STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515047	A. Building B. Wing	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worthington Healthcare Center	2675 36th Street Parkersburg, WV 26104

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 49465 Based on record review, staff interview and resident interview the facility failed to ensure residents were free from physical abuse due to being physically restrained. Resident #43 was physically restrained by a nurse aide who held her head preventing movement when a nurse swabbed her nose to test for COVID. Resident #11 became agitated and a nurse took the resident to their room where they locked the resident's wheelchair and physically held the resident's wheelchair preventing the residnet from moving and leaving the room. Neither resident was able to verbalize how these actions made them feel therefore the reasonable person standard was applied. These actions placed these two (2) residents and the remaining 93 residents at risk for serious harm and/or death because both alleged perpetrators were still employed by the facility and actions were not taken to ensure they did not abuse other residents in the future. All 95 residents were in an immediate jeopardy (IJ) situation. The facility was first notified of the IJ at 6:15 PM, on 02/20/24. The state agency (SA) received the Plan of Correction (POC) at 10:23 PM on 02/20/24. The SA accepted the POC on 02/20/24 at 10:28 PM. The survyeors observed for the implementation of the POC and the IJ was abated on 02/21/24 at 2:00 PM. Resident identifiers: #43 and #11. Facility census: 95. Findings included: a) Resident#43 On 02/20/24 at 9:45AM a medical record review was completed for Resident #43 regarding a reportable incident dated 11/21/23. The reportable was regarding an incident on 11/17/23 during the 2:00 PM - 10:00 PM shift. Resident #43's head was held by Nurse Aide (NA) #55 while Registered Nurse (RN) #40 completed a nasal swab for Covid testing. Upon reviewing RN #40's written statement it was determined that RN #40 felt she was holding the resident's head to help her calm down. The investigation completed by the facility includes statements from RN #40, NA #13, and NA #66. Further review of the statements gathered by the facility as a result this investigation found the following statements. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	b) RN #40 (statement collected by the facility) In a statement collected by the facility, on 11/17/23, RN #40 stated she was doing medication pass when a resident came and asked her to check Resident #43.The resident said Resident #43 was complaining of a sore throat. RN #40 said she explained to Resident #43 that she would be doing a COVID test. According to RN #40, Resident #43 became agitated and was afraid of having her nose swabbed. RN #40 said she explained the protocol to the resident and tried to convince her she would be careful, and it would not hurt. RN #40 said Resident #43's roommate tried to calm her down too. RN #40 said NA #55 helped by holding the resident's hand and her head while she (RN #40) performed the test. c) NA #55 The surveyor obtained a statement from the facility for NA #55. NA#55 gave her statement to Nursing Staff Scheduler (NSS) #51 on 11/20/23 by phone. In her statement the NA said she was, Pulled to west for 1:1. Tried to calm the resident down by holding her hand and her head. Trying to relax resident. NA #55's statement also reflected (RN #40's name) was the nurse trying to administer the Covid test.(Activity Aide(AA)#143's name) was walking by and stopped to help.(AA #143name) was holding the resident's hand. NA #55 stated she was making the resident laugh and smile when it was over. d) NA #66 The statement from the facility for NA #66 was given by NA #66 on 11/20/23 to NSS #51 NA #66 stated she was in a room on front hall when she heard screaming. NA #66 said she went into the hall and saw RN#40, Activity Aide #143, and NA #55 with Resident #43. RN #40 had a swab in her hand. NA #55 was holding the resident's hands and Activity Aide #143 was holding the resident's head. NA #66 said by the time she got all the way to them they had finished the test. e) Activity Assistant (AA) #143 The surveyor received a statement taken by the facility from AA #143. AA #143's statement was taken on 11/20/23. I was walking down the hall and saw the nurse trying to give (Resident #43's name) a Covid test. I saw the aide holding head to assist the nurse with the test. f) Employee #145 The surveyor obtained a statement taken by the facility for Employee #145 on 11/20/23. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	I spoke to the resident, explained who I was and ask her if she recall attempting to get a Covid test on Friday(11-17-23).The resident was non-verbal/Did not indicate she remembered in anyway. g) Resident #8 The surveyor obtained a statement from Resident #8 dated 11/19/23.This statement was taken by an RN. Resident was asked in interview if he's ever seen resident being abused, he stated, 'The other night I was in my room and came out and seen the nurse and the CAN holding resident down to swab her. Resident was asked if he knew who they were he said he didn't know their names, but they were foreign. h) Employee #146 The surveyor obtained a facility statement from Employee #146. This statement was given by the employee on 11/19/23 to Clinical Manager/RN #109 They came to give her a covid test. She didn't want I told her it's okay, I was holding her hand. The one girl held her head and the nurse swabbed her nose, she was screaming the whole time. I told someone but I can't remember who. i) Certified Occupational Therapy Assistant(COTA)#139 The surveyor obtained a facility statement from COTA #139 During session with (Name of Resident #54) and (name of Resident #8) both in therapy room at same time at approx.12:30 PM on 11/19/2023, it was brought up that another patient (Resident #43's name) was being covid tested on Friday (11-17-2023) and that a nurse aide that talks funny with dark hair and a foreigner was holding (Resident #143's name) head back as she was screaming very loudly and that they were disturbed by the screaming and thought that she was allowed to refuse ea covid test if she wanted to refuse .Both patients reported that she could be identified if they saw her. j) NA#13 The surveyor obtained a statement taken by the facility from NA #13. The statement was dated 11/19/23. (NA#66'sname) & I were providing care to a resident on the front hall when we heard screaming. We finished with this resident and we nt to the hall to see (NA#55's name) holding (Resident#43's name) head back for (RN#40's name) to covid swab resident's nose. This incident happened Friday 11/17 after dinner. Further review of the reportable incident found a finding of unsubstantiated despite the multiple staff and resident statements who confirmed it did happen. The survey team completed staff interviews during the course of the survey with the following findings: k) Director of Nursing (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with the Director of Nursing (DON) on 02/20/24 at 9:20 AM she stated, I don't really know about it. Let me get the Administrator and Clinical Manager (CM) #109. l) Clinical Manager (CM) #109 An interview with CM#109 at 9:50 AM on 02/20/24 was conducted. CM#109,stated,I got the call about the incident .I came in and got statements, and completed this skin checks .Then I handed it over to the administration. m) Administrator An interview with the Administrator at 10:00 AM on 02/20/24 was conducted regarding Resident #43.The administrator reviewed d all the paperwork. The administrator stated, They held