their abuse and neglect policy by not reporting an allegation of sexual abuse within the required time frame. This affected one resident (Resident #2). The sample was 9. The census was 80. Review of the facility's Abuse Policy and Procedures/Investigation Protocols, dated 12/14/18, showed: -The facility is committed to protecting residents from mistreatment, neglect, abuse and misappropriation of resident property; -The following policy has been put in place to insure protection and prevention from such treatment: -1. All employees hired are subject to a criminal record check; -a. Results of criminal record check will be reviewed by the Administrator and appropriate department manager to determine employment eligibility; -b. Any criminal conviction that may be cause for concern will result in immediate dismissal (if conviction is after hire) or employment ineligibility; -2. The Department of Health and Senior Services is contacted on each new employee to verify that they are not listed on the EDL (employee disqualification list); -3. All new hires are subject to a 90-day probation period to insure stability for this type of employment; -4. All employees are required to attend an orientation which covers our policies/procedures; (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Time Period for Reporting Possible Abuse/Neglect: The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey agency) in accordance with State law through established procedures; -If an incident occurs that warrants police intervention, the administrator and/or appropriate manager will notify the [NAME] Police Department at [PHONE NUMBER]; -Facility Policy: This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. This facility therefore prohibits mistreatment, neglect, abuse or misappropriation of its residents and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents. This will be done by: -Conducting pre-employment screening of employees; -Orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of mistreatment, neglect, abuse and misappropriation; -Establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; -Identify occurrences and patterns of potential mistreatment; -Immediately protecting residents involved in identified reports of possible abuse; -Implementing systems to investigate all reports and allegations of mistreatment promptly, aggressively and making the necessary changes to prevent future occurrences; -Filing accurate and timely investigative reports. -This facility is committed to protecting our residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends or any other individuals. This facility will not knowingly employ an individual who has been convicted of abusing, neglecting, or mistreating individuals; -Definitions: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Abuse: Abuse means any physical or mental injury, or sexual assault inflicted upon a resident other than by accidental means in a facility. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain and/or maintain physical, mental and psychosocial well-being. This assumes that all instances of abuse of residents even those in a coma, cause physical harm or pain or mental anguish; -Sexual Abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault. Sexual Abuse is defined as non-consensual sexual contact of any type with a resident. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm; -Orientation and Training of Employees: During orientation of new employees, the facility will cover the following topics: -Sensitivity to resident rights and resident needs; -Dementia Management - Person-Centered Care of Persons with Dementia and Prevention of Abuse; -Staff obligations to prevent and report abuse, neglect and misappropriation of resident property; and how to distinguish theft from lost items and willful abuse from insensitive staff actions that should be corrected through counseling and additional training/education; -How to assess, prevent and manage aggressive, violent and/or catastrophic reactions of residents in a way that protects both residents and staff; -How to recognize and deal with burnout, frustration and stress that may lead to inappropriate responses or abusive reactions to residents; -On an annual basis, staff will receive a review of the above topics; -Internal Reporting Requirements and Identification of Allegations: -Employees are required to report any occurrences of potential abuse, neglect, exploitation, and/or misappropriation of resident property they observe, hear about, or suspect to the Administrator or Director of Nursing (DON) via phone call immediately; -Internal Investigation of Allegations and Response: -1. Appointing an Investigator. Once the Administrator/DON determines that there is possible mistreatment, the Administrator or DON will appoint a person to take charge of the investigation. The person in charge of the investigation will obtain a copy of any documentation relative to the incident and the Resident Protection Investigation Procedures. