STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425368	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Johns Island Post Acute	3647 Maybank Highway Johns Island, SC 29455

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 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** Based on a review of the facility policy, observations, interviews, and record review, the facility failed to ensure that self^administration of medications was clinically appropriate as required for Resident (R)8, 1 of 1 resident reviewed for self^administration. Two medications, a nasal spray and an albuterol inhaler, were found at R8's bedside without an assessment or authorization for self^administration. This failure placed the resident at risk for medication errors and adverse health outcomes.Findings Include: Review of the facility policy titled Self^Administration of Medications, last revised February 2012, states: Residents have the right to self^administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation: 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self^administering medications is safe and clinically appropriate for the resident . 3. If it is deemed safe and appropriate for a resident to self^administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self^administer medications is re^assessed periodically based on changes in the resident's medical and/or decision^making status . 8. Self^administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self^administer are stored on a central medication cart or in the medication room. A licensed nurse transfers the unopened medication to the resident when the resident requests them. 9. Any medications found at the bedside that are not authorized for self^administration are turned over to the nurse in charge for return to the family or responsible party. Review of R8's Face Sheet revealed the facility admitted R8 on 03/04/26, with diagnoses including but not limited to: Paraplegia, muscle weakness, chronic obstructive pulmonary disease (COPD), interstitial pulmonary disease, asthma, sleep apnea, sleep deprivation, cognitive communication deficit and a need for assistance with personal care. Review of R8's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/11/26 revealed R8 had a Brief Interview for Mental Status (BIMS)^score of 15 out of 15 indicating R8 was cognitively intact. Further review revealed R8 experienced shortness of breath or trouble breathing when lying flat. Review of R8's Care Plan revealed, Focus: Resident is at risk for complications with the respiratory system due to Asthma, Chronic Obstructive Pulmonary Disease (COPD), Interstitial [NAME] Disease, and Sleep Apnea. Interventions/Tasks: Administer medications as ordered. Monitor for side effects/adverse reactions and effectiveness. No care plan for self-administration of medications noted. Review of R8's Physician Orders revealed: Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally every 6 hours as needed for SOB/Wheezing, and Fluticasone Propionate Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal)) 1 inhalation in each nostril in the morning for Rhinitis. No orders for self-administration of medications noted. During an observation and interview on 05/01/26 at 11:54 AM, a container on R8's bedside dresser contained a Ziploc bag with one Fluticasone Propionate (nasal spray) and one Albuterol Sulfate inhaler. R8 stated that she administers the medications herself as the facility did not provide them for her. R8 also stated that (continued on next page)

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	she was not provided any education for her to self-administer her medications. During an interview on 05/01/26 at approximately 12:30 PM, Licensed Practical Nurse (LPN)4 stated Yes, R8 administers her own nasal spray. When asked if R8 had an order allowing self-administration, LPN4 said No, I do not see one. LPN4 also stated she was unaware of what the facility's policy was regarding residents administering their own medications. During an interview and observation on 05/01/26 at 3:35 PM, the Director of Nursing (DON) stated that R8 should have an order to self^administer medications. The DON explained that the facility usually places an order for self^administration, and when it is time for the resident to self^administer, the nurse typically witnesses the administration. This allows the nurse to verify and document that the medication was administered. The DON stated that the process to have medications at the bedside would be the same and included in the order for self-administration. She also stated that the nurses should know what to do when medications are found at the bedside. They should take the medications and inform the resident that an order is required. The DON noted that staff should explain to the resident why the medication is being removed, the process for obtaining the appropriate order, and that the medication can be returned to the bedside once the order is in place, including how that process works. The DON observed the nasal spray and inhaler at R8's bedside and confirmed the findings. R8 stated that she had to use and supply her own medications, as the facility did not provide them to her.

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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** Based on review of facility policy, record review, interviews, and review of video footage, the facility failed to protect Resident (R)5 from physical abuse by R4. Specifically, on [DATE] at approximately 4:43 AM, R4, while in a wheelchair, rolled behind R5 placed his arm around R5's neck and began to choke R5. Certified Nursing Assistant (CNA)1, who witnessed the incident, separated both residents. Furthermore, the facility neglected to provide care and services to R5, following the physical altercation. Specifically, the altercation occurred on [DATE] at approximately 4:43 AM, R5 was placed in his room at approximately 5:03 AM. R5 was found in his room unresponsive and with no pulse at approximately 7:35 AM. During this time frame, the facility failed to assess R5, failed to conduct a body audit of R5, and failed to follow up with R5, after the physical altercation.On [DATE] at 3:58 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of [DATE]. The IJ was related to 42 CFR 483.12 - Freedom from Abuse, Neglect, and Exploitation.On [DATE], the facility provided an acceptable IJ Removal Plan. On [DATE], the survey team, validated the facility's corrective actions and removed the IJ. The facility remained out of compliance at F600 at a lower scope and severity of D.An extended survey was conducted in conjunction with the Complaint Survey for non-compliance at F600, constituting substandard quality of care.Findings include:Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program with a revision date of [DATE], documented, Residents have the right to be free from abuse, neglect . This includes but is not limited to . physical abuse .Review of the facility policy titled, Abuse and Neglect - Clinical Protocol with a revised date of [DATE], documented, Definitions 1. Abuse is defined . as the willful infliction of injury, . Instances of abuse of all residents, irrespective of any mental or physical condition . It includes . physical abuse . Neglect . means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress . Assessment and Recognition 1. The nurse will assess the individual and document related findings. Assessment data will include: a. Injury assessment (bleeding, bruising deformity, swelling etc.); b. Pain assessment; . g. Vital signs; . 2. The nurse will report findings to the physician .Review of the facility's video footage, in the presence of the Director of Nursing (DON), Administrator, Operations Manager, Regional Director of Clinical Services (RDCS)1 and RDCS2, revealed the following timeline on [DATE]:4:40 AM - R5 was sitting at the nursing station on the [NAME] Unit, in his wheelchair. R4, also in a wheelchair, was sitting in the common area directly across the nursing station on the [NAME] Unit, near the entry doors to the court yard.4:43 AM - R4 starts rolling towards R5, through the common area. R4 moves directly behind R5 and leans forward and places his arm around R5's neck. R5 responds by grabbing R4's arm with both hands. R4 continues to choke R5, as R5 was unable to get R4 to release his hold around R5's neck. R5's head begins to lean backwards by the force applied to his neck. CNA1 comes into view from off screen and approaches both residents. CNA1 grabs R4's arm and R4 released his hold. CNA1 than moves R5 to a desk in the corner of the room, where CNA1 was sitting and CNA1 has a seat back at the desk, with R5 next to the desk. R4 is still in the common area next to the nursing station.4:47 AM - Licensed Practical Nurse (LPN)1 comes into view and makes her way to the nursing station. CNA1 begins talking with LPN1, while CNA1 was still seated at the desk in the corner. LPN1 turns her attention to R4 and they begin to have a conversation. 4:51 AM - LPN1 sits down at the nursing station.4:52 AM - CNA1 sits down at the nursing station. R4 starts to move pass the tables in the common area to the hallway.5:03 AM - CNA1 gets up from the nursing station. CNA1 puts on gloves and rolls R5 to his room.5:07 AM - CNA1 exits the room.5:07 AM - 7:32 AM - Revealed no staff members entered R5's room to follow up with R5 after the physical altercation. At 7:07 AM and 7:12 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	AM, staff members were in the area of R5's room, however the angle of the video footage could not verify, entry into R5's room. 7:33 AM - CNA5 enters R5's room.7:35 AM - CNA5 rushes out of R5's room and continues down the hall. CNA5 and LPN2 return to the room,7:40 AM - Emergency Medical Services (EMS) and fire rescue arrive on scene.7:51 AM - Police officer arrive on scene.8:00 AM - Two more police officers arrive on scene. 