STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445116	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Smithville	825 Fisher Ave Smithville, TN 37166

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 44724 Based on facility policy review, facility investigation review, medical record review, observation, and interview the facility failed to provide an environment free from abuse for 5 of 9 sampled residents (Resident #1, Resident #2, Resident #6, Resident #7 and Resident #8) reviewed for abuse. On [DATE] Resident #2, a vulnerable, severely cognitively impaired, ambulatory female resident wandered into Resident #1's room. Resident #1, an alert male resident with a Brief Interview for Mental Status (BIMS) score of 15 and an extensive psychiatric history, willfully hit Resident #2 multiple times on her head and back. On [DATE] Resident #7, a vulnerable, severely cognitively impaired, female resident in a wheelchair, bumped into Resident #1's wheelchair in the dining room. Resident #1 was verbally abusive and called Resident #7 derogatory names. The facility's failure to recognize and intervene with Resident #1's continued physical and verbally abusive behaviors toward residents placed Resident #2 and Resident #7 in Immediate Jeopardy (IJ), (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident). The facility failed to prevent an incident physical abuse when Resident #6 and Resident #8 were involved in a resident-to-resident altercation on [DATE] which did not rise to an IJ level. The facility failed to report the resident-to-resident altercation that occurred between Resident #6 and Resident #8 on [DATE] to the appropriate agencies. The Administrator was notified of the IJ on [DATE] at 6:38 PM in the Conference room. The facility was cited at F-600 at a scope and severity of K, which constitutes Substandard Quality of Care. The Immediate Jeopardy began [DATE], continued through [DATE], and was removed on [DATE]. A partial extended survey was conducted on [DATE] through [DATE]. An acceptable Removal Plan, which removed the immediacy of the Jeopardy for F-600 was received on [DATE]. The corrective actions were validated onsite by the surveyors on [DATE] through observation, review of records, audit review, education review, and staff interviews. The facility's noncompliance at F-600 continues at a scope and severity of E for monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The findings include: 1. Abuse, Neglect, Misappropriation of Property and Exploitation, dated [DATE], revealed .Abuse, Neglect . will not be tolerated by anyone, including staff, patients .The patient has the right to be free from abuse, neglect .Abuse: the willful infliction of injury .intimidation, or punishment with resulting physical harm, pain or mental anguish .It includes verbal abuse .physical abuse, and mental abuse .Willful .means the individual must have acted deliberately .Verbal Abuse: the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents .or within their hearing distance regardless of their . ability to comprehend .Physical Abuse: includes hitting, slapping, pinching and kicking .PREVENTION POLICY .The center will provide supervision and support services designed to reduce the likelihood of abuse behaviors .All supervisory partners who receive reports of and/or identify inappropriate behaviors will take immediate steps to correct such behaviors .Patients with needs and behaviors that might lead to conflict with partners or other patients will be identified by the Care Planning team, with interventions and follow through designed to minimize the risk of conflict .The Interventions designed to meet the needs of such patients will include .identification of patients whose personal histories render them at risk for abusing other patients or partners .Assessment of appropriate intervention strategies to prevent occurrences .Monitoring the patient for any changes that would trigger abusive behavior .Dementia management program as needed .Any patient event that is reported to any partner by patient, family .any person will be considered an allegation of either abuse, neglect .Any allegation (or) indication of possible willful infliction .Any partner having either direct or indirect knowledge of any event that might constitute abuse, neglect .must report the event immediately, but not later than 2 hours after forming the suspicion if the events that cause the suspicion involve abuse .it is the policy of this facility that abuse allegations (abuse, neglect .mistreatment .) are reported per Federal and State Law .The investigation is conducted immediately .When it is identified that an alleged incident may have occurred .As soon as any partner has knowledge and reports an alleged event . When there is a question as to whether to conduct an investigation, it is best to do so .The results of all investigations will be completed within five working days of the incident .all necessary corrective actions will be taken .Any individual found to be in danger of injury will be removed from the source of the suspected abusive behavior including but not limited to room or staffing changes .to protect the patient (s) from the alleged perpetrator .Increased supervision of the alleged victim and patients . Review of the undated facility policy titled, PATIENT RIGHTS, revealed, .the patient/resident's right to live in an environment which is individualized for them .Your sense of well being and your safety during your stay here are of the utmost importance to us .your care is planed with a group of professionals holding your well-being as their primary concern .Your plan of care will include an assessment of your strengths and needs. The ultimate goal is to assist you to achieve and/or maintain the highest level of functioning . 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses which included Delusional Disorders, Schizoaffective Disorder, bipolar type, Hallucinations, Anxiety Disorder, and Major Depressive Disorder. Review of the care plan for Resident #1 revealed, .Start Date XXX[DATE] Problem: At risk for alteration in behaviors .Pt [patient] has delusions, hallucinations, talks to himself, verbal and physical behaviors toward others, short tempered, easily annoyed, impatient .Approach: Remove patient from triggering situations when possible; respect personal space and rights Start date XXX[DATE] . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Physician Progress Notes dated [DATE] for Resident #1 revealed schizoaffective disorder . does not tolerate dosage [medication dosage] decrease. Review of the Progress Notes dated [DATE] for Resident #1 revealed, .PT [Patient] IS ALERT WITH HALLUCINATIONS NOTED . Review of the Nurse Practitioner (NP) Progress Note dated [DATE] for Resident #1 revealed, .Patient is delusional - reports his mother is coming to get him to take him home for extended work they need to do with children . Review of the Nurse Practitioner Progress Note dated [DATE] for Resident #1 revealed, .Patient is found sitting up in his wheelchair .Delusional .Reports 'I am now the governor and I have served 15 terms' . Review of the Progress Notes dated [DATE] for Resident #1 revealed, .A patient entered [Named Resident #1]'s room and was attempting to sit in his electric wheelchair. [Named Resident #1] was afraid the patient was going to get hurt so he yelled for patent to leave his room and [Named Resident #1] struck the patent with his hand on the head and back . Review of the facility investigation revealed on [DATE] at 6:00 PM, Resident #2 wandered into Resident #1's room. Resident #1 yelled at Resident #2 to get out of his room and while she was at his bedside, he struck the resident with his open hand on the head and back. A nurse aide heard the commotion and immediately intervened. The victim Resident #2 was removed from the room and provided increased observation. The nurse performed a skin assessment on both residents with no injuries noted. A stop sign was placed on Resident #1's room to intervene wandering behavior. The facility investigation revealed the staff were trained on abuse policy and procedures. The staff should be with Resident #2 during mealtimes. A Velcro stop sign was affixed to Resident #1's doorway. The Quality Assurance Performance Improvement (QAPI) will oversee question and answers regarding abuse policy and procedures. The staff will monitor patients for behaviors that may increase their risk for physical abuse. The QAPI committee will confirm compliance with Stop Sign usage. Both residents will continue to be seen by Psych services. Review of the PSYCHOTHERAPY PROGRESS NOTE dated [DATE] for Resident #1 revealed, .Pt .was able to discuss incident yesterday of increased agitation/low frustration tolerance leading to an incident with another resident who came into his room, trying to use his electric w/c [wheelchair] .(pt. Experiencing grandiose baseline delusions) leading to broader issues with interpersonal skills (impulsivity/agitation) .Pt will reduce inappropriate behaviors by 50 % [percent] during review period, substituting with more appropriate patterns of interaction . Review of the Progress Notes dated [DATE] for Resident #1 revealed, .NO ABNORMAL BEHAVIORS. NO YELLING OR CRUSING [cursing] NOTED . Review of the Progress Notes dated [DATE] for Resident #1 revealed, .PT IS ALERT WITH DELUSIONAL BEHAVIORS NOTED AT TIMES . Review of the Progress Notes dated [DATE] for Resident #1 revealed, .Patient takes meds for schizoaffective bipolar type Still with delusions/hallucinations . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Progress Notes dated [DATE] for Resident #1 revealed, .PT IS ALERT WITH DAILY DELUSIONS (HE OWNS MULTIPLE SPORT CARS, HOUSES, OR HE IS KIN TO FAMOUS PEOPLE .) ALL AT BASELINE . Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive impairment. Continued review of the MDS revealed Resident #1 experienced delusions and other behaviors not directed toward others. Review of the PSYCHIATRIC PERIODIC EVALUATION dated [DATE] for Resident #1 revealed, . New/Ongoing Target sx's [symptoms] .Pressured Speech, Impulsive Action, Compulsivity . Review of the PSYCHIATRIC PERIODIC EVALUATION dated [DATE] for Resident #1 revealed, .Pt [patient] has a persistent, chronic mental illness that requires ongoing therapeutic intervention to prevent exacerbation of presenting behaviors/psychological symptoms and to sustain baseline stability and overall well-being . Review of the care plan for Resident #1 revealed, .Problem: At risk for alteration in behaviors .Pt [patient] has delusions, hallucinations, talks to himself, verbal and physical behaviors toward others, short tempered, easily annoyed, impatient .Approach: Remove patient from triggering situations when possible; respect personal space and rights Start date .Approach: When Pt is upset by hallucinations or delusions, attempt to redirect by talking one-on-one in a calm tone about something they enjoy .Start Date [DATE] . Review of the Progress Note dated [DATE] for Resident #1 revealed, .PT WAS SITTING IN DINING ROOM FOR BREAKFAST WHEN A DEMENTED PT ROLLED IN AND BUMPED HIS WHEELCHAIR. PT BECAME AGGRESSIVE CURSING AND YELLING IN DINING ROOM AS LOUD AS HE COULD. NURSE INTERVENED AND REMOVED DEMENTIA PT. PT YELLED AND SCREAMED AT NURSE AND WAS NAME CALLING. PT NOW IN ROOM EATING BREAKFAST . Review of the Behavior Analysis Report (CareAssist only) note dated [DATE] for Resident #1 revealed, .Pt was in the dining room for breakfast another pt [Resident #7] accidentally bumped the back of his [Resident #1's] chair with hers. [Resident #7's wheelchair] and [Named Resident #1] started yelling and screaming at pt. [Named Resident #7] Nurse went in to redirect pt [Resident #7] and he [Resident #1] started cursing nurse calling her a whore he was asked to leaving [leave] the dining room. pt is currently in his room . Review of the Quarterly MDS assessment dated [DATE] revealed Resident #1 had a BIMS score of 15 which indicated intact cognitive abilities. Continued review of the MDS revealed Resident #1 experienced delusions. Observation in the dining room on [DATE] at 10:20 AM, revealed Resident #1 was in the dining room in an electric wheelchair. Observation in the resident's room on [DATE] at 9:00 AM, revealed Resident #1 was in his room sitting in his wheelchair. No stop sign was present over the doorway of Resident #1's room. Observation in resident's room on [DATE] at 8:20 AM, revealed Resident #1 was in the bed and no stop sign was present over the doorway of his room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 1:35 PM, Resident #1 was asked to explain what happened when Resident #2 came into his room. Resident #1 stated, .She went to my wheelchair (electric wheelchair) she turned it on . I told her to go back .I turned on the call light .she wouldn't listen, I don't want to have an accident .scared the wheelchair would have run her over .I patted her on the head .they yelled at me for doing that .I mean the jaws of life would have had to come in here and pull that wheelchair off of her .She didn't say anything to me just headed straight to the wheelchair .She backed off and staff was coming in .I don't remember the social worker coming and talking to me .She came in my room one time nude as a chicken .staff got her out of the room that night . Resident #1 was asked if the Administrator or the Director of Nursing (DON) came to talk with him related to the altercation. Resident #1 replied, No, I got a scholarship to work at [NAME] to work as a manager .They want me to take the job and sell them Hybrids that are coming out . 3. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Alzheimer's disease, Aphasia, Cognitive Communication Deficit, Manic episode, Dementia, Anxiety, and Depression and expired at the facility on [DATE]. Review of the Progress Notes dated [DATE] revealed for Resident #2, .Wanders and will intrude in other Pts' [Patient's] rooms . Review of the Progress Notes dated [DATE] revealed for Resident #2 , .Pt wanders and will intrude in other pt's personal space and rooms . Review of the Progress Notes dated [DATE], for Resident #2 revealed, .Pt wanders and will intrude in other patient's personal space and rooms . Review of the Progress Notes dated [DATE] for Resident #2 revealed, .AMBULATES AD LIB [as much and as often as desired] GAIT SEMI STEADY WITH STAFF ASSISTANCE. W/C [wheelchair] MAIN MODE OF TRANSPORTAION. ABLE TO PROPEL SELF IN HALLWAYS .PT TENDS TO WANDER AT TIMES INTO OTHERS ROOMS . Review of the Nurse Practitioner Progress Note dated [DATE] for Resident #2 revealed, .Patient continues to be up daily with assistance of staff and wheelchair. Patient is able to ambulate short distances with assistance of staff . Review of the Progress Note dated [DATE] for Resident #2 revealed, .PT COMBATIVE WITH CARE AND SHOWER THIS SHIFT. PT ROAMS WHEN UP IN WHEELCHAIR AND ENTERS OTHER ROOMS . Review of the Progress Note dated [DATE] for Resident #2 revealed, .Pt frequently roams when up in W/C and will enter other patients' rooms . Review of the annual MDS assessment dated [DATE] revealed Resident #2 had a staff assessment for mental status which indicated poor short term and long-term memory. Continued review of the MDS revealed no mood or behavior symptoms were present over the last 7 days. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Progress Note dated [DATE] for Resident #2 revealed, .Alert: [Named Resident #2] entered a patients room [Named Resident #1's room] and was attempting to sit in the patients wheelchair. The other patient was afraid that [Named Resident #2] was going to get hurt. The other patient [Named Resident #1] yelled for [Named Resident #2] to get out of the room and struck [Named Resident #2] with his hand on her head and back. Two nurses completed a skin assessment with no new skin issues noted . Review of the PSYCHIATRIC EVALUATION dated [DATE] for Resident #2 revealed, .Staff report cognition loss .Mood is worse with adls [activities of daily living] Patient has associated symptom of confusion .Safety concerns - Staff education regarding communication and re-direction in dementia patients . Review of the edited care plan dated [DATE] for Resident #2 revealed, .At risk for alteration in behaviors r/t [related to] disrobing, cursing at others, wandering, combativeness, and refusal of meds .Assist and encourage Pt to stay in high traffic areas when up in W/C as Pt allows Created :[DATE] .When Pt becomes annoyed with care/interactions .Provide safe environment and attempt care/interactions later when possible. Created: [DATE] .Redirect me when needed I will wander in my W/C. Offer me a snack or drink if I become agitated when redirected. I do not know my personal boundaries .Created: [DATE] .Encourage patient to be up for meals and in dining room to discourage wandering during meal times Created:[DATE] . The facility staff failed to redirect, prevent, or provide a safe environment for Resident #2 on [DATE] prior to her being struck by Resident #1 after wandering into his room. Review of the 5-day MDS assessment dated [DATE] revealed Resident #2 had a staff assessment for mental status which indicated poor short term and long-term memory. Continued review of the MDS revealed no mood or behavior symptoms were present over the last 7 days. 3. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses which included Vascular Dementia, unspecified severity, with mood disturbance and Depression. Review of the care plan for Resident #7 revealed, .Problem Start Date: [DATE] Behavioral Symptoms . Approach Start Date XXX[DATE] .promote safety XXX[DATE] Encourage and assist Pt with staying in high traffic areas when up in W/C as Pt allows .Offer and assist Pt to lay down in bed when wandering in W/C as Pt allows . Review of the Quarterly MDS dated [DATE] revealed Resident #7 had a BIMS score of 6 which indicated severe cognitive impairment. Continued review of the MDS revealed Resident #7 experienced delusions, physical behaviors directed toward others, and wandered ,d+[DATE] days over the last 7 day look back period. Review of the nurse Progress Notes for [DATE] for Resident #7 revealed no details related to the verbally abusive interaction that occurred on [DATE] with Resident #1. Review of the Progress Note dated [DATE] for Resident #7 revealed, .Spoke with NP .and reviewed previous verbal abusive interaction that occurred on [DATE] involving patients [Resident #1 was verbally abusive toward Resident #7] . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the revised care plan for Resident #7 dated [DATE] revealed, .Behavioral Symptoms .At risk for alteration in behaviors refusal of plan of care .Pt has impulsive behaviors with decreased safety awareness, false beliefs/misperceptions, physical behavior towards staff, and wandering Edited XXX[DATE] .Approach Start Date XXX[DATE] Patient may attract negative attention from other patients due to their poor understanding of personal space and spatial boundaries. Redirect as needed .When Pt is wandering, assess for unmet physical needs, psychological distress, and environmental factors. Distract Pt by introducing enjoyed activities .Educate and encourage patient to comply with plan of care . Resident #7 with a BIMS score of 6 does not have the ability to understand the need to comply with the plan of care. Review of the NP progress note dated [DATE] for Resident #7 revealed, .Per staff, patient remains at her baseline. She is pleasantly confused. She is able to propel herself in her wheel chair. She is easily redirected. No acute needs are reported by staff to this provider today .No distress. No needs identified . No mention of Resident #7's involvement in a verbal altercation with Resident #1. Observation in the resident's room on [DATE] at 2:45 PM, revealed staff assisted Resident #7 to bed. Observation in the dining room on [DATE] at 12:30 PM, revealed Resident #7 was in her wheelchair rolling to different residents introducing herself. During an interview on [DATE] at 3:50 PM, Licensed Practical Nurse (LPN) G stated, .I was here the night [Named Resident #2] went into [Named Resident #1]'s room. It was close to supper, [Named Resident #2] liked to wander, and she would get gone before you could get to her .I heard some yelling .[Named Resident #1] told me he hit her .the Administrator was still here, I told him .She was in her wheelchair but she could walk .Her room was straight across from his .they were on the same hall .Nobody seen her get up from her wheelchair that night .It wasn't the first time she had been in his room .he would yell at her and we would remove her .we tried to keep her in a wheelchair close to us .she would wheel throughout the facility .the staff knew she wandered .[Named Resident #1] said he hit her on the back, I looked at her skin I didn't see any redness .Certified Nursing Assistants (CNAs) were putting people to bed .we put a stop sign on [Named Resident #1]'s door to prevent her from going in his room . LPN G was asked if Resident #1 had ever been abusive toward any other residents. LPN G stated, .One time [Named Resident #7] was in the dining room and she bumped into his [Resident #1]wheelchair .He started cursing, I went in the dining room, he cursed me . LPN G was asked if Resident #1 was verbally abusive toward Resident #7. LPN G stated, .Yes I would say that would be verbal abuse, but I don't think I reported it .I did mention it to the NP today [[DATE]] .I was concerned about his outburst .[Named Resident #1] is delusional thinking he is married to the queen .will say he was in the military but he wasn't .He first tried to deny he hit [Named Resident #2] . During an interview on [DATE] at 4:30 PM, CNA H stated, .[Named Resident #1] has rage of fits screaming at other residents .he would scream at his previous roommate [Named Resident #5] .he will scream he would shoot them if he had a gun .[Named Resident #2] would go in everybody's room . CNA H stated, .[Named Resident #1] has been aggressive toward [Named Resident #7] .she wanders and often looking for her children .he will instantly become aggressive toward her .I feel like he could be physical or verbally aggressive toward any resident . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 4:31 PM, CNA W stated, .I heard a man yell, 'get out, get out' .I looked down the hall and seen [Named Resident #2]'s wheelchair sitting outside the room .[Named Resident #1] was laying in the bed .She had went to sit in his electric wheelchair .he was hitting her [Resident #2] on her back .he was raring back hitting her multiple times .I didn't know what else to do but scream stop, stop until I could get over to her .he instantly started apologizing .I got her in her wheelchair and took her to the nurse . [Named Resident #1] had his palm straight to her hitting her in the back and head ,d+[DATE] times .I mean having at it .I don't remember his call light being on . During an interview on [DATE] at 12:50 PM, the DON stated, .I would expect staff to redirect a wandering resident .try to find out the reason for wandering .does the resident need something .hungry .and stay with the resident to verify the resident's safety . The DON was asked if the facility performed any monitoring of Resident #2 after the physical altercation with Resident #1. The DON stated, .we trained our staff on how to protect the patients, going over the abuse policy .wandering patients what do you do .patient safety .the QAPI follow up training I would consider that follow up on [Named Resident #2] . 4. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE], with diagnoses which included End Stage Renal Disease, Renal Dialysis, Muscle Wasting and Atrophy, Heart Failure, Long-Term Use of Anticoagulants, and Malignant Neoplasm of Stomach. Review of the Admission MDS dated [DATE], revealed Resident #6 had a BIMS score of 13, which indicated intact cognition. Review of Registered Nurse (RN) U's Progress Note for Resident #6, dated [DATE] at 10:25 AM, revealed . Alert: I was in patient room giving him medicine and roommate [Resident #8] pushed his own bedside table that accidentally bumped this patients bedside table through the curtain. Patients bedside table bumped patients top of right knee. Patient was not bleeding at the time. Patient then came to nurses station and stated his knee was bleeding. This nurse cleaned and applied a dressing to top of right knee. MD and family notified . Review of a Physician's Order, for Resident #6, dated [DATE] revealed, .abrasion to top of right knee . Special Instructions: abrasion to top of right knee clean with normal saline and pat dry. Apply polymem [a dressing that manages drainage] oval every shift until healed .Every Shift .Day, Night . Review of the NP progress note dated [DATE] at 7:45 PM, for Resident #6, revealed, .Today staff report that the patient did sustain a small abrased area just above his right knee. Staff state that the patient reported that his knee was injured on his bedside table. Patient is found sitting on the side of his bed in his room . When asked what happened to his knee he states 'the curtain was pulled and my roommate pushed his bedside table into my bedside table and my bedside table hit my knee.' Patient did show provider how he sits on the side of his bed with his feet on the lower part of his table and pointed out the area of his table that hit his knee. Provider asked if this hurt and patient stated 'it did a little at the time but not now.' . 5. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses which included Type 2 Diabetes Mellitus, Hypertensive Heart Disease, Chronic Obstructive Pulmonary Disease, and Long-Term Use of Anticoagulants. (continued on next page)

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	445116	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Smithville	825 Fisher Ave Smithville, TN 37166

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 11:45 AM, Resident #6 stated, .Just an hour ago my roommate cursing people throwing a fit and he shoved his tray table toward me and caused my leg to start bleeding .he shoved the nurse [RN U] that was in here too because she told him don't push me .he [Resident #8] yells and hollers and he knows I will get up . The observation revealed blood on the floor and bloody gauze laying on the overbed table. Resident #6 raised up his pants leg on his right leg to show the surveyor where the nurse just bandaged his leg due to the injury he sustained when Resident #8 became angry and pushed his tray table into Resident #6's tray table. During the interview with Resident #6, Resident #8 yelled for the nurse 3 different times. During an interview on [DATE] at 12:30 PM, RN U stated, .[Named Licensed Practical Nurse V] reported to me he [Resident #6] had an old skin tear that reopened . During an interview on [DATE] at 3:25 PM, LPN V stated, .[Named RN U] done [did] all the treatments today . [Named Resident #6]'s roommate [Resident #8] pushed the overbed table toward him and caused a skin tear .the table has now been moved to the other side of [Named Resident #8]'s bed . During an interview on [DATE] at 5:20 PM, RN U was asked about her nurse note on Resident #6. RN U stated, .I was in the room when it happened .[Named Resident #8] pushed his overbed table .water picture hit the floor .the table hit [Named Resident #6] on his knee .[Named Resident #8] was flying off with the 'F' word it aggravated him, he wanted ice in his water .I lied to you earlier .I didn't report it .I applied pressure he [Resident #6] has poor skin he is a dialysis patient . During an interview on [DATE] at 4:00 PM, the SSD was asked if she was notified of the incident between Resident #6 and Resident #8. The SSD stated, .We talked to RN U about it .[[TRUNCATED]

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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** 44724 Based on facility policy review, Facility Reported Investigation (FRI) review, medical record review, and interview, the facility failed to report allegations of abuse within 2 hours for 4 of 9 (Resident #1, Resident #7, Resident #6, and Resident #8) sampled residents reviewed for abuse. The facility failed to report the 5-day investigation of abuse for 2 of 9 (Resident #3 and Resident #4) residents reviewed for abuse. The findings include: 1. Review of the facility policy titled, Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation, dated 2/1/2023 revealed, .Abuse, Neglect, Misappropriation of Patient Property .will not be tolerated by anyone, including staff, patients .The patient has the right to be free from abuse, neglect, misappropriation of patient property .Abuse: the willful infliction of injury .intimidation, or punishment with resulting physical harm, pain or mental anguish .It includes verbal abuse .physical abuse, and mental abuse .Willful .means the individual must have acted deliberately .Verbal Abuse .use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents .or within their hearing distance regardless of their .ability to comprehend .Physical Abuse: includes hitting, slapping, pinching and kicking .TRAINING POLICY .The center will train all partners, through orientation and ongoing in-services, on the prevention, identification, investigation and reporting of abuse, neglect, misappropriation of patient property .Any patient event that is reported to any partner by patient, family .any person will be considered an allegation of either abuse, neglect, misappropriation of patient property .Any allegation (or) indication of possible willful infliction .Any partner having either direct or indirect knowledge of any event that might constitute abuse, neglect, misappropriation of patient property .must report the event immediately, but not later than 2 hours after forming the suspicion if the events that cause the suspicion involve abuse .it is the policy of this facility that abuse allegations (abuse, neglect . mistreatment .misappropriation of resident property) are reported per Federal and State Law .The investigation is conducted immediately .When it is identified that an alleged incident may have occurred .As soon as any partner has knowledge and reports an alleged event .When there is a question as to whether to conduct an investigation, it is best to do so .The results of all investigations will completed within five working days of the incident . Review of the undated facility policy titled, PATIENT RIGHTS, revealed, .the patient/resident's right to live in an environment which is individualized for them .Your sense of well being and your safety during your stay her are of the utmost importance to us .your care is planed with a group of professionals holding your well-being as their primary concern .Your plan of care will include an assessment of your strengths and needs. The ultimate goal is to assist you to achieve and/or maintain the highest level of functioning . 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses which included Delusional Disorders, Schizoaffective Disorder-Bipolar type, Hallucinations, Anxiety Disorder, and Major Depressive Disorder. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive impairment. Continued review of the MDS revealed Resident #1 experienced delusions and other behaviors not directed toward others. Review of the PSYCHIATRIC PERIODIC EVALUATION dated 1/23/2024 for Resident #1 revealed, . New/Ongoing Target sx's [symptoms] .Pressured Speech, Impulsive Action, Compulsivity . Review of the PSYCHIATRIC PERIODIC EVALUATION dated 2/6/2024 for Resident #1 revealed, .Pt [patient] has a persistent, chronic mental illness that requires ongoing therapeutic intervention to prevent exacerbation of presenting behaviors/psychological symptoms and to sustain baseline stability and overall well-being . Review of the Progress Note dated 3/9/2024 for Resident #1 revealed, .PT [patient] WAS SITTING IN DINING ROOM FOR BREAKFAST WHEN A DEMENTED PT [Resident #7] ROLLED IN AND BUMPED HIS WHEELCHAIR. PT BECAME AGGRESSIVE CURSING AND YELLING IN DINING ROOM AS LOUD AS HE COULD. NURSE INTERVENED AND REMOVED DEMENTIA PT. PT YELLED AND SCREAMED AT NURSE AND WAS NAME CALLING. PT NOW IN ROOM EATING BREAKFAST . Review of the Behavior Analysis Report (CareAssist only) note dated 3/9/2024 for Resident #1 revealed, .Pt was in the dining room for breakfast another pt [Resident #7] accidently bumped the back of his [Resident #1's] chair with hers. [Resident #7's wheelchair] and [Named Resident #1] started yelling and screaming at pt. [Named Resident #7] Nurse went in to redirect pt [Resident #7] and he [Resident #1] started cursing nurse calling her a whore he was asked to leaving [leave] the dining room. pt is currently in his room . Review of the Quarterly MDS assessment dated [DATE] revealed Resident #1 had a BIMS score of 15 which indicated intact cognitive abilities. Continued review of the MDS revealed Resident #1 experienced delusions. Observation in the dining room on 3/18/2023 at 10:20 AM, revealed Resident #1 was in an electric wheelchair. Observation in the resident's room on 3/19/2024 at 9:00 AM, revealed Resident #1 was sitting in his wheelchair. Observation in the resident's room on 3/20/2024 at 8:20 AM, revealed Resident #1 was in the bed. 3. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnosis which included Vascular Dementia with Mood Disturbance and Depression. Review of the Quarterly MDS dated [DATE] revealed Resident #7 had a BIMS score of 6 which indicated severe cognitive impairment. Continued review of the MDS revealed Resident #7 experienced delusions, physical behaviors directed toward others, and wandered 4-6 days over the last 7 day look back period. Review of the nurse Progress Notes for 3/9/2024 for Resident #7 revealed no details related to the verbal abusive interaction. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress Note dated 3/18/2024 for Resident #7 revealed, .Spoke with NP .and reviewed previous verbal abusive interaction that occurred on 3/9/24 involving patients [Resident #1 was verbally abusive toward Resident #7] . Review of the NP progress note dated 3/18/2024 for Resident #7 revealed, .Per staff, patient remains at her baseline. She is pleasantly confused. She is able to propel herself in her wheelchair. She is easily redirected. No acute needs are reported by staff to this provider today .No distress. No needs identified . No mention of Resident #7's involvement in a verbal altercation with Resident #1. Observation in the resident's room on 3/19/2024 at 2:45 PM, revealed Resident #7 being assisted to bed. Observation in the resident's room on 3/20/2024 at 12:30 PM, revealed Resident #7 was in her wheelchair rolling to different residents introducing herself. During an interview on 3/18/2024 at 3:50 PM, Licensed Practical Nurse [LPN] G was asked if Resident #1 had ever been abusive toward any other residents. LPN G stated, .One time [Named Resident #7] was in the dining room, and she bumped into his wheelchair .He started cursing, I went in the dining room, he cursed me . LPN G was asked if Resident #1 was verbally abusive toward Resident #7. LPN G stated, .Yes I would say that would be verbal abuse, but I don't think I reported it .I did mention it to the NP today (3/18/2024) .I was concerned about his outburst . During an interview on 3/18/2024 at 4:30 PM, Certified Nursing Assistant (CNA) H stated, .[Named Resident #1] has rage of fits screaming at other residents . CNA H stated, .[Named Resident #1] has been aggressive toward [Named Resident #7] .she wanders and often looking for her children .he will instantly become aggressive toward her .I feel like he could be physical or verbally aggressive toward any resident . During an interview on 3/18/2024 at 4:45 PM, CNA I stated, .[Named Resident #1] will yell at his roommate if he gets in his way .he has a loud tone of voice .don't want anybody getting close to him . During an interview on 3/19/2024 at 8:00 AM, CNA J stated, .[Named Resident #1] he yells and screams mostly at other residents .He got after [Named Resident #7] in the dining room one day because she tried to talk to him .He called her .[derogatory names] . During an interview on 3/19/2024 at 8:20 AM, CNA L stated, .[Named Resident #7] wanders .He gets agitated with his roommate's stuff don't want nothing near him .constantly wanting his roommates stuff moved .[Named Resident #7] agitates him . During an interview on 3/19/2024 AT 8:25 AM, the Social Service Director (SSD), stated, .I wasn't aware of the interaction he [Resident #1] had with [Named Resident #7] on 3/9/2024. I am just now reading this in the notes. I have not done a follow up with either resident because I was not aware of the incident. The staff should have notified the Abuse Coordinator. Verbal abuse is cursing, yelling, demeaning language toward another resident . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/2024 at 8:55 AM, the Director of Nursing (DON) stated, .I was aware that [Name Resident #7] bumped into [Named Resident #1]'s wheelchair in the dining room and [Named LPN G] intervened. I wasn't aware that he called the other resident any derogatory names. I thought he just called the nurse names. As far as I know [Named Resident #1] got along with his roommates . During an interview on 3/19/2024 at 2:50 PM, Resident #1 stated, .I know [Named Resident #7] she is a busy body .comes around pushed me and pocked me in the dining room .It upsets me I don't want to be touched .I had to leave the room .I had to get out of there, she will keep on until she provokes me to a fight .she won't back down .she just keeps on poking at me .she makes me sick .she has wandered in my room twice .they took down my stop sign off my door .[Named Resident #7] won't listen just keeps on trying to talk . 4. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE], with diagnoses which included End Stage Renal Disease, Renal Dialysis, Muscle Wasting and Atrophy, Heart Failure, Long-Term Use of Anticoagulants, and Malignant Neoplasm of Stomach. Review of the Admission MDS dated [DATE], revealed Resident #6 had a BIMS score of 13, which indicated intact cognition. Review of Registered Nurse (RN) U's Progress Note for Resident #6, dated 3/19/2024 at 10:25 AM, revealed .Alert: I was in patient room giving him medicine and roommate [Resident #8] pushed his own bedside table that accidentally bumped this patients bedside table through the curtain. Patients bedside table bumped patients top of right knee. Patient was not bleeding at the time. Patient then came to nurses [nurses's] station and stated his knee was bleeding. This nurse cleaned and applied a dressing to top of right knee. MD and family notified . Review of the NP progress note dated 3/19/2024 at 7:45 PM, for Resident #6, revealed, .Today staff report that the patient did sustain a small abrased area just above his right knee. Staff state that the patient reported that his knee was injured on his bedside table. Patient is found sitting on the side of his bed in his room .When asked what happened to his knee he states 'the curtain was pulled and my roommate pushed his bedside table into my bedside table and my bedside table hit my knee.' Patient did show provider how he sits on the side of his bed with his feet on the lower part of his table and pointed out the area of his table that hit his knee. Provider asked if this hurt and patient stated 'it did a little at the time but not now . 5. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses which included Type 2 Diabetes Mellitus, Hypertensive Heart Disease, Chronic Obstructive Pulmonary Disease, and Long-Term Use of Anticoagulants. Review of the Admission MDS assessment dated [DATE], revealed Resident #8 had a staff assessment for mental status which indicated poor short term and long-term memory. Continued review of the MDS revealed Resident #8 was short tempered and easily annoyed. Further review of the MDS revealed Resident #8 had verbal outbursts, behaviors toward others, and his behaviors affecting his environment. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview in the resident's room on 3/19/2024 at 11:45 AM, Resident #6 stated, . Just an hour ago my roommate cursing people throwing a fit and he shoved his tray table toward me and caused my leg to start bleeding .he shoved the nurse that was in here to because she told him don't push me .he [Resident #8] yells and hollers and he knows I will get up . The observation revealed blood on the floor and bloody gauze lying on the overbed table. Resident #6 raised up his pants leg on his right leg to show the surveyor where the nurse just bandaged his leg due to the injury. During an interview on 3/19/2023 at 12:30 PM, RN U stated, .an LPN reported to me he [Resident #6] had an old skin tear that reopened . During an interview on 3/19/2024 at 3:25 PM, LPN V stated, .[Named RN U] done [did] all the treatments today .[Named Resident #6] s roommate pushed the overbed table toward him and caused a skin tear .the table has now been moved to the other side of [Named Resident #8]'s bed . During an interview on 3/19/2024 at 5:20 PM, RN U was asked about her nurse note on Resident #6. RN U stated, .I was in the room when it happened .[Named Resident #8] pushed his overbed table .water picture hit the floor .the table hit [Named Resident #6] on his knee .[Named Resident #8] was flying off with the 'F' word it aggravated him he wanted ice .I lied to you earlier .I didn't report it .I applied pressure he has poor skin he is a dialysis patient . During an interview on 3/20/2024 at 4:00 PM, SSD was asked if she was notified of the incident between Resident #6 and Resident #8. SSD stated, .We talked to RN U about it .[Named Resident #8] got upset because he wanted his pain medicine .I went down to talk to him [Named Resident #6] because I heard something about the incident .we [DON, Administrator, and department heads] were discussing it last night .I let them know I went down to check on [named Resident #6] .I don't know why I didn't do a progress note . The SSD was asked if Resident #6 continues to be at risk for potential abuse since he continues to be in the room with Resident #8. The SSD stated, .I don't really think so .he can take precautions if he feels he needs to .he isn't at risk because he is alert and oriented . During an interview on 4/11/2024 at 12:08 PM, the Administrator stated, .abuse should be reported immediately .reported to the state agency within 2 hours and the completed investigation should be sent up within 5 days . _____ (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Review of facility investigation #20230313103123 revealed, on 3/13/2023 at 9:30 AM, Resident #4 reported to staff that his roommate (Resident #3) hit him in the side of his head when he (Resident #4) was coming out of the bathroom. Hospice LPN (Licensed Practical Nurse) HH made sure both residents were separated and interviewed both residents. Resident #4 also reported the allegation that Resident #3 had hit him to Hospice LPN HH, Resident #4 stated he tried to hit him back. Resident #3 stated to Hospice LPN HH that he had hit Resident #4 for trying to .run me over . The incident was reported to the state agency on 3/13/2023 at 10:31 AM. Skin assessments performed on both Residents #3 and #4 on 3/13/2023, with no redness or bruises noted. No visible signs of physical abuse. Residents ' representatives, Adult Protective Services, and Police Department were notified of the incident on 3/13/2023. There were no witnesses to the abuse allegation. The facility determined the contact between Resident #3 and Resident #4 could not be verified. Both Residents were referred to Psychiatric Services and the Residents were separated to rooms on 2 separate halls. The final investigation was not uploaded to the state agency system until 2/1/2024. Review of the intake information revealed no additional information was sent to the state agency as of 3/21/2023. 7. Review of the medical record revealed Resident #3 was admitted on [DATE] and readmitted on [DATE] with diagnoses which included Paroxysmal Atrial Fibrillation, History of falling, adjustment disorder with mixed disturbance of emotions and conduct, Unspecified Dementia, and Restlessness and agitation. Review of the Quarterly MDS dated [DATE] for Resident #3 revealed a BIMS score of 5 which indicated severe cognitive impairment. Continued review of the MDS revealed Resident #3 no behaviors over the last 7 days. Continued review of the MDS revealed Resident #3 required extensive assistance related to bed mobility, transfers, dressing, toileting, personal hygiene, and bathing. Further review revealed Resident #3 received an anticoagulant over the last 7 days. Review of the Progress Note dated 3/13/2023 for Resident #3 revealed, .Alleged allegation with roommate. Family and appropriate agency notified . Review of the weekly skin observation dated 3/13/2023 for Resident #3 revealed no injuries related to alleged allegation with his roommate. During an interview on 4/2/2024 at 9:00 AM, Resident #3 stated, .I don't know how they are treating me .yea . yea . Resident #3 could not give any clear answers about his stay at the facility just nodded yes to all questions. 8. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] with diagnosis which included Hemipleagia and Hemiparesis following Cerebral Infarction, Aphasia, Adjustment disorder with mixed anxiety and depressed mood, and mild cognitive impairment. Review of the Admission MDS dated [DATE] for Resident #4 revealed 3/17/2023 for Resident #4 revealed a BIMS score of 12 which indicated moderate impaired cognition. Continued review of the MDS revealed Resident #4 had physical and other behaviors toward others. Continued review of the MDS revealed Resident #4 required extensive assistance related to bed mobility, transfers, dressing, toileting, personal hygiene, and bathing. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress Note dated 3/13/2023 for Resident #4 revealed, .PT [patient] WAS EXITING HIS ROOM AND VOICED THAT HIS ROOMATE HIT AT HIM AFTER HE WAS ROLLING BACKWARDS INTO ROOM AFTER USING THE BATHROOM, PT SAID HE SAID IM [I'm] SORRY AND TRIED TO MOVE AND THE ROOMATE HIT AT HIM AT HIS RIGHT SIDE HEAD. NO BRUSING REDNESS OR CHANGE NOTED IN SKIN. FAMILY MADE AWARE. PT REMOVED AND OUT OF ROOM AT NURSES STATION WITH STAFF . Review of the weekly skin observation dated 3/13/2023 for Resident #4 revealed no injuries related to alleged allegation with his roommate. Review of the Progress Note dated 3/14/2023 for Resident #4 revealed, .Pt resting in bed at this time. No bruising noted to right side of face or c/o [complaints of] pain. Adjusting to room change this shift . Review of the Progress Note dated 3/15/2023 for Resident #4 revealed, .No bruising noted to rt [right] side of face. Adjusting to room change this shift . Review of the Progress Notes from 3/26/2023 to 4/19/2023 revealed Resident #4 had increased inappropriate behaviors toward staff. Review of the Progress Notes dated 4/19/2023 for Resident #4 revealed, .Patient with noted increased inappropriate behaviors toward staff .Redirection and medication changes made with no affects. MD [Medical Doctor] notified and ordered for psych stay. Worked on placement to admit for psyc eval. Transfers patient via EMS [Emergency Management Services] to .Hospital for psych eval . Resident #4 did not return to the facility. During an interview on 3/19/2024 at 11:39 AM, Health Information Management T stated, .I was going down hall and [Named Resident #4] asked if I was a nurse .he said he had a disagreement with his roommate . [Named Resident #3] hit me .I hit him back .Nurse .went to check on them .the Administrator asked me to write out a statement . During an interview on 4/11/2024 at 12:08 PM, the Administrator stated, .abuse should be reported immediately .reported to the state agency within 2 hours and the completed investigation should be sent up within 5 days .we were going through our files just making sure all reportable investigations had been submitted and that is why the date is 2/1/2024 its the day we printed it .

