

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415049	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/24/2024
NAME OF PROVIDER OR SUPPLIER  Hebert Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  180 Log Road Smithfield, RI 02917	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46338</p> <p>Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to keep a resident free from sexual abuse for 1 of 2 residents reviewed, Resident ID #1.</p> <p>Findings are as follows:</p> <p>According to the State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, last revised February 2023, indicates that sexual abuse is defined as .any sexual contact of any type with a resident .Sexual abuse includes, but is not limited to unwanted intimate touching of any kind especially of breasts or perineal area .forced observation of masturbation .Generally, sexual contact is nonconsensual if the resident .lacks the cognitive ability to consent .</p> <p>Review of a facility reported incident submitted to the Rhode Island Department of Health on 6/20/2024 alleges in part, that Nursing Assistant (NA), Staff A, noticed that Resident #1's door was closed and when she opened it, she observed Resident ID #2 holding Resident ID #1's genitalia and was observed to be stroking it.</p> <p>Record review revealed that the alleged victim, Resident ID #1, was admitted to the facility in March of 2024 with diagnoses including, but not limited to aphasia (inability to speak), Alzheimer's disease, and dementia without behavioral disturbance. Additionally, s/he resides on a secured (locked) unit.</p> <p>Review of Resident ID #1's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 0 out of 15, indicating severely impaired cognition.</p> <p>Record review revealed that the alleged perpetrator, Resident ID #2, was admitted to the facility in December of 2023 with diagnoses including, but not limited to, major depressive disorder with severe psychotic disorder (symptoms that affect the mind with loss of contact with reality), anxiety disorder, and insomnia. Additionally, s/he resides on a secured (locked) unit.</p> <p>Review of Resident ID #2's MDS assessment dated [DATE] revealed a BIMS score of 0 out of 15, indicating severely impaired cognition.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During a surveyor interview on 6/20/2024 at approximately 12:00 PM with the Assistant Director of Nursing Services (ADNS), she revealed that Resident ID #1's room is like a dormitory where many residents gather, including Resident ID #2, to eat and watch television. She further revealed that she has never observed Resident ID #2 touch other residents inappropriately, although, she indicated to the surveyor that Resident ID #2 attempted to kiss her a couple of weeks ago.</p> <p>Record review failed to reveal evidence that after Resident ID #2 attempted to kiss the ADNS that the physician was notified of Resident ID #2's inappropriate sexual behaviors or that the care plan for Resident ID #2 was updated to include interventions to mitigate or monitor for such behaviors.</p> <p>During a surveyor interview on 6/20/2024 at 11:41 AM and at 4:43 PM with NA, Staff A, she revealed that she had worked the 11:00 PM to 7:00 AM shift on 6/19/2024 and indicated that at approximately 3:00 AM, she found Resident ID #2 in Resident #1's room, sitting in the chair. She indicated that she was unable to remove Resident ID #2 from Resident ID #1's room, as s/he became combative. Staff A revealed that at this time, she left Resident ID #2 in Resident ID #1's room unsupervised and did not return until 4:30 AM. She indicated that at this time, she was able to redirect Resident ID #2 back to his/her own room. She further revealed that at approximately 7:00 AM on 6/20/2024, she was sitting at the nurse's station when a nurse asked her to open Resident ID #1's door because it was closed. Staff A revealed that when she opened the door, she found Resident ID #2 sitting on Resident ID #1's bed and observed Resident ID #1 with his/her eyes closed, his/her adult incontinent brief was pulled to the side and his/her legs were resting on Resident ID #2's lap while s/he stroked Resident ID #1's genitalia.</p> <p>During a surveyor interview on 6/21/2024 at 1:39 PM with Licensed Practical Nurse, Staff D, she revealed that she worked the 11:00 PM to 7:00 AM shift on 6/19/2024 and indicated that at approximately 3:00 AM, she saw Resident ID #2 enter Resident ID #1's room and shut the door, as s/he does most nights. Staff D further revealed that Resident ID #2 became combative when she asked him/her to leave Resident ID #1's room, so she left him/her in the room, unsupervised, until approximately 4:30 AM when Staff A got him/her out. Furthermore, she indicated that she did not know when Resident ID #2 went back to Resident ID #1's room.</p> <p>Record review revealed the resident had previously exhibited inappropriate behaviors towards staff and other residents, including Resident ID #1, as evidenced by the following progress notes:</p> <p>- 1/2/2024 authored by Registered Nurse, Staff B, states in part .resident inappropriate with staff, walking around naked from the waist down motioning for someone to get in bed with [him/her]. resident redirected back to [his/her] room and given pants to put on .