| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345365 | A. Building<br>B. Wing | 12/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Signature Healthcare of Kinston | 907 Cunningham Road<br>Kinston, NC 28501 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, the facility failed to protect a resident's right to be free from verbal abuse by staff for 1 of 5 residents reviewed for abuse (Resident #101). The findings included: Resident #101 was admitted to the facility on [DATE] with diagnoses including cerebral vascular accident (stroke). He was discharged from the facility to the community on 9/19/25. Resident #101's annual Minimum Data Set (MDS) dated [DATE] indicated he was cognitively intact, had no behaviors or signs of depression, and propelled himself in his wheelchair independently. A facility Investigation Report dated 4/08/25 documented that on 4/05/25 at 1:40 PM, Housekeeper #1 started cursing at him because he wasn't moving his wheelchair down the hallway and had blocked her cart. Housekeeper #1 was witnessed cursing at the resident and was escorted out of the building during the investigation. The facility investigation found two other employees heard the interaction and confirmed Housekeeper #1 did curse at the resident. The facility substantiated verbal abuse. Nurse Aide (NA) #5's written witness statement dated 4/05/25 documented that when Resident #101 was coming down the hallway in his wheelchair, Housekeeper #1 came behind him and stated for him to Move out of the way m******f*****, move b**** and then proceeded to push her housekeeping cart to his wheelchair to move him out of the way. In a phone interview on 12/08/25 at 1:33 PM NA #5 stated Resident #101 had been propelling his wheelchair independently down the hallway. The hallway was crowded because other residents were on the other side of the hallway waiting to go outside to smoke. Housekeeper #1 got upset because Resident #101 was in her way. She started cussing at him in a threatening tone for him to move, which then made the resident angry. She then pushed her housekeeping cart into the back of his wheelchair. The other aide who witnessed the incident, NA #2, helped her to separate Housekeeper #1 and Resident #101. Once he was taken to his room, he calmed down and was back to baseline. NA #2's written witness statement dated 4/05/25 documented that when NA #2 was passing out trays for lunch, Resident #101 was coming down the hall. Housekeeper #1 was behind him. She told him to move out of her way but Resident #101 did not hear her. Housekeeper #1 then shouted that y'all need to learn how to get the f*** out the d*** way and pushed her cart to the side. She yanked the resident's wheelchair, which upset the resident. Resident #101 got up out of his wheelchair and stated he would knock her out. Housekeeper #1 stated he wasn't going to do s*** m*****f*****, grabbed her housekeeping cart again and said, what the f*** you going to do and then pushed her housekeeping cart into the resident. She then stated, you need to get your black a** back to your room and get out of the way. In a phone interview on 12/09/25 at 3:34 PM NA #2 stated she was passing out meal trays and Housekeeper #1 wanted to get past Resident #101, who was propelling himself in the wheelchair. Housekeeper #1 began cussing at him, telling him to get out of her way. Housekeeper #1 threatened Resident #101, stating if he didn't get out of the way, she would run into him with her cart and make him. She then pushed her cart into the back of the wheelchair. NA #2 and NA #5 separated the housekeeper from the Resident and NA #2 took Resident #101 back to his room. She stated once he calmed down, he was back to his baseline. Resident #101 was unable to be interviewed. Attempts to contact Housekeeper #1 were unsuccessful. In a phone interview on 12/08/25 at 11:31 AM the facility Clinical Consultant stated the facility substantiated that Housekeeper #1 verbally abused and threatened Resident #101 with harm. She stated Housekeeper #1 was let go from the facility. In a phone interview on 12/09/25 at 4:09 PM the Administrator stated the facility had substantiated verbal abuse and formulated a Corrective Action Plan. The facility submitted a corrective action plan that was not acceptable to the State Agency. The plan did not include sufficient systemic changes and monitoring. |

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| Signature Healthcare of Kinston | 907 Cunningham Road<br>Kinston, NC 28501 |

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|---|---|
| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from the wrongful use of the resident's belongings or money.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and resident, staff and Medical Director interviews, the facility failed to protect a resident's right to be free from misappropriation property and exploitation for 2 of 6 residents (Resident #103 and Resident #4) reviewed for abuse, neglect and/or misappropriation of property/exploitation. (1) In November 2024, Resident #103 reported her debit card account had been depleted to $9.34 after giving Nurse Aide (NA) #3 her debit card to pay her (NA #3's) light bill. The unauthorized spending to Resident #103's debit card totaled $2265.15. (2) In July 2025, NA #2 told Resident #4 she needed money to feed her children and Resident #4 gave NA #2 $65 dollars and was not reimbursed by the facility.<br><br>Findings included:<br><br>1. Resident #103 was admitted to the facility on [DATE] with diagnoses that included dementia.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #103 was moderately cognitively impaired.