STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445442	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahc Crestview	704 Dupree Road Brownsville, TN 38012

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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	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** 46047 Based on facility policy review, medical record review, and interview, the facility failed to report allegations of abuse for 2 of 20 residents (Residents #68, and #185) sampled for abuse allegation investigations. The findings include: 1. Review of the facility's policy titled Abuse Prohibition Plan, dated 11/2/2023, 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 .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Includes, but not limited to hitting, slapping, pinching, and kicking .It is the policy of this facility that abuse allegations .are reported per Federal and State Regulations and Law .If an incident of abuse or allegation of abuse is reported or discovered after hours, the Administrator or Director of Nursing must be notified immediately of such incident .Delayed reports of abuse incidents or allegations must be reported immediately to the Administrator or Director of Nursing, even though there is a time lapse since the incident occurred .The Administrator shall involve key leadership personnel as necessary to assist with reporting, investigation and follow up .The Medical Director, the Attending Physician, and the Long-Term Care Ombudsman shall be notified of the incident of abuse or allegation of abuse .The resident's family /representative shall be notified by the Administrator or designee of the report of an incident of abuse and that an investigation is being conducted .The facility shall ensure that alleged violations involving abuse, neglect, exploitation or mistreatment .are reported to the Tennessee Department of Health, Health Care Facilities Division and Adult Protective Services .All alleged violations are reported immediately, but not later than 2 hours after the allegation is made .The Administrator shall report the results of all investigations to the State Agency, within 5 days of the allegation . 2. Review of the medical record revealed Resident #68 was admitted to the facility on [DATE], with diagnoses including Seizures, Osteomyelitis, Post-Traumatic Stress Disorder, Anxiety, and Depression. Review of the quarterly MDS dated [DATE], revealed Resident #68 had a BIMS score of 15, which indicated intact cognition. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record revealed Resident #185 was admitted to the facility on [DATE], with diagnoses including Anxiety, Depression, Seizures, and Dementia. Review of the quarterly MDS dated [DATE], revealed Resident #185 had a BIMS score of 7, which indicated severe cognitive impairment. Review of a Nurse's Note dated 11/12/2023, revealed .Incident occurred on 11/11/2023 .Resident [Resident #185] was involved in a physical altercation with another resident [Resident #68] in the 200 hallway, where he [Resident #185]struck another resident [Resident #68] in the back of the head, incident protocol was initiated. Head to toe assessment was completed, no injuries found. Resident [Resident #185] was immediately moved to another room, which resident [Resident #185] was in agreement to move. Resident [Resident #185] stated, I will do anything to get away from him. Family notified. Will continue to monitor. DON notified at the time of this incident. During an interview on 4/26/2024 at 11:24 AM, LPN J was asked about the incident with Resident #68 and Resident #185, LPN J stated, I saw [named Resident #68] wheeling himself from the adjoining bathroom. [Named Resident #68] was complaining of poop on the sink because [named Resident #185]had dementia and thought he could use the bathroom without help and would smear poop. [Named Resident #185] heard [named Resident #68] complaining and hit him on the back of his neck. We separated them and moved [named Resident #185] to another room the same day it happened, in the afternoon. I [LPN J] did an incident report and wrote it up and notified [named Resident #185's] family. [Named Resident #68] was on the phone with his family. We did a visual check of [named Resident #68] no injury noted. I'm not sure if statements were written. During an interview on 4/26/2024 at 1:56 PM, the Administrator was asked when an allegation of abuse should be reported. The Administrator stated, Reported when it is seen or heard .Once it's reported then we do an investigation, have to talk to both sides to see what happened, get statements from whoever was around. I have to report it to the state within 2 hours .After 5 days they send me something and I have to fill that out and send it back .If injured send out to hospital. Staff to Resident-Report immediately and staff has to be suspended for 3 days until investigation is finished. Then the Administrator was asked should all components of the abuse policy be completed. The Administrator stated, Yes. Then the Administrator was asked was this allegation reported to state. The Administrator stated, No, I talked with [named Resident #68] that same day. I asked him if he was hurt, and he said [named Resident #185] came up behind him and hit him in the head because he had talked with [Named Resident #68] that same day. I asked him if he was hurt. It was nothing to it he just barely hit him. He didn't come tell me. If he thought it was bad, I would have reported . The facility failed to report two allegations of abuse to the State Agency.