STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265330	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Village Park	2041 Silva Lane Moberly, MO 65270

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36185 Based on interview and record review, the facility failed to ensure residents or their representatives had the right to participate in the development and implementation of the resident's person-centered plan of care when facility staff did not invite two residents (Resident #1 and #3) or the residents' representatives to routine care plan meetings. A sample of 16 residents was selected for review. The facility census was 178. Review of the facility policy, Comprehensive Care Plans and Base line Care Plans, dated 1/19/22, showed the following: -The purpose of this policy is to ensure that the facility develops a comprehensive care plan for each resident that included measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment; -A licensed nurse, that has been designated by the facility administration will coordinate each assessment with the appropriate participation of health professionals otherwise known for the purposes of the Minimum Data Set (MDS, a federally mandated assessment instrument, completed by the facility staff), for the care planning process by the interdisciplinary team (IDT). This team shall include but is not limited to MDS/Care Plan Coordinator (CPC), Social Services, Dietary, Physical Therapy, Occupational Therapy, Speech therapy, Activities, and various staff of nursing; -The care plan will be oriented toward involving resident/family/responsible party. The policy did not address the frequency and timing of care plan meetings. 1. Review of Resident #3's undated face sheet showed the resident was admitted to the facility on [DATE]. Review of the resident's Annual Minimum Data Set (MDS), a federally mandated assessment instrument, dated 1/17/24 showed the following: -The resident was cognitively intact; -It was very important to the resident to have family or a close friend involved in discussions about his/her care; (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included schizophrenia (mental illness) and post-traumatic stress disorder (PTSD). Review of the resident's care plan, last revised 3/7/23, showed the following: -The guardian will assist in making decisions for the resident, ensure guardian wishes are followed; -Resident and/or guardian and/or family where applicable will be asked about return to community and discharge goal plans with comprehensive care plan meetings. Review of the resident's electronic medical record (EMR) showed no documentation of a resident or representative participating or attending a care plan meeting since the resident's admission. During an interview on 3/21/24 at 10:15 A.M. the resident's guardian said the following: -He/She had attended one care plan meeting at the facility since the resident was admitted , he/she thought it took place last month; -He/She wanted to be involved in the resident's care and to know how the resident was progressing and discuss discharge planning etc.; -He/She had to call and leave various messages to discuss the resident's care and inquire how things were going, a routine care plan meeting would help to answer his/her questions; -He/She wanted to be involved in the resident's care plan meetings. 2. Review of Resident #1's undated face sheet showed the resident was admitted to the facility on [DATE]. Review of the resident's care plan, revised 1/31/24, showed the following: -The resident has a guardian to assist in decision making due to mental illness. Ensure guardian wishes are followed; -Resident/and or guardian and/or family where applicable will be asked about return to the community and discharge goal plans with comprehensive care plan meetings. Review of the resident's quarterly MDS, dated [DATE], showed the following: -The resident was cognitively intact; -It was very important to the resident to have family or a close friend involved in discussions about his/her care; -Diagnoses included bipolar disorder (a mental illness that causes unusual shifts in mood) and schizophrenia. (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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's EMR showed no documentation of a resident or representative participating or attending a care plan meeting since admission. During an interview on 3/21/24 at 3:20 P.M., the resident's guardian said he/she would expect to be involved in care plan meetings. 3. During an interview on 3/27/24 at 3:00 P.M. the MDS Coordinator said the following: -Care plan meetings were to be completed quarterly; -The facility had no system in place for completing routine care plan meetings; -He/She worked at the facility only one or two days a week, so routine care plan meetings were not being done; -He/She worked at two different facilities and when at the facility his/her priority was to get MDS assessments caught up; -He/She thought the Social Service Director notified the resident's representatives of upcoming care plan meetings. During an interview on 3/27/24 at 5:15 P.M. the Social Service Director said the following: -The expectation for care plan meetings was quarterly; -Quarterly care plan meetings were getting missed; -She did not always document when a care plan meeting was done; -Resident #3 had a care plan meeting in January 2024, but it was not documented, she did not know of any other care plan meetings Resident #3 had; -She was not sure if Resident #1 had participated in a plan meeting since he/she was admitted in September of 2023 as there was no documentation of a meeting; -She tried to notify the resident's guardian/family or representative of upcoming care plan meetings, but it did not always get done. During an interview on 3/19/24 at 9:35 A.M. the Director of Nursing said the following:-She was not sure how often care plan meetings took place or who attended the care plan meetings; -She did not participate in care plan meetings because she was pulled to cover the floor or do other things; -The Social Service Director set up care plan meetings. During an interview on 3/27/24 at 5:30 P.M., the administrator said he would expect for care plan meetings to be completed routinely. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO233271