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Residents who allegedly mistreated another resident will be removed from contact with that resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches and placement, considering his/her safety, as well as the safety of other residents; -Accused individuals not employed by the facility will be denied unsupervised access to the resident during the course of the investigation; -Employees of this facility who allegedly mistreated the resident(s) will be suspended or terminated immediately until the results of the investigation have been reviewed by the Administrator; -Investigation Procedures: Regardless of the specific nature of the allegation (physical, sexual, verbal/mental, misappropriation or neglect), the investigation shall consist of: -A review of the incident reports; -Completion of a written report on the status of the investigation; -An interview with the person(s) reporting the incident; if warranted after obtaining statement; -An interview with the resident; -Where appropriate, an interview with the resident's attending physician or psychiatrist; -A review of the medical records of any residents involved in the occurrence; -If the accused individual is an employee, review the personnel file to check for references, background check and documentation of orientation and training; -An interview with staff members having contact with the resident and accused individual during the period of the alleged incident; -Where appropriate, interviews with the resident's roommate, family members, visitors or others who were in the vicinity of the incident; -Interview other employees to determine if they have witnessed other incidents of mistreatment; -Obtain address, phone number and social security number of the accused individual; -An interview with the accused individual or individuals; -A review of all circumstances surrounding the incident; -The Interview Process: -The interviewer will be asking the person being interviewed to write the details of the incident in their own handwriting; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Witnesses must sign and date statements; -As much as possible, all interviews should be conducted with a witness to review; -Record the name, address, phone number, date of birth and social security number of each witness; -For the protection of both employees and residents involved in the investigation, these interviews should be kept confidential during the progress of the investigation and only released with the permission of the Administrator or facility attorney; -Final Investigation Report: -The summary, conclusions and results of the investigation will be recorded on a final written report and submitted to the Administrator within five days of the occurrence. The Administrator or DON may forward a copy to the facility attorney; -After a conclusion based on the investigation is determined, internal reports, interviews, witness statements and identities of individuals involved shall be released only with the permission of the Administrator or facility attorney. Even if the facility investigation is not complete, the Administrator will cooperate with the Department of Health and Senior Services investigation into the matter; -After reviewing the final report, the Administrator or DON will notify the resident's representative of the results of the investigation; -The Administrator or designee shall answer any questions regarding a particular incident; -A summary of incident investigations involving the resident harm and possible mistreatment of the resident will also be sent to the facility Quality Improvement Committee, with the identity of the individual involved kept confidential; -Resident Protection Investigation Paths: Possible Sexual Abuse; - Definition: Sexual abuse is non-consensual sexual contact of any type with a resident. Sexual abuse includes, but is not limited to: -Unwanted intimate touching of any kind especially of breasts or perineal area; -All types of sexual assault or battery, such as rape, sodomy, and coerced nudity; -Forced observation of masturbation and/or pornography; -Taking sexually explicit photographs and/or audio/video recordings of a resident(s) and maintaining and/or distributing them (e.g. posting on social media). This would include, but is not limited to, nudity, fondling, and/or intercourse involving a resident; -Appears to want the contact to occur, but lacks the cognitive ability to consent; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-NA B suspended pending investigation. DON spoke with the resident and the resident said it happened yesterday on 9/14/24 in the afternoon. When asked to describe the staff member the resident said it was Certified Nursing Assistant (CNA) C's sibling. The resident described the staff member as an African American. The resident stated NA B was changing his/her diaper and started playing with his/her genitals. Resident said he/she did not report it to anyone yesterday. DON informed staff when providing care for the resident there needs to be two staff members; -On 9/16/24 at 1:51 P.M., the DON reported the resident told LPN D on 9/15/24 about the allegation of a staff member playing with his/her genitals while changing the resident, resident told LPN D that he/she did not think it was right and did not appear distressed at the time. The resident has told four different stories including different dates and circumstances. Initially the resident reported an African American staff member came into his/her room on Saturday afternoon 9/14/24 to change him/her and while doing so was inappropriately touched. There were not staff members working at that time that matched the resident's description. The resident then reported it happened while he/she was being put to bed. In a statement NA B said after midnight on 9/14/24 the resident asked for help, the resident said his/her bed was wet and he/she needed changed. NA B changed the resident's bedding and the resident and put on a new brief. The resident requested water and NA B got the resident water. A few hours later, the resident said the brief was too small and he/she needed to be changed. NA