STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515152	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montgomery General Elderly Care	501 Adams Street Montgomery, WV 25136

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 49466 Based on observations and resident council interviews, the facility failed to uphold residents' rights to voice grievances freely, without fear of reprisal, as required by CMS standards. This deficiency poses a potential risk to more than a limited number of who currently reside in the facility by creating an environment where individuals may hesitate to utilize the grievance process. Faiclity Census: 58. Findings Included: a) Resident Council Meeting On 10/22/24 at 2:04 PM, a special resident council meeting was held in the facility's main dining room, attended by the activities coordinator (permitted by the residents) and this surveyor. The meeting followed a standard agenda to review ongoing and new matters. During the meeting, the surveyor asked residents if they understood how to file an official grievance. After a brief pause, only Resident #7, identified as the council president, responded, indicating the location of the grievance folder. Other residents were silent, with several displaying hesitant or reserved body language. The surveyor then posed a follow-up question about whether residents feared reprisal for filing grievances. In response, multiple residents were observed exhibiting signs of apprehension, including crossing arms, nodding affirmatively, or verbally confirming a fear of staff retaliation. This observed reluctance and collective unease suggest that residents may not feel safe or supported in expressing concerns, potentially undermining the efficacy of the facility's grievance process. The residents' visible discomfort and hesitation to voice concerns indicate a potential systemic failure by the facility to maintain an open, supportive environment for grievance reporting, as mandated by CMS guidelines. This omission directly impacts the facility's responsibility to foster a transparent culture for resident feedback, increasing the risk that resident needs or grievances may go unaddressed, thereby compromising overall resident well-being.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45173 Based on record review, resident interview and staff interview, the facility failed to provide an environment free from abuse. This was true for 2 (two) of 4 (four) residents reviewed during the Long Term Care Survey process. Resident identifiers: Resident #158, #30, #15. Facility census: 58. Findings included: a) Resident #158 On 10/22/24 at approximately 2:30 PM, a review of the Facility Reported Incident (FRI) revealed Resident #158 bumped another Resident #30's wheelchair with a physical altercation occurring with Resident #30 having sustained bruising to the top of the left hand and left elbow as a result of this altercation. On 10/22/24 at 3:08 PM, a medical record review was completed for Resident #158 which revealed the following diagnoses and medications: Diagnoses: 1. Hallucinations 2. Vascular Dementia with other behavioral disturbance 3. Alzheimer's disease 4. Major depressive disorder recurrent, 5. Delusional disorders 6. Anxiety Medications: 1. Xanax 0.5 milligrams (mg) 1/2 tablet by mouth twice a day 2. Lamictal 200 mg 1 tablet by mouth at bedtime 3. Zyprexa 2.5 mg 1 tablet by mouth once a day 4. Mirtazapine 7.5 mg 1 tablet by mouth at bedtime In addition to the following documentation: On 10/01/23 at 1:52 PM the nursing note read as follows: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident noted hitting another resident on A Hall after wheel chair entangled with wheel chair of another resident. Residents separated. No apparent injury to either resident. All necessary parties notified. Resident POA notified. Dr notified. On 10/24/23 at 10:26 AM the nursing note read as follows: Calling staff inappropriate names such as hussy and rhyming inappropriate statements such as She's from [NAME] because she's a whore On 10/24/23 at 12:20 PM the nursing not read as follows: Resident grabbed and started hitting another resident in the activities room. Both residents in wheel chairs. The other resident grabbed back. Both residents sustained discolorations to left arms. DR notified. resident POA notified. Nursing Home Program reporting of allegations notified. This event occurred at 11:30 am. On 10/26/23 at 3:49 PM the nursing note read as follows: Resident threw water on this recording nurse while giving her 8 am medications. Resident stated You needed a bath. Staff was able to redirect the resident. On 10/28/23 at 12:47 PM the nursing note read as follows: Resident continues to wander halls yelling at other residents, talking to self, hitting and grabbing at staff and or other residents. DR notified. Orders increase Zyprexa to 5 mg po bid. On 10/28/23 at 2:00 PM the nursing note read as follows: Continues with combative behavior with staff and other residents. Wandering halls and into other residents rooms. Grabbing objects in other resident rooms and throwing them. DR notified again. Orders transfer to (Name of local hospital) for further evaluation. On 10/28/23 at 2:10 PM the nursing note read as follows: Resident continues to be combative and needs constant redirection. Resident difficult to redirect. Resident physically and verbally aggressive towards staff and other residents during redirection. Resident hitting, kicking, scratching, and throwing things at staff. LPN (LPN name) notified Dr. of continued behaviors and an order was obtained for resident to be transported to (area hospital ED) for evaluation for behaviors. POA was notified. She was reluctant at first and wanted resident to be isolated for behaviors. This recording nurse advised POA that staff was trying to keep resident redirected and away from other residents but she continues to having combative behaviors. POA notified again of MD's orders to transfer. This recording nurse advised POA that she could meet resident at area hospital facility, but that since she was causing harm to other residents she would have to go for an evaluation. POA voiced understanding and stated I will get ready and meet her up there. Jan Care called for ambulance transport. Discipline Nursing On 10/28/23 at 5:40 PM the nursing note read as follows: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This recording nurse spoke with RN in BARH ER. She stated that the resident was combative upon arrival and had to be sedated to be evaluated. She stated that labs were obtained along with a urine sample. BUN 27 and urine was normal. Resident is awaiting a CT scan of her head and possible referral for social worker for psych eval and treatment. She stated that POA was at bedside. On 10/29/23 at 6:33 AM the nursing note read as follows: RN (Last name of Nurse from hospital) called from (Name of local hospital) and stated that they are sending resident back via BLS and they were pulling out of the facility at 6:23 am. her last v/s were BP 127/56 pulse 50 resp. 20 O2 96% on 2L NC temp 97.8. He stated that the Psych Eval was denied due to her dementia. He stated she had been non-combative while she was there. She had a UTI that was negative. There were no med changes. Head CT was done which showed degenerative white matter changes that were consistent with her age. It showed no acute changes. She was given oral Presidex when she arrived there yesterday. He stated she did fine with it. He stated she swallowed water fine. The daughters were with her in the ER until 7:30-8:00 PM and he stated she had did fine and had not even tried to get up or anything. They did get a Troponin level on her which was 11. They did not do a follow up level. On 10/29/23 at 10:30 AM the nursing note read as follows: Resident's POA, notified that resident had returned to the facility from (Name of local hospital) and has been resting in bed. POA also notified that Zyprexa has been increased to 5 mg BID and she verbalized her understanding, she stated that she will be here to visit with resident today. Call light and fluids within reach and encouraged. Safety precautions in place. Will continue to monitor. On 11/08/23 at 1:52 PM the nursing note read as follows: Res. has been very aggressive to staff and other residents. She is grabbing and smacking at other residents as they pass by. Resident has had multiple interacts with staff and has been aggressive each time, even when just trying to speak to her. She has thrown her lunch tray, as well as fluids offered as well. Dr. has been notified of res. behaviors. New order to transfer to TMH ER for eval d/t behaviors. On 12/11/23 at 9:29 AM a nursing note recorded as Late Entry on 12/12/23 at 3:18 PM read as follows: Res. has had behaviors this AM. Kicking at therapy staff as they walk by in the hallway ambulating another res. Also kicking at other residents as they wheel by her chair in the hallway. Also kicked at a visitors purse(wife visiting her husband). Also does a loud, inaudible yell/growl sound periodically. Denies pain. Not easily redirected from these behaviors. Have offer food, fluids, toileting, and activities, all unsuccessful. On 12/12/23 at 2:19 PM a nursing note read as follows: Resident propelling self throughout facility, attempting to hit and kick at others, redirection not easy. Resident also yelling out randomly. ADLs provided by staff, resident combative at times with care. Denies any discomfort. Dr. reviewed residents medications and behaviors. New order to discontinue Remeron and increase Zyprexa to 5 mg BID. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/22/24 at 4:38 PM, the facility administrator stated the facility does not have specific policy and procedures related to dementia care and behavioral monitoring/interventions. On 10/22/24 at approximately 5:00 PM, a review of facility policy and procedure entitled, Suspected Adult and Elderly Abuse/Neglect was completed which revealed all suspected or alleged violations involving mistreatment, neglect, abuse, including injuries of unknown source and misappropriation of patient/resident property shall be reported immediately to the administrator/Chief Executive Officer (CEO) or designee and to other officials in accordance with State law through established procedures (including to the State survey and certification agency. On 10/22/24 at 6:15 PM, a review of the facility investigation was completed which revealed no corrective action noted on 5 day follow up of investigation involving the two residents. On 10/22/24 at 6:15 PM, an interview was conducted with the facility Social Worker (SW) and Administrator #78 who acknowledged the investigation into the 10/24/24 allegation of abuse was not thorough, not complete and no true corrective action by the facility can be identified, in addition no statements were obtained from facility staff or witnesses. On 10/23/24 at approximately 9:00 AM, a review of Resident #158's care plan was completed: PROBLEM: Resident has physical and verbal behavioral symptoms (resists care at times and has hallucination/curses). Frequently hears people talking about her, thinks her kids or others are being murdered, talks about things that have not really occurred. Also combative with staff and other residents at times. Recently had a hospitalization due to combative behaviors. GOAL: Resident will not harm self or others secondary to physically abusive behavior. Approach: Avoid over stimulation (e.g. noise, crowding, other physically aggressive residents. Divert resident's behavior by assisting resident to activities or to a quiet area for redirection of conversations. Maintain a calm environment and approach to the resident. Remove from group activities when behavior is unacceptable. On 10/23/24 at approximately 10:00 AM, a review of Resident #158's Behavioral/Intervention Monthly Flow Records revealed the following: October 2023 Behavioral/Intervention Monthly Flow Record: 10/03/23: Intermittent behaviors, interventions ineffective (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/04/23: Intermittent behaviors: interventions ineffective 10/05/23: Intermittent behaviors, interventions ineffective 10/06/23: intermittent behaviors, interventions ineffective 10/07/23: intermittent behaviors, interventions ineffective 10/08/23: Intermittent behaviors, interventions ineffective 10/09/23: intermittent behaviors, interventions ineffective 10/10/23: intermittent behaviors, interventions ineffective 10/11/23: intermittent behaviors, interventions ineffective 10/23/23: intermittent behaviors, interventions ineffective 10/24/23: Intermittent behaviors, interventions ineffective 10/25/23: Intermittent behaviors, interventions ineffective 10/26/23: Intermittent behaviors, interventions ineffective 10/29/23: Intermittent behaviors, interventions ineffective 10/30/23: Intermittent behaviors, interventions ineffective November 2023 Behavioral/Intervention Monthly Flow Record: 11/08/24: No behaviors documented. 11/29/23: Continuous behaviors, interventions ineffective. On 10/23/24 at 12:19 PM an interview was conducted with the facility Assistant Director of Nursing (ADON) who stated the facility nurses complete the Behavioral/Intervention Monthly Flow Records. On 10/23/24 at 12:56 PM, an interview was conducted with the facility Director of Nursing (DON). At that time, the DON acknowledged on the Behavioral/Intervention Monthly Flow Records: 1. When a behavior was documented, the outcomes of interventions attempted Resident #158's behaviors were unchanged or worsened. 2. Interventions documented were ineffective 3. The facility was unable to provide further documentation of any interventions attempted were performed to keep other residents safe. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Interventions of the behavioral care plan were not resident centered. 5. That the occurrence on 11/08/23 had not been reported or investigated. b) Resident #15 On 10/21/24 at 1:30 PM, a review of the facility's reported incidents (FRI) was completed. The review found a FRI dated 09/16/24 for Resident #15 (however, the date range for the incident is noted from 09/13/24 through 09/15/24). The information obtained from the FRI, stated verbal abuse from Licensed Practical Nurse (LPN) #73. Resident #15 stated, LPN #73 was fussing at her and became loud and was yelling at the resident. The resident reported LPN #73 made derogatory statements such as calling her fat, telling her we are afraid to leave any food around you, and telling her a list a mile long of people who Resident #15 has been mean to, and threatening to send her up the river. The resident thought LPN #73 was implying she had a rap sheet and she would be sent to another facility. The FRI states, Resident does get her feelings hurt easily and is very child like with how she thinks but that is normal for her. The FRI, also, stated, Victim does not have capacity. (Name of Resident #15) BIMS (Brief Interview for Mental Status) is a 12 which is moderately impaired. No medical intervention was necessary. (Name of Resident #15) has been emotional distress all day and her roommate said she also had cried through the night the night before. (Typed as written.) An interview, with no date or time, during the facility investigation was held with Resident #15's roommate, Resident #45. Resident #45 confirmed the resident and LPN #73 were arguing and she thought they were going to fist fight. Resident #45 stated she couldn't remember details of what was said. The following witness statements were obtained from the staff: An interview was held with Nurse Aide (NA) #67. There was no specific date or time noted on the witness statement. Nurse Aide (NA) #67 stated, LPN #73 wanted to give the resident her breathing treatment. However, the resident was watching TV and did not want to miss it. NA #67 wanted to give Resident #15 her breathing treatment early due to getting off and there would only be one nurse there. NA #67 stated, the resident became upset and started yelling and cussing .calling the staff names. A witness statement with no date or time noted was obtained from NA #40. NA #40 stated, Heard (Name of LPN #73) talking down to (Name of Resident #15) going back to her room. (Name of Resident #15) was testy over what was on TV. (Name of LPN #73) intensified (Name of Resident #15) mood that's how she does. Told (Name of Resident #15) no one cares what (Name of Resident #15) has to say anyway. When NA #40 heard that she went to other end of hall to avoid hearing the rest of the conversation. Feel that if she intervened it would have made things worse for (Name of Resident #15). Treatment of people is unkind. Reminds her of another nurse that was awful she worked with before. Off Sat (Saturday), Friday she worked. (Typed as written.) A witness statement with the date of 09/19/24 but no time noted, NA #7 stated, I was in the dining room when (Name of Resident #15) was crying she said that (Name of LPN #73) .she stated she hated (Name of LPN #73) and when she got up and was leaving the dining room she said to me that she was going to get (Name of LPN #73) fired. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A witness statement was obtained from Activities Director #70. The statement is as follows: Resident (Name of Resident #15) came into the activity room on Monday, September 16th at 10:30 AM and ask if she could speak to me about something private. She said Nurse (Name of LPN #73) came in her room fussing at her. She said (Name of LPN #73) really hurt her because she was making fun of her being fat. She said (Name of LPN #73) said she was afraid of leaving food on a plate around her. She said (Name of LPN #73) she was so overweight. She said (Name of LPN #73) was yelling at her and saying mean things to her. I asked (Name of Resident #15) what was said she couldn't remember what all was said. She expressed that (Name of LPN #73) hurt her so badly she would like if I told (Name of LPN #73) not to come in her room anymore. She said (Name of LPN #73) told her she has had enough on her to send her away up the river. She said (Name of LPN #73) speaks to her roommate (Name of Resident #45) nicely but doesn't speak nice to her. I asked why and she said she feels like (Name of LPN #73) hates her. She said (Name of LPN #73) told her she has a wrap sheet a mile long and its enough to get her transferred to another facility. I expressed to (Name of Resident #15) that (Name of LPN #73) didn't have the authority to send her anywhere and (Name of Resident #15) said well according to her she does. (Name of LPN #73) told her she was mean to the other residents, her roommate and staff members. (Name of Resident #15) also was upset that (Name of LPN #73) made her leave the TV lounge to take her breathing treatments. She said (Name of LPN #73) told her she needed to take the treatment but could come back after she finished but (Name of Resident #15) doesn't want to walk to her room and then walk back. I told (Name of Resident #15) she needed to talk to the social worker about what happened and she said she was going to speak to her. (Name of Resident #15) said she just didn't want (Name of LPN #73) to be her nurse anymore. (Typed as written.) An additional witness statement was obtained from the Administrative Assistant #46. The written statement does not include a date or time. The witness statement states the following: (Name of Resident #15) and (Name of Resident #45) both came into the office and wanted to talk to (Name of Social Services #30). At the time, she was busy with someone in her office, so (Name of Resident #15) and (Name of Resident #45) asked if they could talk to me. (Name of Resident #15) appeared visibly upset so I let them sit by my desk and talk. (Name of Resident #15) said that she was upset with how (Name of LPN #73) had treated her and that she didn't want (Name of LPN #73) in her room or around her anymore. (Name of Resident #15) referenced an instance where (Name of LPN #73) either directly or indirectly made an offhand comment about (Name of Resident #15)'s weight, as well as making a comment about not being able to leave food on a plate around (Name of Resident #15). (Name of Resident #45) seemed to corroborate at least some, if not all, of what had happened. (Name of Resident #15) also mentioned that (Name of LPN #73) said she had a rap sheet on her this long. I also recall (Name of Resident #15) mentioning that someone said she was mean to (Name of Resident #45), (Name of Resident #45) refuted. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/21/24 at 2:15 PM, the five (5) day follow-up investigation dated 09/20/24 at 9:06 AM, was reviewed. The five (5) day follow-up states,No additional outcomes were found. Initial report was made regarding abuse, due to comments allegedly made by (Name of LPN #73), towards resident regarding her weight and sending her out of the facility. (Name of LPN #73 denies making any of the statements, she stated that she witnessed (Name of Resident #15) kicking her roommates walker and overheard (Name of Resident #15) calling her roommate a bitch when she intervened and explained to (Name of Resident #15) that she can't kick her roommate's walker because she or someone else could get hurt. The charge nurse responsible for oversight was not in the vicinity of the location where the incident allegedly occurred. Multiple staff members reiterated that (Name of Resident #15) can throw tantrums when she doesn't get her way. One staff member mentioned (Name of Resident #15) had mentioned prior to the incident that she was planning to get (Name of LPN #73) fired. Interviews and statements from staff and roommate were inconclusive. Most staff members heard (Name of Resident #15) get upset in the lounge when asked to return to her room and take a breathing treatment, but no staff members were around to see or hear the alleged incident take place. The allegation was inconclusive due to a lack of witnesses and evidence. (Typed as written.) On 10/21/24 at 4:15 PM, Resident #15 was interviewed regarding the allegation of verbal abuse. Resident #15 stated, she hollered at me at the top of her lungs, called me fat, and told me I was going to have to go to another place to live. During the interview, Resident #15 was visibly upset. She began to cry, wring her hands and shake. Resident #15 stated, I hate when I hear her voice .I can't get over it no matter how hard I try. The resident stated her roommate heard everything. She said she has talked with staff members about the incident with LPN #73 but continues to be upset. On 10/21/24 at approximately 5:00 PM, Resident 15's roommate at the time, was interviewed regarding the incident. Resident #45 was asked, do you remember an incident with (Name of Resident #15) and a staff member? Resident #45 stated, the nurse screamed at her .she was loud and was reprimanding her as if she were a child. Resident #45 was asked, do you think this was appropriate for a staff member to do? Resident #45 stated, no it was not appropriate I remember it happened I just can't remember all the exact words that were said. On 10/23/24 at 10:49 AM, an interview was held with Social Services #30 and Activities Coordinator #70. Both staff members were asked about the statements by witnesses and the interview which was held with Resident #15. Social Services #30 stated, Because, of . we went through all of the statements. I was ready to substantiate initially. We also got statements that (Name of Resident #15) says I am going to get her fired. The Social Services #30 was asked, was the resident not believed because of documented behaviors and angry statements the resident made? Social Services #30 stated, the staff was suspended. On 10/23/24 at 10:53 AM, the facility Administrator walked into the conference room. The Administrator was told of the previous conversation with Social Services #30 and Activities Coordinator #70. On 10/23/24 at 10:57 AM, the Administrator stated, The statements were reflective of what the resident stated, not what actually happened. I did feel she (LPN #73) was aggressive toward the resident. But based on the statements, I am not sure what happened. I feel the staff pushed the situation by being to loud. She (LPN #73) could not tell me exactly what was said but that she was loud. On 10/23/24 at 10:58 AM, the Administrator stated, I was out at a conference at this event, I was handling things over the phone. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/23/24 at 10:59 AM, Social Services #30 stated, This was a really tough one we went back and forth with this one. On 10/23/24 at 11:00 AM, the Administrator stated, I felt as if her escalating the situation required action . I feel that the resident saying she called her fat and the accusation that we could not substantiate. We feel like it is our job to protect residents, APS (Adult Protective Services) told us they were not interested in investigating, this is what helped lead us to our decision. The Administrator was asked, what would have convinced you this allegation of verbal abuse occurred? The Administrator stated, Another witness to collaborate what was said. NA #42 did not collaborate what she said, because she walked away .the resident is known to tell falsehoods and she had threatened to get the LPN fired. At this time, the written statement by NA #42 was reviewed with the Administrator. The Administrator stated, I do not recall her specific statement, but I do agree with you .the LPN was immediately suspended and upon return to work she was given a Last Chance Agreement. The Last Chance Agreement dated 09/20/24 stated, .It has been brought to the facility's attention that (Name of LPN #73) has previously engaged in inappropriate behavior by escalating situations with aggressive or difficult residents. Despite previous education and guidance on managing such situations with tact and professionalism, the issue persists. Effective immediately, this is the final written warning regarding her conduct. Any future incidents where (Name of LPN #73) raises her voice aggressively or acts in a manner that escalates conflict with residents will result in immediate termination of employment . The Administrator was asked, why was LPN #73 given this Last Chance Agreement? Did you feel the alleged verbal abuse occurred? The Administrator stated, I know she was loud .but I could not verify what actually took place. On 10/23/24 at 11:03 AM, Social Services #30 stated, I have talked to her (Resident #15) many times about the situation. But I do not have notes about this particular situation. I am not sure If I have formally talked to them (Resident #15 and Resident #45) about the situation. On 10/23/24 at 11:20 AM, the Administrator was asked, do you realize the resident remains upset regarding this allegation of verbal abuse .the resident continues to be visibly upset, such as crying and wringing her hands. The Administrator stated, She has been referred to our psych doctor. She comes once a week on Tuesdays. I will see if she has seen her. On 10/23/24 at approximately 12:15 PM, the Administrator was asked, why didn't LPN #73 follow the care plan intervention under the focus area of behavioral symptoms .which is when resident becomes physically abusive, STOP and try task later. Do not force task and Maintain a calm environment and approach to the resident. (Typed as written.) The Administrator stated, the nurse should have came back later regarding the breathing treatment .I agree this escalated Resident #15's behavior. 50552

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45173 Based on record review, resident interview and staff interview, the facility failed to implement the facility Abuse policy and procedure. This was true for 2 (two) of 4 (four) residents reviewed during the Long Term Care Survey Process. Resident identifiers: Resident #158, Resident #30 and Resident #15. Facility census: 58. Findings include: a) a) Resident #158 On 10/22/24 at approximately 2:30 PM, a review of the Facility Reported Incident was completed which revealed Resident #158 bumped another Resident #30's wheelchair with a physical altercation occurring with Resident #30 having sustained bruising to the top of the left hand and left elbow as a result of this altercation. On 10/22/24 at 3:08 PM, a medical record review was completed for Resident #158 which revealed the following diagnoses and medications: Diagnoses: 1. Hallucinations 2. Vascular Dementia with other behavioral disturbance 3. Alzheimer's disease 4. Major depressive disorder recurrent, 5. Delusional disorders 6. Anxiety Medications: 1. Xanax 0.5 milligrams (mg) 1/2 tablet by mouth twice a day 2.Lamictal 200 mg 1 tablet by mouth at bedtime 3. Zyprexa 2.5 mg 1 tablet by mouth once a day 4. Mirtazapine 7.5mg 1 tablet by mouth at bedtime In addition to the following documentation: On 10/01/23 at 1:52 PM the nursing note read as follows: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident noted hitting another resident on A Hall after wheel chair entangled with wheel chair of another resident. Residents separated. No apparent injury to either resident. All necessary parties notified. Resident POA notified. Dr notified. On 10/24/23 at 10:26 AM the nursing not read as follows: Calling staff inappropriate names such as hussy and rhyming inappropriate statements such as She's from [NAME] because she's a whore On 10/24/23 at 12:20 PM the nursing not read as follows: Resident grabbed and started hitting another resident in the activities room. Both residents in wheel chairs. The other resident grabbed back. Both residents sustained discolorations to left arms. DR notified. resident POA/Daughter notified. Nursing Home Program reporting of allegations notified. This event occurred at 11:30 am. On 10/26/23 at 3:49 PM the nursing note read as follows: Resident threw water on this recording nurse while giving her 8 am medications. Resident stated You needed a bath. Staff was able to redirect the resident. On 10/28/23 at 12:47 PM the nursing note read as follows: Resident continues to wander halls yelling at other residents, talking to self, hitting and grabbing at staff and or other residents. DR notified. Orders increase zyprexa to 5mg po bid. On 10/28/23 at 2:00 PM the nursing note read as follows: Continues with combative behavior with staff and other residents. Wandering halls and into other residents rooms. Grabbing objects in other resident rooms and throwing them. DR notified again. Orders transfer to Barh for further evaluation. On 10/28/23 at 2:10 PM the nursing note read as follows: Resident continues to be combative and needs constant redirection. Resident difficult to redirect. Resident physically and verbally aggressive towards staff and other residents during redirection. Resident hitting, kicking, scratching, and throwing things at staff. LPN (LPN name) notified Dr. of continued behaviors and an order was obtained for resident to be transported to (local hospital ED) for evaluation for behaviors. POA was notified. She was reluctant at first and wanted resident to be isolated for behaviors. This recording nurse advised POA that staff was trying to keep resident redirected and away from other residents but she continues to having combative behaviors. POA notified again of MD's orders to transfer. This recording nurse advised POA that she could meet resident at local hospital facility, but that since she was causing harm to other residents she would have to go for an evaluation. POA voiced understanding and stated I will get ready and meet her up there. Jan Care called for ambulance transport. Discipline Nursing On 10/28/23 at 5:40 PM the nursing note read as follows: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This recording nurse spoke with RN in local hospital ED. She