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36185 Based on observation, interview and record review, the facility failed to provide protective oversight for one resident (Resident #1), who had behavioral difficulties and required 24-hour monitoring and management and was at risk for elopement per the resident's Pre-Admission Screening and Resident Review (PASARR), and resided on a secured behavioral unit. On 3/15/24, Hall Monitor A left residents unattended in the gated courtyard during the 9:00 PM smoke break. Resident #1 placed a chair in the corner of the courtyard next to a 12 foot tall fence and used the chair to climb up and over the fence. The resident left the facility without staff knowledge and walked for approximately two miles, crossing a busy four lane highway intersection, then along an outer road before he/she was located at approximately 10:00 P.M. Staff were not aware the resident had left the facility until another resident reported at approximately 9:30 P.M., the resident had left. The facility also failed to consistently implement and communicate interventions to prevent falls for one resident (Resident #7) with a history of falls, including falls with injury. A sample of 16 residents was selected for review. The facility census was 178. The administrator was notified on 3/20/24 at 2:55 P.M. of an Immediate Jeopardy (IJ) which began on 3/15/24. The IJ was removed on 3/22/24, per surveyor onsite verification. The facility did not have a specific policy that addressed monitoring residents during smoke breaks. Review of the facility policy, Intensive Monitoring/Visual Checks, dated 6/30/23, showed the following: -To ensure a system is in place for residents who require increased monitoring for behavioral/psychiatric and medical issues; -All residents on each unit will be monitored by visual checks at least every two hours or may be provided more intensive monitoring every hour; -Special care units will not be left unattended at any time. 1. Review of Resident #11's face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's PASARR Mental Illness Level II Evaluation, dated 9/27/23, showed the following: -Reason for nursing facility application, admission was behavioral difficulties and/or mental illness requiring 24-hour monitoring and management; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Diagnoses included post-traumatic stress disorder (a mental health condition that's triggered by a terrifying event either experiencing it or witnessing it), antisocial personality disorder (a mental health disorder characterized by disregard for other people), cluster B personality disorder (characterized by overly dramatic, emotional, erratic thinking), bipolar disorder-manic with psychotic features (intense or prolonged mood episodes, psychotic symptoms, or hospitalization), schizoaffective disorder (a mental health disorder marked by symptoms such as hallucinations or delusions and mood disorder symptoms such as depression or mania), cannabis abuse, hallucinogenic mushroom, cocaine use disorder, methamphetamine use disorder moderate, in sustained remission; -The resident has a long history of mental health symptoms, he/she was non-compliant with medications, takes a variety of drugs, becomes manic and threatening and ends up in the hospital. The resident lacks the executive functioning skills necessary to make safe decisions; -Current psychiatric support/services inpatient psychiatric treatment, medication administration/management/monitoring, secured behavioral unit, safety precautions 15-minute checks, individual therapy/counseling, group therapy counseling; He/She has previously jumped in front of a car in a suicide attempt, punched himself/herself and pulled his/her hair out; -Overt behaviors included refuses activities, impatient and demanding, wandering, physically threatening, strikes others when provoked; -Initially required frequent intervention, but now that he/she is on medications is doing better, and he/she is less argumentative with staff; -Orientation to person, place, circumstance, and time; -Limitations include poor coping skills, little actual support outside the hospital, he/she is non- complaint with medications and follow-up treatment; -Strengths include has a guardian, no medical problems, he/she is young, has good verbal skills, able to express needs and independence with activities of daily living (ADLs); -The resident's individual needs can be met in a nursing facility at this time; -He/She requires supervision to stay on his/her medications and make sure he/she does not become manic, requires 24/7 supervision until he/she has been on medications for a stabilizing period; -The individual needs or continues to need the following supports and services include provision of specific services to address individual mental health and behavioral needs; -Obtain individual support plan (ISP), individualized treatment plan (ITP), behavioral support plan (BSP) from department of mental health community mental health center and or developmental disability regional office; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Provision of a structured environment include maintain environment with low stimulation, maintain environment with a minimum of visual/auditory distractions, provide instructions at the individuals level of understanding, environmental supports to prevent elopement, assess and plan for the level of supervision required to prevent harm to self and others, provide for individual personal space, provide sensory supports, and establish consistent routines; -Crisis intervention services to include suicidal precautions, assault precautions and elopement precautions; -Monitor his/her behavior for signs and symptoms that he/she is becoming less stable, manic and report immediately. Review of the resident's nursing note dated 1/20/24 at 6:45 P.M., showed the resident reported it upset him/her that he/she must live in the facility due to not being able to hold a job, take classes or jog. The resident felt like the medication was not helping enough for his/her anger. The resident was made aware he/she would meet with administrator regarding his/her concerns, as well as Long-Term Care Psychiatric Management (LTPM) and the Assistant Director of Nursing (ADON) was notified. Review of the resident's care plan revised 1/31/24 showed the following: The resident has a guardian to assist in decision making due to mental illness. Ensure guardian wishes are followed; -Triggers included missing family, being yelled at and loud noises. The resident's care plan did not address elopement risk or smoking precautions. Review of the resident's Elopement Evaluation, dated 1/31/24, showed the following: -History of elopement while at home: No; -Wandering behavior, a pattern or goal directed: No; -Wanders aimlessly or non-goal directed: No; -Wandering behavior likely to affect the privacy of others: No; -Recently admitted or readmitted (within past 30 days) and has not accepted the situation: No; -Elopement Score: not at risk for elopement. Review of the resident's PASRR/ Mental Illness Level II Evaluation, dated 2/16/24, showed the following: -Specific reason for nursing facility application admission or continued stay includes behavioral difficulties and/or mental illness symptoms requiring 24-hour monitoring/management, lack of community/family supports to maintain functioning at home, and alternate care options are unavailable (waiting lists, etc.); (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Living situation since last evaluation has been at the facility since September 2023; -The individual's mental status, psychiatric symptoms and behaviors include anxiety, verbal and physical aggression, irritability, and sleep disturbances. He/She has been suspicious and paranoid and has had abnormal thought processes. The resident said they (the facility) told him/her six months to a year, and he/she thought he/she would listen to them. They lie to people and don't let them out. If they will let me out it will be good. This place (the facility) makes him/her want to go to prison. He/She was prepared to be in a place to better himself/herself; -Psychiatry, counseling staff relay the resident has requested a therapist and is on a waiting list to see one; -Current psychiatric support/services include psychiatric follow-up/consultation, individual therapy/counseling, and a secured behavioral unit; -Groups are offered but the