8:44 AM - Coroner arrives on scene.Review of R4's Face Sheet revealed R4 was admitted to the facility on [DATE], with diagnoses including but not limited to, hereditary and idiopathic neuropathy, dementia, moderate, with other behavioral disturbance, insomnia, and hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease.Review of R4's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed R4 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated R4 suffered from moderate cognitive impairment. Further review of the MDS revealed R4 had no physical or verbal behavioral symptoms directed toward others. Review of R4's Progress Note dated [DATE] at 5:16 AM, revealed a behavior note which documented, Per [CNA1] she witnessed that rolled his wheelchair behind [R5] and began to choke him while choking him aide ask [R4] to let him go and he refused aide had to get up and remove resident hand from around [R5's] neck. Resident started picking with another resident and just wanted to argue with the staff.Review of R4's Care Plan with an initiated date of [DATE], revealed a focus on Insomnia: Resident has difficulty sleeping related to insomnia. The interventions directed staff to, Observe for side effects and effectiveness of antidepressant med use and report to physician as indicated. Further review of the Care Plan revealed a focus on Medication - Antidepressant: Resident requires Antidepressant medication related to sleep/insomnia. with an initiated date of [DATE]. The interventions directed staff to, Observe and report signs of . confusion, agitation. Observe the resident's mood and response to medication. Further review of the Care Plan revealed a focus on Psychosocial - Well-being: Resident is at risk for psychosocial well-being concerns related to Dementia with an initiated date of [DATE]. The interventions directed staff to, Observe for . increased agitation .Review of R5's Face Sheet, revealed R5 was admitted to the facility on [DATE], with diagnoses including but not limited to, age-related osteoporosis with current pathological fracture, chronic obstructive pulmonary disease, atherosclerotic heart disease, presence of xenogenic heart valve, dementia, epilepsy, spondylosis and need for assistance with personal care.Review of R5's 5-day MDS with an ARD of [DATE], revealed R5 had a BIMS score of 5 out 15, which indicated R5 suffered from severe cognitive impairment. Review of R5's Progress Note dated [DATE] at 5:36 AM, documented, [CNA1] witnessed that rolled his wheelchair behand [R5] and began to choke him while choking him aide ask [R4] to let him go and he refused aide had to get up and remove resident hand from around [R5] neck. resident has been separated. DON has been notified.Further review of R5's Progress Notes revealed a note dated [DATE] at 8:00 AM, which documented, Note Text: Late Entry: During rounds, CNA alerted nurse patient not [sic] was not responding to verbal stimuli. Nurse rushed to room to assess patient, after verbal stimuli and physical stimuli initiated, patient found to by pulseless. Patient was DNR. EMS arrived on site to assist, and pronounced patient expired at 0740. Coroner on site.During an interview on [DATE] at 1:36 PM, the Administrator stated, The nurse was in the area of the resident. He [R5] wasn't assessed. I did not see the resident get assessed.During an interview on [DATE] at 1:37 PM, the DON stated, There was an altercation with [R4] and [R5]. [R4] put his arm around [R5] and the CNA had to pull them apart. She only said he put his arm around his neck. She told me it looked like he was being choked. A body audit was conducted after he expired. When asked if an assessment or body audit was conducted after the physical altercation, the DON responded, Not that I know of.During an interview on [DATE] at 1:42 PM, RDCS2 stated, Body audits, assessments should be done to assess for any injuries. The agency nurse and CNA just didn't do them.During an interview on [DATE] at 3:18 PM, CNA5 stated, I got to [R5's] room about 7:15 AM, he was laying on his stomach. The other nurses were down there, they had to see that. I just peeked in there. I told the roommate [R5's roommate] I would be back. I did the rest of my rounds. I walked back down and I (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	turned the light on in [R5's] room, the roommate told me to check on him cause he was talking. I called his name and he didn't say anything. I gave him a little shake and he was unresponsive. Stuff was coming out of his mouth, like drool. The drool was bubbly and his eyes were closed. I ran and asked the nurse, the nurse said he should be fine from the report I got. She went and checked, she said he was getting cold. I got the vital machine and we couldn't get none (referring to the residents pulse). We verified DNR. The EMS did their thing. During shift change, I was told he was sitting up front in his wheelchair. [R4] and [R5] were arguing. [R4] is always arguing with people. He [R4] gets physical with staff and patients.During an interview on [DATE] at 1:31 PM, the DON stated, The night it happened we had an agency nurse and clearly we saw that she did not do any assessments. Everything had already occurred by the time I got here. I did not do any follow up till I got here. We have to do extensive training.During an interview on [DATE] at 4:39 PM, CNA1 stated, [R5] was sitting in the dining room talking to me. [R4] started talking and rambling. [R4] rolled up behind [R5] and placed his arm around his shoulder and neck. I got up and released his hand from around his neck. [R5] was talking trash. I notified the nurse. I asked him if he was ok, he said Yes. I took him [R5] down the hall, got to his room, he stood up on his own, took his pants off, and got in his bed himself. He didn't show any signs. He told me thank you for handling that man for me. I covered him up and started doing my rounds. His roommate rung his bell at 6:57 AM, I told him to give me a minute. I looked over at [R5] and he was laying on his side and I walked out. The nurse didn't do any vitals. I looked at him, there was no changes in his breathing.On [DATE], the facility provided an acceptable IJ Removal Plan, which included the following: . Summary of Incident:On 4-24-26 at approximately 4:;43am [sic] Resident 4 while in a wheelchair, rolled behind Resident 5, who was also in a wheelchair, and placed his arm around R5's neck and began to choke R5. CNA1 who witnessed the incident, separated both residents and remained in the common area with both of the residents. Neither resident appeared to be in any distress. CNA assisted Resident 5 to bed at approximately 5:03am.Immediate Action Taken:1) Resident 5 expired on 4-24-26. Coroner was at the facility.2) Resident 4 remains at the facility and was seen by NP on 4-24-26 with psych and medical director collaboration and new orders noted.3) Education initiated with all staff by DON and RDCS on 4-30-26 to review abuse and neglect and reporting policy and procedure if abuse or neglect occurs, specifically with regard to separating residents and staff will ensure that they are safe and kept apart and assessment and evaluation of resident following an altercation and notifications and documentation. Blast test sent via [NAME] as well as phone calls - if staff did not answer voicemails were left with education information and will obtain wet signature from staff on next scheduled shift. All agency staff will be [sic] received the education on their next scheduled shift at facility.4) Per audit of staff in facility - 2 nurses were identified with agency who had not received the education at start of their shift and they were brought in and education done by RDCS on [DATE] at 3:15 pm.5) Audit of FRIs for last 30 days complete by RDCS on 4-30-26 to ensure that all evaluations and assessments were complete and that residents were kept separated. 6) Audit tool for resident to resident altercations reviewed with Operations Manager and Administrator and DON by RDCS on 4-30-26 to ensure understanding of follow up after a reportable event or altercation to ensure all evaluations and assessments are complete and residents are kept safe.7) Education will be provided to all newly hired staff and agency staff prior to next scheduled shift.ADHOC QA MEETING HELD ON 4-30-26.Members present: [name] LNHA, [name] Operations Manager, [name] RN-DON, [name] RN RDCS.Members via phone were: [name] Medical Director. [name] Medical Director* Root Cause of Issue is identified as failure of facility to ensure a resident was protected from abuse and following a resident to resident altercation there was failure to assess the resident for injury.* Education was initiated for all staff on 4-30-26 by DON and RDCS regarding abuse and abuse reporting and steps to follow following a resident to resident altercation. Abuse and Neglect Policy reviewed.* Audit complete by RDCS on 4-30-26 on Facility Reportable Incidents in last 30 days to ensure that all notifications and evaluations were complete.* DON and Administrator educated on 4-30-26 by RDCS (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	regarding checklist to utilize following each resident to resident altercation to ensure all evaluations are complete.* Education will be provided to all newly hired staff and agency staff prior to next scheduled shift.The above components have been implemented as of 5-1-26 by 10am.