<br><br>An initial report dated 11/24/2024 alleging misappropriation of property for Resident #103 was completed by the former Director of Nursing #1 and faxed to the State Agency. The initial report recorded the facility became aware of the allegation of misappropriation of property on 11/24/2024 at 5:00pm when Resident #103 stated an employee, Nurse Aide (NA) #3 , had borrowed money from Resident #103. The facility's initial report indicated the local law enforcement was notified of Resident #103's allegation on 11/24/2024 at 5:30pm.<br><br>Resident #103's written statement dated 11/24/2024 at 5:05pm when interviewed by the former Director of Nursing #1 stated NA #3 had told Resident #103 that her (NA#3) light bill was a little over $100.00 and Resident #103 had given NA #3 her (Resident #103) debit card to pay the light bill. Resident #103 stated there was a balance of $1900.00 on the debit card when she loaned NA #3 the debit card (date not recorded) and stated NA#3 brought the debit card back to Resident #103 the next day(date not recorded). Resident #103 stated on Friday (date unknown) when checking the balance on the debit card, there was a balance of only $9.34. Resident #103 stated she asked NA #3 why she spent all of Resident#103's money and NA #3 did not have an explanation.<br><br>Attempts to interview Resident #103 were unsuccessful.<br><br>In NA #3's written statement taken by the former Director of Nursing #1 on 11/24/2024, NA #3 reported Resident #103 asked NA #3 to take the debit card to Walmart to get Resident #103 some drinks, snacks and fruit. NA #3 stated Resident #103 told her to get her (NA#3) something as well and a gift for NA #3's kids since it was the holidays and stated she (NA#3) got the items and some meat for herself from Walmart that totaled to a couple hundred dollars. NA #3 stated she gave Resident #103 a hundred-dollar bill for the items bought at Walmart because Resident #103 was going home for Thanksgiving and needed some cash. The former Director of Nursing wrote in NA #3 statement that NA #3 was explained she was suspended pending the investigation of Resident #103's allegation for misappropriation of property.<br><br>Attempts to interview NA #3 were unsuccessful.<br><br>(continued on next page) |

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|---|---|
| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A written statement from NA #4 on 11/24/2024 stated Resident #103 approached and pulled her to the side to ask if she was still friends with NA #3. When NA #4 answered yes, Resident #103 asked NA #4 to call NA #3 and ask NA#3 when she planned to give Resident #103 back her money. When NA #4 asked Resident #103 what she meant, Resident #103 told NA #4 she gave NA #3 a debit card because NA #3 told Resident #103 that she needed help paying the rent. Resident #103 stated she was trying to be nice and told NA #3 that NA #3 could use some of the money on the debit card but would not say how much money was allowed. NA #4 stated the amount used was way over $1900.00 and informed Resident #103 that this needed to be reported to someone in Administration. NA #4 stated she contacted and informed NA #3 Resident #103 wanted to see her about Resident #103's money. NA #4 stated NA #3 did say she used Resident #103's debit card and never confirmed or denied taking extra money from Resident #103. NA #4 stated when Resident #103 asked who she should report the incident to if Resident #103 did not get her money back on Monday (11/25/24), NA #4 told her to see the former Director of Nursing #1. NA #4 reported that she informed Nurse #2 of the conversation with Resident #103 and contacted the former Director of Nursing #1 of the conversation with Resident #103 on 11/24/2024.<br><br>In a phone interview with NA #4 on 12/5/2025 at 8:12 am, she recalled how Resident #103 coming to her on 11/24/2024 stating she didn't know what supervisor to go to tell that she had loaned her (Resident #103) debit card to NA #3 for a certain amount of money (amount unknown). She stated Resident #103 told her NA #3 brought back Resident #103's debit card and NA #3 had spent more than the amount of money (unknown amount) she had loaned NA #3 on the debit card. NA #4 stated Resident #103 wanted to talk with NA #3 to try to get the money back. NA #4 stated NA #3 did not answer the phone when she called NA #3. She explained although Resident #103 was upset her money was gone from the debit card account, Resident #103 didn't want to get NA #3 into any trouble. NA #4 stated she informed Nurse #2 of Resident #103's allegation of money spent with her debit card and notified the former Director of Nursing #1 via phone. NA #4 recalled receiving educational in-services after reporting the incident for abuse, neglect and misappropriation of property and receiving gifts from residents.<br><br>In a written statement by Nurse #2 dated 11/25/2024, Nurse #2 stated Resident #103 informed Nurse #2 on 11/24/2024 that she let NA #3 use her (Resident #103) debit card to pay for NA #3's electric bill that was due because NA #3 was pitiful. Resident #103 informed Nurse #2 that initially the debit card had $1900.00 and NA #3 returned the debit card on Thursday night (date unknown). Nurse #2 stated Resident #103 reported calling her bank to inquire of the debit card balance on Friday morning (date unknown) and was shocked and mad there was only $9.34. Nurse #2 reported Resident #103 stated when she (Resident #103) confronted NA #3 (date unknown) about the money spent on the debit card, NA #3 told Resident #103 she would give $50.00 back to Resident #103 and Resident #103 got mad because Resident #103 knew NA #3 had spent more than $50.00 from Resident #103's debit card.