resident refuses to go to a lot of them. He/She spends most of his/her day in bed, and prefer to stay up in the evening and at night; -The resident has continued to have behavioral problems, mood instability and irrational thinking processes. He/She spent a few weeks in a psychiatric center and can sleep better, although he/she likes to stay up at night; -He/She has a history of medication noncompliance and has a history of drug use; -He/She has previously jumped in front of a car in a suicide attempt, punched himself/herself and pulled his/her hair out; He/She has a history of cutting himself/herself and trying to strangle himself/herself with a tie. He/She has a history of poor coping skills; -Nursing facility/Community Interest: I don't like it at this place. There is a bunch of fights. I would rather be in a faith-based program. I wish I was in a rehab program in a faith-based program. I have wasted six months here. -Individual limitations include ongoing behavioral problems, elevated mood and irritability and irrational thinking processes. He/She lacks insight and judgement; -Provision of a structured environment includes environmental supports to prevent elopement, assess and plan for the level of supervision required to prevent harm to self and others, provide individual personal space, consistent routines, and a schedule for daily tasks/activities; -Needs and rationale as well as level of supervision needed, history of self-injury and elopement risk; -Crisis interventions services include suicidal precautions, assault precautions and elopement precautions; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-History of self-harm and aggression. It is recommended that a safety plan be in place that addresses interventions should these issues occur; -Long term skilled care is not the overall goal. The resident seems confused about the specifics regarding what he/she needs to do to get out. He/She seems unaware of his/her goals regarding discharge. Review of the resident's care plan showed no evidence the facility updated the care plan with interventions for elopement risk precautions as indicated on the PASRR/Mental Illness Level II Evaluation on 9/27/23 and the PASRR/Mental Illness Level II Update dated 2/16/24. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by the facility staff, dated 3/15/24, showed the following: -Cognitively intact; -Makes self-understood and understands others; -No behavioral symptoms exhibited; -No psychosis exhibited; -No wandering behaviors exhibited; -Feeling down, depressed, or hopeless occurred two to six days of the seven day look back period; -Independent ADLs. Review of the resident's progress note dated 3/15/24 at 10:56 P.M., showed it was reported to Registered Nurse (RN) F on 3/15/24 after the 9:00 P.M. smoke break the resident was not able to be located on the unit. Hall monitor E called a Code [NAME] (call to respond to an elopement or anytime a resident is missing from the facility or there was a possibility that a resident left the facility without appropriate supervision). The nurse notified the Administrator. Immediate staff intervention, face checks to every room, all residents accounted for except for this resident. The police were notified about the elopement and responded to the facility. Demographics and a picture of the resident provided to law enforcement officer. The resident was found outside the facility and was returned to the facility by a department head staff. The resident was alert and oriented. The resident was agitated and yelling at staff members. The Director of Nursing (DON) and Long-term Psychiatric Management (LTPM) obtained an order to give Thorazine by mouth (PO) or intramuscular (IM). Obtained an order to send out for further medical and psychiatric evaluation. Physician on call notified. Guardian was notified. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/20/24 at 11:45 A.M., the resident said his/her guardian told him/her to try and give the facility six months and he/she did. He/She left on his/her terms after six months. He/She had planned it out well and the way it was planned out, no one would catch him/her. After the 9:00 P.M. or 11:00 P.M. smoke break (he/she did not remember which one) (on 3/15/24), he/she hid around the corner in the dark and once everyone went back inside, he/she climbed over the fence. It wasn't hard to do. He/She did not want to be at the facility. He/She wanted to have his/her own place and get a job. The facility wasn't doing anything to help him/her get better. During an interview on 3/21/24 at 3:20 P.M. the resident's guardian said the following: -The facility had reported the resident's elopement to him/her; -He/She was new as the resident's guardian, and was not real familiar with him/her yet; -The resident had not been in contact with him/her about wanting to leave the facility. Review of the initial reporting form, dated 3/16/24 at 11:57 A.M. showed the following: -Date and time the alleged incident occurred: 3/15/24 at 9:29 P.M.; -It was reported to administration on 3/15/24 at 9:35 P.M. the resident was noted missing from the unit after 9:00 P.M. smoke break, a Code [NAME] procedure was immediately started. Staff began checking all rooms and when staff went to the smoke area a chair was found wedged in the corner of the smoke yard that the resident used to scale the fence and elope. Staff immediately started looking offsite for the resident. At 10:05 P.M. the resident was found on an outer road about two miles from the facility. The resident was returned to the facility, skin assessment completed and no injuries, order given for the resident to be sent out for psychiatric evaluation. Review of the resident's progress note dated 3/16/24 at 2:20 A.M. showed the resident was admitted to a psychiatric center. During an interview on 3/19/24 at 3:00 P.M. Hall Monitor E said the following: -He/She had worked at the facility for approximately two years; -He/She worked routinely on the hall where Resident #1 resided; -When he/she took the residents outside to smoke, he/she would prop the door open and try to position himself/herself between the door (to the outside gated courtyard) and the inside of the facility, so he/she could monitor the hall at the same time residents were outside smoking; -He/She could not see around the side of the building when residents were outside smoking, he/she tried to watch the residents the best he/she could; -When it was dark, there was only one light on the outside (in the courtyard), and it was over the door; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 3/15//24 at the 9:00 P.M., he/she did not see the resident come out for smoke break at all that night, normally the resident said he/she didn't smoke; -A call light came on (during the 9:00 P.M. smoke break), so he/she went inside to answer the call light. RN F watched the smoke area for a few minutes (he/she thought), while he/she answered the call light inside; -Resident #9 came to him/her (Hall Monitor E) after the smoke break (approximately 9:30 P.M.) and said Resident #11 had escaped. This was how he/she found out the resident was missing; -Resident #9 showed Hall Monitor E where a chair was positioned by the fence outside in the outside smoke area, he/she believed the resident used the chair to get over the fence; -He/She immediately called a Code [NAME] and started looking for