STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495391	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenburnie Rehab & Nursing Center	1901 Libbie Ave Richmond, VA 23226

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 27660 Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to notify the physician and responsible party that a medication was not available for administration for one of ten residents in the survey sample, Resident #2. The findings include: For Resident #2, the facility staff failed to notify the physician and the responsible party when Flonase was not available for administration. The physician order dated, 12/17/24, documented, Flonase Allergy Relief Nasal Suspension 50 MCG/ACT (micrograms per activation) (Fluticasone Propionate) 2 sprays in each nostril one time a day for nasal. The January 2025 MAR (medication administration record) documented the above order. On 1/12/25 and 1/13/25 a 9 was documented in the space for administration. A 9 indicates Other/ See progress notes. On 1/14/25, the block for documenting the administration of the medication was blank. 1/12/25 at 3:15 p.m. The nurse's notes documented, Medication has been ordered. 1/13/25 at 3:15 p.m. The nurse's note documented, Medication has been ordered, pharmacy has been called. The list of over-the-counter medications stocked in the facility, provided by the facility, documented, Flonase . 34 oz (ounces). (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 10:44 a.m. An interview was conducted with LPN (licensed practical nurse) #6, LPN #6 stated if a medication is not available on the medication cart, she looks for it in other places, like another medication cart, medication room. She then checks the (back up pharmacy system) in the house. If it's still not available, she calls the pharmacy. When asked if the medication is a stock over the counter medication, LPN #6 stated the nurse should check the medication room, where they are stocked, if not there you contact (name of central supply staff member). He goes upstairs and gets the over-the-counter medications for you. LPN #6 stated, over the counter medications shouldn't have documented, waiting for pharmacy. She stated worst case scenario, you call the local pharmacy and get it delivered. She stated the nurse should contact the doctor and the responsible party if the medication is not administered and that should be documented in a progress note. The facility policy, Medication Unavailability documented in part, 1. A licensed nurse will notify the provider of the unavailability of medication and discuss an alternative order, if necessary. 2. If alternate medication is ordered and is not available, the licensed nurse will activate the backup pharmacy process and procedures. 3. A licensed nurse will document notification of the provider of the unavailability in the medical record. A licensed nurse will notify the responsible party of any new orders and document notification in the medical record. ASM (administrative staff member) #1, the administrator, ASM #2, ASM #3, the regional director of clinical services, and ASM #4, the medical director, were made aware of the above findings on 1/16/25 at 12:36 p.m. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 42106 Based on staff interview, clinical record review and facility document review, it was determined that the facility failed to protect two of ten residents in the survey sample from verbal abuse by a staff member, Residents #9 and #10. The findings include: For Resident #9 (R9) and Resident #10 (R10), the facility staff failed to ensure that they were free from verbal abuse from LPN (licensed practical nurse) #11 on 12/14/24. Review of a facility synopsis of events dated 12/14/24 documented in part, Residents involved: [Name of Resident #4, #9 and #10] .Supervisor reported employee [Name of LPN #11]. Supervisor stated that [Name of LPN #11] arrived to work and presented as belligerent and intoxicated. The nurse was observed screaming at the above residents, and when he was asked to leave the building, he mentioned that he had over medicated resident [Name of Resident #4] . Employee action initiated or taken: Employee was immediately removed from property and suspended pending investigation. The police was called to report the incident and for assistance with removing the employee from the property . The final investigation for the event dated 12/19/24 documented in part, .It was observed that employee [Name of LPN #11] arrived at work seemingly intoxicated and was overtly belligerent. He was not scheduled to work; he reported to supervisor [Name of LPN #12] that he came in to complete documentation. The supervisor observed him being verbally abusive to residents [Name of Resident #10 and Resident #9] as they were sitting in front of the nurse's station. The supervisor reported the following statement, I called the police to have him physically taken off the property. He became volatile, threatened me and was put in a [Name of ride share service]. He then called the building to make more threats to me. Before he left, he said he over medicated a resident, so we will need to give her something to wake her up. The resident in question is [Name of R4] The residents' vitals were immediately taken, and the MD was notified, the resident was stable and being closely monitored. Upon notifying the family, they made the decision to take the resident to the emergency room for further evaluation and has not returned to facility. [Name of LPN #11] did not issue any medication at the time of the incident. [Name of LPN #11] was referencing his shift from the previous night (3p-11p). [Name of LPN #11] declined to provide a statement of events. Residents involved in the accusation of verbal abuse are unable to be interviewed regarding the incident due to low BIMS scores, neither resident recalled the incident. Center staff interviewed other residents around the incident, residents do not recall hearing the employee verbally berate residents in question. Staff interviews corroborate the supervisors' report of incident. Resident [Name of R4] was unable to be interviewed at the time of the incident and is no longer at the facility. Police investigation is ongoing. Based on the investigative findings, the incident regarding inappropriate staff behavior and verbal abuse towards residents was determined to be substantiated based on employee interviews. In regard to the allegation of over-use of medication, the incident is unsubstantiated due to lack of supporting evidence. In immediate response to the report, the employee was terminated from the facility, a police report was filed regarding the incident . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The witness statements regarding the incident documented a statement dated 12/14/24 at 1:15 p.m. signed by RN (registered nurse) #2 which documented in part, .Did you witness the incident involved? Yes. If yes, where were you relative to the incident? Nurses station. What did you observe? (Please include everything you saw, heard, and any other individuals involved.) I observed [Name of LPN #11] walk around the nurse's station yelling and cursing at the nurses & residents. He said he would kick [Name of Resident #9]. I made the supervisor aware that he is intoxicated . A witness statement dated 12/14/24 at 10:12 a.m. signed by OSM (other staff member) #1 documented in part, .Did you witness the incident involved? Yes. If yes, where were you relative to the incident? Behind the nurse's station. What did you observe? (Please include everything you saw, heard, and any other individuals involved.) I observed [Name of LPN #11] the nursing [sic] cursing, shouting and threatening a patient. He said if you take your brief off again, I'm going to [expletive] you up. Don't play with me, God doesn't even want you here. I also heard him say you guys have to give her something to wake her up, because I [expletive] sure put her down last night. Name(s) of resident(s) involved: [Name of Resident #4 and Resident #9] . Included in the facility synopsis of event folder included a primary source license verification dated 10/9/24 for LPN #11 which documented an active license with no additional public information, a criminal background check from the Virginia State Police dated 10/9/24 which documented Researching under the status, a report submitted by the facility to the Department of Health Professions regarding the incident, a copy of resident rights signed by LPN #11 on 10/7/24, a sworn statement for LPN #11 dated 10/7/24 which documented prior non-barrier crimes. Review of the completed Virginia State Police background check for LPN #11 documented no barrier crimes. On R9's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/20/24, the resident scored six out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were severely impaired for making daily decisions. On 1/16/25 at 8:37 a.m., an interview was conducted with R9 who stated that they did not recall the incident. The comprehensive care plan for R9 failed to evidence a review or revision regarding the verbal abuse incident. The assessments for R9 evidenced an admission trauma screen completed on 12/16/24 which documented no reported trauma. The progress notes for R9 failed to evidence documentation regarding the verbal abuse incident. On R10's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/16/24, the resident scored nine out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were moderately impaired for making daily decisions. On 1/16/25 at 8:42 a.m., an interview was conducted with R10 who stated that they did not recall the incident. The comprehensive care plan for R10 failed to evidence a review or revision regarding the verbal abuse incident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assessments for R10 failed to evidence a trauma screen or social service assessment completed after the verbal abuse incident on 12/14/24. An admission trauma assessment completed prior to the incident on 12/13/24 and a re-admission trauma screen dated 1/2/25 documented no trauma reported. The progress notes for R10 failed to evidence documentation regarding the verbal abuse incident. On 1/15/25 at 4:04 p.m., ASM (administrative staff member) #2, the director of nursing stated that LPN #12 and RN #2 no longer worked at the facility and could not be interviewed. LPN #11 had been terminated on 12/14/24 and was not able to be interviewed. On 1/15/25 at 2:42 p.m., an interview was conducted with LPN #1. LPN #1 stated that she was working on 12/14/24 and heard LPN #11 yelling at the residents. She stated that everyone did. She stated that LPN #11 was not working and had come into the building wearing scrubs but was not scheduled to work. She stated that no one had gotten report from him or counted a medication cart with him, and she didn't not know why he came in. She stated that supervisor had taken over the situation and she did not know what had happened after that. On 1/15/25 at 4:53 p.m., an interview was conducted with OSM #1, transportation. OSM #1 stated that he was on the unit to pick up a resident to take upstairs for dialysis when the incident happened. He stated that he didn't recall word for word what LPN #11 had said to the resident, but he had written a statement up that day. OSM #1 stated that LPN #11 was yelling and cursing when he came through the door and yelling at the resident at the nurse's station. He stated that LPN #11 told them that they needed to give the female resident something to wake her up because he had given them something the night before to put them down. He stated that the supervisor had taken over the situation and he had continued taking his resident up to dialysis and when he came back down LPN #11 was arguing with the supervisor about a backpack. On 1/16/25 at 8:50 a.m., an interview was conducted with OSM #4, the assistant director of social services. OSM #4 stated that when an abuse situation happened, social services went in to interview the resident to get their side of what happened. She stated that if the resident were cognitively impaired, they interviewed any witnesses, but they still checked in with the resident to make sure they were okay. She stated that they did a trauma screen and care plan review to add any new intervention if needed. She stated that any follow up after that depended on the resident and how they were doing. OSM #4 stated that if the resident stated that they were fine they only followed up as needed and offered them psychiatry if they wanted it. She stated that social services followed both R9 and R10 regularly to make sure they were doing okay and the documentation of their follow up would be in the psychosocial and trauma assessments. On 1/16/25 at 9:08 a.m., an interview was conducted with CNA (certified nursing assistant) #1 who stated that if they witnessed a staff member yelling at a resident, they would inform the nurse and try to get someone to help. She stated that this was done because someone could get hurt and it could be considered abuse. On 1/16/25 at 10:54 a.m., an interview was conducted with ASM #2, the director of nursing who stated that the verbal abuse incident happened over the weekend and LPN #12 had called them to report the incident. He stated that he and the administrator had both come to the facility to start questioning staff and residents. He stated that typically social services would follow up with the residents involved to do a trauma screen to make sure they were okay and review the care plan. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 11:33 a.m., an interview was conducted with ASM #1, the administrator who stated that the supervisor at the time had called her that morning to inform her about LPN #11 being in the facility. She stated that she was informed that LPN #11 had come in without being on the schedule to work and stated that he was there to complete some unfinished documentation from the previous shift. She stated that LPN #11 had presented intoxicated, and the staff had observed him verbally berating the named residents. She stated that when the supervisor tried to escort him out, he would not leave so they had called the police to take him out of facility. She stated that she had advised the supervisor to get witness statements from the staff regarding LPN #11's behavior and what he was doing. She stated that for Resident #9 and #10, they had interviewed the resident that morning and they did not recall the incident. She stated that social services followed both residents who were still at the facility and should have completed a trauma screen and psychosocial assessment after the incident. ASM #1 stated that LPN #12 was supposed to write a witness statement but had abruptly resigned that same day and they were not able to get her statement prior to her leaving the building. The facility provided policy, Abuse/Neglect/Misappropriation/Crime effective 10/17/23 documented in part, . Patients of the Center have the legal right to be free from verbal, sexual, mental, and physical abuse, corporal punishment, involuntary seclusion including abuse facilitated or enabled through the use of technology, and free from chemical and physical restraints except in an emergency and/or as authorized in writing by a physician . On 1/16/25 at 12:39 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the findings. No further information was presented prior to exit.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 42106 Based on staff interview, clinical record review and facility document review, it was determined that the facility failed to implement their abuse policy to protect two of ten residents in the survey sample from verbal abuse by a staff member, Residents #9 and #10. The findings include: For Resident #9 (R9) and Resident #10 (R10), the facility staff failed to implement their abuse policy to ensure that they were free from verbal abuse from LPN (licensed practical nurse) #11 on 12/14/24. Review of a facility synopsis of events dated 12/14/24 documented in part, Residents involved: [Name of Resident #4, #9, and #10] .Supervisor reported employee [Name of LPN #11]. Supervisor stated that [Name of LPN #11] arrived to work and presented as belligerent and intoxicated. The nurse was observed screaming at the above residents, and when he was asked to leave the building, he mentioned that he had over medicated resident [Name of Resident #4] . Employee action initiated or taken: Employee was immediately removed from property and suspended pending investigation. The police was called to report the incident and for assistance with removing the employee from the property . The final investigation for the event dated 12/19/24 documented in part, .It was observed that employee [Name of LPN #11] arrived at work seemingly intoxicated and was overtly belligerent. He was not scheduled to work; he reported to supervisor [Name of LPN #12] that he came in to complete documentation. The supervisor observed him being verbally abusive to residents [Name of Resident #10 and Resident #9] as they were sitting in front of the nurse's station. The supervisor reported the following statement, I called the police to have him physically taken off the property. He became volatile, threatened me and was put in a [Name of ride share service]. He then called the building to make more threats to me. Before he left, he said he over medicated a resident, so we will need to give her something to wake her up The resident in question is [R4's Name redacted]. The residents' vitals were immediately taken, and the MD was notified, the resident was stable and being closely monitored. Upon notifying the family, they made the decision to take the resident to the emergency room for further evaluation and has not returned to facility. [Name of LPN #11] did not issue any medication at the time of the incident. [Name of LPN #11] was referencing his shift from the previous night (3p-11p). [Name of LPN #11] declined to provide a statement of events. Residents involved in the accusation of verbal abuse are unable to be interviewed regarding the incident due to low BIMS scores, neither resident recalled the incident. Center staff interviewed other residents around the incident, residents do not recall hearing the employee verbally berate residents in question. Staff interviews corroborate the supervisors' report of incident. Resident [Name of R4] was unable to be interviewed at the time of the incident and is no longer at the facility. Police investigation is ongoing. Based on the investigative findings, the incident regarding inappropriate staff behavior and verbal abuse towards residents was determined to be substantiated based on employee interviews. In regard to the allegation of over-use of medication, the incident is unsubstantiated due to lack of supporting evidence. In immediate response to the report, the employee was terminated from the facility, a police report was filed regarding the incident . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The witness statements regarding the incident documented a statement dated 12/14/24 at 1:15 p.m. signed by RN (registered nurse) #2 which documented in part, .Did you witness the incident involved? Yes. If yes, where were you relative to the incident? Nurses station. What did you observe? (Please include everything you saw, heard, and any other individuals involved.) I observed [Name of LPN #11] walk around the nurse's station yelling and cursing at the nurses & residents. He said he would kick [Name of Resident #9]. I made the supervisor aware that he is intoxicated . A witness statement dated 12/14/24 at 10:12 a.m. signed by OSM (other staff member) #1 documented in part, .Did you witness the incident involved? Yes. If yes, where were you relative to the incident? Behind the nurse's station. What did you observe? (Please include everything you saw, heard, and any other individuals involved.) I observed [Name of LPN #11] the nursing [sic] cursing, shouting and threatening a patient. He said if you take your brief off again, I'm going to [expletive] you up. Don't play with me, God doesn't even want you here. I also heard him say you guys have to give her something to wake her up, because I [expletive] sure put her down last night. Name(s) of resident(s) involved: [Name of Resident #4 and Resident #9] . Included in the facility synopsis of event folder included a primary source license verification dated 10/9/24 for LPN #11 which documented an active license with no additional public information, a criminal background check from the Virginia State Police dated 10/9/24 which documented Researching under the status, a report submitted by the facility to the Department of Health Professions regarding the incident, a copy of resident rights signed by LPN #11 on 10/7/24, a sworn statement for LPN #11 dated 10/7/24 which documented prior non-barrier crimes. Review of the completed Virginia State Police background check for LPN #11 documented no barrier crimes. On R9's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/20/24, the resident scored 6 out of 15 on the BIMS (brief interview for mental status) assessment, indicating R9 was severely impaired for making daily decisions. On 1/16/25 at 8:37 a.m., an interview was conducted with R9 who stated that they did not recall the incident. The comprehensive care plan for R9 failed to evidence anything regarding the verbal abuse incident. The assessments for R9 evidenced an admission trauma screen completed on 12/16/24 which documented no reported trauma. The progress notes for R9 failed to evidence documentation regarding the verbal abuse incident. On R10's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/16/24, the resident scored 9 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were moderately impaired for making daily decisions. On 1/16/25 at 8:42 a.m., an interview was conducted with R10 who stated that they did not recall the incident. The comprehensive care plan for R10 failed to evidence anything regarding the verbal abuse incident. The assessments for R10 failed to evidence a trauma screen or social service assessment completed after the verbal abuse incident on 12/14/24. A re-admission trauma screen dated 1/2/25 documented no trauma reported. The progress notes for R10 failed to evidence documentation regarding the verbal abuse incident. On 1/15/25 at 4:04 p.m., ASM (administrative staff member) #2, the director of nursing stated that LPN #12 and RN #2 no longer worked at the facility and could not be interviewed. LPN #11 had been terminated on 12/14/24 and was not able to be interviewed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 2:42 p.m., an interview was conducted with LPN #1. LPN #1 stated that she was working on 12/14/24 and heard LPN #11 yelling at the residents. She stated that everyone did. She stated that LPN #11 was not working and had come into the building wearing scrubs but was not scheduled to work. She stated that no one had gotten report from him or counted a medication cart with him, and she didn't not know why he came in. She stated that supervisor had taken over the situation and she did not know what had happened after that. On 1/15/25 at 4:53 p.m., an interview was conducted with OSM #1, transportation. OSM #1 stated that he was on the unit to pick up a resident to take upstairs for dialysis when the incident happened. He stated that he didn't recall word for word what LPN #11 had said to the resident, but he had written a statement up that day. OSM #1 stated that LPN #11 was yelling and cursing when he came through the door and yelling at the resident at the nurse's station. He stated that LPN #11 told them that they needed to give the female resident something to wake her up because he had given them something the night before to put them down. He stated that the supervisor had taken over the situation and he had continued taking his resident up to dialysis and when he came back down LPN #11 was arguing with the supervisor about a backpack. On 1/16/25 at 9:08 a.m., an interview was conducted with CNA (certified nursing assistant) #1 who stated that if they witnessed a staff member yelling at a resident, they would inform the nurse and try to get someone to help. She stated that this was done because someone could get hurt and it could be considered abuse. On 1/16/25 at 11:33 a.m., an interview was conducted with ASM #1, the administrator who stated that the supervisor at the time had called her that morning to inform her about LPN #11 being in the facility. She stated that she was informed that LPN #11 had come in without being on the schedule to work and stated that he was there to complete some unfinished documentation from the previous shift. She stated that LPN #11 had presented intoxicated, and the staff had observed him verbally berating the named residents. She stated that when the supervisor tried to escort him out, he would not leave so they had called the police to take him out of facility. She stated that she had advised the supervisor to get witness statements from the staff regarding LPN #11's behavior and what he was doing. She stated that for Resident #9 and #10, they had interviewed the resident that morning and they did not recall the incident. She stated that social services followed both residents who were still at the facility and should have completed a trauma screen and psychosocial assessment after the incident. ASM #1 stated that LPN #12 was supposed to write a witness statement but had abruptly resigned that same day and they were not able to get her statement prior to her leaving the building. The facility provided policy, Abuse/Neglect/Misappropriation/Crime effective 10/17/23 documented in part, . Patients of the Center have the legal right to be free from verbal, sexual, mental, and physical abuse, corporal punishment, involuntary seclusion including abuse facilitated or enabled through the use of technology, and free from chemical and physical restraints except in an emergency and/or as authorized in writing by a physician . The facility provided policy, Responding to Abuse/Neglect/Misappropriation/Crime effective 1/29/24 documented in part, . In response to all allegations of neglect, abuse, injuries of unknown source, mistreatment, exploitation, misappropriation of patient property, or crime against a patient, a licensed nurse will assure patient safety. The accused employee, visitor, or other patient will be removed from the area immediately. A licensed nurse will closely monitor and thoroughly document the behavior and condition of the patient(s) involved . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenburnie Rehab & Nursing Center	1901 Libbie Ave Richmond, VA 23226

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 12:39 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the findings. No further information was presented prior to exit.

