STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445439	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahc MT Juliet	2650 North MT Juliet Road Mount Juliet, TN 37122

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46831 Based on policy review, medical record review, and interview, the facility failed to notify and consult the Physician/Nurse Practitioner (NP) of a change in condition related to falls 1 of 6 (Resident #7) sampled residents reviewed for change in condition. On [DATE], Resident #7 had an unwitnessed fall and was found on the floor with his head under the bed. Resident #7 hit his head while being placed back in bed by staff. The Physician/NP was not notified of Resident #7's unwitnessed fall on [DATE], and on [DATE], Resident #7 experienced a change in mental status. The NP was notified on [DATE] (1 day after the change in mental status and 4 days after the unwitnessed fall) of Resident #7's change in condition and again, was not notified of the unwitnessed fall the resident sustained on [DATE]. The facility's failure to immediately notify the Physician/NP of Resident #7's fall with injury resulted 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, when Resident #7 had an unwitnessed fall and remained in the facility for 4 days following the fall and after experiencing mental status change the night before being transferred to the hospital where he expired in the emergency room (ER). The Administrator was notified of the Immediate Jeopardy on [DATE] at 3:10 PM, in the Administrator's office. The facility was cited at F-580 at a scope and severity of J. The Immediate Jeopardy was effective [DATE] and is ongoing. A partial extended survey was conducted [DATE] to [DATE]. The facility is required to submit a Plan of Correction (POC). The findings include: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policy titled Notification of Change, revised on [DATE], revealed .The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies the resident's representative .when there is a change requiring notification .The facility shall inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification .Circumstances requiring notification include: 1. Accidents .b. potential to require physician intervention .2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status . Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses which included Unspecified Fracture of Third Lumbar Vertebra, Frontal Lobe and Executive Function Deficit, and Urinary Tract Infection. Resident #7 was discharged on [DATE] to Hospital #1. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #7 revealed, a Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive impairment. Review of the facility Clinical Note dated [DATE] but entered into the Electronic Health Record (EHR) on [DATE], revealed, .Resident was found on the floor with his head under the bed .While sliding the resident to get his head clear of the bed the resident raised his head and hit it on the underneath of the bed . The Clinical Note documented on [DATE] and dated [DATE] was not documented as a late entry. Review of the facility Clinical Note dated [DATE], revealed, .Res [resident] appears to be more confused, not understanding simple tasks . During an interview on [DATE] at 11:25 AM, the Director of Nursing (DON) verified the unwitnessed fall on [DATE] for Resident #7 was not charted until [DATE]. The DON stated she became aware of Resident #7's unwitnessed fall after he was sent to Hospital #1 emergency room (ER) for a change in mental status when someone reported to her Resident #7 had a knot and a bruise on his head. She stated she followed-up with LPN G, who said Resident #7 had a fall and hit his head pretty hard on [DATE]. After the DON received report on the fall from [DATE], she initiated an investigation and requested LPN G complete an incident report on [DATE]. The DON stated she educated LPN G when he stated he was unaware he needed to document on the fall. Continued interview revealed, the DON was asked what her expectations were when a resident experienced a fall. She replied, .I expect a head-to-toe assessment, neuro checks, notification to the NP, family, DON, Administrator and implement any new orders received . The DON verified no neuro checks were initiated. The DON was then asked what her expectations for a resident for a change in mental status were. She replied, .To reach out to the NP, obtain, and implement any new orders received . The DON looked at the progress note documented by LPN F and stated .[LPN F] should have contacted the NP herself .The NP should have been notified as soon as the change in mental status was noticed .with any change in condition, there should be follow-up charting for 72 hours . During a telephone interview on [DATE] at 3:57 PM, Licensed Practical Nurse (LPN) G stated .I did not report the fall because I was unfamiliar with the computer system .the Unit Manager was there and saw him on the floor . During a telephone interview on [DATE] at 5:00 PM, the NP stated she was not notified about Resident #7's unwitnessed fall on [DATE]. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 12:45 PM, LPN K, who was the Unit Manager, confirmed she observed Resident #7 on the floor and did not notify the NP, Director of Nursing (DON), Assistant Director of Nursing (ADON), or resident representative about Resident #7's unwitnessed fall on [DATE]. When asked if she followed-up on Resident #7's fall the next day, LPN K stated No, the ADON deals with the falls in the facility. Continued interview revealed LPN K admitted she did not notify the NP, DON, ADON, or family about Resident #7's fall and should have followed-up the next day on the fall from [DATE]. During an interview on [DATE] at 11:17 PM, Family Member (FM) KK, the conservator for Resident #7, stated she had not been notified of a fall on [DATE] nor of a change in mental status on [DATE]. During a telephone interview on [DATE] at 9:06 AM, FM LL, who could also make decisions for Resident #7, confirmed she had not been notified about a fall on [DATE] nor a change in mental status on [DATE]. During a telephone interview on [DATE] at 10:25 AM, the NP stated she was not notified of Resident #7's change in mental status on [DATE] but would expect the facility to notify her of any change in condition for any resident.

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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** 46831 Based on facility policy review, www.hopkinsmedicine.org/health, Police Incident Report dated [DATE] review, facility investigation review, medical record review and interviews, the facility failed to ensure residents were free from abuse/sexual for 6 of 9 (Residents #3, #7, #9, #11, #14, and #15) sampled residents reviewed for abuse/neglect. On [DATE] during group activities Resident #11, who had a BIMS of 12, approached Resident #15, who had a BIMS of 4, began to rub across her shoulders and back, and then tried to kiss her. Resident #15 told Resident #11 to stop and pushed him away. Resident #11 then put some money on the table in front of Resident #15 and pushed it towards her while saying, If this isn't enough, let me know. On [DATE] Resident #11 approached Resident #15 during activities and pulled up his shirt and began rubbing his nipples. Resident #15 pushed him away from her. Resident #11 returned to his table and within a few minutes, stood up, pulled his pants down, and pointed to his penis saying, If any of you ladies want this come to room [ROOM NUMBER]. On [DATE], 5 days after Resident #11 began having inappropriate sexual behaviors, Resident #3, who had a BIMS score of 15, reported to staff that during the night before Resident #11 approached his bed and placed his genitals in his (Resident #3)'s hand. Resident #11 was transferred to a psychiatric facility on [DATE], 8 days after inappropriate sexual behaviors with Resident #15 were documented. On [DATE] during activities The facility failed to prevent Neglect when on [DATE] Resident #7 was found on the floor with his head under the bed. Staff failed to complete a post-fall assessment, an incident report, and notify the Physician/NP on [DATE], and there was no monitoring for adverse outcomes related to the fall. On [DATE] (3 days after the fall), Resident #7 experienced a change in mental status, and the physician/NP was not notified. On [DATE] (4 days after the fall) and 1 day after the change in mental status, the NP was notified and again not made aware of the fall with head injury. Nursing staff transferred Resident #7 to the emergency room (ER) without report of the recent fall with head injury. Resident #7 expired after arrival in the ER. The facility's failure to prevent sexual abuse for Resident #3, #11, and #15 and neglect for Resident #7 resulted in Immediate Jeopardy. The facility failed to ensure Resident #9 was free from physical abuse that resulted in actual HARM when Resident #14 was observed hitting and punching Resident #9's hand and bending her fingers back that resulted in pain, bruising and swelling of Resident #9's hand. The facility's failure to protect residents from abuse and neglect resulted in an 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 Administrator was notified of the Immediate Jeopardy on [DATE] at 3:10 PM in the Administrator's office. The facility was cited at F-600 with a scope and severity of K, which is Substandard Quality of Care. The Immediate Jeopardy was effective [DATE] and is ongoing. A partial extended survey was conducted on [DATE] to [DATE]. The facility is required to submit a Plan of Correction (POC). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The findings include: Review of the facility policy titled, Abuse Prohibition Plan, effective date [DATE], revealed, .The facility has a zero-tolerance policy for abuse .The facility shall attempt to identify and shall investigate any reported violation or allegation of abuse .'Sexual Abuse .' is non-consensual sexual contact of any type with a resident. It includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault ' Physical Abuse' includes, but not limited to hitting, slapping, pinching, and kicking .'Neglect' means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .The investigation shall begin immediately . It is the policy of this facility that Residents shall be protected from the alleged offender(s) .If the alleged offender is a facility Resident, the staff member shall immediately remove the perpetrator from the situation and another staff member shall stay with the alleged offender and wait for further instruction from the Administrator .Employees must always report any allegation of abuse or suspicion of abuse immediately to the supervisor . Review of an undated article titled, Frontotemporal Dementia [FTD], from www.hopkinsmedicine.org/health revealed, .Symptoms of FTD .common symptoms .Behavior and /or dramatic personality changes, such as swearing, increased interest in sex .Socially inappropriate, impulsive, or repetitive behaviors . Review of a Police Incident Report dated [DATE], revealed, .The caller, [Named Administrator], was notified today when she arrived back from vacation .I [Police Officer] was told [Named Resident #3] has a speech problem, and is very delayed when trying to speak .I was not able to speak with him [Resident #3] .[Named Resident #11] has been placed in the psychiatric ward .[Named Administrator] said [Named Resident #11] has these types of episodes when he does not take his medication as prescribed, which he is currently not doing . Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses which included Schizophrenia, Dysphagia, Dysarthria and Anarthria. Dysarthria is a less severe form of Anarthria and causes slurred or slowed speech. Anarthria is the loss of the ability to speak. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 revealed, a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Review of the undated current care plan for Resident #3 revealed there were no focus/problems or interventions on the care plan for risk related to actual abuse allegations. Review of the provider/Nurse Practitioner (NP) progress note dated [DATE] for Resident #3, revealed, . Patient being seen for follow-up on events this past weekend involving roommate .patient reports he does not want to discuss in detail w [with]/me what occurred over the weekend .does affirm allegation against roommate and that he [Resident #3] may be open to discussing w/local PD [Police Department] .Reports emotional and mental distress from prior roommate's actions . (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 facility Clinical Notes for Resident #3 dated [DATE]- [DATE] frequently referenced Resident #3's desire to sit on the front porch, even referenced it as something he loves to do on a daily basis. The Clinical Notes referred to Resident #3 feeling safe and calm, in a good mood and smiling. During an interview on [DATE] at 3:08 PM, MDS Coordinator #1 and #2 confirmed there were no interventions related to actual risk associated with the allegation of nonconsensual sexual contact/sexual abuse Resident #3 reported on [DATE]. MDS Coordinator #1 and #2 agreed residents that experience alleged abuse should be monitored for risk of immediate and late onset of affects such as psychosocial harm. During an interview on [DATE] at 4:11 PM, Resident #3 agreed to interview in the presence of his roommate. Resident #3 was asked to recall the incident with his previous roommate, Resident #11, during the night of [DATE] - [DATE]. The surveyor provided support and patience during the interview as Resident #3 was very slow to answer and had difficulty expressing himself. Resident #3 stated, .[Named Resident #11] came to my bed and tried to push me on my side, 3 or 4 times .almost fell off the bed .he [Resident #11] stopped and looked right at me, took out his d k and put it in my hand .I yelled .he walked away laughing . Resident #3 was asked if he felt safe in the facility, Resident #3 replied, .I am safe with this roommate [pointing towards current roommate] but when he goes home, who will keep me safe .He [Resident #11] is still here, I see him out in the hall . Resident #3 became tearful and paused for several minutes. When asked if he reported the incident to staff after Resident #11 walked away, Resident #3 replied, .I tried but they wouldn't stand still long enough for me to talk, they think I can't talk . Resident #3 thanked the surveyor for standing still and listening to him. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses which included Bipolar Disorder, Schizoaffective Disorder, and Frontotemporal Neurocognitive Disorder. Common symptoms of Frontotemporal Neurocognitive Disorder include but are not limited to behavior such as socially inappropriate, impulsive, or repetitive behaviors, and increased interest in sex. Review of a Psychiatric Evaluation dated [DATE], for Resident #11 revealed, .recently admitted to the facility after being hospitalized at [Named psychiatric medical facility from Named Long term care facility] for verbal aggression, cussing, and threatening his staff .history of medication refusal/spitting medication .BIMS , d+[DATE] . Review of the Admission MDS assessment dated [DATE] for Resident #11 revealed, a BIMS score of 12, which indicated moderately cognitively impaired. Continued review revealed Resident #11 required supervision to walk in corridor. Review of care plan for Resident #11 revealed, . [DATE] .Remind [Resident #11] that BEHAVIOR is not appropriate .Resident prefers to walk around facility constantly and enjoys sitting on front porch . [DATE] . displayed inappropriate sexual behaviors towards others .Redirect [Named Resident #11] and remind him of what is appropriate/not appropriate in social settings XXX[DATE] .rejects or resists care (history of refusing medications) . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #3, the victim of the alleged sexual assault enjoys sitting on the front porch. There were no care plan interventions for either resident to address psychosocial risk associated with repeated exposure in the facility. Review of the facility Clinical Notes for Resident #11 dated [DATE], revealed .Resident was down in the dining room rubbing up against a female resident the [then] gave her money and said if it isn't enough to let him know . Review of the facility Clinical Notes for Resident #11 dated [DATE], revealed .Resident was down in the dining room pulling his pants down and pointing to his penis telling the ladies to come to room [ROOM NUMBER] he had the room # written on a piece of paper. He also went over to another resident and tried to kiss her. Activities went and got the nurse . Review of the facility Clinical Notes for Resident #11 dated [DATE] at 8:45 AM, revealed .Resident was down in the dining room on [DATE] [2023] two different times this resident was making sexual comment's [comments] to the lady residents pulling his shirt up and rubbing his nipples and rubbing himself up on two female residents. Also [Also,] resident was rubbing his penis asking a female resident if she wanted some of that. Resident also had his room # written on a piece of paper telling the lady resident to come to his room. Activities reported this to the nurse . Review of the facility Clinical Notes for Resident #11 dated [DATE] at 1:53 PM, revealed .This resident was in the hallway raising up his shirt and playing with his nipples . Review of the facility Clinical Notes for Resident #11 dated [DATE] at 6:31 PM, revealed .Another resident family member notified Nurse Management this shift of sexual inappropriate behavior towards roommate/resident on last night. Roommate immediately moved out of room, placed in another room. Family [Resident #3's family] at bedside agreeable and aware. Review of the facility Clinical Notes for Resident #11 dated [DATE] at 1:29 PM, revealed, .Resident was down in the dining room cussing and giving the finger to other residents . Review of the NP progress note for Resident #11 dated [DATE] at 1:34 PM, revealed, .Received call from facility administrator yesterday evening regarding recent patient events/behaviors .exhibited sexually inappropriate behaviors on several occasions over the last week .unwanted sexual advances towards other residents and undressing, fondling himself, and exposing genitals in the presence of other residents in the dining/activities room, a common shared area for residents . event occurred over the weekend and prompted nurse to notify facility admin of behavior who in turn notified me .allegedly physically assaulted roommate . Review of the facility Clinical Notes for Resident #11 dated [DATE] at 9:23 AM, revealed, .Admin [Administrator] spoke to NP regarding Resident's behaviors and NP stated she would review his medications and a referral to psych was to be started by the building on Monday ,d+[DATE] [2023] .Nursing made aware . Review of the facility Clinical Notes for Resident #11 dated [DATE] at 9:35 AM, revealed .resident was observed being inappropriate in the dinning [dining] room. resident sent back to his room. spoke with [Named psychiatric facility] psych in [Named city] and sent a referral packet earlier today. waiting for a call back. resident is being observed for any other behaviors . (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 a signed written statement dated [DATE] revealed Registered Nurse (RN) JJJ stated, .was informed by the activities director that [Named Resident #15] was in the dining room and that she was visibly upset .