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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** Based on review of facility policy, record review, and interviews, the facility failed to report to the State Agency (SA), two incidents of resident to resident phsyical abuse, in a timely manner. For 2 of 3 residents reviewed.(Cross Reference F600)Findings include: Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program with a revision date of April 2021, documented, Residents have the right to be free from abuse, neglect, . Policy Interpretation and Implementation The resident abuse, neglect, . program consists of a facility-wide commitment and resource allocation to support the following objectives: . 9. Investigate and report any allegations within timeframes required by federal requirements . Review of R4's Face Sheet revealed R4 was admitted to the facility on [DATE], with diagnoses including but not limited to, hereditary and idiopathic neuropathy, dementia, moderate, with other behavioral disturbance, insomnia, and hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease. Review of R4's Progress Note dated 04/24/26 at 5:16 AM, revealed a behavior note which documented, Per [CNA1] she witnessed that rolled his wheelchair behind [R5] and began to choke him while choking him aide ask [R4] to let him go and he refused aide had to get up and remove resident hand from around [R5's] neck. Resident started picking with another resident and just wanted to argue with the staff. Review of R5's Face Sheet, revealed R5 was admitted to the facility on [DATE], with diagnoses including but not limited to, age-related osteoporosis with current pathological fracture, chronic obstructive pulmonary disease, atherosclerotic heart disease, presence of xenogenic heart valve, dementia, epilepsy, spondylosis and need for assistance with personal care. Review of R5's Progress Note dated 04/24/26 at 5:36 AM, documented, [CNA1] witnessed that rolled his wheelchair behand [R5] and began to choke him while choking him aide ask [R4] to let him go and he refused aide had to get up and remove resident hand from around [R5] neck. resident has been separated. DON has been notified. Review of the facility's video footage revealed that on 04/24/26 at approximately 4:43 AM, R4 starts rolling towards R5, through the common area. R4 moves directly behind R5 and leans forward and places his arm around R5's neck. R5 responds by grabbing R4's arm with both hands. R4 continues to choke R5, as R5 was unable to get R4 to release his hold around R5's neck. R5's head begins to lean backwards by the force applied to his neck. CNA1 comes into view from off screen and approaches both residents. CNA1 grabs R4's arm and R4 released his hold. CNA1 than moves R5 to a desk in the corner of the room. Review of the facility's reportable Accident/Incident dated 04/24/26, revealed a 2 hour reportable for physical abuse with the date and time of Reportable Incident documented as 04/24/26 at 8:01 AM. During an interview on 04/30/26 at 1:42 PM, the Regional Director of Clinical Services (RDCS)1 stated, It did not get to me in time. It was reported to the DON, she's new, the phone call didn't come to me till about 8:00 AM. At that point it was already late, so we needed to figure this all out before (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	we report. During an interview on 05/01/26 at 1:31 PM, the Director of Nursing (DON) stated, I called the Administrator, the disconnect was the day prior, that Thursday and he called the nurse consultant to do the reportable. When I called the Administrator, I though he was going to do it [in reference to reporting the resident to resident physical abuse]. I should have called and followed up that the nurse consultant was notified. The nurse consultant does the reportables for all our buildings. During an interview on 05/01/26 at 2:01 PM, the Administrator stated, Our abuse coordinator is [name of Operations Manager], they called [DON], [DON] called [Operations Manager] and [Operations Manager] did not communicate the information out timely. Review of a 2 Hour Report revealed an incident submitted to the SA alleging physical abuse between R6 and R7 on 04/23/26 at 3:45 PM. Review of a submission report had a timestamp of 04/23/26 at 4:04 PM. Review of a Five-Day Follow-Up Report submitted to the SA on 04/29/26 at 04:01 PM via email indicated a physical abuse incident occurred between R6 and R7 on 04/23/26 at 3:45 PM. Review of the R6's Electronic Medical Record (EMR) indicated a Social Services Note dated 04/23/26 at 12:31 PM that read, Late Entry:Note Text: SSD notified of incident with roommate in common area. SSD spoke to resident to confirm that he was okay and had been checked out by nursing staff. An additional note dated 04/23/26 at 1311 (1:11 PM) read, Resident at DR table after eating lunch, Party B came over to table and begin to use bad words toward resident A, separation took place at this time. During a telephone interview with Licensed Practical Nurse (LPN)6 on 04/30/26 at 2:56 PM, she stated R7 had rolled up to R6 in the dining room table, started cussing and kicked him in his shin. LPN6 confirmed this incident happened right after lunch time, approximately 1:00 PM. During an interview with the Social Services Director on 05/01/26 at 11:30 AM, she stated, she was unsure of the exact time of the incident. She stated her times may have been incorrect, but she sure it occurred after 11:15 AM, due to having held a care plan meeting with one of the residents earlier that day. During an interview with the DON on 05/01/26 at 12:54 PM, she stated the incident occurred around 1 PM, following lunch. She confirmed the incident had been reported late and stated the Regional Director of Clinical Services (RDCS)1, who is a DON at another facility typically does their reporting for them. During an interview with RDCS1 on 05/01/26 at 5:15 PM, she acknowledged the incident was reported late due to her having to log into the system and report off of the nursing notes and what is in the medical record.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, and interviews, the facility failed to thoroughly investigate an incident of resident to resident physical abuse involving Resident (R)4 and R5, for 1 or 3 residents reviewed.(Cross Reference F600 and F726)Findings include:Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program with a revision date of April 2021, documented, Residents have the right to be free from abuse, neglect, . This includes but is not limited to . physical abuse . Policy Interpretation and Implementation The resident abuse, neglect, . prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 3. Ensure adequate staffing and oversight/support . 6. Provide staff orientation and training/orientation programs . 8. Identify and investigate all possible incidents of abuse, neglect, . 9. Investigate and report . 10. Protect residents from any further harm during investigations .Review of the facility's video footage revealed that on 04/24/26 at 4:43 AM, R4 starts rolling towards R5, through the common area. R4 moves directly behind R5 and leans forward and places his arm around R5's neck. R5 responds by grabbing R4's arm with both hands. R4 continues to choke R5, as R5 was unable to get R4 to release his hold around R5's neck. R5's head begins to lean backwards by the force applied to his neck. CNA1 comes into view from off screen and approaches both residents. CNA1 grabs R4's arm and R4 released his hold. CNA1 than moves R5 to a desk in the corner of the room, where CNA1 was sitting and CNA1 has a seat back at the desk, with R5 next to the desk. And R4 still in the common area next to the nursing station.Review of the facility's reportable folder revealed a typed Witness Statement signed on 04/24/26, the statement documented, [CNA1] was sitting at the nurse's station and [R5] was sitting by the desk. [R4] was sitting in his wheelchair and approached [R5] from the back, reached around him, placing his arms around [R5's] shoulder area. [CNA1] jumped up from chair to help assist separate [R5] and [R4] meanwhile [R5] was saying Get off of me, get off of me. [CNA1] was able to separate [R5] and [R4], rolling [R5] away from [R4] [CNA1] then wheeled [R5] back to his room to assist him back to bed. After locking his wheelchair [R5] stood up and took his pants off, and got into the bed while stating, Thank you for helping me. [CNA1] placed the covers on [R5] and walked away to assist another resident. Around 0557 [CNA1] went down the hall to answer the call light in room [ROOM NUMBER]. [R5's roommate], the roommate of [R5], hit the call light but during this time [R5] was facing the left side towards the window and appeared to be sleeping. The witness statement was signed by CNA1 and the Operations Manager on 04/24/26. Further review of the reportable folder revealed it's content to include: 2 hour and 5 day reportables, a summary of events, residents' Face Sheet, summary of video footage, and two other witness statements that both documented, I did not witness the incident.During an interview on 05/01/26 at 1:31 PM, the Director of Nursing (DON) stated, This is the statement when we all watched the video, I was typing and CNA1 signed. We wanted to make sure we had an accurate statement from her. She was really nervous and shaking really bad. The other signature looks like the Administrator's. [CNA1] was the only one who witnessed the actual incident. We did not interview any other residents, cause there were no other residents around when we viewed the footage. During an interview on 05/01/26 at 2:01 PM, the Administrator stated, I didn't sign it (referencing the typed witness statement) so I can't make a statement to how it was produced. They reviewed the footage with [DON] to help her compose a statement. There was no follow ups with other residents on the unit because it was a resident to resident.During an interview on 05/01/26 at 2:07 PM, the Operations Manager stated, It (referencing the typed witness statement) was produced after we called her back about what she had witnessed. We wanted to talk with her about what she saw. I was here with [[NAME] Director of Clinical Services (RDCS)2] and (DON), one of them had typed it up while watching the footage. We kept asking her questions about what she saw. We wanted to make sure we had all the details. I was the other signature. We did not guide or coerce her witness statement.