the resident; -He/She thought maybe 12 residents went out to smoke that night, but it was different every break, he/she didn't document how many residents went out to smoke or how many came back in; -He/She completed hourly face checks on each resident on the hall; -The facility was always short staffed so he/she often would take the residents outside to smoke and try to watch the hall for call lights at the door while he/she was smoking the residents. It was difficult to do both at the same time. During an interview on 3/19/24 at 12:30 P.M. RN F said the following: -He/She was the charge nurse for the 300 hall the night of 3/15/24 when the resident eloped, he/she found out the resident had eloped after the 9:00 P.M. smoke break; -An overhead Code [NAME] was called for the 300 hall sometime after 9:00 P.M.; -He/She responded to the hall and was notified by Hall Monitor E the resident was missing, he/she immediately completed a room search of every room in the building (including closets, bathrooms etc.) -Face checks were completed on all residents in the facility to ensure all other residents were accounted for and no one else was missing; -He/She notified the Administrator the resident could not be located after face checks were all completed; -Only one hall monitor was scheduled to work on the 300 hall (this was routine), a hall monitor from another hall was to come to 300 hall and supervise the floor (answer lights etc.) when the hall monitor assigned the 300 hall took the residents outside to smoke. He/She could also supervise the hall if needed while the hall monitor took residents outside to smoke; -He/She did not go to the 300 hall that night and supervise the hall while the residents went outside to smoke; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The hall monitor was never to leave the outside smoke area unattended to answer a call light inside. Observation on 3/19/24 at approximately 8:00 A.M., of the route the resident would have taken from the facility where he/she was found, showed the following: -The city street in front of the facility a two-lane black top; -The resident would have walked approximately one tenth of a mile to an intersection after dark where he/she would have crossed a busy four lane intersection, with traffic speed of 40 miles per hour and turned left then back right onto an outer road; -Once on the outer road, a two-lane black top with traffic speed of 45 mph, the resident would have walked approximately two miles on an unlit road with several curves, a hill and moderate traffic. There were no sidewalks along the route. Review of the [NAME].ground (a weather website service that lets you access real-time weather information) showed the temperature on 3/15/24 at approximately 10:00 P.M. was 45 degrees Fahrenheit. Observation on 3/19/24 at approximately 12:00 P.M. (on the 300 hall) showed the following: -Hall Monitor G opened the door from the 300 hall into the gated outside courtyard. Hall monitor G positioned himself/herself directly outside the door while he/she lit each resident's cigarette one by one (10 residents total); -Various residents walked around the gated courtyard (outside of Hall Monitor G's line of sight); -Hall Monitor G questioned one of the residents, if he/she was on the correct hall, (as he/she thought this resident did not belong on the 300 hall), another resident spoke up and said, yes, the resident was on the correct hall; -Hall Monitor G said he/she did not know the residents on this hall as well; -Hall monitor G walked to the side of outside smoke area once during the smoke break, but did not check the area before going back inside; -Hall Monitor G did not document/log who came out to smoke or who returned inside the building once smoke break was completed. During an interview on 3/19/24 at 1:15 P.M. Hall Monitor G said he/she had worked at the facility for a couple months and wasn't very familiar with the residents on the 300 hall. He/She was covering the outside smoke break on the 300 hall today. He/She did not participate in the in-service following Resident # 11's elopement. He/She always lit the residents' cigarettes by the door. It was hard to see around the side of the building to supervise all the residents when they were outside smoking. He/She tried to keep an eye on them the best he/she could. He/She thought 10 to 15 residents went out to smoke today on the smoke break he/she supervised. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/20/24 at 9:45 A.M. Licensed Practical Nurse (LPN) A said he/she was the charge nurse today on the 100, 200 and 300 halls. He/She heard a resident got out of the facility on the night shift. The facility would probably schedule an in-service soon (regarding the elopement), but it had not been scheduled yet. He/She heard the residents were not to smoke outside after dark. During an interview on 3/19/24 at 9:35 A.M. the DON said the following: This was the resident's first placement, the resident was just placed under guardianship prior to admission to the facility; -The resident had made no comments about wanting to leave, the resident had not been identified as an elopement risk; -The PASARR had something documented about the resident being an elopement risk, but it got missed or wasn't seen; -The resident left on 3/15/24 around 9:30 P.M., she was not working, but was told a Code [NAME] was called, room searches were completed and most likely the police were notified; -The resident was found on a side street walking; facility staff found the resident and brought him/her back; -The resident had no injuries and was sent out for psychiatric evaluation; -Staff should never leave the smoke area unsupervised. During an interview on 3/27/24 at 5:35 P.M. the Administrator said the following: -He would expect the facility staff to position themselves in the outside smoke area, where all residents are within line of sight, staff should not stand at the door; -Staff should never leave the outside smoke area unattended; -On 3/15/24 during the 9:00 P.M. smoke break, Hall Monitor E left the outside smoke area unattended to answer a call light inside, he/she should have never left the outside smoke area unattended. 2. Review of the facility policy, Post Fall Protocol, last revised 6/30/23, showed the following: -The purpose of the policy was to ensure that all residents who have had a fall have accurate assessment and follow through to prevent further injury and the recurrence of falls; -A fall is any event, not purposeful, and not from external force that results in the resident coming in contact with the next lower surface; -The LPN or RN on duty will perform a full head to toe assessment of affected resident immediately when informed of a fall; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Immediate vital signs are taken. Neurological assessments will be completed if the fall is unobserved, if the resident hits any part of their head or if the resident is cognitively impaired; -Stabilization/first aide of any injuries. Call 911 if needed; -Notify physician of incident and any injuries immediately upon discovery; -Notify the responsible party of the incident; -Documentation of the resident fall must be completed in the risk management section and include, but not limited to, the time, location, equipment involved if any, resident ' s activity at the time of the incident, description of