B got a different brief and changed the resident and did not fasten the brief too tightly so it would not be uncomfortable. The resident then asked to sit up in bed and told NA B that a staff member that looked like him/her had touched him/her earlier in the night. NA B went and got his/her sibling CNA C, and the resident said it was not CNA C but the person looked like him/her. Neither NA B nor CNA C reported what the resident said. The resident told the PA the incident happened on Wednesday night and the staff member did it with a towel. The DON believes the resident mistook being cleaned as being touched inappropriately. Review of witness statement from NA B, undated, showed: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-During my shift starting Saturday night 9/14/24 going into Sunday morning a hour or 2 after 12:00 A.M. I heard the resident asking for help from his/her room. When I went to check on him/her he/she told me that his/her bed was wet, so I asked him/her if he/she needed his/her brief changed and he/she said yes. I went to get towels, a brief and a bed pad and told him/her I was going to change him/her brief for him/her. I sprayed him/her with soap and wiped him/her with towels and replaced his/her brief and bed pad and he/she asked for a drink of water which I gave to him/her. Sometime later he/she turned on his/her call light and I went to check on him/her. He/She told me that his/her brief was too tight. I told him/her I will be going to get a new brief and that I would make sure I didn't make it too tight. I changed his/her brief again and he/she told me he/she wanted to sit up for a bit. I helped him/her sit up in the bed for a bit and when he/she told me he/she was ready to lay back down I helped him/her lay back down and asked him/her was the position of the bed comfortable for him/her and he/she said yes. He/She then told me that someone was in his/her room earlier playing with him/her. I asked him/her what did he/she mean and he/she said someone touched him/her. He/She then said that it looked like my sibling, but it wasn't my sibling. When he/she said that I assumed maybe he/she thought I was CNA C at the time given the circumstances as I was the only one who had been in there to change him/her but I did not touch him/her inappropriately and I felt maybe he/she had just woken up from his/her sleep and was a bit disoriented. It was close to time to start getting the residents up so as me and CNA C prepared, we started with the resident since he/she had already woken up. He/She asked me to get him/her a cup of water for another drink and then he/she asked if I could get him/her a peanut butter and jelly sandwich and I did then I asked him/her if he/she needed anything else he/she said no. I told CNA C about what he/she said and it was time to start getting the residents up and we did the resident first since he/she had recently woken up. When we went into his/her room he/she told CNA C the same thing he/she told me when I was in there to change his/her brief. He/She told CNA C that the staff member looks like CNA C's sibling, but it wasn't CNA's sibling. CNA C pointed at me and asked him/her was I the person he/she was talking about, and the resident looked at me and said no it wasn't me it was somebody else. We proceeded to get the rest of the residents up and that was the end of shift. Review of witness statement from CNA C, undated, showed: -At some point in the night NA B approached me and stated the resident had told him/her someone came into his/her room and was inappropriately touching him/her. The resident was asleep the first time we checked on him/her. So, when NA B checked on the resident, he/she had just woken up and after a long time of working with the resident I know that he/she can be disoriented when waking up or at random. So, when NA B told me that I brushed it off because there were times where the resident told me his/her sibling was just in his/her room or other people that were not around or haven't seen the resident that day. Later for get up we got the resident up first because he/she was yelling my name for help. The resident then told me the same thing that someone touched him/her and the resident said that person looked like my sibling bit it was not my sibling. I even pointed to my sibling and asked him/her if it was NA B and the resident said no it was not NA B but when the resident said no he/she was smirking like it was a joke as if there's no way it was NA B that did it. We got him/her changed and dressed and he/she never mentioned it again. I am not calling the resident a liar but he/she does have a brain injury which is why he/she says things that do not make sense. The resident is often confused and talks to people who are not there. Review of witness statement from LPN D, dated 9/15/24, showed: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/24/24 at 10:17 A.M., the DON said she did not believe what the resident said happened. The first time she interviewed the resident, he/she said he/she was touched inappropriately on his/her genital area. The resident stated he/she did not know who it was and said it happened around 3:30 P. M. to 4:00 P.M. in the afternoon. The resident said it was not NA B or CNA C. The PA interviewed the resident after the DON interviewed the resident the next day. The resident told LPN D on Sunday and LPN D reported it to the DON and the DON came into the building Sunday evening and interviewed the resident and NA B and the other staff. NA B said when he/she went in to clean up the resident Saturday 9/14/24 night into