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, and interviews, the facility failed to create a Comprehensive Person Centered Care plan for Resident (R)4, related to his aggressive behaviors and R8 related to self administration, for 2 of 3 residents reviewed for Care Plans.Findings include:Review of the facility policy titled, Behavioral Assessment, Intervention, and Monitoring with a revision date of February 2025, documented, Policy Statement 1. Residents will have minimal complications associated with the management of altered or impaired behavior . Policy Interpretation and Implementation . 2. As part of the comprehensive assessment, staff evaluate (based on input from the resident, family and caregivers, review of the medical record, and general observations): a. the resident's usual patterns of cognition, mood, and behavior; . 3. The nursing staff identify, document, and inform the physician about specific details regarding changes in the an individual's mental status, behavior, . 5. New onset or changes in behavior are evaluated and documented, regardless of the degree of risk to the resident or others. Interventions and Management 1. The IDR evaluates behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to the resident, and develops a plan of care accordingly. 3. The care plan includes, as a minimum: a a description of the behavioral symptoms, . b. targeted and individualized interventions for the behavioral and/or psychosocial symptoms; . d. specific and measurable goals for targeted behaviors; and e. how the staff will monitor the effectiveness of the interventions. 4. Interventions are individualized and part of an overall care environment . Monitoring 1. The IDR monitors for and documents any new, worsening, or improved symptoms in the resident's behavior, mood, and function .Review of the facility policy titled, Care Plans - Comprehensive with a revised date of September 2010, documented, An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Interpretation and Implementation 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident . 2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. 3. Each resident's comprehensive care plan is designed to: a. incorporate identified problem areas; . e. Reflect treatment goals, timetables and objectives in measurable outcomes; . g. Aid in preventing or reducing declines in the resident's functional status . 4. Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools . 5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes . 6. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, .Review of R4's Face Sheet revealed R4 was admitted to the facility on [DATE], with diagnoses including but not limited to, hereditary and idiopathic neuropathy, dementia, moderate, with other behavioral disturbance, insomnia, and hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease.Review of R4's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/02/26, revealed R4 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated R4 suffered from moderate cognitive impairment. Further review of the MDS revealed R4 had no physical or verbal behavioral symptoms directed toward others. Review of R4's Care Plan dated with an initiated dated of 07/28/25, revealed a focus on Insomnia: Resident has difficulty sleeping related to insomnia. The interventions directed staff to, Observe for side effects and effectiveness of antidepressant med use and report to physician as indicated. Further review of the Care Plan revealed a focus on Medication - Antidepressant: Resident requires Antidepressant medication related to sleep/insomnia. with an initiated date of 07/28/25. The (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions directed staff to, Observe and report signs of . confusion, agitation. Observe the resident's mood and response to medication. Further review of the Care Plan revealed a focus on Psychosocial - Well-being: Resident is at risk for psychosocial well-being concerns related to Dementia with an initiated date of 08/25/25. The interventions directed staff to, Observe for . increased agitation . Further review of R4's care plan did not reveal a targeted individualized care plan related to R4's aggressive behaviors, prior to the resident to resident physical abuse on 04/24/26.Review of R4's Care Plan with a date initiated on 04/24/26, revealed a focus on Psychosocial- Behavior: Exhibits or is at risk for behavioral symptoms grabbing others/ invasion of privacy due to: dementia. Review of this care plan revealed it was initiated after the resident to resident physical abuse on 04/24/26.Review of R4's Progress Note dated 04/24/26 at 5:16 AM, revealed a behavior note which documented, Per [CNA1] she witnessed that rolled his wheelchair behind [R5] and began to choke him while choking him aide ask [R4] to let him go and he refused aide had to get up and remove resident hand from around [R5's] neck. Resident started picking with another resident and just wanted to argue with the staff.Review of R5's Progress Note dated 04/24/26 at 5:36 AM, documented, [CNA1] witnessed that rolled his wheelchair behind [R5] and began to choke him while choking him aide ask [R4] to let him go and he refused aide had to get up and remove resident hand from around [R5] neck. resident has been separated. DON has been notified.Review of R4's Progress Note dated 03/03/26 at 6:41 PM, revealed a nurse's note which documented, Resident and roommate [name] were observed arguing this morning after shift change. Both resident and roommate were making threats towards each other. Staff separated the two men at this time. This has been an ongoing problem, being that both men believed the other was the problem .During an interview on 04/30/26 at 3:18 PM, CNA5 stated, [R4] is always arguing with people. He gets physical with staff and patients. A CNA gave him his lunch tray and [R4] came out the room with the lunch tray on the bedside table and he was cursing, like he always does, and he was running the bedside table into the CNA. I think this happened the same day (referencing the resident to resident altercation involving R5). From what I see, he is always that aggressive. Months ago, when [name of former roommate] was his roommate, he took a shoe helper and smacked [roommate] in his face. [R4] does have behaviors. He's mean to everyone. They tell us to keep it simple, don't say too much.During an interview on 04/30/26 at 3:36 PM, CNA2 stated, This morning, [R4] was eating his breakfast, he was cussing at me when i asked if he was done. One day he kept pushing his table into my legs pretty hard. He is angry and aggressive on a daily basis. The nurses are aware of his behaviors.During an interview on 05/01/26 at 11:38 AM, CNA6 stated, Recently he's (referencing R4's behaviors) been aggressive a lot, verbally.During an interview on 05/01/26 at 11:41 AM, CNA4 stated, He (referencing R4's behaviors) is very stern and has a harsh attitude. He is verbally aggressive.During an interview on 05/01/26 at 11:48 AM, the Licensed Medical Social Worker (LMSW) and the Social Worker Assistant (SWA) both revealed they were not aware of R4's behaviors and have not observed R4's behaviors.During an interview on 05/01/26 at 12:00 PM, the MDS Coordinator stated, I do medical care plans. I oversee and review all care plans. I complete the MDS and social services completes behavior MDS. I don't look at everyone of them, but I make sure things are in place. When asked about R4's lack of behavior care plan and indications in the MDS, the MDS Coordinator stated, Good question. I can assume the Psychosocial was put in to cover a broad spectrum.During an interview on 05/01/26 at 1:31 PM, the Director of Nursing (DON) stated, I wouldn't know why he (R4) wasn't care planned for behaviors. Care plan is done by MDS or SS. I'm not sure, there has to be a disconnect, cause when I see him, he is very pleasant.During a follow up interview on 05/01/26 at 2:49 PM, the DON stated, I'll have someone look. MDS does the care plans. It's (referencing R4's behaviors) discussed in our IDT meetings and then the care plans are updated.