any injuries, any action taken, resident ' s condition at the time of the incident, and details of the incident, including but not limited to immediate actions taken and actions taken to minimize recurrence; -Update care plan to include individualized interventions with date; -Refer to therapy department for screens and evaluation and treatment to prevent recurrence. Review of the facility policy, Focus Risk Assessment Plan Scope/Severity for Falls (FRAPSS), revised 6/29/23, showed the following: -Purpose: To assess all residents for potential for falls in the facility. To ensure a comprehensive interdisciplinary plan of care is established for all residents who are identified for increase risk of falls. To identify precipitating factors for fall risk and to be proactive in implementing interventions to prevent or reduce the incident of further falls; -Resident will be assessed using the FRAPSS form for fall risk upon admission, quarterly and in an acute situation where a resident has fallen; -Every resident who has a fall including those without injury will be screened by the therapy department and nursing interventions will be put in place to reduce the risk of further falls; -A FRAPSS Level 1 score of 0-15 indicates minimal risk for falls; -A FRAPSS Level 2 score of 16-25 indicates potential for more than minimal harm; -FRAPSS Level 3 score of 26-34 indicates potential for actual harm; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-FRAPSS Level 4 score of 35 and up indicates immediate jeopardy with two or more falls with one or more resulting in a significant injury. Additional interventions may include, based on the IDT, hospitalization , 30 day discharge letter sent to the legal guardian if the facility feels the resident ' s needs cannot continue to be met, 1:1 supervision while awake with body alarm on the resident, and bed alarms on resident while asleep, including other individualized plans of care as assessed by the IDT. The administrator, DON, and therapy director will meet and establish interventions and plan of care that will reduce the risk of resident falling and ensure that protective oversight of the resident is a priority. The DON will continue to assess the resident as a high priority resident in the facility and the plan of care will be modified to ensure the highest level of safety is on place for the resident; -Nursing interventions will be individualized and addressed on the plan of care for the resident. Review of Resident #7's diagnoses list showed the resident had diagnoses that included chronic obstructive pulmonary disease (COPD, a group of diseases that cause airflow blockage and breathing-related problems), heart failure, dementia, major depressive disorder, arthritis, glaucoma, mild intellectual disabilities and need for assistance with personal care. Review of the resident's care plan, last reviewed 1/17/24, showed the following: -The resident displayed impaired thought processes related to senile dementia; -The resident had impaired vision and wore glasses. The resident was also hard of hearing but refused to wear his/her hearing aides; -The resident required assistance of one staff with all activities of daily living (ADLs) and required consistent queuing. Provide protective oversight and assist where needed; -The resident was at risk for falls related to weakness and side effects of medications. The resident had a history of falls; -Encourage the resident to ask for assistance when walking and transferring as needed; -Focus Risk Assessment Plan Scope/Severity (FRAPSS) for Falls assessment quarterly and as needed; -Ensure appropriate footwear and clothing; -Ensure adequate lighting; -One staff to provide limited assistance with mobility/transfers as needed/requested; -Monitor for weakness, dizziness, blurred vision, unsteady gait/balance and report to the physician as needed; -Therapy evaluation/treatment as needed; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 4/6/23 the resident sat self on floor and was upset and said, my favorite nurse doesn't work here anymore. The resident was educated on how to voice feelings and concerns. The resident was assessed and stable. Administrator, DON and physician were notified; -On 4/23/23 the resident slid out the chair onto the floor. The resident was assessed with no injuries. The resident was monitored by staff. The resident was placed on the list for provider rounds. Administrator, DON and physician were notified. Review of the resident's nurse's notes showed the following: -On 2/18/24 at 3:08 A.M., staff witnessed the resident asleep and fall forward from the wheelchair. Assessment completed and the resident assisted back to his/her room. Vital signs were within normal limits. A skin tear was noted to the left wrist which was cleaned and covered. Guardian, assistant DON, DON, administrator, and physician on call were notified. Education was provided to the resident on call light use and resident safety; -On 2/25/24 at 11:13 A.M., the resident had an unwitnessed fall. The resident was sitting on his/her buttocks on the floor in the dining room. There was a laceration to the right eye that was actively bleeding. The resident said a chair would not move when he/she attempted to sit down and the resident fell and hit his/her head. The resident reported pain to the right eyebrow. The resident was transferred from the floor to the wheelchair with assistance of two staff. Guardian, DON, administrator, and physician on call notified. Vital signs within normal limits. The resident was transferred to the hospital by Emergency Medical Service (EMS); -On 3/2/24 at 6:00 A.M., the resident was sleeping in the wheelchair in the dining room and fell out of the chair, bumping his/her forehead. No swelling, redness or bruising noted. Vital signs within normal limits. Guardian, physician, and administration notified. The resident was sent to the hospital by ambulance; -On 3/5/24 at 1:29 A.M., the resident fell from the wheelchair to the floor and bumped the side of his/her forehead. The resident complained of pain. Tylenol administered. Vital signs within normal limits. The resident was assessed and sent to the hospital for further evaluation. Physician, DON and guardian notified; -On 3/6/24 at 3:14 P.M., physical therapy (PT) and occupational therapy (OT) ordered for the resident after multiple falls without effectiveness from other interventions. Would like to place seatbelt on resident to keep him/her from falling out of the wheelchair, as well as placing the resident on a toileting schedule so he/she would not fall with toilet transfers. Therapy notified of new orders; -On 3/13/24 at 8:24 P.M., the resident was found on the floor by staff. Resident assisted back up. The resident denied any pain or discomfort. The resident refused a neurological assessment. Guardian, physician and administration notified; -On 3/15/24 at 7:19 P.M., (late entry) the resident was up in the wheelchair and allegedly slipped out of the wheelchair onto his/her bottom. The fall was unwitnessed. No visible injuries. Vital signs within normal limits. Policy of facility is to send out for further assessment. Guardian and administration notified. The resident was sent to the hospital; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 3/17/24 at 6:30 A.M., the resident was up in a chair by the nurses station. Allegedly the resident went to the