<br><br>In a phone interview with Nurse #2 on 12/3/2025 at 7:21 pm, she stated Resident #103 was alert and oriented and told her on 11/24/2024 that the reason Resident #103 gave NA #3 her debit card was because NA#3's family needed the money and NA #3 was to pay her back the money. Nurse #2 stated the Administrator, Director of Nursing and the Assistant Director of Nursing were notified upon learning Resident #103 was upset because her money had been drained (spent) from the debit card. She explained NA #3 was notified by the Administration team not to report to work on 11/24/2024, and Resident #103 was reimbursed for the lost money on the debit card. She stated Resident #103 was observed interacting with staff and residents with no changes in behaviors and staff received educational in-services on abuse, neglect and misappropriation of property and receiving gifts.<br><br>(continued on next page) |

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|---|---|
| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A police report for debit card fraud dated 11/24/2025 at 6:56 pm recorded Resident #103 reported NA #3 had used Resident #103's debit card and took $1900.00. The police officer recorded NA #3 stated Resident #103 had given her permission to use the debit card months ago to purchase food for herself and Resident #103. NA #3 reported after purchasing the groceries at Walmart, she returned the debit card to Resident #103. The police report stated Resident #103 was unable to provide any statements and/or proof money was missing from the debit card account.<br><br>A review of the expenditures reported by the debit card's bank on 11/25/2024 included the following:<br><br>On 10/23/2024, $442.45 spent at Piggly Wiggly (a grocery store)<br><br>On 11/2/2024, $506.50 spent at Walmart (retail store)<br><br>On 11/2/2024. $49.69 spent at Walmart<br><br>On 11/2/24, $87.06 spent at Dollar General (retail store)<br><br>On 11/3/24, $107.61 spent at Wal-Mart<br><br>On 11/3/2024, $60.00 spent at Cricket Wireless (mobile phone store)<br><br>On 11/4/2024, $5.09 spent at Piggy Wiggly<br><br>On 11/16/24, $887.85 spent at Real Estate Agent-Managers (rental company)<br><br>On 11/18/24, $118.90 spent at Real Estate- 530 Nunn Road (rental company)<br><br>The facility's investigation report dated 11/26/2024 and signed by former Director of Nursing #1 recorded Resident #103 reported on 11/24/2024 at 5:00 pm she had given a debit card to NA #3 to pay for her (NA #3) light bill that NA #3 had told her was a little over $100.00. Resident #103 reported NA #3 took her debit card and brought the debit card back the next day (date unknown). Resident #103 stated there was a $1900.00 balance on the debit card when Resident #103 loaned the debit card to NA #3. Resident #103 stated on Friday (date unknown) when she called the bank to check the balance of the debit card, there was a balance of $9.34 on the debit card. Resident #103 reported she asked NA #3 why she spent all of her (Resident #103) money and NA #3 did not have an explanation. NA #3 was suspended pending the investigation on 11/24/2024. On 11/25/2024, Resident #103 and Administrator contacted the bank of the debit card and was provided a list of unauthorized transactions that totaled $2264.85 that the facility reimbursed Resident #103. Resident #103 was issued a new debit card and educated by the former Director of Nursing #1 not to give or loan her debit card to any staff member or resident. The investigation report recorded no physical injury or harm and no mental anguish to Resident #103 and the former Director of Nursing #1 monitored the social well-being of Resident #103 for 72 hours with no negative findings. Resident #103's requested the local police department filed charges against NA #3. NA #3 was terminated on 11/26/2024. The investigation report reported Resident #103's allegation of misappropriation or property was substantiated and the investigation report was faxed to the State Agency on 11/27/2024.<br><br>(continued on next page) |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A psychiatric provider note dated 12/5/2024 recorded Resident #103 had mild dementia and was alert, oriented and in good spirits. Resident #103 had adjusted well to the facility with no acute psychiatric complaints noted or reported recently.<br><br>A review of check invoice dated 12/5/2024 for misappropriated funds due to employee theft in the amount of $2265.15 was requested by the Administrator for Resident #103.<br><br>A copy of a corporate check to Resident #103 dated 12/12/2024 was in the amount for $2265.15.<br><br>In a phone interview with the former Director of Nursing #1 on 12/5/2025 at 3:00pm, she stated Resident #103 had given her debit card to NA #3 to purchase some groceries for Resident #103 and NA #3 had returned the debit card to Resident #103. She recalled when Resident #103 checked the balance on the debit card, there was unexplained money missing off the debit card. She stated it appeared NA #3 had used the debit card over a period of time in November 2024 without the permission of Resident #103 to use. She stated NA #3 was suspending pending investigation and was terminated at the end of the investigation. She stated the local police and state agency were notified and facility reimbursed Resident #103 money. She reported skin assessments were conducted on residents with BIMS less than 8 and resident interviews were conducted on a BIMS greater than 8 with no further issue identified with misappropriation of property and/or exploitation. She stated education on receiving gifts and misappropriation of property was provided to the staff.