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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** 42106 Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to evidence a complete investigation into an elopement for one of 10 residents in the survey sample, Resident #5. The findings include: For Resident #5 (R5), the facility staff failed to evidence a complete and thorough investigation of an elopement on 9/30/24. Review of a facility synopsis of events dated 9/30/24 for R5 documented in part, .Resident exited facility without supervision. Resident has been returned to the facility at this time without injury . The investigation folder contained an investigation summary dated 9/30/24 which documented in part, .Investigation Findings: Resident had been walking throughout the facility without incident at various times during the day and evening. During rounding, staff identified that they were unable to locate [Name of R5]. Resident was located outside of the facility and returned. Social Services continue to follow residents as indicated. Pain and skin assessments were completed with no concerns noted. Based on the investigative findings, the incident of Resident Elopement is substantiated. We will continue to keep all our residents free from harm and abuse. We will continue our abuse prevention and investigation program, and abuse education will be ongoing. Please accept this as our final on this event. If you have any questions, please contact me. [Name of former director of nursing, Facility Name]. The investigation folder contained hand-written statements from staff stating the last time they saw R5 or that they had not seen R5 during their shift. The folder failed to evidence any documentation regarding the status or function of R5's wander guard at the time of the incident, the door alarms at the time of the incident or if any staff heard the door alarms sounding at the time of the incident. On the most recent MDS (minimum data set), a five-day assessment with an ARD (assessment reference date) of 10/2/24, the resident scored two out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were severely impaired for making daily decisions. R5 was assessed as having wandering behaviors. R5 was admitted to the facility on [DATE]. The progress notes for R5 documented in part, - 9/26/24 07:02 (7:02 a.m.) Type of Behavior: Resident wandering all shift into rooms on unit, resident wandered onto roommates' side of the room. Non-pharmacological Intervention: Resident redirected multiple times, attempted to give resident an activity at nurse's station. Effect: Not effective, resident continued to wander into rooms. PRN (as needed) Medication: Seroquel administered. Outcome: Resident continues to wander around unit. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 9/30/24 23:41 (11:41 p.m.) Writer informed by sister that EMS (emergency medical services) notified her and informed her that resident observed sitting on the curb on [NAME] Ave. 97.8 (temperature), 67 (pulse), 20 (respirations), 116/52 (blood pressure), O2 (oxygen) sats (saturations) 97% ora (on room air), resident transported back to facility by EMS. The progress notes for R5 documented private one on one sitter care after the elopement on 9/30/24 until discharge from the facility to a memory care facility on 10/7/24. The progress notes failed to evidence any further elopements for R5 other than the 9/30/24 incident. The physician orders for R5 documented a wander guard ordered on 9/26/24 with placement to be checked every shift and function to be checked every night shift. The eTAR (electronic treatment administration record) for R5 dated 9/1/24-9/30/24 documented the wander guard with an expiration date of 6/25 initially placed on 9/26/24 with function checked every night shift from 9/26-9/29/24. It further documented another wander guard with an expiration date of 6/25 placed on 9/30/24. It documented the placement of the wander guard checked every shift. An elopement assessment for R5 dated 9/26/24 documented a high risk for elopement/exit seeking. The comprehensive care plan for R5 documented in part, The resident is at risk for elopement related to impaired cognition, wandering and history of elopement. Created on: 09/26/2024. Revision on: 10/11/2024. Under Interventions it documented in part, wanderguard. Created on: 09/27/2024. Revision on: 10/11/2024 . Review of the maintenance logs for daily testing of the wander guard system documented the doors functioning as designed on 9/30/24 at 10:20 a.m. Testing of the wander guard system was completed with OSM (other staff member) #3, director of maintenance on 1/15/25 at 4:35 p.m. revealed all doors functioning as designed with the wander guard device in the radius of the alarm. On 1/16/25 at 10:54 a.m., an interview was conducted with ASM (administrative staff member) #2 who stated that they were not working at the time of R5's elopement. When asked the process for investigation of an elopement, ASM #2 stated that he would interview staff to determine the last time the resident was seen, check the BIMS score to determine if the resident may have signed themselves out, search for the resident, notify the physician, responsible party, police and authorities. He stated that when the resident was located, they brought them back to the facility and completed a full assessment on them. He stated that if the resident had a wander guard on at the time of the elopement it should be checked to see if it was still on, if it was working and make sure that it caused the door alarms to sound. ASM #2 stated that based on the facility policy the staff should be checking the wander guard periodically to make sure it was functioning. ASM #2 reviewed the facility synopsis of events for R5's elopement on 9/30/24 and stated that if they had a wander guard at the time of the elopement there should have been checks on the function and checks on the doors included in the investigation because it was part of the root cause of why they got out of the building and how they got past the door. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 11:33 a.m., an interview was conducted with ASM #1, the administrator. ASM #1 stated that they remembered the elopement with R5. She stated that the staff had called an elopement code, notified the former director of nursing and assistant director of nursing. She stated that by the time they arrived at the facility R5 was already back at the facility. ASM #1 stated that the former director of nursing had completed the investigation into the elopement, and they had determined that R5's wander guard had stopped working. She stated that R5 still had the wander guard on when he returned but it was not working and had not set the alarms off. She stated that they had applied a new wander guard that night and checked it at the doors to make sure it was working correctly. She stated that the investigation should have included that information. The facility provided policy, Abuse/Neglect/Misappropriation/Crime effective 10/17/23 documented in part, . The Administrator and/or Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigative protocol will include, but not be limited to, collecting evidence, interviewing alleged victims and witnesses, and involving other appropriate individuals, agents, or authorities to assist in the process and determinations .The written follow-up investigative reporting document that is submitted must contain sufficient detail to demonstrate that a thorough investigation was conducted . On 1/3/25 at 12:09 p.m., ASM #1, interim administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, regional vice president of operations, and ASM #5, regional director of clinical services were made aware of the findings. No further information was presented prior to exit.

