STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345233	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deer Park Health and Rehabilitation	306 Deer Park Road Nebo, NC 28761

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37538 Based on observations, record review, interviews with the resident and staff the facility failed to assess if a cognitively impaired resident had the ability to self-administer eye drops and a medicated cream that was kept at the beside for 1 of 1 resident reviewed for self-administration (Resident #24). The findings included: Resident #24 was admitted to the facility on [DATE] with diagnoses including dementia. Review of Resident #24's physician orders revealed cyclosporine ophthalmic emulsion 0.05% instill 1 drop in both eyes two times a day for dry eyes dated 1/29/24. There was no active physician order for the use of nystatin cream. There was no physician's order to indicate Resident #24 could self-administer cyclosporine eye drops or nystatin cream. The significant change of condition Minimum Data Set, dated dated dated [DATE] revealed Resident #24's cognition was moderately impaired. Review of the medical records revealed there was no assessment to indicate it was clinically appropriate for Resident #24 to self-administer cyclosporine eye drops or nystatin cream. Review of Resident #24's care plan revised on 2/6/24 revealed there was no focus area for self-administration of cyclosporine eye drops or nystatin cream. During an observation and interview on 04/15/24 at 9:31 AM in the room of Resident #24 on the overbed table in clear view was tube of nystatin cream that appeared almost gone and an individual dose of cyclosporine eye drops. The label on the nystatin cream read 30 grams-100,000 units with an expiration date 4/2025 and the label on the eye drops read cyclosporine 0.05% with an expiration date 3/2025. Resident #24 stated she self-administered the eye drops and had been doing so for a long time and was currently using the nystatin cream on her privates gesturing towards her perineal area. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 04/16/24 at 11:22 AM Nurse #5 revealed she was the assigned nurse for Resident #24. Nurse #5 observed the tube of nystatin cream, but the individual dose of the cyclosporine eye drop was no longer on the overbed table. Nurse #5 revealed Resident #24's ability to self-administer medications would need to be assessed and nystatin cream required a physician's order before using. Nurse #5 revealed she had not noticed the medications on the overbed table and explained to Resident #24 her ability to self-administer would need to be assessed and medications were stored on med cart, and she would need to remove them from the room. During an interview on 04/16/24 at 12:41 PM the Director of Nursing (DON) stated the Interdisciplinary Team would need to complete a self-administer assessment and obtain a physician's order before a resident was allowed to have medications in the room. The DON stated she was not sure if Resident #24 could self-administer eye drops and with no active physician's order the nystatin cream should not be used, and neither should be left in the resident's room. During an interview on 04/16/24 at 1:16 PM the Administrator stated Resident #24 would need to be assessed by the Interdisciplinary Team for the ability to self-administer and the medications would need to be locked up and require a physician's order for the use. The Administrator stated she did not consider Resident #24 was able to self-administer nystatin cream or eye drops.

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37538 Based on record review, observations, and interviews with residents and staff, the facility failed to honor the resident's choice to smoke a tobacco cigarette for 2 of 3 residents reviewed for choices (Resident #26 and Resident #69). This practice had the potential to affect residents that smoked cigarettes. The findings included: 1. Resident #26 was admitted to the facility on [DATE]. Review of the care plan focus area for smoking revised 7/12/23 revealed Resident #26 currently smoked or vaped. Interventions included completing a smoking evaluation on admission and quarterly or as needed and wear a smoker apron as needed. Review of the significant change in status Minimum Data Set, dated dated dated [DATE] revealed Resident #26's cognition was intact and currently used tobacco. Review of the most recent quarterly smoking safety screen dated 11/7/23 indicated Resident #26 required supervision to safely smoke. During an interview on 04/15/24 at 2:22 PM Resident #26 stated he preferred to smoke tobacco cigarettes, but since the facility changed their smoking policy, he was only allowed to vape using an electronic cigarette. An interview was conducted on 04/16/24 at 12:52 PM with the Administrator. The Administrator revealed the decision to change the smoking policy was made on 02/2024 to only allow smoking residents to vape using an electronic cigarette. She revealed the decision was made by the previous administration including the Former Administrator. She was aware some of the residents preferred to smoke tobacco cigarettes including Resident #26 after he voiced this during the Resident Council Meeting on 3/2024. She revealed being an Administrator in Training when the smoking policy was changed and officially became the Administrator on 3/5/24 and she was currently reviewing the regulations from the Centers for Medicare and Medicaid Services related to smoking. An interview was conducted on 04/17/24 at 8:54 AM with the Former Administrator. The Former Administrator revealed the changes to the facility's smoking policy was discussed with the residents who smoked that they were allowed to vape using an electronic cigarette. He stated the decision was made by the Interdisciplinary Team (IDT) and considered vaping/electronic cigarettes were a safer alternative to smoking a lit cigarette. He revealed the IDT made the decision because they saw smoking residents needed a higher level of supervision and described staff held lit cigarettes and IDT was concerned about infection control and safety of staff and the need of additional staff to provide a higher level of supervisions for residents smoking a lit cigarette. He did not recall any specific resident voiced they wanted to smoke a cigarette instead of vape and stated he did not consider the rights of the residents that were admitted to facility as a smoker were not honored and described using an electronic cigarette was same as smoking a tobacco cigarette but did not require to be lit. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview on 04/16/24 at 2:19 PM the Administrator revealed the facility would need to change the smoking policy to allow residents who smoked tobacco cigarettes prior 02/2024 be, grandfather in. She revealed those residents residing in the facility prior to 02/2024 when the change in the smoking policy was made could continue to smoke tobacco cigarettes or vape using an electronic cigarette per their preference. During a follow-up interview on 04/18/24 at 11:09 AM Resident #26 revealed he was a supervised smoker and staff lit his cigarette for him. He revealed per his preference he was waiting for a family member to bring tobacco cigarettes for him to smoke and he did not want to vape using an electric cigarette. 49000 2. Resident #69 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #69 had moderate cognitive impairment. She had range of motion of her upper extremities with no impairment. She used a manual wheelchair. A review of her smoking assessments revealed that Resident #69 was assessed for smoking on 5/31/23, 7/6/23, 10/12/23 and 11/7/23. She was deemed able to smoke safely with supervision. Resident #69 was able to hold, light and use ashtray independently. She was to wear a smoking apron and be supervised. On 4/17/24 at 3:30 PM Resident #69 was observed smoking in the designated smoking area. She was smoking an e-cigarette. Resident #69 was being supervised by staff and had a smoking apron on. On 4/16/24 at 9:05 AM interviewed Resident #69. She was unable to speak and could only shake her head yes or no. Resident #69 was asked if she smoked, and she indicated yes by a head nod. Resident #69 used her hands and held her fingers like she was holding something between her thumb and index finger pinched together and shook her head no. She then held her index and middle finger to her mouth making a v shape indicating holding a cigarette. She was asked if she smoked a vape and she indicated yes with a head nod. She was asked if she ever smoked cigarettes and she indicated yes. Resident #69 was asked if she was smoking cigarettes when she first moved into the facility and she indicated yes. Resident #69 was asked if she now smokes a vape and she indicated yes. Resident #69 was asked if she would like to smoke cigarettes instead of a vape and she indicated yes. 4/16/24 at 12:52 PM an interview was conducted with the Administrator. She stated that she officially became the Administrator on 3/5/24. She stated that the previous Administrator and Director of Nursing (DON) made the decision on 2/1/24 to change the smoking policy. She stated the residents smoking vape materials are kept at the nursing station and/or the activity room and the smoking assessments are completed by the nurse as scheduled. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/17/24 at 8:54 AM a telephone interview was conducted with the previous Administrator. He stated that he discussed the changes made to the smoking policy with the residents that smoked and informed them that they would only be allowed to vape. He was not sure of the date when this discussion happened. The previous Administer stated the facilities governing body decided vaping was a safer alternative to smoking. The previous Administrator stated he did not consider that the resident rights were not being honored. He went on to say that the governing body made the decision because they saw smoking residents needing a higher level of supervision and staff were having to hold some of the residents' cigarettes. Also, the higher level of supervision added additional staff needed to supervise. The facility at the time had a lot of smoking residents but he didn't recall any specific smoking incident occurring or any resident voicing they wanted to smoke a cigarette instead of vaping.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37538 Based on observations, record review, and interviews with staff the facility failed to maintain areas used by residents by not repairing bathroom doors with missing and splintered wood surfaces (room [ROOM NUMBER], 215, and 219); failed to repaint scuffed areas on metal door frames (rooms [ROOM NUMBERS]); and failed to repair the footboard of a bed with rough and jagged surface areas (room [ROOM NUMBER]-B) on 2 of 2 units observed for environment (North and South). The findings included: 1a. An observation on 04/15/24 at 8:09 AM revealed the bathroom door in room [ROOM NUMBER] had several areas that varied in size and shape where the wood was missing and appeared splintered. Most of the damage was below the doorknob and along the edges of the door. The lower portion of the metal door frame around the bathroom door had several areas where the paint was missing on each side and exposed the bare metal of the frame up to knee height. 1b. Observations on 04/15/24 at 8:51 AM and 04/18/24 at 12:18 PM revealed the bathroom door in room [ROOM NUMBER] had several areas that varied in size and shape where the wood was missing and appeared splintered. Most of the damage was below the doorknob and along the edges of the door. 1c. Observations on 04/15/24 at 11:59 AM and 04/18/24 at 12:16 PM revealed the bathroom door in room [ROOM NUMBER] had several areas that varied in size and shape where the wood was missing and appeared splintered. The lower portion of the metal door frame around the bathroom door had several areas where the paint was missing on each side and exposed the bare metal of the frame up to knee height. 2. An in-room observation on 4/15/24 at 8:59 AM of room [ROOM NUMBER] found the footboard of B bed damaged. The footboard contained an area approximately 16 inches long that included the top, corner, and declining edge with missing and damaged smooth top wood layer. The area was rough when touched with jagged edges. An observation of the room's entrance door found the edge spanning the length of the door was missing its smoother outer veneer and was rough and splintered to touch. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A walkthrough observation and interview was completed to share environmental concerns for rooms 111, 214, 215, 219 on 04/19/24 from 12:40 PM through 1:00 PM with the Maintenance Director. The Maintenance Director explained staff reported environment issues using TELS (an online computerized maintenance reporting application) and he received those on his personal cell phone and repair task remained on TELS until he signed off it was complete. He revealed the main task he and the Maintenance Assistant, who was recently hired approximately three months ago, was remodeling the therapy hall that was currently closed with plans to reopen. He stated the North or South units reported issues included repair of doors and blinds that need fixed, and he kept a paper list of those rooms. He revealed the Administrator and him recently completed a walk around of the facility and if wood was missing from doors and sharp edges on furniture were identified he planned to cover the areas on the doors with a plastic molding edge guard and if the middle of door was damaged, he would apply putty and sand and re-stain the area. He observed the bathroom door of room [ROOM NUMBER] and stated he thought that was on his list of repairs and currently the door needed a plastic guard along the edges where damaged, putty, and sanded to fix the missing and splintered wood. He observed the bathroom door and metal frame of rooms [ROOM NUMBERS] and stated the door needed a plastic guard along the edges where damaged, putty, and sanded to fix and the scuff marks on the metal framing needed repainted. He observed the footboard of bed B in room [ROOM NUMBER] and stated he did not know about it. The Maintenance Director revealed the Regional Maintenance Supervisor was supposed to order more plastic guards he used to fix the edges of the doors, but he had not received those yet and it had been approximately one and half months of waiting for the supplies. Review of the Maintenance Directors list of resident rooms that need repairs revealed rooms 111, 214, 215, and 219 were not on the list. During an interview on 04/19/24 at 4:14 PM the Administrator stated the Regional Maintenance Director was ordering supplies to fix the doors but was on leave. She revealed the Maintenance Director kept a list of repairs needed in resident rooms. It was shared with the Administrator that the list did not include environment issues identified and appeared the missing and splintered damage to the surface areas was not recent and affected several areas on the doors. The Administrator stated she would not wait for the Regional Maintenance Director to provide supplies, instead would call a vendor to repair areas of missing and splintered wood to prevent a resident from being injured.