Sunday morning, the resident told NA B someone had touched him/her inappropriately. NA B and CNA C went into the resident's room together and the resident could not tell them anything else. NA B and CNA C did not report the allegation to anyone. The DON expected both NA B and CNA C to report the allegation immediately to the Charge Nurse and the DON. The DON said she educated NA B and told him/her if anyone makes an accusation, it needs to be reported immediately. The DON said NA B is new and the facility just hired him/her. NA B is not certified and is going through classes to obtain his/her certification. The DON said there have not been any complaints regarding NA B and the care provided. The resident has a history of making false allegations of people touching him/her. The DON said the RR said the resident has made allegations in the past and asked the facility not to terminate NA B regarding the allegation. CNA C did not say why he/she did not report the allegation to anyone. The DON did not reeducate CNA C. During an interview on 9/25/24 at 7:11 A.M., NA B said he/she went into the resident's room to check on him/her. The resident needed to be changed, and NA B sat him/her up on bed. The second time he/she went into change him/her is when the resident told NA B someone was playing with him/her. NA B asked the resident what he/she meant, and the resident said someone was touching him/her and it looked like your sibling, but it wasn't your sibling. NA B said that threw him/her off when he/she said that because NA B knew he/she was the only one in the room at that point. NA B thought maybe he/she was confused, and he/she was talking about NA B and not CNA C. NA B said he/she did not touch the resident inappropriately at all when providing peri care (washing the genitals and anal area). He/She provided the peri care as normal. NA B said he/she used a washcloth and soap spray when cleaning the resident. After that, NA B told his/her sibling what happened. CNA C went into the room with NA B and the resident said the same thing to CNA C. The resident said someone was playing with him/her and told CNA C it looked like his/her sibling NA B. CNA C pointed to NA B and asked if it was NA B and the resident said it was not NA B. NA B said he/she didn't tell anyone other than CNA C because he/she was thrown off and didn't know what to do. (continued on next page)

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	265140	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marymount Manor	313 Augustine Rd Eureka, MO 63025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/24 at 7:33 A.M., CNA C said NA B approached CNA C during the night shift on 9/14/24 and informed him/her what the resident said; that someone went into his/her room and was feeling on him/her inappropriately. CNA C went into the resident's room towards the end of the shift. The resident did not give too much detail and just said someone was feeling on him/her inappropriately. The resident said the staff member kind of looked like your sibling, but it was not your sibling, NA B and CNA C were both in the room at that time. CNA C made sure the resident knew who CNA C was and who he/she was talking to. CNA C asked the resident to look at him/her and asked the resident if it was NA B and had the resident look at NA B and asked the resident if it was NA B and he/she said, oh no it was not NA B. CNA C said sometimes when he/she went in to care for the resident, at like midnight, the resident might say something when he/she wakes up. The resident has said his/her sibling was just in his/her room yelling and woke him/her up. CNA C said he/she has not reported that type of situation to the nurse but with the accusation the resident made, he/she should have reported it to the nurse. CNA C said he/she did not report it because he/she has seen the resident have confusion before. CNA C would normally report it if the resident was in the right state of mind. CNA C now knows he/she should have reported it right away even if the resident is confused. During an interview on 9/25/24 at 7:49 A.M., Certified Medication Technician (CMT) E said he/she worked the night shift on 9/14/24 on the resident's hall. CMT E said there was nothing abnormal that night. CMT E said the resident yells out and is not very coherent. The resident will yell out different staff members names and family members names. CMT E administered Tylenol to the resident around 6:00 A.M. The resident did not mention anything to CMT E when he/she administered the medication. The resident never reported anything to him/her about being touched inappropriately. During an interview on 9/25/24 at 9:30 A.M., the resident said this staff member changed his/her diaper and he/she was lying in bed and the staff member had his/her hand in a towel and he/she was doing circles on his/her genital area. The resident said he/she felt like the staff member was doing more than just cleaning and it made him/her feel uncomfortable. The resident said it was disgusting and makes him/her feel sick. The resident said he/she is almost positive it was a staff member and he/she thinks the person had staff member clothes on. The resident could not describe what staff member clothes the person had on. The resident said he/she does not know who it was. The resident said the staff member came into his/her room that night and asked if he/she needed anything, and the resident said no he/she was fine, and the person left. The resident does not know if he/she has seen that person again after that night. The staff member was African American and