her head and hand to comfort her .I don't see a problem with this. n) Resident#8 During an interview on 02/20/24 at 10:37 AM with Resident #8 who has a BIMS of 15 the resident stated, I remember what happened. She was screaming. My room was across from hers at the time. I wanted to smack them off of her. An interview on 02/20/24 at 10:51 AM with NA #66 she stated, I feel like what I remember ,we heard screaming, and we came out, (Name of Activity Assistant #143) was behind her and (Name of RN #40) was in front of her. I don't remember much, but I did feel like it was an issue. I felt like she had the right to say no. An interview on 02/20/24 at 10:54 AM with NA #13 she states, I was in a room up the hall, and I heard screaming, I came out of the room and saw (Name of NA#55) was holding her head, and the nurse was putting a swab in her nose. I don't remember what nurse I reported it to but the east wing (Name of CL #109 came in and told me to write down what I had seen on the paper, So I did. Just the way she was screaming I felt like I needed to report it. They definitely did the swab ;she was taking the swab out of her nose when I went into the room. Telephone interview with NA #55 on 02/20/24 at 2:39 PM she stated, What I remember r is the nurse needed help. I went to help her. I was holding her head and hands to calm her down. If I knew I was going to be in trouble I would have never gone into the room. The nurse was so busy she was just trying to get it done. An attempt was made to contact RN #40 via telephone, as well as RN #26 pm 02/20/2 at 2:00 PM with no answer or return call. At the time of this survey NA #55 and RN #40 were both still employed at the facility and this allegation was unsubstantiated event though there were multiple witness statements confirming the incident did happen on11/17/23. o) Resident#11 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A facility reportable incident (FRI) dated 10/03/23 in the (AM), was reviewed involving Resident #11. The allegations contained in this reportable was RN #40 , locked Resident #11's wheelchair and held the back of the wheelchair which prevented the resident from freely leaving the room which she was confined to. This allegation was reported as possible involuntary seclusion. The facility investigated and gathered the following statements: p) NA#141 The surveyor obtained a statement taken by the facility on10/02/23. NA #41 said while giving NA a lunch break and taking on the 1:1 she was stopped by the RN #40 and was asked to give another patient care while she took the 1:1. NA#41 said RN #40 forced Resident #11 back into her room locking her wheelchair and holding the back of the wheelchair so Resident #11was unable to leave her room. q) RN#40 gave a statement on10/03/23: RN#40 said she was doing her medication pass when a family member of one of the resident's asked her to call for Resident#101's nurse aide. RN #40 said she asked NA#141 if she was assigned to Resident #101. NA #141 said she was the aide for Resident #101. NA #141 also said she was watching Resident #11 because the nurse aide assigned to Resident#11 was on break and had asked her to watch Resident#11 while also attending Resident #101. NA #141 said she had a conversation with Resident #11 while walking around the facility. She said Resident #11 was as going to the exit door and kept saying she was going home. When RN #26, who was the assigned nurse to Resident#11 noticed this behavior she said she would take over Resident #11 so RN #40 could finish medication pass. Resident #11 started hitting and punching us and kept on saying bad words. The staff took Resident #11 to her room while RN #26 had a conversation with the resident trying to have her calm down. Then wrote at the bottom of this same statement was a short statement from RN #26. The summarization of the statement is: r) RN #26 RN#26 agreed with RN#40's statement that the incident with the wheelchair was for a limited period and was therapeutic. This allegation was unsubstantiated by the facility. However, an in-service entitled Abuse and Neglect dated 10/03/23 was completed by Clinical Manager #7 for the staff. Further education was completed with RN #40 by Clinical Manager #7 on 10/03/23 which involved reviewing the facility policy entitled [NAME] Virginia Abuse, Neglect and Misappropriation. The section regarding involuntary seclusion was highlighted. Both RN #40 and the Clinical Manager (CM) #7 signed and dated the facility policy. Clinical Manager #7 verified RN #40 was still employed by the facility as a night shift nurse. s) Clinical Manager (CM) #7 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with Clinical Manager (CM) #7 on 02/20/24 at approximately11:15 AM she stated, I was directed by the administrator to conduct an in-service and to do individual education with RN#40. I did not have any further action regarding this reportable. An attempt was made to contact RN #40 via phone, as well as RN #26 On 02/20/24 at 2:00 PM with no answer or call back at this time. t) NA #142 NA#142 was not able to be interviewed because she no longer works at this facility. During an interview with the Administrator on 02/20/24 at 5:00 PM regarding the incident with Resident #11 he stated, During the investigation you have to weigh the totality of all the statements received and two (2) RNs were in the room, versus an Activity Assistant. Sometimes you have to see what actually happened versus someone seeing what they think happened. The statement from both RN's does not conclude that the wheelchair was held. u) Plan of Correction On 02/20/24 the Nursing Home Administrator, Director of Nursing, and the Corporate Office implemented the following plan: Employee(RN) #40 was suspended pending investigation and legal review and HR review, if it determined that the employee could return to work, employee #40 will have extensive abuse and neglect training, by the Regional Team Member. Employee (NA) #55 was suspended pending investigation and legal review and HR review ,if is it determined that the employee could return to work Employee #55 will have extensive abuse and neglect training by the Regional Team Member. Residents with BIMS scores of 12 and above were interviewed for potential physical abuse. Residents with BIMS scores of 11 or below had a skin assessment completed for potential physical Abuse. Staff will be reeducated on the Abuse, Neglect, and Misappropriation Policy, through in person, text blast will be physically educated prior to the next shift with signatures. The training will be conducted by the Regional Team Member. There will be training for all staff on Resident Rights including the right to be free from any physical restraints imposed for purposes of discipline or convenience and not required to treat the resident medical symptoms. The training will be conducted by the Regional Team Member. Staff will be reeducated on restraint alternatives. There will be a team review of all reportable events to determine if physical abuse occurred, per state definitions. The team will include, Social Services, Director of Nursing or Designee, and Executive Director. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	After a thorough review the team will determine if substantiated. Audits will be conducted by the regional Director of Clinical Operations weekly x 4 weeks and monthly x 6 months and randomly thereafter with correction upon discovery. Audit results will be reviewed by the QAPI Committee monthly x 6months.