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>- 6/11/2024, authored by Licensed Practical Nurse, Staff C, indicated that Resident ID #2 was found sitting in a chair in Resident ID #1's room as [s/he] always does. Staff was alerted to the room and observed Resident ID #2 standing over Resident ID #1 telling [him/her] to get out in an aggressive manner. The staff explained that this is Resident ID #1's room and that s/he needed to return to his/her own room. Resident ID #2 refused to leave and just kept staring at Resident ID #1 trying to intimidate [him/her]. Resident ID #2 was pulling Resident ID #1's blanket away from a staff member that was trying to place the blanket on Resident ID #1. Staff C felt at this time that situation wasn't going to pass so staff removed Resident ID #1 from his/her room and sat him/her outside of the nurse's station. Resident ID #2 walked over to Resident ID #1 and kept starting at him/her. Resident ID #2 returned to Resident ID #1's room and won't keep [his/her] eyes off other resident and is occasionally walking to the doorway looking at Resident ID #1.</p> <p>Record review failed to reveal evidence that following the above-mentioned incidents, the physician was notified of Resident ID #2's behaviors, or that the care plan for Resident ID #2 was updated to include interventions to mitigate or monitor for inappropriate behaviors directed towards others.</p> <p>Review of a document titled, PSYCHIATRIC EVALUATION AND CONSULTATION, dated 4/16/2024 failed to reveal evidence that Resident ID #2's inappropriate behaviors from 1/2/2024 were addressed. Additionally, it stated that Nursing denies concerns and to monitor for behaviors.</p> <p>During a surveyor interview on 6/21/2024 at 4:37 PM with the Administrator, in the presence of the DNS, they were unable to provide evidence that Resident ID #1 was kept free from sexual abuse.</p> <p>Due to the facility's failure to contact the provider, update the resident's care plan to include interventions to mitigate and monitor for behaviors on 1/2/2024, 6/11/2024, when Resident ID #2 attempted to kiss the ADNS, and throughout the duration of the 11:00 PM to 7:00 AM shift on 6/20/2024, resulted in Resident ID #1 being sexually abused by Resident ID #2 as s/he was unable to form consent due to his/her cognitive impairment. Additionally, these failures placed all the cognitively impaired residents who reside on the secured unit at risk for more than minimal harm.</p> <p>Cross Reference F 679</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>46338</p> <p>Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to provide an ongoing program to support the residents in their choice of activities designed to meet their interests and support the well-being of each resident, based on the comprehensive assessment, care plan and preferences for 4 of 4 residents reviewed for activities who reside on the North B Unit ( a secured/locked unit), Resident ID #s 4, 5, 6 and 7.</p> <p>Findings are as follows:</p> <p>1. Record review of the Facility Assessment states in part, .Staffing for a 24-hour period includes: Dementia: North B .1-2 Activity Aides .</p> <p>Record review for the North B Unit failed to reveal evidence of an Activities calendar available or posted for the residents.</p> <p>During a surveyor interview with the Director of Recreation on 6/21/2024 at 2:51 PM, she provided a monthly Activities calendar for the month of June 2024 upon the surveyor's request.</p> <p>Record review of the June 2024 Activities Calendar revealed the following scheduled activities for the North B Unit:</p> <ul style="list-style-type: none"> <li>- 6/20/2024: 10:00 AM Coffee-N-More and 2:00 PM Afternoon Devotionals</li> <li>- 6/21/2024: 10:00 AM Manicures &amp; Music and 2:00 PM Friday Flicks</li> <li>- 6/22/2024- No activities scheduled</li> <li>- 6/23/2024- No activities scheduled</li> <li>- 6/24/2024: 10:00 AM Morning Movement and 2:00 PM Monday Matinee</li> </ul> <p>During surveyor observations of the North B Unit on 6/20/2024 at 2:00 PM failed to reveal evidence that the 2:00 PM Afternoon Devotionals had taken place.</p> <p>During surveyor observation on 6/21/12014 at approximately 9:00 AM one resident on the unit received a manicure. Additional observation at 2:00 PM failed to reveal evidence that the Friday Flicks was held.</p> <p>During a surveyor observation on 6/24/2024 at 2:00 PM failed to reveal evidence that the Monday Matinee was held.</p> <p>2A. Record review revealed Resident ID #7 was readmitted to the facility in January of 2022 with diagnoses including, but not limited to Alzheimer's disease, major depressive disorder, and anxiety disorder.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of an Admission Minimum Data Set (MDS) Assessment, Section F, titled, Preferences for Customary Routine and Activities, dated 6/16/2021, revealed an interview for activity preference which indicated that while the resident is in the facility, it is very important for the resident to have books, to read the newspaper, and magazines, to listen to music that s/he likes, to go outside to get fresh air when the weather is good, to do things with groups of people, and to do his/her favorite activities. It further revealed that it is somewhat important for the resident to be around animals such as pets and to participate in religious services or practice.