dining room and slipped out of the wheelchair onto his/her bottom. The fall was unwitnessed. The resident was assessed and no injuries identified. The resident said he/she was trying to sit in another chair at the table. The resident denied pain. Vital signs within normal limits. Administration and family notified. Sending resident out for further evaluation; -On 3/19/24 at 2:38 A.M., the resident was found on the floor under the sink. The resident was assessed with a skin tear to the left elbow. Sent to the hospital; -On 3/22/24 at 10:44 A.M., the resident reported a fall during night shift and was able to get himself/herself up and back into bed and did not report the fall to night shift. Resident made complaints of pain in middle back, head, and right elbow. Skin assessment showed two skin tears on left elbow with purple bruising, superficial scratch on top of his/her head on the right side, scratch on top of left thigh, redness on right upper back, purple bruising on left knuckles, and redness on the left shoulder. Vital signs within normal limits. Physician, guardian, DON notified. The resident was transported to the hospital by EMS. Review of the resident's care plan, revised 1/17/24, showed no updates or interventions added after the resident fell on [DATE], 2/25/24, 3/2/24, 3/5/24, 3/13/24, 3/15/24, 3/17/24, 3/19/24, or 3/22/24. Review of the resident's FRAPSS score for falls, dated 3/22/24, showed the resident was at high risk for falls, Level 4. Observation of the resident's room on 3/27/24 at 12:35 P.M., showed the resident was not in the room. There was a motion sensor pad alarm (device that contains sensors that trigger an alarm or warning light wh

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33955 Based on observation, interview and record review, the facility failed to ensure sufficient staff were employed with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain the highest practicable mental and psychosocial well-being for residents who resided on locked behavioral health units. The facility failed to ensure staff who provided one on one (1:1) supervision to residents were fully informed of the reason for the 1:1 monitoring they provided. The facility pulled staff from activities, laundry, housekeeping, and maintenance, away from their normally assigned duties, to monitor residents' smoking times and to provide 1:1 monitoring of residents who had experienced a behavioral health crisis. This resulted in the Hangout (common indoor/outdoor recreation area that residents from all units shared) being closed or monitored by one activity staff member which limited the times in which residents could access the area. The facility census was 176. Review of the facility policy, Intensive Monitoring/Visual Checks, revised 6/30/23, showed the following: -Residents who require more intensive monitoring due to medical/ behavioral/psychiatric symptoms will be monitored on visual face checks by the licensed nurse or designee and the Certified Nurse Aide (CNA) or designee; -Residents may require more intensive monitoring based on their medical and behavioral/psychiatric needs; -Resident who are showing poor impulse control, including verbal or physical aggression, elopement ideations, suicidal/homicidal ideations, decompensation mentally or medically, may also be placed on one to one or two to one monitoring (within eyesight of staff at all times) at the discretion of administrative staff; -Residents who require intensive monitoring of one to one will always have a staff member within eyesight. Review of the facility's undated Hall Monitor duties showed the following: -Monitoring residents during smoking schedules; -Completion of face checks and intensive monitoring; -Documentation; -Answering call lights; -Encouraging residents to maintain a clean living area; (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Walk the halls to monitor and assist with daily activities and report changes in behavior to the charge nurse; -Previous experience preferred but not required. Review of the facility assessment, last updated November 2023, showed the following: -Average number of occupied beds was 176; -Common diagnoses of residents included psychosis (hallucinations, delusions etc.), impaired cognition, mental disorder, depression, bipolar disorder, schizophrenia, post-traumatic stress disorder, anxiety, behaviors that require interventions, personality disorder, schizoaffective disorder, explosive disorder; -Process to make admission decisions for persons with new diagnosis or condition the facility is less familiar with included all referrals reviewed by the interdisciplinary team (IDT) to determine if the facility could meet resident needs safely, sufficiently and to determine if any new skill sets required by staff providing direct care. The IDT reviews all possible admits before admission , ensuring all necessary equipment, supplies, and/or outpatient services are available. The Director of Nursing (DON) will assess necessary education, return demonstration and in-servicing required to safely meet residents ' needs; -The facility had access to the corporate management company to assist with locating resources that may be necessary to provide care and to ensure the facility has all essential support and education to ensure any residents admitted with a new diagnosis needs are being met; -The facility would build relationships with residents and get to know him/her and engage the resident in conversation. Find out what the resident ' s preferences and routines are; what makes a good day for the resident; what upsets him/her and incorporate that information in the care planning process. Make sure staff caring for the resident have this information; -176 residents received long term care psychiatric management; -The number of residents with behavioral health needs was left blank; -Average daily staffing plan to meet the needs of residents were 1 full time administrator on day shift, 1 full time DON on day shift, 4 licensed practical nurses (LPNs), 14 certified nurse aides (CNAs), 1 minimum data set (MDS) coordinator, 6 hall monitors, 1 dietary manager on day shift, 1 cook on day shift, 1 prep cook, 3 dietary aides on day shift, 1 cook on evening shift, 3 dietary aides on evening shift, 1 activity staff, 1 restorative aide, 8 certified medication technicians (CMTs); -Specialized units include [NAME] (59 beds), Parkwood (46 beds) and Homestead (44 beds); -Staffing assignments to coordinate continuity of care for residents as follows: [NAME] Day Shift: 1 CMT, 3 aides. Parkwood Day Shift: 1 CMT, 2 aides. Meadowbrook Day Shift: 1 CMT, 3 aides. Homestead Day Shift: 1 CMT, 2 aides; (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-[NAME] Night Shift: 1 CMT (until done), 3 aides. Parkwood Night Shift: 1 CMT (until done), 2 aides. Meadowbrook Night Shift: 1 CMT (until done), 2 aides. Homestead Night Shift: 1 CMT (until done), 2 aides. -The acuity of each specialized unit is assessed, and staff is designated to the halls depending on the need or acuity of the hall. There is an assignment sheet completed each day with where the staff work. Assignments are based on the resident's acuity and needs. More staff are assigned to units that have residents that require more care; -Training is completed upon hire and ongoing throughout the year while employed at the facility. The facility does in-services