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F 0656 Level of Harm - 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** 44724 Based on facility policy review, medical record review, observations, and interviews, the facility failed to develop and implement a comprehensive person-centered care plan for 2 of 17 residents sampled (Resident #5 and Resident #7) that resulted in actual harm for Resident #5. The findings include: Review of the policy titled, Documentation Guidelines, dated 6/2023 revealed, .The center will ensure an interdisciplinary and comprehensive approach to the development of the patient's care plan of care. Patient's goals for care and preferences will be determined and used to develop their plan of care .Full care plan within 7 days of completion .of a clinical MDS assessment .Problems are patient conditions, needs, or weakness which currently do, or potentially could, prevent the patient from achieving or maintaining the highest practicable level of weel-being .Care Plan Approaches are specific, individualized steps partners and patients will take together to assist the patient to achieve the goal .Approaches serve as instructions of patient care an provide for continuity of care by all partners . Review of the facility policy titled, Incident and Accident Process, dated 1/2024 revealed, .An incident or accident is defined as any occurrence that is outside the norms or any happening that is not consistent with the routine operation of the center or care of a particular patient .When any incident results in injury, as defined below, and/or there is evidence of negligence, they must be reported to clinical risk management . Significant injury including: Fracture or dislocation of bones or joints, Closed head injury with altered consciousness, and Subdural hematoma .Any condition requiring medical treatment outside the center that is inconsistent with the routine management of the patient's preexisting condition(s) .The DON [Director of Nursing] should review all incidents for accuracy and complete documentation .is data complete and thorough and paints a picture of what happened .Was the care plan updated to reflect the incident .Is additional investigation needed to determine the exact events of the incident .What can be done to avoid similar incidents recurring on this or any patient in the center . Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnosis which included Alzheimer's disease, Dementia, and Long-term use of anticoagulants. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 4 which indicated severe cognitive impairment. Continued review of the MDS revealed Resident #5 required extensive assist with bed mobility, transfer, locomotion on unit and off unit, and dressing. Further review of the MDS revealed Resident #5 received an anticoagulant (blood thinner) over the last 7 days. Review of fall event dated 11/18/2023 revealed Resident #5 had a witnessed fall in the hallway while leaning over in wheelchair. Resident #5 sustained an abrasion noted to his forehead with the witnessed fall. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) from 11/1/2023 to 11/30/2023 revealed Resident #5 received Eliquis (blood thinner) 2.5 mg (milligram) by mouth twice a day. Review of the Progress note dated 11/18/2023 for Resident #5 revealed, .PT WAS WITNESSED LEANING OVER IN WHEELCHAIR AND fell TO THE FLOOR. PT NOTED TO HAVE AN ABRASION NOTED TO FOREHEAD. [Named Conservator B] MADE AWARE, [Named Nurse Practitioner (NP) C] AWARE . Review of the Physician Progress Notes dated 11/24/2023 for Resident #5 revealed, .Routine visit for patient [with] progressive dementia .per Nursing fell last week bending over reaching for glasses Abrasion to R [right] forehead . Review of the care plan for falls for Resident #5 revealed .Problem Start Date 6/18/2019 .At risk for falls r/t [related to] Hx [history] of falls, Alzheimer's and Dementia with decreased safety awareness, Delusional disorder .Goal .Patient will have fall risks minimized through 120 days or next review .11/18/2023 Encourage me to ask for assistance when picking items up off the floor .8/19/2023 Encourage me to ask for assistance when wanting to leave the dining room .4/16/2023 I will go from my low bed to mats and crawl in the floor in my room at times. I will do this instead of using my call light for assistance .8/4/2022 place bed control out of reach so that I do not adjust my bed to unsafe level .6/18/2019 Encourage patient to use non-skid footwear during transfers/ambulation .Encourage to use call light for needed assistance . The care plan interventions to prevent falls were not appropriate for Resident #5. Resident #5 had a BIMS score of 4 with the inability to remember to ask for assistance or any ability to put non-skid footwear on prior to transfers and no ambulation occurred over the last 7 days of the MDS look back period. Review of the 5-day MDS assessment dated [DATE] for Resident #5 revealed a BIMS score of 4 which indicated severe cognitive impairment. Continued review of the MDS revealed Resident #5 required substantial/maximal assistance with sit to stand, chair/bed to chair transfer, and walking 10 feet was not attempted. Further review of the MDS revealed Resident #5 received an anticoagulant over the last 7 days. Review of the MAR dated 1/1/2024-1/31/2024 revealed an order for Eliquis 2.5 mg by mouth twice a day administered from 1/1/2024-1/23/2024. Review of the Progress Notes dated 1/23/2024 for Resident #5 revealed, .2:05PM .PT [patient] WAS LEANING FOWARD IN WHEELCHAIR REACHING TO THE FLOOR AND fell OUT OF CHAIR HITTING HEAD ON FLOOR CREATING AN ABRASION. [Named Conservator B] AWARE AND NP .[Named NP C] AND HOSPICE AWARE WITH NO NEW ORDERES [orders] AT THIS TIME . The circumstance of Resident #5's fall on this date (1/23/2024) was identical to the fall on 11/18/2023, with a post care plan intervention, which was not appropriate to prevent further falls due to Resident 5's impaired cognitive status. Review of the neuro checks dated 1/23/2024 for Resident #5 revealed: 1:30 PM B/P 124/60, P 114; (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	2:00 PM B/P 102/87, P 66; 2:30 PM 105/60, P 55; 3:00 PM 130/55, P 67; 4:00 PM 107/89, P 66; 5:00 PM 90/62, P 76; 6:00 PM 98/40, P 50; 7:00 PM 90/46, P 43; 11:00 PM 90/52, P 70. Review of the Progress Notes dated 1/23/2024 for Resident #5 revealed, .6:50PM .PT NOTED TO HAVE A DECLINE THIS AFTERNOON HOSPICE HERE TO EVAL . Review of the Hospice D's Visit Note Report dated 1/23/2024 for Resident #5 revealed, .Vital Signs .Pulse 98 .Blood Pressure 88/52 .PT HAD FALL HYPOTENSIVE [NAME] [DECLINE] NOTED IN STATUS AND SLURRED SPEECH .MOANING TENSE .TYLENOL FOR PAIN ADDED ROXANOL [Narcotic given for severe pain] .RESPIRATORY STATUS .SHALLOW SHORTNESS OF BREATH .HEART RATE FINDINGS IRREGULAR TACHYCARDIA .PALE .ABRASION FOREHEAD .FALL REPORT ABRASION AREA TO FOREHEAD HYPOTENSIVE .HOSPICE NURSE IN FACILITY FOR VISIT FOR OTHER RESIDENTS. FACILITY NURSE ASKED NURSE TO VISIT WITH PT DUE TO RECENT FALL DECLINE THROUGHTOUT DAY. NURSE ENTERED ROOM .INCREASED PALE IN COLOR AND SLURRED SPEECH NOTED WITH WORDS. ABRASION NOTED TK [TO] FOREHEAD RISED AREA .HAND GRIPS WEAK .PT TENSE AND MOANING WITH TOUCH BREATHING SHALLOW HYPOTENSIVE IRREGULAR . HEART RATE .NEW ORDER PER MD [MEDICAL DOCTOR] .ROXANOL 0.5ML [MILLILITERS] BY MOUTH OR UNDER TONGUE EVERY 2 HOURS AS NEEDED FOR PAIN RESTLESSNESS AND OR AIR HUNGER .PT DAID [SAID] HE WAS COLD .NEW ORDERS REPORTED TO NURSE AND CONSERVATOR MADE AWARE BY FACILITY NURSE HOSPICE NURSE BESIDE NURSE .VISIT TIME . 7:00PM . Review of the Nurse Practitioner (NP) C's progress note dated 1/24/2024 for Resident #5 revealed, .He was admitted to hospice services on 1/19/24. Staff did notify ths [this] provider, by way of phone, yesterday evening that the patient had fell forward out of his wheelchair and hit his head on the floor. The nurse reported that the patient was now having what she believed were neurological changes. She stated that he appeared more drowsy and confused .New orders were given to discontinue patient's Eliquis at this time due to possibility of bleeding .Today staff report that the patient continues to be more confused than his baseline. He is reported to have increased agitation and also hypotension .Patient is found in his room .drowsy and with nonsensical speech . Review of the Progress Notes dated 1/24/2024 for Resident #5 revealed, .1:01PM .ALERT .PT RESTING IN BED AT THIS TIME.ABRASION CONTS [continues] OT [to] FOREHEAD.PT COMBATIVE THIS AM DURING CARE. SMALL AMOUNT OF BLOOD NOTED TO MOUTH, CLEANSED WITH TOOTHETTES . (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of the Progress Notes dated 1/25/2024 for Resident #5 revealed, .2:54AM .ALERT .Patient with abrasion noted .Patient noted to be rambling/mumbling with this nurse not able to understand patient .Patient with blood noted to mouth from recent fall .Patient has continued to attempt to get out of bed without assistance with staff providing education to patient to not get up without assistance . Resident #5 with a BIMS score of 4 was unable to comprehend any type of education on safety. Review of Hospice D's Visit Note Report for Resident #5 dated 1/25/2024 revealed, .Pulse 110 .Blood Pressure 86/53 .OCCASIONAL MOAN OR GROAN .FRIGHTENED .KNEES PULLED UP .UNABLE TO SPEAK .HE IS DISORIENTED .UNABLE TO BE REDIRECTED .COMBATIVE WITH ANY ACTIVITY . DAZED LOOK ON HIS FACE. HE IS HYPOTENSIVE AND TACHCARDIC .7:02 AM . Review of the Progress Notes dated 1/25/2024 for Resident #5 revealed, .10:27AM .ALERT .Pt confused with combativeness .Pt reaching for things not present in the room. Abrasion to forehead remains . Review of the Progress Notes dated 1/25/2024 for Resident #5 revealed, .11:55AM .Spoke with NP this am regarding patients decline. Patient has been combative with staff when attempting to provide .care .Hospice made aware of patients decline and will be out to make a visit this shift . Review of the Progress Notes dated 1/26/2024 for Resident #5 revealed, .12:43AM .Patient .mumbling with this nurse unable to understand what patient is saying. Patient continues with abrasion to forehead .Patient combative with staff this shift .Patient has continued to attempt to get out of bed without assistance with staff . Review of the Progress Notes dated 1/26/2024 for Resident #5 revealed, .11:32AM .ALERT .Pt unable to swallow anything PO [by mouth] at this time. Abrasion remains to forehead .Neurochecks completed from recent fall. R/T [related to] pt decline, Roxanol administered for pain per order . Review of the Progress Note dated 1/26/2024 for Resident #5 revealed, .2:48PM .patient unable to take PO meds due to decline in conditions. meds discontinued per NP and hospice . Review of the Progress Note dated 1/26/2024 for Resident #5 revealed, .10:11PM .This nurse was notified that pt was unresponsive. Went in to [into] pt's room to assess. Pt seen lying on bed unresponsive, no spontaneous movements and no response to verbal and painful stimuli noted. Pupils were fixed dilated, non reactive to light and accommodation. Carotid pulse not palpated. No heart and lung sounds auscultated. No noted rise and fall of abdomen. Pt pronounced dead at 9:57pm [PM] . During an interview on 4/10/2023 at 2:13 PM, the DON was asked if the care plan intervention for Resident #5's fall was an appropriate intervention for a resident with a BIMS score of 4. The DON stated, .No, I thought we went back and fixed the care plans for the residents with poor cognition .he can't remember to ask for assistance and to use non skid socks would not be appropriate .I thought we changed the word encourage to the word remind . (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/19/2024 at 12:28 PM, Registered Nurse (RN) R stated, .with any fall you perform a head to toe assessment .if a resident hits their head we would start neuro checks .Call MD immediately with any changes RN R was asked if the facility would treat a hospice resident that had a fall any different. RN R stated, .we still treat a hospice patient the same notify hospice, call doctor, family and update them with any changes .just because the resident is on hospice doesn't mean they can't go to the hospital if that is what the family wants to do . RN R stated, .when a fall happens you put in an event in the computer system .it asks if the resident takes anticoagulants .you should call the MD to see if they want to continue the blood thinner .a resident could have a fracture, subdural hematoma .watch their blood pressure to see if it is dropping .heart rate going up .changes in their cognition .could be signs of a bleed . During an interview on 3/20/2023 at 3:06 PM, LPN G stated, .I talked to [Named Conservator B] after his fall . I think I told her he hit his head, I don't remember if I told her he was taking a blood thinner .I think I talked to her about his decline in his blood pressure .I told the NP about his changes . During a telephone interview on 4/5/2024 at 7:55 AM, Conservator B called this surveyor back and stated, .I knew [Named Resident #5] had been declining and was placed on hospice but I have no record that I was told he was taking a blood thinner when he fell and hit his head .I even asked my boss to see if she recalled anything being said about blood being found in his mouth .just because a resident is on hospice it doesn't mean they shouldn't be sent out for treatment .I just recently sent a hospice patient out of a facility due to a head injury .I had a doctor tell me that if the blood pressure can be more stabilized it helps with the patients comfort. I was notified by email about the fall .I have no records of any phone call related to the fall .I wish I would have been told about blood in his mouth .I did receive a call on the day he passed away . Conservator B provided the email dated 1/23/2024 at 2:15 PM from LPN G which revealed, .Hey, just wanted to let you know that [Named Resident #5] fell out of wheelchair and got an abrasion to forehead During an interview on 4/8/2024 at 11:48 AM, Hospice LPN HH stated, .I was at the facility visiting other hospice residents on 1/23/2024 and [Named LPN HH] wanted me to see [Named Resident #5] because he was hypotensive after his fall .he was restless .I heard [Named LPN HH] call the conservator and made her aware of .his overall decline .I think it was between 6:00 PM and 7:00 PM when I saw him .I know the NP was notified related to him being on Eliquis and his blood pressure being lower . Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnosis which included Vascular Dementia, unspecified severity. Review of the care plan for Resident #7 revealed, .Start Date: 11/09/2023 .Behavioral Symptoms .At risk for alteration in behaviors refusal of plan of care .Pt has impulsive behaviors with decreased safety awareness, false beliefs/misperceptions, physical behavior towards staff, and wandering .Approach Start Date . 3/19/2024 Patient may attract negative attention from other patients due to their poor understanding of personal space and spatial boundaries. Redirect as needed .When Pt is wandering, assess for unmet physical needs, psychological distress, and environmental factors. Distract Pt by introducing enjoyed activities .Educate and encourage patient to comply with plan of care . (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Resident #7 with a BIMS score of 6 does not have the ability to understand the need to comply with the plan of care. Review of the Quarterly MDS dated [DATE] revealed Resident #7 had a BIMS score of 6 which indicated severe cognitive impairment. Continued review of the MDS revealed Resident #7 experienced delusions, physical behaviors directed toward others, and wandered 4-6 days over the last 7 day look back period. Review of the NP progress note dated 3/18/2024 for Resident #7 revealed, .Per staff, patient remains at her baseline. She is pleasantly confused . Observation in the resident's room on 3/19/2024 at 2:45 PM, revealed Resident #7 being assisted to bed. Observation in the dining room on 3/20/2024 at 12:30 PM, revealed Resident #7 was in her wheelchair rolling to different residents introducing herself.