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46047 Based on facility policy review, medical record review, and interview, the facility failed to thoroughly investigate allegations of abuse for 2 of 20 residents (Residents #68, and #185) sampled residents reviewed for allegation of abuse. The findings include: 1. Review of the facility's policy titled Abuse Prohibition Plan, dated 11/2/2023, revealed INVESTIGATION . The policy of this facility is that reports of abuse, neglect . are promptly and thoroughly investigated .The investigation shall begin immediately. The information gathered, and the findings/conclusion shall be provided to the Administrator .The investigation and conclusion .shall be reported to the State Agency .within 5 calendar days of the initial report of abuse, incident, or allegation .The individual conducting the investigation shall at a minimum .Review the completed allegation/incident documentation .Review the Resident's medical record to determine events leading up to the incident .Interview the person(s) reporting the incident .Interview any witnesses to the incident .Interview the resident (as medically appropriate) . Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident .Interview the resident's roommate .Interview other residents to whom the accused employee provides care or services .Review all events leading up to the alleged incident .Witness reports shall be reduced to writing. Witnesses shall be required to write a statement and be interviewed by the Abuse Coordinator/designee. They shall review the interview, then sign and date it, attesting to its accuracy . Employees of this facility who have been accused of resident abuse shall be suspended from duty until the results of the investigation have been reviewed by the Administrator .The results of the investigation shall be documented .The Administrator shall provide to the resident and his/her representative of the results of the investigation and corrective action taken as necessary .Investigation of Resident to Resident Altercation shall include .Whether the altercation was a willful action that results in physical injury, mental anguish, or mental pain .Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions .There may be some situations in which the psychosocial outcome to the resident may be difficult to determine or incongruent with what would be expected. In these situations, it is appropriate to consider how a reasonable person in the resident's circumstances would be impacted by the incident .The Administrator shall report the results of all investigations to the State Agency, within 5 working days of the allegation . 2. Review of the medical record revealed Resident #68 was admitted to the facility on [DATE] with diagnoses including Seizures, Post-Traumatic Stress Disorder, Anxiety, and Depression. Review of the quarterly MDS dated [DATE], revealed Resident #68 had a BIMS score of 15, which indicated intact cognition. 3. Review of the medical record revealed Resident #185 was admitted to the facility on [DATE] with diagnoses including Anxiety, Depression, Seizures, and Dementia. Review of the quarterly MDS dated [DATE], revealed Resident #185 had a BIMS score of 7, which indicated severe cognitive impairment. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Nurse's Note dated 11/12/2023, revealed .Incident occurred on 11/11/2023 .[Named Resident #68] was involved in a physical altercation with another resident [Resident #185] in the 200 hallway, where he [Resident #68] struck another resident [Resident #185] in the back of the head, incident protocol was initiated .Resident [Resident #68] was immediately moved to another room .Resident [Resident #68] stated, I will do anything to get away from him.DON notified at the time of this incident. During an interview on 4/26/2024 at 11:24 AM, LPN J was asked about physical altercation between Resident #68 and Resident #185. LPN J stated, I saw [named Resident #68] wheeling himself from the adjoining bathroom .[named Resident #185] heard named resident [Resident #68] complaining and hit him on the back of his neck .I did an incident report and wrote it up .I'm not sure if statements were written. During an interview on 4/26/2024 at 1:56 PM, the Administrator was asked when an allegation of abuse should be reported. The Administrator stated, .when it is seen or heard .Once it's reported then we do an investigation .It was nothing to it he [Resident #68] just barely hit him [Resident #185]. He [Resident #185] didn't come tell me. If he [Resident #185] thought it was bad, I would have reported . The administrator was then asked if the abuse between Resident #68 and Resident #185 should have been investigated, she stated Yes. The facility failed to complete a thorough investigation for four allegations of abuse.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48285 Based on policy review, medical record review and interview, the facility failed to ensure a care plan meeting was scheduled and interventions implemented to ensure cognitively intact residents expressing sexual desires towards one another were care planned for their right to privacy and intimacy for 2 of 2 (Resident #31 and #61) cognitively intact residents expressing desires of intimacy with one another. The findings include: 1. Review of the facility's policy titled Sexual Expression of the Resident, revision date of 10/24/2022, revealed .It is the policy of this facility to respect all residents and their rights. This policy applies to individuals who exhibit intact cognitive decision-making capacity. Residents residing in the facility shall be allowed to express themselves in the way they prefer, given they have mental capacity to make informed decisions .Procedure .social service staff shall notify the interdisciplinary team .Residents with decisional capacity have the right to privacy, including private space for sexual expression .licensed independent practitioners shall be notified regarding residents participating in sexual activity for a clinical and cognitive evaluation to determine intact cognitive-decision-making-capacity and capacity to consent .Care plan meetings with the interdisciplinary team shall be scheduled as soon as possible for initial notification of the social service staff .Outcomes of the interdisciplinary team review shall be shared with the resident involved and documented in the plan of care .Based on the plan of care, intimacy and sexual expression shall be permitted if both parties consent .facility shall ensure the resident's right to privacy, including a private place for intimacy and/or sexual expression .Residents who express the desire to be sexually active shall receive education on the definition of abuse, sexual assault, and who to contact to report issues . 