had really short hair. The resident said he/she told the staff members so-called sibling about it but he/she doesn't know if it was the sibling or not. The resident reported the incident to LPN D a couple of hours after it happened. The resident said they were at a function where they were all having lunch together. The resident said he/she was not sure if he/she should tell LPN D or not and the resident waited a couple hours and then told LPN D. The resident said it happened in the late afternoon, he/she didn't remember what day it happened, but it was a weekday. The resident said he/she feels safe at the facility. During an interview on 9/25/24 at 10:06 A.M., the RR said he/she is aware of the accusation the resident made. The facility contacted him/her. The RR said the resident has a history of making accusations. He/She made them at his/her previous facility. The RR said he/she cannot rely on the resident's mental capacity and he/she doesn't know what to believe half the time. During an interview on 9/25/24 at 10:36 A.M., LPN D said during the afternoon/evening on 9/15/24, the resident called LPN D over to him/her. LPN D thought the resident was going to say he/she needed change

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. 46104 Based on interview and record review, the facility failed to follow their written policy permitting residents to return to the facility after they have been hospitalized , for one of 9 sampled residents (Resident #1). The census was 80. Review of the facility's Discharge Procedures policy, undated, showed: -Discharge Procedures - The facility shall permit each resident to remain in the facility unless: -The transfer or discharge is appropriate because the resident's welfare and the resident's needs cannot be met by the facility; -The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; -The safety of individuals in the facility is endangered; -The health of individuals in the facility would otherwise be endangered; -The resident has failed, after reasonable and appropriate notice, to pay for (or have paid under Medicare or Medicaid) a stay at the facility; -Definitions: -Transfer: Moving a resident from one institutional setting to another institutional setting for care; -Discharge: Releasing from a facility or refusing to readmit a resident from a community setting under circumstances where the resident has not consented or agreed with the move or decision to refuse readmittance. Refusal to readmit a former resident shall not constitute a discharge if the former resident has been absent from the facility for more than ninety days; -Consent to or agreement with transfer or discharge means one of the following: -1. The resident or a legally authorized representative has consented to, agreed with, or requested the discharge; -2. The resident's treating physician has ordered the transfer, and the releasing facility intends to readmit the resident (example: hospitalization); -Consent of the resident: The resident, with sufficient mental capacity to fully understand the effects and consequences of the transfer or discharge, consents to or agrees with the transfer or discharge; (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Legally authorized representative: A duly appointed guardian or an attorney-in fact who has current and valid power to make health care decisions for the resident; -Documentation: When transferring or discharging a resident, the resident's clinical record shall be documented. Record and document in detail in each affected resident's record the reason for the transfer or discharge. The recording of the reason for transfer or discharge shall be entered into the resident's record prior to the date the resident receives notification of transfer or discharge, or prior to the time when the transferring or discharging facility decides to transfer or discharge the resident. Documentation for the transfer or discharge is obtained from: -The resident's personal physician; -The facility administrator or Director of Nursing; -Before transfer or discharge, the facility shall: -1. Send written notification to the resident in a language and manner reasonably calculated to be understood by the resident. The notice must also be sent to any legally authorized representative of the resident and to at least one family member. A copy of the notice will be forwarded to the Department of Health and Senior Services regional office and the regional coordinator of the Missouri State Ombudsman's office; -2. Include the following information in the written notice: -The reason for the transfer or discharge. Include specific details regarding the reason and previous intervention attempts, if appropriate; -The effective date of transfer or discharge; -The resident's right to appeal the transfer or discharge to the director of the Department of Health and Senior Services hearing official within thirty days of the receipt of the notice; -The address to which the request for a hearing should be sent: Administrative Hearings Unit, Division of Legal Services, PO Box 570, [NAME] City MO 65102-1527; -That filing an appeal will allow a resident to remain in the facility until the hearing is held unless a hearing official finds otherwise; -The location to which the resident is being transferred or discharged ; -The name, address and telephone number of the designated regional long- term care ombudsman office; -Time Frames: The notice of transfer or discharge shall be made no less than 30 days before the resident is to be transferred or discharged . In the case of an emergency discharge, the notice