[Named Resident #15] had made allegations that [Named Resident #11] had been trying to hug on her .given her money .After the activities director had informed me of the situation, we brought it to the DON's attention . Review of a signed written undated statement revealed LPN O stated, .This nurse was informed of Resident [Resident #11] playing with his genital area and Rubbing his nipples and this nurse informed staff that he should be sent to his Room for that behavior . Review of the facility Clinical Notes for Resident #11 dated [DATE] - [DATE] revealed multiple behaviors for Resident #11 which included spitting out medications, refusing medications, walking in the hallway with his shirt pulled up over his abdomen, and outburst of yelling and cursing staff. Interviews conducted during the survey revealed Administration and nursing staff denied abnormal behaviors for Resident #11 since his return from the psychiatric unit after the sexual allegations. Review of the (Named Psychiatric facility) Discharge Summary for Resident #11 dated [DATE], revealed, . Reason for Admission and Examination .Patient is admitted for sexually inappropriate behaviors where he put his genitalia in his roommate's hand, pulling his pants down showing his genitalia, pulling his shirt up rubbing his nipples . Review of the Psychiatric Evaluation (Amended) for Resident #11 dated [DATE], revealed, .currently readmitted to the facility after being hospitalized .for hypersexuality .While hospitalized , the resident was started on Provera [hormone] 5 mg [milligram] by mouth twice daily for hypersexuality .The residents ' medication, Provera, was being ordered this day from the pharmacy . Review of the NP Progress Note for Resident #11 dated [DATE] at 2:05 PM, revealed, .Assessment . Nymphomania [hypersexuality] (finding) .Oth [other] sexual dysfnct [dysfunction] .modified 13 Oct. [October] 2023 . During an interview on [DATE] at 2:10 PM, the Administrator stated Resident #11 had no sexual behavior prior to this incident on [DATE]. The Administrator stated Resident #11 had refused medications for a few days before and then had the inappropriate behaviors. When asked what were the effects of Resident #11 not taking his medications, the Administrator replied, .Resident #11 was in activities and pulled his shirt up . rubbed his nipples . [Named Resident #3] reported to his sister that [Named Resident #11] had tried to put his genitals in [Named Resident #3]'s hand . [Named Family member (FM) HH] reported the incident to the nurse, who reported to the Administrator . During an interview on [DATE] at 4:42 PM, the Activities Director stated Resident #11 was in activities when he pulled up his shirt and rubbed his nipples. She stated she removed Resident #11 from the activity room, escorted him to the nurse and reported what had happened in the dining 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 9:32 AM, the DON stated, .I did a small investigation that involved [Named Resident #11] and his behavior in the dining room with other residents present .[Named Resident #11] was redirected and escorted from the dining room to his room .[Named Resident #11] was placed on 1 to 1 with the MDS [Minimum Data Set] Coordinator in his room .He [Resident #11] had been refusing his medications and this is why he was having behaviors . When asked what intervention had been initiated for Resident #11's inappropriate sexual behavior with Resident #15, the DON replied, .I spoke with [Named Resident #11] and told him he was not to hug anyone else without their permission . During an interview on [DATE] at 11:10 AM, Licensed Practical Nurse (LPN) O confirmed Resident #11 was sent to a psychiatric facility due to exposing himself to other residents. LPN O stated, .The day [[DATE]] [Named Resident #11] left going to [Named psychiatric facility] he was alone in his room. I walked him out to the car and he became agitated and hit the window of the car .He [Resident #11] had behaviors of spitting out his medications and cussing staff . During an interview on [DATE] at 11:47 AM, the Activity Director confirmed she had reported and documented Resident #11's inappropriate sexual behaviors multiple times beginning [DATE], and continuing on [DATE], and [DATE]. The Activity Director stated, .on the 18th [[DATE]] [Named Resident #11] was in activities and walked up to [Resident #15], put his hands on her shoulders and began to massage her .He [Resident #11] tried to kiss her while he was rubbing her and she pushed him away .He [Resident #11] put some money on the table in front of her [Resident #15] and pushed it towards her and said, ' .If that isn't enough, just let me know .' then he laughed and walked back to his table . I asked him to leave activities and reported it to the nurse, not sure which one, I think she was agency .On the 21st [[DATE]] he [Resident #11] was sitting at his table, stood up, and pulled his pants down then pointed to his penis and yelled, ' .if any of you ladies wants this come to room [ROOM NUMBER] .' he [Resident #11] had a piece of paper with the number 311 written on it He then walked over and tried to kiss [Named Resident #15] .I went and got the nurse [Named LPN H] .she [LPN H] came in and told him to go to his room .On the 22nd [[DATE]] he [Resident #11] he walked up to [Named Resident #15] rubbed up against her, and started rubbing his nipples and making sexual comments like ' .Do you want some of that .' then handing a piece of paper with his room number on it .I told him to leave activities and went to get a nurse .he [Resident #11] was walking down the hall outside of activities and pulled up his shirt and started rubbing his nipples . I went and told the nurse . may have been a different agency nurse .I told them he could not come back to activities . When asked if she had reported the inappropriate behaviors to anyone else, the Activity Director replied, .We talked about it in the morning meetings that week and [Named DON] said the psych nurse would see him . The Activity Director stated, .The Administrator and the DON have been upset about my documentation and said we would be in trouble if the State came in and seen it .I will not change my statements and say I heard that he [Resident #11] had done those things, I saw it happen . During an interview on [DATE] at 12:11 PM, the Social Services Director (SSD) confirmed there had been discussions about the inappropriate sexual behaviors reported by the Activity Director in the morning meetings. The SSD stated, .Either the Administrator or the DON keeps a record of the morning meetings .He [Resident #11] was to be seen by the NP .I think the Administrator spoke to the NP on the 26th [[DATE]] .He [Resident #11] would write letters to his girlfriend and bring them to me .the letters contained very explicit sexual content . (continued on next page)

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	445439	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahc MT Juliet	2650 North MT Juliet Road Mount Juliet, TN 37122

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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 12:50 PM, the DON reviewed a binder that contained the minutes for the morning meetings and confirmed there were no meeting minutes in the binder for [DATE] - [DATE]. The DON stated, .There were no interventions related to [Named Resident #11]'s sexual behaviors in activities because we did not know about them .I think the documentation by Activity was actually just hearsay .he [Resident #11] was sent out to psych .He [Resident #11] has had no continued behavior since returning to the facility . During an interview on [DATE] at 1:13 PM, LPN H confirmed the Activity Director notified her about Resident #11's inappropriate behavior. LPN H stated, .[Named Activity Director] told me he [Resident #11] was exposing himself to people in the dining room .I went down there and he [Resident #11] was sitting in his chair drinking coffee and smiling at me . When asked if she investigated or asked any of the residents present in the room about the behavior, LPN H replied, .There was nothing to investigate, he was sitting there drinking coffee . When asked if she had been trained on Abuse since being employed by the facility, LPN H replied, .Yes, many times . LPN H was asked if she had to actually see abuse in order to act on an allegation. LPN H replied, .Tell me if it was my responsibility to report the allegation, since the Activity Director was in management . During an interview on [DATE] at 3:08 PM, MDS Coordinator HHH and MDS Coordinator III confirmed neither one had performed 1 on 1 monitoring for Resident #11 prior to the resident being transferred to a psychiatric facility. MDS Coordinator HHH and III both confirmed Resident #11's inappropriate sexual behaviors on ,d+[DATE] - [DATE] had been presented by the Activity Director and discussed in the morning meetings. During an interview on [DATE] at 3:18 PM, the Administrator stated, .We were unable to substantiate the allegations of sexual abuse between [Named Resident #3] and [Named Resident #11] because it was not witnessed and both residents have an extensive history of psych behaviors, but no sexual behaviors . [Named Resident #3] has not been happy with living in the facility and does not want to be here .I think he [Resident #3] has been sexually inappropriate with staff .