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 49465 Based on record review, staff interview and resident interview the facility failed to ensure residents were free from physical abuse. Staff physically restrained two (2) residents. Resident #43 was and #11 were both physically restrained. A nurse aide (NA) nurse aide held her head preventing movement so the nurse could perform a swab of the nose to test Resident #43 for COVID. Resident #11 became agitated and a nurse took the resident to their room where they locked the resident's wheelchair and physically held the resident's wheelchair preventing them from moving and leaving their room. Neither resident was able to verbalize how these actions made them feel therefore the reasonable person standard was applied. Not only did these failures harm Resident #11 and Resident #43 but they also placed them and the remaining 93 residents at risk for serious harm and/or death. The alleged perpetrators were still employed by the facility and actions were not taken to ensure they did not abuse other residents in the future. This placed all 95 residents in an immediate jeopardy (IJ) situation. The facility was notified of the IJ at 6:15 PM, on 02/20/24. The state agency (SA) received the Plan of Correction (POC) at 10:23PM on 02/20/24. The SA accepted the POC on 02/20/24 at 10:28 PM. The SA observed for the implementation of the POC and the IJ was abated on 02/21/24 at 2:00 PM. Resident identifiers: #43 and #11. Facility Census: 95. Findings include: a) Resident #43 On 02/20/24 at 9:45AM a medical record review was completed for Resident # 43 regarding a reportable incident dated 11/21/23. The report was in regards to an incident on 11/17/23 where the resident's head was held by Nurse Aide (NA) #55 while Registered Nurse (RN) #40 completed a nasal swab for Covid testing. Upon reviewing RN #40's written statement, she states, She (Referring to NA #55) holds Resident #43's head just to make her calm down. The time of the of incident was documented as the 2 PM - 10 PM shift. The investigation included statements from RN #40, NA #13, and NA #66. b) RN #40 (statement collected by the facility) In a statement collected by the facility, on 11/17/23, RN #40 stated she was doing medication pass when a resident came and asked her to check Resident #43.The resident said Resident #43 was complaining of a sore throat. RN #40 said she explained to Resident #43 that she would be doing a COVID test. According to RN #40, Resident #43 became agitated and was afraid of having her nose swabbed. RN #40 said she explained the protocol to the resident and tried to convince her she would be careful, and it would not hurt. RN #40 said Resident#43's roommate tried to calm her down too. RN #40 said NA #55 helped by holding the resident's hand and her head while she (RN#40) performed the test. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	c) NA#55 The surveyor obtained a statement from the facility for NA#55. NA#55 gave her statement to Nursing Staff Scheduler (NSS) #51 on 11/20/23 by phone. In her statement the NA said she was, Pulled to west for 1:1. Tried to calm the resident down by holding her hand and her head. Trying to relax resident. NA #55's statement also reflected (RN #40's name) was the nurse trying to administer the Covid test.(Activity Aide(AA)#143's name) was walking by and stopped to help.(AA #143name) was holding the resident's hand. NA #55 stated she was making the resident laugh and smile when it was over. d) NA #66 The statement from the facility for NA #66 was given by NA #66 on 11/20/23 to NSS #51 NA #66 stated she was in a room on front hall when she heard screaming. NA #66 said she went into the hall and saw RN#40, Activity Aide #143, and NA #55 with Resident #43. RN #40 had a swab in her hand. NA #55 was holding the resident's hands and Activity Aide #143 was holding the resident's head. NA #66 said by the time she got all the way to them they had finished the test. e) Activity Assistant (AA) #143 The surveyor received a statement taken by the facility from AA #143. AA #143's statement was taken on 11/20/23. I was walking down the hall and saw the nurse trying to give (Resident #43's name) a Covid test. I saw the aide holding head to assist the nurse with the test. f) Employee #145 The surveyor obtained a statement taken by the facility for Employee #145 on 11/20/23. I spoke to the resident, explained who I was and ask her if she recall attempting to get a Covid test on Friday(11-17-23).The resident was non-verbal/Did not indicate she remembered in anyway. g) Resident #8 The surveyor obtained a statement from Resident #8 dated 11/19/23.This statement was taken by an RN. Resident was asked in interview if he's ever seen resident being abused, he stated, 'The other night I was in my room and came out and seen the nurse and the CAN holding resident down to swab her. Resident was asked if he knew who they were he said he didn't know their names, but they were foreign. h) Employee#146 (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The surveyor obtained a facility statement from Employee #146. This statement was given by the employee on 11/19/23 to Clinical Manager/RN #109 They came to give her a covid test. She didn't want I told her it's okay, I was holding her hand. The one girl held her head and the nurse swabbed her nose, she was screaming the whole time. I told someone but I can't remember who. Certified Occupational Therapy Assistant(COTA)#139 The surveyor obtained a facility statement from COTA #139 During session with (Name of Resident #54) and (name of Resident #8) both in therapy room at same time at approx.12:30 PM on 11/19/2023, it was brought up that another patient (Resident #43's name) was being covid tested on Friday (11-17-2023) and that a nurse aide that talks funny with dark hair and a foreigner was holding (Resident #143's name) head back as she was screaming very loudly and that they were disturbed by the screaming and thought that she was allowed to refuse ea covid test if she wanted to refuse .Both patients reported that she could be identified if they saw her. i) NA#13 The surveyor obtained a statement taken by the facility from NA #13. The statement was dated 11/19/23. (NA#66'sname) & I were providing care to a resident on the front hall when we heard screaming. We finished with this resident and we nt to the hall to see (NA#55's name) holding (Resident#43's name) head back for (RN#40's name) to covid swab resident's nose. This incident happened Friday 11/17 after dinner. Further review of the reportable incident found a finding of unsubstantiated despite the multiple staff and resident statements who confirmed it did happen. The survey team completed staff interviews during the course of the survey with the following findings: j) Director of Nursing During an interview with the Director of Nursing (DON) on 02/20/24 at 9:20 AM she stated, I don't really know about it. Let me get the Administrator and Clinical Manager(CL)#109. An interview with CL#109 at 9:50 AM on 02/20/24 was conducted. CL#109,stated,I got the call about the incident .I came in and got statements, and completed this skin checks .Then I handed it over to the administration. k) Administrator An interview with the Administrator at 10:00 AM on 02/20/24 was conducted regarding Resident #43.The administrator reviewed d all the paperwork. The administrator stated, They held her head and hand to comfort her .I don't see a problem with this. l) Resident#8 (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 02/20/24 at 10:37 AM with Resident #8 who has a BIMS of 15 the resident stated, I remember what happened. She was screaming. My room was across from hers at the time. I wanted to smack them off of her. An interview on 02/20/24 at 10:51 AM with NA #66 she stated, I feel like what I remember ,we heard screaming, and we came out, (Name of Activity Assistant #143) was behind her and (Name of RN #40) was in front of her. I don't remember much, but I did feel like it was an issue. I felt like she had the right to say no. An interview on 02/20/24 at 10:54 AM with NA #13 she states, I was in a room up the hall, and I heard screaming, I came out of the room and saw (Name of NA#55) was holding her head, and the nurse was putting a swab in her nose. I don't remember what nurse I reported it to but the east wing (Name of CL #109 came in and told me to write down what I had seen on the paper, So I did. Just the way she was screaming I felt like I needed to report it. They definitely did the swab ;she was taking the swab out of her nose when I went into the room. Telephone interview with NA #55 on 02/20/24 at 2:39 PM she stated, What I remember r is the nurse needed help. I went to help her. I was holding her head and hands to calm her down. If I knew I was going to be in trouble I would have never gone into the room. The nurse was so busy she was just trying to get it done. An attempt was made to contact RN #40 via telephone, as well as RN #26 pm 02/20/2 at 2:00 PM with no answer or return call. At the time of this survey NA #55 and RN #40 were both still employed at the facility and this allegation was unsubstantiated event though there were multiple witness statements confirming the incident did happen on11/17/23. m) Resident #11 A facility reportable incident (FRI) dated 10/03/23 in the (AM), was reviewed involving Resident #11. The allegations contained in this reportable was RN #40 , locked Resident #11's wheelchair and held the back of the wheelchair which prevented the resident from freely leaving the room which she was confined to. This allegation was reported as possible involuntary seclusion. The facility investigated and gathered the following statements: n) NA #141 The surveyor obtained a statement taken by the facility on10/02/23. NA #41 said while giving NA a lunch break and taking on the 1:1 she was stopped by the RN #40 and was asked to give another patient care while she took the 1:1. NA#41 said RN #40 forced Resident #11 back into her room locking her wheelchair and holding the back of the wheelchair so Resident #11was unable to leave her room. o) RN #40 gave a statement on10/03/23: (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	RN#40 said she was doing her medication pass when a family member of one of the resident's asked her to call for Resident#101's nurse aide. RN #40 said she asked NA#141 if she was assigned to Resident #101. NA #141 said she was the aide for Resident #101. NA #141 also said she was watching Resident #11 because the nurse aide assigned to Resident#11 was on break and had asked her to watch Resident#11 while also attending Resident #101. NA #141 said she had a conversation with Resident #11 while walking around the facility. She said Resident #11 was as going to the exit door and kept saying she was going home. When RN #26, who was the assigned nurse to Resident#11 noticed this behavior she said she would take over Resident #11 so RN #40 could finish medication pass. Resident #11 started hitting and punching us and kept on saying bad words. The staff took Resident #11 to her room while RN #26 had a conversation with the resident trying to have her calm down. p) RN #26 Then wrote at the bottom of this same statement was a short statement from RN #26. The summarization of the statement is: RN#26 agreed with RN#40's statement that the incident with the wheelchair was for a limited period and was therapeutic. This allegation was unsubstantiated by the facility. However, an in-service entitled Abuse and Neglect dated 10/03/23 was completed by Clinical Manager #7 for the staff. Further education was completed with RN#40 by Clinical Manager #7 on 10/03/23 which involved reviewing the facility policy entitled [NAME] Virginia Abuse, Neglect and Misappropriation. The section regarding involuntary seclusion was highlighted. Both RN#40 and the clinical manager #7 signed and dated the facility policy. Clinical Manager #7 verified RN#40 was still employed by the facility as a night shift nurse. q) Clinical Manager (CM) #7 During an interview with Clinical Manager (CL) #7 on 02/20/24 at approximately11:15 AM she stated, I was directed by the administrator to conduct an in-service and to do individual education with RN#40. I did not have any further action regarding this reportable. An attempt was made to contact RN #40 via phone, as well as RN#26 On 02/20/24 at 2:00 PM with no answer or call back at this time. r) NA#142 NA #142 was not able to be interviewed because she no longer works at this facility. s) Administrator During an interview with the Administrator on 02/20/24 at 5:00 PM regarding the incident with Resident #11 he stated, During the investigation you have to weigh the totality of all the statements received and 2 RNs were in the room, versus an Activity Assistant. Sometimes you have to see what actually happened versus someone seeing what they think happened .The statement from both RN's does not conclude that the wheelchair was held. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	t) Plan of Correction On 02/20/24 the Nursing Home Administrator, Director of Nursing, and the Corporate Office implemented the following plan: Employee(RN) #40 was suspended pending investigation and legal review and HR review, if it determined that the employee could return to work, employee #40 will have extensive abuse and neglect training, by the Regional Team Member. Employee (NA) #55 was suspended pending investigation and legal review and HR review ,if is it determined that the employee could return to work Employee #55 will have extensive abuse and neglect training by the Regional Team Member. Residents with BIMS scores of 12 and above were interviewed for potential physical abuse. Residents with BIMS scores of 11 or below had a skin assessment completed for potential physical Abuse. Staff will be reeducated on the Abuse, Neglect, and Misappropriation Policy, through in person, text blast will be physically educated prior to the next shift with signatures. The training will be conducted by the Regional Team Member. There will be training for all staff on Resident Rights including the right to be free from any physical restraints imposed for purposes of discipline or convenience and not required to treat the resident medical symptoms. The training will be conducted by the Regional Team Member. Staff will be reeducated on restraint alternatives. There will be a team review of all reportable events to determine if physical abuse occurred, per state definitions. The team will include, Social Services, Director of Nursing or Designee, and Executive Director. After a thorough review the team will determine if substantiated. Audits will be conducted by the regional Director of Clinical Operations weekly x 4 weeks and monthly x 6 months and randomly thereafter with correction upon discovery. Audit results will be reviewed by the QAPI Committee monthly x 6months.