2. Review of medical record revealed Resident #31 was admitted to the facility on [DATE], with diagnoses including Hemiplegia, Anxiety, Depression, Cognitive Communication Deficit, and Schizophrenia. Review of the admission Minimum Data Set (MDS) dated [DATE], revealed Resident #31 scored a Brief Interview for Mental Status (BIMS) of 14, which indicated the Resident was cognitively intact. Review of the Care Plan dated 9/29/2023, revealed Resident #31 expressed, physical behavior symptoms and public display of inappropriate behaviors directed at others at times. If sexual behavior is inappropriate or unwanted, staff should conduct frequent checks, including 1:1 during times when the sexual activity is a pattern. Behavior Symptoms .has verbal behavioral symptoms directed toward others .Openly expresses anger with others and physical sexual expression with staff and resident at times. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Clinical Note dated 11/11/2023, revealed .[Resident #31] and a male resident [Resident #61] was sitting in the courtyard engaging in inappropriate behavior, residents were separated from the behavior. This nurse [licensed practical nurse (LPN l)] checked resident BIM score and resident has a score of 14 and voiced she gave consent for the inappropriate behavior. This nurse spoke with resident [Resident #31] with TX [treatment] nurse as witness this nurse [LPN l] informed [Resident #31] that public display of inappropriate behavior could not happen again. DON [Director of Nursing] was notified of inappropriate behavior with psych [psychiatric nurse practitioner] to be notified per DON. Review of the PSYCHIATRIC PERIODIC EVALUATION note for Resident #31 dated 11/21/2023, revealed . There were some inappropriate bx [behavior] between her and another male resident [Resident #61] in a public area .Notified resident that there could be no interactions like this in public . Review of the Clinical Note for Resident #31 dated 11/26/2023, revealed .[Resident #31] is also walking down the hall and going to other halls looking for male residents, resident [Resident #31]stating I'm [NAME] [horny] I want some [sex] .informed she [Resident #31] can not go looking for sexual desires .RP [Responsible Party] was informed . Review of the Clinical Notes for Resident #31 dated 1/29/2024, revealed .Patient [Resident #31] is very sexual. Patient likes to talk about it on the phone with people .Ombudsman was here .met with patient [Resident #31] about asking patients [residents] to have sex. One patient [Resident #61] in particular she had stated wanted to have sex with her [Resident #61] denied it and wants her [Resident #31] to stay away from him. This was also addressed with patient [Resident #31] .[Resident #31] also told if she wanted to talk about body parts and sex she could ask for the portable phone where those conversations could be kept private and not in the front dining room. Patient [Resident #31] stated that she understood .Family is aware of patient's [Resident #31] behaviors . Review of the quarterly MDS dated [DATE], revealed Resident #31 had a BIMS score of 15, which indicated she was cognitively intact. Review of the untitled document for Resident #31 dated 3/6/2024, revealed .F/u [follow up] inappropriate sexual behavior .seen today at request of facility staff for report of inappropriate sexual behavior .caught in front lobby touching each other [Resident #31 and Resident #61] sexually and kissing .Patient [Resident #31] has history of manipulating other residents inappropriately .PSYCH: judgment/insight impaired .Excessive sexual drive (disorder) . Review of the EDUCATION RECORD-RESIDENT OR FAMILY for Resident #31 dated 3/6/2024, revealed . CHECK THE APPROPRIATE REASON FOR THE EDUCATION .sexual express . [Resident #31] had stated that she wanted to be involved in sexual expression was informed it was to be in private location that we could provide. Patient [Resident #31] had been witnessed by staff members in public . During an interview on 4/25/2024 at 8:14 AM, the Nurse Practitioner (NP) stated staff went in front lobby to turn off the lights and Resident #31 and Resident #61 were in there alone, they both jumped up and Resident #61 ran. The NP stated, [Resident #31] is manipulative .[Resident #61] said that after the [NAME] he wasn't going to hide it, he liked her [Resident #31] . There was no documentation the Interdisciplinary team (IDT) had conducted a care plan meeting to ensure the Resident's Right to privacy and intimacy. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record revealed that Resident #61 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Respiratory with Hypoxia, and Depression. Review of the quarterly MDS dated [DATE], revealed Resident #61 had a BIMS score of 15 which indicated the resident was cognitively intact. Review of the Care Plan entry dated 11/13/2023, revealed Resident #61 had inappropriate sexual behaviors at times, Record behaviors on Behavior Tracking Form. Monitor pattern of behavior (time of day), Remind [Resident #61] that behavior is not appropriate, remove from situation; allow time to calm down. Review of the Clinical Note for Resident #61 dated 11/11/2023, revealed Notified by CNA [Certified Nursing Assistant] that resident [Resident #61] was outside on public patio with his hand down female resident [Resident #31] pants, rubbing her between her legs. Both residents oriented and capable of making decisions. Stopped by CNA, as in a public area. Female's [Resident #31] charge nurse also made aware and said she was going to speak to female resident [Resident #31]. Let both residents know that if they choose to do anything private, they must be in private. Review of the Clinical Note dated 11/12/2023, revealed a Psychiatric Nurse Practitioner (NP) would be made aware of inappropriate behaviors between Resident #31 and Resident #61 in a public place. The Clinical note documented Resident #61 had voiced he had consent from Resident #31. Resident #61 was talked to by Charge Nurse and will be closely monitored by staff. Review of the Social Service Entry note dated 11/13/2023, revealed Quarterly [assessment] completed. [Resident #61] is alert and friendly . [Resident #61] is up with walker going around the facility at will . [Resident #61] enjoys going to acts [activities] [Resident #61] was caught recently having inappropriate touching with another oriented patient [Resident #31] in the courtyard. Explained to patient [Resident #61] about appropriate and inappropriate locations Resident #61] agreed. Social visits with patient [Resident #61]. Family comes and visits frequently. No DC [Discharge] plans as patient [Resident #61] requires level of care. Review of the quarterly MDS dated [DATE], revealed Resident #61 scored a BIMS of 15 which indicated that the resident was cognitively intact. There was no documentation the Interdisciplinary team (IDT) had conducted a care plan meeting to ensure the Resident's Right to privacy and intimacy. 4. During an interview on 4/24/2024 at 2:17 PM, the Psychiatric Nurse Practitioner NP was asked about Resident #31 and Resident #61. The Psychiatric NP stated [Resident #31] was wanting a private space for sexual contact with [Resident #61]. [Resident #61] wanted that at the start and changed his mind . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/25/2024 at 11:25 AM, the Director of Nursing (DON) was asked about the relationship between Resident #31 and Resident #61. The DON stated, They [Resident #31 and Resident #61] were in public fondling each other .reported to social worker . I called the psych [psychiatric] NP. She [The Psychiatric NP] said they [Resident #31 and Resident #61] were both consenting . [Resident #31] asked for a private room for encounters between her and [Resident #61]. [Resident #61] didn't ever come and ask for a private room. Psych [Psychiatric NP] said they [Resident #31 and Resident #61] are consenting adults and have to be provided a private place .

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F 0689 Level of Harm - Actual harm 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** 30974 Based on policy review, medical record review, facility investigation, and interview, the facility failed to ensure effective fall interventions were in place to prevent injury, and failed to complete neuro checks for 2 of 3 (Resident #23 and #73) sampled residents reviewed for accidents. The facility's failure to implement effective fall interventions when Resident #23 fell and sustained a closed fracture (broken bone) of right distal femur (large upper bone of the leg) resulted in actual harm. The findings include: 1. Review of the facility's policy titled, Fall Risk-Fall Prevention, dated 4/20/2023, revealed Purpose: To provide a coordinated system to identify Residents at risk for falls and develop an individualized interdisciplinary plan of care to reduce the risk of falls and subsequent injury .Implement interventions, including adequate supervision, consistent with a Resident's needs, goals, plan of care and current standards of practice in order to reduce the risk of a fall .Monitor for effectiveness of the interventions and modify the interventions as necessary, in accordance with current standards of practice .Residents with a BIMS [Brief Interview for Mental Status] of 13 or greater [indicates no cognitive impairment] may be educated on the use of the call light system and reminded to ask for assistance . Review of the facility's policy titled, Neurological Exam, dated 11/28/2023, revealed .Neuro assessments shall be performed for 72 hours .Neuro-checks shall be initiated when there is an unobserved fall and the residents [resident's] BIMS is less than 13 . 2. Review of the medical record revealed Resident #23 was admitted to the facility on [DATE], with diagnoses that included Dementia, Schizoaffective Disorder, Seizures, Mood Disorder, Anxiety, and Depression. Review of the Care Plan dated 1/17/2023-1/17/2024, revealed .At Risk for Falls R/T [related to] self ambulatory, unsteady gait, poor safety awareness .Place call bell/light within easy reach .Provide reminders to use ambulation and transfer assist devices .Remind [named Resident #23] to call for assistance before moving from bed-to-chair and from chair-to-bed .has exhibited Wandering Behavior potential for elopement . Patient transferred to Memory Care Unit for safety and to prevent potential elopement .Redirect [named Resident #23] behavior/activity when wandering is observed .Provide orientation to facility layout and room as needed .Redirect when wandering .Monitor resident's location to ensure safety . Further review of the 1/17/2023-1/17/2024 care plan revealed, .Provide diversional activities .