[Named Resident #11] had been refusing medication and spitting it out so his behavior increased and he was sent out .before that he was seen by the NP and had a medication change . When asked about the documentation of Resident #11's sexually inappropriate behaviors during activities reported by the Activity Director, the Administrator stated, .Well, after we got those notes cleaned up, we had to talk to [Named Activity Director] and explain why she could not document what someone tells her rather than what she actually sees. I think the behaviors was just what someone told her happened . When asked what she meant by getting the notes cleaned up, the Administrator replied, .We reviewed the notes and then asked staff if anything had been reported to them because [Named Activity Director] said she had reported to the nurse .We didn't find anyone she had reported the information to . The facility investigation contained signed written statements from 2 nurses confirming notification of Resident #11's sexual behaviors. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on [DATE] at 3:30 PM, former Assistant Director of Nursing (ADON) stated, .I conducted the morning meetings when the DON was unavailable .The minutes would be recorded and placed in the big binder in the DON ' s office .Yes, I was aware of the behaviors reported by [Named Activity Director] not sure what all the interventions were, I am sure a staff member had to be present in the dining room when he [Resident #11] was in there . When asked if having a staff member present would stop Resident #11's inappropriate behavior, the ADON replied, Of course. When asked about the behavior that occurred with Activity staff present in the dining room, the ADON replied, .There was staff in there and it happened anyway, well ain't that something . Review of the medical record revealed Resident #15 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease with Early Onset, and Chronic Kidney Disease, Stage 3. Review of the Admission MDS assessment dated [DATE] for Resident #15 revealed, a BIMS score of 4 which indicated severe cognitive impairment. Resident #15 was independent with mobility/walking. Review of the Psychotherapy progress notes for Resident #15 dated [DATE] - [DATE], revealed no notes or evaluations related to nonconsensual sexual contact and inappropriate sexual behaviors toward Resident #15 from Resident #11. No Psychotherapy progress notes for [DATE] - [DATE] were provided by the facility. Review of undated care plan for Resident #15 revealed, .exhibits wandering behavior . Continued review revealed there was no problems/focus and interventions for risk related to victim of inappropriate sexual behavior and nonconsensual sexual contact by Resident #11 on [DATE] - [DATE]. Review of the facility Clinical Notes for Resident #15 dated [DATE]-[DATE], revealed there were no documentation of inappropriate sexual behaviors and nonconsensual sexual contact experienced by Resident #15 from Resident #11. During an interview on [DATE] at 3:08 PM, MDS Coordinator HHH and III confirmed there were no interventions related to actual risk associated with the nonconsensual sexual contact Resident #15 experienced from [DATE]-[DATE]. MDS Coordinator HHH and III agreed residents that experience alleged abuse should be monitored for risk of immediate and late onset of affects such as psychosocial harm. During an interview on [DATE] at 4:00 PM, Resident #15 was smiling, giggling, and very childlike in behavior (bouncing in chair during interview). Resident #15 was asked if she had a fun time in activity and if anyone ever bothered her or upset her during activity. Resident #15 replied, .I like to color and make pretty things . When asked if anyone had ever made her mad or touched her in a bad way. Resident #15 replied, .[Named (first name) Resident #11] kisses me here [pointed to her neck] and tells me how much he loves me .he just loves me all the time .but I tell him to get back .I don't want nobody kissing me . Resident #15 then got up from the table and walked away. During an interview on [DATE] at 4:27 PM, the Administrator was asked what the facility had done to protect Resident #15 from targeted nonconsensual sexual behavior from other residents. The Administrator stated, . [Named Resident #15] is young and pretty and puts herself in very social situations .She socializes, laughing and talking with everyone . The Administrator was asked if she thought Resident #15 caused the nonconsensual contact that occurred in [DATE]. The Administrator stated, No, I feel like she is so friendly and people take it wrong .[Named Resident #1) had been sent out to a psychiatric unit and I really don't know of any other interventions the facility could put in place . (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 medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses which included Unspecified Fracture of Third Lumbar Vertebra, Frontal Lobe and Executive Function Deficit, and Urinary Tract Infection. Resident #7 was discharged on [DATE] to Hospital #1. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #7 revealed, a BIMS score of 15 which indicated no cognitive impairment. Continued review revealed Resident #7 had an indwelling catheter. Review of the care plan for Resident #7 revealed, .Problem .[[DATE]] at risk for UTI (Urinary Tract Infection) . Interventions .Provide cues/assist [Named Resident #7] to drink fluids with medications and between meals . Monitor [Named Resident #7] for burning/painful urination .Obtain urine samples as ordered .Periwipes available to resident .Record I & O .Catheter care .Change catheter as needed for blockage or malfunction . Check catheter tubing for proper drainage and position .Keep drainage bag covered to promote dignity . Observe for discomfort, urine color, clarity, amount, odor, presence of blood; Notify MD of abnormal findings and follow up as indicated .Offer extra fluids throughout the day .Problem .At Risk For Falls R/T [related to] impaired mobility .Interventions .Keep area free of obstructions to reduce the risk of falls or injury .Place call bell/light within easy reach .Provide reminders to use ambulation and transfer assist devices .Remind [Resident #7] to call for assistance before moving from bed-to-chair and from chair-to-bed .[[DATE]] At risk for complications related to [Resident #7] has diagnosis of diabetes Interventions .Administer medications as ordered and monitor for adverse side effects .Diet as ordered .Labs as ordered, report abnormal findings to MD [Medical Doctor] with follow-up as indicated .Monitor blood sugar levels per MD order and notify MD of abnormal findings as indicated .Observe for excessive thirst, excessive eating, frequent voiding, change in level of consciousness, perspiration, fatigue, nausea/vomiting, tremors, provide interventions as per MD order; monitor for effectiveness and report to MD if ineffective .Monitor for change in level of consciousness . Problem .At risk for complications of renal failure .Observe for edema, warmth and color of extremities, shortness of breath, and vital signs daily. Report abnormalities to MD with follow-up as indicated .Problem . At risk for infection R/T indwelling catheter. [Resident #7] needs catheter related to bladder-neck obstruction . Interventions .Clean around catheter with soap and water .Keep tubing below level of bladder and free of kinks or twists .Report any sign of infection (temperature, pain, urine that looks cloudy, dark, or with blood) . [[DATE]] Footwear will fit properly and have non-skid soles . Review of the facility document (Incident Report) dated [DATE], LPN G documented, Observed resident on the floor between both beds and his head under his bed. Resident did not have non-skid footwear on. While assisting resident up from the floor, raised his head and bumped it on the bottom of the bed. Resident mental status was at his normal. Resident was resting comfortably in bed when writer [LPN G] exited room. Continued review revealed a bruise to Resident #7's forehead. Review of the facility Clinical Note dated [DATE] but entered on ,d+[DATE] [TRUNCATED]