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49000 Based on observation, record reviews, and resident, resident representatives, staff, psychotherapist, Psychiatric Nurse Practitioner (NP), Physician Assistant and Medical Director interviews, the facility failed to protect a resident's right (Resident #3) to be free of sexual abuse from another resident (Resident #52). Resident #3 had severely impaired cognition and Resident #52 had moderately impaired cognition and a history of sexual behaviors. On 3/25/23 Resident #52 was observed by staff inviting Resident #3 into his room and was told by staff to leave the door open. Shortly after, Resident #52 was observed inappropriately touching Resident #3's leg. On 7/25/23 Resident #52 was found in Resident #3's room looking at her while she slept. On 1/30/24 Nurse Aide (NA) #1 heard yelling coming from Resident #3's room. NA #1 and Nurse #1 found Resident #52 in Resident #3's room with his hand inside of her incontinent brief with skin to skin contact. Resident #3 stated stop you're hurting me. Resident #3 was incapable of consenting to the sexual act. Resident #3's Responsible Party (RP) indicated she would have been very upset by the incident. A reasonable person expects to be protected from abuse in their home environment and sexual abuse would cause trauma. In addition, the facility failed to prevent resident to resident abuse when a resident (Resident #264) used his fist to punch Resident #30 on the right side of the face. This deficient practice affected 4 of 12 residents reviewed for abuse. Immediate jeopardy began on 1/30/24 when Resident #3 was not protected from sexual abuse. Immediate jeopardy was removed on 4/22/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at the lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. Example #2 was cited at a scope and severity of D. The findings included: 1. Resident #52 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction (stroke), and dementia. Resident #52's care plan dated 10/18/22 indicated he had a behavior problem and had been sexually promiscuous with other residents. Resident #52 would deny and was easily redirected. Interventions included to administer medications as ordered, monitor/document for side effects and effectiveness, anticipate and meet the resident's needs, intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, and remove from situation and take to alternate location as needed. The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #52 had moderately impaired cognition and had no behaviors. He was independent with all his mobility and used a manual wheelchair. Resident #3 was admitted to the facility on [DATE] with the following diagnoses: cerebral infarction (stroke), dementia with agitation, Alzheimer's disease and Parkinson's disease. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #3's care plan dated 12/2/22 indicated at times, Resident #3 had been verbally and sexually inappropriate while in a heavy traffic area of the facility. Her word for sex is [NAME]. Interventions included to assess resident's understanding of the situation, allow time for the resident to express self and feelings towards the situation, and psychiatric/psychogeriatric consult as indicated. The quarterly MDS dated [DATE] indicated Resident #3 had severely impaired cognition and no behaviors. Resident #3 was a partial/moderate assist for her mobility and used a manual wheelchair. A review of Resident #52's medical record indicated a progress note dated 3/26/23 at 11:15 AM documented by Nurse #2. The progress note indicated it was a late entry note for 3/25/23 at 10:00 AM. Nurse #2 documented that Resident #52 was heard by several staff members inviting a female resident down to his room. Staff told him he needed to leave his door open. A few minutes later, as a staff member went by the room, the two were seen touching each other inappropriately and were parted from each other by two staff members. Resident #52 immediately denied inviting her to his room and said he did not want her to come back. A phone interview with Nurse #2 on 4/21/24 at 9:22 AM revealed the female resident who was observed in Resident #52's room on 3/25/23 was Resident #3. Nurse #2 stated she could barely remember all the details but Resident #52 was seen inviting Resident #3 into his room earlier that day. Nurse #2 stated she thought it was fine because they were just talking, and she told Resident #52 to keep his door open. Nurse #2 further stated that a few minutes later, it might have been a housekeeper (she was not certain) who witnessed Resident #52 and Resident #3 touching inappropriately. Nurse #2 stated she did not witness it and both residents denied having done anything. From what she could remember, the staff member reported that Resident #52 was seen touching Resident #3's knee. Nurse #2 removed Resident #3 from Resident #52's room. Nurse #2 stated she reported the incident to an on-call provider, but she could not remember whether she reported it to the Director of Nursing or the Administrator. There were no revisions made to Resident #52's care plan related to sexually promiscuous behaviors after the 3/25/23 incident. Further review of Resident #52's medical record indicated he was seen by the psychotherapist on 3/30/23. Resident #52 reported sadness and depression and missing his family. He also reported increased tiredness and sleeping throughout the day. The therapist provided review of alternative symptoms often experienced with depression: irritability, forgetfulness, and lack of interest to engage in activities. The therapist recommended for Resident #52 to increase time he listened to music. A Psychiatry Follow-up Note dated 4/25/23 by the Psychiatric NP in Resident #52's medical record indicated he was made aware of the incident on 3/25/23 between Resident #52 and Resident #3. He documented that Resident #52 could be sexually inappropriate with staff at times. He was prescribed Paroxetine (a medication used to treat depression) 30 milligrams (mg) daily and Estradiol (hormone essential for modulating libido, erectile function, and spermatogenesis or the process of sperm cell development) 1 mg daily for history of sexual inappropriate behavior. Paroxetine had been increased to 40 mg daily on 3/29/23. He was treated with Paroxetine, Trazodone (antidepressant and sedative), Clonazepam (sedative), and Estradiol. He was agreeable to a visit next month. The Psychiatric NP indicated in his note to monitor him closely. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note dated 7/24/23 at 5:21 AM documented by Nurse #3 in Resident #52's medical record indicated Resident #52 had insomnia tonight. He had been wandering in the hallways and going into other residents' rooms but was quickly redirected back to his room. A phone interview with Nurse #3 on 4/22/24 at 1:24 PM revealed that on 7/24/23, Resident #52 kept rolling around near the day room and kept heading towards Resident #3's room. Nurse #3 stated that Resident #52 told her that he was just rolling around. She indicated at approximately 1:30 AM she saw Resident #52 enter Resident #3's room, she went down to the room and saw Resident #52 by Resident #3's bedside and he was just looking at her. Resident #3 was sleeping at the time. Nurse #3 stated that she did not see Resident #52 touch Resident #3, and that she moved him out of the room and back to his room. Nurse #3 indicated she was not aware of the 3/25/23 incident between Resident #52 and Resident #3. She reported she was aware of Resident #52's care plan having a care area identified for inappropriate sexual behaviors, but she did not know the history or why he had this care planned. There were no revisions made to Resident #52's care plan related to behaviors after the 7/24/23 incident. The annual MDS for Resident #3 dated 12/9/23 indicated she was severely cognitively impaired, and had no behavioral symptoms. Resident #3 required substantial/maximal assistance with most activities of daily. Resident #3 used a manual wheelchair and was able to self-propel herself. A review of Resident #52's quarterly MDS dated [DATE] revealed that he was moderately cognitively impaired. He did not display any physical or verbal behavioral symptoms towards others but rejection of care occurred 1 to 3 days during the assessment period. He only required supervision from staff with most activities of daily living including bed mobility and transfers. Resident #52 used a manual wheelchair and was able to self-propel himself. On 1/29/24 the Psychiatric NP saw Resident #52. The note indicated one of the chief complaints was staff reporting resident had become more sexually inappropriate. The NP did an examination and found Resident #52 oriented to person, place and situation and found him to be moderately impaired. His findings were Resident #52 had dementia with behavioral disturbances, depression, anxiety, insomnia and sexually inappropriate behavior. The NP's recommendations were no new psychiatric medications at this time. To continue ongoing supportive/behavioral strategies as currently implemented by staff. To encourage participation in recreational activities. He recommended Buspirone 5 mg three times a day for sexual inappropriate behavior. The NP will assess at the next visit. An incident report dated 1/30/24 completed by Nurse #1 indicated that on 1/30/24 at 1:35 AM during rounds Nurse Aide (NA) #1 and Nurse #1 observed Resident #52 at the bedside of Resident #3 with his hands inside the top of her brief. Resident #3 and #52 were separated immediately. Resident #3 was assessed for injury, and none was identified. Resident #3 was moved to his room and Resident #52 was placed on 15 minute checks. No physical or mental injury/harm was identified. On 1/30/24 at 8:30 AM, the local police department was notified of the incident. An observation was made on 4/14/24 at 9:51 AM of the room locations for Resident #3 and Resident #52 prior to the 1/30/24 incident. The residents resided on the same hall with 1 room in between their rooms. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the assigned police officer was attempted by phone on 4/22/24 at 3:00 PM and was unsuccessful. A written statement dated 1/30/24 by Nurse Aide (NA) #1 indicated during his round, he went to check on Resident #3 and found Resident #52 with his hands down Resident #3's pants. Both residents were separated while the nurse was notified. The incident occurred at 1:35 AM on 1/30/24 in Resident #3's room. On 4/19/24 at 10:48 AM, a telephone interview was conducted with NA #1. He stated on the night shift on 1/30/24 around 1:30 AM, he was doing rounds on the floor and he heard yelling coming from Resident #3's room. When he went to check on Resident #3, he found Resident #52 with his hands under Resident #3's brief. There was skin to skin contact. NA #1 was unable to recall if Resident #3 said anything when he entered the room. NA #1 got Nurse #1 to come down and then they separated Resident #52 and Resident #3. He put Resident #52 back in his room. NA #1 stated he could not remember the details of how he notified the nurse but did say he did not leave the two residents. NA #1 stated he had not ever seen Resident #52 in this resident or any other resident's room before. NA #1 was not aware of any previous incidents of sexual behavior. NA #1 also stated that he could barely remember the details regarding this incident between Resident #3 and Resident #52 and he would go by whatever was indicated in his written statement. A progress note dated 1/30/24 at 2:49 AM in Resident #3's medical record documented by Nurse #1 indicated she was alerted by NA #1 to come to Resident #3's room around 1:35 AM. Upon entering the room, Nurse #1 noted Resident #52 at Resident #3's bedside. Upon further assessment, Resident #52 was noted to have his right hand in Resident #3's brief. Resident #3 was stating, stop you're hurting me. Both residents were immediately separated. A skin assessment was completed on Resident #3 and no injuries were noted. Resident #3 was alert per baseline with confusion. No signs and symptoms of pain, discomfort, or acute distress were noted or reported. Resident #3 was relocated to a different room. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/19/24 at 8:20 AM, a telephone interview was conducted with Nurse #1. Nurse #1 stated that she was alerted by NA #1 to come to Resident #3's room and saw Resident #52 sitting at her bedside. Resident #52's hand was in Resident #3's brief and there was skin to skin contact. Nurse #1 stated she didn't remember seeing his hand moving but it looked like he was fondling her under her brief because his hand was right over her pelvic area. Nurse #1 stated as she entered Resident #3's room, she heard Resident #3 stating, stop, you're hurting me. After Nurse #1 told Resident #52 to remove his hand from under Resident #3's brief, she asked him what he was doing and Resident #52 stated to her, She asked for it. The two residents were immediately separated, and Resident #3 was moved to another room and eventually off the hall to the other side of the building in an empty room. Nurse #1 notified the administration and the Physician Assistant who saw the residents on the next shift. Nurse #1 stated that she had never seen Resident #52 go into another female's room prior to this incident. Nurse #1 was not aware of the 3/25/23 or 7/24/23 incidents between Resident #52 and Residents #3. Nurse #1 further stated that she assessed Resident #3 and did not find any physical injury. Prior to this incident, Nurse #1 stated that she saw Resident #52 in his room, but she couldn't remember what time. When Resident #52 went back in his room after the two residents were separated, he kept coming down to the nurses' station, and trying to explain about what happened. Resident #52 stated that Resident #3 invited him to her room. Nurse #1 stated she could not remember anything else that Resident #52 said about the incident. Resident #52 was placed on 15 minute checks starting on 1/30/24 till 2/9/24. Nurse #1 stated that in her opinion, what happened between Resident #52 and Resident #3 was sexual abuse because Resident #52 was alert during the incident and he knew what he was doing, while Resident #3 was not able to give consent. On 4/16/24 at 9:30 AM, Resident #52 was interviewed. Resident #52 stated that Resident #3 used to come to his room, and she would flirt with him. When asked if he remembered the incident on 1/30/24 in Resident #3's room, Resident #52 stated that he did not remember the incident. Resident #52 stated that he was a married Christian man. He denied ever going into Resident #3's room. Resident #52 stated he didn't want to talk about it anymore and refused to answer any more questions. On 4/16/24 at 1:20 PM, a telephone interview with Resident #3's responsible party (RP) was conducted. Resident #3's RP said that he was made aware of the 1/30/24 incident and they ended up moving Resident #3 to another room. He stated that Resident #3 was still very confused by the move. The RP stated that Resident #3 was raped 3 times by the age of 9. The RP also stated that Resident #3 did have a history of touching men at a different facility. He was not aware of any other issues with her and other men at this facility other than on 1/30/24. A follow-up phone interview with Resident #3's RP on 4/24/24 at 3:30 PM revealed Resident #3 was not able to give sexual consent. Resident #3's RP stated that she would be offended by a stranger touching her and she would be very upset. The RP indicated he had not spoken with the police. A progress note dated 2/13/24 by Nurse #3 revealed that she overheard a conversation with Resident #52 and another resident at the nurses desk. Nurse #3 stated that Resident #52 noticed that Resident #3 was no longer in the room on the south hall and Resident #52 stated there's a man in Resident #3's room. She's gone. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/19/24 at 2:50 PM, a phone interview was conducted with the Psychotherapist. She stated that she saw Resident #52 once a month. She stated that he had not been very engaging the last few months and was more isolated. She said that she had noticed that his cognition was declining since the start of this year. He had been more confused as time went on. She stated that she had not seen any hypersexuality with him prior to the 1/30/24 incident. She was not aware of any other incidents between Resident #52 and a female resident since the incident on 1/30/24. She stated that she thought he would have had an understanding of what he was doing during the 1/30/24 incident. The Psychotherapist also saw Resident #3 every two weeks. She stated that Resident #3 had declined as well in her cognition. The Psychotherapist stated that she did not observe any changes with Resident #3 after the incident on 1/30/24. She stated that Resident #3 told her that she did not remember the incident. On 4/19/24 at 3:18 PM, a phone interview was conducted with the Psychiatric NP. He stated that he met Resident #52 for the first time on 12/4/23. Resident #52 was seen by a different provider prior to this. The Psychiatric NP stated that he usually saw Resident #52 every 4 to 6 weeks unless there was something acute and he would see him sooner. He stated that he was aware that Resident #52 was sexually inappropriate with another resident (Resident #3) on 1/30/24. He stated that Resident #52 had dementia and his ability to make decisions was not good. He shared that when he spoke with Resident #52, he had no recall of the event. The Psychiatric NP stated that he had seen a cognitive decline with Resident #52 since he started seeing him on 12/4/23. He went on to say that Resident #52's confusion fluctuated, and he had times of clarity and times of confusion. On 1/29/24 when he saw Resident #52, he was alert and oriented to person, place and situation. He stated that when he saw Resident #52 on 1/29/24 one of the chief complaints was that staff were reporting that Resident #52 was becoming more sexually inappropriate. The Psychiatric NP made the recommendation of Buspirone 5 mg three times a day for sexually inappropriate behaviors. The Psychiatric NP stated that he couldn't say how Resident #52's cognition was during the incident without being there himself. The Psychiatric NP further stated that he last saw Resident #3 on 2/26/24. Resident #3 had many diagnoses including Parkinson's disease and dementia. The Psychiatric NP stated that Resident #3's mental cognitive ability also fluctuated. When he saw her on 2/26/24, Resident #3 had no recollection of the incident and could not remember any stressful events happening to her. The Psychiatric NP stated that he was not able to say if Resident #3 could give consent sexually, and that it depended on her cognition at that day and time. On 4/19/24 at 4:00 PM, an interview with the Physician Assistant (PA) revealed that he saw Resident #3 on 1/30/24 after the incident had happened but she (Resident #3) did not remember anything. The PA stated that Resident #3 was very confused. The PA also stated that he saw Resident #52 on 1/30/24 and he denied anything had happened. The PA stated that Resident #52 could also be confused but he also had periods when he was not confused. The PA could not say if the incident was sexual abuse since both residents could have times of confusion. He stated that he didn't think there was any intent from Resident #52 to hurt Resident #3. He added that he had never seen Resident #52 in other resident rooms. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/22/24 at 1:24 PM, an interview with the Medical Director (MD) revealed he was unsure where the history of sexually inappropriate behavior came from regarding Resident #52. He stated that when the facility received history and physical from the hospital or wherever the resident was coming from, it generally didn't give much detail. The MD stated that the notes from the psychotherapist would indicate more information about Resident #52's sexually inappropriate behavior. The MD refused to answer any questions regarding the incident on 1/30/24 between Resident #52 and Resident #3. The MD asked for guidance on what the facility could have done to prevent the incident that happened between Resident #52 and Resident #3. On 4/18/24 at 2:57 PM, an interview with the Director of Nursing (DON) revealed that she was an MDS Nurse in the facility at the time of the 1/30/24 incident but she remembered Resident #52 being placed on frequent observations. She indicated she had no idea Resident #52 had a history of sexually inappropriate behaviors prior to the 1/30/24 incident. The DON stated that for the past few months Resident #52 mostly stayed in his room while Resident #3 was out and about all the time. The DON shared that Resident #3 usually didn't go into other residents' rooms and that she just stayed in the hallways. She stated that Resident #3 would make sexual remarks to staff at times. She said that after the 1/30/24 incident the staff kept Resident #3 and Resident #52 separated and they did frequent observations. On 4/19/24 at 12:49 PM, a telephone interview was conducted with the former DON. She stated that she remembered the incident that happened on 1/30/24. The former DON stated that she was not working that day (1/30/24), but she remembered calling the local police department about the incident. The former DON further stated that she did not know the details of the incident in March 2023 involving Resident #52 and Resident #3, but she knew that an incident had happened. The previous DON felt that the facility did not do enough to prevent Resident #52 from getting access to Resident #3. On 4/19/24 at 9:00 AM, the Administrator was interviewed. She stated that she was in training when the incident happened on 1/30/24 between Resident #52 and Resident #3. The Administrator stated she remembered the local police department and the on call psychiatric provider were notified. She stated that she knew Resident #3 would make sexual suggestions but Resident #3 was unable to recall the events on that day. The Administrator stated she did not know of any other incidents that involved Resident #52, but the facility gave Resident #52 a 30-day discharge notice after the incident on 1/30/24 but they had been unsuccessful in finding another facility that would take him. The Administrator stated that they ended up substantiating the allegation of abuse because there were witnesses. The Administrator was notified of immediate jeopardy on 4/19/24 at 6:49 PM. The facility provided the following immediate jeopardy removal plan. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/30/24, at approximately 1:30 AM, Resident #52 was sitting in Resident #3's room with his hand inside Resident #3's brief as Nurse Aide (NA) #1 staff entered the room. Resident #3 was severely cognitively impaired and was not capable of consenting to sexual activity. NA #1 alerted Nurse #1 to come to the room. Resident #3 was heard stating stop you're hurting me when Nurse #1 walked into the room. Resident #52 and Resident #3 were separated by NA #1 and Nurse #1 immediately on 1/30/24. Resident #3 was examined by Nurse #1 for any injuries including a skin check and no injuries were noted. Resident #3 was moved to 117 on 1/30/24 at 2:00 AM and then after consideration by the Director of Nursing (DON) and Administrator she was moved to room [ROOM NUMBER] on the other side of the facility at 8:30 AM. Resident #52 was taken to his room and was placed on every 15- minute checks from 1/30/24 to 2/9/24. No sexually inappropriate behavior was observed during the observation period and the Interdisciplinary Team (IDT) discontinued every 15-minute checks on 2/9/24. A review of nursing notes dated 1/30/24 and 1/31/24 revealed Resident #3 did not demonstrate or verbalize anxiety and no emotional or physical distress was observed. The facility's Physician Assistant was informed of the incident on 1/30/24. Resident #3 was examined on 1/30/24 by the Physician Assistant. Full assessment completed by Physician Assistant with no bruising noted and the resident denied the event. Resident #3 was seen by Psychiatric services on 2/8/24. It was determined that Resident #3 was at baseline. Observation by Psychiatric services included resident report of decreased memory recall during the examination. The Psychiatry provider for Resident #52 was notified on 1/30/24 of his inappropriate sexual behaviors and emailed an order on 1/30/24 to change Resident #52's Buspirone to 5 mg po three times for inappropriate sexual behaviors and anxiety. This order was initiated on 1/31/24. Resident #52 was seen by Psychiatric services on 3/11/24. The Physician Assistant examined Resident #52 on 1/30/24. On 4/19/24, Resident #52 was placed on 1:1 observation indefinitely. The Administrator reviewed the schedule to ensure that the facility has an individual assigned by the Staffing Coordinator as 1:1 supervision with Resident #52. Resident #52 is not in hallways or other resident areas unsupervised. Any behaviors identified during the 1:1 supervisor will be documented and reported to the facility Administrator and Director of Nursing. Head to toe skin assessments for residents with Brief Interview for Mental Status (BIMs) lower than 11 were completed by the Administrative Nurses (including the Director of Nursing) on 4/19/24. No concerns were identified. On 04/19/24, the Social Worker interviewed all residents with a BIMs score of 12 or above. The questions included with Social Worker interviews with residents were the following: 1. Have you had ever been inappropriately touched/abused/neglected or experienced misappropriation of resident property by another resident or staff here at the facility? 2. Do you feel safe here at the facility? Based on resident interviews there were no other reported incidents of abuse from any residents. Other residents at risk for abuse and other residents with inappropriate sexual behaviors were discussed and identified with the IDT during the Ad Hoc Quality Assurance and Performance Improvement (QAPI) held on 4/19/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff interviews for those currently in the facility were conducted by the Social Worker and Administrator on 4/19/24 in person which included: 1. Have you witnessed or been made aware of inappropriate touching or any other form of abuse by staff or a resident? Staff not interviewed on 4/19/24 will be interviewed by the Staff Development Coordinator (SDC), Staffing Coordinator, and Nursing Supervisors prior to working their next shift. Interviews will be conducted in person, and via phone. The SDC, Staffing Coordinator, and Nursing Supervisors were notified and educated by the Administrator of this responsibility on 4/19/24. Staff will not be allowed to work before they have been interviewed by either the Staff Development Coordinator, Staffing Coordinator or the Nursing Supervisors. The active employee list will be tracked by the SDC and given to the Staffing Coordinator and Nursing Supervisors to ensure all staff have been interviewed prior to their next working shift via phone or in person. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring. The Director of Nursing (DON) educated 100% of facility staff, including agency staff, on abuse/neglect/misappropriation policy as well as identification of sexual abuse in the elderly, and reporting of abuse/neglect/misappropriation per facility policy with a review of the F600 regulation including inappropriate sexual behaviors. Abuse education specifics include definition of abuse, forms of abuse, how to recognize abuse, and what to do if abuse is suspected. In addition, education was completed on signs of Sexual Abuse against the Elderly and verbal descriptions of the typical signs. Staff were educated either in person or by phone on 4/19/24. The Staff Development Coordinator (SDC) will continue education for any staff member including Agency staff not available for education on 4/19/24. Any staff member including Agency staff who was not available to receive the education on 4/19/24 will not be permitted to work until education is completed. The SDC will be responsible for tracking staff, including Agency staff not educated on 4/19/24 by comparing the staffing schedule and active employee roster daily to verify education. The Director of Nursing will verify completion of education. The Director of Nursing and the Staff Development Coordinator were notified of the plan on 4/19/24. Nursing supervisors were provided the abuse education and informed on 4/19/24 by the Director of Nursing and the Staff Development Coordinator of the need to provide the abuse education after hours and on weekends. Nursing Supervisors will be notified by the Staff Development Coordinator of the employees that need the education prior to their next working shift. The abuse education will be included for new hires during orientation by the Staff Development Coordinator. Director of Nursing, Administrative Nurses and Social Worker reviewed the electronic medical records and care plans to identify current residents with behaviors of inappropriate sexual behaviors or potential for behaviors of inappropriate touching on 4/21/24. Care plans were reviewed to ensure interventions were in place and any new interventions were added to the resident's Kardex (care plan interventions) documentation for staff to reference key resident information. Staff will be made aware of residents with behaviors of inappropriate sexual behaviors, or potential for behaviors of inappropriate touching by resident specific Kardex interventions. Nurses, Nurse Aides and Department Heads were educated on how to review resident Kardex's by the Staffing Coordinator in person and via phone on 4/21/24. After 4/21/24 Nurses, Nurse Aides, and Department Heads will not be allowed to work their next shift until they have received the education from the Staffing Coordinator or Nursing Supervisors. The Staffing Coordinator and the Nursing Supervisors will compare the staffing schedule and active employee roster daily to verify education. The Staffing Coordinator and the Nursing Supervisors were notified of the plan by the Administrator on 4/21/24. This education will be included for new hires during orientation by the Staff Development Coordinator. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/19/24, the facility completed an Ad Hoc QAPI to review the Immediate Jeopardy for sexual abuse, the immediate jeopardy removal plan, education, and discuss and plan for audits and monitoring. Other residents at risk for abuse and other residents with inappropriate sexual behaviors were discussed and identified with the IDT during the Ad Hoc QAPI held on 4/19/24. The Ad Hoc QAPI meeting was attended by the Administrator, Director of Nursing, Unit Managers, Social Worker, Activities Director, Dietary Manager, Housekeeping Manager, Staffing Coordinator, Business Office Manager, Admissions Director, Maintenance Director, and Regional MDS Consultant. The Medical Director was in attendance via phone. The facility Administrator and Director of Nursing are responsible for continued compliance. The alleged date of immediate jeopardy removal is 4/22/24. On 4/25/24, the facility's credible allegation of immediate jeopardy removal was validated. Resident #52 was observed to have a 1 on 1 staff with him. Documentation regarding staff training on abuse/neglect/misappropriation policy as well as identification of sexual abuse in the elderly and reporting of abuse/neglect/misappropriation per facility policy with a review of the F600 regulation including inappropriate sexual behaviors. Staff interviews revealed receipt of training related to the definition of abuse, forms of abuse, how to recognize abuse, and what to do

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49000 Based on record review and staff interviews, the facility failed to file a report with the state agency within 2 hours for an incident of resident-to-resident abuse (Residents #3, #52) and an allegation of employee to resident abuse (Resident# 37). In addition, the facility failed to file a report with the Adult Protective Services (APS) within the required timeframe for Residents #3 and #52 after an allegation of sexual abuse. This deficient practice affected 3 of 12 residents reviewed for abuse (Residents #3, #37, #52). Th findings included: Deer Park Health & Rehabilitation's Abuse, Neglect & Exploitation policy: VII. Reporting/Response A. The facility will have written procedures that included: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 1. A progress note dated 1/30/24 at 2:49 AM in Resident #3's medical record documented by Nurse #1 indicated: Nurse #1 was alerted to Resident #3's room by NA #1 around 1:35 AM. Upon entering the room, Nurse #1 noted Resident #52 at Resident #3's bedside. Upon further assessment, Resident #52 was noted to have his right hand in Resident #3's brief. Resident #3 was stating, stop you're hurting me. Both residents were immediately separated. Skin assessment completed (on Resident #3) and no injuries noted. Resident #3 was alert per baseline with confusion. No signs and symptoms of pain or discomfort noted. No signs or symptoms of acute distress noted or reported. Plan of care ongoing. Resident #3 was relocated to [another room]. A review of the Initial Allegation Report submitted to the state revealed an allegation of abuse and the facility became aware of the incident on 1/30/24 at 1:35 AM. Further review of the Initial Allegation Report was prepared by the former Director of Nursing on 1/30/24 and was submitted to the state agency on 1/30/24 at 11:35 AM. The allegation details of the Initial Allegation Report stated that at 1:35 AM during rounds the AM staff observed Resident #52 at the bedside of female Resident #3 with his hand inside the top of her brief. The residents were separated immediately. Resident #3 was assessed for injuries, and none were identified. Resident #3 was moved to a different room and Resident #52 was placed on 15-minute checks. Law enforcement was notified on 1/30/24 at 8:30 AM. There was no documentation regarding notification of Adult Protection Services (APS). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Investigation Report submitted to the state on 2/2/24 at 1:40 PM revealed APS was notified about the allegation of sexual abuse on 2/1/24 and the report was prepared and signed by the Administrator in Training on 2/2/24. On 4/19/24 at 12:49 PM a telephone interview was conducted with the former Director of Nursing (DON). She stated that she was not working on 1/30/24 so she was unsure why the Initial Allegation Report was not submitted within the 2-hour timeframe that was required. After hearing about the incident she did come in to the facility on or about 8:30 AM and called law enforcement. The former DON spoke with Resident #3 at 10:00 AM. She remembered the Administrator and Administrator in training were notified. She believed the Social Worker would have called Adult Protective Services. During an interview on 4/19/24 at 9:00 AM the Administrator stated that she was the Administrator in Training when the incident occurred on 1/30/24 between Resident #52 and Resident #3. The Administrator stated that she was going by the federal regulation as she understood it and not following the facility's abuse policy regarding notifying of agencies involved. 45272 2. Resident #37 was admitted on [DATE] with diagnosis of hypertension, and chronic obstructive pulmonary disease (COPD). A review of the quarterly Minimal Data Set (MDS) dated [DATE] coded Resident #37 with severe cognitive impairment. He required extensive 2-person assistance with toileting, transfer, and bed mobility. A review of the initial allegation dated 3/5/24 revealed the facility became aware of the allegation of abuse for Resident #37 on morning of 3/5/24 at 8:00 AM. Resident #37 alleged NA #2 was being rough during care on 3/4/24. The initial incident abuse investigation was completed by the Administrator and time stamped submitted to the State Agency on 3/5/24 at 1:49 PM. A review of Nurse #3 progress note dated 3/4/24 at 11:25 PM read in part, Resident #37 was yelling out, so this nurse went to his room to check on him. Upon assessment, Resident #37 had 3 large skin tears on his left forearm and a smaller sing tear on his right upper forearm near the elbow. Resident #37 stated your boy done this; your boy done this. NA #2 had just finished a round on that hall, and NA #2 was questioned about what happened. NA #2 told Nurse #3, Resident #37 was combative with care and hit his arm on the side rail. NA #2 was counselled to have 2 NAs assist when providing care if the resident was resistive to care and to notify the nurse before providing care. Resident #37's skin tears were cleaned with wound cleaner and xeroform and bordered gauze dressing was applied. Resident #37 kept telling Nurse #3 I'm alright honey. Nurse #3 was unavailable for interview. (continued on next page)

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Deer Park Health and Rehabilitation	306 Deer Park Road Nebo, NC 28761

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NA #2 was interviewed on 4/18/24 at 3:09 PM. He stated on 3/4/24 he was completing his last round on the floor around 9:00 PM before the end of his shift. NA #2 stated he went into Resident #37's room and told Resident #37 he was going to provide care to him. NA #2 stated Resident #37 became combative and flailed his arms hitting the headboard and the side rail of the bed. Resident #37 told NA #2 to get out, and NA #2 replied he was there to provide care to him. NA #2 said he finished providing care (incontinence) and Resident #37 calmed down once his brief was changed. NA #2 said he was sent home by Nurse #3 after the incident. An interview was conducted on 04/18/24 at 9:35 AM with the Administrator. The Administrator stated she completed the initial allegation report and followed the instructions included on the form. She revealed when an allegation of abuse was alleged, she used the guidance written on the form that included the requirements for reporting to the State Agency. She read the instruction from the initial allegation report she used and stated the facility was required to report within 2 hours if there was serious bodily injury and if not within 24 hours. The Administrator stated the skin tears to Resident #37 was not considered serious injury and based on the instructions on the form she did not report to the State Agency within 2 hours of becoming aware of the incident. A follow-up interview with the Administrator was conducted on 4/18/24 at 3:54 PM. She stated Nurse #3 notified her of the abuse allegation on 3/5/24 at 8:00 AM.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37538 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of behaviors and discharge status for 2 of 13 residents whose MDS were reviewed (Resident #264 and Resident #113). The findings included: 1. Resident #264 was admitted to the facility on [DATE] with diagnoses including dementia with agitation and depression. Resident #264 was discharged to the hospital on 10/15/23. A frequent observation worksheet dated 10/14/23 revealed Resident #246's location was being monitored and documented every 15 minutes and included multiple notations of wandering. Review of a nurse progress note dated 10/15/23 at 8:35 AM revealed Resident #264 was in another resident's room and when asked to leave, he initiated a physical altercation. Review of the discharge Minimum Data Set (MDS) dated [DATE] indicated Resident #264 demonstrated physical behavioral symptoms directed toward others but did not include wandering behaviors that intruded on the privacy or activities of others. During an interview on 04/23/24 at 10:30 AM the Social Worker (SW) confirmed she coded the discharge MDS dated [DATE] behavior section for Resident #264. The SW stated the lookback period for coding behaviors was 7 days and included review of the nurse progress notes. After reviewing the nurse's progress note dated 10/15/24 at 8:35 AM the SW stated Resident #264 demonstrated wandering behaviors during the lookback period and coding the discharge MDS incorrectly was an oversight on her part. An interview was conducted with Director of Nursing (DON) on 04/24/24 at 2:32 PM. The DON stated the coding of discharge MDS for Resident #264 behaviors was done by the SW and should be correct. During an interview on 04/24/24 at 2:35 PM the Administrator stated the MDS should reflect Resident #264's behaviors and be correctly coded for wandering. 41069 2. Resident #113 was admitted to the facility on [DATE] and was discharged home on 2/21/24. The discharge return not anticipated Minimum Data Set assessment dated [DATE] indicated under the discharge status, that Resident #113 was discharged to a short-term general hospital. An interview with the Director of Nursing on 4/25/24 at 2:30 PM revealed she was working as the MDS Coordinator in February 2024 and had made an error by accidentally clicking on the wrong thing in Resident #113's MDS.