[Named Resident #23] is receiving antipsychotic drugs on a regular basis secondary to impulse control disorder .Remind [Named Resident #23] that BEHAVIOR is not appropriate .Remove from situation; allow time to calm down . The care plan to remind a severely cognitively impaired resident to use ambulation and transfer assist devices and remind the resident to call for assistance was inappropriate. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Nurses' Note dated 4/8/2023, revealed Res. [Resident #23] alert, verbal, able to make some needs known. Ambulatory in hallway with walker. Res trying to take food from meal cart. Tried to take water from nurse's hand. Walked up on nurse twice in aggressive manner, but no threat or physical action taken. Res. was upset that 'everybody else gets medicine'. Repeatedly attempting to enter female res. room. Redirected res. [Resident #23] each time, but continues to come back to that door and trying to enter . The facility failed to follow its policy to use education on use of call lights remind to ask for assistance for residents with a BIMS score of 13 or greater and to modify interventions as necessary. The facility failed to implement effective interventions when continued redirection for wandering into other residents' room was ineffective. Review of the Nurses' Note dated 4/9/2023, revealed Res. [Resident #23] repeatedly entering female [resident's] room. Angry and aggressively approaching nurse when told not to enter room. Verbal insults to this nurse when instructed not to enter room. Review of the Nurses' Note dated 5/16/2023, revealed Res. [Resident #23] pacing most of the day with walker. Rare exit seeking noted. Repeatedly entering rooms of female res [residents] sometimes when they were in the rooms and sometimes when they were out, despite being told not to enter. Res [Resident #23] on the constant lookout for any kind of food item or drink that he can find. Trying to take other res food from tray. Repeatedly trying to get into trash can to look at it . Review of the Nurses' Note dated 8/6/2023, revealed Res. [Resident #23] continues to wander the halls, entering other res [residents] rooms at will. Unable to redirect. Res [Resident #23] continues to steal snacks, food, and drink from med cart, other residents, food cart, or any item he can find. Res [Resident #23] cannot stop this behavior. It is every day, as long as he is awake he is wandering and searching for food items. When given food or drink, he may or may not consume it, but will always attempt to take food or drink item that is left unsecured. Review of the Nurses' Note dated 8/20/2023, revealed Res [Resident #23] awake, up ambulating in hallway with walker. Going into female res [residents'] rooms. Instructed to not enter any room but his own. Res [Resident #23] verbalized understanding, reminded frequently and continued to enter other rooms. At present sitting in chair in his room. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 had a BIMS score of 2, which indicated severe cognitive impairment. The facility failed to follow its policy to use education on use of call lights remind to ask for assistance for residents with a BIMS score of 13 or greater and to modify interventions as necessary. Resident #23 had a BIMS of 2, which indicated severe cognitive impairment, and did not have a BIMS of greater than 13 per facility policy. The facility failed to implement effective interventions/modify when continued redirection for wandering into other residents' room was ineffective. Review of the facility's FALL RISK assessment dated [DATE], revealed a score of 18, which indicated moderate risk. (continued on next page)

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Ahc Crestview	704 Dupree Road Brownsville, TN 38012

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's OCCURANCE INVESTIGATION INTERVIEW, dated 11/7/2023, revealed .FALL . WITNESSED [by Resident #71] .I heard [Named Resident #71] yell Get out of my room. [Named Resident #23] stated he fell .Resident fell on his R [right] side .He was walking with his walker .Resident told not to go in another resident room . Review of the facility's Interdisciplinary Team Occurrence Investigation Worksheet dated 11/7/2023, revealed Transferred to Hospital .No .STEPS IMPLEMENTED TO PREVENT RECURRENCE .[Named Resident #23] will be redirected to his hall and will not go into [named Resident #71's] room . Resident #23 ambulated with a walker and would attempt to enter Resident #71's room. Resident #71 often stood in her doorway and did not want anyone coming into her room. On 11/7/2023 Resident #23 attempted to enter Resident #71's room and she grabbed Resident #23's walker to turn him around causing Resident #23 to fall. Resident #23 was transferred to the hospital where he was admitted for a right femur fracture. Resident #23 had a surgical repair for the right fractured femur. Resident #23 was readmitted to the facility on [DATE]. Review of the discharge MDS assessment (with return anticipated) dated 11/7/2023, revealed Resident #23 had short term memory problems, was moderately cognitively impaired, made poor decisions, and required cues/supervision. Review of the Nurses' Note dated 11/13/2023, revealed .The resident [Resident #23] returned from hospital due to Right hip fracture .The resident received a hemiarthroplasty [partial hip replacement] and is now stable . Review of the Care Plan dated 11/20/2023, revealed .at risk for complications related to Right Femur Fracture .Call light available and answered promptly . Review of the Care Plan dated 12/15/2023, revealed .