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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. 49465 Based on record review, staff interview and resident interview the facility failed to ensure their policy as it pertained to abuse, abuse investigation, and abuse prevention was implemented. Two (2) residents were found to have been abused by being physically restrained. Resident #43 was physically and restrained by a nurse aide who held her head preventing movement so the nurse could perform a swab of the nose to test Resident #43 for COVID. Resident #11 became agitated and a nurse took the resident to her room where they locked the residents wheelchair and physically held the resident's wheelchair preventing her from moving and leaving her room. The state agency (SA) determined these failures caused Resident #11 and Resident #43 to suffer physically and mentally. Neither resident was able to verbalize how these actions made them feel. Not only did these failures harm Resident #11 and Resident #43 but they also placed the remaining 93 residents at risk for serious harm and/or death because both alleged perpetrators were still employed by the facility and actions were not taken to ensure these perpetrators did not abuse other residents in the future. This placed all 95 residents in an immediate jeopardy (IJ) situation. The facility was first notified of the IJ at 6:15 PM, on 02/20/24. The SA received the Plan of Correction (POC) at 10:23 PM on 02/20/24. The SA accepted the POC on 02/20/24 at 10:28 PM. The SA observed for the implementation of the POC and the IJ was abated on 02/21/24 at 2:00 PM. Resident Identifiers: #43 and #11. Facility Census: 95. Findings included: a) Abuse Policy A review of the facility's abuse policy titled: [NAME] Virginia Abuse, Neglect, & Misappropriation Policy # NS 1018-03 revealed the following definition of immediately read: means as soon as possible, in the absence of a shooter state time frame requirements, but not later than 2 hours after the allegations is made, if the events that cause the allegation involve abuse or result in bodily injury, or not later than 24 hours if the events that cause the allegation do no involve abuse and do result in serious bodily injury. Under section titled Protection: In the event an allegation is made the facility will take measures to protect residents from harm during an investigation. Accurate and timely reporting of incidents, both alleged and substantiated, will be sent to officials in accordance with state law. Under section II Training, Number 2 section B Read: Understanding behavioral symptoms of resident including those with dementia and related diseases that may increase the risk of abuse and neglect and how to respond (including interventions to deal with aggressive behaviors). (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Aggressive and/or catastrophic reactions to residents Wandering or elopement- type behaviors Resistance to care Outbursts of yelling out Difficulty in adjusting to new routines or staff. Under Prevention #4 read: An employee who is alleged or accused of being a party to abuse, neglect, misappropriation of property will be immediately removed from the area(s) of resident care, interviewed by facility leadership for a written statement and not left alone If multiple employees are involved, the employees will be separated until individual statements are completed. The employees will not be permitted to be alone in the facility at any time until the investigation is complete. #5 reads After completing statement(s), the employee(s) will be asked to vacate the facility until further investigation of the incident is completed. The employee(s) will be notified of the finding of the investigation Appropriate measures will be taken with the employee(s) post investigation including but not limited to: I. Returning to work including no change in regular pay during off time. Ii. Additional education and training III. Disciplinary action if appropriate including termination following facility HR termination policies and guidance. b) Resident #43 On 02/20/24 at 9:45AM a medical record review was completed for Resident # 43 regarding a reportable incident dated 11/21/23. The reportable was in regard to an incident on 11/17/23 were the resident's head was held by Nurse Aide (NA) #55 while Registered Nurse (RN) #40 completed a nasal swab for Covid testing. Upon reviewing RN #40's written statement it was determined NA #55 held Resident #43's heaad just to calm her down. The time of the of incident was documented as the 2 PM - 10 PM shift. The investigation included statements from RN #40, NA #13, and NA #66. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the statements gathered by the facility as a result this investigation found the following statements: c) Registered Nurse #40 Registered Nurse (RN) #40 gave the following statement on 11/17/23: RN #40 (statement collected by the facility) In a statement collected by the facility, on 11/17/23, RN #40 stated she was doing medication pass when a resident came and asked her to check Resident #43.The resident said Resident #43 was complaining of a sore throat. RN #40 said she explained to Resident #43 that she would be doing a COVID test. According to RN #40, Resident #43 became agitated and was afraid of having her nose swabbed. RN #40 said she explained the protocol to the resident and tried to convince her she would be careful, and it would not hurt. RN #40 said Resident#43's roommate tried to calm her down too. RN #40 said NA #55 helped by holding the resident's hand and her head while she (RN#40) performed the test. d) NA#55 The surveyor obtained a statement from the facility for NA#55. NA#55 gave her statement to Nursing Staff Scheduler (NSS) #51 on 11/20/23 by phone. In her statement the NA said she was, Pulled to west for 1:1. Tried to calm the resident down by holding her hand and her head. Trying to relax resident. NA #55's statement also reflected (RN #40's name) was the nurse trying to administer the Covid test.(Activity Aide(AA)#143's name) was walking by and stopped to help.(AA #143name) was holding the resident's hand. NA #55 stated she was making the resident laugh and smile when it was over. f) NA #66 The statement from the facility for NA #66 was given by NA #66 on 11/20/23 to NSS #51 NA #66 stated she was in a room on front hall when she heard screaming. NA #66 said she went into the hall and saw RN#40, Activity Aide #143, and NA #55 with Resident #43. RN #40 had a swab in her hand. NA #55 was holding the resident's hands and Activity Aide #143 was holding the resident's head. NA #66 said by the time she got all the way to them they had finished the test. g) Activity Assistant (AA) #143 The surveyor received a statement taken by the facility from AA #143. AA #143's statement was taken on 11/20/23. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I was walking down the hall and saw the nurse trying to give (Resident #43's name) a Covid test. I saw the aide holding head to assist the nurse with the test. h) Employee #145 The surveyor obtained a statement taken by the facility for Employee #145 on 11/20/23. I spoke to the resident, explained who I was and ask her if she recall attempting to get a Covid test on Friday(11-17-23).The resident was non-verbal/Did not indicate she remembered in anyway. i) Resident #8 The surveyor obtained a statement from Resident #8 dated 11/19/23.This statement was taken by an RN. Resident was asked in interview if he's ever seen resident being abused, he stated, 'The other night I was in my room and came out and seen the nurse and the CAN holding resident down to swab her. Resident was asked if he knew who they were he said he didn't know their names, but they were foreign. j) Employee#146 The surveyor obtained a facility statement from Employee #146. This statement was given by the employee on 11/19/23 to Clinical Manager/RN #109 They came to give her a covid test. She didn't want I told her it's okay, I was holding her hand. The one girl held her head and the nurse swabbed her nose, she was screaming the whole time. I told someone but I can't remember who. k) Certified Occupational Therapy Assistant(COTA)#139 The surveyor obtained a facility statement from COTA #139 During session with (Name of Resident #54) and (name of Resident #8) both in therapy room at same time at approx.12:30 PM on 11/19/2023, it was brought up that another patient (Resident #43's name) was being covid tested on Friday (11-17-2023) and that a nurse aide that talks funny with dark hair and a foreigner was holding (Resident #143's name) head back as she was screaming very loudly and that they were disturbed by the screaming and thought that she was allowed to refuse ea covid test if she wanted to refuse .Both patients reported that she could be identified if they saw her. l) NA#13 The surveyor obtained a statement taken by the facility from NA #13. The statement was dated 11/19/23. (NA#66'sname) & I were providing care to a resident on the front hall when we heard screaming. We finished with this resident and we nt to the hall to see (NA#55's name) holding (Resident#43's name) head back for (RN#40's name) to covid swab resident's nose. This incident happened Friday 11/17 after dinner. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the reportable incident found a finding of unsubstantiated despite the multiple staff and resident statements who confirmed it did happen. The survey team completed staff interviews during the course of the survey with the following findings: m) Director of Nursing During an interview with the Director of Nursing (DON) on 02/20/24 at 9:20 AM she stated, I don't really know about it. Let me get the Administrator and Clinical Manager(CL)#109. An interview with CL#109 at 9:50 AM on 02/20/24 was conducted. CL#109,stated,I got the call about the incident .I came in and got statements, and completed this skin checks .Then I handed it over to the administration. n) Administrator An interview with the Administrator at 10:00 AM on 02/20/24 was conducted regarding Resident #43.The administrator reviewed d all the paperwork. The administrator stated, They held her head and hand to comfort her .I don't see a problem with this. o) Resident#8 During an interview on 02/20/24 at 10:37 AM with Resident #8 who has a BIMS of 15 the resident stated, I remember what happened. She was screaming. My room was across from hers at the time. I wanted to smack them off of her. An interview on 02/20/24 at 10:51 AM with NA #66 she stated, I feel like what I remember ,we heard screaming, and we came out, (Name of Activity Assistant #143) was behind her and (Name of RN #40) was in front of her. I don't remember much, but I did feel like it was an issue. I felt like she had the right to say no. An interview on 02/20/24 at 10:54 AM with NA #13 she states, I was in a room up the hall, and I heard screaming, I came out of the room and saw (Name of NA#55) was holding her head, and the nurse was putting a swab in her nose. I don't remember what nurse I reported it to but the east wing (Name of CL #109 came in and told me to write down what I had seen on the paper, So I did. Just the way she was screaming I felt like I needed to report it. They definitely did the swab ;she was taking the swab out of her nose when I went into the room. Telephone interview with NA #55 on 02/20/24 at 2:39 PM she stated, What I remember r is the nurse needed help. I went to help her. I was holding her head and hands to calm her down. If I knew I was going to be in trouble I would have never gone into the room. The nurse was so busy she was just trying to get it done. An attempt was made to contact RN #40 via telephone, as well as RN #26 pm 02/20/2 at 2:00 PM with no answer or return call. At the time of this survey NA #55 and RN #40 were both still employed at the facility and this allegation was unsubstantiated event though there were multiple witness statements confirming the incident did happen on11/17/23. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49465 Based on observation, record review and staff interview the facility failed to implement care plans related to fall interventions. This failed practice was found true for (2) two of (3) three residents reviewed for falls. Resident identifiers #44 and #1. Facility Census 95. Findings Include: a) Resident #44 A record review on 02/19/24 at 1:00 PM of Resident #44's care plan revealed the resident was at risk for falls and had a fall from bed on 02/10/24. Further record review of Resident #44's care plan found an intervention for, Fall mat to side of bed this intervention was initiated 02/13/24. An observation on 02/19/24 at 1:46 PM of Resident #44 found her lying in bed. No fall mat was beside the bed or in the room. An Observation on 02/21/24 at 11:30 AM of Resident # 44 in her bed, the fall mat was not at bedside. An interview on 02/21/24 at 11:40 AM with Clinical Manager (CM) # 109, confirmed the fall mat was not at bedside. b) Resident #1 A record review on 02/19/24 at 1:10 PM of Resident #1's care plan revealed Resident #1was at risk for falls and has had the following falls: 01/24/24 Fall in the dining room 02/13/24 Fall in the lobby 02/02/24 Fall in the room 02/18/24 Fall in the dining room Further record review of Resident #1's care plan reads, {recessed cup with lid to decrease spillage of hot liquids.} An observation on 02/21/24 at 11:30AM, Resident #1 was in the dining room. She had a cup of coffee in a regular coffee cup. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/21/24 at 2:30 PM with Occupational Therapy Assistant (OTA) # 139 describes a recessed cup as being a cup with a concave lid with a hole in the top . sometimes it has 2 handles and sometimes it has one handle. She confirmed that a regular coffee cup is not a recessed cup.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 49465 Based on record review, staff interview and resident interview the facility failed to be administered in a manner which enabled it to use its resources effectively and efficiently to enable each resident to attain or maintain the highest practicable physical mental and psycho social well being. The facility's administration failed to identify and substantiate physical abuse and involuntary seclusion and take appropriate actions to ensure the alleged perpetrators did not abuse residents in the future. Neither resident was able to verbalize how these actions made them feel therefore the reasonable person standard was applied. These actions placed these two (2) residents and the remaining 93 residents at risk for serious harm and/or death because both alleged perpetrators were still employed by the facility and actions were not taken to ensure they did not abuse other residents in the future. All 95 residents were in an immediate jeopardy (IJ) situation. The facility was first notified of the IJ at 6:15 PM, on 02/20/24. The state agency (SA) received the Plan of Correction (POC) at 10:23 PM on 02/20/24. The SA accepted the POC on 02/20/24 at 10:28 PM. The survyeors observed for the implementation of the POC and the IJ was abated on 02/21/24 at 2:00 PM. Resident identifiers: #43 and #11. Facility census: 95. Findings included: a) Resident#43 On 02/20/24 at 9:45AM a medical record review was completed for Resident #43 regarding a reportable incident dated 11/21/23. The reportable was regarding an incident on 11/17/23 during the 2:00 PM - 10:00 PM shift. Resident #43's head was held by Nurse Aide (NA) #55 while Registered Nurse (RN) #40 completed a nasal swab for Covid testing. Upon reviewing RN #40's written statement it was determined that RN #40 felt she was holding the resident's head to help her calm down. The investigation completed by the facility includes statements from RN #40, NA #13, and NA #66. Further review of the statements gathered by the facility as a result this investigation found the following statements. RN #40 (statement collected by the facility) In a statement collected by the facility, on 11/17/23, RN #40 stated she was doing medication pass when a resident came and asked her to check Resident #43.The resident said Resident #43 was complaining of a sore throat. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	RN #40 said she explained to Resident #43 that she would be doing a COVID test. According to RN #40, Resident #43 became agitated and was afraid of having her nose swabbed. RN #40 said she explained the protocol to the resident and tried to convince her she would be careful, and it would not hurt. RN #40 said Resident#43's roommate tried to calm her down too. RN #40 said NA #55 helped by holding the resident's hand and her head while she (RN#40) performed the test. NA#55 The surveyor obtained a statement from the facility for NA#55. NA#55 gave her statement to Nursing Staff Scheduler (NSS) #51 on 11/20/23 by phone. In her statement the NA said she was, Pulled to west for 1:1. Tried to calm the resident down by holding her hand and her head. Trying to relax resident. NA #55's statement also reflected (RN #40's name) was the nurse trying to administer the Covid test.(Activity Aide(AA)#143's name) was walking by and stopped to help.(AA #143name) was holding the resident's hand. NA #55 stated she was making the resident laugh and smile when it was over. NA #66 The statement from the facility for NA #66 was given by NA #66 on 11/20/23 to NSS #51 NA #66 stated she was in a room on front hall when she heard screaming. NA #66 said she went into the hall and saw RN#40, Activity Aide #143, and NA #55 with Resident #43. RN #40 had a swab in her hand. NA #55 was holding the resident's hands and Activity Aide #143 was holding the resident's head. NA #66 said by the time she got all the way to them they had finished the test. Activity Assistant (AA) #143 The surveyor received a statement taken by the facility from AA #143. AA #143's statement was taken on 11/20/23. I was walking down the hall and saw the nurse trying to give (Resident #43's name) a Covid test. I saw the aide holding head to assist the nurse with the test. Employee #145 The surveyor obtained a statement taken by the facility for Employee #145 on 11/20/23. I spoke to the resident, explained who I was and ask her if she recall attempting to get a Covid test on Friday(11-17-23).The resident was non-verbal/Did not indicate she remembered in anyway. Resident #8 The surveyor obtained a statement from Resident #8 dated 11/19/23.This statement was taken by an RN. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident was asked in interview if he's ever seen resident being abused, he stated, 'The other night I was in my room and came out and seen the nurse and the CAN holding resident down to swab her. Resident was asked if he knew who they were he said he didn't know their names, but they were foreign. Employee #146 The surveyor obtained a facility statement from Employee #146. This statement was given by the employee on 11/19/23 to Clinical Manager/RN #109 They came to give her a covid test. She didn't want I told her it's okay, I was holding her hand. The one girl held her head and the nurse swabbed her nose, she was screaming the whole time. I told someone but I can't remember who. Certified Occupational Therapy Assistant(COTA)#139 The surveyor obtained a facility statement from COTA #139 During session with (Name of Resident #54) and (name of Resident #8) both in therapy room at same time at approx.12:30 PM on 11/19/2023, it was brought up that another patient (Resident #43's name) was being covid tested on Friday (11-17-2023) and that a nurse aide that talks funny with dark hair and a foreigner was holding (Resident #143's name) head back as she was screaming very loudly and that they were disturbed by the screaming and thought that she was allowed to refuse ea covid test if she wanted to refuse .Both patients reported that she could be identified if they saw her. NA#13 The surveyor obtained a statement taken by the facility from NA #13. The statement was dated 11/19/23. (NA#66'sname) & I were providing care to a resident on the front hall when we heard screaming. We finished with this resident and we nt to the hall to see (NA#55's name) holding (Resident#43's name) head back for (RN#40's name) to covid swab resident's nose. This incident happened Friday 11/17 after dinner. Further review of the reportable incident found a finding of unsubstantiated despite the multiple staff and resident statements who confirmed it did happen. The survey team completed staff interviews during the course of the survey with the following findings: Director of Nursing During an interview with the Director of Nursing (DON) on 02/20/24 at 9:20 AM she stated, I don't really know about it. Let me get the Administrator and Clinical Manager(CL)#109. An interview with CL#109 at 9:50 AM on 02/20/24 was conducted. CL#109,stated,I got the call about the incident .I came in and got statements, and completed this skin checks .Then I handed it over to the administration. Administrator (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview with the Administrator at 10:00 AM on 02/20/24 was conducted regarding Resident #43.The administrator reviewed d all the paperwork. The administrator stated, They held her head and hand to comfort her .I don't see a problem with this. Resident#8 During an interview on 02/20/24 at 10:37 AM with Resident #8 who has a BIMS of 15 the resident stated, I remember what happened. She was screaming. My room was across from hers at the time. I wanted to smack them off of her. An interview on 02/20/24 at 10:51 AM with NA #66 she stated, I feel like what I remember ,we heard screaming, and we came out, (Name of Activity Assistant #143) was behind her and (Name of RN #40) was in front of her. I don't remember much, but I did feel like it was an issue. I felt like she had the right to say no. An interview on 02/20/24 at 10:54 AM with NA #13 she states, I was in a room up the hall, and I heard screaming, I came out of the room and saw (Name of NA#55) was holding her head, and the nurse was putting a swab in her nose. I don't remember what nurse I reported it to but the east wing (Name of CL #109 came in and told me to write down what I had seen on the paper, So I did. Just the way she was screaming I felt like I needed to report it. They definitely did the swab ;she was taking the swab out of her nose when I went into the room. Telephone interview with NA #55 on 02/20/24 at 2:39 PM she stated, What I remember r is the nurse needed help. I went to help her. I was holding her head and hands to calm her down. If I knew I was going to be in trouble I would have never gone into the room. The nurse was so busy she was just trying to get it done. An attempt was made to contact RN #40 via telephone, as well as RN #26 pm 02/20/2 at 2:00 PM with no answer or return call. At the time of this survey NA #55 and RN #40 were both still employed at the facility and this allegation was unsubstantiated event though there were multiple witness statements confirming the incident did happen on11/17/23. Resident#11 A facility reportable incident (FRI) dated 10/03/23 in the (AM), was reviewed involving Resident #11. The allegations contained in this reportable was RN #40 , locked Resident #11's wheelchair and held the back of the wheelchair which prevented the resident from freely leaving the room which she was confined to. This allegation was reported as possible involuntary seclusion. The facility investigated and gathered the following statements: NA#141 The surveyor obtained a statement taken by the facility on10/02/23. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	NA #41 said while giving NA a lunch break and taking on the 1:1 she was stopped by the RN #40 and was asked to give another patient care while she took the 1:1. NA#41 said RN #40 forced Resident #11 back into her room locking her wheelchair and holding the back of the wheelchair so Resident #11was unable to leave her room. RN#40 gave a statement on10/03/23: RN#40 said she was doing her medication pass when a family member of one of the resident's asked her to call for Resident#101's nurse aide. RN #40 said she asked NA#141 if she was assigned to Resident #101. NA #141 said she was the aide for Resident #101. NA #141 also said she was watching Resident #11 because the nurse aide assigned to Resident#11 was on break and had asked her to watch Resident#11 while also attending Resident #101. NA #141 said she had a conversation with Resident #11 while walking around the facility. She said Resident #11 was as going to the exit door and kept saying she was going home. When RN #26, who was the assigned nurse to Resident#11 noticed this behavior she said she would take over Resident #11 so RN #40 could finish medication pass. Resident #11 started hitting and punching us and kept on saying bad words. The staff took Resident #11 to her room while RN #26 had a conversation with the resident trying to have her calm down. Then wrote at the bottom of this same statement was a short statement from RN #26. The summarization of the statement is: RN#26 agreed with RN#40's statement that the incident with the wheelchair was for a limited period and was therapeutic. This allegation was unsubstantiated by the facility. However, an in-service entitled Abuse and Neglect dated 10/03/23 was completed by Clinical Manager #7 for the staff. Further education was completed with RN#40 by Clinical Manager #7 on 10/03/23 which involved reviewing the facility policy entitled [NAME] Virginia Abuse, Neglect and Misappropriation. The section regarding involuntary seclusion was highlighted. Both RN#40 and the clinical manager #7 signed and dated the facility policy. Clinical Manager #7 verified RN#40 was still employed by the facility as a night shift nurse. During an interview with Clinical Manager (CL) #7 on 02/20/24 at approximately11:15 AM she stated, I was directed by the administrator to conduct an in-service and to do individual education with RN#40. I did not have any further action regarding this reportable. An attempt was made to contact RN #40 via phone, as well as RN#26 On 02/20/24 at 2:00 PM with no answer or call back at this time. NA#142 was not able to be interviewed because she no longer works at this facility. During an interview with the Administrator on 02/20/24 at 5:00 PM regarding the incident with Resident #11 he stated, During the investigation you have to weigh the totality of all the statements received and 2 RNs were in the room, versus an Activity Assistant. Sometimes you have to see what actually happened versus someone seeing what they think happened .The statement from both RN's does not conclude that the wheelchair was held. c) Plan of Correction (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/20/24 the Nursing Home Administrator, Director of Nursing, and the Corporate Office implemented the following plan: Employee(RN) #40 was suspended pending investigation and legal review and HR review, if it determined that the employee could return to work, employee #40 will have extensive abuse and neglect training, by the Regional Team Member. Employee (NA) #55 was suspended pending investigation and legal review and HR review ,if is it determined that the employee could return to work Employee #55 will have extensive abuse and neglect training by the Regional Team Member. Residents with BIMS scores of 12 and above were interviewed for potential physical abuse. Residents with BIMS scores of 11 or below had a skin assessment completed for potential physical Abuse. Staff will be reeducated on the Abuse, Neglect, and Misappropriation Policy, through in person, text blast will be physically educated prior to the next shift with signatures. The training will be conducted by the Regional Team Member. There will be training for all staff on Resident Rights including the right to be free from any physical restraints imposed for purposes of discipline or convenience and not required to treat the resident medical symptoms. The training will be conducted by the Regional Team Member. Staff will be reeducated on restraint alternatives. There will be a team review of all reportable events to determine if physical abuse occurred, per state definitions. The team will include, Social Services, Director of Nursing or Designee, and Executive Director. After a thorough review the team will determine if substantiated. Audits will be conducted by the regional Director of Clinical Operations weekly x 4 weeks and monthly x 6 months and randomly thereafter with correction upon discovery. Audit results will be reviewed by the QAPI Committee monthly x 6months.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45173 Based on record review and staff interview, the facility failed to maintain a complete and accurate medical record for Resident #97. This is true for one (1) of five (5) residents reviewed during the survey process. Resident Identifier: #97. Facility Census: 95. Findings Included: a) Resident #97 On 02/20/24 at 11:00 PM, a record review was completed for Resident #97. The record review found a discharge summary dated 10/23/23. The discharge summary under the section 3 Course of Illness/Progress stated, Resident has been unable to participate in getting up with therapy due to FX (fracture). (Typed as written.) After reviewing the physical therapy notes throughout the stay at the facility, the resident did participate fully and attended the therapy sessions in the facility gym while seated in a wheelchair. In addition, other therapy progress notes state, Pt (patient) propel wc (wheelchair) x (times) 75' (feet) sba (stand by assistance). On 02/20/24 at 1:30 PM, Clinical Manager (CM) #109 reviewed the discharge summary. CM #109 confirmed the statement was incorrect based on the therapy notes. No further information was obtained during the survey process.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45173 Based on observation and staff interview, the facility failed to maintain appropriate infection control standards for the cleaning and disinfecting of the [NAME] Unit and maintaining the storage of clean linen. These were random opportunities for discovery. Facility Census: 95. Findings Include: a) Cleansing Dwell Time On 02/20/24 at 9:25 AM, Housekeeper (HK) #46 on the [NAME] wing was asked what type of cleanser does the facility use for surfaces and floors? HK #46 stated (Name of Cleanser) for the floors and surfaces. HK #46 was then asked, what is the dwell time? HK #46 stated, about 5 (five) minutes . On 02/20/24 at 9:40 AM, the Housekeeping Director (HKD) #41 confirmed the name of the cleanser and the dwell time was 10 minutes .it must remain wet . HKD #41 stated, we have reviewed the dwell times .I'm not sure why HK #46 didn't know. On 02/20/24 at 10:00 AM, the label and directions were reviewed for the facility cleanser. The directions state, Treated surfaces must remain visibly wet for 10 minutes. No further information was obtained during the survey process. b) Linen Cart On 02/20/24 at 1:45 PM, the linen cart on the East wing was observed. The linen cart was uncovered with a flap across the top the cart. On 02/20/24 at 1:50 PM, Nurse Aide (NA) #31 and NA #87 confirmed the linen cart had the flap across the top of the cart and was not covered. On 02/21/24 at approximately 3:00 PM, the Director of Nursing (DON) was notified and confirmed the linen cart should be covered. No further information was obtained during the survey process.