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review, interviews, and review of facility policy, the facility failed to ensure the comprehensive care plan was updated and revised to reflect changes in condition and care needs for 1 of 2 residents (R8) reviewed for care plans. The care plan was not updated when R8's peripherally inserted central catheter (PICC) line was removed, and it did not include interventions related to self^administration of medications. This failure created the potential for unmet needs and inconsistent care. Findings Include: Review of the facility policy titled, Care Plans - Comprehensive with a revised date of September 2010, documented, Policy Statement: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Interpretation and Implementation: 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident . 2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. 3. Each resident's comprehensive care plan is designed to: a. incorporate identified problem areas; . e. Reflect treatment goals, timetables and objectives in measurable outcomes; . 8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. 9.The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: a. When there has been a significant change in the resident's condition . Review of the facility policy titled Self^Administration of Medications, last revised February 2012, documented: Residents have the right to self^administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation: 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self^administering medications is safe and clinically appropriate for the resident . 3. If it is deemed safe and appropriate for a resident to self^administer medications, this is documented in the medical record and the care plan.Review of R8's Face Sheet revealed the facility admitted R8 on 03/04/26, with diagnoses including but not limited to: Lupus, cognitive communication defect, paraplegia, and a need for assistance with personal care. Review of R8's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/11/26 revealed R8 had a Brief Interview for Mental Status (BIMS)^score of 15 out of 15 indicating R8 was cognitively intact. Further review revealed R8 received Intravenous (IV) medications and had IV access while a resident of this facility and within the last 14 days. Review of R8's Care Plan revealed, Focus: Vascular Access: Resident is at risk for complications due the presence of a [] Central line [] Midline [] Peripheral line [x] PICC line [] Port-A-Cath with (enter number of lumens) for the treatment of long term IV antibiotic therapy r/t osteomyletitis [sic] initiated on 3/10/26. No care plan for self-administration of medications noted. Review of R8's Progress Note dated 04/27/26 at 7:27 AM, documented a Medication Administration Note that documented, OK to DC PICC line PICC Line was removed on 4/28/26 at her ID appointment. Review of a Consultation Report dated 04/28/26 documented, Diagnosis: PICC line was D/c'd today and removed.During an interview on 05/01/26 at 11:54 AM, R8 stated, My PICC line had been removed a few days ago, on Tuesday by the surgeon.During an interview on 05/01/26 at approximately 12:45 PM, Licensed Practical Nurse (LPN)4 stated [R8] does not have a PICC, LPN4 was unaware when R8's PICC was removed, and said She should have an order in her chart for when it was discontinued, but I'm not seeing one. She further stated that R8 was still care planned for having a PICC line. LPN4 also said Yes, when asked if R8 self-administers her nasal spray. LPN4 also stated she was unaware of what the facility's policy was regarding residents administering their own medications. During an interview on 05/01/26 at 3:35 PM, the Director of Nursing (DON) stated in order for R8 to have meds (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at the bedside she would have orders and be care planned. DON confirmed what R8's care plan and that she no longer had a PICC. The DON also stated the Minimum Data Set Nurse (MDS) was responsible for managing the care plans, with the exception of the behaviors part and that they should know what to do.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, interviews, and review of video footage, the facility failed to provide appropriate care for Resident (R)5, who had a respiratory care plan and physician orders, after the resident was choked by another resident on [DATE]. Additionally, the facility failed to provide wound care according to professional standards of practice for R8.On [DATE] at 5:30 PM, the survey team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of [DATE]. The IJ was related to 42 CFR 483.25 - Quality of Care.On [DATE], the facility provided an acceptable IJ Removal Plan. On [DATE], the survey team, validated the facility's corrective actions and removed the IJ. The facility remained out of compliance at F684 at a lower scope and severity of D.An extended survey was conducted in conjunction with the Complaint Survey for non-compliance at F684, constituting substandard quality of care.Findings include: Review of the facility policy titled Abuse and Neglect Protocol with a revised date of [DATE], documented, . Monitoring and Follow-Up 1. Staff and physician will monitor individuals who have been abused to address any issues regarding their medical condition, mood, and function. Review of R5's Face Sheet, revealed R5 was admitted to the facility on [DATE], with diagnoses including but not limited to, age-related osteoporosis with current pathological fracture, chronic obstructive pulmonary disease, atherosclerotic heart disease, presence of xenogenic heart valve, dementia, epilepsy, spondylosis and need for assistance with personal care. Review of R5's 5-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed R5 had a Brief Interview of Mental Status (BIMS) score of 5 out 15, which indicated R5 suffered from severe cognitive impairment. Further review of R5's MDS revealed active diagnoses under the section heart/circulation, to include anemia, coronary artery disease, hypertension. Additionally, active diagnoses under the section pulmonary included, asthma, chronic obstructive pulmonary disease, or chronic lung disease. Further review of the MDS under the section Health Conditions indicated shortness of breath or trouble breathing when lying flat. The MDS also indicated R5 was receiving Respiratory Therapy. Review of R5's Physician Orders revealed the following orders: incruse ellipta inhalation aerosol powder activated 62.5 MCG/ACT, albuterol sulfate HFA inhalation aerosol solution 108 (90 base) MCG/ACT - 2 puff inhale orally every 4 hours as needed for wheezing or SOB, symbicort inhalation aerosol 80-4.5 MCG/ACT (Budesonide-Formoterol Fumarate Dihydrate) 2 puff inhale orally two times a day for COPD, monitor for shortness of breath every shift, and keep HOB (head of bed) elevated due to SOB when lying flat. Review of R5's Medication Administration Record (MAR) for the month of [DATE], revealed, Keep HOB elevated due to SOB when lying flat every day and night shift with a start date of [DATE]. Review of the MAR revealed that this order was checked off as administered on [DATE] from 7P - 7A. However, interview with CNA5, who stated she entered the room at 7:15 AM on [DATE] and the HOB was not elevated. On [DATE] from 7A - 7P revealed this order was coded as 10 which indicated the resident was unavailable. Further review of the MAR revealed, Albuterol Sulfate HFA Inhalation Aerosol Solution 708 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally every 4 hours as needed for wheezing or SOB with a start date of [DATE]. According to the MAR, this order was left blank from [DATE] - [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R5's Care Plan revealed a focus area Cognitive Impairment: Resident exhibits cognitive loss related to Dementia with a date initiated of [DATE], directed staff to, Anticipate needs and meet promptly. Observe for indicators of clinical changes: fever, n/v, cough, . Further review of the Care Plan revealed a focus area Respiratory: Resident is at risk for complications with the respiratory system due to Chronic Obstructive Pulmonary Disease (COPD) with an date initiated of [DATE], directed staff to, 4/13-Position with HOB elevated to prevent episodes of shortness of breath while lying flat. Administer medications as ordered. Monitor for side effects/adverse reactions and effectiveness. Monitor for shortness of breath, irregular respiration, wheezing, crackles, rhonchi, excessive secretions, coughing spells, decreased energy, rapid breathing, complaint of chest tightness or hurting, tightness of neck or chest muscles, malaise or fatigue and inform physician promptly. Monitor vital signs, skin color, oxygen saturation, and airway function. Further review revealed a care plan with a focus on Neurological Disease: Resident has a neurological disorder and is at risk for complications related to diagnosis of Epilepsy with an initiated date of [DATE], directed staff to, Administer medication as ordered. Monitor length