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on facility policy review, medical record review, www.wunderground.com, Electrical Company invoice, observation and interview, the facility failed to provide adequate supervision to prevent an accident for 2 (Resident #5 and Resident #10) of 6 sampled residents reviewed for accidents. The facility failed to ensure adequate supervision to prevent an exit seeking, wandering, cognitively impaired resident (Resident #10) with a Brief Interview for Mental Status (BIMS) score of 9, assessed to be an elopement risk, from leaving a safe environment and exiting the facility to an unsafe environment. Resident #10 (wearing a wander guard bracelet) exited a double door connected to the door alarm/wander guard system that malfunctioned on [DATE] at an unknown time until [DATE] at 2:00 AM. No alarm was activated when Resident #10 exited through the double doors. Resident #10 walked approximately 618 feet down a sidewalk, an embankment, and into a street to a house in the nearby community. Resident #10 knocked on the door and stated, I am trying to find my house. A member of the house (a previous male employee) recognized Resident #10 and drove her back to the facility at approximately 2:15 AM. The staff were unaware Resident #10 was missing from the facility. Resident #10 reported to the nurse when she returned that she fell down the hill. Resident #10 had dirt on the back of her clothes. Resident #10 reported to the Nurse Practitioner (NP) on [DATE] that she bit her tongue when she fell , and a small laceration to right side of her tongue was noted. The facility also failed to provide supervision to ensure an environment free of accidents for Resident #5, a vulnerable high fall risk resident, receiving blood thinner. On [DATE] at 2:05 PM, Resident #5 had a witnessed fall which resulted in a head injury. The Conservator was notified of the fall via email. At 5:00 PM Resident #5's blood pressure had decreased to ,d+[DATE]. Licensed Practical Nurse (LPN) A (Hospice nurse) noted Resident #5 was pale in color, with slurred speech, an abrasion/ raised area to forehead, weak grip, shallow breathing, was tense and moaning, hypotensive with an irregular heart rate, and Resident #5 stated he was cold. On [DATE] and [DATE] staff noted in a nursing note: Resident #5 had blood in his mouth and was combative with care and restless. Resident #5 expired in the facility on [DATE], 3 days after the fall. The facility's failure to provide adequate supervision for vulnerable residents resulted in Resident #10's elopement and Resident #5's accident which placed the residents in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident) with actual harm. The Administrator was notified of the Immediate Jeopardy (IJ) for F-689 on [DATE] at 4:33 PM related to Resident #10 in the conference room. The Administrator and the Senior [NAME] President were notified of the IJ on [DATE] at 6:33 PM related to Resident #5 in the conference room. The facility was cited at F-689 at a scope at severity of J, which is Substandard Quality of Care. The Immediate Jeopardy began [DATE], continued through [DATE], and was removed on [DATE]. An acceptable Removal Plan, which removed the immediacy of the Jeopardy for F-689 was received on [DATE]. The corrective actions were validated onsite by the surveyors on [DATE] through observation, review of records, audit review, education review, and staff interviews. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's noncompliance at F-689 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. The findings include: 1. Review of the facility policy titled, Incident and Accident Process, dated ,d+[DATE] revealed, .An incident or accident is defined as 'any occurrence that is outside the norms or any happening that is not consistent with the routine operation of the center or care of a particular patient .All patient incidents should be documented in the EHR [electronic health record] .When any incident results in injury, as defined below, and/or there is evidence of negligence, they must be reported to clinical risk management .Significant injury including: Fracture or dislocation of bones or joints, Closed head injury with altered consciousness, and Subdural hematoma .Any condition requiring medical treatment outside the center that is inconsistent with the routine management of the patient's preexisting condition(s) .The DON [Director of Nursing] should review all incidents for accuracy and complete documentation .is data complete and thorough and paints a picture of what happened .Was the care plan updated to reflect the incident .Is additional investigation needed to determine the exact events of the incident .What can be done to avoid similar incidents recurring on this or any patient in the center . Review of the undated facility policy titled, MISSING PATIENT PROCEDURE, revealed, .In the event a patient is discovered missing from the building, the following policies and procedures shall govern the situation .Person discovering that a patient may be potentially missing or not accounted for shall report the situation to their immediate supervisor .If the patient has not lawfully left the center, an immediate search of the building shall take place (corridor by corridor) at the direction of the charge nurse. Every patient's room bathroom, closet, or storage area will be thoroughly searched .Concurrent with the internal search, an external search of the grounds and adjacent areas shall be scanned for a wandering patient .including street and side street proximal to the center the charge nurse shall delegate this task .The Administrator and Director of Nurses shall be notified of situation immediately as well .When a missing patient has been found, an incident report and detailed description of the search shall be completed and forwarded to the DON and Administrator .All staff should be alert as to the whereabouts of all patients at all times to the extent possible and should be familiar with these procedures . 2. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Alzheimer's disease with late onset, Dementia without Behavioral Disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of the care plan for Resident #10 revealed, .Problem Start Date XXX[DATE] Elopement: At risk for complications r/t [related to] impaired cognition due to dementia, wanders .Goal Target Date XXX[DATE] Will have elopement risk minimized through next 120 days or next review. Will remain in safe confines of center unless supervised by staff/representative .Approach Start Date XXX[DATE] apply and maintain wanderguard as need for accidental or self removing .Approach Start Date XXX[DATE] check wanderguard placement & function as ordered. Replace one month prior to expiration date .Approach Start Date XXX[DATE] Redirect and reassure patient during episodes of exit-seeking . The care plan for Resident #10 revealed at risk for elopement since [DATE]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Smithville	825 Fisher Ave Smithville, TN 37166

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Progress Notes dated [DATE] for Resident #10 revealed, .pt [patient] noted to pace hallways this night when asked what she was doing she stated she didn't know and felt like walking .when oriented to time of night pt stated maybe i [I] should sleep . Review of the Progress Notes dated [DATE] for Resident #10 revealed, .Frequently requires redirection by staff. Occasionally delusional . Review of the Elopement Risk dated [DATE] for Resident #10 revealed, .Has patient exhibited wandering or exit seeking behavior in the last 90 days .No .Is patient cognitively impaired with poor decision making skills . Yes .Does patient have indications of dementia or a diagnosis of dementia .Yes .Elopement Risk Score: 0.0 . The progress notes revealed Resident #10 was pacing the halls and expressed she did not know why, which placed this resident to be at risk for an elopement. Review of the Progress Notes dated [DATE] for Resident #10 revealed, .pt wandering in hallway earlier looking for daughter going room to room redirected returned to her room and 10 mins. [minutes] later doing same thing .easily redirected but doesn't last long. since med d'c 'd [discontinued] pt is more alert but some paranoia noted along with wandering in the evening and night .will monitor . Review of the Elopement Risk dated [DATE] for Resident #10 revealed, .Has patient exhibited wandering or exit seeking behavior in the last 90 days .No .Is patient cognitively impaired with poor decision making skills . Yes .Does patient have indications of dementia or a diagnoses of dementia .Yes .Elopement Risk Score: 0.0 . The progress notes revealed Resident #10 was wandering the halls and searching for family which placed the resident to be at risk for an elopement. Review of the Progress Notes dated [DATE] for Resident #10 revealed, .NP, notified of Pt's increased paranoia and not sleeping at night. New order noted for Trazadone [antidepressant] 25mg [milligram] PO [by mouth] q [every] HS.[hour of sleep] Review of the Progress Notes dated [DATE] for Resident #10 revealed, .pt wanders halls looking for daughter or trying to figure out 'what i am supposed to do' redirected multiple times by staff . Review of the Progress Notes dated [DATE] for Resident #10 revealed, .pt wandering in hallway off and on during the night looking for family .redirected and then 30 mins. later same thing .will monitor . Review of the Progress Notes dated [DATE] for Resident #10 revealed, .pt in hallways last night looking around then would go into room a few mins later looking around again .off and on all night .when asked what are you looking for stated 'i dont know' would go back to room and lay down .will monitor . Review of the Progress Notes dated [DATE] for Resident #10 revealed, .pt up at night looking up and down hallways .then will dart back in room .when asked if pt needs something stated 'i'm [stated I'm] just looking . will monitor . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Progress Notes dated [DATE] for Resident #10 revealed, .pt paranoid and packing clothes up unable to redirect .will monitor . Review of the Progress Notes dated [DATE] for Resident #10 revealed, .Staff report behaviors such as packing to leave and wondering [wandering] -state . Review of the Elopement Risk dated [DATE] for Resident #10 revealed, .Has patient exhibited wandering or exit seeking behavior in the last 90 days .Yes .Is patient cognitively impaired with poor decision making skills . Yes .Does patient have indications of dementia or a diagnosis of dementia .Yes .Elopement Risk Score: 1.0 Level: The patient is at risk for elopement. Proceed with appropriate safety intervention . Review of the Progress Notes dated [DATE] for Resident #10 revealed, .Episodes of wandering up et [and] down halls looking for family . Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had Brief Interview for Mental Status (BIMS) score of 9 which indicated moderately impaired cognition. Continued review of the MDS revealed Resident #10 wandered ,d+[DATE] days over the last 7 days. Continued review of the MDS revealed Resident #10 required supervision with locomotion on unit and no setup or physical help from staff for locomotion off unit. Continued review of the MDS revealed Resident #10 was able to walk 10 feet - 150 feet independently. Review of the care plan for Resident #10 revealed, .Problem Start Date XXX[DATE] .Behavioral Symptoms . At risk for altercation in behaviors r/t refusal of plan of care .Pt has wandering, delusions, and hallucinations . Approach Start Date XXX[DATE] .promote safety .Remind patient that words and actions have impact; redirect as needed .Remove patient from triggering situations when possible; respect personal space and rights . The behavior care plan for Resident #10 revealed she wandered and was delusional which placed the resident at risk for elopement. Review of the Progress Notes dated [DATE] for Resident #10 revealed, .Pt had walked to other unit .was frantically and repeatedly asking for . her ex husband [named Ex-husband] . Review of the Progress Notes dated [DATE] for Resident #10 revealed, .wanders throughout building looking for family members .will continue to monitor . Review of the Order History for Resident #10 revealed XXX[DATE] .Wanderguard: check for placement and skin integrity under band nightly .Wanderguard .expiration date Jun [June] 2023; check skin for placement, skin integrity, and functionality daily . Review of the Progress Notes dated [DATE] for Resident #10 revealed, .Pt is noted with increased confusion and pacing . Review of the Progress Notes dated [DATE] for Resident #10 revealed, .Continues to wander in hallway and requires some redirection . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Progress Notes dated [DATE] for Resident #10 revealed, .pt wanders halls looking for family members or locations . Review of the Elopement Risk dated [DATE] for Resident #10 revealed, .Has patient exhibited wandering or exit seeking behavior in the last 90 days .No .Is patient cognitively impaired with poor decision making skills . Yes .Does patient have indications of dementia or a diagnoses of dementia .Yes .Elopement Risk Score: 0.0 . The progress notes revealed Resident #10 was wandering the halls and searching for family which placed the resident to be at risk for an elopement. Review of the Progress Notes dated [DATE] for Resident #10 revealed, .increased confusion/paranoia noted this week .pacing and looking for husband or family .rummaging/hoarding items primarily on bed .refuses to allow staff to remove items . Review of the Progress Notes dated [DATE] for Resident #10 revealed, .Staff state that patient continues with occasional behaviors (packing to leave and wandering) . Review of the Progress Notes dated [DATE] for Resident #10 revealed, .Pt noted in room packing stating that she is going home that the Md [medical doctor] okayed it . Review of the Elopement Risk dated [DATE] for Resident #10 revealed, .Has patient exhibited wandering or exit seeking behavior in the last 90 days .No .Is patient cognitively impaired with poor decision making skills . Yes .Does patient have indications of dementia or a diagnosis of dementia .Yes .Elopement Risk Score: 0.0 . The progress notes revealed Resident #10 was wandering the halls, searching for family, and packing to leave which placed the resident to be at risk for an elopement. Review of the Progress Notes dated [DATE] for Resident #10 revealed, .pt exited building .walked to near by house .was returned to facility by member of the community .pt reports falling on hill outside door .no injury or pain noted .NP and daughter .notified .pt resting in bed at this time .will continue to monitor . Review of the POST FALL REPORT dated [DATE] revealed, .pt stated fell while outside on the hill . Review of the Progress Notes dated [DATE] for Resident #10 revealed, .PT SEEN BY NP .THIS AM .PT REPORTED TO HAVE BITTEN HER TONGUE WHEN SHE fell .NP ORDERED WARM SALT WATER WRINSES [rinses] FOR THIS .PT CALM, NOT EXIT SEEKING .WILL CONT [CONTINUE] TO MONITOR . Review of the NP Progress Notes dated [DATE] for Resident #10 revealed, .Patient is seen today for follow up after exiting the facility early this morning and a self reported fall upon her return. Per staff, the patient did have dirt on the back of her clothes consistent with a fall as she had reported .Patient's daughter and daughter-in-law did arrive and the patient did report to them that her tongue was sore. Patient states that she thinks she bit it. No other injuries noted. Family is concerned about insomnia and requests that the patients night time sleep medicine 'trazadone' be increased . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Order History dated [DATE] - [DATE] for Resident #10 revealed .Wanderguard: check for placement and skin integrity under band nightly .Wanderguard .expiration date Jun [June] 2023; check skin for placement, skin integrity, and functionality daily . Review of an invoice from Electrical Company revealed, the Senior [NAME] President (SVP) called the company on [DATE] at 6:10 AM and stated need electrical work at exit door on South end exit today. Continued review of the invoice revealed Electrical Company OO arrived at the facility on [DATE] and relocated exit light and power to exit panel and lock to an unswitched circuit. Review of the www.wunderground.com [weather underground] website the weather on [DATE] was a low of 67 degrees, high of 79 degrees, with 1.35 inches of rain for the day. During an interview on [DATE] at 4:20 PM the Director of Nursing (DON) stated, .we have an investigation on [Named Resident #10] exiting the building . Observation in the dining room on [DATE] at 10:57 AM, revealed Resident #10 was sitting at a table playing bingo. After the activity she followed staff out of the activity and goes straight to her bed to lay down and cover up. During an interview on [DATE] at 8:00 AM, the Administrator stated, .we were unable to determine what time she left .I don't know which house exactly she went to, but I have an address and phone number of the previous employee that brought her back to the building . During an interview on [DATE] at 9:05 AM, Family Member (FM) X stated, .They called me in the middle of the night said she [Resident #10] got out the door because the electricity went out or something .She wandered to a house in the neighborhood .I understood she either knocked on the door or rung the doorbell . that is the only time I knew she ever got out of the building .She went down an embankment .she said she fell .might have got some minor scratches .I went and looked where she walked out you could see in the mud where she slipped .I am so glad she didn't wander where them 2 bull dogs were chained up .a gentleman from the house she walked to brought her back .I know by 3:16 AM she was back in the building .The staff didn't even realize she was gone .she went out the double door close to her room .I don't have any idea the last time the staff had seen her .I was told the alarm didn ' t sound it wasn't working or something .I went down to the facility and the alarm was not working on the door .The facility said they would get the door fixed immediately but I couldn't understand why that was the only safety device they had in place to monitor the residents . During a telephone interview on [DATE] at 12:15 PM, Licensed Practical Nurse (LPN) Z stated, .I was working the night [Named Resident #10] left the building .I was not aware she was missing .She knocked on a door of a house near by .a CNA that use to work here was living there and he recognized her and brought her back to the facility .She had gotten up a couple of times .wandering a few times that night .I am not sure what time she left the building .I usually give her medicines between 7:00 PM - 9:00 PM .we were aware she was missing when the building got the phone call .We turned the light switch off to help the residents rest and that disengaged the door. She was more confused when she came back .mud and grass on her bottom . she said she slide down the hill . She didn't have any injuries .I contacted the person on call but I can't remember who that was .I spoke to the [Named Administrator] as well .I know the doors are checked by the maintenance department .they had someone to come out and repair the wiring to the door .we did a check for all the residents being in the building after she exited the building . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 12:19 PM, LPN AA stated, .I was working that night when [Named Resident #10] got out of the building .the phone at the facility rang and someone asked if we had a resident missing .and then the doorbell rang and a gentleman had brought [Named Resident #10] back .We didn't know she was missing .She was a little scared and confused .she had some mud on her bottom and leg . [Named Resident #10] knocked on the neighbors door and said something about work she had to do in the basement .I am not sure how he got her back to the facility . During a telephone interview on [DATE] at 12:23 PM, CNA BB, stated, .[Named Resident #10] was having a hard time sleeping that night .[[DATE] the night Resident #10 eloped from the facility]kept wanting her son, wanting to leave to catch the bus .She went to sleep I thought .later I thought I heard a door closing .I thought the sound came from the vending machine .then an employee that use to work here brought her back to the building .she had walked to his family's house down the road .She had mud on her clothes, it had rained that day .we didn't see no visible injuries .I think that light switch was connected to the door and when we turned the lights off the door wasn't working .I usually do a round to check on everybody at 10:30 PM, 12:00 AM, or 1:00 AM .I don't remember what time it was I performed a check on her . During an interview on [DATE] at 1:50 PM, LPN Q stated, .If we had a missing wander guard or a missing resident, we would immediately do a head count . During an interview on [DATE] at 2:10 PM, the Administrator stated, .the door shorted out when the light switch was turned to the off position .we had an electrician come out to fix the door the next day .Initially the staff did not know she was gone .the staff said they heard a sound like a door slamming .two of the CNAs started checking the unit and that is when they realized [Named Resident #10] was missing . During an observation and interview on [DATE] at 4:15 PM, the Administrator and this Surveyor walked off the potential footage Resident #10 walked when she exited the facility on [DATE]. Resident #10 exited the 200 hall double doors, walked along a sidewalk, potentially walked down an embankment into the road. Resident #10 continued to walk to the fifth house to the right and knocked on the door. The potential footage walked was approximately 618 feet. The Administrator was asked if an interview was obtained from the former employee who brought Resident #10 back to facility, and he replied, No. During a telephone interview on [DATE] at 4:15 PM, Former Employee EE stated, .[Named Resident #10] walked to our house and knocked on the door around 2:00 AM .She was really confused and said she was trying to find her house, she was needing to go home .I had taken care of her before when I worked at the facility as a nurse aide .I helped to calm her down and got her into my car .in the meantime my family was calling the facility to make sure they had a missing resident .an employee came to the door to get her .They didn't know she was missing .She had one of those ankle bracelets on but [Named LPN Z] said it must have been broken . During a telephone interview on [DATE] at 4:34 PM, CNA GG stated, .[Named Resident #10] did get out of the building .I don't remember the time or if we knew really what time she left .she knocked on a neighbors door .I don't know if we knew she was gone or not .she would walk around the building independently . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 12:00 PM, the DON stated, .I would expect if a resident exited the building the nurse would do a full body assessment .chart the last time the resident was observed in the building .the alarm on the door did not sound when [Named Resident #10] went out the side door .I know the light switched contributed to her exiting the building .I did not interview [Named Former Employee EE] .I would expect my staff to know a resident was missing . Record review revealed there was no documentation for the last time Resident #10 was observed in the facility. _____ 3. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnosis which included Alzheimer's disease, Dementia, and Long Term Use of Anticoagulants. Review of the Quarterly MDS dated [DATE] revealed Resident #5 had a BIMS score of 4 which indicated severe cognitive impairment. Continued review of the MDS revealed Resident #5 required extensive assist with bed mobility, transfer, locomotion on unit and off unit, and dressing. Further review of the MDS revealed Resident #5 received an anticoagulant (blood thinner) over the last 7 days. Review of fall event dated [DATE] revealed Resident #5 had a witnessed fall in the hallway while leaning over in his wheelchair. Resident #5 sustained an abrasion noted to his forehead with the witnessed fall. Review of the neuro check sheet revealed the frequency to be performed was every 30 minutes times (x) 4, every 1 hour x 4, every 4 hours x 4, and every 8 hours x 6. Review of the neuro checks for [DATE] - [DATE] revealed missing documentation on [DATE] at 3:00 PM for the neuro check. Review of the Medication Administration Record (MAR) from [DATE] to [DATE] revealed Resident #5 received Eliquis (blood thinner) 2.5 mg by mouth twice a day. Review of the Progress note dated [DATE] for Resident #5 revealed, .PT WAS WITNESSED LEANING OVER IN WHEELCHAIR AND fell TO THE FLOOR. PT NOTED TO HAVE AN ABRASION NOTED TO FOREHEAD. [Named Conservator B] MADE AWARE, [Named NP C] AWARE . The progress note does not reveal if Conservator B was made aware of the risk of a fall with head injury while receiving a blood thinner for Resident #5. Review of the Physician Progress Notes dated [DATE] for Resident #5 revealed, .Routine visit for patient [with] progressive dementia, Afib [Atrial Fibrillation] .per Nursing fell last week bending over reaching for glasses Abrasion to R [right] forehead . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the care plan for falls for Resident #5 revealed .Problem Start Date [DATE] .At risk for falls r/t [related to] Hx [history] of falls, Alzheimer's and Dementia with decreased safety awareness, Delusional disorder .Goal .Patient will have fall risks minimized through 120 days or next review XXX[DATE] Encourage me to ask for assistance when picking items up off the floor XXX[DATE] Encourage me to ask for assistance when wanting to leave the dining room XXX[DATE] I will go from my low bed to mats and crawl in the floor in my room at times. I will do this instead of using my call light for assistance XXX[DATE] place bed control out of reach so that I do not adjust my bed to unsafe level XXX[DATE] Encourage patient to use non-skid footwear during transfers/ambulation .Encourage to use call light for needed assistance . The care plan interventions to prevent falls were not appropriate for Resident #5. Resident #5 had a BIMS score of 4 with the inability to remember to ask for assist or the ability to put non-skid footwear on prior to transfers and no ambulation occurred over the last 7 days of the MDS look back period. Review of the 5-day MDS assessment dated [DATE] for Resident #5 revealed a BIMS score of 4 which indicated severe cognitive impairment. Continued review of the MDS revealed Resident #5 required substantial/maximal assistance with sit to stand, chair/bed to chair transfer, and walking 10 feet was not attempted. Further review of the MDS revealed Resident #5 received an anticoagulant over the last 7 days. Review of the MAR dated [DATE]-[DATE] revealed an order for Eliquis 2.5 mg by mouth twice a day administered from [DATE]-[DATE]. Review of Hospice D's Visit Note Report dated [DATE], revealed Resident #5 was admitted to hospice with primary diagnoses of Cerebral Atherosclerosis and secondary diagnoses of Dementia. Review of the Visit Note Report revealed Resident #5 was confused, able to verbalize his name, self-propels in wheelchair short distances, and 3 or more falls in past 3 months. Review of Hospice D's Visit Note Report dated [DATE], revealed Resident #5 was being changed by CNA; the Hospice nurse assisted with Resident #5 transferring from bed to the wheelchair. Resident #5 stood, and nurse pivoted patient to the chair. Continued review of the Visit Note Report revealed Resident #5's vital signs were within normal limits (blood pressure (b/p) ,d+[DATE], Pulse (P) 88, Respirations (R) 16, Temperature (T) 97.2). Review of the Hospice D's Visit Note Report dated [DATE] for Resident #5 revealed, .CHAPLAIN HOSPICE EVALUATION .Narrative .ESCORTED PATIENT TO DINING AREA HE EVENTUALLY RESPONDED. HE WAS ABLE TO ANSWER SOME QUESTIONS. PATIENT STATED HE WAS A CHRISTIAN. HE STATED HE WAS FROM [NAME]. HE SMILED AND SEEMED PROUD THAT HE WAS A FIREFIGHTER .THIS CHAPLAIN OFFERED PRAYER AND PATIENT SAID SURE .PATIENT DID STATE HE WAS MARRIED AND HAD 2 CHILDREN. HIS FAMILY DOES NOT SEEM TO BE ENVOLVED [involved] IN HIS CARE XXX[DATE] 01:33 PM . Review of the Progress Notes dated [DATE] for Resident #5 revealed, .2:05PM .PT [patient] WAS LEANING FORWARD IN WHEELCHAIR REACHING TO THE FLOOR AND fell OUT OF CHAIR HITTING HEAD ON FLOOR CREATING AN ABRASION. [Named Conservator B] AWARE AND NP .[Named NP C] AND HOSPICE AWARE WITH NO NEW ORDERES [orders] AT THIS TIME . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's progress notes did not reflect Conservator B was made aware of Resident #5's routine administration of a blood thinner and the risks of a fall with a head injury. Review of the care plan for falls for Resident #5 revealed .At risk for falls r/t [related to] Hx [history] of falls, Alzheimer's and Dementia with decreased safety awareness, Delusional disorder .Goal .Patient will have fall risks minimized through 120 days or next review XXX[DATE] Encourage me to ask for assistance when picking items up off the floor XXX[DATE] Encourage patient to use non-skid footwear during transfers/ambulation .Encourage to use call light for needed assistance . The circumstance of Resident #5's fall on this date ([DATE]) was identical to the fall on [DATE] with a post fall care plan intervention not being appropriate to prevent further falls. Review of the neuro checks dated [DATE] for Resident #5 revealed: a. 1:30 PM B/P ,d+[DATE], P 114; b. 2:00 PM B/P ,d+[DATE], P 66; c. 2:30 PM ,d+[DATE], P 55; d. 3:00 PM ,d+[DATE], P 67; e. 4:00 PM ,d+[DATE], P 66; f. 5:00 PM ,d+[DATE], P 76; g. 6:00 PM ,d+[DATE], P 50; h. 7:00 PM ,d+[DATE], P 43; i. 11:00 PM ,d+[DATE], P 70. Review of the Progress Notes dated [DATE] for Resident #5 revealed, .6:50PM .PT NOTED TO HAVE A DECLINE THIS AFTERNOON HOSPICE HERE TO EVAL PT WITH NEW ORDERS. CONSERVATOR AWARE OF DECLINE . Review of Hospice D's Visit Note Report dated [DATE] for Resident #5 revealed, .Vital Signs .Pulse 98 . Blood Pressure ,d+[DATE] .PT HAD FALL HYPOTENSIVE [NAME] [DECLINE] NOTED IN STATUS AND SLURRED SPEECH .MOANING TENSE .TYLENOL FOR PAIN ADDED ROXANOL [Narcotic given for severe pain] .RESPIRATORY STATUS .SHALLOW SHORTNESS OF BREATH .HEART RATE FINDINGS IRREGULAR TACHYCARDIA .PALE .ABRASION FOREHEAD .FALL REPORT ABRASION AREA TO FOREHEAD HYPOTENSIVE .HOSPICE NURSE IN FACILITY FOR VISIT FOR OTHER RESIDENTS. FACILITY NURSE ASKED NURSE TO VISIT WITH PT DUE TO RECENT FALL DECLINE THROUGHTOUT DAY. NURSE ENTERED

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on facility policy review, job description review, employee file review, medical record review, observation, and interview, the facility failed to provide competent and proficient nursing staff to assure residents' safety and attain or maintain the highest practicable physical wellbeing for 3 of 17 (Resident #5, Resident #7 and Resident #6) sampled residents reviewed. The facility failed to have a person-centered appropriate intervention in place to prevent a second fall for Resident #5 on 1/23/2024, which resulted in a head injury. The nurse failed to provide pertinent details related to a fall with a head injury for Resident #5 who was on long term use of an anticoagulant (blood thinner). Resident #1 and Resident #7 were involved in a resident-to-resident altercation on 3/9/2024 which resulted in verbal abuse with Resident #7. Resident #6 and Resident #8 were involved in a resident-to-resident altercation on 3/19/2024 which resulted in physical harm for Resident #6. The Director of Nursing (DON) failed to perform yearly licensed nurse performance evaluations for 3 of 5 licensed nurse files reviewed. The findings include: 1. Review of the job description titled, Job Descriptions, Nurse, Director of Nursing, dated 10/12/2021 revealed, .Demonstrated leadership and supervisory skills in the areas of nursing administration, nursing practice .Is responsible for maintaining clinical competency as evidenced by application of integrated nursing knowledge and skill, leadership, and communications skills .Monitors to see that there is accurate and adequate documentation in the medical record including electronic health record .Plan and encourages participation in in-service and continuing education for all levels of nursing personnel (including CNA training program .) .Promotes and delegate accountability for maintaining an effective performance appraisal system for nursing . Review of the job description titled, Job Descriptions, Registered Nurse, dated 11/2/2021 revealed, .Ability to meet performance requirements .Is responsible for maintaining clinical competency as evidenced by application of integrated nursing knowledge and skills, leadership, and communication skills .Utilizes the nursing process in assessment, planning and implementing care .Integrates current standards of practice as well as local, state, and federal regulations related to nursing services in the care of patients .Assures the personal dignity and physical safety of each patient . Review of the job description titled, Job Descriptions, Licensed Practical Nurse, dated 11/2/2021 revealed, . Ability to meet performance requirements .Is responsible for maintaining clinical competency as evidenced by application of integrated nursing knowledge and skills, leadership, and communication skills .Integrates current standards of practice as well as local, state, and federal regulations related to nursing services in the care of patients .Maintains open and ongoing communication with patients and families, providing opportunity and encouragement to participate in decision making .Assure the personal dignity and physical safety of each patient . Review of the job description titled, Job Descriptions, Certified Nurse Assistant, dated 11/3/2021 revealed, . Ability to meet performance requirements .Attend in-service programs, as assigned, to learn procedures and develop skills and meet state requirements . (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation, dated 2/1/2023 revealed, .Abuse, Neglect .will not be tolerated by anyone, including staff, patients .The patient has the right to be free from abuse, neglect .Abuse: the willful infliction of injury .intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain, physical, mental, and psychosocial well-being .It includes verbal abuse . physical abuse, and mental abuse .Willful .means the individual must have acted deliberately .Verbal Abuse: the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents .or within their hearing distance regardless of their .ability to comprehend .Physical Abuse: includes hitting, slapping, pinching and kicking .Neglect: the failure of the facility, its employees .to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress .PREVENTION POLICY .The center will provide supervision and support services designed to reduce the likelihood of abuse behaviors .All supervisory partners who receive reports of and/or identify inappropriate behaviors will take immediate steps to correct such behaviors .Patients with needs and behaviors that might lead to