[Resident #23] At risk for mood swings related to .has diagnoses of depression and impulse disorder . Review of the annual Minimum Data Set (MDS) dated [DATE], revealed Resident #23 had a BIMS of 2, which indicated severe cognitive impairment, wandering behavior occurred daily, no falls were documented, and the resident received antipsychotic, antidepressant, and antiplatelet medications. Review of the Care Plan dated 1/17/2024 - Present, revealed .At Risk for Falls R/T self ambulatory, unsteady gait, poor safety awareness .Provide patient with extra snacks b/t [between] meals to reduce/limit wandering and taking food .Place call bell/light within easy reach .Provide reminders to use ambulation and transfer assist devices .Remind [named Resident #23] to call for assistance before moving from bed-to-chair and from chair-to-bed .has exhibited Wandering Behavior at times .Memory Care Unit. Ensure all doors alarms/locks are armed to reduce the risk of [named Resident #23] leaving secure area .Redirect [named Resident #23] behavior/activity when wandering is observed .Provide orientation to facility layout and room as needed .Redirect when wandering . The facility failed to follow its policy to use education on use of call lights remind to ask for assistance for residents with a BIMS score of 13 or greater and to modify interventions as necessary. Resident #23 had a BIMS of 2, which indicated severe cognitive impairment, and did not have a BIMS of greater than 13 per facility policy. The facility failed to implement effective interventions/modify when continued redirection for wandering into other residents' room was ineffective. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the quarterly MDS dated [DATE], revealed Resident #23 had a BIMS of 2, which indicated severe cognitive impairment. During an interview on 4/24/2024 at 4:33 PM, CNA G was asked about Resident #23. CNA G stated, [Named Resident #23] has been in [the memory] unit a long time. He ambulated with his walker all the time and he would steal food wherever he found it. He would wander into all the residents' rooms, male and female. Now [after the fractured femur] he has to use [his] wheelchair due to lack of strength. He goes to showers and is total dependent for all ADLs [Activities of Daily Living] except eating. He would not participate in therapy, so he does not receive therapy at this time . During an interview on 4/26/24 at 10:15 AM, the Director of Rehabilitation was asked about Resident #23. Director stated, He was ambulating in [the] Memory Care unit with his walker. He was picked up post traumatic fall [with a fracture]. His dementia is worse now since [his] fall. Some get scared after a fall .used to be able to reason with to get him [Resident #23] to do things in therapy back in 2022. After his fall he [Resident #23] just would not participate in therapy or restorative .[Resident #23] had a doctor visit with ortho [Orthopedic doctor that performs surgery on bones] and the doctor seemed pleased with his progress of getting around in his wheelchair . During an interview on 4/26/2024 at 10:30 AM, CNA H was asked about Resident #23. CNA H stated, He is used to going in the rooms of other residents and pilfering their stuff and eating their food. He knows what he is doing because he laughs and said 'I know' when you redirect him. When you ask why [are] you doing that he would say 'I don't know.' I didn't take him to [the] main dining room because he won't stay and he be [is] constantly rolling back here. He won't go all the way to [Named Resident #71's] room he turns around at the nurse station. He won't go to [Named Resident #8's] room either because she curses like a sailor. He continues going into other residents' room in his wheelchair. His sister is aware of his roaming here because she [has] seen him doing it. I stand him up with the standing lift but we can't get him to walk. When elderly persons falls, they get scared .We just try to redirect him, but he laughed [laughs]. He snatched a cookie from a female resident that was eating a cookie. She turned around and started cursing him and he gave it back. His interventions was to redirect and provide extra food/snacks . During an interview on 4/26/2024 at 2:41 PM, the Director of Nursing (DON) was asked, Would you expect other interventions besides being redirected for Resident #23 since he continued to wander. The DON stated, I would do other interventions if there had been an injury, or maybe MDS [coordinator] could do other interventions. He didn't mean no harm to anyone. He was just looking for food or something. He is in [a] wheelchair and still going into resident rooms . The facility's failure to ensure effective interventions were implemented resulted in an actual harm when Resident #23 sustained a fall with a right femur fracture. 3. Review of the medical record revealed Resident #73 was admitted to the facility on [DATE], with diagnoses that included Chronic Obstructive Pulmonary Disease, Fracture Left Femur, Acute Respiratory Failure, Diabetes, and Panic Disorder. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Care plan dated 2/15/2024, revealed .At Risk For Falls R/T [related to] weakness, poor endurance, functional decline .All Staff .Place call bell/light within easy reach .Provide reminders to use ambulation and transfer assist devices .provide the Resident and/or Resident Representative with education regarding strategies to reduce the risk for falls .Remind [Named Resident #73] to call for assistance before moving from bed-to-chair and from chair-to-bed .Respond promptly to calls for assist to the toilet .Short-term memory impaired-unable to recall after 5 minutes .Re-orient to time, location, events, and activities as needed .Use cues to enhance participation in self-care .Report any decline in ability to participate/perform ADL care . The facility failed to follow its policy to use education on use of call