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46831 Based on facility policy review, medical record review, and interview, the facility failed to ensure the appropriate information for transfer or discharge was communicated to the receiving healthcare facility or provider for 1 of 3 residents (Resident #7) sampled residents reviewed. Resident #7 was transferred to Hospital #1 Emergency Department (ED) on 1/29/2024 for evaluation of a change in mental status. Facility nursing staff failed to communicate information related to Resident #7's unwitnessed fall on 1/25/2024 on the written report to Hospital #1. The findings include: Review of the facility policy titled, Transfer and Discharge, revised 10/24/2022 and effective 11/20/2023 revealed, .For a transfer to another provider, the following information must be provided to the receiving provider . Other necessary information, including a copy of the resident's discharge summary, as applicable, to ensure a safe and effective transition of care .Emergency Transfers/Discharges-for medical reasons, or for the immediate safety and welfare of a resident, initiated by the facility (nursing responsibilities unless otherwise specified) . Any other documentation, as applicable, to ensure a safe and effective transition of care . Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses which included Unspecified Fracture of Third Lumbar Vertebra, Frontal Lobe and Executive Function Deficit, and Urinary Tract Infection. Resident #7 was discharged on [DATE] to Hospital #1. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #7 revealed, a BIMS score of 15 which indicated no cognitive impairment. Review of the facility clinical note dated 1/25/2024 but entered on 1/29/2024, revealed LPN G documented . Resident was found on the floor with his head under the bed. Staff was assisting to get resident off the floor. While sliding the resident to get his head clear of the bed the resident raised his head and hit it on the underneath of the bed . Review of the facility clinical note dated 1/28/2024, revealed LPN F documented .Res [Resident] appears to be more confused, not understanding simple tasks . Review of the facility Hospital Transfer Form dated 1/29/2024 but completed on 1/30/2024, revealed .Mental Disorders/Neurological/Psychiatric Issues .Change in Mental Status . There was no documentation to show LPN G reported the unwitnessed fall on 1/25/2024 or the change in mental status that started on 1/28/2024 on the Hospital Transfer Form. During a telephone interview on 3/27/2024 at 3:57 PM, LPN G was asked if he reported the 1/25/2024 unwitnessed fall when Resident #7 was transferred out to the hospital. LPN G replied, .No. I just told them about the change in mental status . The facility failed to ensure Hospital #1 received accurate and appropriate information related to Resident #7's 1/25/2024 fall that could have likely resulted in a delay of treatment in the ED.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38441 Based on facility policy review, medical record review, and interview, the facility failed to implement a comprehensive person-centered care plan for 3 (Resident #3, Resident #10, and Resident #15) of 20 residents reviewed. The findings include: Review of the facility's policy titled Comprehensive Care plan dated 11/30/2026 revised 10/24/2022 effective 11/9/2023, revealed .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident .that include measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs .'Person Centered' means to focus on the resident as the locus [focus] of control and support the resident in making their own choices and having control over their daily lives .at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses which included Schizophrenia, Dysphagia, Dysarthria and Anarthria. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 revealed, a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Review of the undated current care plan for Resident #3 revealed there were no focus/problems or interventions on the care plan for risk related to actual abuse allegations. Review of the provider/Nurse Practitioner (NP) progress note dated 9/26/2023 for Resident #3, revealed, . Patient being seen for follow-up on events this past weekend involving roommate .patient reports he does not want to discuss in detail w [with]/me what occurred over the weekend .does affirm allegation against roommate and that he [Resident #3] may be open to discussing w/local PD [Police Department] .Reports emotional and mental distress from prior roommate's actions . Review of the facility Clinical Notes for Resident #3 dated 9/26/2023- 9/29/2023 frequently referenced Resident #3's desire to sit on the front porch, even referenced it as something he loves to do on a daily basis. The Clinical Notes referred to Resident #3 feeling safe and calm, in a good mood and smiling. During an interview on 4/2/2024 at 3:08 PM, MDS Coordinator #1 and #2 confirmed there were no interventions related to actual risk associated with the allegation of nonconsensual sexual contact/sexual abuse Resident #3 reported on 9/24/2023. MDS Coordinator #1 and #2 agreed residents that experience alleged abuse should be monitored for risk of immediate and late onset of affects such as psychosocial harm. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/2024 at 4:11 PM, Resident #3 agreed to interview in the presence of his roommate. Resident #3 was asked to recall the incident with his previous roommate, Resident #11, during the night of 9/23/2023 - 9/24/2023. The surveyor provided support and patience during the interview as Resident #3 was very slow to answer and had difficulty expressing himself. Resident #3 stated, .[Named Resident #11] came to my bed and tried to push me on my side, 3 or 4 times .almost fell off the bed .he [Resident #11] stopped and looked right at me, took out his d k and put it in my hand .I yelled .he walked away laughing . Resident #3 was asked if he felt safe in the facility, Resident #3 replied, .I am safe with this roommate [pointing towards current roommate] but when he goes home, who will keep me safe .He [Resident #11] is still here, I see him out in the hall . Resident #3 became tearful and paused for several minutes. When asked if he reported the incident to staff after Resident #11 walked away, Resident #3 replied, .I tried but they wouldn't stand still long enough for me to talk, they think I can't talk . Resident #3 thanked the surveyor for standing still and listening to him. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease, Atrial Fibrillation and Dementia. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #10 revealed, a BIMS score of 14 which indicated no cognitive impairment. Review of Comprehensive Care Plan for Resident #10 dated 1/5/2024 revealed, .1/5/2024 risk for falls r/t (related to) impaired mobility .transfers-Assist .to desired location with assistance .Hoyer lift X [times] 2 person assist with transfer . Review of the Clinical Note documented late on 1/25/2024 at 3:29 PM for effective date 1/24/2024 at 12:30 PM, the DON documented Pt [patient]stated she was having knee pain from transfer. AIT (Administrator in training) and myself entered room to speak with pt[patient] regarding the transfer pain. PT [patient] states she was transferred by 2 people and her knee began to hurt once she was back in bed. Stated that she did not want any pain medication. AIT asked her if she would like any heat or ice. Pt stated she did not want those either. NP [Nurse Practitioner] made aware of concerns. Xray ordered. Review of Physical Therapy Treatment Encounter Note dated 1/25/2024, revealed PTA [Physical Therapist Assistant] documented Entered patient's room pt [patient] reported increase pain in R knee due to tech twisted and broke her leg when they were transferring her back to bed and she is unable to move her legs this session. Assist can [Certified Nursing Assistant] with toilet hygiene rolling R <> L [right to left] with max [maximum] A [assist] .spoke with nursing with patient's concerns and comments .Pt responded poorly with PT [physical therapy] interventions . On 1/23/2024 Resident #10 was transferred from the wheelchair to bed by CNA EE and CNA FF without using a mechanical lift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/2024 at 1:00 PM, CNA EE had been working at the facility for 7 years. She stated she had just taken over the group and was asked by Resident #10 to put her in the bed because her leg was hurting. Therapy had gotten Resident #10 up that morning and had been working with her. CNA EE requested the assistance of CNA FF to transfer the resident. CNA EE stated she used a gait belt and did an underarm 2-person lift to transfer the resident to the bed. The resident requested her legs be straightened out and was clean and dry. CNA EE stated she had not cared for Resident 10 often previously other than to do her weekly weights. When asked how the weights were done, she stated by named mechanical lift. When asked where she would check to see how to get the resident up, CNA EE stated she would check the Kiosk/care plan to find out how to transfer the resident. During an interview on 4/2/2024 at 330 PM, revealed CNA FF had been working at the facility for approximately 7 years. CNA FF stated she was asked to assist in putting Resident #10 to bed. Resident #10 was in a wheelchair and complained of pain. CNA FF stated they used a gait belt and stood her up with the assistance of CNA EE. CNA FF stated, she had never worked with this resident before. CNA FF stated the resident complained of pain prior to the transfer as well as during the transfer. During an interview on 4/10/2024 at 9:15 AM, the Doctor of Physical Therapy [DPT] stated that Resident #10 was added to their case load on 1/5/2024 and evaluated on 1/8/2024. The transfer recommendation for nursing staff was for them to transfer Resident #10 with a mechanical lift and therapy transferred the resident with a sliding board. This plan of care continues to be in place at present. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses which included Bipolar Disorder, Schizoaffective Disorder, and Frontotemporal Neurocognitive Disorder. Common symptoms of Frontotemporal Neurocognitive Disorder include but are not limited to behavior such as socially inappropriate, impulsive, or repetitive behaviors, and increased interest in sex. Review of the Admission MDS assessment dated [DATE] for Resident #11 revealed, a BIMS score of 12, which indicated moderately cognitively impaired. Continued review revealed Resident #11 required supervision to walk in corridor. Review of care plan for Resident #11 revealed, . 