STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455699	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at the Creek	1405 Valhalla Dr Wharton, TX 77488

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15976 Based on observation, interview and record review, the facility failed to ensure each residents had the right to be free of abuse for 2 of 9 residents (Resident #2 and Resident #3) reviewed for resident-to-resident abuse. The facility failed to ensure Resident #2 was free from abuse when CR#1 banged Resident #2's head on the floor causing a laceration to the back of his head and requiring 32 staples. The facility failure to ensure residents were free from abuse due to Resident #3 and Resident #4 having an altercation resulting in Resident #3 sustaining a cut to the chin by Resident #4. An Immediate Jeopardy (IJ) was identified on 09/27/2024 at 4:24pm. While the IJ was removed on 09/30/2024 at 2:22pm, the facility remained out of compliance at a scope of Level 2 (E) Although there was IJ for two persons, the potential for more than minimal harm is isolated, the facility continued to monitor the implementation and effectiveness of their corrective systems. These failures could place residents who are dependent on staff for care and supervision at risk for abuse and neglect. Findings Included: Record review of the facility's resident room roster revealed Resident #2 and Resident #3 resided on Hall B (secured unit). Record review of CR#1's face sheet dated 9/25/2024 revealed [AGE] year-old male who was admitted to the facility on [DATE] and discharged [DATE]. His diagnoses included bipolar disorder (episodes of mood swings), schizoaffective disorder (mental health condition), unspecified psychosis (loss of contact with reality), anxiety (mental health disorder that cause fear and worry), essential hypertension (high blood pressure), mood disorder (mental heal disorder that affects emotional state) and insomnia (poor sleeping habits). Record review of CR#1's quarterly Minimum Data Set, dated dated dated [DATE] revealed the resident had a BIMS score of 09 indicating he had cognitive issues. For Behavior, the Resident was coded as having no behaviors, was coded as set up or clean up assistance only for activities of daily living and was continent of bowel and bladder. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's care plan dated 1/24/2024 revealed: . Focus Resident had episodes of inappropriate behaviors and is at risk for further increased episodes and injury resident yells and curses. Goal: Resident has episodes of appropriate behaviors should be reduced to more than two episodes weekly will be free from injury over the next 90 days. Intervention: Encourage the resident to attend social events. Explain procedures using terms/gesture. Give meds as ordered by the doctor. Monitor behavior and chart and report progress/decline to MD. Observe for warning signs of behavior. Record review of nurse's notes written on 09/23/2024 at 4:20am by LVN K revealed Resident #2 was attacked his roommate CR#1 after they had an argument. The fight ended up in the hallway, Resident #2 fell then CR#1 got on top of him and banged his head on the floor, several times which caused a bad cut on the back of Resident #2's head lots of bleeding, called ambulance, CR#1 got hit on the nose, and has a scratch on his back, notified NP A also left message for Resident #2's family. Record review of Resident #2's face sheet dated 9/25/2024 revealed he was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included schizoaffective disorder (mental health condition), unspecified psychosis (loss of contact with reality), anxiety (a mental disorder that cause worry and fear), essential hypertension (high blood pressure) and insomnia (inability to sleep). Record review of Resident #2's quarterly Minimum Data Set, dated dated dated [DATE] coded Resident #2 for Cognitive skills for decision making as moderately impaired. For behavior he was coded as delusional and exhibited no behavioral symptoms. For ADL's he was coded as needing supervision and was occasionally incontinent of bowel and bladder. Record review of Resident #2's care plan dated 6/17/2024 revealed: Focus: Resident had episodes of inappropriate behaviors and is at risk for further increased episodes and injury resident wanders throughout the facility, placing gloves on hand and wandering in an out of other resident's room. Took a TV out of another resident room and put it in his room. Goal: Resident has episodes of appropriate behaviors should be reduced to more than two episodes weekly will be free from injury over the next 90 days. Intervention: Encourage the resident to attend social events. Explain procedures using terms/gesture that the resident can understand. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Give meds as ordered by the doctor, lab as ordered and report findings to MD. Monitor behavior and chart and report progress/decline to MD. Observe for warning signs of behavior. had impaired cognitive function. Focus: Secure unit: Resident #2 requires secure unit related to cognitive disorder, wandering. Goal: Resident #2's safety will be maintained through appropriate supervision and structured /supportive environment through the review. Intervention: Administered medication as ordered. Behavior control: Utilize techniques such as redirection, distraction and calming. Record review of Nurses Progress Notes dated 9/23/2024 written by LVN K read in part . Resident #2 was attacked by his roommate CR#1 after they had an argument. The fight ended up in the hallway, Resident #2 fell then CR#1 got on top of him and banged his head on the floor, several times which caused a laceration on the back of Resident #2's head and bleeding. 9/23/2024 08:30 written by LVN B read in part . Note Text : resident arrived back to facility via stretcher with EMS x2, resident alert and oriented x1, pleasantly confused, noted ace wrap with gauze to head, assisted resident to bed, resident in sitting position, bp 135/76, pulse 76, c/o discomfort, received new order for Tylenol 650mg bid x7days, assessed back of head and noted laceration in shape of 'Y left side measuring at 6cm and right side measuring at 6.5cm, no active bleeding, no redness noted, 32 staples in place, raised area above laceration, spoke with family and aware of arrival back to facility. 9/23/2024 08:53 Form Summary :Late Entry: by LVN B Form Summary: Change of Condition Identified: laceration to back of head. Vital Signs: BP 148/60 - 9/24/2024 09:54 Position: Sitting l/arm , P 66 - 9/24/2024 09:54 Pulse Type: Regular , R 18.0 - 9/12/2024 00:04, O2 95.0 % - 9/12/2024 00:04 Method: Room Air. What do you think is going on with the resident: altercation with male resident, laceration to back of head with 32 staples in place, new order for Tylenol bid x7days for pain. NP Notified Responsible Party Notified Record review of the hospital report dated 09/23/2024 revealed documentation: Patient comes from nursing home via EMS for head injury. EMS informs us that the patient was assaulted by another patient. The other patient took the patient to the floor and hit his head multiple times on the floor. The patient did not lose consciousness, patient follows command and answer questions appropriately. Patient has laceration to the back of the head with bleeding, pressure wrap applied by EMS. Record review of the hospital event report dated on 09/23/2024 revealed Resident #2 was admitted to the emergency room with a Y shaped 12 cm laceration on the occipital region with minimal bleeding. #50 staples were used to the head. CT of the head was done it showed no acute bleed and no acute fracture. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the Provider's investigation report revealed documentation that CR#1 and Resident #2 altercation were CR#1 banged Resident #2's head on the floor causing a 12 cm laceration to the head back resulting in Resident #2 receiving 32 sutures to the head back was investigated. There were only one CNA on the unit. Observation on 9/25/2024 at 12:20pm revealed Resident #2 in his room, sitting on his bed. He was alert and oriented with some forgetfulness. He was clean and groomed with no offensive odor. He was noted with a laceration to the back of his head with staples. In an interview via interpreter on 9/25/2024 at 12:20pm with Resident #2 he said he did not remember exactly what happened. Resident #2 said he recall CR#1 was in his bed yelling and the next thing his head was hurting. He said he was told that his roommate CR#1 banged his head on the floor. Resident#2 said he and CR#1 had argued before, but CR#1 never hit him. He said he was not really scared of CR#1 but he did not want him to be his roommate again because he did not want a repeat of what happened. He said it was okay for CR#1 to be around but not in his room. He said he did not remember how many staff was working when the incident took place. In an interview with CNA J on 9/25/2024 at 1:25pm she said she was working the 10pm-6am shift on 9/22/2024 on the secure unit when around 4:15am she heard CR#1 yelling, he wanted his roommate out of his room . She said she went to the room and calmed CR#1 down and reminded him that Resident #2 was his roommate. She said when he had calmed down and was back on his side of the room, she left the room. She