shall be made as soon as practicable before the discharge when it specifically alleged in the notice: (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The safety of individuals in the facility would be endangered. The notice must include specific facts upon which the facility has based its determination that the safety of said individuals would be so endangered; -The health of individuals in the facility would be endangered. The notice must include specific facts upon which the facility has based its determination that the health of said individuals would be so endangered; -The resident's health has improved sufficiently to allow a more immediate transfer or discharge. The notice must include specific facts upon which the facility has based its determination; -An immediate transfer or discharge is required by the resident's urgent medical needs. The notice must include specific facts upon which the facility has based its determination; -The resident has not resided in the facility for thirty days; -hospitalized Residents: If a hospitalized resident, and/or proxy, decides the resident will not return to the facility following hospitalization , facility will document conversation with family in the resident's medical record. When the resident, and/or proxy, comes to pick up the resident's belongings, the facility will have the resident, and/or proxy, sign the discharge form stating the resident will no longer return to the facility. The facility staff will inform the resident, and/or proxy, should they wish to return, the facility will follow new admission protocols by reviewing the resident's hospital records to determine admission. Review of the facility's Admissions Policy, dated 10/30/17, showed: -Purpose: The facility understands that the transition into a skilled nursing facility can be trying. The purpose of this policy and procedure is to facilitate a fluid transition of a resident into the skilled nursing facility; -5. Medical information will be requested to be reviewed by the interdisciplinary team to ensure the facility will be able to meet the needs of the potential resident. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/18/24, showed: -Admission: 7/11/24; -Moderate cognitive impairment; -Preadmission screening and resident review (PASRR): Has the resident been evaluated by level II PASRR and determined to have a serious mental illness and/or mental retardation or related condition: Yes; -Level II PASRR conditions: Serious mental illness and mental retardation; -Delirium: Is there evidence of an acute change in mental status from the resident's baseline: Behavior not present; (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Inattention: Did the resident have difficulty focusing attention, for example being easily distractable, or having difficulty keeping track of what was being said: Behavior not present; -Disorganized thinking: Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject): Behavior not present; -Social isolation: Never; -Behavioral symptoms: -Physical behavioral symptoms directed toward others (hitting, pushing, scratching, grabbing, abusing others sexually): Behavior not exhibited; -Verbal behavioral symptoms directed toward others (threatening others, screaming at others, cursing at others): Behavior not exhibited; -Other behavioral symptoms not directed toward others (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds): Behavior not exhibited; -Rejection of care: Behavior not exhibited; -Lower extremity (hip, knee, ankle, foot): Impairment on one side; -Dependent on staff for toileting, lower body dressing, put on/take off footwear, roll left to right, sit to lying and lying to sitting on the side of the bed; -Substantial/Maximal assistance (helper does more than half the effort) for upper body dressing and personal hygiene; -Always incontinent of bladder and bowel; -Discharge Plan: Is there an active discharge plan in place for the resident to return to the community: No; -Diagnoses included bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), diabetes, diabetic peripheral (away from the center) angiopathy (disease of the blood vessels) with gangrene (death of body tissue due to a lack of blood flow or a serious bacterial infection), cutaneous (skin) abscess of left lower limb, chronic kidney disease (CKD, impaired kidney function), respiratory failure with hypoxia (low levels of oxygen in body that can causing difficulty breathing, confusion, restlessness, rapid heart rate, and bluish colored skin) and severe sepsis (Sepsis causes an inflammatory response in the body. Severe sepsis occurs when one or more of your body's organs are damaged from the inflammatory response) with septic shock (life-threatening condition that happens when blood pressure drops to a dangerously low level after an infection). (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's current care plan, showed no care plan interventions related to behaviors or interventions. Review of the resident's nurse's notes, dated 7/11/24 through 7/26/24, showed: -7/11/24 at 6:11 P.M., resident admitted to the facility; -7/11/24 at 6:17 P.M., resident alert and oriented (A&O) times (x) 2 (Level of awareness of (1) self, (2) place, (3) time, and (4) situation. The higher the number, the better oriented a person is considered. Healthcare providers score a person's orientation on a scale of 1 to 4.) with some mild retardation noted; -7/13/24 at 11:09 P.M., resident resistive to care at times. One on one resident becomes less anxious and makes needs known; -7/15/24 at 12:14 P.M., resident needs total care