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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 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. 42106 Based on clinical record review, staff interview and facility document review, it was determined that the facility failed to review and/or revise the comprehensive care plan for two of ten residents in the survey sample, Residents #9 and #10. The findings include: 1. For Resident #9 (R9), the facility staff failed to review and revise the care plan as needed after a verbal abuse incident on 12/14/24. Review of a facility synopsis of events dated 12/14/24 for R9 documented in part, Residents involved: [Name of Resident #4, #9 and #10] .Supervisor reported employee [Name of LPN #11]. Supervisor stated that [Name of LPN #11] arrived to work and presented as belligerent and intoxicated. The nurse was observed screaming at the above residents, and when he was asked to leave the building, he mentioned that he had over medicated resident [Name of Resident #4] . Employee action initiated or taken: Employee was immediately removed from property and suspended pending investigation. The police was called to report the incident and for assistance with removing the employee from the property . The final investigation for the event dated 12/19/24 documented in part, .It was observed that employee [Name of LPN #11] arrived at work seemingly intoxicated and was overtly belligerent. He was not scheduled to work; he reported to supervisor [Name of LPN #12] that he came in to complete documentation. The supervisor observed him being verbally abusive to residents [Name of Resident #10 and Resident #9] as they were sitting in front of the nurse's station. The supervisor reported the following statement, I called the police to have him physically taken off the property. He became volatile, threatened me and was put in a [Name of ride share service]. He then called the building to make more threats to me. Before he left, he said he over medicated a resident, so we will need to give her something to wake her up. The resident in question is [Name of R4] The residents' vitals were immediately taken, and the MD was notified, the resident was stable and being closely monitored. Upon notifying the family, they made the decision to take the resident to the emergency room for further evaluation and has not returned to facility. [Name of LPN #11] did not issue any medication at the time of the incident. [Name of LPN #11] was referencing his shift from the previous night (3p-11p). [Name of LPN #11] declined to provide a statement of events. Residents involved in the accusation of verbal abuse are unable to be interviewed regarding the incident due to low BIMS scores, neither resident recalled the incident. Center staff interviewed other residents around the incident, residents do not recall hearing the employee verbally berate residents in question. Staff interviews corroborate the supervisors' report of incident. Resident [Name of R4] was unable to be interviewed at the time of the incident and is no longer at the facility. Police investigation is ongoing. Based on the investigative findings, the incident regarding inappropriate staff behavior and verbal abuse towards residents was determined to be substantiated based on employee interviews. In regard to the allegation of over-use of medication, the incident is unsubstantiated due to lack of supporting evidence. In immediate response to the report, the employee was terminated from the facility, a police report was filed regarding the incident . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The witness statements regarding the incident documented a statement dated 12/14/24 at 1:15 p.m. signed by RN (registered nurse) #2 which documented in part, .Did you witness the incident involved? Yes. If yes, where were you relative to the incident? Nurses station. What did you observe? (Please include everything you saw, heard, and any other individuals involved.) I observed [Name of LPN #11] walk around the nurse's station yelling and cursing at the nurses & residents. He said he would kick [Name of Resident #9]. I made the supervisor aware that he is intoxicated . A witness statement dated 12/14/24 at 10:12 a.m. signed by OSM (other staff member) #1 documented in part, .Did you witness the incident involved? Yes. If yes, where were you relative to the incident? Behind the nurse's station. What did you observe? (Please include everything you saw, heard, and any other individuals involved.) I observed [Name of LPN #11] the nursing [sic] cursing, shouting and threatening a patient. He said if you take your brief off again, I'm going to [expletive] you up. Don't play with me, God doesn't even want you here. I also heard him say you guys have to give her something to wake her up, because I [expletive] sure put her down last night. Name(s) of resident(s) involved: [Name of Resident #4 and Resident #9] . On R9's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/20/24, the resident scored six out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were severely impaired for making daily decisions. The comprehensive care plan for R9 failed to evidence a review or revision regarding the verbal abuse incident. On 1/16/25 at 8:50 a.m., an interview was conducted with OSM #4, the assistant director of social services. OSM #4 stated that when an abuse situation happened, social services went in to interview the resident to get their side of what happened. She stated that if the resident were cognitively impaired, they interviewed any witnesses, but they still checked in with the resident to make sure they were okay. She stated that they did a trauma screen and care plan review to add any new intervention if needed. She stated that any follow up after that depended on the resident and how they were doing. OSM #4 stated that if the resident stated that they were fine they only followed up as needed and offered them psychiatry if they wanted it. She stated that social services followed R9 regularly to make sure they were doing okay and the documentation of their follow up would be in the psychosocial and trauma assessments. On 1/16/25 at 9:07 a.m., OSM #4 stated that she had reviewed R9's care plan and she had personally not made any revisions for the care plan. She stated that any revisions were made by the MDS nurse. On 1/16/25 at 9:15 a.m., an interview was conducted with LPN #5, MDS coordinator who stated that they normally did not review the care plans after an abuse incident, and it would be the nurse doing it at that moment. She stated that she thought that if a situation came up later after the event, then they would revise the care plan. On 1/16/25 at 10:30 a.m., an interview was conducted with LPN #6 who stated that the purpose of the care plan was basically to know what to do for the patient. She stated that the care plan was to show the services they were to provide for the resident, and everyone played a role in the care planning process. She stated that everything went on the care plan, good, bad and different. She stated that if the resident was a recipient of abuse, the care plan should be revised because everything needed to be documented, and the resident should be monitored afterwards. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 10:54 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing who stated that after the verbal abuse incident for R9, social services typically would do a trauma screen to make sure they were okay, and the care plan would be reviewed. The facility provided policy, Care Planning effective 11/01/2019 documented in part, .Care plans will be updated on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment . On 1/16/25 at 12:39 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the findings. No further information was presented prior to exit. 2. For Resident #10 (R10), the facility staff failed to review and revise the care plan as needed after a verbal abuse incident on 12/14/24. Review of a facility synopsis of events dated 12/14/24 for R10 documented in part, Residents involved: [Name of Resident #4, #9 and #10] .Supervisor reported employee [Name of LPN #11]. Supervisor stated that [Name of LPN #11] arrived to work and presented as belligerent and intoxicated. The nurse was observed screaming at the above residents, and when he was asked to leave the building, he mentioned that he had over medicated resident [Name of Resident #4] . Employee action initiated or taken: Employee was immediately removed from property and suspended pending investigation. The police was called to report the incident and for assistance with removing the employee from the property . The final investigation for the event dated 12/19/24 documented in part, .It was observed that employee [Name of LPN #11] arrived at work seemingly intoxicated and was overtly belligerent. He was not scheduled to work; he reported to supervisor [Name of LPN #12] that he came in to complete documentation. The supervisor observed him being verbally abusive to residents [Name of Resident #10 and Resident #9] as they were sitting in front of the nurse's station. The supervisor reported the following statement, I called the police to have him physically taken off the property. He became volatile, threatened me and was put in a [Name of ride share service]. He then called the building to make more threats to me. Before he left, he said he over medicated a resident, so we will need to give her something to wake her up. The resident in question is [Name of R4] The residents' vitals were immediately taken, and the MD was notified, the resident was stable and being closely monitored. Upon notifying the family, they made the decision to take the resident to the emergency room for further evaluation and has not returned to facility. [Name of LPN #11] did not issue any medication at the time of the incident. [Name of LPN #11] was referencing his shift from the previous night (3p-11p). [Name of LPN #11] declined to provide a statement of events. Residents involved in the accusation of verbal abuse are unable to be interviewed regarding the incident due to low BIMS scores, neither resident recalled the incident. Center staff interviewed other residents around the incident, residents do not recall hearing the employee verbally berate residents in question. Staff interviews corroborate the supervisors' report of incident. Resident [Name of R4] was unable to be interviewed at the time of the incident and is no longer at the facility. Police investigation is ongoing. Based on the investigative findings, the incident regarding inappropriate staff behavior and verbal abuse towards residents was determined to be substantiated based on employee interviews. In regard to the allegation of over-use of medication, the incident is unsubstantiated due to lack of supporting evidence. In immediate response to the report, the employee was terminated from the facility, a police report was filed regarding the incident . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The witness statements regarding the incident documented a statement dated 12/14/24 at 1:15 p.m. signed by RN (registered nurse) #2 which documented in part, .Did you witness the incident involved? Yes. If yes, where were you relative to the incident? Nurses station. What did you observe? (Please include everything you saw, heard, and any other individuals involved.) I observed [Name of LPN #11] walk around the nurse's station yelling and cursing at the nurses & residents. He said he would kick [Name of Resident #9]. I made the supervisor aware that he is intoxicated . A witness statement dated 12/14/24 at 10:12 a.m. signed by OSM (other staff member) #1 documented in part, .Did you witness the incident involved? Yes. If yes, where were you relative to the incident? Behind the nurse's station. What did you observe? (Please include everything you saw, heard, and any other individuals involved.) I observed [Name of LPN #11] the nursing [sic] cursing, shouting and threatening a patient. He said if you take your brief off again, I'm going to [expletive] you up. Don't play with me, God doesn't even want you here. I also heard him say you guys have to give her something to wake her up, because I [expletive] sure put her down last night. Name(s) of resident(s) involved: [Name of Resident #4 and Resident #9] . On R10's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/16/24, the resident scored nine out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were moderately impaired for making daily decisions. The comprehensive care plan for R10 failed to evidence a review or revision regarding the verbal abuse incident. On 1/16/25 at 8:50 a.m., an interview was conducted with OSM #4, the assistant director of social services. OSM #4 stated that when an abuse situation happened, social services went in to interview the resident to get their side of what happened. She stated that if the resident were cognitively impaired, they interviewed any witnesses, but they still checked in with the resident to make sure they were okay. She stated that they did a trauma screen and care plan review to add any new intervention if needed. She stated that any follow up after that depended on the resident and how they were doing. OSM #4 stated that if the resident stated that they were fine they only followed up as needed and offered them psychiatry if they wanted it. She stated that social services followed R10 regularly to make sure they were doing okay and the documentation of their follow up would be in the psychosocial and trauma assessments. On 1/16/25 at 9:07 a.m., OSM #4 stated that she had personally not made any revisions for the care plan. She stated that any revisions were made by the MDS nurse. On 1/16/25 at 9:15 a.m., an interview was conducted with LPN #5, MDS coordinator who stated that they normally did not review the care plans after an abuse incident, and it would be the nurse doing it at that moment. She stated that she thought that if a situation came up later after the event, then they would revise the care plan. On 1/16/25 at 10:30 a.m., an interview was conducted with LPN #6 who stated that the purpose of the care plan was basically to know what to do for the patient. She stated that the care plan was to show the services they were to provide for the resident, and everyone played a role in the care planning process. She stated that everything went on the care plan, good, bad and different. She stated that if the resident was a recipient of abuse, the care plan should be revised because everything needed to be documented, and the resident should be monitored afterwards. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 10:54 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing who stated that after the verbal abuse incident for R10, social services typically would do a trauma screen to make sure they were okay, and the care plan would be reviewed. On 1/16/25 at 12:39 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the findings. No further information was presented prior to exit.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 42106 Based on clinical record review, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide care and services to maintain a resident's highest level of well-being for one of 10 residents in the survey sample, Resident #4. The findings include: For Resident #4 (R4), the facility staff were made aware of a potential medication overdose on 12/14/24. The progress notes documented R4 being lethargic and responsive by sternal rub, however the nurse practitioner only gave telephone orders to continue to monitor the resident and the resident was taken to the emergency room via private vehicle at the family's discretion. On the most recent MDS (minimum data set), a five-day assessment with an ARD (assessment reference date) of 12/14/24, R4 scored 13 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were cognitively intact for making daily decisions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility synopsis of events dated 12/14/24 documented in part, Residents involved: [Name of Resident #4, #9 and #10] .Supervisor reported employee [Name of LPN #11]. Supervisor stated that [Name of LPN #11] arrived to work and presented as belligerent and intoxicated. The nurse was observed screaming at the above residents, and when he was asked to leave the building, he mentioned that he had over medicated resident [Name of Resident #4] . Employee action initiated or taken: Employee was immediately removed from property and suspended pending investigation. The police was called to report the incident and for assistance with removing the employee from the property . The final investigation for the event dated 12/19/24 documented in part, .It was observed that employee [Name of LPN #11] arrived at work seemingly intoxicated and was overtly belligerent. He was not scheduled to work; he reported to supervisor [Name of LPN #12] that he came in to complete documentation. The supervisor observed him being verbally abusive to residents [Name of Resident #10 and Resident #9] as they were sitting in front of the nurse's station. The supervisor reported the following statement, I called the police to have him physically taken off the property. He became volatile, threatened me and was put in a [Name of ride share service]. He then called the building to make more threats to me. Before he left, he said he over medicated a resident, so we will need to give her something to wake her up. The resident in question is [Name of R4] The residents' vitals were immediately taken, and the MD was notified, the resident was stable and being closely monitored. Upon notifying the family, they made the decision to take the resident to the emergency room for further evaluation and has not returned to facility. [Name of LPN #11] did not issue any medication at the time of the incident. [Name of LPN #11] was referencing his shift from the previous night (3p-11p). [Name of LPN #11] declined to provide a statement of events. Residents involved in the accusation of verbal abuse are unable to be interviewed regarding the incident due to low BIMS scores, neither resident recalled the incident. Center staff interviewed other residents around the incident, residents do not recall hearing the employee verbally berate residents in question. Staff interviews corroborate the supervisors' report of incident. Resident [Name of R4] was unable to be interviewed at the time of the incident and is no longer at the facility. Police investigation is ongoing. Based on the investigative findings, the incident regarding inappropriate staff behavior and verbal abuse towards residents was determined to be substantiated based on employee interviews. In regard to the allegation of over-use of medication, the incident is unsubstantiated due to lack of supporting evidence. In immediate response to the report, the employee was terminated from the facility, a police report was filed regarding the incident . The witness statements regarding the incident documented a statement dated 12/14/24 at 10:12 a.m. signed by OSM (other staff member) #1 documented in part, .Did you witness the incident involved? Yes. If yes, where were you relative to the incident? Behind the nurse's station. What did you observe? (Please include everything you saw, heard, and any other individuals involved.) I observed [Name of LPN #11] the nursing [sic] cursing, shouting and threatening a patient. He said if you take your brief off again, I'm going to [expletive] you up. Don't play with me, God doesn't even want you here. I also heard him say you guys have to give her something to wake her up, because I [expletive] sure put her down last night. Name(s) of resident(s) involved: [Name of Resident #4 and Resident #9] . The progress notes for R4 documented in part, - 12/13/2024 21:15 (9:15 p.m.) .Skilled Nursing Focus: Resident A&O x1 and confused. No distress/pain noted. No SOB (shortness of breath) noted. All scheduled meds accepted and tolerated without incident. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenburnie Rehab & Nursing Center	1901 Libbie Ave Richmond, VA 23226

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 12/14/2024 10:55 (10:55 a.m.) Note Text: Resident noted more lethargic, am (morning) medications held. np (nurse practitioner) aware. - 12/14/2024 10:57 (10:57 a.m.) .Other change in condition . Mental Status Evaluation: Unresponsiveness; - Functional Status Evaluation: Decreased mobility . Nursing observations, evaluation, and recommendations are Resident observed sitting in chair arousal with sternal rubs. vss (vital signs stable) . on call np [Name of NP] called. Will continue to monitor . - 12/14/2024 15:26 (3:26 p.m.) Note Text : Resident Sent Out to Hospital. - 12/14/2024 22:08 (10:08 p.m.) Note Text: This writer contacted [Name of hospital] for status update on resident. [Name of R4] was officially admitted with a diagnosis of elevated troponin levels as well as lethargy and elevated Lactic acid levels. A hospital transfer form for R4 dated 12/14/24 at 12:18 p.m. documented the resident being transferred to the hospital due to lethargy. It documented a most recent blood pressure of 146/79 taken on 12/14/24 at 12:22 p.m., pulse of 76 taken on 12/14/24 at 4:23 p.m. and oxygen saturation of 97% taken on 12/14/24 at 4:24 p.m. Review of the eMAR (electronic medication administration record) for R4 dated 12/1/24-12/31/24 failed to evidence documentation of any medications administered to R4 on 12/14/24. The eMAR documented no medications administered by LPN #11. It further documented the last medications administered to R4 being Acetaminophen 650mg (1), Metoprolol tartrate 25mg (2), and Docusate sodium 100mg (3) given by mouth on 12/13/24 at 5:00 p.m. On 1/15/25 at 4:04 p.m., ASM (administrative staff member) #2, the director of nursing stated that LPN #12 and the on-call nurse practitioner from 12/14/24 no longer worked at the facility and could not be interviewed. LPN #11 had been terminated on 12/14/24 and was not able to be interviewed. On 1/15/25 at 2:42 p.m., an interview was conducted with LPN #1 who stated that they were caring for R4 on 12/14/24 when they went to the hospital. She stated that LPN #12 had taken over the situation with LPN #11, but she had heard him yelling at the residents and stating that he had medicated R4. LPN #1 stated that R4 was sitting at the nurse's station in a high back chair, and they were monitoring her for changes. She stated that was the first time she had worked with R4, so she did not know what her baseline was, but she did not seem to be in any distress, she was just resting in the chair. She stated that when she went to give the medications, R4 seemed to be more out of it than normal and they had to do a sternal rub to get her to respond so she had held her morning medication and called the nurse practitioner to let her know. She stated that she could not remember why the nurse practitioner had only said to continue to monitor her at that time but thought that maybe she had explained the situation that the family was coming in to take the resident to the hospital due to the alleged overmedication. She stated that she thought that R4 went out before lunchtime and the family took them out in their personal vehicle, but she did not see them when they left. She stated that she probably should have documented the situation better about what she reported to the nurse practitioner, but she did remember that they had to do sternal rubs to get R4 to respond to them. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 4:08 p.m., an interview was conducted with LPN #3 who stated that they did not remember R4 but if there was a change in condition, they went to assess the resident and notified the physician or nurse practitioner. She stated that if the resident was only responsive with a sternal rub, they needed urgent attention, that the code status should be checked and 911 should be called to get them out as soon as possible. She stated that if the physician or nurse practitioner gave them recommendations that she did not agree with she would tell them what she felt needed to be done, that she had to use her own judgement because it was her license she was working under. She stated that she did not have any issues with the providers not listening to her because they knew that she knew what was best for her residents. On 1/15/25 at 4:13 p.m., an interview was conducted with LPN #4 who stated that they cared for R4 during the night on 12/13-12/14/24. LPN #4 stated that R4 had been up in the geri-chair at the nurse's station for observation because she was a fall risk and had been agitated and confused so they were all watching her for safety. He stated that LPN #11 was working on another cart and was at the nurse's station a lot, but he did not witness him administer any medication to R4. LPN #4 stated that he had gone down the hall several times to administer medications to his other residents, so he did not have eyes on R4 the entire night, but he recalled that she slept soundly through the night and had not had any issues. He stated that he had clocked out and left the facility prior to LPN #11 returning to the facility and he did not notice any red flags or strange behavior from LPN #11 other than he would leave the floor often for long periods of time, but he did not see anything out of the ordinary. On 1/16/25 at 9:19 a.m., an interview was conducted with ASM #4, medical director. ASM #4 stated that they did not care for R4 at the facility however if a resident had a change in condition and was only responsive with a sternal rub that he would like to have some vital signs and obtain an assessment to get a better picture of what was going on. He stated that he would want to know what the baseline was, when the resident was last observed normal and if these were new symptoms. He stated if there was suspicion of an overdose there was Naloxone (Narcan) readily available at the nurse's station and may have been an option depending on the information available at the time. ASM #4 stated that as the medical director he was made aware of an incident with a nurse at the facility but not the specifics of which resident. He stated that aside from an overdose, if the resident was stable with vital signs but still only responsive with sternal rubs, they would still have to find out why they were unresponsive, and he certainly would not have stopped there because there were additional things that would have been done if the plan was to continue monitoring in the facility. Review of the facility in-house Omnicell stock medications documented a par level of 2 vials of Naloxone 0.4mg/ml stocked at the facility with 3 vials in stock. On 1/16/25 at 10:30 a.m., an interview was conducted with LPN #6 who stated that if there was a suspicion of an overdose and the resident was not responsive the procedure was to obtain vital signs, call 911 and send the resident out. She stated that Narcan was available in the Omnicell as needed, depending on the assessment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 10:54 a.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 stated that the incident with R4 happened over the weekend, and it was reported to them by telephone by the former supervisor. He stated that initially he was told that it was an altercation between the supervisor and the nurse and then he was told that the nurse had stated that he had overmedicated the resident, and he had gotten involved. ASM #2 stated that he came to the facility to start questioning staff and residents. He stated that R4 had already left for the hospital when he arrived, so he had reviewed the chart, medication list, medication cart and narcotic count sheets. He stated that he had spoken with R4's family by telephone and the nurse at the hospital who advised that they suspected a heart attack. ASM #2 stated that as a nurse advocate for the resident, if the resident was unresponsive and only arousable with a sternal rub, that something additional needed to be done for the resident. He stated that if the resident was going to stay in the facility there were additional things they could do to reverse it, like fluids, labs or something to make a clear determination of what is going on for the patient. He stated at the end of the day if the nurse had any reservations about the decision that the physician or nurse practitioner made, they could call him or the medical director to discuss because the patient was the one that they needed to take care of. He stated that he didn't think that anyone thought about Narcan because there was questions to what medication could have been given and no missing medications. He stated that when he came in, he was told that the family had taken R4 out by car to the emergency room . On 1/16/25 at 11:33 a.m., an interview was conducted with ASM #1, administrator who stated that the former supervisor had called them that morning to advise them of the incident between them and the former nurse. She stated that she had come in to the facility to start the investigation into the oversedation of R4. She stated that R4 had already left to go to the hospital when she arrived at the facility, and she was told by the former supervisor that the vital signs were stable, and the resident was stable when they left the facility with the family. She stated that she was not made aware that R4 was unresponsive and only responsive to sternal rubs at any time prior to them going to the emergency room . On 1/16/25 at 11:58 a.m., an interview was conducted with OSM (other staff member) #5, admissions coordinator. OSM #5 stated that she came to the facility when she was called about the incident that morning between 8:30 a.m. to 9:00 a.m. She stated that she saw R4 sitting in the hallway near the nurse's station with their family member at the bedside feeding them. She stated that R4 was alert and responsive then. The facility policy, .Potentially life-threatening conditions require nursing assessment critical thinking skills to determine whether a patient should be transferred to an acute care setting. The most appropriate transportation mode will be arranged in the event a decision is made to transfer a patient who requires health care services in an acute care setting. This decision will be made by a licensed nurse when the patient's condition is so acute that time does not permit waiting for provider's response . On 1/16/25 at 12:39 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit. Reference: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for 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** 27660 Based on resident interview, staff interview, and clinical record review, it was determined the facility staff failed to provide supervision to protect one of ten residents from a fire on 1/1/2025. The findings include: For Resident #1 (R1), the facility staff failed to put in interventions to prevent a fire. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 11/20/24, the resident scored a four out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired for making daily decisions. On 1/15/25 at 10:05 a.m. An observation was made of (R1) He was sitting on the side of his bed, when asked if there had been a fire in his room recently, the resident stated, That wasn't me in that other room. The resident could not recall there being a fire in his room. On 1/15/25 at 10:15 a.m., An interview was conducted with Resident #2 (R2), R2 explained how he had been at the nurse's station attempting to call his wife on the phone. He gave up after a few tries and returned to his room. When he entered his room, he noted the end of his bed, the mattress was on fire. He stated he grabbed the sheets and balled them up and put the fire out. On the most recent MDS, an admission assessment, with an ARD of 12/22/24, the resident scored a 15 out of 15, indicating the resident was not cognitively impaired for making daily decisions. On 1/15/25 at 11:27 a.m. An observation was made of R1 ambulating in the hall, going past the main entrance door. Pleasant when spoken to. He stated he was taking a little stroll. The nurse's note dated, 12/30/24 at 4:50 p.m.(was a nurse identified for the nurse note) documented, Behavior Note: Type of Behavior: Burn smell observed in room, staff in to assist resident observed with a lighter staff checked room no more lighters observed, and no more burning articles observed. Left vm (voicemail) for RP (responsible party) and notified MD (medical doctor). per MD to monitor oncoming nurse aware. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note dated, 1/1/25 at 6:30 p.m. documented, This writer was notified by CNA (certified nursing assistant) on the floor stating that a 'fired was in the resident's room.' This writer attended to room, and resident was there near his bed on the side of the window in standing position. No observation of fire nor smoke filled room observed. This writer asked, What happened?' and the resident gave no response just shrugged his shoulders. this writer questioned resident ' Did he have a lighter?' Resident's response was if I give it to you will you give me my lighter back? This writer responded, 'No.' Resident was asked May we search your person and your personal belongings.' Resident allowed his personal area to be check for fire materials and even assisted by opening the drawer to the dresser/nightstand, but no fired materials was found. Resident allowed his clothing pockets to be checked and again no fire materials such as matches, cigarette lighter etc., was found. Resident was asked, 'Are you okay/ and the resident responded, 'I'm fine.' Resident's room was inspected for fire materials with his consent in which none was found on him nor in his personal belongings. Denied pain or discomfort. Resident was assessed for respiratory distress, and he was not observed to have a cough nor SOB (shortness of breath). Skin integrity remained intact. VS (vital signs) 130/72 (blood pressure), 97.7 (temperature), 80 (pulse) 18 (respirations), 98% (oxygen saturation) RA (on room air). Director of nursing (DON) notified. The nurse's note dated, 1/1/25 at 6:31 p.m. documented, (On-call for VCU -Virginian Commonwealth University) gave new order for safety checks hourly for 24 hours. The nurse's note dated, 1/1/25 at 10:00 p. m. The nurse's note dated, 1/1/25 at 10:00 p.m. documented, Resident's RP and son was notified that resident had a room change for safety to [NAME] unit(what was the difference between the two units). The note dated, 1/1/25 at 11:30 p.m. documented, Resident has been non-compliant with room change to [NAME] unit although he was agreeable at the time. Resident continued to open door to his old room on [NAME] unit. RP notified. The nurse's note dated, 1/1/25 at 11:45 p.m. documented, DON (director of nursing) of facility made aware of resident's non-compliance with room change. Supervisor on duty notified and made multiple rounds during the shift. The nurse's note dated, 1/2/25 at 12:21 a.m. documented, Upon arrival, rsd (resident) was noted walking back to [NAME] from [NAME], rsd noted agitated and saying 'This just don't make sense.' Rsd walked back to his initial room, 'I'm not leaving.' Writer asked Rsd what happened, rsd noted confused and disoriented. Saff informed writer, rsd needed to be relocated to [NAME] r/t (related to) fire in room. Rsd is unable to be educated d/t (due to) cognitive impairment dx (diagnosis). Several attempts made by staff and writer to encourage room change, all were unsuccessful. No scent of smoke noted, no environmental concerns noted. No s/sx (signs and symptoms) of respiratory distress noted. During rounds writer noted rsd asleep in bed (in lowest position) with call bell within reach. No s/sx of distress noted. Will continue safety checks and monitoring. The nurse practitioner's note dated, 1/2/25 at 5:40 p.m. documented in part, (R1) was seen this morning in his semi-private room at facility. (R1) is reported to have had burned thing in his room and neither him nor his roommate could report how the curtain got burned. (R1) does not have any visible burns. He does not recall events. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The psychiatric nurse practitioner's note dated, 1/7/25 at 12:00 a.m. documented in part, This is a [AGE] year-old male with history of depression and dementia He was last seen by this provider on 12/20/24 and no changes were made to his psychotropic medications. This is a consultation at the request of staff because patient was involved in setting a fire in his room. He is met in the common room today participating in an activity. He is on 1:1 because of his recent behaviors. However, it is unknow how his room's curtain got burned. Patient stated that he does not smoke, and he does not have any lighter. He also stated that he has no intention to burn this place, and he does not have a clue about this curtain burning. There is no evidence that he responds to internal stimuli. He is not combative or agitated. He is currently on Trazodone (used to treat depression and insomnia) (1) and Melatonin (used to treat insomnia) (2) without any side effects. Reinforced safety measures. The facility synopsis of event dated 1/7/25 documented in part, On January 1, 2025, (LPN -licensed practical nurse #10) verbally reported to the Administrator that (R1) was observed with a lighter; Resident set the mattress and privacy curtain on fire in his assigned room. The roommate was not in the room during the incident, there were no injuries to report. Investigation: During the interview with (Resident #2 - R2), with a BIMS of 15, he stated that at about 6p. on 1/1/25, he was at the nursing station trying to call his wife. After unsuccessful attempts to reach wife, he decided to return to his room. When he arrived to his room, he noticed his bed was on fire. He balled up some sheets that were at the foot of his bed and used them to put out the fire. He stated that he shouted 'Fire! Fire!' and staff immediately came to his room but arrived when the fire was already out, he does not know how and what started the fire. He denied smoking or having a lighter. The resident in (B bed), (R1) was interviewed. He denied having a lighter and stated that there was no fire. (R1) has a BIMS of 05 and does not recall seeing or lighting a fire. (R1) has a history of wandering and socializing with other residents in the day room, including resident that smoke. He also has a smoking history but stated he stopped smoking a out 7 months ago. Although (R1) denies smoking or having a lighter, staff confiscated a lighter from him on 12/30/24. Staff were unable to find any other lighter in his possession after a consented room search. However, the possibility of (R1) getting lighter from elsewhere cannot be determined based on his history of wandering and socializing with visitor and other residents. A statement was obtained for the CNA (certified nursing assistant) (CNA #3), who first heard and responded to the incident. CNA (#3) stated that at about 6:30 p.m., she was picking up meal trays from rooms on the 200 hallways when she heard resident (R2) screaming fire! Fire! (CNA #3) immediately called the other CNAs (CNA #4 and CNA #5) and the nurse (LPN -licensed practical nurse #9) to the room. When they arrive at the room with a fire extinguisher, there was no fire or smoke in the room. Resident (R2) stated to them that his bed was on fire, and he put the fire out. They noticed a burn area on the lower right side of the resident in (A bed)'s mattress and some burn spots on the privacy curtains. Both residents were removed from the room per recommendations of the charge nurse, (LPN #9). The CNA and the nurse searched the room and found a lighter on (R2) pants that was on his bed. An interview with (LPN #9), she stated that when she arrived at the room, there was no fire or smoke but noticed a palm size burnt area towards the foot of the bed mattress on the right side. She asked what happened, and resident (R2) stated that there was a fire in his bed, and he put it out with a 'balled up' sheet. The nurse asked CNAs to remove both residents from the room, notified maintenance team, notified administrator, DON, responsible parties of both residents, instituted safety checks and one-on-one monitoring for (R1), due to his cognitive status, and moved both residents to different rooms. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility maintenance team checked the room for safety, conducting a bed inspection in which there found no evidence of an electrical issue. During an interview with the Maintenance Assistant, he stated that the fire alarm system did not trigger due to the lack of smoke to initiate the alarm system as designed. (Name of Fire Protection System) came in on 1/2/25 to inspect all smoke alarm systems in the building, all systems were cleared and are working appropriately. The Charge nurse assessed both residents for pain, respiratory distress, and skin integrity. No pain or respiratory concerns were raised by both residents. A skin assessment was performed on (R2) and no burns or bruises were noted on his hands. No skin complications were noticed on either (R1) or (R2). Social services completed trauma screening to evaluated psychosocial well-being of both residents in (room number). no issues were reported during the trauma screening with regards to the fire incident. (R1) was also referred to the psych (psychiatric) physician for evaluation and review of medication. Care plan has been updated for both residents. (R2) was educated not to attempt to put out fire using his hands. (R1) was placed on one-to-one staff monitoring for safety checks to monitor or observe his routine and maintain safety. (R1) will continue one-on-one staff assistance until the physician and IDT (interdisciplinary) team determine that he can no longer have access to a lighter. A smoking screen has been completed for all residents in the building. Residents who smoke have been provided with lock boxes to store their smoking paraphernalia so as to prevent other residents from accessing them. The Administrator held an emergency Resident Council Meeting to emphasize safe smoking practices and proper/discreet storage of all smoking-related items. The residents in attendance were educated on not sharing their smoking cigarettes and lighter with other residents. Residents who smoke have been educated on the importance of lock boxes and how to use them. Based on the above findings, the burn area on the mattress in (room number) indicates that there was a fire in the room. Because no electrical malfunctions were noted upon bed inspection and a lighter was found on the bed, it is highly probable that (R1) may have started the fire in the room. (R1) was the only one present in the room when the fire started, no other resident was observed going into the room, and a lighter had previously been confiscated from him. He is also unable to recall that there was a fire in his room due to his cognitive status. The facility has provided lock boxes to residents who smoke to store their smoking devices to prevent resident with wandering behaviors from accessing them. The facility staff education on RACE (rescue, alarm confine extinguish/evacuate) has been initiated. The comprehensive care plan dated, 6/19/24, documented in part, Focus: The resident has behaviors. Increased agitation, perseverating on fiancee', refusing therapy services. Resident propels self to other residents' rooms and collect items. The is at risk for safety concerns related to fire due to him collecting and attempting to use smoking devices or lighter. The Interventions dated 6/19/24, documented, administer medications as ordered. Divert resident by giving them alternative objects or activity. An interview was conducted with CNA #2 on 1/15/25 at 3:45 p.m. CNA #2 stated she was passing trays and stated she did not see anything on fire in the resident's room. An interview was conducted with LPN #8 on 1/15/25 at 3:51 p.m. LPN #8 stated on 12/30/24, she was assigned to Med (medication) cart #3 that evening when a NCA came and stated they smelled something burning. (R1) was standing in his room holding a book (National Geographic Magazine) and a lighter was on it. She smelled smoke but couldn't find anything that was burned. She asked R1 for the lighter and he gave it to her. She stated she didn't check him room, she just briefly looked around. LPN #8 stated she reported it to (R1)'s assigned nurse. She stated his nurse went to the room LPN #8 did not accompany the nurse back to the room. (continued on next page)

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	495391	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenburnie Rehab & Nursing Center	1901 Libbie Ave Richmond, VA 23226

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with LPN #7 on 1/15/25 at 3:54 p.m. LPN #7 stated that LPN #8 gave her the lighter from R1 on 12/30/24. LPN #7 proceeded to R1's room and didn't smell smoke, didn't see any lighters. The resident told her he didn't smoke. She stated there was nothing burned. She notified the MD, ADON (assistant director of nursing) and left a voicemail for the RP. She stated she did search the room, with permission from the resident, and found no other fire materials. There were no more issues that shift from (R1). An interview was conducted with OSM (other staff member) #2, the maintenance assistant, on 1/15/25 at 3:58 p.m. OSM #2 stated he was working on 1/1/25 and was upstairs. He got a phone call that there had been an incident with fire, he asked what fire as no alarms went off. He went downstairs to the resident's room. There was no smell of smoke, the linens had been balled up and were on the floor inside the room. The mattress of (R2)'s bed had a palm size burn area that went into the mattress at the right side of the foot of the bed. He observed three burn holes in the privacy curtain, there were approximately three inches by a half inch in size. He spoke to the administrator. He was told the CNA put it out. Nobody could tell him how the fire started. He was instructed to do a bed inspection, to determine if it was electrical in nature, and found no evidence that the fire was electrical. He checked the walls, ceiling, outlets and everything looked fine. OSM #2 stated the mattress, and the curtains are both made of fire retardant materials. He stated, that's probably why they didn't go up in fire and smoke. An interview was conducted with LPN #9 on 1/15/25 at 4:27 p.m. LPN #9 stated she was the evening and night nurse on 1/1/25. The CNA came to me and stated there was a fire in (room number of R1 and R2). She ran to the room and did not smell smoke and there was no fire. She asked (R2) what happened. She couldn't smell smoke, everyone was okay. LPN #9 asked (R1) what happened, and he just shrugged his shoulders. She stated she notified everyone, MD, RP, administrator. She stated she got permission from both residents to search them and their belongings. LPN #9 stated she didn't see any other fire materials in the room. She called the administrator and DON to find rooms for both residents to move into. Both residents and their RP's agreed to move to another room. (R1) was an independent walked with a wander guard on his ankle. He kept on coming back to his old room. We redirected him but he kept coming back to his room and then refused to leave the room. Maintenance changed out the mattress and privacy curtains. An interview was conducted with OSM #2, the director of maintenance, on 1/15/25 at 4:54 p.m. OSM #2 stated the gentleman from the (Fire Equipment company) came on 1/2/25 and stated there wasn't enough smoke to have generated the alarm. The mattress was a standard fire-retardant mattress, so it didn't just go up in flames. An interview was conducted with LPN #10 on 1/15/25 at 4:56 p.m. LPN #10 stated se was at the nurse's station. (R2) was up there trying to call his wife. CNA called down the hall and stated the bed was on fire. She ran down the hallway and didn't see a fire. She observed an area on the bed of (R2) it was warm to touch but no flames. The privacy curtain had three burn holes in it. She sent the CNA to get the charge nurse for that room. She asked the residents to leave the room, but they refused to leave. LPN #10 stated she asked everyone what happened, and no one could tell her what happened. When asked if she saw a lighter, LPN #10 stated she did not see one. There was a pair of pants on top of (R2)'s bed. She picked them up and there was nothing in them. She stated (R1) was pacing back and forth on his side of the room. LPN #9 came in the room and took over. A CNA told her later that they had found a lighter in the pants across the top of the bed. She stated it wasn't there when she checked them before. R2 told her he had put out the flames. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with ASM (administrative staff member) #1, the administrator, on 1/16/25 at 11:45 a.m. When asked how a lighter got into the resident's room, ASM #1 stated they were unable to determine how it got there. R1 is a wanderer, and the assumption was that he wandered into someone's room and picked it up. ASM #1 was asked if she was aware of the finding of a lighter on R1 on 12/30/24, ASM #1 stated she was not made aware of that until after 1/1/25 investigation was initiated. An interview was conducted on 1/16/25 at 11:57 a.m. with ASM #2, the director of nursing. When asked, on 12/30/24, when he was made aware of the finding of a lighter in R1's possession, what did he do? Did he notify the administrator? ASM #2 stated he told the staff to do to a deep search of the room for any further fire paraphernalia. We did an active sear of the room. They didn't know where he got the lighter. The resident was not a smoke. He was a wanderer and may have picked it up in his walking around the facility. He stated he didn't tell ASM #1 of the incident on 12/30/24. ASM #1, ASM #2, ASM #3, the regional director of clinical services and ASM #4, the medical director, were made aware of the above finding on 1/16/25 at 12:36 p.m. No further information was provided prior to exit. References: (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681038.html (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/natural/940.html.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 42106 Based on clinical record review, staff interview and facility document review, it was determined that the facility failed to provide medically related social services after a verbal abuse incident for one of 10 residents in the survey sample, Resident #10. The findings include: For Resident #10 (R10), the facility staff failed to evidence social service follow up after verbal abuse from LPN (licensed practical nurse) #11 on 12/14/24. Review of a facility synopsis of events dated 12/14/24 for R10 documented in part, Residents involved: [Name of Resident #4, #9 and #10] .Supervisor reported employee [Name of LPN #11]. Supervisor stated that [Name of LPN #11] arrived to work and presented as belligerent and intoxicated. The nurse was observed screaming at the above residents, and when he was asked to leave the building, he mentioned that he had over medicated resident [Name of Resident #4] . Employee action initiated or taken: Employee was immediately removed from property and suspended pending investigation. The police was called to report the incident and for assistance with removing the employee from the property . The final investigation for the event dated 12/19/24 documented in part, .It was observed that employee [Name of LPN #11] arrived at work seemingly intoxicated and was overtly belligerent. He was not scheduled to work; he reported to supervisor [Name of LPN #12] that he came in to complete documentation. The supervisor observed him being verbally abusive to residents [Name of Resident #10 and Resident #9] as they were sitting in front of the nurse's station. The supervisor reported the following statement, I called the police to have him physically taken off the property. He became volatile, threatened me and was put in a [Name of ride share service]. He then called the building to make more threats to me. Before he left, he said he over medicated a resident, so we will need to give her something to wake her up. The resident in question is [Name of R4] The residents' vitals were immediately taken, and the MD was notified, the resident was stable and being closely monitored. Upon notifying the family, they made the decision to take the resident to the emergency room for further evaluation and has not returned to facility. [Name of LPN #11] did not issue any medication at the time of the incident. [Name of LPN #11] was referencing his shift from the previous night (3p-11p). [Name of LPN #11] declined to provide a statement of events. Residents involved in the accusation of verbal abuse are unable to be interviewed regarding the incident due to low BIMS scores, neither resident recalled the incident. Center staff interviewed other residents around the incident, residents do not recall hearing the employee verbally berate residents in question. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff interviews corroborate the supervisors' report of incident. Resident [Name of R4] was unable to be interviewed at the time of the incident and is no longer at the facility. Police investigation is ongoing. Based on the investigative findings, the incident regarding inappropriate staff behavior and verbal abuse towards residents was determined to be substantiated based on employee interviews. In regard to the allegation of over-use of medication, the incident is unsubstantiated due to lack of supporting evidence. In immediate response to the report, the employee was terminated from the facility, a police report was filed regarding the incident . On R10's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/16/24, the resident scored nine out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were moderately impaired for making daily decisions. The assessments for R10 failed to evidence a trauma screen or social service assessment completed after the verbal abuse incident on 12/14/24. An admission trauma screen completed prior to the incident on 12/13/24 and a re-admission trauma screen dated 1/2/25 documented no trauma reported. The progress notes for R10 failed to evidence documentation regarding the verbal abuse incident or social service assessment after the incident on 12/14/24. The comprehensive care plan for R10 failed to evidence a review or revision regarding the verbal abuse incident. On 1/16/25 at 8:50 a.m., an interview was conducted with OSM (other staff member) #4, the assistant director of social services. OSM #4 stated that when an abuse situation happened, social services went in to interview the resident to get their side of what happened. She stated that if the resident were cognitively impaired, they interviewed any witnesses, but they still checked in with the resident to make sure they were okay. She stated that they did a trauma screen and care plan review to add any new intervention if needed. She stated that any follow up after that depended on the resident and how they were doing. OSM #4 stated that if the resident stated that they were fine they only followed up as needed and offered them psychiatry if they wanted it. She stated that social services followed R10 regularly to make sure they were doing okay and the documentation of their follow up would be in the psychosocial and trauma assessments. On 1/16/25 at 10:54 a.m., an interview was conducted with ASM #2, the director of nursing who stated that typically social services did a trauma screen after an abuse incident to make sure the resident was okay, and the care plans were reviewed. On 1/16/25 at 11:33 a.m., an interview was conducted with ASM #1, the administrator who stated that the supervisor at the time had called her that morning to inform her about LPN #11 being in the facility. She stated that she was informed that LPN #11 had come in without being on the schedule to work and stated that he was there to complete some unfinished documentation from the previous shift. She stated that LPN #11 had presented intoxicated, and the staff had observed him verbally berating the named residents. She stated that when the supervisor tried to escort him out, he would not leave so they had called the police to take him out of facility. She stated that she had advised the supervisor to get witness statements from the staff regarding LPN #11's behavior and what he was doing. She stated that for Resident #10, they had interviewed the resident that morning and they did not recall the incident. She stated that social services followed the resident and should have completed a trauma screen and psychosocial assessment after the incident. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided policy, Social Work and Discharge Planning Policies and Procedures effective 1/6/20 documented in part, .In conjunction with medical and clinical staff, Social Work and Discharge Planning Staff will identify and provide assistance in meeting patients' psychosocial and medically related social service needs including but not limited to communication/sensory assistance needs, and/or community resource service needs . Provide emotional support and guidance in decision making. Document interventions in patient medical record . On 1/16/25 at 12:39 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the findings. No further information was presented prior to exit.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27660 Based on staff interview, facility document review and clinical record review it was determined the facility staff failed to ensure medications were available at the scheduled time of administration for one of ten residents in the survey sample, Resident #2. The findings include: For Resident #2, the facility staff failed to ensure, Flonase (used to treat allergies) was available for administration. The physician order dated, 12/17/24, documented, Flonase Allergy Relief Nasal Suspension 50 MCG/ACT (micrograms per activation) (Fluticasone Propionate) 2 sprays in each nostril one tine a day for nasal. The January 2025 MAR (medication administration record) documented the above order. On 1/12/25 and 1/13/25 a 9 was documented in the space for administration. A 9 indicates Other/ See progress notes. On 1/14/25, the block for documenting the administration of the medication was blank. The nurse's notes dated 1/12/25 at 3:15 p.m. documented, Medication has been ordered. The nurse's note dated 1/13/25 at 3:15 p.m. documented, Medication has been ordered, pharmacy has been called. The list of over-the-counter medications stocked in the facility, provided by the facility, documented, Flonase . 34 oz (ounces). An interview was conducted with LPN (licensed practical nurse) #6, on 1/16/25 at 10:44 a.m. LPN #6 stated if a medication is not available on the medication cart, she looks for it in other places, like another medication cart, medication room. She then checks the (back up pharmacy system) in the house. If it's still not available, she calls the pharmacy. When asked if the medication is a stock over the counter medication, LPN #6 stated the nurse should check the medication room, where they are stocked, if not there you contact (name of central supply staff member). He goes upstairs and gets the over-the-counter medications for you. LPN #6 stated, over the counter medications shouldn't have documented, waiting for pharmacy. She stated worse case scenario, you call the local pharmacy and get it delivered. She stated the nurse should contact the doctor and the responsbible party if the medication is not administered and that should be documented in a progress note. Observation was made of the [NAME] unit, there was no Flonase in the medication room. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with OSM (other staff member) # 6, the central supply staff member) on 1/16/25 at 10:46 a.m. OSM #6 stated over the counter medications are stocked in the medication rooms on each floor. He stated they stock the normal things like Tylenol, Advil, vitamins and supplements. When asked about stocking Flonase, OSM #6 stated that he can only order from his supplier and they only carry a generic, deep sea, a saline nasal spray, and that's not equivalent to the Flonase, he was told by the nurses. OSM #6 was asked if the medication is not on his approved list to order, then the resident may have a delay in getting the medications, OSM #6 stated, he didn't know. OSM #6 stated he is not authorized to go to the local drug store to get over the counter medications. Observation was made of the stock room which was the medication room on the [NAME] unit with OSM #6. There was no Flonase in stock. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/16/25 at 10:59 a.m. ASM #2, stated, the nurse should contact the doctor, responsible party and the central supply clerk to let them know they don't have the medications. (OSM #6) handles the ordering of the over-the-counter medications. The facility policy, Medication Unavailability documented in part, 1. A licensed nurse will notify the provider of the unavailability of medication and discuss an alternative order, if necessary. 2. If alternate medication is ordered and is not available, the licensed nurse will activate the backup pharmacy process and procedures. 3. A licensed nurse will document notification of the provider of the unavailability in the medical record. A licensed nurse will notify the responsible party of any new orders and document notification in the medical record. ASM #1, the administrator, ASM #2, ASM #3, the regional director of clinical services, and ASM #4, the medical director, were made aware of the above findings on 1/16/25 at 12:36 p.m. No further information was provided prior to exit.