said, shortly after she left, she heard them yelling and they were on the floor in the hallway and the next thing she saw was CR#1 banging Resident #2's head on the floor and it was bleeding. She said she pulled CR#1 off Resident #2 and put CR #1 in the room and closed the door. She said when she saw the blood coming from his head she called the nurse on her phone, applied pressure to the head until the nurse came and took over. She said 911 was called, physician and family notified, and the resident was, sent to the hospital. Further interview revealed she was the only CNA who was working on the secured unit at the time of the incident. She said 2 aides were schedule to work the unit but there was a call in, and the other aide had to go to another hall. She said it was her first time working the unit. Further interview with CNA J revealed she was trained on abuse/ neglect, managing aggressive residents and reporting abuse and neglect. She said Resident #2 was a very quiet man and he was not aggressive and did not display any behavior issues. Record review of the staff sign in sheet for 09/22/2024 revealed on the 10:00pm to 6:00am only 1 CNA sign in for the shift. Record review of the Facility assessment dated [DATE] read in part . Unit consideration: 200 hall, secure unit: Long term stay requires 2 CNAs all shifts. Night shift is staffed 2 CNAs, Nurses: 2 nurses split 100/200 left and 2 nurses split 200, 300 and 400 halls right. In an interview with CNA L on 9/25/2024 at 4:25pm she said she worked the secure unit and most of the time there were two CNAs on the 200 hall. She said she had never witnessed any abusive behavior on the hall with any resident. She said CR#1 was not physically abusive. She said CR#1 will yell and shout at times but was never physically aggressive toward any resident. She said Resident #2 was not aggressive and had never displayed any aggressive behavior. She said if there were behavior issues, she would defuse the situation. Separate the residents and calm them down. She said she was in-serviced on abuse and neglect. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 9/25/2024 at 4:40pm with RN A she said she worked with Resident #2 and he was a quiet resident. She said he never displayed any aggressive behavior. She said he never gets mad or gets angry. She said CR#1 yells and screams, he wanders a lot, but he was never physically aggressive to his roommate or any resident. She said she was surprised when she heard there was an altercation between the two residents. She said the CR#1 was in the psych hospital for evaluation. She said Residents #2 was in a room by himself, he did not currently have a roommate. In an interview on 9/25/2024 at 4:45 pm with LVN D she said she worked with both CR#1 and Resident #2. She said she worked with Resident#2 and he never displayed any aggressive behavior. She said the resident was very quiet and spoke mostly Spanish. She said she had never witnessed CR#1 being abusive to any resident. She said CR#1 wanders, will yells and scream but never displayed any aggressive behavior towards any resident. In an interview on 9/26/2024 at 1:00pm with CNA H she said she usually worked on the secure unit., She, said that she had never seen CR#1 physically abusive to anyone. She said he has a behavior of yelling but not physically abusive. She said two staff usually worked the secured unit. She said if a CNA called out then the CNA and the nurses would work the hall. In an interview on 9/27/2024 at 12:20am with LVN C he said he was working the 6:00pm to 6:00am shift on 9/22/2024 the morning when the CR#1 and Resident #2 had the fight. He said he did not actually see what happened but when he went to the unit the resident was on the floor and the nurse was assisting the resident. He said 911 was called and the resident was sent to the hospital. He said usually there would be two aides on the unit, but there was only one aide working the unit that shift. In an interview on 9/27/2024 at 9:34am LVN K revealed she was the nurse in charge of the 6:00pm to 6:00am shift on the secured unit the night the incident took place. She said she was on the unit earlier to calm down a resident who was very agitated and left when he fell asleep. She said when she left the unit the residents were quiet. She said she was on another hall when CNA J called her phone and told her that CR#1 banged Resident #2's head on the floor and it was bleeding. She said she immediately went to the hall, saw the resident on the floor and she assessed the resident, call 911, the family and send the resident to the hospital. She said there was only one aide on the unit that shift. She said when the aide called in on 9/22/2024 she called the on-call staff, but they did not send a replacement. Record review of Resident #3's face sheet dated 9/25/2024 revealed he was a [AGE] year-old male that had been admitted to the facility on [DATE] with diagnoses of unspecified dementia (chronic condition that causes a person to lose the ability to think, learn and remember), diabetes mellitus (disease that result in too much sugar in the blood), essential hypertension(a condition of high blood pressure that is not attributed to another medical condition), unspecified psychosis(a severe mental condition in which thought and emotions are affected), depression(the elevation or lowering of a person's mood), and anxiety disorder(a feeling of worry). Record review of Resident #3's MDS dated [DATE] revealed Section C: BIMS Summary a disease that result score was 02 (which represented severe cognitive impairment). Section E0100- Behavior Z. No delusions or hallucinations. Section E0900 wandering-Presence & frequency was coded 0- behavior not exhibited. Section GG- Functional Abilities and Goals- C. Toileting hygiene was coded as 01- represented dependent (helper does all the effort). D. Sit to stand 04- Supervision or touching assistance (helper provides verbal cues). H0300-Urinary and bowel incontinence was coded as 3-always incontinent. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #3's care plan dated 5/22/2024 revealed: Cognitive impairment: Resident #3 has impaired cognition and is at risk for further decline and injury. Goal: Resident #3 needs will be met, and dignity maintained over the next 90 days. Interventions: Allow time for tasks and responses, explain all procedures. Resident #3 deemed at Risk for Wandering as evidence by: Dementia/Alzheimer, and Resident #3 is ambulatory. Goal: Resident #3 will be able to wander in a safe environment without the occurrence of injury and dignity will be maintained over the next 90 days. Interventions: Maintain resident safety during increased episodes, observe and document resident's location frequently throughout shift, and offer fluids and snacks during increased episodes of wandering. Resident #3 has bowel and bladder incontinence and is at risk for skin break down. Goal: Dry and odor free and no occurrence of skin breakdown will occur over the next 90 days. Intervention: Provide incontinent care after each incontinent episode and prn. Record review of Resident #3's nursing progress note revealed on 9/2/2024 at 8:21 p.m.: CNA called for LVN A stated that resident was hit by another male resident. Resident unable to state what happened. Noted skin tear to forehead and left side of face, noted bruising to left eye and temple, no facial grimacing noted, cleansed, applied Tao. Resident continues to wander hallways and other resident's room, continues to redirect frequently. Notified NP, DON, Administrator, FM aware of incident. Record review of Resident #3's nursing progress note dated 8/10/2024 at 4:41pm: Note Text: CNA reported to nurse this resident #3 went in another male resident's room (Resident 4), and when the other male resident asked this male resident to leave, he began hitting the other male resident. The other male resident then hit him back, and this resident received a small cut to the chin. Residents separated to other areas of unit. Cleansed cut to chin with normal saline, pat dry and apply TAO and band aid. RP, NP, administrator notified of incident. Will continue to monitor. Noted authored by LVN D. Record review of Resident #4's face sheet dated 9/25/2024 revealed he was a [AGE] year-old male that was admitted to the facility on [DATE] with diagnoses of unspecified psychosis a severe mental condition in which thought, and emotions are affected), depression (the elevation or lowering of a person's mood) and benign prostatic hyperplasia (age associated prostate gland enlargement). Record review of Resident #4's quarterly MDS dated [DATE] revealed: Section C0500- BIMS summary score was coded as 7 (which represented severe impairment). Section E0100- Behavior- Z. No delusions or hallucinations Section)-Special treatments coded 0 for Psychological Therapy (by any licensed mental health professional). Record review of nursing progress noted dated 8/10/2014 at 1:18pm. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Note Text: Resident was in his restroom when he walked out, he says another resident was standing in his room by his bed. He asked the other resident to get out, then the other resident grabbed his Kleenex off his bed, the resident asked him to put it back, the other resident refused saying no and threw two punches (missing him). The other resident then grabbed this residents' fingers on his left hand and squeezed them together, this was when this resident punched the other resident in the chin. The two parties were separated, and the other resident was escorted out of the room. This resident has no physical injuries at this time and no c/o of pain. Will monitor closely throughout the shift. Note was signed by LVN D. Record review of nursing progress note dated 9/2/2023: Note text: CNA called the nurse stating that she overheard a noise coming from resident #4's room. Resident #4 had become physically aggressive with another resident. Upon observation noted resident sitting in bed, Resident #4 stated that make resident came into his room and he told him to leave and he said no so he punched Resident #3. Resident #4 had no visible signs of injuries. Educated Resident #4 to call for staff instead of being aggressive. Resident understood the education. NP notified, DON, Administrator made aware as well as Resident #4's RP. The notes were signed by LVN A. A telephone interview with FM of Resident #3 on 9/25/24 at 12:03pm revealed that the resident had been in 3 different incidents at the facility. He was reevaluated at local hospital for his medications. She said he had no permanent injuries from the incident, but he had a black eye and bruising. Resident #3 goes in and out of everybody's room and when they want him out, he gets aggressive. He had an incident about two weeks ago and this was the third incident since he had been at the facility (May 2024) and was sent for medication evaluation. He returned around the 20th. He was in another facility before being admitted to the current facility and he was hallucinating and getting very aggressive. The FM stated he was only at a facility for about two weeks before he started breaking mirrors or anything that had his reflection. The FM said he was doing well at first now getting aggressive again. Resident#3 was considered middle to late stage or psychotic dementia diagnosis. The FM said he has anger towards men, and this had been observed. His dementia was causing him to wander and that will not stop, he's been doing that for a while. The FM said his wandering was progressively getting worst. The FM said unfortunately staff must redirect him when he was doing this, and it does not seem like this was being done. The FM stated there was never enough staff when the FM visits. The FM said when CNA was requested to help Resident #3 a few times they were told by unknown CNA that they were the only one on the floor and would get help. Observation and interview with Resident #4 on 9/25/2024 at 12:36pm, revealed he was in his room eating lunch. He was well-dressed in a blue jean shirt and jeans. He stated that he remembered the incident between him and Resident #3. He said that he could not remember the residents name, but a male came in his room, and he asked him to leave. He said he told him no so he whipped his expletive. He said other residents might wander into the room but when he tell them to get out or staff catch them at the door and there were no problems. He said after he asked the resident to leave, he laid in his roommate's bed. He said he told him again and then hit him twice in the face. He said he would never hit a woman, but he will hit a man that comes in his room uninvited. He said he gets along with his roommate well. He said the same resident had been in his room before and he kicked his expletive then, too. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with CNA E on 9/25/2024 at 12:54pm, stated she had been employed only a few months. She said Resident #3 wanders a lot. She said when he was awake, he wanders constantly. She said she sometimes placed a chair in the hallway to watch the residents and re-direct the wanderers. She said Resident #3 tries to get into other residents' beds. She said staff must keep a close eye on him. She said there were usually 2 CNA's and 1 nurse on the memory care hall. But sometimes they do not have two because of call-in and no shows. A telephone interview with LVN A on 9/25/2024 at 4:50pm, LVN stated Resident #3 and Resident #4 had an altercation after Resident #3 wandered into Resident #4's room and he asked him to leave. Resident #3 refused and proceeded to lay in his roommates' bed. She said she was the nurse on duty but was not in the unit at the time. She had been called by an unknown CNA after the altercation had been broken up. She said she assessed both residents and documented the bruise to Resident #3's eye. She said she had been employed since 2019 and worked the 6pm-6am shift. She said she worked Halls A (100) and B (200), the right side of B on secure unit. She stated after the incident the DON in-serviced them on Abuse and Neglect. She said wandering residents were redirected with snacks, fluids, and this will usually keep him redirected successfully. Sometimes Resident #3 can become combative and staff were instructed to give him space, offer food which he loves to eat, and this usually distracts him. She said he wanders a lot and staff had to keep a better eye on him. She admitted they were sometimes short-staffed on the secured unit, mostly the 2p-10pm shift. In an interview with the Administrator on 9/27/2024 at 4:15 pm he said CNA J reported that CR#1 and Resident #2 had a resident to resident altercation and CR#1 banged Resident#2's head to the floor. He said he has increased staff by adding an activity assistant, to work in the secured unit. He said incidents have decreased since adding the staff. Record review of the facility's policies and procedures titled Abuse, Neglect and Exploitations dated April 2024 read in part . Policy: The nursing facility strictly opposed abuse, neglect and exploitation or any mistreatment of resident by anyone at the facility including staff, resident, volunteers or visitors and others. The policy contained 7 key components training, screening, prevention, identification, protection, investigation, and reporting/response. Abuse prevention: The facility Administrator or designee serves as the Abuse Prevention Coordinator. Abuse: Any willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. Neglect: The failure of the facility, its employees, service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect may include the failure of the caregiver to provide the necessities of life including protection from harm. The Administrator and DON was notified on 09/27/2024 at 4:24 p.m., an Immediate Jeopardy situation (IJ) was identified due to the above failures. The Administrator was provided the IJ template on 09/27/2024 and a Plan or Removal (POR) was requested. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	PLAN OF REMOVAL. Immediate Action The SW will complete 100 % safe surveys on residents on the secure unit. The completion date is 9/27/24. The DON/Designee will in-Service all staff on Abuse and neglect policy - Staff absent at the time of in-Service will receive in-service prior to start of their shift. The completion date is 9/27/24. The Administrator held and ad-hoc QAPI meeting on 9/27/24 to address incidents and accidents that occurred in the past 30 days. The charge nurses and resident care specialists will conduct hourly rounds to monitor residents for changes in behavior to prevent resident to resident abuse. The DON/designee will monitor the processes that have been put in place. The abuse prohibition coordinator will ensure that facility staff education and training related to abuse/neglect/exploitation is completed following all allegations of abuse/neglect/exploitation. The Administrator was in-serviced by the RDO on 9/27/24 on the topic's roles and responsibilities of the Abuse Prohibition Coordinator and responding timely to abuse allegations. The policies and procedures were reviewed on 9/27/24 by the Administrator, DON, ADON, and RDO with no changes at this time. The DON and Administrator will ensure that there are always two employees on the secure unit. On 9/28/24 secure unit staff in-serviced on de-escalation techniques, identifying and monitoring residents with agitation and aggression with changes reported to the charge nurse immediately. The in-service was completed by the Senior Director of the Psych hospital]In-Patient Psych. CR#1 and Resident #2 were assessed by the charge nurse prior to their discharges. Skin assessments, pain assessments, SBARs, and incident reports were completed for CR#1 and Resident #2 by the charge nurse. CR#1 was sent out to the Psych hospital In-Patient Psych to be further evaluated and is currently a patient at the In-Patient Psych. Resident #2 was sent to the ER for further evaluation following the incident on 9/23/24 and returned to the facility on [DATE] with new physician orders. CR#1 and Resident #2 care plans have been reviewed by the IDT Team and revised by MDS Coordinator. Monitoring the POR on 09/27/2024: During the survey monitoring, the Administrator was interviewed regarding what he believed was the root cause of the IJ. The Administrator believed that there was a staffing issue. He said he was not aware that the unit was not fully staffed. He said there was a plan in place to monitor this issue, and the staff were in-service on checking on residents every two hours in the general population and every hour on the secure unit. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During the survey monitoring, the Director of Nursing (DON) was also interviewed regarding what she believed was the root cause of the IJ. The DON believed there was a staffing issue. The DON planned to ensure that two CNAs were on the secure unit, monitoring was done every hour on the secure unit and every two hours on the other units and as needed. The DON's expectation was for the RN's and LVN's to follow the rules and regulations and be in compliance, be at work on time and take care of the residents. On 09/27/2024 In-Service trainings was initiated by the ADON to licensed nurses. In an interview on 9/28/2024 at 1.56pm with CNA M she said she was in-serviced on abuse/ neglect on 9/27/24 and on 9/28/2024. she was in-serviced on resident-to-resident altercation: Separate residents if there was an altercation, talk to the charge nurse and let them know what was going on and what needed to be done. Monitor the residents and allow them to calm down. Redirect them to do something like an activity. She was also in-serviced on Dignity- respecting the resident as individual and, reporting abuse/neglect to the abuse coordinator. She verbalized understanding of the in-services provided. In an interview on 9/28/2024 at 2:05pm with CNA L she said she was in-serviced on abuse /neglect and calling in. Staff related that neglect was: Was when a person put on the light and needs to be changed and the staff said she would be back and never went back that would be neglect and abuse was when a staff cursing a resident would be verbal abuse and physical abuse was when a staff hit a resident. She verbalized understanding of the in-services provided. In an interview on 9/28/2024 at 2:10pm with MA A he said he was in-serviced on abuse/neglect, different types of abuse such as verbal and physical abuse, neglect -not providing care to resident and reporting of abuse. He said he was also in-serviced on communication and who to call if he could not make it to work. The staff verbalized understanding of the in-service provided. In an interview on 9/28/2024 at 2:39pm with RN C she said she was in-serviced on abuse/neglect, Attendance policy and if she has to call in, she must talk to a live person, and they should call in four hours prior to her shift. Staff were supposed to be at work on time: Delay in patient care and relieving staff. If she calls the on-call person and no one answer to call the Administrator, DON and ADON. Staff verbalized understanding of in-service provided. In an interview on 9/28/2024 at 2:30pm with RN B she said she was in-serviced that morning on Abuse/neglect, how to De-escalate residents when they get agitated. Regarding staff call in- If you have to call in 2 hours prior to when you are schedule to work and let the on call person know. Staff verbalized understanding of in-service provided. In an interview on 9/28/2024 at 3:30pm with CNA E she said she was in-serviced on Abuse/Neglect.: Call in's she said they cannot text have to ensure that they talk to a person. Report on time for work wait for relief to get to the building. She said they were in-serviced on abuse/neglect at least once a month. Staff verbalized understanding of in-services provided. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 9/28/2024 at 3:40pm with Staffing Coordinator she said she was in serviced on abuse and neglect and staff calling in. She said abuse/neglect be reported to the abuse coordinator. She said the types of abuse were verbal abuse saying unkind thing or cursing, physical abuse hitting touching or handling a resident roughly and neglect was not taking care of residents. She said staff should call in: 4 hours before the start of their shift. If they did not get to the on-call person, they should call the administrator or DON. Staff verbalized understanding of the in-service provided. Interviews were conducted between 9/29/2024-9/30/2024 with CNAs B, C and E, LVNs B and D, RN A were all staff from the morning (6a-6p) shift. They all were able to explain the procedure for call-ins, attendance policy, abuse and neglect, when to let management know if they notice staff were on the schedule but was not at work. Charge Nurses LVN D, RN A and RN B stated they were required to

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25263 Based on observation, record review and interview the facility failed to ensure the MDS assessment accurately reflected the resident's status for 2 of 6 (Resident #2 and Resident #3) reviewed for MDS assessment accuracy in that: -The facility failed to ensure Resident #2's MDS accurately addressed his wandering. -The facility failed to ensure Resident #3's MDS accurately reflected his wandering. This failure placed residents at risk of not receiving care and services to meet the needs of the residents. Findings Included: Resident #2 Record review of Resident #2's face sheet revealed he was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included schizoaffective disorder (mental health condition), unspecified psychosis (loss of contact with reality), anxiety (a mental disorder that cause worry and fear), essential hypertension (high blood pressure) and insomnia (inability to sleep). Record review of Resident #2's quarterly Minimum Data Set, dated dated dated [DATE] coded Resident #2 for Cognitive skills for decision making as moderately impaired. For behavior he was coded as delusional and exhibited no behavioral symptoms. For ADL's he was coded as needing supervision and was occasionally incontinent of bowel and bladder. Record review of Resident #2's care plan dated 6/17/2024 revealed: Focus Resident had episodes of inappropriate behaviors and is at risk for further increased episodes and injury resident wanders throughout the facility, placing gloves on hand and wandering in an out of other resident's room. Took a TV out of another resident room and put it in his room. Goal: Resident has episodes of appropriate behaviors should be reduced to more than two episodes weekly will be free from injury over the next 90 days. Intervention: Encourage the resident to attend social events. Explain procedures using terms/gesture that the resident can understand. Give meds as ordered by the doctor, lab as ordered and report findings to MD. Monitor behavior and chart and report progress/decline to MD. Observe for warning signs of behavior. had impaired cognitive function. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Focus: Secure unit: Resident #2 requires secure unit related to cognitive disorder, wandering. Goal: Resident #2's safety will be maintained through appropriate supervision and structured /supportive environment through the review. Intervention: Administered medication as ordered. Behavior control: Utilize techniques such as redirection, distraction and calming. Record review of Nurses Progress Notes dated 9/23/2024 read in part . Resident #2 was attacked by his roommate CR#1 after they had an argument. The fight ended up in the hallway, Resident #2 fell then CR#1 got on top of him and banged his head on the floor, several times which caused a laceration on the back of Resident #2's head and bleeding. 9/23/2024 08:30 Nursing Note Note Text: resident arrived back to facility via stretcher with emts x2, resident alert and oriented x1, pleasantly confused, noted ace wrap with gauze to head, assisted resident to bed, resident in sitting position, bp 135/76, pulse 76, c/o discomfort, received new order for Tylenol 650mg bid x7days, assessed back of head and noted laceration in shape of 'Y left side measuring at 6cm and right side measuring at 6.5cm, no active bleeding, no redness noted, 32 staples in place, raised area above laceration, spoke with family and aware of arrival back to facility. 9/23/2024 08:53 Form Summary: Late Entry: Form Summary: Change of Condition Identified: laceration to back of head Vital Signs: BP 148/60 - 9/24/2024 09:54 Position: Sitting l/arm , P 66 - 9/24/2024 09:54 Pulse Type: Regular , R 18.0 - 9/12/2024 00:04, O2 95.0 % - 9/12/2024 00:04 Method: Room Air. What do you think is going on with the resident: altercation with male resident, laceration to back of head with 32 staples in place, new order for Tylenol bid x7days for pain. NP Notified Responsible Party Notified ' Observation on 9/25/2024 at 12:20 p.m. revealed Resident #2 in his room, sitting on his bed. He was alert and oriented with some forgetfulness. He was clean and groomed with no offensive odor. He was noted with a laceration to the back of his head with staples. Resident #3 Record review of Resident #3's face sheet dated 9/25/2024 revealed he was a [AGE] year-old male that had been admitted to the facility on [DATE] with diagnoses of unspecified dementia (chronic condition that causes a person to lose the ability to think, learn and remember), diabetes mellitus (disease that result in too much sugar in the blood), essential hypertension(a condition of high blood pressure that is not attributed to another medical condition), unspecified psychosis(a severe mental condition in which thought and emotions are affected), depression(the elevation or lowering of a person's mood), and anxiety disorder(a feeling of worry). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's MDS dated [DATE] revealed Section C:BIMS Summary score was 02 (which represented severe cognitive impairment). Section E0100- Behavior Z. No delusions or hallucinations. Section E0900 wandering-Presence & frequency was coded 0- behavior not exhibited. Record review of Resident #3's care plan dated 5/22/2024 revealed: Cognitive impairment: Resident #3 has impaired cognition and is at risk for further decline and injury. Goal: Resident #3 needs will be met, and dignity maintained over the next 90 days. Interventions: Allow time for tasks and responses, explain all procedures. Resident #3 deemed at Risk for Wandering as evidence by: Dementia/Alzheimer, and Resident #3 is ambulatory. Goal: Resident #3 will be able to wander in a safe environment without the occurrence of injury and dignity will be maintained over the next 90 days. Interventions: Maintain resident safety during increased episodes, observe and document resident's location frequently throughout shift, and offer fluids and snacks during increased episodes of wandering. A telephone interview with FM of Resident #3 on 9/25/24 at12:03pm stated he had been in 3 different incidents at the facility . He was reevaluated at local hospital for his medications. She said he had no permanent injuries from the incidents, but he had a black eye and bruising. She said Resident #3 went in and out of everybody's room and when they wanted him out, he gets aggressive. He had an incident about two weeks ago and this was the third incident since he had been at the facility (May, 2024) and was sent for medication evaluation. He returned around the 20th. He was in a facility in a local town before being admitted to his current facility and he was hallucinating and getting very aggressive. The FM stated he was only at a facility for about two weeks before he started breaking mirrors or anything that had his reflection. The FM said he was doing well at first now he was getting aggressive again. Resident #3 was considered middle to late stage or psychotic dementia diagnosis. The FM said he has anger towards men, and this had been observed. His dementia was causing him to wander and that will not stop, he's been doing that for a while. The FM said his wandering was progressively getting worse. Observation and interview with Resident #4 on 9/25/2024 at 12:36pm, revealed he was in his room eating lunch. He was well-dressed in a blue jean shirt and jeans. He stated that he remembered the incident on 9/2/2024 between him and Resident #3. He said that he could not remember the residents name, but a male came into his room, and he asked him to leave. He said Resident #3 told him no so he whipped his expletive. He said other residents might wander into the room but when he told them to get out or if staff catch them at the door there were no problems. He said after he asked the resident to leave, he laid in his roommate's bed. He said he told him again and then hit him twice in the face. He said he would never hit a woman, but he will hit a man that comes in his room uninvited. He said he get along with his roommate. He said the same resident had been in his room before and he kicked his expletive then, too on 8/10/2024. An interview with CNA E on 9/25/2024 at 12:54pm, CNA stated she had been employed only a few months. She said Resident #3 wandered a lot. She said when he was awake, he wandered constantly. She said she sometimes place a chair in the hallway to watch the residents and re-direct the wanderers. She said Resident #3 tried to get into other residents' beds. She said staff must keep a close eye on him. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A telephone interview with LVN A on 9/25/2024 at 4:50pm, LVN stated Resident #3 and Resident #4 had an altercation after Resident #3 wandered into Resident #4's room and he asked him to leave. Resident #3 refused and proceeded to lay in his roommates' bed. She said she was the nurse on duty but was not in the secured unit at the time. She had been called by an unknown CNA after the altercation had been broken up. She said she assessed both residents and documented the bruise to Resident #3's eye. Sometimes Resident #3 can become combative and staff were instructed to give him space, offer food which he loves to eat, and this usually distracts him. She said he wanders a lot and staff had to keep a better eye on him. An interview with LVN E on 9/30/2024 at 11:53am, she said she had been employed here since January 2024. She said she worked in the secured unit sometimes. She said Resident #3 was ambulatory and he walked a lot. He does go to other rooms and lay in bed. She had to get him out of other residents' beds in the past month. She returned him to his room. She said he was very confused due to his dementia/Alzheimer diagnosis and was not mentally stable. An interview with the MDS Nurse on 9/30/2024 at 3:57pm, revealed she had been the MDS nurse since 2023. She said the Social Services Director was responsible for completing and updating sections C and E. Section C was BIMS summary and section E was behaviors. She said she was not near her computer to check but if Resident #3 was not coded for wandering it might have been because the wandering started after that MDS was completed. She said the SW did the psychosocial, history, mood and helped to develop the care plan. She was asked about CR #1's behavior displayed on 9/23/2024. She said his MDS should have been updated after the event. She said she was not sure why it had not been updated. She would look at it when she was back to work. She said she worked 4-5 days per week. An interview with the DON on 9/30/2024 at 4:45pm revealed she had been employed since May 2022. When asked about her expectation for her nursing staff she said, all nurses to be incompliance with state regulations, come to work and do what they are supposed to do. She said all initial resident assessments were done by a corporate team and the facility staff does not do assessments prior to residents being admitted into the facility. She said the MDS nurse and SW were responsible for keeping the MDS accurate. She stated she managed all clinical staff. She said she would investigate this issue. An interview with the Administrator and DON on 9/30/2024 at 5:15pm, the Administrator stated that their company had central intake which was about 6 marketers that placed all residents at the facility. He stated that after a review of each resident clinicals their IDT team determined if they would accept or deny admission. He stated he was not sure if Resident #3 had wandering and other physical aggression when he was admitted . He said he would have to check his admission paperwork. He stated the facility hired a new Social Services Director as of 1 week ago, but the former SW was still PRN and should be updating MDS sections that she was responsible for such as behaviors. He said his expectation was that all assessments were current and accurate. A MDS assessment policy was requested but not received by exit.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25263 Based on observation, interview, and record review the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility's assessment tool for 2 of 19 residents (Resident #2 and Resident #3)reviewed for sufficient staff. -The facility failed to ensure adequate supervision was provided for Resident #3's wandering to prevent resident-to resident altercations between Residents #3 and #4 on 8/10/24 and 9/2/2024 in which Resident #3 sustained injuries to his face. -The facility failed to ensure there was sufficient staff on the secured unit overnight shift (10pm-6am) on 9/22/2024 to prevent a resident-to-resident altercation between CR #1 and Resident #2. Resident #2 had to be hospitalized and received 32 staples to the back of his head due to Resident #2 banging his head on the floor. The facility had 1 CNA for 19 residents on the secured unit. An Immediate Jeopardy (IJ) was identified on 09/27/2024 at 4:24 p.m. While the IJ was removed on 9/30/2024 at 2:22 p.m., the facility remained out of compliance at a scope of isolated and a severity level 2 due to the facility's need to monitor the implementation and effectiveness of their corrective systems. These failures could have caused all residents on the secured unit to have injuries, hospitalization s, and pain. Findings Included: Record review of facility's census dated 9/25/2024, revealed there were 19 residents that resided in the secured unit. Record review of facility's resident room roster revealed Resident #2 and Resident #3 resided on Hall B (secured unit). Record review of the facility's nursing schedule revealed CNA B and CNA F were scheduled to work Hall 200 (secured unit) on 9/2/2024 the date of incident between Resident #3 and #4. Further record review of the facility's nursing schedule revealed CNA J, D and H were all on the schedule to work in the secured unit on 9/22/2024 overnight shift (10 p.m.-6 a.m.). CNA J was the only CNA in the secured unit when an altercation occurred between CR#1 and Resident #2. Record review of the incident-by-incident type report provided on 9/27/2024, revealed Residents #3 and Resident #4 had physical altercations on 8/10/2024 and 9/2/2024. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the incident-by-incident type report provided revealed Resident #2 was on the receiving end of physical aggression on 9/23/2024. CR#1 Record review of CR#1's face sheet revealed [AGE] year-old male who was admitted to the facility on [DATE] and discharge 9/24/2024. His diagnoses included bipolar disorder (episodes of mood swings), schizoaffective disorder (mental health condition), unspecified psychosis (loss of contact with reality), anxiety (mental health disorder that cause fear and worry), essential hypertension (high blood pressure), mood disorder(mental heal disorder that affects emotional state) and insomnia(poor sleeping habits). Record review of CR#1's quarterly Minimum Data Set, dated dated dated [DATE] revealed the resident as a BIMS score of 09 indicating he had cognitive issues. For Behavior the Resident was coded as having no behaviors, was coded as set up or clean up assistance only for activities of daily living and was continent of bowel and bladder. Record review of CR#1's care plan dated 1/24/2024 . Focus Resident had episodes of inappropriate behaviors and is at risk for further increased episodes and injury resident yells and curses. Goal: Resident has episodes of appropriate behaviors should be reduced to more than two episodes weekly will be free from injury over the next 90 days. Intervention: Encourage the resident to attend social events. Explain procedures using terms/gesture. Give meds as ordered by the doctor. Monitor behavior and chart and report progress/decline to MD Observe for warning signs of behavior. Record review of nurse's notes written on 09/23/2024 at 4:20am by LVN K revealed Resident #2 was attacked his roommate CR#1 after they had an argument. The fight ended up in the hallway, Resident #2 fell then CR#1 got on top of him and banged his head on the floor, several times which caused a bad cut on the back of Resident #2's head lots of bleeding, called ambulance, CR#1 got hit in the nose, and has a scratch on his back, notified NP A also left message Resident #2's family. Resident #2 Record review of Resident #2 face sheet revealed he was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included schizoaffective disorder (mental health condition), unspecified psychosis (loss of contact with reality), anxiety (a mental disorder that cause worry and fear), essential hypertension (high blood pressure) and insomnia (inability to sleep). (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 9/25/2024 at 12:20pm revealed Resident #2 in his room, sitting on his bed he was alert and oriented with some forgetfulness. He was clean and groomed with no offensive odor. He was noted with a laceration to the back of his head with staples. In an interview via interpreter on 9/25/2024 at 12:20pm with Resident #2 he said he did not remember exactly what happened. Resident #2 said he recall CR#1 was in his bed yelling and the next thing his head was hurting. He said he was told that his roommate CR#1 bang his head on the floor. Resident#2 said he and CR#1 had argued before, but CR#1 in never hit him. He said he was not really scared of CR#1 but he did not want him to be his roommate again because he did not want a repeat of what happen. He said it was okay for CR#1 to be around but not in his room. He said he did not remember how many staff was working when the incident took place. Record review of Resident #2 quarterly Minimum Set dated 7/5/2024 coded Resident #2 for Cognitive skills for decision making as moderately impaired. For behavior he was coded as delusional and exhibited no behavioral symptoms. For ADL's he was coded as needing supervision and was occasionally incontinent of bowel and bladder. Record review of Resident #2's care plan revealed Resident #2 Record review of Resident #2's care plan dated 6/17/2024 revealed: Focus Resident had episodes of inappropriate behaviors and is at risk for further increased episodes and injury resident wanders throughout the facility, placing gloves on hand and wandering in an out of other resident's room. Took a TV out of another resident room and put it in his room. Goal: Resident has episodes of appropriate behaviors should be reduced to more than two episodes weekly will be free from injury over the next 90 days. Intervention: Encourage the resident to attend social events. Explain procedures using terms/gesture that the resident can understand. Give meds as ordered by the doctor, lab as ordered and report findings to MD. Monitor behavior and chart and report progress/decline to MD. Observe for warning signs of behavior. had impaired cognitive function. Focus: Secure unit: Resident #2 requires secure unit related to cognitive disorder, wandering. Goal: Resident #2's safety will be maintained through appropriate supervision and structured /supportive environment through the review. Intervention: Administered medication as ordered. Behavior control: Utilize techniques such as redirection, distraction and calming. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Nurses Progress Notes dated 9/23/2024 read in part . Resident #2 was attacked by his roommate CR#1 after they had an argument. The fight ended up in the hallway, Resident #2 fell then CR#1 got on top of him and banged his head on the floor, several times which caused a laceration on the back of Resident #2's head and bleeding. 9/23/2024 08:30 Nursing Note Note Text: resident arrived back to facility via stretcher with emts x2, resident alert and oriented x1, pleasantly confused, noted ace wrap with gauze to head, assisted resident to bed, resident in sitting position, bp 135/76, pulse 76, c/o discomfort, received new order for Tylenol 650mg bid x7days, assessed back of head and noted laceration in shape of 'Y left side measuring at 6cm and right side measuring at 6.5cm, no active bleeding, no redness noted, 32 staples in place, raised area above laceration, spoke with family and aware of arrival back to facility. 9/23/2024 08:53 Form Summary: Late Entry: Form Summary: Change of Condition Identified: laceration to back of head Vital Signs: BP 148/60 - 9/24/2024 09:54 Position: Sitting l/arm , P 66 - 9/24/2024 09:54 Pulse Type: Regular , R 18.0 - 9/12/2024 00:04, O2 95.0 % - 9/12/2024 00:04 Method: Room Air. What do you think is going on with the resident: altercation with male resident, laceration to back of head with 32 staples in place, new order for Tylenol bid x7days for pain. NP Notified Responsible Party Notified Record review of hospital report dated 09/23/2024 revealed documentation: Patient comes from nursing home via EMS for head injury. EMS informs us that the patient was assaulted by another patient. The other patient took the patient to the floor and hit his head multiple times on the floor. The patient did not lose consciousness, patient follows command and answer questions appropriately. Patient has laceration to the back of the head with bleeding, pressure wrap applied by EMS. Record review of hospital event report dated on 09/23/2024 revealed Resident #2 was admitted to the emergency room with a Y shaped 12 cm laceration on the occipital region with minimal bleeding. #50 staples were used to the head. CT of the head was done it showed no acute bleed and no acute fracture. Resident #3 Record review of Resident #3's face sheet dated 9/25/2024 revealed he was a [AGE] year-old male that had been admitted to the facility on [DATE] with diagnoses of unspecified dementia (chronic condition that causes a person to lose the ability to think, learn and remember), diabetes mellitus (disease that result in too much sugar in the blood), essential hypertension(a condition of high blood pressure that is not attributed to another medical condition), unspecified psychosis(a severe mental condition in which thought and emotions are affected), depression(the elevation or lowering of a person's mood), and anxiety disorder(a feeling of worry). (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #3's MDS dated [DATE] revealed Section C: BIMS Summary a disease that result score was 02 (which represented severe cognitive impairment). Section E0100- Behavior Z. No delusions or hallucinations. Section E0900 wandering-Presence & frequency was coded 0- behavior not exhibited. Section GG- Functional Abilities and Goals- C. Toileting hygiene was coded as 01- represented dependent (helper does all the effort). D. Sit to stand 04- Supervision or touching assistance (helper provides verbal cues). H0300-Urinary and bowel incontinence was coded as 3-always incontinent. Record review of Resident #3's care plan initiated dated 5/22/2024 and target date of 10/31/2024 revealed: Cognitive impairment: Resident #3 has impaired cognition and is at risk for further decline and injury. Goal: Resident #3 needs will be met, and dignity maintained over the next 90 days. Interventions: Allow time for tasks and responses, explain all procedures. Resident #3 deemed at Risk for Wandering as evidence by: Dementia/Alzheimer, and Resident #3 is ambulatory. Goal: Resident #8 will be able to wander in a safe environment without the occurrence of injury and dignity will be maintained over the next 90 days. Interventions: Maintain resident safety during increased episodes, observe and document resident's location frequently throughout shift, and offer fluids and snacks during increased episodes of wandering. Resident #3 has bowel and bladder incontinence and is at risk for skin break down. Goal: Dry and odor free and no occurrence of skin breakdown will occur over the next 90 days. Intervention: Provide incontinent care after each incontinent