conflict with partners or other patients will be identified .Monitoring the patient for any changes that would trigger abusive behavior .Dementia management program as needed .any person will be considered an allegation of either abuse, neglect .Any allegation (or) indication of possible willful infliction .Any complaint of deprivation by an individual caregiver of goods and services necessary to attain or maintain physical, mental, and psychological well being .Any partner having either direct or indirect knowledge of any event that might constitute abuse, neglect .must report the event immediately, but not later than 2 hours after forming the suspicion if the events that cause the suspicion involve abuse .it is the policy of this facility that abuse allegations (abuse, neglect .mistreatment .) are reported per Federal and State Law .The investigation is conducted immediately .When it is identified that an alleged incident may have occurred .As soon as any partner has knowledge and reports an alleged event .When there is a question as to whether to conduct an investigation, it is best to do so .The results of all investigations will be completed within five working days of the incident .Any individual found to be in danger of injury will be removed from the source of the suspected abusive behavior including but not limited to room or staffing changes .to protect the patient (s) from the alleged perpetrator .Increased supervision of the alleged victim and patients . Review of the facility policy titled, .Incident and Accident Process ., dated 1/2024 revealed, .An incident or accident is defined as any occurrence that is outside the norms or any happening that is not consistent with the routine operation of the center or care of a particular patient .All patient incidents should be documented in the EHR [electronic health record] .When any incident results in injury, as defined below, and/or there is evidence of negligence, they must be reported to clinical risk management .Significant injury including: Fracture or dislocation of bones or joints, Closed head injury with altered consciousness, and Subdural hematoma .Any condition requiring medical treatment outside the center that is inconsistent with the routine management of the patient's preexisting condition(s) .The DON [Director of Nursing] should review all incidents for accuracy and complete documentation .is data complete and thorough and paints a picture of what happened .Was the care plan updated to reflect the incident .Is additional investigation needed to determine the exact events of the incident .What can be done to avoid similar incidents recurring on this or any patient in the center . 2. Review of LPN G's personnel file, on 4/10/2024 at 1:15 PM, revealed LPN G's date of hire was 6/2/2005. LPN G's personnel file revealed her last performance evaluation was completed on 4/9/2018. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of RN U's personnel file, on 4/10/2024 at 1:25 PM, revealed RN U's date of hire was 12/1/2013. RN U's personnel file revealed her last performance evaluation was completed on 4/19/2018. Review of LPN JJ's personnel file, on 4/10/2024 at 4:10 PM, revealed LPN JJ's date of hire was 4/15/1993. LPN JJ's personnel file revealed her last performance evaluation was completed on 4/18/2018. During an interview on 4/10/2024 at 4:20 PM, Accounts Payable QQ stated, .At some point last year, we started doing performance evaluations to get back on track. After COVID we had postponed this. The DON felt we needed to do them to help them improve and let them know what they were doing good, wanted to connect with the partners . During an interview on 4/10/2024 at 5:00 PM, the Administrator stated, .During COVID 2020-2021, we suspended performance evals for a lot of reasons .the PIE (performance improvement evaluation) was not done due to pandemic regardless annual review middle of 2023 we started tracking that and adding to our annual plan . 3. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnosis which included Alzheimer's disease, Dementia, and Long-Term Use of Anticoagulants. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 4 which indicated severe cognitive impairment. Continued review of the MDS revealed Resident #5 required extensive assist with bed mobility, transfer, locomotion on unit and off unit, and dressing. Further review of the MDS revealed Resident #5 received an anticoagulant (blood thinner) over the last 7 days. Review of the Medication Administration Record (MAR) from 11/1/2023 to 11/30/2023 revealed Resident #5 received Eliquis (blood thinner) 2.5 milligram (mg) by mouth twice a day. Review of the Physician Progress Notes dated 11/24/2023 for Resident #5 revealed, .Routine visit for patient [with] progressive dementia .per Nursing fell last week bending over reaching for glasses Abrasion to R [right] forehead . Review of the care plan for falls for Resident #5 revealed, .Problem Start Date 6/18/2019 .At risk for falls r/t [related to] Hx [history] of falls, Alzheimer ' s and Dementia with decreased safety awareness, Delusional disorder .Goal .Patient will have fall risks minimized through 120 days or next review .11/18/2023 Encourage me to ask for assistance when picking items up off the floor .8/19/2023 Encourage me to ask for assistance when wanting to leave the dining room .6/18/2019 Encourage patient to use non-skid footwear during transfers/ambulation .Encourage to use call light for needed assistance . The care plan interventions to prevent falls were not appropriate for Resident #5. Resident #5 had a BIMS score of 4 with the inability to recall asking for assistance or any ability to put non-skid footwear on prior to transfers and no ambulation occurred over the last 7 days of the MDS look back period. Review of the MAR dated 1/1/2024-1/31/2024 revealed an order for Eliquis 2.5 mg by mouth twice a day administered from 1/1/2024-1/23/2024. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress Notes dated 1/23/2024 for Resident #5 revealed, .2:05PM .PT [patient] WAS LEANING FOWARD IN WHEELCHAIR REACHING TO THE FLOOR AND fell OUT OF CHAIR HITTING HEAD ON FLOOR CREATING AN ABRASION. [Named Conservator B] AWARE AND NP .[Named NP C] AND HOSPICE AWARE WITH NO NEW ORDERES [orders] AT THIS TIME . The circumstance of Resident #5's fall on this date (1/23/2024) was identical to fall on 11/18/2023 with a post care plan intervention not being appropriate to prevent further falls. Review of the medical record dated 1/23/2024-1/25/2024 for Resident #5, revealed resident became hypotensive after his fall, had neurologic changes, became combative, increase symptoms of pain, blood in his mouth two different times, and slurred speech. Review of the Hospice D's Visit Note Report dated 1/23/2024 for Resident #5 revealed, .Vital Signs .Pulse 98 .Blood Pressure 88/52 .PT HAD FALL HYPOTENSIVE [NAME] [DECLINE] NOTED IN STATUS AND SLURRED SPEECH .MOANING TENSE .TYLENOL FOR PAIN ADDED ROXANOL [Narcotic given for severe pain] .RESPIRATORY STATUS .SHALLOW SHORTNESS OF BREATH .HEART RATE FINDINGS IRREGULAR TACHYCARDIA .PALE .ABRASION FOREHEAD .FALL REPORT ABRASION AREA TO FOREHEAD HYPOTENSIVE .HOSPICE NURSE IN FACILITY FOR VISIT FOR OTHER RESIDENTS. FACILITY NURSE ASKED NURSE TO VISIT WITH PT DUE TO RECENT FALL DECLINE THROUGHTOUT [throughout] DAY. NURSE ENTERED ROOM .INCREASED PALE IN COLOR AND SLURRED SPEECH NOTED WITH WORDS. ABRASION NOTED TK [TO] FOREHEAD RISED [raised] AREA .HAND GRIPS WEAK .PT TENSE AND MOANING WITH TOUCH BREATHING SHALLOW HYPOTENSIVE IRREGULAR .HEART RATE .NEW ORDER PER MD [MEDICAL DOCTOR] .ROXANOL 0. 5ML [milliliters] BY MOUTH OR UNDER TONGUE EVERY 2 HOURS AS NEEDED FOR PAIN RESTLESSNESS AND OR AIR HUNGER .PT DAID [said] HE WAS COLD .7:00PM . Review of the Progress Notes dated 1/25/2024 for Resident #5 revealed, .2:54AM .ALERT .Patient with abrasion noted .Patient noted to be rambling/mumbling with this nurse not able to understand patient .Patient with blood noted to mouth from recent fall .Patient has continued to attempt to get out of bed without assistance with staff providing education to patient to not get up without assistance . Resident #5 with a BIMS score of 4 was unable to comprehend any type of education on safety. Review of Hospice D's Visit Note Report for Resident #5 dated 1/25/2024 revealed, .Pulse 110 .Blood Pressure 86/53 .OCCASIONAL MOAN OR GROAN .FRIGHTENED .KNEES PULLED UP .UNABLE TO SPEAK .HE IS DISORIENTED .UNABLE TO BE REDIRECTED .COMBATIVE WITH ANY ACTIVITY . DAZED LOOK ON HIS FACE. HE IS HYPOTENSIVE AND TACHCARDIC .7:02 AM . Review of the Progress Notes dated 1/25/2024 for Resident #5 revealed, .10:27AM .ALERT .Pt confused with combativeness .Pt reaching for things not present in the room. Abrasion to forehead remains . Review of the Progress Notes dated 1/26/2024 for Resident #5 revealed, .12:43AM .Patient .mumbling with this nurse unable to understand what patient is saying. Patient continues with abrasion to forehead .Patient combative with staff this shift .Patient has continued to attempt to get out of bed without assistance with staff . Review of the Progress Notes dated 1/26/2024 for Resident #5 revealed, .11:32AM .ALERT .Pt unable to swallow anything PO [by mouth] at this time. Abrasion remains to forehead . (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress Note dated 1/26/2024 for Resident #5 revealed, .10:11PM .This nurse was notified that pt was unresponsive. Went in to [into] pt's room to assess. Pt seen lying on bed unresponsive, no spontaneous movements and no response to verbal and painful stimuli noted. Pupils were fixed dilated, non reactive to light and accommodation. Carotid pulse not palpated. No heart and lung sounds auscultated. No noted rise and fall of abdomen. Pt pronounced dead at 9:57pm . During an interview on 3/19/2024 at 12:28 PM, Registered Nurse (RN) R stated, .with any fall you perform a head to toe assessment .if a resident hits their head we would start neuro checks .Call MD immediately with any changes RN R was asked if the facility would treat a hospice resident that had a fall any different. RN R stated, .we still treat a hospice patient the same notify hospice, call doctor, family and update them with any changes .just because the resident is on hospice doesn ' t mean they can ' t go to the hospital if that is what the family wants to do . RN R stated, .when a fall happens you put in an event in the computer system .it asks if the resident takes anticoagulants .you should call the MD to see if they want to continue the blood thinner .a resident could have a fracture, subdural hematoma .watch their blood pressure to see if it is dropping .heart rate going up .changes in their cognition .could be signs of a bleed . During an interview on 3/20/2023 at 3:06 PM, LPN G stated, .I talked to [Named Conservator B] after his fall . I think I told her he hit his head, I don't remember if I told her he was taking a blood thinner .I think I talked to her about his decline in his blood pressure . During a telephone interview on 4/5/2024 at 7:55 AM, Conservator called this surveyor back and stated, .I knew [Named Resident #5] had been declining and was placed on hospice but I have no record that I was told he was taking a blood thinner when he fell and hit his head .I even asked my boss to see if she recalled anything being said about blood being found in his mouth .just because a resident is on hospice it doesn't mean they shouldn't be sent out for treatment .I just recently sent a hospice patient out of a facility due to a head injury .I had a doctor tell me that if the blood pressure can be more stabilized it helps with the patients comfort. I was notified by email about the fall .I have no records of any phone call related to the fall .I wish I would have been told about blood in his mouth .I did receive a call on the day he passed away . The Conservator provided the email dated 1/23/2024 at 2:15 PM from LPN G which revealed, .Hey, just wanted to let you know that [Named Resident #5] fell out of wheelchair and got an abrasion to forehead During an interview on 4/8/2024 at 11:48 AM, Hospice LPN HH stated, .I was at the facility visiting other hospice residents on 1/23/2024 and [Named LPN HH] wanted me to see [Named Resident #5] because he was hypotensive after his fall .he was restless .I heard [Named LPN HH] call the conservator and made her aware of .his overall decline .I never heard the facility nurse say to [Conservator B] that Resident #5 was taking a blood thinner and there could be a potential for a bleed due to the head injury . During an interview on 4/10/2023 at 2:13 PM, the DON was asked if the care plan intervention for Resident #5's fall was an appropriate intervention for a resident with a BIMS score of 4. The DON stated, .No, I thought we went back and fixed the care plans for the residents with poor cognition .he can't remember to ask for assistance and to use non skid socks would not be appropriate .I thought we changed the word encourage to the word remind . (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff failed to implement appropriate care plan interventions for Resident #5, who had severe cognitive impairment and failed to notify the conservator of risks of a fall with a head injury for a resident taking blood thinners. 4. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses which included Delusional Disorders, Schizoaffective Disorder-Bipolar type, Hallucinations, Anxiety Disorder, and Major Depressive Disorder. Review of the Annual MDS (MDS) assessment dated [DATE] revealed Resident #1 had a BIMS score of 15 which indicated no cognitive impairment. Continued review of the MDS revealed Resident #1 experienced delusions and other behaviors not directed toward others. Review of the Progress Note dated 3/9/2024 for Resident #1 revealed, .PT WAS SITTING IN DINING ROOM FOR BREAKFAST WHEN A DEMENTED PT ROLLED IN AND BUMPED HIS WHEELCHAIR. PT BECAME AGGRESSIVE CURSING AND YELLING IN DINING ROOM AS LOUD AS HE COULD. NURSE INTERVENED AND REMOVED DEMENTIA PT. PT YELLED AND SCREAMED AT NURSE AND WAS NAME CALLING . Review of the Behavior Analysis Report (CareAssist only) note dated 3/9/2024 for Resident #1 revealed, .Pt was in the dining room for breakfast another pt accidently bumped the back of his chair with hers. [Resident #7] and [Named Resident #1] started yelling and screaming at pt . Observation in the dining room on 3/18/2023 at 10:20 AM, Resident #1 was in an electric wheelchair. 5. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnosis which included Vascular Dementia with Mood Disturbance and Depression. Review of the care plan for Resident #7 revealed, .Approach Start Date .3/19/2024 Patient may attract negative attention from other patients due to their poor understanding of personal space and spatial boundaries. Redirect as needed .When Pt is wandering, assess for unmet physical needs, psychological distress, and environmental factors. Distract Pt by introducing enjoyed activities .Educate and encourage patient to comply with plan of care . Resident #7 with a BIMS score of 6 does not have the ability to understand the need to comply with the plan of care. Review of the Quarterly MDS dated [DATE] revealed Resident #7 had a BIMS score of 6 which indicated severe cognitive impairment. Continued review of the MDS revealed Resident #7 experienced delusions, physical behaviors directed toward others, and wandered 4-6 days over the last 7 day look back period. Review of the nurse Progress Notes for 3/9/2024 for Resident #7 revealed no details related to the verbally abusive interaction with Resident #1. Review of LPN G's Progress Note dated 3/18/2024 for Resident #7 revealed, .Spoke with NP .and reviewed previous verbal abusive interaction that occurred on 3/9/24 involving patients [Resident #1 was verbally abusive toward Resident #7] . (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nurse Practitioner (NP) progress note dated 3/18/2024 for Resident #7 revealed, .Per staff, patient remains at her baseline. She is pleasantly confused . The NP note does not mention Resident #7's involvement in a verbal altercation with Resident #1. Observation in the resident's room on 3/19/2024 at 2:45 PM, revealed Resident #7 being assisted to bed. Observation in the dining room on 3/20/2024 at 12:30 PM, revealed Resident #7 was in her wheelchair rolling to different residents introducing herself. During an interview on 3/18/2024 at 3:50 PM, Licensed Practical Nurse (LPN) G stated, .One time [Named Resident #7] was in the dining room and she bumped into his [Resident #1]'s wheelchair .He started cursing, I went in the dining room, he cursed me . LPN G was asked if Resident #1 was verbally abusive toward Resident #7. LPN G stated, .Yes I would say that would be verbal abuse, but I don't think I reported it .I did mention it to the NP today [3/18/2024] .I was concerned about his outburst .[Named Resident #1] is delusional thinking he is married to the queen .will say he was in the military but he wasn't .He first tried to deny he hit [Named Resident #1] . The interview revealed LPN G failed to report a resident-to-resident altercation involving verbal abuse. During an interview on 3/18/2024 at 4:30 PM, Certified Nursing Assistant (CNA) H stated, .