lights remind to ask for assistance for residents with a BIMS score of 13 or greater and to modify interventions as necessary. Resident #73 had a BIMS of 12, which indicated moderate cognitive impairment, and did not have a BIMS of greater than 13 per facility policy. Review of the admission MDS dated [DATE], revealed Resident #73 had a BIMS score of 12, which indicated moderate cognitive impairment with no behaviors identified and required partial to moderate assistance with most activities of daily living (ADLs). Review of Nurse's Notes dated 2/15/2024, revealed Resident arrived to the facility by ambulance and escorted in by paramedics. She is alert and oriented [AAO] X [times] 3 upon arrival and with a lot of anxiety. She has been on the call light every 5-10 minutes. She has been very restless. She is on oxygen at 2L [liters]. She has a bruise on both eyes and 5 stitches over her right eye that can be removed on 2/18. She is still very weak, incontinent, and is a fall risk. Review of Nurse's Notes dated 2/22/2024, revealed Found resident on the floor, in her room on her left side facing the door. Unknown what resident was doing and she was unable to state what she was doing. She states she did not hit her head and there are no visible injuries but resident states her left hip hurts. While laying [lying] in bed resident cannot lay on her back or move her left leg without complaining of pain. MD [Medical Doctor] notified and order received for hip x-rays. Resident is her own RP [Responsible Party] with a BIMs of 12. Neuros not initiated . During an interview on 4/26/2024 at 2:53 PM, the DON was asked should neuro checks have been done with an unwitnessed fall and a BIMS of 12. The DON stated, Yes ma'am.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47835 Based on policy review, medical record review, observation, and interview, the facility failed to follow the prescribed physician orders for oxygen for 1of 4 (Resident #74) sampled residents reviewed for respiratory care. The findings include: 1. Review of the facility's policy titled, Oxygen Concentrator and Oxygen Storage, dated 12/1/2022, revealed . Oxygen should be administered only under orders of the attending physician .Obtain physician's orders for the rate of flow and route administration of oxygen .Turn the unit on to the desired flow rate . Review of the facility's policy titled, Medication Administration, dated 8/4/2023, revealed .Medications shall be administered by licensed medical or nursing personnel acting within the scope of their practice and per the Physician's Signed Order .Check that the medication dose matches the dosage ordered .Review the EMAR [electronic medication administration record] to identify the medication to be administered .Administer medications as ordered . 2. Review of the medical record revealed Resident #74 was admitted to the facility on [DATE], with diagnoses including Hemiplegia and Hemiparesis, Dysphagia, Chronic Obstructive Pulmonary Disease, and Anxiety Disorder. Review of a Physicians' Order dated 2/23/2024, revealed .Apply O2 [oxygen] at 2 L/min [liters per minute] per nasal cannula as needed for dyspnea .sats lower than 88% . Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #74 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated he had severe cognitive impairment. Shortness of breath when laid flat and received oxygen. Observation in the resident's room on 4/22/2024 at 10:10 AM, 4/23/2024 at 5:31 PM, 4/25/2024 at 8:05 AM and 9:47 AM, revealed Resident #74's oxygen was set at a level of 4 liters per minute. During an interview on 4/25/2024 at 11:07 AM, LPN B was asked what Resident #74's oxygen should be set on. LPN B confirmed the correct oxygen level was 2 L/min according to the doctor's order. During an interview on 4/25/2024 at 11:11 AM in Resident #74's room, LPN B looked at Resident #74's oxygen concentrator and confirmed the rate was set at the incorrect level of 4 L/min and changed it to the correct level of 2 L/min. LPN B confirmed that according to the doctor's orders, Resident #74's oxygen should not have been set to 4 L/min. During an interview on 4/26/2024 at 3:10 PM, the DON confirmed that staff should follow physician's orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50780 Based on policy review, observation and interview the facility failed to ensure medications were stored appropriately when staff (Registered Nurse (RN A) left 1 of 9 medication storage areas (100-400 hallway cart) unlocked, unattended, and out of line of site. The findings include: 1. Review of the Medication Administration: Medication, Controlled and Biological Storage, Night/Emergency Box and Backup Pharmacy policy, revised 9/5/2023, revealed It is the policy of this facility to ensure all medications housed on our premises shall be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation and security .The medications shall be labeled in accordance with accepted professional Principals to include necessary instructions and expiration dates when applicable .All dugs and biologicals shall be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls .Only authorized personnel shall have access to the keys to locked compartments . 