</p> <p>Record review of the resident's care plan dated 10/19/2021 and revised on 10/2/2023 revealed that s/he is an elopement risk relative to impaired safety awareness with the intervention of providing structured activities such as walking outside, conversation, books, reorientation strategies which include signs, pictures, and memory boxes.</p> <p>Surveyor observations of Resident ID #7 on the following dates and times failed to reveal evidence that the resident was offered or participated in any group activities or 1:1 activity:</p> <ul style="list-style-type: none"> <li>- 6/20/2024 - 1:36 PM, resident was sitting in the activity/dining room alone staring out the window</li> <li>- 6/21/2024 - 8:32 AM, resident was observed in the activity/dining room sitting with another resident without staff present, s/he was observed falling asleep on and off with a sheet of paper titled Daily Chronicle in front of him/her - 6/21/2024 - 9:45 AM, the resident was observed to sitting alone in the activity room, falling asleep on and off</li> <li>- 6/21/2024 - 2:40 PM, s/he was sitting alone in the activity/dining room with his/her head on the table asleep</li> <li>- 6/21/2024 - 3:10 PM, s/he was observed standing in the hallway, then walking to his/her room</li> <li>- 6/21/2024 - 3:22 PM, s/he was observed coming out his/her room and then sat in the activity/dining room alone.</li> </ul> <p>2B. Record review revealed Resident ID #4 was admitted to the facility in November of 2021 with diagnoses including, but not limited to, dementia, dysphagia (difficulty swallowing), and anxiety disorder.</p> <p>Review of an Admission MDS Assessment, Section F, titled, Preferences for Customary Routine and Activities, dated 11/26/2021, revealed an interview for activity preference which indicated that while the resident is in the facility, it is very important for the resident to go outside to get fresh air when the weather is good and to keep up with news. It further revealed that it is somewhat important for the resident to participate in religious services or practice, to have books, to read the newspaper, and magazines, to listen to music that s/he likes, to do things with groups of people, and to do his/her favorite activities.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident ID #4's care plan dated 11/19/2021 stated s/he has the potential to be physically aggressive related to dementia with the intervention of giving him/her as many choices as possible for activities, encourage him/her to attend activities throughout the day for socialization as well as encourage him/her to participate in activities that promote exercise, and improve mobility.</p> <p>Surveyor observations of Resident ID #4 on the following dates and times failed to reveal evidence that the resident was offered or participated in any group activities or 1:1 activity:</p> <ul style="list-style-type: none"> <li>- 6/20/2024 - 11:00 AM, resident was observed sitting in his/her room alone with no television, music or reading materials</li> <li>- 6/20/2024 - 1:50 PM, s/he was observed sitting in his/her room alone</li> <li>- 6/20/2024 - 3:05 PM, s/he was observed sitting in his/her room alone</li> <li>- 6/21/2024 - 9:24 AM, s/he was observed sitting in his/her room alone</li> <li>- 6/21/2024 - 11:38 AM, s/he was observed sitting in her room alone</li> <li>- 6/21/2024 - 2:00 PM, s/he was observed in his/her room alone</li> <li>- 6/21/2024 - at approximately 2:30 PM, s/he was observed sitting down with his/her roommate in their room alone</li> <li>- 6/21/2024 - 3:26 PM, s/he was observed sitting in his/her room alone</li> <li>- 6/24/2024 - 11:30 AM, the resident was observed standing in his/her room alone</li> <li>- 6/24/2024 - 2:22 PM, s/he was observed entering another resident's room but was redirected out by a staff member and s/he became emotional and was observed to be crying</li> </ul> <p>2C. Record review revealed Resident ID #6 was readmitted to the facility in June of 2024 with diagnoses including, but not limited to, Alzheimer's disease, major depressive disorder, and vascular dementia.</p> <p>Review of an Admission MDS Assessment, Section F, titled, Preferences for Customary Routine and Activities, dated 6/14/2024, revealed an interview for activity preference which indicated that while the resident is in the facility, it is very important for the resident to keep up with the news. It further revealed that it is somewhat important for the resident to participate in religious services or practice, to have books, to read newspaper, and magazines, to listen to music that s/he likes, to do things with groups of people, and to do his/her favorite activities, to go outside to get fresh air when the weather is good.</p> <p>Record review of Resident ID #6's care plan dated 6/17/2024 stated that the resident has impaired cognitive function relative to dementia and Alzheimer's disease with the intervention of engaging him/her in simple, structured activities.