[Named Resident #1] has been aggressive toward [Named Resident #7] .she wanders and often looking for her children .he will instantly become aggressive toward her .I feel like he could be physical or verbally aggressive toward any resident . During an interview on 3/19/2024 at 8:00 AM, CNA J stated, .He got after [Named Resident #7] in the dining room one day because she tried to talk to him .He called her .[derogatory names] .[Named Resident #7] just moved and said 'why don't you want to talk to me' .we try to keep the patients away from him .he doesn't like anyone getting close to him . During an interview on 3/19/2024 AT 8:25 AM, the Social Service Director (SSD), stated, .I never knew [Named Resident #1] was aggressive. I wasn't aware of the interaction he had with [Named Resident #7] on 3/9/2024. I am just now reading this in the notes. I have not done a follow up with either resident because I was not aware of the incident. The staff should have notified the Abuse Coordinator. Verbal abuse is cursing, yelling, demeaning language toward another resident. I would have observed [Named Resident #7] demeanor toward [Named Resident #1] to see if she would shy away from him or would she continue with her normal behavior. [Named Resident #7] is a very social person, so I would watch for any changes in her behavior . During an interview on 3/19/2024 at 8:55 AM, the Director of Nursing (DON) stated, .I was aware that [Name Resident #7] bumped into [Named Resident #1]'s wheelchair in the dining room and [Named LPN G] intervened. I wasn't aware that he called the other resident any derogatory names. I thought he just called the nurse names . (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/2024 at 2:50 PM, Resident #1 stated, .I know [Named Resident #7] she is a busy body .comes around pushed me and poked me in the dining room .It upsets me I don't want to be touched .I had to leave the room .I had to get out of there, she will keep on until she provokes me to a fight .she makes me sick .[Named Resident #7] won't listen just keeps on trying to talk . 6. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE], with diagnoses which included End Stage Renal Disease, Renal Dialysis, Muscle Wasting and Atrophy, Heart Failure, Long-Term Use of Anticoagulants, and Malignant Neoplasm of Stomach. Review of the Admission MDS dated [DATE], revealed Resident #6 had a BIMS score of 13, which indicated intact cognition. Review of a Physician's Order, for Resident #6, dated 3/19/2024 revealed, .abrasion to top of right knee . Special Instructions: abrasion to top of right knee clean with normal saline and pat dry. Apply polymem [a dressing that manages drainage] oval every shift until healed .Every Shift .Day, Night . Review of Registered Nurse (RN) U's Progress Note for Resident #6, dated 3/19/2024 at 10:25 AM, revealed, .Alert: I was in patient room giving him medicine and roommate [Resident #8] pushed his own bedside table that accidentally bumped this patients [patient's] bedside table through the curtain. Patients bedside table bumped patients top of right knee. Patient was not bleeding at the time. Patient then came to nurses station and stated his knee was bleeding. This nurse cleaned and applied a dressing to top of right knee. MD and family notified . Review of the NP progress note dated 3/19/2024 at 7:45 PM, for Resident #6, revealed, .Today staff report that the patient did sustain a small abrased area just above his right knee. Staff state that the patient reported that his knee was injured on his bedside table. Patient is found sitting on the side of his bed in his room .When asked what happened to his knee he states 'the curtain was pulled and my roommate pushed his bedside table into my bedside table and my bedside table hit my knee.' Patient did show provider how he sits on the side of his bed with his feet on the lower part of his table and pointed out the area of his table that hit his knee. Provider asked if this hurt and patient stated 'it did a little at the time but not now. ' . 7. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses which included Type 2 Diabetes Mellitus, Hypertensive Heart Disease, and Chronic Obstructive Pulmonary Disease. Review of the Admission Annual MDS assessment dated [DATE] revealed Resident #8 had poor short term and long term memory. Continued review of the MDS revealed Resident #8 was short tempered and easily annoyed. Further review of the MDS revealed Resident #8 had verbal outbursts, behaviors toward others, and his behaviors affecting his environment. During an observation and interview on 3/19/2024 at 11:45 AM, Resident #6 stated, .Just an hour ago my roommate cursing people throwing a fit and he shoved his tray table toward me and caused my leg to start bleeding .he shoved the nurse that was in here too because she told him don't push me .he [Resident #8] yells and hollers and he knows I will get up . The observation revealed blood on the floor and bloody gauze laying on the overbed table. Resident #6 raised up his pants leg on his right leg to show the surveyor where the nurse just bandaged his leg due to the injury. (continued on next page)

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	445116	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Smithville	825 Fisher Ave Smithville, TN 37166

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/2023 at 12:30 PM, RN U stated, .an LPN reported to me he [Resident #6] had an old skin tear that reopened . During an interview on 3/19/2024 at 3:25 PM, LPN V stated, .[Named RN U] done all the treatments today . [Named Resident #6]'s roommate pushed the overbed table toward him and caused a skin tear . During an interview on 3/20/2024 at 4:00 PM, SSD was asked if she was notified of the incident between Resident #6 and Resident #8. SSD stated, .We talked to RN U about it .[Named Resident #8] got upset because he wanted his pain medicine .I went down to talk to him [Named Resident #6] because I heard something about the incident .we [DON, Administrator, and department heads] were discussing it last night .I let them know I went down to check on [named Resident #6] .I don't know why I didn't do a progress note . The SSD was asked if Resident #6 continues to be at risk being in the room with Resident #8. The SSD stated, .I don't really think so .he can take precautions if he feels he needs to .he isn't at risk because he is alert and oriented . During an interview on 3/19/2024 at 5:20 PM, RN U was asked about her nurse note on Resident #6. RN U stated, .I was in the room when it happened .[Named Resident #8] pushed his overbed table .water picture hit the floor .the table hit [Named Resident #6] on his knee .[Named Resident #8] was flying off with the 'F' word it aggravated him, he wanted ice .I lied to you earlier .I didn't report it . The interview revealed RN U previously informed the surveyor the injury for Resident #8 was an old skin tear. RN U stated she did not report the incident between Resident #6 and Resident #8. During an interview on 4/4/2024 at 1:32 PM, the DON stated, We started the performance evaluations back last year some time .I am observing the nurses daily . During an interview on 4/10/2024 at 5:00 PM, the Administrator stated, .Abuse should be reported immediately .reported to state agency within 2 hours .complete an investigation and send up our findings within 5 days .

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 44724 Based on record review and interview, the facility failed to conduct yearly performance evaluations for 2 of 6 Certified Nurse Assistant (CNA MM and CNA NN) personnel files reviewed. The findings include: 1. Review of the job description titled, Job Descriptions, Nurse, Director of Nursing, dated 10/12/2021 revealed, .Demonstrated leadership and supervisory skills in the areas of nursing administration, nursing practice .Is responsible for maintaining clinical competency as evidenced by application of integrated nursing knowledge and skill, leadership, and communications skills .Monitors to see that there is accurate and adequate documentation in the medical record including electronic health record .Plan and encourages participation in in-service and continuing education for all levels of nursing personnel (including CNA training program .) .Promotes and delegate accountability for maintaining an effective performance appraisal system for nursing . Review of the job description titled, Job Descriptions, Certified Nurse Assistant, dated 11/3/2021 revealed, . Ability to meet performance requirements .Attend in-service programs, as assigned, to learn procedures and develop skills and meet state requirements . 2. Review of CNA MM's personnel file, on 4/10/2024 at 1:15 PM, revealed CNA MM's date of hire was 6/16/2020. Continued review of CNA MM's employee filed revealed no performance evaluation completed over the last year. Review of CNA NN's personnel file, on 4/10/2024 at 1:25 PM, revealed CNA NN's date of hire was 12/7/2021. Continued review of CNA NN's employee file revealed no performance evaluation completed over the last year. During an interview on 4/4/2024 at 1:32 PM, the DON stated, We started the performance evaluations back last year some time . During an interview on 4/10/2024 at 4:20 PM, the Accounts Payable QQ stated, .At some point last year, we started doing performance evaluations to get back on track. After COVID we had postponed this. The DON felt we needed to do them to help them improve and let them know what they were doing good, wanted to connect with the partners . During an interview on 4/10/2024 at 5:00 PM, the Administrator stated, .During COVID 2020-2021, we suspended performance evals for a lot of reasons .the PIE (performance improvement evaluation) was not done due to pandemic regardless annual review middle of 2023 we started tracking that and adding to our annual plan .

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 44724 Based on facility policy review, Facility Reported Investigation review, medical record review, observation, and interview, the facility's Quality Assurance Performance Improvement (QAPI) committee failed to monitor implemented plans of action for a resident-to-resident abuse. The findings include: Review of the facility policy titled, QAPI [Quality Assurance Performance Improvement] Plan 2024-2025 NHC HealthCare Center, revealed, .Quality Assurance Performance Improvement is the basis for all care delivered in this center. QAPI is what we do every day as we deliver care to our patients. All departments and all services are included covered by the QAPI Plan. Clinical care will be monitored by reviewing clinical outcome monitors on a consistent basis as well as monitoring the CMS quality measures .The main focus of QAPI will be safety and high quality in all clinical interventions while emphasizing autonomy and choice in daily life for all patients .QAPI is the responsibility of every partner during their everyday work. Ultimately the Administrator and Director of Nursing are accountable for the success or failure of the program .Root Cause Analysis will be used to determine the underlying causes of issues .The 5 Why Method of root cause analysis will be used to determine root causes of problems . Review of the facility investigation revealed on 7/26/2023 at 6:00 PM, Resident #2 wandered into Resident #1's room. Resident #1 yelled at Resident #2 to get out of his room and while she was at his bedside, he struck the resident with his open hand on the head and back. A nurse aide heard the commotion and immediately intervened. The victim Resident #2 was removed from the room and provided increased observation. A stop sign was placed on Resident #1's room to intervene wandering behavior. The facility investigation revealed the staff were trained on abuse policy and procedures. A Velcro stop sign was affixed to Resident #1's doorway. The Quality Assurance Performance Improvement (QAPI) will oversee question and answers regarding abuse policy and procedures. The staff will monitor patients for behaviors that may increase their risk for physical abuse. The QAPI committee will confirm compliance with Stop Sign usage. Both residents will continue to be seen by Psych [psychiatric] services. Review of the facility event recovery form revealed, .Event .[Named Resident #2] entered into [Named Resident #1's] room and was touching his electric wheelchair. [Named Resident #1] hit [Named Resident #2] .7/26/23 [7/26/2023] QA [Quality Assurance] nurse, Director of Nursing [DON] .started in-servicing on patient protection .Beginning the week of 7/31/2023 DON .QA Nurse will monitor compliance by interviewing 10 partners of what we do if we suspect abuse and on the types of abuse every month x [times] 3 .interviewing 5 partners on each shift weekly x 4 as to what would you do if you see a patient entering another patient's room and then continuing monthly x 2 .The monitor and in-service training will be continued as determined by the Administrator and Director of Nursing . Review of the Performance Improvement Plan (PIP) dated 8/3/2023 revealed the study title was, .What do you do if you suspect abuse . The (PIP) revealed only 9 employee names. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/2024 at 10:50 AM, Certified Nursing Assistant (CNA) S was asked to review the sheets related to the PIP dated 8/3/2023 related to the incident between Resident #1 and Resident #2. CNA S stated, .that is not my signature .I don't remember this training .It looks like someone just wrote my name down . CNA S signed her name, and it was not her signature on the PIP. Review of the PIP dated 8/9/2023 revealed the study title was, .What would you do if you see a patient entering in another patient's room . During an interview on 3/19/2023 at 10:28 AM, Licensed Practical Nurse (LPN) Q reviewed the sheet related to the PIP dated 8/9/2024 and stated, .That's not my signature on the education. I don't know what the education was about on this note .Usually when we have some type of training or in-service we sign the sheet, not have someone write our name down . LPN Q signed her name, and it was not her signature on the PIP. Review of the PIP dated 8/25/2023 revealed the study was, .Partners will be able to name the types of abuse . The form had 1-10 with Y beside the number. No employee names or signatures were on the form. Review of the PIP dated 9/26/2023 revealed the study title was, .What would you do if you seen [saw] a pt [patient] entering another pts [patient's] room . No employee names or signatures were on the form. Review of the PIP dated 9/26/2023 revealed the study title was, .Stop sign will remain in place to doorway . The form revealed no patient name. Review of the PIP dated 9/26/2023 revealed the study was, .What would you do if you suspect abuse . No employee names or signatures were on the form. Review of the PIP dated 10/26/2023 revealed the study title was, .redirect patient out of room .20 partners .y [yes] . No employee names or signatures were on the form. Review of the PIP dated 10/26/2023 revealed the study was, .What would you do if you seen a pt entering another pts room . No employee names or signatures were on the form. Review of the PIP dated 10/26/2023 revealed the study was, .Remove the patient from harm or stay with them .report immediately .20 partners .y (yes) . No employee names or signatures were on the form. Review of the PIP dated 11/27/2023 revealed the study title was, .What would you do if you see a patient entering in another patient's room . The form had number 1-10 with Y (yes) beside the number. No employee names or signatures were on the form. Review of the PIP dated 11/27/2023 revealed the study was, .Able to identify types of abuse .Able to identify what they would do if suspect abuse . The form had number 1-10 with the word employee noted. No employee names or signatures were on the form. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/2023 at 10:45 AM, Registered Nurse R (the employee that performed the PIP education) stated, .I used these sheets for education not monitoring of the wandering resident. I just mainly done [did] teaching on what to do for a wandering resident .redirect them out of the patient's room . During an interview on 4/4/2024 at 12:30 PM the DON was asked to provide the documentation for increased observation for Resident #2 which the facility investigation dated 7/26/2023 noted would be completed. The DON stated, .I think the education on how to protect the patients and going over the policy for wandering residents covered increased observations . During an interview on 4/10/2024 at 12:08 PM, the Administrator reviewed the PIP documentation on education and was asked how he could verify and hold staff accountable without any staff signatures. The Administrator stated, .I think we done it that way due to HIPAA [Health Insurance Portability Accountability Act] .try not to have identifiable information related to residents or staff . The Administrator was unable to answer this surveyor's question of how the facility would verify and hold staff accountable for the education provided without staff signatures.