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45272 Based on record review and staff, Transportation Driver, Dialysis Nurse, and Medical Director (MD) interviews, the facility failed to assess a resident after a fall prior to moving them from the floor. Resident #103 fell during a transfer at the dialysis center and was moved off the floor prior to being assessed for injuries. Resident #103 sustained a clavicle fracture and right ankle strain. This was for 1 of 2 sampled residents reviewed for quality of care (Resident #103). The findings included: Resident #103 was admitted to the facility on [DATE] and had a diagnosis end stage renal disease, cerebral infarction, muscle wasting and atrophy. Resident #103's admission Minimum Data Set (MDS) assessment, dated 2/27/24, coded Resident #103 as severely cognitively impaired and as totally dependent on staff for transfers. A physician's order dated 3/6/24 read the resident receives dialysis on Monday, Wednesday, and Fridays in the afternoon. An interview with the Transportation Driver was conducted on 4/16/24 at 1:20 PM. The Transportation Driver stated he had witnessed the incident at the dialysis center on 3/25/24. He said he arrived to transport Resident #103 back to the facility and was told by a dialysis nurse he needed to go back to the nursing facility to get a lift sling and nurse aides to transfer Resident #103 from the dialysis chair to her transport chair. The Transportation Driver stated the dialysis nurse told him Resident #103 was transferred to the dialysis chair without the use of her sling and Resident #103 would not be transferred back to the transport chair manually again because it violated the dialysis center's policy. The Transportation Driver said he called the nursing facility and spoke to the Scheduler and reported the situation, and the Scheduler told him she would get some help for him when he returned to the nursing facility. The Transportation Driver then drove to the facility and picked up Nurse Aide (NA) #3 and NA #2 and a sling. The Transportation Driver stated NA #3 and NA #2 went back to the dialysis center with a sling to transfer Resident #103. At the dialysis center, the Transportation Drives said he saw Resident # 103's blanket and a sling in a biohazard bag laying on the floor and was unsure why they were in a bag. NA #3 and #2 then attempted to put the sling under Resident #103 but were unable to roll her in the dialysis chair to place the sling underneath her. NA #3 and #2 tried to manually transfer Resident #103 from the dialysis chair as to the transport chair, but Resident #103's knee buckled under her and she was assisted to the floor on her knees by NA #3 and NA #2. Both NA #3 and NA #2 decided to move Resident #103 from the floor back into her chair. A dialysis tech then went over to assist the NAs with lifting Resident #103 off the floor and into her chair. The Transportation Driver said each NA was lifting Resident #103 by using their arm under the Resident's arm to lift the resident up. The dialysis tech was in front of the Resident with her arms wrapped around the back of the Resident during the lift from the floor. During the lift, the Transportation Driver heard someone say they heard a pop, and Resident #103 made a noise to indicate she had pain. Once Resident #103 was placed into the chair, one of the NAs said the Resident needs to be assessed. The Transportation Driver said EMS was called by the dialysis center and they were told to leave the facility. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Nurse Aide (NA) #3 and NA #2 were interviewed together on 4/16/24 at 3:08 PM. NA #3 stated they were unable to get the lift sling they brought from the facility under Resident #103, and it was decided by her and NA #2 to transfer Resident #103 manually. NA #3 said the first attempt to transfer Resident #103 did not work and the resident slid to the floor with assistance from her and NA #2. NA #3 stated they had lifted the resident with their arms under her arms, and when Resident #103 was standing, her knees buckled, and she was lowered onto her knees upright. NA #3 and NA #2 both agreed Resident #103 was not assessed by a nurse when she was assisted from the floor. While Resident #103 was on her knees, a dialysis technician came over to assist with lifting the resident from the floor and into her chair. NA #2 said he was lifting under Resident #103's right arm, NA #3 was at the back of the resident with her arms around the front of the resident, and the dialysis technician was on the residents left side and a gait belt was used for the transfer. NA #2 said when they were lifting Resident #103, he heard a pop, and Resident #103 complained of pain in her left shoulder and said she was feeling nauseous. A dialysis nurse then assessed Resident #103, and then called EMS. The dialysis nurse told NA #3 and NA #2 they could leave. The Dialysis Nurse who was assigned to Resident #103 on 3/25/24 was interviewed on 4/17/24 at 8:45 AM via phone. The Dialysis Nurse stated she did not recall exactly how the NAs tried to transfer Resident #103 out of the dialysis chair, but the resident slipped and fell to the floor on her left side and hurt her shoulder and ankle. The NAs then lifted Resident #103 back into the chair by placing their arms under her arms and lifting. The interview further revealed Resident #103 complained of pain in her left shoulder and was assessed by the Dialysis Nurse. Emergency Medical Services was contacted and Resident #103 was sent to the hospital for an evaluation. Resident #103's hospital discharge summary dated 3/25/24 was reviewed. The discharge summary revealed the resident was dropped being transferred at a dialysis center on 3/25/24 the resident complained of left shoulder pain, right ankle, right knee pain and right hip pain. Examination of Resident #103 found left side mid-shaft clavicle fracture, and a right ankle strain. The discharge summary did not indicate any pain medication was ordered, and to follow-up with orthopedics. Resident #103 returned to the facility on the same day. A review of progress notes found a nursing note created on 3/26/24 by Nurse #1 with an effective date of 3/25/24 that read in part as follows: Resident #103 returned to the facility from the hospital via Emergency Medical Services. The resident was alert and responsive and had a sling on her left arm due to a fractured clavicle. The Resident was transferred to bed by paramedics, and the resident was not in any distress. A review of Resident #103's medical administration record (MAR) 3/26/24 through 4/17/24 found Resident #103 received acetaminophen once on 3/26/24 with a pain of 6 on a scale of 1 to 10 (10 being the highest level of pain). The review found no other pain medication given to the resident, and the resident's pain level was monitored every shift. The Director of Nursing (DON) documented a progress note dated 3/26/24 that read in part, the Medical Director was notified of the emergency room (ER) visit last night with report of left clavicle fracture and orders for sling. Resident #103's order for acetaminophen as needed (PRN) for pain. The Resident stated she had pain but it was bearable. No further orders at this time. On 3/28/24 a physician's order was written for Resident #103 to receive oxycodone HCL Oral tablet 5 MG, give by mouth every 12 hours as needed for pain. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The DON was interviewed on 4/17/24 at 9:12 AM. The DON did not know if Resident #103 was assessed by a nurse after the fall or when her shoulder was hurt, the NAs present could not assess her. Resident #103 was in the care of the dialysis center while she was there, and she did not know the dialysis center's protocol and policies for a fall or injury. A follow up interview was conducted with the DON on 4/19/24 at 12:09 PM. The DON said the facility's policy was to assess a resident after a fall by a nurse and evaluate if the resident is safe to move. The Medical Director was interviewed on 4/19/24 at 11:49 AM via phone. The Medical Director said after a resident in the care of the nursing facility had a fall, the resident should be assessed by a nurse before moving or lifting.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 45272 Based on observation, record review, and resident, family member, Transportation Driver, Dialysis Center staff, and Medical Director interviews, the facility failed to ensure a resident was transferred safely. Resident #103 sustained a fractured left clavicle and a sprained right foot from a fall when two nurse aides transferred Resident #103 after completion of her dialysis treatment without the use of a total lift. Resident #103 was not cleared by therapy to be transferred manually. The facility also failed to prevent Resident #37 from obtaining skin tears when the nurse aide continued to provide care after the resident became combative and was hitting his arms on the headboard and siderail. This was for 2 of 5 sampled residents reviewed for supervision to prevent accidents (Resident #103, Resident #37). The findings included: 1. Resident #103 was admitted to the facility on [DATE] and had a diagnosis end stage renal disease, cerebral infarction, muscle wasting and atrophy. A review of Resident #103's physician orders found and ordered dated 2/20/24 for acetaminophen 1000 MG every 8 hours as needed for pain via tube. On 2/20/24 to assess the resident every shift for pain monitoring. Resident #103's care plan, updated on 2/22/24, noted Resident #103 required staff assistance for activities of daily living (ADL) care needs related to generalized weakness. One of the interventions dated 2/20/24 identified Resident #103 required 2-person assist with transfers with a mechanical lift. Resident #103's admission Minimum Data Set (MDS) assessment, dated 2/27/24, coded Resident #103 as severely cognitively impaired and as totally dependent on staff for transfers. A physician's order dated 3/6/24 read the resident receives dialysis on Monday, Wednesday, and Fridays in the afternoon. Resident #103's hospital discharge summary dated 3/25/24 was reviewed. The discharge summary revealed the resident was dropped being transferred at a dialysis center on 3/25/24 the resident complained of left shoulder pain, right ankle, right knee pain and right hip pain. Examination of Resident #103 found left side mid-shaft clavicle fracture, and a right ankle strain. The discharge summary did not indicate any pain medication was ordered, and to follow-up with orthopedics. Resident #103 returned to the facility on the same day. A review of progress notes found a nursing note created on 3/26/24 by Nurse #1 with an effective date of 3/25/24 that read in part as follows: Resident #103 returned to the facility from the hospital via Emergency Medical Services. The resident was alert and responsive and had a sling on her left arm due to a fractured clavicle. The Resident was transferred to bed by paramedics, and the resident was not in any distress. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of Resident #103's medical administration record (MAR) 3/26/24 through 4/17/24 found Resident #103 received acetaminophen once on 3/26/24 with a pain of 6 on a scale of 1 to 10 (10 being the highest level of pain). The review found no other pain medication given to the resident, and the resident's pain level was monitored every shift. The Director of Nursing (DON) documented a progress note dated 3/26/24 that read in part, the medical director was notified of the emergency room (ER) visit last night with report of left clavicle fracture and orders for sling. Resident #103's order for acetaminophen as needed (PRN) for pain. The Resident stated she had pain but it was bearable. No further orders at this time. On 3/28/24 a physician's order was written for Resident #103 to receive oxycodone HCL Oral tablet 5 MG, give by mouth every 12 hours as needed for pain. An in-room observation of Resident #103 on 4/15/24 at 8:19 AM found the resident laying in bed without distress or indication of pain or discomfort. Resident #103 verbally indicated she was not in any pain or discomfort when asked. Resident #103's Family Member #1 was interviewed on 4/16/24 at 12:16 PM via phone. He stated Resident #103's broken clavicle happened while she was at her dialysis appointment. Family Member #1's understanding was Resident #103 was taken to her dialysis appointment without the sling needed to transfer her, as she normally had with her. Family Member #1 said 2 or 3 staff, unknown if from the dialysis center or the resident's facility or a combination tried to pick up Resident # 103 to transfer and dropped her to the floor, breaking her clavicle. The dialysis center called EMS, and she was sent to the hospital. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview with the Transportation Driver was conducted on 4/16/24 at 1:20 PM. The Transportation Driver stated he had witnessed the incident at the dialysis center on 3/25/24. He said he arrived to transport Resident #103 back to the facility and was told by a dialysis nurse he needed to go back to the nursing facility to get a lift sling and nurse aides to transfer Resident #103 from the dialysis chair to her transport chair. The Transportation Driver stated the dialysis nurse told him Resident #103 was transferred to the dialysis chair without the use of her sling and Resident #103 would not be transferred back to the transport chair manually again because it violated the dialysis center's policy. The Transportation Driver said he called the nursing facility and spoke to the Scheduler and reported the situation, and the Scheduler told him she would get some help for him when he returned to the nursing facility. The Transportation Driver then drove to the facility and picked up Nurse Aide (NA) #3 and NA #2 and a sling. The Transportation Driver stated NA #3 and NA #2 went back to the dialysis center with a sling to transfer Resident #103. At the dialysis center, the Transportation Drives said he saw Resident # 103's blanket and a sling in a biohazard bag laying on the floor and was unsure why they were in a bag. NA #3 and #2 then attempted to put the sling under Resident #103 but were unable to roll her in the dialysis chair to place the sling underneath her. NA #3 and #2 tried to manually transfer Resident #103 from the dialysis chair as to the transport chair, but Resident #103's knee buckled under her and she was assisted to the floor on her knees by NA #3 and NA #2. Both NA #3 and NA #2 decided to move Resident #103 from the floor back into her chair. A dialysis tech then went over to assist the NAs with lifting Resident #103 off the floor and into her chair. The Transportation Driver said each NA was lifting Resident #103 by using their arm under the Resident's arm to lift the resident up. The dialysis tech was in front of the Resident with her arms wrapped around the back of the Resident during the lift from the floor. During the lift, the Transportation Driver heard someone say they heard a pop, and Resident #103 made a noise to indicate she had pain. Once Resident #103 was placed into the chair, one of the NAs said the Resident needs to be assessed. The Transportation Driver said EMS was called by the dialysis center and they were told to leave the facility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	NA #3 and NA #2 were interviewed together on 4/16/24 at 3:08 PM. NA #2 stated he and NA #3 went to the dialysis center with the Transportation