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Surveyor observations of Resident ID #6 on the following dates and times failed to reveal evidence that the resident was offered or participated in any group activities or 1:1 activity:</p> <ul style="list-style-type: none"> <li>- 6/20/2024 - 1:30 PM - 2:00 PM, the resident was observed sitting in his/her room alone watching television</li> <li>- 6/20/2024 - 3:00 PM, s/he was observed propelling back and forth in the hallway</li> <li>- 6/21/2024 - 8:38 AM, the resident was observed sitting in the activity/dining room with another resident, s/he had a piece of paper titled Daily Chronicle in front of him/her which s/he was not reading - 6/21/2024 - 8:46 AM, the resident was observed falling asleep on and off in the activities/dining room</li> <li>- 6/21/2024 - 9:30 AM, s/he was observed propelling around the activity/dining room saying I've got to go continuously</li> <li>- 6/21/2024 - 9:45 AM, the resident was observed entering another resident's room, then propelled around the room for approximately 10 minutes - 6/21/2024 - 9:58 AM, s/he went back to the same room but s/he was redirected out of the room by staff</li> <li>- 6/21/2024 - 10:32 AM, the resident was observed being brought out his/her room by 2 nursing assistants after morning care, however s/he was left in the hallway where s/he self-propelled back and forth until approximately 12:00 PM - 6/21/2024 - 3:05 PM, the resident was observed entering a community bathroom where s/he was seen banging on the wall until the Activity Director got him/her out - 6/24/2024 - 10:30 AM, the resident was observed sitting in his/her room alone watching television</li> <li>- 6/24/2024 - 2:24 PM, s/he was observed in his/her room alone</li> </ul> <p>During a surveyor interview on 6/21/2024 at 2:47 PM with Resident ID #6's family member, s/he revealed that the facility does not have any activities for the residents. S/he indicated that s/he sees the residents sit or wander around the unit with no ongoing activities. Furthermore, s/he revealed that s/he often observes the residents walk in and out of each other's rooms until they are tired.</p> <p>2D. Record review revealed Resident ID #5 was readmitted to the facility in January of 2018 with diagnoses including, but not limited to, Alzheimer's disease, major depressive disorder, and anxiety disorder.</p> <p>Review of an Admission MDS Assessment, Section F, titled, Preferences for Customary Routine and Activities, dated 1/20/2018, failed to reveal evidence of an interview for activity preferences for this resident.</p> <p>Record review of his/her care plan dated 10/19/2020 and revised on 11/10/2023 failed to reveal evidence of a social care plan for the resident.</p> <p>Surveyor observations of Resident ID #5 on the following dates and times failed to reveal evidence that the resident was offered or participated in any group activities or 1:1 activity:</p> <ul style="list-style-type: none"> <li>- 6/20/2024 - 1:30 PM, the resident was observed pacing around his/her room</li> </ul> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 6/20/2024 - 2:08 PM, s/he was observed standing in the room near his/her roommate</p> <p>- 6/20/2024 - 3:05 PM, s/he was observed standing looking out the window</p> <p>- 6/21/2024 - 8:34 AM, the resident was observed standing on his/her side of the room pacing around</p> <p>- 6/21/2024 - 9:25 AM, s/he was observed pacing around his/her room</p> <p>- 6/21/2024 - 10:21 AM, s/he was observed moving a chair and the bedside table around his/her room. When the surveyor entered the room, s/he stopped and appeared to listen to the surveyor. - 6/21/2024 - 11:38 AM, the resident was observed looking at the back of the building from his/her window</p> <p>- 6/21/2024 - 2:05 PM, s/he was observed pacing around his/her room</p> <p>During a surveyor interview on 6/21/2024 at approximately 2:00 PM with Licensed Practical Nurse (LPN), Staff E, she revealed that she is not aware of an activities calendar for the North B Unit. She indicated that an activities aide comes to the unit once a day, either in the morning or in the afternoon, never both. She further indicated that when there is no activities aide on the unit, the Nursing Assistants do not complete activities. She further revealed that there are never activities scheduled for North B Unit on the weekends. Furthermore, she indicated that she notices that the residents tend to wander more when there are no activities for them to participate in.</p> <p>During a surveyor interview on 6/21/2024 at 2:51 PM with the Director of Recreation, she revealed that the activities calendars are set weekly, Mondays to Sundays. However, the North B Unit does not have activities scheduled on the weekends because she only has 1 aide scheduled for the whole facility on the weekends. Additionally, she revealed that the North B Unit's activities take place from 10:00 AM to 11:30 AM and from 2:00 PM to 3:00 PM. Furthermore, she was unable to explain why the 2:00 PM scheduled activities on 6/20/2024 and 6/21/2024 were not provided to the residents as indicated on the provided calendar.</p> <p>During a surveyor interview on 6/24/2024 at approximately 3:00 PM with the Administrator, she acknowledged that the North B Unit does not provide regularly scheduled activities. She indicated she would expect more scheduled activities on the unit. Additionally, she was unable to provide evidence that the facility provided an ongoing activities program to support the residents in their choice of activities designed to meet their interests and support the well-being of each resident, based on the comprehensive assessment, care plan and preferences.</p> <p>Cross Reference F 600</p>		