stated that the resident was combative upon arrival and had to be sedated to be evaluated. She stated that labs were obtained along with a urine sample. BUN 27 and urine was normal. Resident is awaiting a CT scan of her head and possible referral for social worker for phsych eval and treatment. She stated that POA was at bedside. On 10/29/23 at 6:33 AM the nursing note read as follows: RN (Last name of Nurse from hospital) called from (Name of local hospital) and stated that they are sending resident back via BLS and they were pulling out of the facility at 6:23 am. her last v/s were BP 127/56 pulse 50 resp. 20 O2 96% on 2L NC temp 97.8. He stated that the Psychiatric Evaluation was denied due to her dementia. He stated she had been non-combative while she was there. She had a UTI that was negative. There were no med changes. Head CT was done which showed degenerative white matter changes that were consistent with her age. It showed no acute changes. She was given oral Presidex when she arrived there yesterday. He stated she did fine with it. He stated she swallowed water fine. The daughters were with her in the ER until 7:30-8:00 pm and he stated she had did fine and had not even tried to get up or anything. They did get a Troponin level on her which was 11. They did not do a follow up level. On 10/29/23 at 10:30 AM the nursing note read as follows: Resident's POA, notified that resident had returned to the facility from (Name of local hospital) and has been resting in bed. POA also notified that Zyprexa has been increased to 5 mg BID and she verbalized her understanding, she stated that she will be here to visit with resident today. Call light and fluids within reach and encouraged. Safety precautions in place. Will continue to monitor. On 11/08/23 at 1:52 PM the nursing note read as follows: Res. has been very aggressive to staff and other residents. She is grabbing and smacking at other residents as they pass by. Resident has had multiple interacts with staff and has been aggressive each time, even when just trying to speak to her. She has thrown her lunch tray, as well as fluids offered as well. Dr. has been notified of res. behaviors. New order to transfer to TMH ER for eval d/t behaviors. On 12/11/23 at 9:29 AM a nursing note recorded as Late Entry on 12/12/23 at 3:18 PM read as follows: Res. has had behaviors this AM. Kicking at therapy staff as they walk by in the hallway ambulating another res. Also kicking at other residents as they wheel by her chair in the hallway. Also kicked at a visitors purse(wife visiting her husband). Also does a loud, inaudible yell/growl sound periodically. Denies pain. Not easily redirected from these behaviors. Have offer food, fluids, toileting, and activities, all unsuccessful. On 12/12/23 at 2:19 PM a nursing note read as follows: Resident propelling self throughout facility, attempting to hit and kick at others, redirection not easy. Resident also yelling out randomly. ADLs provided by staff, resident combative at times with care. Denies any discomfort. Dr. reviewed residents medications and behaviors. New order to discontinue Remeron and increase Zyprexa to 5mg BID. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/22/24 at 4:38 PM, the facility administrator stated the facility does not have specific policy and procedures related to dementia care and behavioral monitoring/interventions. On 10/22/24 at approximately 5:00 PM, a review of facility policy and procedure entitiled, Suspected Adult and Elderly Abuse/Neglect was completed which revealed all suspected or alleged violations involving mistreatment, neglect, abuse, including injuries of unknown source and misappropriation of patient/resident property shall be reported immediately to the administrator/Cheif Executive Officer (CEO) or designee and to other officals in accordance with State law through established procedures (including to the State survey and certification agency. On 10/22/24 at 6:15 PM, a review of the facility investigation was completed which revealed no corrective action noted on 5 day follow up of investigation involving the two residents. On 10/22/24 at 6:15 pm, an interview was conducted with the facility Social Worker (SW) and Administrator #78 who acknowledged the investigation into the 10/24/24 allegation of abuse was not thorough, not complete and no true corrective action by the facility can be identified, in addition no statements were obtained from facility staff or witnesses. On 10/23/24 at approximately 9:00 AM, a review of Resident #158's care plan was completed: PROBLEM: Resident has physical and verbal behavioral symptoms (resists care at times and has hallucination/curses). Frequently hears people talking about her, thinks her kids or others are being murdered, talks about things that have not really occurred. Also combative with staff and other residents at times. Recently had a hospitalization due to combative behaviors. GOAL: Resident will not harm self or others secondary to physically abusive behavior. Approach: Avoid over stimulation (e.g. noise, crowding, other physically aggressive residents. Divert resident's behavior by assisting resident to activities or to a quiet area for redirection of conversations. Maintain a calm environment and approach to the resident. Remove from group activities when behavior is unacceptable. On 10/23/24 at approximately 10:00 AM, a review of Resident #158's Behavioral/Intervention Monthly Flow Records revealed the following: October 2023 Behavioral/Intervention Monthly Flow Record: 10/03/23: Intermittent behaviors, interventions ineffective (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/04/23: Intermittent behaviors: interventions ineffective 10/05/23: Intermittent behaviors, interventions ineffective 10/06/23: intermittent behaviors, interventions ineffective 10/07/23: intermittent behaviors, interventions ineffective 10/08/23: Intermittent behaviors, interventions ineffective 10/09/23: intermittent behaviors, interventions ineffective 10/10/23: intermittent behaviors, interventions ineffective 10/11/23: intermittent behaviors, interventions ineffective 10/23/23: intermittent behaviors, interventions ineffective 10/24/23: Intermittent behaviors, interventions ineffective 10/25/23: Intermittent behaviors, interventions ineffective 10/26/23: Intermittent behaviors, interventions ineffective 10/29/23: Intermittent behaviors, interventions ineffective 10/30/23: Intermittent behaviors, interventions ineffective November 2023 Behavioral/Intervention Monthly Flow Record: 11/08/24: No behaviors documented. 11/29/23: Continuous behaviors, interventions ineffective. On 10/23/24 at 12:19 PM an interview was conducted with the facility Assistant Director of Nursing (ADON) who stated the facility nurses complete the Behavioral/Intervention Monthly Flow Records. On 10/23/24 at 12:56 PM, an interview was conducted with the facility Director of Nursing (DON). At that time, the DON acknowledged on the Behavioral/Intervention Monthly Flow Records: 1. When a behavior was documented, the outcomes of interventions attempted Resident #158's behaviors were unchanged or worsened. 2. Interventions documented were ineffective 3. The facility was unable to provide further documentation of any interventions attempted were performed to keep other residents safe. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A witness statement was obtained from Activities Director #70. The statement is as follows: Resident (Name of Resident #15) came into the activity room on Monday, September 16th at 10:30 AM and ask if she could speak to me about something private. She said Nurse (Name of LPN #73) came in her room fussing at her. She said (Name of LPN #73) really hurt her because she was making fun of her being fat. She said (Name of LPN #73) said she was afraid of leaving food on a plate around her. She said (Name of LPN #73) said she was so overweight. She said (Name of LPN #73) was yelling at her and saying mean things to her. I asked (Name of Resident #15) what was said she couldn't remember what all was said. She expressed that (Name of LPN #73) hurt her so badly she would like if I told (Name of LPN #73) not to come in her room anymore. She said (Name of LPN #73) told her she has had enough on her to send her away up the river. She said (Name of LPN #73) speaks to her roommate (Name of Resident #45) nicely but doesn't speak nice to her. I asked why and she said she feels like (Name of LPN #73) hates her. She said (Name of LPN #73) told her she has a wrap sheet a mile long and its enough to get her transferred to another facility. I expressed to (Name of Resident #15) that (Name of LPN #73) didn't have the authority to send her anywhere and (Name of Resident #15) said well according to her she does. (Name of LPN #73) told her she was mean to the other residents, her roommate and staff members. (Name of Resident #15) also was upset that (Name of LPN #73) made her leave the TV lounge to take her breathing treatments. She said (Name of LPN #73) told her she needed to take the treatment but could come back after she finished but (Name of Resident #15) doesn't want to walk to her room and then walk back. I told (Name of Resident #15) she needed to talk to the social worker about what happened and she said she was going to speak to her. (Name of Resident #15) said she just didn't want (Name of LPN #73) to be her nurse anymore. (Typed as written.) An additional witness statement was obtained from the Administrative Assistant #46. The written statement does not include a date or time. The witness statement states the following: (Name of Resident #15) and (Name of Resident #45) both came into the office and wanted to talk to (Name of Social Services #30). At the time, she was busy with someone in her office, so (Name of Resident #15) and (Name of Resident #45) asked if they could talk to me. (Name of Resident #15) appeared visibly upset so I let them sit by my desk and talk. (Name of Resident #15) said that she was upset with how (Name of LPN #73) had treated her and that she didn't want (Name of LPN #73) in her room or around her anymore. (Name of Resident #15) referenced an instance where (Name of LPN #73) either directly or indirectly made an offhand comment about (Name of Resident #15)'s weight, as well as making a comment about not being able to leave food on a plate around (Name of Resident #15). (Name of Resident #45) seemed to corroborate at least some, if not all, of what had happened. (Name of Resident #15) also mentioned that (Name of LPN #73) said she had a rap sheet on her this long. I also recall (Name of Resident #15) mentioning that someone said she was mean to (Name of Resident #45), (Name of Resident #45) refuted. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/21/24 at 2:15 PM, the five (5) day follow-up investigation dated 09/20/24 at 9:06 AM, was reviewed. The five (5) day follow-up states,No additional outcomes were found. Initial report was made regarding abuse, due to comments allegedly made by (Name of LPN #73), towards resident regarding her weight and sending her out of the facility. (Name of LPN #73 denies making any of the statements, she stated that she witnessed (Name of Resident #15) kicking her roommates walker and overheard (Name of Resident #15) calling her roommate a bitch when she intervened and explained to (Name of Resident #15) that she can't kick her roommate's walker because she or someone else could get hurt. The charge nurse responsible for oversight was not in the vicinity of the location where the incident allegedly occurred. Multiple staff members reiterated that (Name of Resident #15) can throw tantrums when she doesn't get her way. One staff member mentioned (Name of Resident #15) had mentioned prior to the incident that she was planning to get (Name of LPN #73) fired. Interviews and statements from staff and roommate were inconclusive. Most staff members heard (Name of Resident #15) get upset in the lounge when asked to return to her room and take a breathing treatment, but no staff members were around to see or hear the alleged incident take place. The allegation was inconclusive due to a lack of witnesses and evidence. (Typed as written.) On 10/21/24 at 4:15 PM, Resident #15 was interviewed regarding the allegation of verbal abuse. Resident #15 stated, she hollered at me at the top of her lungs, called me fat, and told me I was going to have to go to another place to live. During the interview, Resident #15 was visibly upset. She began to cry, wring her hands and shake. Resident #15 stated, I hate when I hear her voice .I can't get over it no matter how hard I try. The resident stated her roommate heard everything. She said she has talked with staff members about the incident with LPN #73 but continues to be upset. On 10/21/24 at approximately 5:00 PM, Resident 15's roommate at the time, was interviewed regarding the incident. Resident #45 was asked, do you remember an incident with (Name of Resident #15) and a staff member? Resident #45 stated, the nurse screamed at her .she was loud and was reprimanding her as if she were a child. Resident #45 was asked, do you think this was appropriate for a staff member to do? Resident #45 stated, no it was not appropriate I remember it happened I just can't remember all the exact words that were said. On 10/23/24 at 10:49 AM, an interview was held with Social Services #30 and Activities Coordinator #70. Both staff members were asked about the statements by witnesses and the interview which was held with Resident #15. Social Services #30 stated, Because, of . we went through all of the statements. I was ready to substantiate initially. We also got statements that (Name of Resident #15) says I am going to get her fired. The Social Services #30 was asked, was the resident not believed because of documented behaviors and angry statements the resident made? Social Services #30 stated, the staff was suspended. On 10/23/24 at 10:53 AM, the facility Administrator walked into the conference room. The Administrator was told of the previous conversation with Social Services #30 and Activities Coordinator #70. On 10/23/24 at 10:57 AM, the Administrator stated, The statements were reflective of what the resident stated, not what actually happened. I did feel she (LPN #73) was aggressive toward the resident. But based on the statements, I am not sure what happened. I feel the staff pushed the situation by being to loud. She (LPN #73) could not tell me exactly what was said but that she was loud. On 10/23/24 at 10:58 AM, the Administrator stated, I was out at a conference at this event, I was handling things over the phone. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/23/24 at 10:59 AM, Social Services #30 stated, This was a really tough one we went back and forth with this one. On 10/23/24 at 11:00 AM, the Administrator stated, I felt as if her escalating the situation required action . I feel that the resident saying she called her fat and the accusation that we could not substantiate. We feel like it is our job to protect residents, APS (Adult Protective Services) told us they were not interested in investigating, this is what helped lead us to our decision. The Administrator was asked, what would have convinced you this allegation of verbal abuse occurred? The Administrator stated, Another witness to collaborate what was said. NA #42 did not collaborate what she said, because she walked away .the resident is known to tell falsehoods and she had threatened to get the LPN fired. At this time, the written statement by NA #42 was reviewed with the Administrator. The Administrator stated, I do not recall her specific statement, but I do agree with you .the LPN was immediately suspended and upon return to work she was given a Last Chance Agreement. The Last Chance Agreement dated 09/20/24 stated, .It has been brought to the facility's attention that (Name of LPN #73) has previously engaged in inappropriate behavior by escalating situations with aggressive or difficult residents. Despite previous education and guidance on managing such situations with tact and professionalism, the issue persists. Effective immediately, this is the final written warning regarding her conduct. Any future incidents where (Name of LPN #73) raises her voice aggressively or acts in a manner that escalates conflict with residents will result in immediate termination of employment . The Administrator was asked, why was LPN #73 given this Last Chance Agreement? Did you feel the alleged verbal abuse occurred? The Administrator stated, I know she was loud .but I could not verify what actually took place. On 10/23/24 at 11:03 AM, Social Services #30 stated, I have talked to her (Resident #15) many times about the situation. But I do not have notes about this particular situation. I am not sure If I have formally talked to them (Resident #15 and Resident #45) about the situation. On 10/23/24 at 11:20 AM, the Administrator was asked, do you realize the resident remains upset regarding this allegation of verbal abuse .the resident continues to be visibly upset, such as crying and wringing her hands. The Administrator stated, She has been referred to our psych doctor. She comes once a week on Tuesdays. I will see if she has seen her. On 10/23/24 at approximately 12:15 PM, the Administrator was asked, why didn't LPN #73 follow the care plan intervention under the focus area of behavioral symptoms .which is when resident becomes physically abusive, STOP and try task later. Do not force task and Maintain a calm environment and approach to the resident. (Typed as written.) The Administrator stated, the nurse should have came back later regarding the breathing treatment .I agree this escalated Resident #15's behavior. 50552

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45173 49465 Based on record review and staff interview, the facility failed to ensure all allegations of abuse and or neglect were reported to appropriate state agencies as required. This was true for two (2) of four (4) residents reviewed for the care area of abuse during the long term care survey. Resident Identifiers: #4 and #158. Facility Census: 58. Findings Include: a) Resident #4 A review of the facilities grievance and concerns on 10/22/24 at 5:38 PM, revealed a concern that reads as follows: (Resident #4 named) wanted put in bed during mealtime and two staff have to put her in bed and most staff were feeding other residents and told her soon as they could put her to bed they would. Resident stated that a nurse said Poor Thing to her because she was ready to go to bed and stated her hips were hurting from the wheelchair. The staff that made the comment received verbal disciplinary action. During an interview on 10/22/24 at 5:41 PM, the Administrator stated, I remember the incident. The original person she said it was, was not who it was. We found it was a (Nurse Aide) NA. The NA said that she did not mean that in a derogatory way, she meant it as a sweet gesture. The administrator additionally stated, We will report it now. b) Resident #158 On 10/22/24 at approximately 2:30 PM, a review of the Facility Reported Incident was completed which revealed Resident #158 bumped another Resident #30's wheelchair with a physical altercation occurring with Resident #30 having sustained bruising to the top of the left hand and left elbow as a result of this altercation. On 10/22/24 at 3:08 PM, a medical record review was completed for Resident #158 which revealed the following diagnoses and medications: Diagnoses included Hallucinations, Vascular Dementia with other behavioral disturbance, Alzheimer's disease, Major depressive disorder recurrent, Delusional disorders and Anxiety. In addition to the following documentation: On 10/01/23 at 1:52 PM the nursing note read as follows: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident noted hitting another resident on A Hall after wheel chair entangled with wheel chair of another resident. Residents separated. No apparent injury to either resident. All necessary parties notified. Resident POA notified. Dr notified. On 10/24/23 at 10:26 AM the nursing not read as follows: Calling staff inappropriate names such as hussy and rhyming inappropriate statements such as She's from [NAME] because she's a whore On 10/24/23 at 12:20 PM the nursing not read as follows: Resident grabbed and started hitting another resident in the activities room. Both residents in wheel chairs. The other resident grabbed back. Both residents sustained discolorations to left arms. DR notified. resident POA notified. Nursing Home Program reporting of allegations notified. This event occurred at 11:30 am. On 10/26/23 at 3:49 PM the nursing note read as follows: Resident threw water on this recording nurse while giving her 8 AM medications. Resident stated You needed a bath. Staff was able to redirect the resident. On 10/28/23 at 12:47 PM the nursing note read as follows: Resident continues to wander halls yelling at other residents, talking to self, hitting and grabbing at staff and or other residents. DR notified. Orders increase Zyprexa to 5 mg po bid. On 10/28/23 at 2:00 PM the nursing note read as follows: Continues with combative behavior with staff and other