<br><br>In a phone interview with the previous Administrator on 12/3/2025 at 3:31 pm, he stated Resident #103 gave NA #3 the debit card to buy her (Resident #103) groceries and NA #3 was not given permission to purchase items for herself (NA #3). He explained NA #3 was not given permission by Resident #103 to spend the amount of money not related for Resident #103's needs on the debit card. He stated the employee was suspended during the investigation of the allegation for misappropriation of property and terminated immediately upon completion of the investigation. He stated the facility refunded Resident #103 with a check in the amount of money identified as unauthorized use and Resident #103 was satisfied with the resolution of refunding her money.<br><br>The facility provided a plan of correction that was not acceptable to the State Agency as the facility did not conduct a systemic approach to prevent future incidents of misappropriation of residents' property.<br><br>2. A review of the facility's policy titled Abuse, Neglect, and Misappropriation of Property dated 5/27/16 and last reviewed on 1/31/25 revealed in part the definition of exploitation as taking advantage of a resident for personal gain.<br><br>Resident #4 was admitted to the facility on [DATE] with diagnoses that included heart failure, hypertension, diabetes, seizure disorder, depression, and schizophrenia.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was cognitively intact.<br><br>An initial allegation report dated 7/29/25 was sent from the facility to the State Agency alleging misappropriation of Resident #4's property. Details of the allegation stated NA #2 asked Resident #4 for money to feed her children.<br><br>(continued on next page) |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility's investigation report dated 8/4/25 was sent from the facility to the State Agency. The investigation report recorded that Resident #4 did give NA #2 money to feed her children. NA #2 was suspended pending the investigation, her employment was terminated on 8/1/25. The allegation was substantiated by facility staff.<br><br>An interview was conducted with Resident #4 on 12/3/25 at 10:10 AM. Resident #4 stated she did remember the incident when NA #2 came into her room and asked her for $20.00 to feed her children. Resident #4 said she did not feel $20.00 would be enough to feed her children so she gave her $65.00. She went on to say NA #2 stated she would pay Resident #4 back, but she did not. The facility did not reimburse Resident #4 or offer to reimburse her. Resident #4 indicated NA #2 told Resident #4 to tell the staff she was picking up food for Resident #4 so she would not get fired. Resident #4 never saw NA #2 again. Resident #4 stated this incident made her feel angry.<br><br>In an interview with the Social Services Director on 12/3/25 at 9:45 AM, she stated she could not remember the staff member that made her aware of the incident when NA #2 asked Resident #4 for money. She did not know if the funds were reimbursed to Resident #4.<br><br>An interview with the Assistant Director of Nursing was conducted on 12/3/25 at 10:20 AM, she stated she could not recall the name of the staff member that reported to her that a staff member had borrowed $20.00 to $30.00 from Resident #4 and did not repay the resident. She added she reported it to the Administrator and the Director of Nursing immediately after learning of the incident.<br><br>An interview was conducted with the Administrator on 12/3/25 at 10:30 AM, he stated the incident was reported to the Administrator and the Director of Nursing. The Director of Nursing and the Assistant Director of Nursing then went to interview Resident #4. Resident #4 reported that NA #2 asked Resident #4 for money to feed her children. The Administrator added it was the facility policy to replace missing items or money. He added the facility did not replace the money that was taken as he felt Resident #4 gave it freely.<br><br>In a follow-up interview with the Administrator on 12/3/25 at 3:45 PM, he stated he was not sure if the facility offered to replace the money that was taken. In this case he felt Resident #4 gave NA #2 the money voluntarily and that was why it would not have been reimbursed.<br><br>An interview with the Medical Director was held on 12/3/25 at 11:20 AM. She remembered that this incident was reported to her. She did not feel this incident caused any harm to the resident.<br><br>The facility provided a plan of correction for past non-compliance. The plan could not be accepted by the State Agency. |

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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to report allegations of abuse and misappropriation of property/exploitation to Adult Protective Services (APS) for 3 of 6 residents reviewed for abuse, neglect, misappropriation of property and/or exploitation (Resident #103, Resident #101 and Resident #74).<br><br>Findings included:<br><br>The facility's Abuse, Neglect and Misappropriation of Property policy statement last reviewed 1/31/2025 indicated the facility Administrator was responsible for reporting all investigation results of abuse, neglect and misappropriation of property to applicable State agencies as required by Federal and State law.<br><br>1. Resident #103 was admitted to the facility on [DATE].