episode and prn. Record review of Resident #3 nursing progress note revealed on 9/2/2024 at 8:21 p.m.: CNA called for LVN A stated that resident was hit by another male resident. Resident unable to state what happened. Noted skin tear to forehead and left side of face, noted bruising to left eye and temple, no facial grimacing noted, cleansed, applied Tao. Resident continues to wander hallways and other resident's room, continues to redirect frequently. Notified NP, DON, Administrator, FM aware of incident. Note authored by LVN B Record review of Resident #3 nursing progress note dated 8/10/2024 at 4:41pm: Note Text: CNA reported to nurse this resident #3 went in another male resident's room(Resident 34), and when the other male resident asked this male resident to leave, he began hitting the other male resident. The other male resident then hit him back, and this resident received a small cut to the chin. Resident's separated to other areas of unit. Cleansed cut to chin with normal saline, pat dry and apply TAO and bandaid. RP, NP, administrator notified of incident. Will continue to monitor. Noted authored by LVN D. Resident #4 Record review of Resident #4's face sheet dated 9/25/2024 revealed he was a [AGE] year-old male that was admitted to the facility on [DATE] with diagnoses of unspecified psychosis a severe mental condition in which thought and emotions are affected), depression (the elevation or lowering of a person's mood)and benign prostatic hyperplasia (age associated prostate gland enlargement). (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #4's quarterly MDS dated [DATE] revealed: Section C0500- BIM summary score was coded as 7 (which represented severe impairment). Section E0100- Behavior- Z. No delusions or hallucinations Section O-Special treatments coded 0 for Psychological Therapy (by any licensed mental health professional). Record review of nursing progress noted dated 8/10/2014 at 1:18pm. Note Text: Resident was in his restroom when he walked out, he says another resident was standing in his room by his bed. He asked the other resident to get out, then the other resident grabbed his Kleenex off his bed, the resident asked him to put it back, other resident refused said no and threw two punches (missing him). The other resident then grabbed this residents' fingers on his left hand and squeezed them together, this is when this resident punched the other resident in the chin. The two parties were separated, and the other resident was escorted out of the room. This resident has no physical injuries at this time and no c/o of pain. Will monitor closely throughout the shift. Note was signed by LVN D. Record review of Resident #4's nursing progress note dated 9/2/2023 revealed: Note text: CNA called the nurse stating that she overheard a noise coming from resident #4's room. Resident #4 had become physically aggressive with another resident. Upon observation noted resident sitting in bed, Resident #4 stated that make resident came into his room and he told him to leave and he said no so he punched Resident #3. Resident #4 had no visible signs of injuries. Educated Resident #4 to call for staff instead of being aggressive. Resident understood the education. NP notified, DON, Administrator made aware as well as Resident #4's RP. The note was signed by LVN A. Record review of SBAR summary for Resident #4: Change in condition Identified: Physically aggression initiated 9/2/2024, vitals taken and NP notified, DON and family. SBAR completed by LVN B. A telephone interview with FM of Resident #3 on 9/25/24 at12:03p.m. stated he had been in 3 different incidents at the facility. He was reevaluated at local hospital for his medications. She said he had no permanent injuries from the incident, but he had a black eye and bruising. Resident #3 goes in and out of everybody's room and when they want him out, he gets aggressive. He had an incident about two weeks ago and this was the third incident since he had been at the facility (May, 2024) and was sent for medication evaluation. He returned around the 20th. He was in a facility in a local town before being admitted to his current facility and he was hallucinating and getting very aggressive. FM stated he was only at a facility for about two weeks before he started breaking mirrors or anything that had his reflection. FM said he was doing well at first and now he was getting aggressive again. She said Resident #3 is considered middle to late stage or has a psychotic dementia diagnosis. FM said he has anger towards men, and this had been observed. His dementia caused him to wander and that will not stop he had been doing that for a while. FM said his wandering was progressively getting worst. FM said unfortunately staff must redirect him when he is doing this, and it does not seem like this is being done. FM stated there never seemed to be enough staff working when the FM visited. Observation on 9/25/2024 at12:43pm revealed Resident #3 was in bed asleep. There was a urine odor in his room. He was the only resident that resided in this room. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation and interview with Resident #4 on 9/25/2024 at 12:36pm, revealed he was in his room eating lunch. He was well-dressed in a blue jean shirt and jeans. He stated that he remembered the incident between him and Resident #3. He said that he could not remember the residents name, but a male came in to his room and he asked him to leave. He said Resident #3 told him no so he whipped his expletive. He said other residents might wander into the room but when he told them to get out or if staff catch them at the door there were no problems. He said after he asked the resident to leave, he laid in his roommate's bed. He said he told him again and then hit him twice in the face. He said he would never hit a woman, but he will hit a man that comes in his room uninvited. He said he get along with his roommate. He said he the same resident had been in his room before and he kicked his expletive then, too . An interview with CNA E on 9/25/2024 at 12:54pm, CNA stated she had been employed only a few months. She said Resident #3 wanders a lot. She said when he is awake, he wanders constantly. She said she sometimes place a chair in the hallway to watch the residents and re-direct the wanderers. She said Resident #3 tries to get into other residents' beds. She said staff must keep a close eye on him. She said there are usually 2 CNA's and 1 nurse on the memory care hall. But sometimes they do not have two because of call-in and no shows. In an interview with CNA J on 9/25/2024 at 1:25pm she said she was working the 10pm-6am shift on the secure unit when around 4:15am she heard CR#1 yelling, he wanted his roommate out of his room. She said she went to the room and calm CR#1 down and remind him that Resident #2 was his roommate. She said when he was calmed down and was back on his side of the room, she left the room. She said, shortly after she left, she heard them yelling and they were on the floor in the hallway and the next thing she saw was CR#1 banging Resident #2's head on the floor and it was bleeding. She said she pulled CR#1 off Resident #2 and put CR #1 in the room and closed the door. She said when she saw the blood coming from his head she called the nurse on her phone, applied pressure to the head until the nurse came and took over. She said 911 was called, physician and family and the resident was, sent to the hospital. Further interview revealed she was the only CNA who was working on the secured unit at the time of the incident. She said 2 aides were schedule to work the unit but there was a call in, and the other aide had to go to another hall. She said it was her first time working the unit. Further interview with CNA J revealed she was trained on abuse/ neglect, managing aggressive residents and reporting abuse and neglect. She said Resident #2 was a very quiet man and he was not aggressive and did not display any behavior issues. She said she had never witnessed CR#1 being aggressive to any resident. A telephone interview with LVN A on 9/25/2024 at 4:50pm, LVN stated Resident #3 and Resident #4 had an altercation after Resident #3 wandered into Resident #4's room and he asked him to leave. Resident #3 refused and proceeded to lay in his roommates' bed. She said she was the nurse on duty but was not in the unit at the time. She had been called by an unknown CNA after the altercation had been broken up. She said she assessed both residents and documented the bruise to Resident #3's eye. She said she had been employed since 2019 and worked the 6pm-6am shift. She said she worked Halls A (100) and B(200), the right side of B or secure unit. She stated after the incident the DON in-serviced them on Abuse and Neglect She said wandering residents are redirected with snacks, fluids, and this will usually keep him redirected successfully. Sometimes Resident #3 can become combative and staff are instructed to give him space, offer food which he loves to eat, and this usually distracts him. She said he wanders a lot and staff had to eye a better eye on him. She admitted they are sometimes short-staffed on the secured unit. Mostly the 2p-10pm shift. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview with CNA F on 9/26/2024 at 12:11pm, she stated she did work the lock down unit (Hall 200-secured unit). She said had been employed for 2 years. She stated she no longer worked at the facility and did not know anything about the incident with Resident #3 and Resident #4. She said there was never enough staff to work in the secured unit. She said they were always short staffed. The call ended. In interview on 9/26/2024 at 1:38pm with the staffing Coordinator she stated she had been employed for [AGE] years off and on at this facility. She stated the Dementia unit (secured unit) normally staff during the daytime with 2 CNA, and the activity director and evenings were staffed normally with 2 aides and hospitality aide and at night 2 CNAs. She stated that staffing was an issue because staff sometimes call in, but she will usually come in to work or stay over or work a double shift when this happens. She said she would cover the shift herself because she was a CNA. She said on 9/2/2024, she was at work. However, she was not working the floor. She said she had CNA's staffed in the secured unit when Resident #3 and Resident #4 had the altercation. She said sometimes these altercations happens really fast and all they can do is break them up. She said she was not on call when the incident between Residents #1 and #2's altercation occurred on 9/23/2024 and she was not at work or on-call that weekend. She said she was not aware that CNAs did not come to work. She denied knowing which staff did not show up. She said she did not have the schedule on her phone and would have to check. She said Sunday (9/2224) overnight shift had two CNA's and a nurse and that was supposed to be sufficient for the overnight shift. In an interview on 9/26/2024 at 5:18pm with the Administrator, he stated there had been Resident to Resident altercations in the locked unit (2 incidents), he had increased staffing in the secured unit by adding two dedicated activity assistants about 3 months ago to keep the residents on the secured unit busy and to increase staff morale. He stated that the residents were a high elopement risk, and this was the reason Residents #1, 2, 3, and 4 were on the secure unit. They do not have a specialized unit (not dementia unit) just at risk of elopement. He said they had lots of PRN staff that pick and choose shifts. He said staffing was difficult and was indeed a challenge. He said he felt they have made some great strides. He stated that he kept 6 CNAs on each shift for all halls and nurses that came in to help out . He stated staffing is an issue, however they have enough staff to pick up shifts in the event of a call-in. An interview on 9/27/2024 at 3:05 p.m., Asst. Activity B/Transportation she said she had been employed for about 5 months. She said she helped to pass coffee in the dining room, socialize with residents and take them out on cigarette breaks. She said she worked 8am-5pm Monday-Friday. She said she worked the front area (A, C, D) Halls 100, 300 and 400. She said Activity Assistant A worked B Hall 200(secured unit). She said she does not have any CNA duties (like changing residents briefs). She was mostly there to socialize and keep the residents in the secured unit busy doing activities. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a subsequent interview with the Administrator on 9/27/2024 at 3:50 p.m. he was asked if he was aware that there was only 1 CNA on the overnight shift (10pm-6am) working on Hall 200 (secured unit) on night of 9/22/2023 into early morning of 9/23/2024. He stated no one had called to inform him as he was the on-call manager that weekend. He said he later learned that CNA's G and H were both no-call no-shows on the overnight shift. He stated that there were 6 other staff at the facility that could have helped the secured unit. He did not know why the decision was not made to move staff to the secured unit. He said the weekend supervisor should have known to move CNA's back to the secured unit as needed. He stated when they were short-staffed from call-ins the BOM, ADON, and DON have all came in to work shifts. He said it was unfortunate that the resident-to-resident altercation occurred that morning (9/23/24). He said the altercation between Resident #3 and #4 was stopped by staff and they had enough back there. He said Resident #3 did get hit by Resident #4 after wandering into his room. Investigator asked if staff should have been able to prevent the altercation?. He said, if they went to get him after learning he went inside someone else's room. He said, he is just a wanderer. An interview with RN C on 9/29/24 at 2:04pm, she said she had been employed about 1 year. She said she was one of the weekend supervisors. She said most of the residents on the secured unit really need 1-1 care. She said management needed to staff by the residents' acuity does not census in the secured unit to be able to take care of the residents' needs. She said there were too many with aggression in the secured unit and not enough staff to handle them. She said redirecting the residents is a very important skill that required staff to pay very close attention to the residents. She said on weekends they are frequently short. She said they make do. She said she pull CNAs from other halls to go to the secured unit. Sometimes the other halls are short too. She stated she was did not work An interview with CNA B on 9/30/2024 at 2:15pm, revealed her to state she had been employed since 2022. She said she worked Hall B (secured unit) on 9/2/2024 day of incident with Resident #3 and #4's incident. She said Resident #3 wandered a lot and he went into Resident #4's room and CNA F said she saw Resident #4 punching Resident #3. She yelled for her to come to help. She helped Resident #3 back to his room and the nurse assessed him. She said they received in-services for ANE, falls, call-ins, behavior training (how to separate residents, signs of agitation or aggression, changes in their behaviors or moods). She said they were usually staffed well in the secured unit but occasionally someone call in and they do not have enough staff. She stated she was not there when the altercation occurred between An interview with the DON on 9/30/2024 at 4:45pm revealed she had been employed since May 2022. When asked about her expectation for her nursing staff she said, all nurses to be incompliance with state regulations, come to work and do what they were supposed to do. She said resident assessments were done by a corporate team and the facility staff does not do assessments prior to being admitted into the facility. She said nurses were now doing rounding every hour for safety of the residents. She said she was not sure why no one called about the two no-call no- show staff. She said even if there was another CNA back there on 9/23/2024 they cannot stop them from having altercations even if they were standing right there. She said they were adequately staffed. She said she came in to work, ADON and all of management if they need them. The residents were taken care of. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility assessment tool dated 8/5/2024 revealed the 200 Hall evening shift (2pm-10pm) was staffed with 2 CNas, a nurse and two medication aides-one split between 100/200(left) and one split between200 right/300/400, 2 nurses split between 100/200(left) 200/300/400 (right). Further review stated 200 Hall secure unit, long-term stay, required two CNas all shifts. Record review of the DON's job description revealed : Summary/Objective In keeping with our organization's goals, the primary purpose of the Director of Nursing is to plan, organize, develop, and direct the overall operation of our Nursing Department. Success in this position is measured by compliance with current federal, state, and local standards, guidelines, and regulations that govern the facility. Additionally, success is measured through patient quality outcomes, staff retention, and staff education/performance. Assist in calculating the number of direct nursing care personnel on duty each shift and determine the staffing needs of the nursing service department necessary to meet the total nursing needs of the residents as well as report such information to ensure that accurate staffing information is achieved and communicated. Monitor absenteeism to ensure that an adequate number of nursing care personnel are on duty at all times. An IJ was identified on 9/27/2024 at 4:24 p.m. The IJ template and Plan of removal were provided to the Administrator via email at 4:28 p.m. The following Plan of Removal was submitted by the facility and was accepted on 9/28/2024 at 10:42 a.m. and indicated the following: Plan of Removal F-725 On 9/27/24 The DON verified the current number of staff on the secure unit to assure sufficient staffing for the evening shift. At least two staff members will be present at all times. The completion date is 9/27/24. The DON reviewed the staffing schedule for the next 7 days to assure staffing is adequate. Ensuring at least two staff members are available on the secure unit. The completion date is 9/27/24. The DON/Designee will In-Service all nursing staff on attendance policy including adhering to the schedule. - Staff absent at the time of In-Service will receive in-service prior to start of their shift. The attendance policy states: (continued on next page)

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