residents. Wandering halls and into other residents rooms. Grabbing objects in other resident rooms and throwing them. DR notified again. Orders transfer to (name of local hospital) for further evaluation. On 10/28/23 at 2:10 PM the nursing note read as follows: Resident continues to be combative and needs constant redirection. Resident difficult to redirect. Resident physically and verbally aggressive towards staff and other residents during redirection. Resident hitting, kicking, scratching, and throwing things at staff. LPN (Name of LPN) notified Dr. of continued behaviors and an order was obtained for resident to be transported to (name of local hospital) ER for evaluation for behaviors. POA was notified. She was reluctant at first and wanted resident to be isolated for behaviors. This recording nurse advised POA that staff was trying to keep resident redirected and away from other residents but she continues to having combative behaviors. POA notified again of MD's orders to transfer. This recording nurse advised POA that she could meet resident at (name of local hospital) facility, but that since she was causing harm to other residents she would have to go for an evaluation. POA voiced understanding and stated I will get ready and meet her up there. (Ambulance Company name) called for ambulance transport. Discipline Nursing On 10/28/23 at 5:40 PM the nursing note read as follows: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This recording nurse spoke with RN in (name of local hospital) ER. She stated that the resident was combative upon arrival and had to be sedated to be evaluated. She stated that labs were obtained along with a urine sample. BUN 27 and urine was normal. Resident is awaiting a CT scan of her head and possible referral for social worker for psych eval and treatment. She stated that POA was at bedside. On 10/29/23 at 6:33 AM the nursing note read as follows: RN (Last name of Nurse from hospital) called from (Name of local hospital) and stated that they are sending resident back via BLS and they were pulling out of the facility at 6:23 am. her last v/s were BP 127/56 pulse 50 resp. 20 O2 96% on 2L NC temp 97.8. He stated that the Psychiatric Evaluation was denied due to her dementia. He stated she had been non-combative while she was there. She had a UTI that was negative. There were no med changes. Head CT was done which showed degenerative white matter changes that were consistent with her age. It showed no acute changes. She was given oral Presidex when she arrived there yesterday. He stated she did fine with it. He stated she swallowed water fine. The daughters were with her in the ER until 7:30-8:00 PM and he stated she had did fine and had not even tried to get up or anything. They did get a Troponin level on her which was 11. They did not do a follow up level. On 10/29/23 at 10:30 AM the nursing note read as follows: Resident's POA, notified that resident had returned to the facility from (Name of local hospital) and has been resting in bed. POA also notified that Zyprexa has been increased to 5 mg BID and she verbalized her understanding, she stated that she will be here to visit with resident today. Call light and fluids within reach and encouraged. Safety precautions in place. Will continue to monitor. On 11/08/23 at 1:52 PM the nursing note read as follows: Res. has been very aggressive to staff and other residents. She is grabbing and smacking at other residents as they pass by. Resident has had multiple interacts with staff and has been aggressive each time, even when just trying to speak to her. She has thrown her lunch tray, as well as fluids offered as well. Dr. has been notified of res. behaviors. New order to transfer to (local hospital name) ER for eval d/t behaviors. On 12/11/23 at 9:29 AM a nursing note recorded as Late Entry on 12/12/23 at 3:18 PM read as follows: Res. has had behaviors this AM. Kicking at therapy staff as they walk by in the hallway ambulating another res. Also kicking at other residents as they wheel by her chair in the hallway. Also kicked at a visitors purse(wife visiting her husband). Also does a loud, inaudible yell/growl sound periodically. Denies pain. Not easily redirected from these behaviors. Have offer food, fluids, toileting, and activities, all unsuccessful. On 12/12/23 at 2:19 PM a nursing note read as follows: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident propelling self throughout facility, attempting to hit and kick at others, redirection not easy. Resident also yelling out randomly. ADLs provided by staff, resident combative at times with care. Denies any discomfort. Dr. reviewed residents medications and behaviors. New order to discontinue Remeron and increase Zyprexa to 5 mg BID. On 10/22/24 at 4:38 PM, the facility administrator stated the facility does not have specific policy and procedures related to dementia care and behavioral monitoring/interventions. On 10/22/24 at approximately 5:00 PM, a review of facility policy and procedure entitled, Suspected Adult and Elderly Abuse/Neglect was completed which revealed all suspected or alleged violations involving mistreatment, neglect, abuse, including injuries of unknown source and misappropriation of patient/resident property shall be reported immediately to the administrator/Chief Executive Officer (CEO) or designee and to other officials in accordance with State law through established procedures (including to the State survey and certification agency. On 10/22/24 at 6:15 PM, a review of the facility investigation was completed which revealed no corrective action noted on 5 day follow up of investigation involving the two residents. On 10/22/24 at 6:15 PM, an interview was conducted with the facility Social Worker (SW) and Administrator #78 who acknowledged the investigation into the 10/24/24 allegation of abuse was not thorough, not complete and no true corrective action by the facility can be identified, in addition no statements were obtained from facility staff or witnesses. On 10/23/24 at approximately 9:00 AM, a review of Resident #158's care plan was completed: PROBLEM: Resident has physical and verbal behavioral symptoms (resists care at times and has hallucination/curses). Frequently hears people talking about her, thinks her kids or others are being murdered, talks about things that have not really occurred. Also combative with staff and other residents at times. Recently had a hospitalization due to combative behaviors. GOAL: Resident will not harm self or others secondary to physically abusive behavior. Approach: Avoid over stimulation (e.g. noise, crowding, other physically aggressive residents. Divert resident's behavior by assisting resident to activities or to a quiet area for redirection of conversations. Maintain a calm environment and approach to the resident. Remove from group activities when behavior is unacceptable. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/23/24 at approximately 10:00 AM, a review of Resident #158's Behavioral/Intervention Monthly Flow Records revealed the following: October 2023 Behavioral/Intervention Monthly Flow Record: 10/03/23: Intermittent behaviors, interventions ineffective 10/04/23: Intermittent behaviors: interventions ineffective 10/05/23: Intermittent behaviors, interventions ineffective 10/06/23: intermittent behaviors, interventions ineffective 10/07/23: intermittent behaviors, interventions ineffective 10/08/23: Intermittent behaviors, interventions ineffective 10/09/23: intermittent behaviors, interventions ineffective 10/10/23: intermittent behaviors, interventions ineffective 10/11/23: intermittent behaviors, interventions ineffective 10/23/23: intermittent behaviors, interventions ineffective 10/24/23: Intermittent behaviors, interventions ineffective 10/25/23: Intermittent behaviors, interventions ineffective 10/26/23: Intermittent behaviors, interventions ineffective 10/29/23: Intermittent behaviors, interventions ineffective 10/30/23: Intermittent behaviors, interventions ineffective November 2023 Behavioral/Intervention Monthly Flow Record: 11/08/24: No behaviors documented. 11/29/23: Continuous behaviors, interventions ineffective. On 10/23/24 at 12:19 PM an interview was conducted with the facility Assistant Director of Nursing (ADON) who stated the facility nurses complete the Behavioral/Intervention Monthly Flow Records. On 10/23/24 at 12:56 PM, an interview was conducted with the facility Director of Nursing (DON). At that time, the DON acknowledged on the Behavioral/Intervention Monthly Flow Records: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. When a behavior was documented, the outcomes of interventions attempted Resident #158's behaviors were unchanged or worsened. 2. Interventions documented were ineffective 3. The facility was unable to provide further documentation of any interventions attempted were performed to keep other residents safe. 4. Interventions of the behavioral care plan were not resident centered. 5. That the occurrence on 11/08/23 had not been reported or investigated. 50552