<br><br>An initial report dated 11/24/2024 for misappropriation of property was completed by the former Director of Nursing #1 and faxed to the State Agency. The initial report recorded the facility became aware on 11/24/2024 at 5:00 pm that Resident #108 alleged an employee, Nurse Aide (NA) #3 had borrowed money from Resident #103. The facility's initial report indicated the local law enforcement was notified of Resident #103's allegation on 11/24/2024 at 5:30 pm. There was no documentation that APS was notified of the allegation of misappropriation of property and/or exploitation.<br><br>The facility's investigation report dated 11/26/2024 and signed by former Director of Nursing #1 recorded Resident #103 had given a debit card to NA #3 to pay for her (NA#3) light bill that NA #3 had told her was a little over $100.00. Resident #103 stated there was a $1900.00 balance on the debit card when Resident #103 loaned the debit card to NA #3. Resident #103 stated NA #3 brought the debit card back and when Resident #103 checked the balance on the debit card days later, there was a balance of $9.34 on the debit card. The investigation report recorded the allegation was substantiated, and the facility reimbursed Resident #103 a total of $2264.85 for documented unauthorized use of Resident #103's debit card. The investigation report was faxed to the State Agency on 11/27/2024, and there was no documentation that APS was notified of the allegation of misappropriation of property and/or exploitation on the investigation report.<br><br>In a phone interview with the former Director of Nursing #1 on 12/5/2025 at 3:00pm, she stated she remembered the investigation into the allegation of misappropriation of property and/or exploitation for Resident #103. She stated the State Agency and local law enforcement were notified and she could not recall if the APS was notified. She stated APS should have been notified of the allegation of misappropriation of property and stated the Administration at the time would have been responsible for notifying APS.<br><br>In a phone interview with the previous Administrator on 12/3/2025 at 3:31 pm, he explained he did not know what the facility's policy was for notifying APS when Resident #103 reported the allegation of misappropriation of property and/or exploitation on 11/24/2024. He stated he could not say that APS was not notified or notified if it was not recorded on the investigation report. The previous Administrator stated APS should have been notified of the allegation.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345365 | A. Building<br>B. Wing | 12/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Signature Healthcare of Kinston | 907 Cunningham Road<br>Kinston, NC 28501 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview with the State Signature Clinical Coordinator on 12/6/2025 at 9:55am she stated APS should have been notified of Resident #103's allegation of misappropriation of property and/or exploitation and was unable to recall if APS was notified.<br><br>An attempt to interview APS was unsuccessful.<br><br>2. Resident # 101 was admitted to the facility on [DATE] with diagnoses including cerebral vascular accident (stroke). He was discharged from the facility on 9/19/25.<br><br>A facility Investigation Report dated 4/08/25 documented that on 4/05/25 at 1:40 PM, Housekeeper #1 started cursing at him because he wasn't moving his wheelchair down the hallway and had blocked her cart. Housekeeper #1 was witnessed cursing at the resident, and was escorted out of the building during the investigation. The facility investigation found two other employees heard the interaction and confirmed Housekeeper #1 did curse at the resident. The facility substantiated verbal abuse. The report documented that Adult Protective Services (APS) had not been notified.<br><br>Nurse Aide (NA) #5's written witness statement dated 4/05/25 documented that when Resident #101 was coming down the hallway in his wheelchair, Housekeeper #1 came behind him and stated for him to Move out of the way m******f*****, move b**** and then proceeded to push her housekeeping cart to his wheelchair to move him out of the way.<br><br>In a phone interview on 12/08/25 at 1:33 PM NA #5 stated Resident #101 had been propelling his wheelchair independently down the hallway. The hallway was crowded because other residents were on the other side of the hallway waiting to go outside to smoke. Housekeeper #1 got upset because Resident #101 was in her way. She started cussing at him in a threatening tone for him to move, which then made the resident angry. She then pushed her housekeeping cart into the back of his wheelchair. The other aide who witnessed the incident, NA #2, helped her to separate Housekeeper #1 and Resident #101. Once he was taken to his room, he calmed down and was back to baseline.<br><br>NA #2's written witness statement dated 4/05/25 documented that when NA #2 was passing out trays for lunch, Resident #101 was coming down the hall. Housekeeper #1 was behind him. She told him to move out of her way but Resident #101 did not hear her. Housekeeper #1 then shouted that y'all need to learn how to get the f*** out the d*** way and pushed her cart to the side. She yanked the resident's wheelchair, which upset the resident. Resident #101 got up out of his wheelchair and stated he would knock her out. Housekeeper #1 stated he wasn't going to do s*** m*****f*****, grabbed her housekeeping cart again and said what the f*** you going to do and then pushed her housekeeping cart into the resident. She then stated you need to get your black a** back to your room and get out of the way.