monthly and as needed along with online training and 1:1 education. All employees are CALM certified to handle behavioral crisis (Crisis Alleviation Lessons and Methods). Review of the facility's Daily Staffing Sheets showed the following: -On 3/21/24 Day Shift: The DON was scheduled as the charge nurse. Meadowbrook unit had 2 aides (instead of 3 aides as listed on the facility assessment). There were four residents who required 1:1 monitoring. Activity aide I was pulled from monitoring the Hangout area to provide 1:1 monitoring for Resident #12. Activity aide L was pulled from activities to provide 1:1 monitoring for Resident #1. The other activity staff member called in and was not replaced on the schedule, leaving no staff to provide activities or monitor the Hangout area. Housekeeper K was pulled from housekeeping to provide 1:1 monitoring for Resident #14. Housekeeper M was pulled from housekeeping to provide 1:1 monitoring for Resident #13; -On 3/22/24 Day Shift: Four residents required 1:1 monitoring. Housekeeper O was pulled from housekeeping to provide 1:1 monitoring for Resident #14. Housekeeper P was pulled to be a hall monitor on the 900 hall (locked behavioral unit). Activity aide H was pulled from monitoring the Hangout area to provide 1:1 monitoring for Resident #13; -On 3/23/24 Day Shift: Five residents required 1:1 monitoring. Housekeeper Q was pulled from housekeeping to provide 1:1 monitoring for Resident #14. Housekeeper was pulled from housekeeping to be a hall monitor on the 900 hall. Activity aide H was pulled from monitoring the Hangout area to provide 1:1 monitoring for Resident #13. Housekeeper R was pulled from housekeeping to be the hall monitor on the 800 hall (locked behavioral unit); -On 3/24/24 Day Shift: Five residents required 1:1 monitoring. Housekeeper Q was pulled from housekeeping to provide 1:1 monitoring for Resident #12. Housekeeper R was pulled from housekeeping to be the hall monitor on the 800 hall. Housekeeper P was pulled from housekeeping to be the hall monitor on the 900 hall. This left no staff members in housekeeping. Activity staff H was pulled from activities to provide 1:1 monitoring for Resident #13; -On 3/25/24 Day Shift: Five residents required 1:1 monitoring. Activity aide T was pulled from monitoring the Hangout area to provide 1:1 monitoring for Resident #13. Housekeeper Q was pulled from housekeeping to provide 1:1 monitoring for Resident #1. Housekeeper S called in and was not replaced. Housekeeper K was pulled from housekeeping to provide 1:1 monitoring for Resident 12. This left no staff members in housekeeping; (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 3/26/24 Day Shift: There were six residents who required 1:1 monitoring. Activity aide I was pulled from activities to provide 1:1 monitoring for Resident #12. Housekeeper K was pulled from housekeeping to provide 1:1 monitoring for Resident #14; -On 3/27/24 Day Shift: There were six residents who required 1:1 monitoring. Housekeeper S was pulled from housekeeping to be the hall monitor on the 800 hall. Housekeeper K was pulled from housekeeping to provide 1:1 oversight for Resident #12. Activity aide H was pulled from activities to provide 1:1 monitoring for Resident #5. 1. During an interview on 3/19/24 at 1:40 P.M. Maintenance Staff U said the following: -He/She was pulled to work the 100 and 200 halls because the facility was short-staffed; -This was the first time he/she had worked the floor; -He/She did not know the names of each of the residents or really anything about the residents; -He/She was aware a resident had eloped, but did not know of any changes put in place because of the elopement; -He/She also took residents outside for smoke break. He/She did no know of of any new measures put in place for smoke break; -He/She did not document who went outside or who returned inside after the smoke break; -It made him/her uncomfortable to work the floor. During an interview on 3/19/24 at 3:00 P.M. Hall Monitor E said the following: -He/She had worked at the facility for approximately two years and routinely worked on the 300 hall; -He/She routinely asked for assistance to supervise the hall when he/she took residents out to smoke and was always ignored; -The residents on the hall were much bigger than him/her, if the residents were upset about waiting to smoke, he/she would go ahead take them out to smoke, as it was just him/her against all the residents on the hall and it was intimidating; -When he/she took residents out to smoke he/she would prop the door open and try to position himself/herself between the door, to the outside gated courtyard area),and the inside of the facility so he/she could monitor the hall and the resident's outside smoking at the same time. 2. Observation on 3/27/24 at 10:55 A.M. showed Activity aide I provided 1:1 monitoring for Resident #1 as the resident lay in bed sleeping in his/her room. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/24 at 10:58 A.M. Activity aide I said he/she was providing 1:1 monitoring for Resident #1 due to a recent elopement. Activity aide I was pulled from activities to provide 1:1 monitoring for Resident #1, which left only one activity aide to provide activities and monitor the residents in the Hangout area. When there were two activity aides monitoring the Hangout, the residents could come in and out as they pleased. The Hangout was currently open from 9:00 A.M. to 5:00 P.M. There was an indoor area and an outside area of the Hangout, but with only one staff to monitor the residents, they could only be outside for 30 minutes at a time to smoke and then they had to come back inside. This had upset many of the residents who utilized the Hangout. Activity aide I was frequently pulled from activities to provide 1:1 monitoring. 3. Observation on 3/27/24 at 11:00 A.M. showed Activity aide H provided 1:1 monitoring for Resident #5 as the resident lay in bed in his/her room. During an interview on 3/27/24 at 11:05 A.M. Activity aide H said he/she was providing 1:1 monitoring for Resident #5 because the resident had been in a physical altercation with another resident. Activity aide H was not sure who the other resident was that Resident #5 had been in an altercation with, or if the other resident lived on Resident #5's unit. Activity aide H was pulled from activities so there was only one activity staff member to monitor the Hangout. There were supposed to be two staff members in the Hangout to monitor the residents, one who monitored the residents in the outside area and one who monitored residents in the inside area. Since there was only one activity staff in the Hangout, that staff member had to take all the residents to the outside area to smoke at one time and then have all the residents come back inside at the same time so they could be monitored. This was upsetting to many to of the residents as they could previously come and go from the outside to inside as they wished. 4. Observation and interview on 3/27/24 at 11:10 A.M. showed Housekeeper K sat outside of Resident #12's room. Housekeeper K said he/she was providing 1:1 monitoring for Resident #12. Housekeeper K said he/she was not sure why Resident #12 required 1:1 monitoring, but assumed it was because of physical aggression. Housekeeper K did not know if the aggression was directed towards staff or other residents. Housekeeper K kept residents in line of sight when providing 1:1 monitoring. Housekeeper K said he/she could not put hands on the resident or provide any care. Resident #12 had required 1:1 monitoring for at least the last month. Housekeeper K was frequently pulled from housekeeping duties to provide 1:1 monitoring for residents. 