8/22/2023 .Remind [Resident #11] that BEHAVIOR is not appropriate .Resident prefers to walk around facility constantly and enjoys sitting on front porch . 9/26/2023 . displayed inappropriate sexual behaviors towards others .Redirect [Named Resident #11] and remind him of what is appropriate/not appropriate in social settings .10/3/2023 .rejects or resists care (history of refusing medications) . Resident #3, the victim of the alleged sexual assault enjoyed sitting on the front porch. There were no care plan interventions for either resident to address psychosocial risk associated with repeated exposure in the facility. Review of the facility Clinical Notes for Resident #11 dated 9/22/2023 at 8:45 AM, revealed .Resident was down in the dining room on 09/21/23 [2023] two different times this resident was making sexual comment's [comments] to the lady residents pulling his shirt up and rubbing his nipples and rubbing himself up on two female residents. Also [Also,] resident was rubbing his penis asking a female resident if she wanted some of that. Resident also had his room # written on a piece of paper telling the lady resident to come to his room. Activities reported this to the nurse . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Clinical Notes for Resident #11 dated 9/24/2023 at 6:31 PM, revealed .Another resident family member notified Nurse Management this shift of sexual inappropriate behavior towards roommate/resident on last night. Roommate immediately moved out of room, placed in another room. Family [Resident #3's family] at bedside agreeable and aware. Review of the medical record revealed Resident #15 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease with Early Onset, and Chronic Kidney Disease, Stage 3. Review of the Admission MDS assessment dated [DATE] for Resident #15 revealed, a BIMS score of 4 which indicated severe cognitive impairment. Resident #15 was independent with mobility/walking. Review of undated care plan for Resident #15 revealed, .exhibits wandering behavior . Continued review revealed there was no problems/focus and interventions for risk related to victim of inappropriate sexual behavior and nonconsensual sexual contact by Resident #11 on 9/18/2023-9/22/2023, and Resident #19 on 2/21/2024. Review of the facility Clinical Notes for Resident #15 dated 2/22/2024, revealed, .Presented to DON office with activities director and 100 hall nurse. Stated that resident CC [Resident #19] kissed her on her cheek and she was only letting someone know about it because she did not want him to kiss her anymore . During an interview on 4/2/2024 at 11:47 AM, the Activity Director confirmed she had reported and documented Resident #11's inappropriate sexual behaviors multiple times beginning 9/18/2023, and continuing on 9/21/2023, and 9/22/2023. The Activity Director stated, .on the 18th [9/18/2023] [Named Resident #11] was in activities and walked up to [Resident #15], put his hands on her shoulders and began to massage her .He [Resident #11] tried to kiss her while he was rubbing her and she pushed him away .He [Resident #11] put some money on the table in front of her [Resident #15] and pushed it towards her and said, ' .If that isn't enough, just let me know .' then he laughed and walked back to his table . I asked him to leave activities and reported it to the nurse, not sure which one, I think she was agency .On the 21st [9/21/2023] he [Resident #11] was sitting at his table, stood up, and pulled his pants down then pointed to his penis and yelled, ' .if any of you ladies wants this come to room [ROOM NUMBER] .' he [Resident #11] had a piece of paper with the number 311 written on it He then walked over and tried to kiss [Named Resident #15] .I went and got the nurse [Named LPN H] .she [LPN H] came in and told him to go to his room .On the 22nd [9/22/2023] he [Resident #11] walked up to [Named Resident #15] rubbed up against her, and started rubbing his nipples and making sexual comments like ' .Do you want some of that .' then handing a piece of paper with his room number on it . During an interview on 4/2/2024 at 1:13 PM, LPN H stated, .[Named Resident #19] is obsessed with [Named Resident #15], always trying to give her candy and bring her things, but she doesn't return the feelings .she pushes him away .One day in activities he [Resident #19] was beside her [Resident #15] and she pushed him away, had to tell both of them to go to their room and cool off . During an interview on 4/2/2024 at 3:08 PM, MDS Coordinator HHH and III confirmed there were no interventions related to actual risk associated with the nonconsensual sexual contact Resident #15 experienced from 9/18/2023-2/21/2024. MDS Coordinator HHH and III agreed residents that experience alleged abuse should be monitored for risk of immediate and late onset of affects such as psychosocial harm. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahc MT Juliet	2650 North MT Juliet Road Mount Juliet, TN 37122

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed Resident #19 was admitted to the facility on [DATE], with diagnoses which included Catatonic Disorder due to known Physiological Condition, Chronic Obstructive Pulmonary Disorder (COPD) and Schizophrenia. Other diagnoses included Other Sexual Dysfnct. Review of the Quarterly MDS assessment dated [DATE] revealed Resident #19 had a BIMS score of 5, which indicated severely cognitively impaired. Resident #19 was independent with mobility/walking. Review of the undated current care plan for Resident #19 revealed, .Resident practices sexual expression daily on his bed with roommate in room .Dx [Diagnosis] Hypersexuality . Review of the facility Clinical Notes for Resident #19 dated 3/6/2024 at 4:43 PM, revealed, .Resident observed attempting to be affectionate towards another resident .redirected to room . During an interview on 4/2/2024 at 11:47 AM, the Activity Director stated, .[Named Resident #19] frequently tried to get next to [Named Resident #15] .[Resident 19] got mad at [Named Resident #11] because he said [Named Resident #11] told him he was going to rape [Named Resident #15] and said he [Resident #11] had [NAME] coming out of his chest .I reported it to all the nurses .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32777 Based on facility policy review, medical record review, facility investigation review, hospital record review, and interview, the facility failed to assess after a fall, care for a resident after a fall, and monitor after a fall for 1 of 6 (Resident #7) sampled residents reviewed for falls. On [DATE] at 5:30 PM, Resident #7, known to have a history of falls with injury, was found on the floor following an unwitnessed fall from bed. There was no documentation to show a post-fall assessment was completed prior to moving Resident #7 from the floor to the bed. There was no documentation to show neuro checks were conducted. There was no incident report or investigation documented following the unwitnessed fall to determine the root cause. There were no immediate interventions documented following the fall. On [DATE] (4 days after the unwitnessed fall) Resident #7 was transferred to the hospital on [DATE] for a change in mental status. The findings include: Review of the facility policy titled, Accidents and Supervision, revised [DATE] revealed, .The facility shall establish and utilize a systemic approach to address resident risk and environmental hazards to minimize the likelihood of accidents .1. Identification of Hazards and Risks .a. Communicating the interventions to all relevant staff .Providing training as needed .d. Documenting interventions .e. Ensuring that the interventions are put into action . Review of the facility policy titled, Fall Risk-Fall Prevention, revised [DATE] revealed, .1. The fall risk assessment shall be completed by a licensed nurse .b. After a fall .c. Upon a significant change in medical status . Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses which included Unspecified Fracture of Third Lumbar Vertebra, Frontal Lobe and Executive Function Deficit, and Urinary Tract Infection. Resident #7 was discharged on [DATE] to Hospital #1. Review of the care plan for Resident #7 revealed, .[[DATE]] At Risk For Falls R/T [related to] impaired mobility .Interventions .Keep area free of obstructions to reduce the risk of falls or injury .Place call bell/light within easy reach .Provide reminders to use ambulation and transfer assist devices .Remind [Resident #7] to call for assistance before moving from bed-to-chair and from chair-to-bed .[[DATE]] Footwear will fit properly and have non-skid soles . Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #7 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Review of the facility document (Incident Report) dated [DATE], revealed LPN G documented, Observed resident on the floor between both beds and his head under his bed. Resident did not have non-skid footwear on. While assisting resident up from the floor, raised his head and bumped it on the bottom of the bed. Resident mental status was at his normal. Resident was resting comfortably in bed when writer [LPN G] exited room. Continued review revealed a bruise to Resident #7's forehead. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Clinical Note dated [DATE] but not entered into the Electronic Health Record (EHR) until [DATE], revealed LPN G documented Resident #7 was found on the floor with his head under the bed. Continued review revealed that while staff were assisting him out from under the bed, he raised his head and hit it on the bottom of the bed. LPN G documented there were no injuries. The Clinical Note was not documented as a late entry. Review of the facility Clinical Note dated [DATE] revealed LPN F documented Resident #7 experienced a change in condition. The provider was not notified of Resident #7's change in condition until [DATE], the following day. Review of the facility Fall Risk assessment dated [DATE] revealed Resident #7 had a history of multiple falls in the last 90 days, had an unsteady gait and was at moderate risk for falls. Review of the hospital record dated [DATE] at 10:05 AM revealed, .PT [patient] was found unresponsive in bed .[nursing home] staff reports patient is normally talking and oriented, BG [blood glucose] was 517 . Bruising on forehead purple and yellow in color . Resident #7 expired at the hospital on [DATE]. Septic shock was documented as the cause of death. During an interview on [DATE] at 11:25 AM, the DON verified the unwitnessed fall on [DATE] for Resident #7 was not charted until [DATE]. The DON stated she became aware of Resident #7's unwitnessed fall after he was sent to Hospital #1 emergency room (ER) for a change in mental status when someone reported to her Resident #7 had a knot and a bruise on his head. She stated she followed-up with LPN G, who said Resident #7 had a fall and hit his head pretty hard on [DATE]. After the DON received report on the fall from [DATE], she initiated an investigation and requested LPN G complete an incident report on [DATE]. The DON stated she educated LPN G when he stated he was unaware he needed to document on the fall. Continued interview revealed, the DON was asked what her expectations were when a resident experienced a fall. She replied, .I expect a head-to-toe assessment, neuro checks, notification to the NP, family, DON, Administrator and implement any new orders received . The DON looked at the progress note documented by LPN F and stated .[LPN F] should have contacted the NP herself .The NP should have been notified as soon as the change in mental status was noticed .with any change in condition, there should be follow-up charting for 72 hours . During a telephone interview on [DATE] at 3:57 PM, LPN G stated Resident #7 experienced an unwitnessed fall on Thursday, [DATE] .[LPN K] found him [Resident #7] .we went in and assessed him [LPN G, CNA AA, CNA CC] .everything seemed fine .he was being belligerent when we got him up off the floor .[LPN G] did not do an incident report .I was off Friday [[DATE]], Saturday [[DATE]], Sunday [[DATE]] .Monday [[DATE]], the night nurse [LPN F] informed me [Resident #7] needed a urine .when I got to his room between 9 AM and 10 AM to give meds .he was totally different .I went to call the NP .got order to send Resident #7 out .found out later Resident #7 had passed .a few days later, CNA AA and CNA CC said Resident #7 had multiple falls over the weekend [after the fall on [DATE]] .Resident #7 was between his and his roommate's bed .lying on his back .Resident #7 said he slid out of bed and landed on his bottom .Resident #7 bumped his head on the frame of the bed when we got him up .Resident #7 had scooted under the bed .head was under the bed .No visible injuries noted at that time .I did neuro checks but did not chart it .I was not trained well on that system . on that Monday, he had a bruise to the forehead or temporal area . Continued interview revealed LPN G stated .I did not report the fall because I was unfamiliar with the computer system and the Unit Manager was there and saw him on the floor . LPN G was asked if he reported the fall when Resident #7 was transferred out to the hospital. LPN G replied, No. I just told them about the change in mental status . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on [DATE] at 5:00 PM, the facility NP was asked what her expectations were to report a change in mental status. She replied, .I would expect to be notified immediately after the patients immediate needs were met, no matter the time .On call is available for the night shift .If emergent or unstable, I would expect staff to call 911 and then notify me immediately after . Continued interview revealed, the NP was not notified about Resident #7's fall on [DATE] and was contacted on [DATE] about a change in mental status for Resident #7. During an interview on [DATE] at 12:45 PM, LPN K, the Unit Manager, recalled she was about to leave for the day and went to tell the nurse something when she observed LPN #4 with ,d+[DATE] unnamed CNAs in Resident #7's room. Resident #7 was positioned on the floor, toward the foot of the bed, sitting up with his back against the bed. When asked her expectations for staff when a fall occurred, LPN K stated she would expect the nurse on duty to complete an event note, progress note, and 72-hour charting. When asked if LPN K followed-up on Resident #7's fall the next day, LPN K stated No, the ADON [Assistant Director of Nursing] dealt with the falls in the facility. Continued interview revealed LPN K admitted she did not notify the NP, DON, ADON, or family about Resident #7's fall and should have followed-up the next day on the fall from [DATE]. During an interview on [DATE] at 3:07 PM, CNA GG stated Resident #7 did fall and was found on the floor face down, beside the bed and the bedside table. CNA GG stated he did not observe the fall but did notify the unnamed nurse and helped get Resident #7 up off the floor into the bed. When asked if Resident #7 had experienced any change in mental status, CNA GG stated Resident #7 would typically curse and yell, but he actually became calm and quiet after the unwitnessed fall. Continued interview revealed, CNA GG felt there was something different with Resident #7 and asked the unnamed nurse if she felt Resident #7 looked okay, the unnamed nurse replied, Yes.

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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. Deficiency Text Not Available

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44447 Based on facility policy review, (Named Glucometer- a device used to check blood sugar levels with the use of a blood sample) User's Guide review, Guidelines for General Use of (Named germicidal cloth) wipes used by the facility review, DME (Durable Medical Equipment) supplier recommendation letter review, medical record review, observation, and interview, the facility failed to ensure practices to prevent the potential spread of infection were maintained when a multi-use blood glucose meter was not cleaned and disinfected with facility required cleansing wipes to prevent cross-contamination of bloodborne pathogens for 2 of 11 (Residents #17 and Resident #18) sampled residents reviewed for blood glucose monitoring. Observations on 4/2/2024 revealed Licensed Practical Nurse (LPN) P failed to clean and disinfect the multi-use blood glucose meter before and after use on each resident in accordance with recommendations and facility policy, failed to perform hand hygiene, and failed to don gloves when performing point of care testing for Resident #18. Observations on 4/3/2024 revealed LPN E, LPN O, and Registered Nurse (RN) A failed to clean and disinfect the blood glucose meters that are used for multiple residents, in accordance with manufacturer recommendations and facility policy. The facility's failure to ensure staff properly disinfected the blood glucose meter that was used for multiple residents, in accordance with recommendations and the facility ' s policy, placed the residents at risk for potential contamination with bloodborne pathogens and the likelihood to cause serious injury, harm, impairment, and/or death resulted in Immediate Jeopardy. The facility had 7 residents receiving blood glucose monitoring with a multi-use blood glucose meter and the facility's failure had the potential to affect the 11 residents receiving blood glucose monitoring with a multi-use blood glucose meter. 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) was identified related to the facility ' s failure to appropriately clean and disinfect a multi-use blood glucose meter during medication administration. The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy for F-880 on 4/4/2024 at 4:45 PM, in the Director of Nursing (DON)'s office. The facility was cited Immediate Jeopardy at F-880 at a scope/severity of K. The Immediate Jeopardy began on 4/2/2024 and is ongoing. A partial extended survey was conducted 4/4/2024 to 4/11/2024. The facility is required to submit a Plan of Correction (POC). The findings include: Review of the facility's policy titled, Cleaning and Disinfecting Glucometer, revised 10/9/2023, revealed, . Policy: To minimize the risk of transmitting blood-borne diseases .device shall be cleaned and disinfected after each use .Protocol: The facility shall ensure blood glucometers are cleaned and disinfected after each use and according to manufacturer's instructions for multiple-resident use . (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the (Named Glucometer) User's Guide dated 2/10/2020 revealed, .Healthcare Professional Information .Healthcare professionals performing blood glucose (BG) test with this system on multiple patients must always wear gloves .Important Safety Instructions .Adhere to standard precautions when handling or using this device. All parts of the glucose monitoring system should be considered potentially infectious and are capable of transmitting blood-borne pathogens between patients and healthcare professionals .The meter should be disinfected after use on each patient .This blood glucose monitoring system may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed .Cleaning Instructions: Cleaning is the removal of visible dirt and debris . The cleaning process does not reduce the risk for transmission of infectious diseases .wash hands with soap and water .put on single-use [disposable] medical protective gloves .Wipe the glucometer thoroughly including the front, back and sides .Remove gloves .Disinfection Instruction: The meter must be disinfected between patient uses .Before disinfecting clean the meter .Wash hands with soap and water and put on single-use medical protective gloves .Wipe the glucose meter thoroughly including the front, back and sides . allow to remain wet for two minutes .take off gloves and wash hands .before proceeding to the next patient . Review of the General Guidelines For Use, dated 2021, revealed, .