<br><br>In a phone interview on 12/09/25 at 3:34 PM NA #2 stated she was passing out meal trays and Housekeeper #1 wanted to get past Resident #101, who was propelling himself in the wheelchair. Housekeeper #1 began cussing at him, telling him to get out of her way. Housekeeper #1 threatened Resident #101, stating if he didn't get out of the way, she would run into him with her cart and make him. She then pushed her cart into the back of the wheelchair. NA #2 and NA #5 separated the housekeeper from the Resident and NA #2 took Resident #101 back to his room. She stated once he calmed down, he was back to his baseline.<br><br>Resident #101 was unable to be interviewed.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Attempts to contact Housekeeper #1 were unsuccessful.<br><br>In a phone interview on 12/08/25 at 11:31 AM the facility Clinical Consultant stated the facility substantiated that Housekeeper #1 verbally abused and threatened Resident #101 with harm. She stated Housekeeper #1 was let go from the facility.<br><br>In a phone interview on 12/09/25 at 4:09 PM the Administrator stated the facility had substantiated verbal abuse.<br><br>In a phone interview on 12/09/25 at 4:05 PM, the Administrator stated former Director of Nursing #2 had been responsible for notifying APS and he wasn't sure if it was done. He stated he relied on her documentation that APS had not been notified and stated they should have been.<br><br>Attempts to contact former Director of Nursing #2 were unsuccessful.<br><br>3. Resident #74 was admitted to the facility on [DATE] with diagnoses including bipolar disorder and anxiety disorder.<br><br>A Facility Investigation Report dated 2/07/25 documented Resident #74 alleged Nurse Aide (NA) #5 had taken a 4-carat diamond gold and platinum ring that she had purchased online approximately one year prior. She stated she had shown the ring to NA #5 and the next morning the ring was gone. The investigation noted Resident #74 did see or know who took the ring but said NA #5 was the only person that knew it where it was located. The investigation report documented Adult Protective Services (APS) was not notified of the allegation.<br><br>In a phone interview with the previous Administrator on 12/3/2025 at 3:31 pm, he explained he did not know what the facility's policy was for notifying APS for the allegation of misappropriation of property and/or exploitation. He stated he could not say that APS was not notified or notified if it was not recorded on the investigation report. The previous Administrator stated APS should have been notified of the allegation. |

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| F 0641<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the physician's documented gradual dose reduction (GDR) as clinically contraindicated on the Minimum Data Set (MDS) assessment for 1 of 31 residents reviewed for MDS assessment accuracy (Resident #4).The findings included:Resident #4 was admitted to the facility on [DATE].A review of the psychiatric provider note dated 9/5/25 revealed an attempted dosage reduction to the psychotropic regiment was likely to impair the resident's function and exacerbate underlying psychiatric condition. confirmed she had completed that section of the MDS for the 9/17/25 assessment.The annual MDS dated [DATE] for Resident #4 indicated a GDR had not been documented by the physician as clinically contraindicated.An interview was conducted with MDS Nurse #1 on 12/5/25 at 10:55 AM who confirmed she had completed the Medication section of the MDS for Resident #4's 9/17/25 assessment. She stated the physician documented GDR as clinically contraindicated was marked no which was an error on her part and should have been marked yes. An interview with Administrator was held on 12/5/25 at 11:05 AM. He stated his expectation was for MDS assessments to be accurate. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for an evaluation for a Level II Preadmission Screening and Resident Review (PASRR) for a resident who was admitted to the facility with serious mental health diagnoses for 1 of 1 resident reviewed for PASRR (Resident #18).Findings included:A PASRR Level 1 Determination Notification Letter dated 8/11/25 indicated Resident #18 had a Level I PASRR with no expiration date and no mental or behavioral health restrictions. The hospital's Discharge summary dated [DATE] included bipolar disorder as a secondary diagnosis for Resident #18 and recorded Resident #18's psychiatric history consisted of bipolar disorder, post-traumatic stress disorder (PTSD) and depression that included significant anxiety and trauma history.Resident #18 was admitted to the facility on [DATE] with diagnoses including a bipolar disorder, an anxiety disorder, depression, PTSD and tremors.Physician progress notes dated 8/27/25 recorded Resident #18 had an history of bipolar disorder.Psychiatric physician notes dated 8/28/25 recorded Resident #18 had a history of depression, anxiety and PTSD, and Resident #18 reported a history of a bipolar disorder. Resident #18 was receiving scheduled Fluoxetine (antidepressant), Mirtazapine (antidepressant), Bupropion (antidepressant), Buspirone (antianxiety medication) and Primidone (anticonvulsant). The resident also had an as needed (PRN) order for Lorazepam (antianxiety medication) and Hydroxyzine (an antihistamine medication effective in treating anxiety) . The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #18 was not currently considered by the state level II PASRR process to have a serious mental illness or intellectual disability. The MDS indicated Resident #18 was cognitively intact and Resident #18's active psychiatric /mood disorders included a bipolar disorder, anxiety, depression and PTSD. Resident #18 had received anticonvulsive medications, antianxiety medication and antidepressant medications