5. Observation on 3/27/24 at 11:24 A.M. showed Resident #13 lay in bed with blankets covering his/her head. Hall Monitor N sat in a chair at the foot the resident's bed, providing 1:1 monitoring. During an interview on 3/27/24 at 11:25 A.M. Hall Monitor N said he/she normally worked a different unit, but was currently providing 1:1 monitoring for Resident #13. Hall Monitor N thought Resident #13 was on 1:1 monitoring due to suicidal ideation. Hall Monitor N did not know the specifics of the resident's suicidal ideation, if he/she had a plan, or if the resident had made an attempt to harm himself/herself. For the 1:1 monitoring Hall Monitor N kept Resident #13 in line of sight. If the resident made an attempt to harm himself/herself Hall Monitor N would yell down the hall for assistance from other staff members. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265330	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Village Park	2041 Silva Lane Moberly, MO 65270

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During an interview on 3/27/24 at 11:38 A.M. Resident #6 said he/she was in an altercation with Resident #5 where he/she and Resident #5 exchanged words and then hit each other about a week ago. The lens popped out of Resident #6's glasses during the incident. Resident #6 punched a wall a few days ago out of frustration. Resident #6 said punching things was one of his/her coping mechanisms. Other coping mechanisms included listening to music and going outside. Resident #6 said he/she would like to be able to go for walks outside. Resident #6 said he/she wished the outside Hangout area was still open at all times so he/she could go outside and walk when feeling frustrated. 7. During an interview on 3/27/24 at 3:30 P.M. Environmental Service Supervisor said there were currently six residents who required 1:1 supervision from staff members who were pulled from dietary, housekeeping, maintenance and the activity departments. When residents required 1:1 supervision, staff were pulled from different departments to assist with coverage. This caused issues with the staff members from non-nursing departments not being able to complete their normally assigned tasks and things had been missed. The Hangout was previously open from 6:00 A.M. to 11:00 P.M. The hours were changed a few months ago to 9:00 A.M. to 5:00 P.M. For at least the last two months there has only been one activity aide assigned to monitor the Hangout. That required all residents go to the outside portion to smoke all together while the inside portion was closed and vice versa because there was only one staff to monitor the residents. The Environmental Service Supervisor was responsible for finding the staff to provide the 1:1 monitoring for residents. The 1:1 staff had a sheet where they document any issues that occurred during the shift and they share that sheet with the oncoming staff taking over. All of the staff providing 1:1 monitoring received Crisis Alleviation Lessons and Methods (CALM) training, but most of those staff had never been through a Code [NAME] (behavioral emergency). If staff providing 1:1 monitoring required additional assistance for a behavioral emergency, they would have to yell for help from other staff members. 8. Observation on 3/17/24 showed the following: -At 4:20 P.M., Activity Aide L was in the inside portion of the Hangout signing out cigarettes for residents. There were 26 residents in the inside portion of the Hangout. Activity Aide L was the only staff in the Hangout; -At 4:25 P.M. Activity Aide L ushered the 26 residents from the inside portion of the Hangout to the outside portion of the Hangout to smoke. Activity Aide L lit the cigarettes for the residents and was the only staff member in the Hangout area monitoring 26 residents. During an interview on 3/27/24 at 4:30 P.M. Activity Aide L said typically there were two staff scheduled to monitor the Hangout. For the last several weeks there had only been one staff member to monitor the Hangout as the other activity staff were pulled to provide 1:1 monitoring, or to be a Hall Monitor on a unit. The Hangout opened at 9:00 A.M. and if there was only one staff member to monitor, the scheduled smoke times were every 30 minutes, with the smoke breaks lasting about 10 to 15 minutes. When there was only one staff monitoring the Hangout, the residents had to all go outside as one group and all go back inside as one group as there was only one staff to monitor them. This was upsetting to some of the residents as they could not come and go to utilize the outdoor/indoor spaces of the Hangout as they wished. Residents were able to go back inside and return to their units individually once they had extinguished and disposed of their cigarettes. (continued on next page)

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	265330	A. Building B. Wing	03/27/2024

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. During an interview on 4/3/24 at 1:10 P.M. the Director of Nursing (DON) said staff who provided 1:1 or who monitored smoking for residents should be familiar with the residents they monitored. Ancillary staff who provided 1:1 monitoring of residents were basically given a report by the nurse, along with a sheet with the resident's name and the frequency of the checks required. The 1:1 staff don't have the specifics of what happened with the resident to require the 1:1 monitoring. The DON was aware that activity staff were being pulled for 1:1 monitoring of residents, which then limited the Hangout access for other residents. That had been occurring for a few months. The residents had complained and did not like the Hangout access being limited. Residents had expressed feeling cooped up on their units. The Hangout was used as a reward for good behavior and now they do not have that reward. There were more altercations and behavioral codes on the floor because of that. There were duties and tasks that got missed because staff from other departments were providing 1:1 monitoring for residents. Floors and resident rooms weren't getting cleaned, but staff had to be pulled to assure the 1:1 monitoring was covered. The DON was pulled from her DON duties to work the floor daily for the first six months she was in the DON position. For the last three months she averaged about three shift a week as a nurse on the floor. While working the floor, she was unable to complete the DON duties. During an interview on 3/27/24 at 5:42 P.M. the administrator said staff providing 1:1 monitoring of residents should have an understanding of why the resident required 1:1 supervision. That should be explained from the off-going staff they are replacing. The Hangout was open from 9:00 A.M. to 5:00 P.M. When two staff are able to monitor the Hangout, residents could come and go from the inside portion to the outside portion as they pleased. For the past several weeks there had only been one staff monitoring the Hangout, so the outside portion of the Hangout was suspended. If the Hangout staff member felt comfortable he/she could take the residents out to smoke.