2. Observation of the 100-400 Hall medication cart on 4/26/2024 at 11:20 AM, revealed the cart sitting in the 400 hallway next to the Nurse's office. RN A was asked to unlock the medication cart so the surveyor could observe contents, and was told that the surveyor would need her to stand with the cart during the observation. RN A unlocked the medication cart and stood with the surveyor to look through the large drawers, when the surveyor opened a small drawer containing medications, RN A walked away and went into the Nurse's office. The surveyor walked to the entrance of the office and observed RN A sitting at the desk out of view of the medication cart. 3. During an interview on 4/26/2024 at 11:20 AM, the Director of Nursing (DON) was asked, Should the medication cart be left unlocked and unattended. The DON stated, No, not if it is not in the line of sight. The facility failed to ensure that medications were stored properly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50780 Based on policy review, review of the IV (Intravenous) Medication Administration skills check off form, observation and interview, the facility failed to ensure infection control practices were followed during IV medication administration when 1 of 2 nurses (LPN (Licensed Practical Nurse) E) failed to clean an administration port prior to administration of IV medications and fluids and when 3 of 10 staff members (CNA C, CNA D, and the Life Enrichment Coordinator) failed to perform hand hygiene during dining. The findings include: 1. Review of the facility policy titled, Medication Administration, revised 8/4/2023, revealed .Medications shall be administered by licensed medical or nursing personnel acting within the scope of their practice and per the Physician's Signed Order. While administering medications the nurse shall observe the 8 Rights of Medication Administration .IV Medication/Fluids .Follow infection precautions and related techniques to minimize the risk of contamination .Adhere to accepted professional standards of practice for preparation, insertion, administration, maintenance, and discontinuance of IV medications/fluids . Review of the document [Named Company] .IV Medication Administration check off form, revealed .Perform another vigorous scrub of [with] antiseptic pad for at least 5 seconds and allow to dry. Attach the syringe or tubing [with medication] to the site . Review of the facility policy titled, Hand Hygiene, dated 3/28/2024, revealed .Staff involved in direct resident contact shall perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Staff shall assist residents as needed and encourage them to perform hand hygiene procedures to prevent the spread of infection .Hand hygiene is indicated and shall be performed under the conditions listed .before and after eating .between resident contacts .after handling contaminated objects . 2. Review of medical record revealed Resident #383 was admitted to the facility on [DATE], with diagnoses of Sepsis, Cerebrovascular Disease, Anemia, Diabetes, IVABT (intravenous antibiotic) for ESBL (Extended spectrum beta-lactamase) in blood. Review of the Care Plan dated 4/16/2024, revealed Risk for UTI (Urinary Tract Infection) and IV and sepsis addressed. ADLs (Activities of Daily Living) addressed, Patient planning to return home . Review of the signed Physician's Orders dated 4/19/2024, revealed: 4/16/2023 INVANZ POWDER FOR INJECTION (Antibiotic to treat infection) . 1gm (gram)/ (per) NS (Normal Saline) 100ml (Milliliter) Every 1 Day for 12 Days. 4/16/2023 Pre-Filled Normal Saline (sterile solution containing sodium chloride) 0.9 % (percent) injection syringe 2 Times Daily 10 ml IV. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/16/2024 Heplock flush (used to keep IV catheters open and flowing freely) Flush PICC (peripherally inserted central catheter) with 5 ml Heparin after flushing with normal saline every day. Review of the Medication Administration Record (MAR) date April 2024, revealed: 4/23/2024 Sodium Chloride IV PIGGYBACK 1000ML BAG 15 ml/hr (hour) Observation during medication administration on 4/23/2024 at 10:28 AM, revealed LPN E disconnected the PICC tubing, clamped PICC line and laid the PICC tubing on the bed. LPN E administered the Heparin flush into the PICC line without cleaning the PICC line. During an interview on 4/26/2024 at 11:15 AM the DON (Director of Nursing) confirmed that you should not flush a port that is lying on the bed with Heparin without cleaning it. The DON confirmed that you should not connect an IV tubing to the port without cleaning the port. 3. Observation in Resident #52's room on 4/22/2024 at 12:08 PM, revealed CNA C dropped a straw on the floor, picked it up and did not perform hand hygiene, then opened the condiments for Resident #52. Observation in Resident #32's room on 4/22/2024 at 12:09 PM, revealed CNA C entered the room without performing hand hygiene, set up tray, and opened condiments. Observation in Resident #57's room on 4/22/2024 at 12:11 PM, revealed CNA C entered the room, set up tray and did not perform hand hygiene. Observation in Resident #27's room on 4/22/2024 at 12:13 PM, revealed CNA C entered the room, placed tray on over bed table, repositioned resident, moved the covers, set up tray and opened condiments. She did not perform hand hygiene after repositioning resident. Observation in the dining room on 4/22/2024 at 12:21 PM, revealed the Life Enrichment Coordinator served tray to resident and did not perform hand hygiene. Observation in the dining room on 4/22/2024 at 12:24 PM, revealed the Life Enrichment Coordinator got the tray from meal cart, served resident, set up the tray, went and got another tray. Hand hygiene was not performed. Observation in Resident #10's room on 4/23/2024 at 5:57 PM, revealed CNA D entered room and set up tray, moved the table closer, used bare hand to pick up resident's bread and placed tuna on the bread. Hand hygiene was not performed. During an interview on 4/26/2024 at 3:36 PM, the DON confirmed that staff should not touch residents' food with bare hands and hand sanitizer should be done between residents and if hands are visibly soiled or contaminated hand washing should be performed. Facility staff failed to perform proper infection control during medication administration and failed to practice proper hand hygiene during dining.