during the MDS assessment period. Resident #18's care plan dated 9/2/25 included a focus for the alteration in Resident #18's mood as evidenced by a bipolar disorder, anxiety, depression. The care plan was updated on 10/22/25 to include Resident #18 complained of seeing and hearing things that were not present. Interventions included consulting with psychiatry, reporting changes in mood to the physician and providing non-pharmacological interventions prior to initiation or increasing of psychotropic medications. The care plan included a focus for PTSD and the interventions included observing and reporting for signs and symptoms of re-traumatization that included anxiety, avoidance, depression, sleep disturbance and new or worsening behaviors. The care plan also indicated Resident #18 was a risk for drug related side effects due to the use of psychotropic medications that included antianxiety, anticonvulsants and antidepressants. Interventions included assessing and recording the effectiveness of drug treatment and monitoring and reporting signs of sedation, anticholinergic (reduced involuntary muscle movements) and /or extrapyramidal (drug-induced movement disorders primarily associated with antipsychotic medications) symptoms. There was no care plan that referenced a PASRR Level II.A medical provider note dated 10/23/25 recorded Resident #18 was having mild hallucinations and was receiving multiple psychiatric medications and pain medications. A routine order for Quetiapine (antipsychotic used to treat depression in patients with a bipolar disorder) was ordered on 9/5/25 and the dosage was increased from 25 milligrams (mg) to 50mg daily.A psychiatric progress note dated 11/20/25 recorded Resident #18's had increased hallucinations at night. Melatonin (medication for insomnia/difficulty sleeping) and Mirtazapine for bipolar disorder were discontinued as possible contributors to the hallucinations and Quetiapine was increased to 100mg at night for PTSD and nightmare disorder. The psychiatric progress notes also recorded Lorazepam prn had been changed to a scheduled dose of Clonazepam (antianxiety medication) three times a day on 8/28/25.There was no Level II PASRR evaluation found in Resident #18's electronical medical record (EMR).On 12/3/2025 at 10:24 am, the Social Worker was unable to provide documentation that a request for an evaluation for a Level II PASRR had been submitted for Resident #18. An interview was conducted with the Social Worker on 12/4/25 at 2:52 pm. She explained that Resident #18 had a PASRR Level I screening at the hospital that indicated he did not have a serious mental illness. She stated she assumed the hospital entered all of Resident #18's diagnoses including anxiety, depression, PTSD and bipolar disorder into the Medicaid Uniform Screening Tool (MUST) that would have triggered a PASRR Level II evaluation if necessary to be completed at that time. She further explained that she thought if a PASRR Level II determination evaluation was necessary, then it would have been completed at that time. She stated she was unable to see the information entered into MUST by the hospital |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff and Medical Director interview, the (a) facility failed to ensure that required emergency tracheostomy (trach) equipment, including an Ambu bag (self-inflating bag that pushes air into lungs), was kept at the bedside as ordered and as required by facility policy and (b) failed to ensure infection-control practices were followed during tracheostomy care for 1 of 2 residents reviewed for tracheostomy care (Resident #8).Findings included:(a) A review of the facility's Tracheostomy Policy revealed that, for emergency management, an emergency tracheostomy tube and an Ambu bag were required to be kept at the resident's bedside.A review of standing admission orders included maintain trach equipment at the bedside at all times, including the obturator (An obturator is a curved rod that fits inside the tracheal cannula, which is a tube inserted into the trachea during tracheostomy), a spare trach tube, and an Ambu bag.On 10/13/2025 Resident #8 was admitted with diagnoses including respiratory failure and tracheostomy status. A tracheostomy is a surgically created opening (stoma) in the windpipe (trachea).A review of the admission Minimum Data Set (MDS) dated [DATE], showed that trach care, suctioning, and oxygen therapy had been recorded under respiratory treatments at the time of admission.A review of Care Plan dated 10/13/2025 revealed resident at risk for adverse outcomes related to trach including increased oral secretions and dislodgement. Interventions included ensuring trach straps secure and suction per medical doctor orders.On 12/01/2025 at 11:15 am, Resident #8 was observed lying in bed with a trach in place. Four spare trach tubes and an obturator were present in the bedside table; however, no Ambu bag was at the bedside or in the bedside table. On 12/03/2025 at 11:41 am, another observation showed that no Ambu bag was present in Resident #8's room, bedside table or in bathroom. During an interview on 12/03/2025 at 11:52 am, Nurse #1 acknowledged that there had not been an Ambu bag at the bedside and stated the Ambu bag may be on the crash cart. When asked to locate it on the crash cart, Nurse #1 was unable to locate an Ambu bag. During an interview with the Director of Nursing (DON) on 12/03/2025 at 12:20 pm, the DON stated she had not known the facility's trach policy. At 12:23 pm, the DON accompanied the surveyor to the resident's room and confirmed that there was not an Ambu bag at the bedside. The DON looked at bedside, in