of acute neurological symptoms . Monitor vital signs as ordered and PRN. Observe for signs and symptoms of neurological changes . Further review of R5's Care Plan revealed a care plan with a focus on Cardiac: At risk for impaired cardiac function and complications related to Atherosclerotic Heart Disease, Hyperlipidemia, Hypertension (HTN), and Xogenic Heart Valve with a date initiated of [DATE], directed staff to, Administer medication as ordered . Notify physician of signs of cardiac distress such as chest pain, irregular heart rate, fainting, chest pain, dizziness, decreased activity tolerance. Obtain vital signs as indicated. Review of R5's Progress Note dated [DATE] at 5:36 AM, documented, [CNA1] witnessed that rolled his wheelchair behind [R5] and began to choke him while choking him aide ask [R4] to let him go and he refused aide had to get up and remove resident hand from around [R5] neck. resident has been separated. DON has been notified. Further review of R5's Progress Notes revealed a note dated [DATE] at 8:00 AM, which documented, Note Text: Late Entry: During rounds, CNA alerted nurse patient not [sic] was not responding to verbal stimuli. Nurse rushed to room to assess patient, after verbal stimuli and physical stimuli initiated, patient found to by pulseless. Patient was DNR. EMS arrived on site to assist, and pronounced patient expired at 0740. Coroner on site. Review of the facility's video footage, in the presence of the Director of Nursing (DON), Administrator, Operations Manager, Regional Director of Clinical Services (RDCS)1 and RDCS2, revealed the following timeline on [DATE]: 4:43 AM - R4 starts rolling towards R5, through the common area. R4 moves directly behind R5 and leans forward and places his arm around R5's neck. R5 responds by grabbing R4's arm with both hands. R4 continues to choke R5, as R5 was unable to get R4 to release his hold around R5's neck. R5's head begins to lean backwards by the force applied to his neck. Certified Nursing Assistant (CNA)1 comes into view from off screen and approaches both residents. CNA1 grabs R4's arm and R4 released his hold. CNA1 than moves R5 to a desk in the corner of the room, where CNA1 was sitting and CNA1 has a seat back at the desk, with R5 next to the desk. And R4 still in the common area next to the nursing station. 5:03 AM - CNA1 gets up from the nursing station. CNA1 puts on gloves and rolls R5 to his room. 5:07 AM - CNA1 exits the room. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7:33 AM - CNA5 enters R5's room. 7:35 AM - CNA5 rushes out of R5's room and continues down the hall. CNA5 and Licensed Practical Nurse (LPN)2 return to the room. 7:40 AM - Emergency Medical Services (EMS) and fire rescue arrive on scene. 7:51 AM - Police officer arrive on scene. 8:00 AM - Two more police officers arrive on scene. 8:44 AM - Coroner arrives on scene. During an interview on [DATE] at 1:36 PM, the Administrator stated, The nurse was in the area of the resident. He [R5] wasn't assessed. I did not see the resident get assessed. During an interview on [DATE] at 1:42 PM, RDCS2 stated, Body audits, assessments should be done to assess for any injuries. The agency nurse and CNA just didn't do them. During an interview on [DATE] at 1:37 PM, the DON stated, A body audit was conducted after he (R5) expired. When asked if an assessment or body audit was conducted after the physical altercation, the DON responded, Not that I know of. During an interview on [DATE] at 3:18 PM, CNA5 stated, I got to [R5's] room about 7:15 AM, he was laying on his stomach. The other nurses were down there (in the hallway), they had to see that. I just peaked in there. I told the roommate [R5's roommate] I would be back. I did the rest of my rounds. I walked back down and I turned the light on in [R5's] room, the roommate told me to check on him cause he wasn't talking. I called his name and he didn't say anything. I gave him a little shake and he was unresponsive. Stuff was coming out of his mouth, like drool. The drool was bubbly and his eyes were closed. I ran and asked the nurse, the nurse said he should be fine from the report I got. She went and checked, she said he was getting cold. I got the vital machine and we couldn't get none (referring to the residents pulse). During an interview on [DATE] at 4:39 PM, CNA1 stated, His roommate rung his bell at 6:57 AM, I told him to give me a minute. I looked over at [R5] and he was laying on his side and I walked out. The nurse didn't do any vitals. I looked at him, there was no changes in his breathing. During a follow up interview on [DATE] at 1:12 PM, CNA5 stated, When I first saw him, he was laying on his stomach, like he was trying to get off the bed, he always does that. He was laying flat, his bed was low. No, the head of the bed was not elevated. The bed was flat. 2. Review of the facility policy titled, Wound Care, last revised [DATE] states, Purpose, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing . Reporting: 1. Notify the supervisor if the resident refuses the wound care. 2. Report other information in accordance with facility policy and professional standards of practice. Review of R8's Face Sheet revealed the facility admitted R8 on [DATE], with diagnoses including but not limited to: Lupus, bacteremia, sepsis, osteomyelitis of vertebra, sacral and sacrococcygeal region, immunodeficiency, stage 3 pressure ulcers of the right and left buttocks, stage 4 pressure (continued on next page)

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	425368	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Johns Island Post Acute	3647 Maybank Highway Johns Island, SC 29455

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ulcers of the sacral region, colostomy and paraplegia. Review of R8's admission MDS with an ARD of [DATE] revealed R8 had a BIMS score of 15 out of 15, indicating R8 was cognitively intact. Further review revealed R8 had two (2) stage 3 pressure ulcers, one (1) stage 4 pressure ulcer and was a risk for pressure ulcers/injuries and required care for pressure ulcers/injuries. Review of R8's Care Plan revealed Focus: Skin: Resident has a pressure ulcer to coccyx and left and right buttocks and is at risk for further breakdown and/or slow, delayed healing. Interventions included, administer treatment as ordered. Review of a Consultation Report dated [DATE], documented, To whom it may concern at [name of facility] facility, I had the pleasure seeing [R8] today for routine postoperative visit stage IV sacral wounds .Please continue local wound care .Recommendations: . Cleanse wounds x3 with Dakins and then apply collagen and calcium alginate with dry dressing over the wound. Exchanged every other day or as needed for saturation/soiling or dislodgement or more. Review of R8's Physician's Orders dated [DATE] with a start date of [DATE] revealed the following: WOUND CARE - Coccyx clean with Dakins, place collagen in wound bed and pack with calcium alginate [every other day] QOD and [as needed] PRN. every day shift for wound care. WOUND CARE LEFT BUTTOCKS clean with Dakins, place collagen on wound bed and pack calcium alginate QOD and PRN every day shift for wound care. WOUND CARE right buttocks clean with Dakins, place collagen on wound bed and pack calcium alginate QOD and PRN every day shift for wound care. All three orders were entered for daily dressing changes instead of every other day. Review of R8's Progress Note dated [DATE] at 1:00 AM, documented, Chief Complaint / HPI: patient being seen for wound care. Additional Notes . patient will need close monitoring of wounds by skilled nursing staff as all wounds will be difficult to care for independently secondary to size and location of the wounds. Review of R8's Medication Administration Note dated [DATE] at 14:42 documented, Wound Care Coccyx .resident did her own wound care. Review of R8's Medication Administration Note dated [DATE] at 14:43 documented, Wound Care right buttocks .resident did her own wound care. Review of R8's Orders Administration Note dated [DATE] at 14:43 documented, resident refused to let staff do her wound care and insisted that she do it herself. Review of R8's Medication Administration Note dated [DATE] at 14:44 documented, Wound Care left buttocks .resident did her own wound care. During an interview on [DATE] at 11:54 AM, R8 stated that Yesterday, the Wound Care Nurse (WCN) refused to change her dressing and told me that since I know so much, do it myself. R8 states that she keeps her own dressings and supplies at the bedside for when she has to change her own dressings. She stated that since the WCN refuses to use Dakins to cleanse her wounds and instead uses a different wound cleanser, she does it herself with Dakins, that she got from a nurse, here at the facility. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at approximately 12:30 PM, Licensed Practical Nurse (LPN)4 stated that WCN is responsible for changing R8's daily wound care dressings and if it is a weekend, the nurse assigned is responsible. LPN4 further stated that R8 sometimes does some of her own care herself, like dressings . LPN4 lastly stated that to her knowledge, R8 has only refused care once or twice. During an interview on [DATE] at approximately 1:00 PM, the WCN stated, To her knowledge, R8 has only refused a dressing change only once, stating that it had already been done. The WCN then stated that she is only aware of R8 changing her own dressing, if it was soiled or accidentally removed, during evenings or weekends, when she is not there. The WCN is unaware whether R8 has any woundˆcare supplies at her bedside, though R8 should have active orders for meds and supplies at the bedside. The WCN notes that R8's wound care orders were just changed yesterday afternoon from wound cleanser to Dakin's solution. During an observation and interview on [DATE] at 1:35 PM, R8 was observed in her room, in her bed with her buttocks exposed and her wound visible. R8 did not have gloves. R8 then placed gauze over the wound and stated, I had been waiting for the WCN to come and change my dressings. R8 also stated that the WCN had refused to change her dressings the day prior and stated to her since you know how to, you do it and then left without changing them. R8 stated that she frequently changes her own wound dressings. R8 reported she was using a Dakin's wound cleaner solution, provided by a nurse and then pointed to an unlabeled white spray bottle with the words BUBBLES written in black sharpie across the top. R8 said, Open it up and smell it, and you will see it's Dakins. R8 noted that the WCN currently does not use Dakin's to cleanse her wounds, but some other kind of wound cleaner. During an observation and interview of R8's dressing change on [DATE] at 2:50 PM, R8 stated to the WCN, You know you didn't change my dressings yesterday, and you told me since I know so much, do it myself, and then you left. The WCN became visibly upset and sighed. The WCN later asked R8, How long have you had your wounds? and R8 responded, Why you asking me this, you know I had these when I came, they been there a long time. When the WCN asked when the wound became so big, R8 replied, Did you not read my hospital notes, it says I had a surgery and they cut it. During an observation and interview on [DATE] at 3:35 PM, the Director of Nursing (DON) stated that her expectation was for the WCN to follow physician orders. The DON stated that she was not entirely sure if R8 was doing her own dressing changes, but knew she would assist at times, but if so, she would have orders to do so. DON was then asked to come to R8's room with surveyor. DON was shown the wound care supplies at R8's bedside. R8 then stated to the DON that she got the Dakins from a nurse here at the facility and stated that the WCN refuses to change her dressing at times and that she would do it herself. On [DATE], the facility provided an acceptable IJ Removal Plan, which included the following: Resident 5 was involved in a resident to resident altercation on 4-24-26 and placed in bed by the CNA at approximately 503am. Nurse did not assess the resident or follow up with the resident after the physical altercation. Resident 8 was here for short term rehab and has wounds to her sacrum that are chronic and were present on admission. She admitted with wound supplies she preferred to keep at bedside. her discharge plan is to discharge home. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	She has orders for wound care to be performed daily and staff have been doing this however, on a few occasions she has refused to allow staff to perform the wound care stating she had done it herself. This was documented in nurses notes. IMMEDIATE ACTION TAKEN: 1) Resident 5 expired at facility on 4-24-26. 2) Resident 8 remains at the facility and orders in place for every other day wound care. 3) Education initiated with all licensed nurses by DON and RDCS on 5-1-26 to ensure understanding of following physician orders, providing treatments as ordered, documenting any refusals of care or treatment and non-compliance with any care and ensuring that residents have no medications at bedside. All education will be provided to newly hired staff and agency staff prior to next shift worked. ADHOC QA MEETING HELD 5-1-26 Members present were: [name] - Operations Manager, [name] RN Director of Nursing, [name] LNHA Members via phone: Dr. [name] and Dr. [name] Root Cause: Facility failed to document adequately resident reference to keep wound supplies at bedside and failed to care plan refusals of care. Education initiated on 5-1-26 by DON and RDCS for all licensed nurses via phone and blast text via [NAME] as well as education provided in person to staff in the facility for both day shift and night shift on 5-1-26 regarding following physician orders, ensuring that resident's do not have medications at bedside and that any refusals or non-compliance must be documented. Education will be provided to all newly hired nurses and agency nurses will be provided prior to next shift worked. Audit of Resident 8 TAR complete by RDCS on 5-1-26 to ensure that any refusals of wound care for March and April were documented. Resident 8 was educated that she cannot have medications at bedside and requested that she give the Dakins to the DON and she did on 5-1-26@7:30pm. Checklist for resident to resident altercations was provided to DON and Admin on 4-30-26 by RDCS and will be utilized for each facility reported altercation to ensure all documentation and evaluations are complete. Education provided to DON by RDCS on 5-1-26 to ensure that each day Monday - Friday a review of missed documentation will be compete [sic] during clinical meeting to ensure any refusals of care have appropriate documentation. The above components have been implemented as of 5-1-26 by 8 pm.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on review of the facility's policies, document review, and interviews, the facility failed to ensure all staff, to include agency staff, received orientation, training, and in-services on facility policies and procedures, prior to working with residents. Specifically, the facility had agency staff working as a charge nurse, floor nurse, and aide without the proper training. This deficient practice had the potential to effect all residents in the facility.Findings include:Review of the facility's policy titled, In- Service Training, All Staff, revised in August 2022, revealed Policy Statement: All staff must participate in initial orientation and annual in-service training. Policy Interpretation: 1. All staff are required to participate in regular in-service education. In-service education participation is considered working time for which staff are paid their regular wages. 7. Training requirements are met prior to staff providing services to residents, annually, and as necessary based on the facility assessment. 8. Completed training is documented by the staff development coordinator, or his or her designee and includes: a. the date and time of the training; b. the topic of the training; c. the method used for training; d. a summary of the competency assessment; and e. the hours of training completed.Review of the facility's policy titled, Staffing, Sufficient and Competent Nursing revised April 2025 revealed Policy Interpretation and Implementation: Sufficient Staff. 1. Licensed nurses and certified nursing assistants are available 24 hours a day, seven (7) days a week to provide competent resident care services including: c. assessing, evaluating, planning, and implementing resident care plans . 2. A licensed nurse is designated as a charge nurse on each shift. b. A charge nurse is a licensed nurse with specific responsibilities designated by the facility that may include staff supervision, emergency coordination, provider or physician support, and direct care.On 04/30/26 at 12:15 PM, while in the Administrator's office watching video footage of an incident, in the presence of the Operations Manager and the Regional Director of Clinical Services (RDCS)2, orientation documentation and training were requested for agency staff currently working in the building. In the video footage, Licensed Practical Nurse (LPN)1, who was an agency staff member, was observed interacting with residents. Further review of the footage revealed LPN3, who is also an agency staff member, interacting with residents.During an interview on 05/01/26 at 11:40 AM, LPN5 indicated it was her first day at the facility. She stated she had not been given any training, or orientation, or in-services; she had only been given a clipboard and login.Multiple attempts were made to contact LPN1 via telephone, with no success.During an interview on 05/01/26 at 11:41 AM, Certified Nursing Assistant (CNA)4 indicated she was an Agency CNA and it was her first time back at the facility in a few weeks. She stated, upon hire, she did not obtain any training, orientation, or in-services from the facility. When asked if she had in-services based on the ongoing survey findings, she stated she did not. She indicated that her shift had begun at 7:00 AM that day.During an observation of a document for LPN5, provided by the Administrator on 05/01/26 at 4:00 PM, indicated LPN5 had a Certificate of Signature with a timestamp of 01 May 2026 18:45:48 UTC. When asked, the Administrator stated, I learned UTC is five hours ahead of Eastern Standard Time (EST), so the document was signed at 3:45 PM. When asked when did LPN5's shift began for the day, the Administrator acknowledged LPN5 had just signed the orientation document and had been working with residents since 7 AM that morning.During an interview with the Administrator on 05/01/26 at 12:01 PM, he entered the conference room with a binder, that contained multiple facility policies. He stated, This is the Nurses' quick guide, that agency staff are to review, when time allows. When asked, who monitors that staff have completed required in-services, orientation and training, the Administrator stated, We do not have any sign-in sheets to prove these have been completed. Staff are supposed to complete prior to starting, but we use a lot of agency staff. This is something we are just going to have to work on.At the conclusion of the survey on 05/01/26, the Administrator still had not yet provided documentation of orientation completion or training and in-services for LPN1 and LPN3.