with transfers and activities of daily living (ADLs, activities related to personal care bathing, toileting, dressing, etc.) and meals. Resident assisted into wheelchair and resident yelled so much the resident was assisted back to bed; -7/16/24 at 1:05 P.M., resident at times can make sense when verbalizing his/her needs; -7/18/24 at 11:25 A.M., resident A&O x 1 (self). Resident hollers out inappropriately and difficult to redirect; -7/19/24 at 11:30 A.M., resident yells loudly at people in hallway walking past his/her door, resident yells for his/her mom; -7/20/24 at 6:26 P.M., resident slid out of wheelchair earlier today. Resident now yelling loudly that his/her shoulder hurts. Nurse did range of motion (ROM) with right shoulder after fall and resident had no complaints of pain at that time. Now resident yelling loudly to call the ambulance, primary care physician (PCP) and resident representative (RR) notified resident being sent to emergency room (ER) for evaluation and treatment for right shoulder pain; -7/20/24 at 7:12 A.M., resident returned to facility from hospital at 6:35 A.M. with nondisplaced fracture to right humerus (long bone that runs from the shoulder and scapula (shoulder blade) to the elbow). Resident noncompliant with right arm sling, removes arm from sling; -7/21/24 at 1:22 P.M., resident is screaming down the hall and stating he/she wants to go to the hospital. Spoke with RR and RR will be at the facility today with treats to talk to resident. Resident refusing to wear sling to right arm; -7/22/24 at 12:27 P.M., interdisciplinary team (IDT) review of ER visit and return to facility. Diagnosis closed fracture of proximal humerus with routine healing, unspecified fracture morphology (number of fragments and fracture lines). Resident returned to facility with new order to follow up with physician; (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-7/22/24 at 4:44 A.M., IDT clinical review 7/19/24 5:14 P.M., fall with injury. Resident became anxious while sitting up in wheelchair and slid into the floor. Assessed with complaints of pain to right shoulder. PCP and RR notified. Sent to ER for evaluation and treatment; -7/24/24 at 11:12 A.M., resident skilled for above knee amputation (AKA) and right humerus fracture. Resident in bed yelling that he/she drank to much whiskey last night (resident did not). Resident will not allow sling to be put on right arm; -7/25/24 at 1:46 P.M., resident skilled for AKA and right humerus fracture. Resident in bed resting at this time, quieter today; -7/26/24 at 9:21 P.M., resident noted to have increased discomfort, behavioral issues noted throughout the day, attempts to redirect using non-pharmacological methods. Used music, hydration, repositioning, and soda etc. continued to be ineffective, as needed (PRN) pain medication utilized with minimal relief. Resident at this time requested to be sent to ER. Administration notified per facility policy any resident or family member requesting to go to the hospital needs to be sent to the ER. Call out to PCP and RR related to resident's request. Call placed to 911, emergency medical technicians (EMT) arrived at 3:55 P.M. Resident transferred to stretcher and resident out of building at 4:05 P.M. Spoke with RR informed of resident's decision and was thanked by RR. Review of the resident's hospital notes, dated 7/26/24, showed: -7/26/24 at 4:28 P.M., Resident presents with chief complaint of pain in upper right arm; -7/26/24 at 7:13 P.M., Registered Nurse (RN) at hospital received a call from Licensed Practical Nurse (LPN) A charge nurse at the facility. LPN A said the facility is refusing to accept the resident back into their care because the resident is agitated, yells, and disturbs other residents. LPN A said the facility made this decision 15 minutes (min) ago and they have not tried any interventions to help the resident, have not tried to transfer the resident to a different facility, and that, the doctors are not willing to prescribe anything to chemically restrain the resident. LPN A said the decision was made by the Director of Nursing (DON) and Interim Administrator (IA); -7/26/24 at 7:19 P.M., RN at hospital received a call from the DON confirming the facility is not accepting the resident back into their care; -7/26/24, admitted Emergency Department (ED) observation at 9:58 P.M. During an interview on 9/24/24 at 10:17 A.M., the DON said the resident was sent to the hospital on 7/26/24 because of his/her disruptive behaviors. The DON said residents on the hall made comments threatening to harm the resident due to his/her disruptive behaviors of yelling out all the time. The DON said she was concerned for the resident's safety and refused to accept the resident back from the hospital. The DON said she spoke with the IA and the IA agreed on not accepting the resident back at the facility. The DON said an emergency discharge letter was not given to the resident at discharge and an emergency discharge was not given the next day. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/24 at 12:10 P.M., the IA and DON said they both expected staff to be knowledgeable of and follow the facility policies. They were concerned for the residents' safety and felt it was an unsafe situation for the resident and everyone else due to the resident's outbursts and behaviors. They expected if an emergency discharge notice needed to be given, the emergency discharge process would be followed. The emergency discharge notice was not given to the resident and the emergency discharge process was not followed for the resident. MO00239903