[Named germicidal wipes] .If present, use a wipe to remove visible soil prior to disinfecting .Unfold a clean wipe and thoroughly wet surface .Allow treated surface to remain wet for two (2) minutes. Let air dry . Review of a letter of recommendation from DME supplier dated 4/4/2022, revealed, .As referenced in the manual for the [Named glucometer], the meter may be cleaned and disinfected using [Named disinfecting wipes] or any other EPA [Environmental Protection Agency]-registered disinfecting wipe .important note to consider when using an alternative EPA-registered disinfecting wipe is that the [Named glucometer] has been shown safe in disinfecting via [by way of] testing validation with [Named disinfecting wipes], but additional testing has not been conducted on other EPA-registered wipes .For this reason, customers are encouraged to follow the disinfectant's instructions for use carefully to ensure disinfection . Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 was admitted to the facility on [DATE]. Resident #17 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated moderate cognitive impairment. Resident #17's active diagnoses included Diabetes Mellitus. Resident #17 received insulin 6 of 7 days of the look-back period. Review of the medical record revealed Resident #17 received Lispro [short acting] insulin before meals per sliding scale [based on pre-defined BG ranges requiring a finger stick blood test]. Review of the medical record revealed Resident #18 was admitted to the facility on [DATE] with diagnoses which included Acute and Chronic Respiratory Failure, Acute on Chronic Diastolic (Congestive) Heart Failure, and Type 1 Diabetes Mellitus. Continued review revealed Resident #18 had a diagnosis of Methicillin Resistant Staphylococcus Aureus infection (MRSA). Review of the Quarterly MDS assessment dated [DATE] revealed Resident #18 had a BIMS score of 15, which indicated no cognitive impairment. Active Diagnoses included Diabetes Mellitus with hyperglycemia. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Physician Order Sheet dated March 2024 revealed Resident #18 had orders which included . 11/21/2023 .lispro [short acting insulin] .administer SQ [subcutaneous-under the skin] ACHS [before meals and at bedtime] per sliding scale. Review of the Medication Administration Record (MAR) dated 4/2/2024 revealed Resident #18 received insulin ACHS per sliding scale. Documentation on Resident #18's MAR revealed BG levels were checked at 8:00 AM and 12:00 PM, on the day of the surveyor's onsite observation. Review of the undated Care Plan Report for Resident #18 revealed, .At Risk for Infection .assessed for signs and symptoms of infection .STATUS: Active .GOAL DATE: 5/29/2024 .Metabolic-Diabetes Status .Administer a finger stick blood test per order .STATUS: Active . Observation and interview on the 200 Hall on 4/2/2024 at 11:24 AM, revealed Licensed Practical Nurse (LPN) P walked out of the dining room holding a used blood glucose test strip wrapped in a blood soiled alcohol pad and used lancet (device used to prick the finger to obtain a blood sample) in her right hand. LPN P carried a glucometer in her left hand. LPN P did not have gloves on either hand. LPN P placed the used glucometer on top of the medication cart and threw away the BG test strip and alcohol pad in the trash and the lancet in the biohazard container. LPN P documented Resident #18's BG on the Electronic Health Record (EHR) and picked up the dirty glucometer and placed it back in the medication cart. When asked if LPN P completed a BG fingerstick for Resident #18 in the dining room without donning gloves, LPN P replied, Yes. When asked if not following infection control protocol during a BG fingerstick was safe, LPN P replied, No. LPN P confirmed the glucometer was used for multiple residents' point of care finger sticks. Observation and interview on 200 Hall on 4/2/2024 at 11:34 AM, revealed, LPN P took a BG test strip, an alcohol pad, a lancet, and the dirty glucometer out of the cart and placed the test strip, alcohol pad, and the lancet in a plastic cup. LPN P took a pair of gloves, the dirty glucometer, and plastic cup into Resident #17's room. LPN P informed Resident #17 she was going to perform a fingerstick for a BG level before lunch. LPN P placed the dirty glucometer on the bedside table and inserted the BG test strip into it, then proceeded to wipe Resident #17's finger off with the alcohol pad and started to place the lancet in position to prick the resident's finger. The surveyor requested LPN P stop and step into the hallway for a private conversation. The surveyor advised LPN to not continue with the BG fingerstick without properly disinfecting the dirty glucometer. LPN P agreed and walked to the medication cart and placed the glucometer on top of the cart. LPN P used an alcohol pad and wiped the glucometer off then placed it back on top of the medication cart. LPN P was asked if the alcohol pad was approved to disinfect the glucometer with and she replied, I think so. LPN P was asked how long the surface of the glucometer had to remain wet for disinfection, she replied, 30 seconds. The surveyor asked LPN P to read the information for properly disinfecting the glucometer before using the glucometer on any other residents. LPN P locked the medication cart and walked away. During an interview in the DON's office on 4/2/2024 at 11:41 AM, the DON stated she expected the multi-use glucometers to be cleaned and disinfected after every finger stick BG test. The DON stated the nurse should use the (Named germicidal cleaning cloth). The DON was made aware of LPN P's deficient practice during observation. The DON stated she would go and correct LPN P right away. The DON stated LPN P was an agency nurse and asked the surveyor if she wanted to follow a facility nurse for a glucometer BG finger stick observation. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation and interview on 4/3/2024 at 12:05 PM, revealed LPN E stated she had completed the afternoon BG finger sticks. LPN E was asked to demonstrate cleaning and disinfection of the multi-use glucometer on the 300 Hall medication cart. LPN E provided a verbal step by step tutorial which included using one alcohol pad to clean and disinfect the glucometer. When asked what the required length of time the glucometer had to stay wet, LPN E replied, 30 seconds to 1 minute. When asked if the alcohol wipe was an approved wipe for disinfecting the glucometer, LPN E replied, Yes, I think so. LPN E asked the surveyor if the alcohol wipe was okay to use on the glucometer. The surveyor replied, The appropriate method and supplies would depend on the manufacturer's recommendations and the facility policy. Observation and interview on 4/3/2024 at 12:14 PM, revealed LPN O performed a BG finger stick in the dining room, placed the used test strip, alcohol pad, and lancet in a plastic cup and walked back down the hall to the 200 Hall medication cart wearing the gloves she wore during the fingerstick procedure. Without changing gloves, LPN O took a germicidal cloth out of the medication cart, wiped the glucometer off, then placed the glucometer in a plastic cup to dry. The surveyor asked LPN O how long the glucometer was required to stay wet for disinfection, LPN O replied, 5 minutes. LPN O was asked if the glucometer should be cleaned off with a germicidal cloth, then disinfected with a second cloth, she replied, No. Observation and interview on 4/3/2024 1:16 PM, revealed Registered Nurse (RN) A was asked to demonstrate how to clean and disinfect the multi-use glucometer on the 400 Hall medication cart. RN A took the glucometer out of the cart along with a barrier paper and a germicidal cloth wipe. RN A gave a verbal tutorial which did not include the use of 1 germicidal wipe to clean the glucometer and then 1 germicidal wipe to disinfect the glucometer. RN A was asked how long the surface of the glucometer was required to remain wet for disinfection, she replied. Maybe 1 minute until it is dry. It doesn't take long. Observation of the nurse station and interview with the Administrator in Training (AIT) on 4/3/2024 at 1:19 PM, revealed a laminated copy of the General Guidelines For Use noted above was posted at the nurse station with the following handwritten notes printed on the document.*FOR MULTI-RESIDENT/SHARED EQUIPMENT* .Wet for 2 minutes! .Use between Residents . The surveyor requested a copy of the posted guidelines and stated the 3 nurses that were observed and interviewed had not correctly demonstrated the use of the germicidal cloth to clean and disinfect the multi-use glucometers.