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, and interviews, the facility failed to ensure the accurate transcription of physician orders for 1 of 2 resident (R8) reviewed. R8's woundˆcare order was entered incorrectly on the Medication Administration Record (MAR) as daily, while the Physician's instruction required treatment every other day (QOD). This failure created the potential for incorrect treatment frequency and adverse outcomes. Findings Include:Review of the facility policy titled Medication Orders, last revised November 2014, states Purpose: The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. Supervision by a Physician: . 2. A current list of orders must be maintained in the clinical record of each resident . Recording Orders .6. Treatment Orders-When recording treatment orders, specify the treatment, frequency and duration of the treatment. Example: Apply 4X4 duoderm with border to stage 1 ulcer on coccyx; change every 3 days and as needed per wound care protocol.Review of R8's Face Sheet revealed the facility admitted R8 on 03/04/26, with diagnoses including but not limited to: bacteremia, sepsis, osteomyelitis of vertebra, sacral and sacrococcygeal region, stage 3 pressure ulcers of the right and left buttocks and stage 4 pressure ulcers of the sacral region. Review of R8's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/11/26 revealed R8 had a Brief Interview for Mental Status (BIMS)ˆscore of 15 out of 15 indicating R8 was cognitively intact. Further review revealed R8 had 2 stage 3 pressure ulcers, 1 stage 4 pressure ulcer and was a risk for pressure ulcers/injuries. Review of R8's Care Plan revealed Focus: Skin: Resident has a pressure ulcer to coccyx and left and right buttocks and is at risk for further breakdown and/or slow, delayed healing. Interventions included, administer treatment as ordered.Review of a Consultation Report dated 04/28/26, documented, To whom it may concern at [NAME] Island Post Acute Rehab facility, I had the pleasure seeing [R8] today for routine postoperative visit stage IV sacral wounds .Please continue local wound care .Recommendations: . Cleanse wounds x3 with Dakins and then apply collagen and calcium alginate with dry dressing over the wound. Exchanged every other day or as needed for saturation/soiling or dislodgement or more.Review of R8's Physician's Orders dated 04/30/26 with a start date of 05/01/26 revealed the following: WOUND CARE - Coccyx clean with Dakins, place collagen in wound bed and pack with calcium alginate [every other day] QOD and [as needed] PRN. every day shift for wound care. WOUND CARE LEFT BUTTOCKS clean with Dakins, place collagen on wound bed and pack calcium alginate QOD and PRN every day shift for wound care. WOUND CARE right buttocks clean with Dakins, place collagen on wound bed and pack calcium alginate QOD and PRN every day shift for wound care. All three orders were entered for daily dressing changes instead of every other day. During an observation and interview on 05/01/26 at 2:50 PM, the Wound Care Nurse (WCN) reviewed R8's wound care orders prior to the WCN changing R8 dressings. The WCN read the order and then proceeded to enter R8's room. The WCN was asked by surveyor to once again review the orders and re-confirm them. The WCN read the order and confirmed it was entered for daily dressing changes, but the instructions stated every other day. The WCN was then notified by the surveyor of the contradicting orders and informed the WCN to review the consultation report. The WCN then opened the report and stated that she had not reviewed this. When asked if this was normal practice for the WCN to not review orders for wound care she stated No and the staff typically place the report on my desk. The WCN then confirmed that R8's orders should have been entered to be completed every other day and not daily.During an interview on 05/01/26 at 3:35 PM, the Director of Nursing (DON) stated that her expectation was for the WCN to follow physician orders. The DON stated that when R8 comes back from an appointment with a consult sheet, the nurse will review it. She further stated that the WCN reviews the orders in great detail. When asked about the conflicting orders for R8, the DON said she wasn't sure why it said that, unless the provider saw it (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and changed it would be the only thing that I can think of. The DON then reviewed and confirmed both the consultation report and physician's order.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of the facility policy, observations, interviews, and record review, the facility failed to maintain appropriate infection prevention and control practices during wound care for 1 of 1 residents reviewed for wound care, Resident R (8). This failure had the potential to expose the resident to crossˆcontamination, delayed wound healing, and increased risk of infection, including the possibility of developing a preventable wound infection or worsening of the existing wound. Findings Include: Review of the facility policy titled, Enhanced Barrier Precautions, last revised December 2024, states, Policy Statement: Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Policy Interpretation and Implementation . 2. Enhanced barrier precautions apply when . b. A resident .has a wound or indwelling medical devices. 7. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). 8. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include . j. wound care (any skin opening requiring a dressing).Review of the facility policy titled, Wound Care, last revised October 2010 states, Purpose, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing . Steps in the Procedure . 3. Position resident. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites. 8. Pour liquid solutions directly on gauze sponges on their papers. 10. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. 11. Place one (1) gauze to cover all broken skin. Wash tissue around the wound that is usually covered by the dressing, tape or gauze with antiseptic or soap and water.Review of R8's Face Sheet revealed the facility admitted R8 on 03/04/26, with diagnoses including but not limited to: Lupus, bacteremia, sepsis, osteomyelitis of vertebra, sacral and sacrococcygeal region, immunodeficiency, stage 3 pressure ulcers of the right and left buttocks, stage 4 pressure ulcers of the sacral region, colostomy and paraplegia. Review of R8's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/11/26 revealed R8 had a Brief Interview for Mental Status (BIMS)ˆscore of 15 out of 15 indicating R8 was cognitively intact. Further review revealed R8 had 2 stage 3 pressure ulcers, 1 stage 4 pressure ulcer and was a risk for pressure ulcers/injuries. Review of R8s Care Plan revealed Focus: Skin: Resident has a pressure ulcer to coccyx and left and right buttocks and is at risk for further breakdown and/or slow, delayed healing related to Cardiovascular disease, decreased mobility, and incontinence. Interventions included, administer treatment as ordered, and utilize EBP's during high-contact resident care activities.During an observation and interview on 05/01/26 at 2:50 PM, the Wound Care Nurse (WCN) was observed conducting a dressing change for R8's wounds. The WCN and her helper both donned gowns in the hallway before entering R8's room. The WCN then washed her hands, donned new gloves, grabbed an already opened gauze from a plastic cup labeled Dakins, and began cleaning the wound bed. The WCN then opened a plastic trash bag attached to the bedside table and discarded that gauze. The WCN then grabbed another gauze from this cup without completing hand hygiene or changing her gloves and continued to touch and clean R8's wound. She then removed her gloves and washed her hands and donned a new pair of gloves. The WCN was noted to be opening the plastic trash bag multiple times and moving the bedside around before grabbing gauze to cover and dress the wound. Throughout this process, an Air conditioner turned on and begun to blow on the bedside table with the supplies to complete the dressing change was. This process was observed for all three of R8's dressings that the WCN changed, all confirmed by the WCN.