Driver to pick up Resident #103 on 3/25/24. NA #2 said the Scheduler had asked them to go with the Transportation Driver to pick up Resident #103. NA #2 said Resident #103 was in her dialysis chair when they arrived, and observed she did not have a sling under her. The dialysis staff did not provide an explanation why Resident #103 did not have a sling under her in the chair. NA #3 stated they were unable to get the lift sling they brought from the facility under Resident #103, and it was decided by her and NA #2 to transfer Resident #103 manually because Resident #103 was transferred without using a sling earlier by the dialysis staff. NA #3 said the first attempt to transfer Resident #103 did not work and the resident slid to the floor with assistance from her and NA #2. NA #3 stated they had lifted the resident with their arms under her arms, and when Resident #103 was standing, her knees buckled, and she was lowered onto her knees upright. NA #3 and NA #2 both agreed Resident #103 was not assessed by a nurse when she with as assisted to the floor. While Resident #103 was on her knees, a dialysis technician came over to assist with lifting the resident from the floor and into her chair. NA #2 said he was lifting under Resident #103's right arm, NA #3 was at the back of the resident with her arms around the front of the resident, and the dialysis technician was on the residents left side and a gait belt was used for the transfer. NA #2 said when they were lifting Resident #103, he heard a pop, and Resident #103 complained of pain in her left shoulder and said she was feeling nauseas. A dialysis nurse then assessed Resident #103, and then called EMS. The dialysis nurse told NA #3 and NA #2 they could leave. Both NA #3 and NA #2 stated they knew Resident #103 was a total mechanical lift but did not know if the resident was weight bearing at that time. The NAs said they were provided with an in-service from the DON when they returned to the facility that day on the uses of slings and lifts for a resident required a total lift. The Scheduler was interviewed on 4/16/24 at 3:59 PM. She stated the Transportation Driver called her at the facility the evening of 3/25/24. The Transportation Driver told her Resident #103 did not have a sling under her at dialysis and could not be transferred to the transport chair. The Scheduler said Resident #103 had a lift pad under her, and dialysis would not let her return to the nursing facility with it. Resident #103 was working with therapy before her dialysis appointment and was placed in her transport chair without the sling she normally had with her when she went to dialysis. The Transportation Driver said he needed to come back to the nursing facility to get a sling and needed help with the transfer. The Scheduler stated she told NA #3 and NA #2 to get a sling and go with the Transportation Driver to pick up Resident #103. The Scheduler said she thought Resident #103 was weight bearing because she was working with therapy, and knew she required a total lift sling to get up. The Scheduler stated her assumption was Resident #103 would have been transferred using the lift sling the NAs were taking back to the dialysis center. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The Dialysis Nurse who was assigned to Resident #103 on 3/25/24 was interviewed on 4/17/24 at 8:45 AM via phone. She stated she saw Resident #103 had arrived at the dialysis center for treatment without a sling under her for transferring to the dialysis chair. The Dialysis Nurse stated Resident #103 had always been transferred using a lift, but they had to transfer her using 4 dialysis staff and a lift pad. The dialysis center Administrator told her after the transfer they could not transfer without using a lift. When Resident #103 finished her dialysis treatment, the Transportation Driver was asked to get help from the nursing facility to transfer Resident #103 out of the dialysis chair because they were not allowed. The Transportation Driver came back to the dialysis center with 2 NAs and a sling, and the NAs were unable to place the sling under the resident. The Dialysis Nurse stated she did not recall exactly how the NAs tried to transfer Resident #103 out of the dialysis chair, but the resident slipped and fell to the floor on her left side and hurt her shoulder and ankle. The NAs then lifted Resident #103 back into the chair by placing their arms under her arms and lifting. The interview further revealed Resident #103 complained of pain in her left shoulder and was assessed by the Dialysis Nurse. Emergency Medical Services was contacted and Resident #103 was sent to the hospital for an evaluation. The DON was interviewed on 4/17/24 at 9:12 AM and stated Resident #103 was in her dialysis chair and did not have her sling for transfer because therapy had worked with her prior to her dialysis treatment and did not use a total lift with her. The dialysis center had transferred Resident #103 into her dialysis chair before her treatment but would not transfer her again when the treatment was completed. The Transportation Driver called the facility and spoke to the Scheduler, because she had left for the day. The Transportation Driver came to the facility, picked up NA #3 and NA #2 and a sling, then went back to the dialysis center for Resident #103. The DON said NA #3 and NA #2 were unable to place the lift sling under the Resident #103 and tried to transfer Resident #103 manually from the dialysis chair. Resident #103's legs buckled and was assisted to her knees on the floor by the NA. The DON said a dialysis technician helped NA #3 and NA#2 lift Resident #103 from the floor to her chair. The DON said NA #2 was on one side of Resident #103 and the dialysis technician was on the other side with NA #3 assisting from the residents back. While lifting, they heard a pop, and the dialysis center called EMS and told the NA's they could leave. The DON stated at that time Resident #103 required the use of a total mechanical lift and was only transferred manually when therapy worked with her. The DON did not know if Resident #103 was assessed by a nurse after the fall or when her shoulder was hurt, the NAs present could not assess her. Resident #103 was in the care of the dialysis center while she was there, and she did not know the dialysis center's protocol and policies for a fall or injury. The DON stated Resident #103 was transported to the dialysis center by non-emergent EMS until she was cleared for mechanical lift. A follow up interview was conducted with the DON on 4/19/24 at 12:09 PM. She stated the NAS should have used a lift to transfer Resident #103 as required by her plan of care. The DON said the facilities policy was to assess a resident after a fall by a nurse and evaluate if the resident is safe to move. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deer Park Health and Rehabilitation	306 Deer Park Road Nebo, NC 28761

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The Administrator was interviewed on 4/17/24 at 9:29 AM. On 3/25/24 she was on vacation and returned to work on 3/26/24. The Administrator said her understanding was the dialysis center transferred Resident #103 into the dialysis chair but would not transfer the resident back into the transport chair. The Transportation Driver went back to the facility to get a sling and 2 NAs to help transfer Resident #103 at the dialysis center. The dialysis center would not let the NA's use the lift pad they placed under the resident when she was transferred to the dialysis chair. The Administrator stated NA #3 and NA #2 were manually transferring Resident #103 from the dialysis chair to the transport chair and Resident #103's knees buckled, and she was assisted to her knees on the floor by the NAs. Then, with the help of a dialysis technician, the NAs manually lifted the resident up to the chair and someone said they heard a pop. The Administrator stated the dialysis center called EMS and Resident #103 was sent to the ER. The NAs were provided lift training after the incident, and Resident #103 was transported to dialysis treatments by ambulance. The Dialysis Technician was interviewed on 4/17/24 at 12:13 PM via phone. She stated Resident #103 arrived at the dialysis center and did not have her lift sling underneath her. The dialysis RN asked the transportation driver to get a sling and some help to transfer the resident. The Dialysis Technician stated the two NAs tried to transfer the resident from her dialysis chair to the transportation chair as they lifted the resident from under her arms and out of the chair. Resident #103 was assisted to the floor by the NAs and was sitting on her knees, shins and butt while on the floor. Resident #103 did not fall to the floor on her left side or lay on the floor on her side. The Dialysis Technician said the NAs needed help with getting the resident up off the floor and she went to help them. Resident #103 was not assessed by anyone when she was on the floor prior to her being lifted again, the move from the floor to the chair. She said NA #2 was on one side lifting the resident under her arm and she was in front of the resident with her arms wrapped around the resident's back while they were lifting her. During the lift NA #2 lifted the resident's arm from under her armpit. Resident #103's arm did not provide resistance and went straight up, over the resident's head with NA #2's arm. The Dialysis Technician said she heard a loud pop noise and was placed into the chair. The Dialysis Technician did not see the NAs moving the resident's arm when placed into her chair. The Dialysis Technician then told her nurse that she heard a pop and the resident needed to be assessed. The dialysis center then called EMS to the facility, and the resident was sent to the hospital. The dialysis center administrator was interviewed on 4/17/24 at 2:50 PM via phone. She stated the transportation driver was asked to get a sling and some help to transfer the resident from the dialysis chair to the transportation chair. She told the transportation driver they were a no lift facility and would not transfer the resident without her sling. The administrator said she called the nursing facility and spoke to a nurse about this situation and explained they needed to bring a sling and some help for the transfer. She then went home for the day. While at home it was reported to her that the resident had slid down with assistance when the NAs were transferring her to the transport chair. She was told the Resident #103 hit the floor on her side and then the NAS picked her up from the floor into the chair and someone heard a pop noise. The dialysis nurse then called EMS and sent her out to the hospital. The next day she learned about the clavicle fracture and called the resident's family and spoke to the nursing facility about the incident. The dialysis center administrator stated resident #103 had always arrived to the dialysis center with her sling underneath her. She was unaware why the resident did not have her sling with her on that occasion. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The Rehab Director was interviewed on 4/17/24 at 3:30 PM and stated Resident #103 was working on transferring, upper body dressing, lower body dressing, and grooming before the incident. The rehab director said the resident required the use of a mechanical lift and sling for all transfers not being done by the therapist. The Rehab Director stated after the incident the resident was not allowed to be transferred with a sling and the therapists were getting the resident up out of bed. The Rehab Director said when he worked with the resident after the accident, she had not expressed any pain or discomfort in her shoulder area, and they continued to work with her on pivot transfers. The Rehab Director stated on 3/25/24, the day of the incident there was miscommunication that occurred. The therapist we're not aware the resident was going to dialysis after therapy and therefore did not have her sling underneath her as she normally would have had for dialysis. The Medical Director was interviewed on 4/19/24 at 11:49 AM via phone. He stated he expected NAs to follow Resident #103's care plan and use a mechanical lift and sling when indicated. The medical director said after a resident in the care of the nursing facility had a fall, the resident should be assessed by a nurse before moving or lifting. 2. Resident #37 was admitted on [DATE] with diagnosis of dementia, hypertension, and chronic obstructive pulmonary disease (COPD). A review of the quarterly Minimal Data Set (MDS) dated [DATE] coded Resident #37 with severe cognitive impairment. He required extensive 2-person assistance with toileting, transfer, and bed mobility. A review Resident #37's care plan revealed he was care planned for resisting care and yelling for help or nurse and not knowing what he needed (11/17/22). Interventions for the care plan included explaining all procedures to the resident before starting care and allowing the resident to adjust to changes. Resident #37 was care planned for being incontinent with bowel and bladder with an intervention that included check resident for incontinence every care round (5/14/22). Resident #37 had a physician order for Geri-sleeves to bilateral arms as tolerated, every day shift for protection (1/13/24). A review of Nurse #3 progress note dated 3/4/24 at 11:25 PM read in part, Resident #37 was yelling out, so this nurse went to his room to check on him. Upon assessment, Resident #37 had 3 large skin tears on his left forearm and a smaller sing tear on his right upper forearm near the elbow. The geri-sleeves were found pushed down on Resident# 37's wrists. Resident #37 stated your boy done this; your boy done this. Nurse Aide (NA) #2 had just finished a round on that hall, and NA #2 was questioned about what happened. NA #2 told Nurse #3, Resident #37 was combative with care and hit his arm on the side rail. NA #2 was counselled to have 2 NAs assist when providing care if the resident is resistive to care and to notify the nurse before providing care. Resident #37's skin tears were cleaned with wound cleaner and xeroform and bordered gauze dressing was applied. Resident #37 kept telling Nurse #3 I'm alright honey. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	NA #2 was interviewed on 4/18/24 at 3:09 PM. He stated on 3/4/24 he was completing his last round on the floor around 9:00 PM before the end of his shift. NA #2 stated he went into Resident #37's room and told Resident #37 he was going to provide care to him. NA #2 stated Resident #37 became combative and flailed his arms hitting the headboard and the side rail of the bed. Resident #37 told NA #2 to get out, and NA #2 replied he was there to provide care to him. NA #2 said he continued to provide care (incontinence) and Resident #37 calmed down and stopped flailing his arms once his brief was changed. NA #2 did not hold the resident down while providing care. NA #2 said he did not see any injuries or skin tears on the resident's arms and the resident was wearing protective arm sleeves on both arms. He said he would have reported the injuries to his nurse if he had seen any. NA #2 said the next shift's NA went into Resident #37's room and saw the skin tears and reported them to the nurse. NA #2 said he was sent home and was suspended by the facility for 3 days while they investigated. NA #2 went on to say Resident #37 had a history of being combative with care, and he normally got help when Resident #37 was being resistive to care. He said he was trying to finish his resident rounds before his shift ended on 3/4/24, and he should have stopped when Resident #37 became resistive to care. He stated he should have found another NA or nurse to help him with providing care. NA #2 stated he has not been assigned to work with Resident #37 since that incident, and the Director of Nursing (DON) provided him with education on always getting help for another NA when a resident was resistive to care, or to stop care and reapproach the resident later. The previous facility DON was interviewed on 4/18/24 at 3:50 PM via phone. She stated that she was the DON for the building for that incident but was not in the building when it happened. The former DON stated she could not recall the time she was notified by the Administrator of the incident. She stated the Administrator completed the investigation and she then reviewed the interviews and closed the facility reported incident (FRI) investigation. The former DON said she did have a verbal discussion with NA #2 on providing care before his next scheduled shift and she gave NA #2 a write-up but could not recall the details. The former DON said NA #2 was suspended for 2 or 3 days, after the incident. A review of the investigation report dated 3/5/24 revealed the facility became aware of the new skin tears to the left and right forearm for Resident #37 on morning of 3/5/24. The Administrator was notified at 7:30 AM and the DON was made aware. A facility reported incident (FRI) for injury of an unknow origin was started and a 24-hour report was initiated, and the medical director was notified. Nurse #3 reported Resident #37 stated your boy did it on the night of 3/4/24. NA #2 was interviewed and stated Resident #37 was combative with care the night before and the resident had hit his arms on the headboard, but he did not see any skin tears and Resident #37 did not make any complaints to him during or after care. NA #2 stated he didn't think anything had happened to Resident #37 and that was why he did not report it to the nurse. He left the facility after Nurse #3 questioned him. NA #2 was suspended on 3/5/24 while the incident was being investigated. All residents on NA #2 assigned hall had skin assessments completed and alert and oriented residents did not report any concerns with NA #2. Alert and oriented residents were interviewed were asked if they had witnessed any abuse and if they feel safe here and they all reported they have witnessed no abuse and felt safe in the facility. Resident # 37 was interviewed and had not recollection of the incident. The allegation was completed on 3/7/24 and the allegation was not substantiated due to Resident #37 being unable to recall the incident or identify NA #2 and the resident's injury was not intentional. NA # 2 was educated and counseled to always use 2 staff members for residents that have the ability to be combative, and to leave the resident in a safe position and come back and attempt care later and notify his nurse of any out of the ordinary occurrences. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Nurse #3 was unavailable for interview. The Wound Nurse Practitioners (NP) progress note dated 3/6/24 was reviewed. The progress note revealed a new wound area on the left forearm with measurement 20 cm x 8 cm x 0.20 cm. The wound NP recommended the wounds to be treated daily and as needed (PRN) using a wound cleanser with xeroform and gauze to cover the wound. The Wound NP provider was interviewed on 4/18/24 at 1:37 PM via phone. He stated he treated Resident # 37's wounds on 3/6/24 and the wound did not look abnormal to him, the skin tears were like previous skin tears the resident had had. Resident #37 had thin and fragile skin and would receive skin tears easily. He wore a protective sleeve on his arms to prevent skin tears. There were 3 skin tears on Resident #37's left forearm, so he took one generalized measurement of the area for treatment. The Wound NP said the skin tears had been resolved. The Administrator was interviewed on 4/18/24 at 3:54 PM. She stated NA #2 had already been sent home when she was notified by Nurse #3 around 7:30 AM the following day that Resident #37 had skin tears on his arms from being combative receiving care from NA# 2. The Administrator said the next morning she had interviewed NA #2. NA #2 told her Resident #37 had become combative with care, and the resident was flailing his arms while he was providing care. NA #2 said he did not know the resident was injured, or he would have reported it to his nurse. The Administrator said the former DON had counseled NA #2 and had given him a write -up on 3/5/24. NA #2 was suspended for 3 days until the investigation was completed. The Administrator said Resident #37 was interviewed on 3/5/24 and did not remember the incident and was unable to identify any staff. The Administrator said generally, when a resident was combative with care, an NA should stop care and reapproach later or get another NA to help with providing care. The DON was interviewed on 4/19/24 at 12:09 PM. She stated Resident #37 had a history of being combative when he received care. The DON said if a resident was combative with care, NA #2 should have stopped providing care and walked away or gotten help from another NA or nurse before attempting to provide care again.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36217 Based on record review and interviews with the resident, staff, and the Consultant Pharmacist, the Consultant Pharmacist failed to identify drug irregularities and provide recommendations for 1 of 5 residents reviewed for unnecessary medications (Residents #71). The findings included: Resident #71 was admitted to the facility on [DATE] with diagnoses including non-Alzheimer's dementia, anxiety disorder, and depression. The physician's orders dated 11/21/22 revealed Resident #71 had an order to receive 1 tablet of Risperdal (a second-generation antipsychotic medication associated with risk of abnormal involuntary movements disorder) 0.5 milligrams (mg) by mouth three times daily for mood. A review of medication administration records (MARs) indicated Resident #71 had received Risperdal 0.5 mg three times daily as ordered since its initiation on 11/21/22. A review of Resident #71's medical records revealed his last abnormal involuntary movements assessment was completed on 01/08/23. No subsequent abnormal involuntary movements assessment had been documented since then. The annual Minimum Data Set (MDS) dated [DATE] assessed Resident #71 with severe impairment in cognition. A review of Resident #71's medical records revealed the Consultant Pharmacist had conducted medication regimen reviews (MRRs) monthly in the past 12 months in the following date ranges: - March - between 04/01/23 to 04/27/23 - April - between 05/01/23 to 05/24/23 - May - between 06/01/23 to 06/29/23 - June - between 07/01/23 to 07/27/23 - July - between 08/01/23 to 08/29/23 - August - between 09/01/23 to 09/26/23 - September - between 10/01/23 to 10/24/23 - October - between 11/01/23 to 11/28/23 - November - between 12/01/23 to 12/24/23. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- December - between 01/01/24 to 01/22/24. - January - between 02/01/24 to 02/22/24. - February - between 03/01/24 to 03/22/24 A further review of Resident #71's medical records revealed no recommendations related to abnormal involuntary movements assessment had been made by the Consultant Pharmacist to the facility in the past 12 months. During an interview conducted on 04/17/24 at 3:34 PM, Nurse #5 confirmed Resident #71 had received Risperdal three times daily in the past 12 months. She could not recall performing any abnormal involuntary movements assessment for Resident #71 in the past 12 months and denied seeing Resident #71 with signs and symptoms of abnormal involuntary movements disorder so far. An attempt to interview Resident #71 on 04/17/24 at 3:39 PM was unsuccessful. He was unable to engage in the interview. During an interview conducted on 04/18/24 at 10:46 AM, the Medical Record Coordinator confirmed the last abnormal involuntary movements assessment completed for Resident #71 was on 01/08/23. She could not find any subsequent abnormal involuntary movements assessment documented for Resident #71 in the past 12 months. An interview was conducted with the Director of Nursing (DON) on 04/18/24 at 12:56 PM. She explained when the facility switched its medical record system from paper based to electronic based more than one year ago, numerous assessments ordered for residents were lost during the transition. It was her expectation for the facility to complete an abnormal involuntary movements assessment at least once every 6 months for residents receiving antipsychotic medication. She expected the Consultant Pharmacist to make a recommendation if the mentioned assessment was not in place. During an interview conducted on 04/18/24 at 4:26 PM, the Administrator stated the DON oversaw all the monitoring and assessments. She added the facility had 4 different DONs in the past 1 year and attributed the incident to frequent changes of leadership in the nursing department. It was her expectation for the facility to conduct abnormal involuntary movements assessment for residents receiving antipsychotic medication. She expected the Consultant Pharmacist to alert the facility when the mentioned assessment was not in place. A phone interview was conducted on 04/19/24 at 10:14 AM with the Consultant Pharmacist. He acknowledged that he had performed MRR monthly for Resident #71 in the past 12 months. He did not notice Resident #71 had not been assessed for abnormal involuntary movements since 01/08/23. He stated residents who received antipsychotic medication should have an abnormal involuntary movements assessment completed at baseline and then at least once every 6 months. Otherwise, it could cause a delay in early detection of movement disorders. He attributed the incident as his oversight.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41069 Based on record reviews, and interviews with staff, Hospice Nurse, Physician Assistant, Medical Director and Consultant Pharmacist interviews, the facility failed to limit the duration of a psychotropic medication (a drug that affects brain activities associated with mental processes and behaviors) ordered on an as needed (PRN) basis to 14 days and/or indicate the duration and rationale for the PRN order to be extended beyond 14 days, when appropriate (Resident #94) and failed to monitor for abnormal involuntary movements on a resident receiving an antipsychotic medication (Resident #71) for 2 of 5 residents reviewed for unnecessary medications. The findings included: 1. Resident #94 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder. A review of Resident #94's medical record indicated an active order dated 12/30/23 for Lorazepam 0.5 milligrams (mg) give 1 tablet by mouth every 24 hours as needed for agitation related to anxiety disorder and an active order dated 2/7/24 for Lorazepam 0.5 mg give 0.5 tablet by mouth in the morning for anxiety. (Lorazepam is a psychotropic medication). A Medication Regimen Review (MRR) dated 1/21/24 indicated a recommendation by the Consultant Pharmacist regarding the order for Lorazepam 0.5 mg every 24 hours as needed for agitation to be limited to 14 days and if the agent was appropriate to be continued beyond 14 days, to document rationale and indicate the duration for the PRN order. The MRR was addressed by the Physician Assistant (PA) on 2/6/24 with a note: Gradual dose reduction (GDR) - will decrease to 0.25 mg every day scheduled. The MRR dated 3/21/24 indicated another recommendation by the Consultant Pharmacist regarding the order for Lorazepam 0.5 mg every 24 hours as needed for agitation to be limited to 14 days and if the agent was appropriate to be continued beyond 14 days, to document rationale and indicate the duration for the PRN order. The MRR was addressed by the PA on 4/16/24 with a note: Disagree, patient still with outburst. The quarterly Minimum Data Set assessment dated [DATE] indicated Resident #94 was severely cognitively impaired, had no behavioral symptoms, took antianxiety medications, and received hospice care. A phone interview with the Hospice Nurse assigned to Resident #94 on 4/18/24 at 10:02 AM revealed the pharmacy recommendations were usually addressed by the facility doctor, and they just let her know if there were any changes with her medications. The Hospice Nurse stated they normally kept an order for PRN Lorazepam and Resident #94 needed it because sometimes she had increased agitation in the afternoons. The Hospice Nurse stated there was no issue with limiting the duration of the PRN Lorazepam to 14 days because it could be renewed if still needed after 14 days. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A phone interview with the Consultant Pharmacist (CP) on 4/18/24 at 10:30 AM revealed he had been recommending to the providers about Resident #94's PRN Lorazepam order needing a stop date. The CP stated he would need to talk to them about it because the stop date didn't need to be 14 days. The CP added that the stop date could be 30 days or 90 days depending on their assessment and then they could renew the order afterwards if the PRN Lorazepam was still needed. The CP further stated that orders for prn psychotropics such as Lorazepam were required to have a stop date. An interview with the Physician Assistant (PA) on 4/18/24 at 3:35 PM revealed he usually ordered PRN Lorazepam for 14 days at a time but Resident #94 was still having outburst and behaviors, so he decided to keep her on PRN Lorazepam with no stop date. The PA stated that he had seen when weaning hospice residents off their psychotropics, they would revert back to their behaviors. A phone interview with the Medical Director (MD) on 4/19/24 at 11:33 AM revealed Resident #94 was on hospice, and she needed to keep the PRN Lorazepam order because it was part of her comfort regimen, and it was being utilized. The MD stated he had not seen the pharmacy recommendations, but he wasn't always sure whether the pharmacist reviewed everything including utilization. The MD stated that he would have to talk to the pharmacist further because he was concerned about the medication being available when needed if the 14 day stop date ended on a weekend. An interview with the Director of Nursing (DON) on 4/19/24 at 5:03 PM revealed she had seen the 3/21/24 MRR and the note by the PA to continue but she did not know if he meant to continue for 14 days and then review. The DON stated Resident #94's PRN Lorazepam order should have a stop date. 36217 2. Resident #71 was admitted to the facility on [DATE] with diagnoses including non-Alzheimer's dementia, anxiety disorder, and depression. The physician's orders dated 11/21/22 revealed Resident #71 had an order to receive 1 tablet of Risperdal (a second-generation antipsychotic medication associated with risk of abnormal involuntary movements disorder) 0.5 milligrams (mg) by mouth three times daily for mood. A review of medication administration records (MARs) indicated Resident #71 had received Risperdal 0.5 mg three times daily as ordered since its initiation on 11/21/22. A review of Resident #71's medical records revealed his last abnormal involuntary movements assessment was completed on 01/08/23. No subsequent abnormal involuntary movements assessment had been documented since then. The annual Minimum Data Set (MDS) dated [DATE] assessed Resident #71 with severe impairment in cognition. During an interview conducted on 04/17/24 at 3:34 PM, Nurse #5 confirmed Resident #71 had received Risperdal three times daily in the past 12 months. She could not recall performing any abnormal involuntary movements assessment for Resident #71 in the past 12 months and denied seeing Resident #71 with signs and symptoms of abnormal involuntary movements disorder so far. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An attempt to interview Resident #71 on 04/17/24 at 3:39 PM was unsuccessful. He was unable to engage in the interview. During an interview conducted on 04/18/24 at 10:46 AM, the Medical Record Coordinator confirmed the last abnormal involuntary movements assessment completed for Resident #71 was on 01/08/23. She could not find any subsequent abnormal involuntary movements assessment documented for Resident #71 in the past 12 months. An interview was conducted with the Director of Nursing (DON) on 04/18/24 at 12:56 PM. She explained when the facility switched its medical records system from paper based to electronic based more than one year ago, numerous assessments ordered for residents were lost during the transition. It was her expectation for the facility to complete an abnormal involuntary movements assessment at least once every 6 months for residents receiving antipsychotic medication. During an interview conducted on 04/18/24 at 4:26 PM, the Administrator stated the DON oversaw all the monitoring and assessments. She added the facility had 4 different DONs in the past 1 year and attributed the incident to frequent changes of leadership in the nursing department. It was her expectation for the facility to conduct abnormal involuntary movements assessment for residents receiving antipsychotic medication. A phone interview was conducted on 04/19/24 at 10:14 AM with the Consultant Pharmacist. He stated residents who received antipsychotic medication should have an abnormal involuntary movements assessment completed at baseline and then at least once every 6 months. Otherwise, it could cause a delay in early detection of movements disorder.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 36217 Based on observation, staff interviews, and record reviews, the facility failed to record the opening date for 1 opened insulin, failed to remove 1 expired insulin in 1 of 4 medication carts (Seafoam Hall), and failed to remove expired over the counter (OTC) medications and supplements in accordance with the manufacturer's expiration date for 1 of 4 medication carts (Silver Hall) and 1 of 2 medication storage rooms observed during medication storage checks (South medication storage room). The findings included: A review of manufacturer's package inserts for insulin Lispro revealed an unopened pen or vial should be stored under refrigeration between 36 to 46 Fahrenheit (F) and protected from light. Once it was opened, it could be stored in the refrigerator or at room temperature up to 86 F for up to 28 days. a. A medication storage audit was conducted on 04/16/24 at 3:21 PM in the presence of Nurse #4. The following insulins were found in the medication cart of Seafoam Hall and ready to be used: 1. One used insulin Lantus pen with the strength of 100 unit per milliliter (ml) without an opening and expiration date. 2. One used insulin Lispro pen with the strength of 100 unit per ml opened on 02/20/24 expired on 03/18/24. During an interview conducted on 04/16/24 at 3:27 PM, Nurse #4 confirmed insulin Lantus was undated when it was opened and insulin Lispro was expired. He explained he did not work with the medication cart at Seafoam Hall frequently and did not know when the medication cart was last checked. He stated all the expired medication including insulin should be removed from the medication cart and each insulin should be dated when it was opened. b. A medication storage audit was conducted on 04/16/24 at 3:57 PM in the presence of Unit Manager #1. The following medications were found on the shelf of South medication storage room and ready to be used: 1. One unopened bottle containing 30 soft gels of Coenzyme Q-10 30 milligrams (mg) expired on 02/29/24. 2. Three unopened bottles with each bottle containing 100 tablets of zinc 50 mg supplement expired on 03/31/24. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Unit Manager (UM) #1 on 04/16/24 at 4:09 PM. She stated she was responsible for the South medication storage room. As the UM, she checked the medication storage room at least once per week to ensure proper storage and free of expired medication. When she received a new shipment of OTC, she would rotate the medications. She explained the expired OTC medications or supplements were rarely used by the residents in recent months. c. A medication storage audit was conducted on 04/16/24 at 4:22 PM in the presence of Nurse #5. The following medications were found in the medication cart for Silver Hall and ready to be used: 1. One used bottle containing 100 tablets of calcium citrate 600 mg supplement expired on 03/31/24. During an interview conducted on 04/16/24 at 4:28 PM, Nurse #5 stated she did not work with the medication cart for Silver Hall on a regular basis. Normally she would check her medication cart in the Blue Hall at least once a week on Sunday and she would recheck each time before administration. She explained calcium citrate was rarely used by resident in recent months and stated all the expired medication should be removed from the medication cart in a timely manner. An interview was conducted with the Director of Nursing (DON) on 04/18/24 at 12:56 PM. She stated all the nurses were instructed to date the insulin when it was opened, audit the entire medication cart at least once in third shift every Sunday, and check the expiration date before administration. She attributed the incidents to nurses' carelessness and constant distraction by the residents or other staff. It was her expectation for the nurses to remove all the expired medications from the medication cart or medication storage rooms according to manufacturer's expiration date and date the insulin once it had been used. During an interview conducted on 04/1/24 at 4:26 PM, the Administrator expected nurses to date the insulin once it was opened and remove all expired medications from the medication carts. It was her expectation for the UM to check the medication storage room at least once weekly to ensure the facility was free of expired medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45272 Based on observations and staff interviews the facility failed to clean and maintain the walk-in refrigerator, oil deep fryer area, circulatory fans of the walk-in freezer, and a storage shelf for ready-to-use cookware. This practice had the potential to affect all residents. The findings included a. An observation of the walk-in refrigerator on 4/15/24 at 7:48 AM found a build up of grey/black and fuzzy in appearance substance. The substance was found in a vertical line of approximately 1 foot long and 1 inch wide between storage shelves. On 4/18/24 at 10:02 AM a follow-up observation was conducted of the walk-in refrigerator with the Dietary Manager (DM). The grey/black fuzzy substance in the walk-in refrigerator remained unchanged. The DM stated during the observation the walk-in refrigerator is on a cleaning schedule and was last cleaned on 4/4/24. The DM stated the grey/black substance was an oversight. b. On 4/15/24 at 8:00 AM an observation of the oil fryer area found a circular area approximately 3 inches deep and 4 inches wide contained a build-up of food particles and [NAME] grease. On 4/18/24 at 10:13 AM the circular area at the oil fryer area was observed unchanged. The DM stated during the observation they circular area was not a drain but should have been cleaned each night when the floor was cleaned and was overlooked. c. An observation of the walk-in freezer on 4/18/24 at 10:08 AM with the DM found a thick build-up of debris that was crumbly to touch on the circulatory fans. The DM stated during the observation the circulatory fans were not included on the cleaning schedule and would be added to the schedule. d. On 4/18/24 at 10:18 AM the top shelf of a rack that contained ready -to-use utensils/pots/pitchers was observed with a thick, fluffy, and crumbly to touch substance spanning the top shelf. The DM stated during the observation the ready-to-use rack was on a routine cleaning schedule and the top shelf was overlooked. The Administrator was interviewed on 4/19/24 at 1:55 PM and stated the identified areas in the kitchen were overlooked and the cleaning needed to be more detailed.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41069 Based on observations, record reviews, resident, resident representatives, family and staff interviews, and interviews with psychotherapist, Psychiatric Nurse Practitioner, Physician Assistant and the Medical Director, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint investigation survey conducted on [DATE] and the recertification and complaint investigation survey conducted on [DATE]. This was for repeat deficiencies in the areas of accident hazards/supervision and medication storage that were originally cited on [DATE] during the recertification and complaint investigation survey, and subsequently recited during the recertification and complaint investigation survey completed on [DATE]. In addition, a repeat deficiency in the area of abuse was originally on [DATE] during the recertification and complaint investigation survey, and subsequently recited during the recertification and complaint investigation survey completed on [DATE]. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross-referenced to: F600 - Based on observation, record reviews, and resident, resident representatives, staff, psychotherapist, Psychiatric Nurse Practitioner (NP), Physician Assistant and Medical Director interviews, the facility failed to protect a resident's right (Resident #3) to be free of sexual abuse from another resident (Resident #52). Resident #3 had severely impaired cognition and Resident #52 had moderately impaired cognition and a history of sexual behaviors. On [DATE] Resident #52 was observed by staff inviting Resident #3 into his room and was told by staff to leave the door open. Shortly after, Resident #52 was observed inappropriately touching Resident #3's leg. On [DATE] Resident #52 was found in Resident #3's room looking at her while she slept. On [DATE] Nurse Aide (NA) #1 heard yelling coming from Resident #3's room. NA #1 and Nurse #1 found Resident #52 in Resident #3's room with his hand inside of her incontinent brief with skin to skin contact. Resident #3 stated stop, you're hurting me. Resident #3 was incapable of consenting to the sexual act. Resident #3's Responsible Party (RP) indicated she would have been very upset by the incident. A reasonable person expects to be protected from abuse in their home environment and sexual abuse would cause trauma. In addition, the facility failed to prevent resident to resident abuse when a resident (Resident #264) used his fist to punch Resident #30 on the right side of the face resulting in injury to the inside of the mouth causing the gum to bleed and redness to the cheek. A reasonable person would not expect to be physically abused in their own home and could experience feelings of fear, intimidation, depression, and anxiety. This deficient practice affected 4 of 12 residents reviewed for abuse. During the recertification and complaint investigation survey on [DATE], the facility failed to protect a resident's right to be free from abuse. On [DATE] while providing care, a nurse aide put her leg on the resident's upper leg to restrain the resident who was being combative. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F689 - Based on observation, record review, resident, family and staff interviews, the facility failed to ensure a resident was transferred safely. Resident #103 sustained a fractured left clavicle and a sprained right foot from a fall when two nurse aides transferred Resident #103 after completion of her dialysis treatment without the use of a total lift. Resident #103 was not cleared by therapy to be transferred manually. The facility also failed to prevent Resident #37 from obtaining skin tears when the nurse aide continued to provide care after the resident became combative and was hitting his arms on the headboard and siderail. This was for 2 of 5 sampled residents reviewed for supervision to prevent accidents (Resident #103, Resident #37). During the recertification and complaint investigation survey on [DATE], the facility failed to use two-person transfer assist for a resident which resulted in a fall without injury. F761 - Based on observation, staff interviews, and record reviews, the facility failed to record the opening date for 1 opened insulin, failed to remove 1 expired insulin in 1 of 4 medication carts (Seafoam Hall), and failed to remove expired over the counter (OTC) medications and supplements in accordance with the manufacturer's expiration date for 1 of 4 medication carts (Silver Hall) and 1 of 2 medication storage rooms observed during medication storage checks (South medication storage room). During the recertification survey on [DATE], the facility failed to date opened medication vials and discard outdated medications in medication rooms and medication carts. An interview with the Administrator on [DATE] at 6:38 PM revealed she had only been to one QAPI (Quality Assurance/Performance Improvement) meeting since having started working as the Administrator at the facility. The Administrator shared that she had a list of issues that she and the Director of Nursing had planned on handling since both of them were new. The Administrator stated that a lot of the reasons for the repeat citations had to do with the changeover in management. She further stated that the facility had gone through different administration with different styles and no consistency.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 45272 Based on observations and staff interviews the facility failed to maintain the two-compartment sink as evidenced by a leaking drainpipe. This had the potential to affect the cleanliness and sanitation of the kitchen. The findings included: An observation of the kitchen with the Dietary Manager (DM) on 4/18/24 at 10:16 AM found the two-compartment (a sink used to wash, or prep food in) sink's drainpipe leaking onto the kitchen floor. Water was observed dripping from a pipe connection on the sink's drain trap onto the kitchen floor and draining to the floor drain. The DM stated during the observation she was unaware the sink drainpipe had been leaking and was unaware how long it had been leaking, and that the sink had recently been used to rinse food. The DM asked the assistant DM if she was aware of the leaking drainpipe who stated she was not aware of the leaking drain. The Maintenance Manager was interviewed on 4/19/24 at 1:00 PM. He stated he was not aware of the leaking two compartment sink drainpipe and there was not a work order submitted prior to the observation made on 4/18/24. The Maintenance Manager said the leaking pipe would be repaired. The Administrator was interviewed on 4/19/24 at 1:55 PM and stated she was not aware of the leaking two compartment sink drain. The leaking drainpipe should have been reported to the Maintenance Manager to be repaired.