bedside table, in closet, in bathroom and in roommate's closet. The DON stated that there should be an Ambu bag on the crash cart. The DON agreed that the Ambu bag was not immediately visible to a person approaching the crash cart. The DON then cut the crash cart's red tag and located an Ambu bag inside the cart. DON stated she was not sure why Nurse #1 was unable to locate the Ambu bag. On 12/03/2025 at 4:30 pm, maintenance staff provided a measurement showing that the distance between the crash cart and the resident's room had been 143 feet one way.An interview on 12/04/2025 at 11:28 am with the Medical Director revealed that the admission order for the Ambu bag was a standing order for a trach. Medical Director felt it would be okay if Ambu bag was kept on crash cart if nursing staff knew where to locate it. The Medical Director found it concerning nursing staff unable to locate Ambu bag on crash cart. (b) On 12/4/2025 at 11:00 am, an observation of tracheostomy care for Resident #8 showed Nurse #1 brought supplies into the room, placing them on the bedside table, and performing hand hygiene. Nurse #1 opened the trach kit on the bedside table and requested a Nursing Assistant (NA) #3 to hand her a cup, which NA #3 retrieved from a cart outside the room. Nurse #1 placed the cup on the bedside table, opened normal saline, and poured it into the cup. Nurse #1 put on sterile gloves from the trach kit and placed the sterile drape on the resident's lap. When the resident attempted to touch the drape, Nurse #1 held the resident's hands down while wearing sterile gloves, contaminating the sterile gloves. Without changing gloves or reestablishing sterility, Nurse #1 moved the cup of saline from the bedside table to the resident's lap, placing it onto the drape and continuing the procedure. While continuing to wear the contaminated sterile gloves, Nurse #1 lifted the resident's head and removed the old Velcro trach ties, applied new ties, removed the old dressing, cleaned the stoma site with normal saline and long cotton-tipped applicators, removed the inner cannula, inserted a new cannula, and disposed of supplies. After discarding gloves and supplies, Nurse #1 obtained a suctioning kit, put on sterile gloves from the package, and performed suctioning. At no time during the observation did Nurse #1 stop the procedure, change gloves, or re-establish sterility after contaminating the sterile gloves by touching the resident's hands and moving non-sterile items. Nurse #1 stated she was trained by another nurse on the floor on how to do tracheostomy care. She stated that she shadowed another nurse for about four days prior to doing tracheostomy care and working on the floor.An interview on |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews with staff, the facility failed to follow the approved menu for 1 of 7 residents on a pureed diet (Residents #80). The findings included: The Week 2 dietitian approved menu indicated residents on a pureed diet were to receive pureed cornbread. Resident #80 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing). Resident #80's physician orders dated [DATE] documented he was to receive a pureed diet. During an observation of tray line on [DATE] at 12:07 PM, [NAME] #1 plated Resident #80's meal which included pureed chicken, pureed broccoli, and pureed candied yams. There was no pureed cornbread or pureed bread product available to serve and none was observed on his tray. Resident #80's tray was then covered and put into the dining room cart for service. In an interview on [DATE] at 12:08 PM, [NAME] #1 stated she forgot to make a pureed bread item to serve. In an interview on [DATE] at 12:09 PM, the Corporate Dietary Manager (DM) confirmed [NAME] #1 did not serve a pureed bread option and after surveyor intervention, asked the Regional Dietary Manager to make some for service. Attempts to reach the Registered Dietitian were unsuccessful. |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.<br><br>Based on observations, record review, and interviews with staff, the facility failed to provide 1 of 3 meals observed at the regular scheduled times (lunch 12/01/25). The lunch meal was served 2 hours after the posted mealtimes to the dining room and all 5 halls. The findings included: The posted mealtimes documented lunch service in the dining room was to begin at 12:00 PM, the 500 hall at 12:15 PM, the 400 Hall at 12:30 PM, the 300 Hall at 12:45 PM, the 200 Hall at 1:00 PM, and the 100 Hall at 1:15 PM. Observation of the lunch meal service on 12/01/25 revealed the lunch meal trays arrived at 2:15 PM in the dining room, at 2:20 on the 500 Hall, at 2:23 PM on the 400 Hall, at 2:25 PM on the 300 Hall, at 2:32 PM on the 200 Hall, and at 2:40 PM on the 100 Hall. In an interview on 12/01/25 at 2:21 PM, the Regional Dietary Manager (acting as the interim dietary manager) confirmed the lunch trays were still being plated in the kitchen and had not been served to the 300, 200, and 100 Halls. She stated the lunch meal was being served late due to staffing issues in the kitchen. The dishes from the dinner meal on 11/20/25 had not been washed because the dietary aides who were working that night had quit without notice, so the dishes had to be washed the morning of 12/01/25. As a result, breakfast was served 2 hours late at approximately 10:00 AM, which affected when the dishes would be ready to use to serve lunch. In an interview on 12/3/25 at 10:30 AM, the Administrator stated he was aware of dining service being late in the past and the facility had been trying to address the concern, but staffing had not been identified as the reason for late meals. |