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45173 Based on record review, resident interview, observation and staff interview, the facility failed to complete a through and complete investigation regarding allegations of verbal abuse for Resident #15 and physical abuse for Resident #158. This was true for two (2) of four (4) residents reviewed under the care area of abuse. Resident Identifiers: #15 and #158. Facility Census: 58. Findings Include: a) Resident #15 On 10/21/24 at 1:30 PM, a review of the facility's reported incidents (FRI) was completed. The review found a FRI dated 09/16/24 for Resident #15 (however, the date range for the incident is noted from 09/13/24 through 09/15/24). The information obtained from the FRI, stated verbal abuse from Licensed Practical Nurse (LPN) #73. Resident #15 stated, LPN #73 was fussing at her and became loud and was yelling at the resident. The resident reported LPN #73 made derogatory statements such as calling her fat, telling her we are afraid to leave any food around you, and telling her a list a mile long of people who Resident #15 has been mean to, and threatening to send her up the river. The resident thought LPN #73 was implying she had a rap sheet and she would be sent to another facility. The FRI states, Resident does get her feelings hurt easily and is very child like with how she thinks but that is normal for her. The FRI, also, stated, Victim does not have capacity. (Name of Resident #15) BIMS (Brief Interview for Mental Status) is a 12 which is moderately impaired. No medical intervention was necessary. (Name of Resident #15) has been emotional distress all day and her roommate said she also had cried through the night the night before. (Typed as written.) An interview, with no date or time, during the facility investigation was held with Resident #15's roommate, Resident #45. Resident #45 confirmed the resident and LPN #73 were arguing and she thought they were going to fist fight. Resident #45 stated she couldn't remember details of what was said. The following witness statements were obtained from the staff: An interview was held with Nurse Aide (NA) #67. There was no specific date or time noted on the witness statement. Nurse Aide (NA) #67 stated, LPN #73 wanted to give the resident her breathing treatment. However, the resident was watching TV and did not want to miss it. NA #67 wanted to give Resident #15 her breathing treatment early due to getting off and there would only be one nurse there. NA #67 stated, the resident became upset and started yelling and cussing .calling the staff names. A witness statement with no date or time noted was obtained from NA #40. NA #40 stated, Heard (Name of LPN #73) talking down to (Name of Resident #15) going back to her room. (Name of Resident #15) was testy over what was on TV. (Name of LPN #73) intensified (Name of Resident #15) mood that's how she does. Told (Name of Resident #15) no one cares what (Name of Resident #15) has to say anyway. When NA #40 heard that she went to other end of hall to avoid hearing the rest of the conversation. Feel that if she intervened it would have made things worse for (Name of Resident #15). Treatment of people is unkind. Reminds her of another nurse that was awful she worked with before. Off Sat (Saturday), Friday she worked. (Typed as written.) (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A witness statement with the date of 09/19/24 but no time noted, NA #7 stated, I was in the dining room when (Name of Resident #15) was crying she said that (Name of LPN #73) .she stated she hated (Name of LPN #73) and when she got up and was leaving the dining room she said to me that she was going to get (Name of LPN #73) fired. A witness statement was obtained from Activities Director #70. The statement is as follows: Resident (Name of Resident #15) came into the activity room on Monday, September 16th at 10:30 AM and ask if she could speak to me about something private. She said Nurse (Name of LPN #73) came in her room fussing at her. She said (Name of LPN #73) really hurt her because she was making fun of her being fat. She said (Name of LPN #73) said she was afraid of leaving food on a plate around her. She said (Name of LPN #73) said she was so overweight. She said (Name of LPN #73) was yelling at her and saying mean things to her. I asked (Name of Resident #15) what was said she couldn't remember what all was said. She expressed that (Name of LPN #73) hurt her so badly she would like if I told (Name of LPN #73) not to come in her room anymore. She said (Name of LPN #73) told her she has had enough on her to send her away up the river. She said (Name of LPN #73) speaks to her roommate (Name of Resident #45) nicely but doesn't speak nice to her. I asked why and she said she feels like (Name of LPN #73) hates her. She said (Name of LPN #73) told her she has a wrap sheet a mile long and its enough to get her transferred to another facility. I expressed to (Name of Resident #15) that (Name of LPN #73) didn't have the authority to send her anywhere and (Name of Resident #15) said well according to her she does. (Name of LPN #73) told her she was mean to the other residents, her roommate and staff members. (Name of Resident #15) also was upset that (Name of LPN #73) made her leave the TV lounge to take her breathing treatments. She said (Name of LPN #73) told her she needed to take the treatment but could come back after she finished but (Name of Resident #15) doesn't want to walk to her room and then walk back. I told (Name of Resident #15) she needed to talk to the social worker about what happened and she said she was going to speak to her. (Name of Resident #15) said she just didn't want (Name of LPN #73) to be her nurse anymore. (Typed as written.) An additional witness statement was obtained from the Administrative Assistant #46. The written statement does not include a date or time. The witness statement states the following: (Name of Resident #15) and (Name of Resident #45) both came into the office and wanted to talk to (Name of Social Services #30). At the time, she was busy with someone in her office, so (Name of Resident #15) and (Name of Resident #45) asked if they could talk to me. (Name of Resident #15) appeared visibly upset so I let them sit by my desk and talk. (Name of Resident #15) said that she was upset with how (Name of LPN #73) had treated her and that she didn't want (Name of LPN #73) in her room or around her anymore. (Name of Resident #15) referenced an instance where (Name of LPN #73) either directly or indirectly made an offhand comment about (Name of Resident #15)'s weight, as well as making a comment about not being able to leave food on a plate around (Name of Resident #15). (Name of Resident #45) seemed to corroborate at least some, if not all, of what had happened. (Name of Resident #15) also mentioned that (Name of LPN #73) said she had a rap sheet on her this long. I also recall (Name of Resident #15) mentioning that someone said she was mean to (Name of Resident #45), (Name of Resident #45) refuted. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/21/24 at 2:15 PM, the five (5) day follow-up investigation dated 09/20/24 at 9:06 AM, was reviewed. The five (5) day follow-up states,No additional outcomes were found. Initial report was made regarding abuse, due to comments allegedly made by (Name of LPN #73), towards resident regarding her weight and sending her out of the facility. (Name of LPN #73 denies making any of the statements, she stated that she witnessed (Name of Resident #15) kicking her roommates walker and overheard (Name of Resident #15) calling her roommate a bitch when she intervened and explained to (Name of Resident #15) that she can't kick her roommate's walker because she or someone else could get hurt. The charge nurse responsible for oversight was not in the vicinity of the location where the incident allegedly occurred. Multiple staff members reiterated that (Name of Resident #15) can throw tantrums when she doesn't get her way. One staff member mentioned (Name of Resident #15) had mentioned prior to the incident that she was planning to get (Name of LPN #73) fired. Interviews and statements from staff and roommate were inconclusive. Most staff members heard (Name of Resident #15) get upset in the lounge when asked to return to her room and take a breathing treatment, but no staff members were around to see or hear the alleged incident take place. The allegation was inconclusive due to a lack of witnesses and evidence. (Typed as written.) On 10/21/24 at 4:15 PM, Resident #15 was interviewed regarding the allegation of verbal abuse. Resident #15 stated, she hollered at me at the top of her lungs, called me fat, and told me I was going to have to go to another place to live. During the interview, Resident #15 was visibly upset. She began to cry, wring her hands and shake. Resident #15 stated, I hate when I hear her voice .I can't get over it no matter how hard I try. The resident stated her roommate heard everything. She said she has talked with staff members about the incident with LPN #73 but continues to be upset. On 10/21/24 at approximately 5:00 PM, Resident 15's roommate at the time, was interviewed regarding the incident. Resident #45 was asked, do you remember an incident with (Name of Resident #15) and a staff member? Resident #45 stated, the nurse screamed at her .she was loud and was reprimanding her as if she were a child. Resident #45 was asked, do you think this was appropriate for a staff member to do? Resident #45 stated, no it was not appropriate I remember it happened I just can't remember all the exact words that were said. On 10/23/24 at 10:49 AM, an interview was held with Social Services #30 and Activities Coordinator #70. Both staff members were asked about the statements by witnesses and the interview which was held with Resident #15. Social Services #30 stated, Because, of . we went through all of the statements. I was ready to substantiate initially. We also got statements that (Name of Resident #15) says I am going to get her fired. The Social Services #30 was asked, was the resident not believed because of documented behaviors and angry statements the resident made? Social Services #30 stated, the staff was suspended. On 10/23/24 at 10:53 AM, the facility Administrator walked into the conference room. The Administrator was told of the previous conversation with Social Services #30 and Activities Coordinator #70. On 10/23/24 at 10:57 AM, the Administrator stated, The statements were reflective of what the resident stated, not what actually happened. I did feel she (LPN #73) was aggressive toward the resident. But based on the statements, I am not sure what happened. I feel the staff pushed the situation by being to loud. She (LPN #73) could not tell me exactly what was said but that she was loud. On 10/23/24 at 10:58 AM, the Administrator stated, I was out at a conference at this event, I was handling things over the phone. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/23/24 at 10:59 AM, Social Services #30 stated, This was a really tough one we went back and forth with this one. On 10/23/24 at 11:00 AM, the Administrator stated, I felt as if her escalating the situation required action . I feel that the resident saying she called her fat and the accusation that we could not substantiate. We feel like it is our job to protect residents, APS (Adult Protective Services) told us they were not interested in investigating, this is what helped lead us to our decision. The Administrator was asked, what would have convinced you this allegation of verbal abuse occurred? The Administrator stated, Another witness to collaborate what was said. NA #42 did not collaborate what she said, because she walked away .the resident is known to tell falsehoods and she had threatened to get the LPN fired. At this time, the written statement by NA #42 was reviewed with the Administrator. The Administrator stated, I do not recall her specific statement, but I do agree with you .the LPN was immediately suspended and upon return to work she was given a Last Chance Agreement. The Last Chance Agreement dated 09/20/24 stated, .It has been brought to the facility's attention that (Name of LPN #73) has previously engaged in inappropriate behavior by escalating situations with aggressive or difficult residents. Despite previous education and guidance on managing such situations with tact and professionalism, the issue persists. Effective immediately, this is the final written warning regarding her conduct. Any future incidents where (Name of LPN #73) raises her voice aggressively or acts in a manner that escalates conflict with residents will result in immediate termination of employment . The Administrator was asked, why was LPN #73 given this Last Chance Agreement? Did you feel the alleged verbal abuse occurred? The Administrator stated, I know she was loud .but I could not verify what actually took place. On 10/23/24 at 11:03 AM, Social Services #30 stated, I have talked to her (Resident #15) many times about the situation. But I do not have notes about this particular situation. I am not sure If I have formally talked to them (Resident #15 and Resident #45) about the situation. On 10/23/24 at 11:20 AM, the Administrator was asked, do you realize the resident remains upset regarding this allegation of verbal abuse .the resident continues to be visibly upset, such as crying and wringing her hands. The Administrator stated, She has been referred to our psych doctor. She comes once a week on Tuesdays. I will see if she has seen her. On 10/23/24 at approximately 12:15 PM, the Administrator was asked, why didn't LPN #73 follow the care plan intervention under the focus area of behavioral symptoms .which is when resident becomes physically abusive, STOP and try task later. Do not force task and Maintain a calm environment and approach to the resident. (Typed as written.) The Administrator stated, the nurse should have came back later regarding the breathing treatment .I agree this escalated Resident #15's behavior. b) Resident #158 On 10/22/24 at approximately 2:30 PM, a review of the Facility Reported Incident was completed which revealed Resident #158 bumped another Resident #30's wheelchair with a physical altercation occurring with Resident #30 having sustained bruising to the top of the left hand and left elbow as a result of this altercation. On 10/22/24 at 3:08 PM, a medical record review was completed for Resident #158 which revealed the following diagnoses and medications: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Diagnoses included Hallucinations, Vascular Dementia with other behavioral disturbance, Alzheimer's disease, Major depressive disorder recurrent, Delusional disorders, and Anxiety. In addition to the following documentation: On 10/01/23 at 1:52 PM the nursing note read as follows: Resident noted hitting another resident on A Hall after wheel chair entangled with wheel chair of another resident. Residents separated. No apparent injury to either resident. All necessary parties notified. Resident POA notified. Dr notified. On 10/24/23 at 10:26 AM the nursing not read as follows: Calling staff inappropriate names such as hussy and rhyming inappropriate statements such as She's from [NAME] because she's a whore On 10/24/23 at 12:20 PM the nursing not read as follows: Resident grabbed and started hitting another resident in the activities room. Both residents in wheel chairs. The other resident grabbed back. Both residents sustained discolorations to left arms. DR notified. resident POA/Daughter notified. Nursing Home Program reporting of allegations notified. This event occurred at 11:30 am. On 10/26/23 at 3:49 PM the nursing note read as follows: Resident threw water on this recording nurse while giving her 8 am medications. Resident stated You needed a bath. Staff was able to redirect the resident. On 10/28/23 at 12:47 PM the nursing note read as follows: Resident continues to wander halls yelling at other residents, talking to self, hitting and grabbing at staff and or other residents. DR notified. Orders increase Zyprexa to 5 mg po bid. On 10/28/23 at 2:00 PM the nursing note read as follows: Continues with combative behavior with staff and other residents. Wandering halls and into other residents rooms. Grabbing objects in other resident rooms and throwing them. DR notified again. Orders transfer to (name of local hospital) for further evaluation. On 10/28/23 at 2:10 PM the nursing note read as follows: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident continues to be combative and needs constant redirection. Resident difficult to redirect. Resident physically and verbally aggressive towards staff and other residents during redirection. Resident hitting, kicking, scratching, and throwing things at staff. LPN R. [NAME] notified Dr. of continued behaviors and an order was obtained for resident to be transported to (name of local hospital) ER for evaluation for behaviors. POA was notified. She was reluctant at first and wanted resident to be isolated for behaviors. This recording nurse advised POA that staff was trying to keep resident redirected and away from other residents but she continues to having combative behaviors. POA notified again of MD's orders to transfer. This recording nurse advised POA that she could meet resident at (name of local hospital) facility, but that since she was causing harm to other residents she would have to go for an evaluation. POA voiced understanding and stated I will get ready and meet her up there. (Name of local ambulance service) called for ambulance transport. Discipline Nursing On 10/28/23 at 5:40 PM the nursing note read as follows: This recording nurse spoke with RN in (name of local hospital) ER. She stated that the resident was combative upon arrival and had to be sedated to be evaluated. She stated that labs were obtained along with a urine sample. BUN 27 and urine was normal. Resident is awaiting a CT scan of her head and possible referral for social worker for psych eval and treatment. She stated that POA was at bedside. On 10/29/23 at 6:33 AM the nursing note read as follows: RN (Last name of Nurse from hospital) called from (Name of local hospital) and stated that they are sending resident back and they were pulling out of the facility at 6:23 AM. her last v/s were BP 127/56 pulse 50 resp. 20 O2 96% on 2L NC temp 97.8. He stated that the Psych Eval was denied due to her dementia. He stated she had been non-combative while she was there. She had a UTI that was negative. There were no med changes. Head CT was done which showed degenerative white matter changes that were consistent with her age. It showed no acute changes. She was given oral Presidex when she arrived there yesterday. He stated she did fine with it. He stated she swallowed water fine. The daughters were with her in the ER until 7:30-8:00 PM and he stated she had did fine and had not even tried to get up or anything. They did get a Troponin level on her which was 11. They did not do a follow up level. On 10/29/23 at 10:30 AM the nursing note read as follows: Resident's POA, notified that resident had returned to the facility from (Name of local hospital) and has been resting in bed. POA also notified that Zyprexa has been increased to 5 mg BID and she verbalized her understanding, she stated that she will be here to visit with resident today. Call light and fluids within reach and encouraged. Safety precautions in place. Will continue to monitor. On 11/08/23 at 1:52 PM the nursing note read as follows: Res. has been very aggressive to staff and other residents. She is grabbing and smacking at other residents as they pass by. Resident has had multiple interacts with staff and has been aggressive each time, even when just trying to speak to her. She has thrown her lunch tray, as well as fluids offered as well. Dr. has been notified of res. behaviors. New order to transfer to (name of local hospital) ER for eval d/t behaviors. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/23 at 9:29 AM a nursing note recorded as Late Entry on 12/12/23 at 3:18 PM read as follows: Res. has had behaviors this AM. Kicking at therapy staff as they walk by in the hallway ambulating another res. Also kicking at other residents as they wheel by her chair in the hallway. Also kicked at a visitors purse(wife visiting her husband). Also does a loud, inaudible yell/growl sound periodically. Denies pain. Not easily redirected from these behaviors. Have offer food, fluids, toileting, and activities, all unsuccessful. On 12/12/23 at 2:19 PM a nursing note read as follows: Resident propelling self throughout facility, attempting to hit and kick at others, redirection not easy. Resident also yelling out randomly. ADLs provided by staff, resident combative at times with care. Denies any discomfort. Dr. reviewed residents medications and behaviors. New order to discontinue Remeron and increase Zyprexa to 5 mg BID. On 10/22/24 at 4:38 PM, the facility administrator stated the facility does not have specific policy and procedures related to dementia care and behavioral monitoring/interventions. On 10/22/24 at approximately 5:00 PM, a review of facility policy and procedure entitled, Suspected Adult and Elderly Abuse/Neglect was completed which revealed all suspected or alleged violations involving mistreatment, neglect, abuse, including injuries of unknown source and misappropriation of patient/resident property shall be reported immediately to the administrator/Chief Executive Officer (CEO) or designee and to other officials in accordance with State law through established procedures (including to the State survey and certification agency. On 10/22/24 at 6:15 PM, a review of the facility investigation was completed which revealed no corrective action noted on 5 day follow up of investigation involving the two residents. On 10/22/24 at 6:15 PM, an interview was conducted with the facility Social Worker (SW) and Administrator #78 who acknowledged the investigation into the 10/24/24 allegation of abuse was not thorough, not complete and no true corrective action by the facility can be identified, in addition no statements were obtained from facility staff or witnesses. On 10/23/24 at approximately 9:00 AM, a review of Resident #158's care plan was completed: PROBLEM: Resident has physical and verbal behavioral symptoms (resists care at times and has hallucination/curses). Frequently hears people talking about her, thinks her kids or others are being murdered, talks about things that have not really occurred. Also combative with staff and other residents at times. Recently had a hospitalization due to combative behaviors. GOAL: Resident will not harm self or others secondary to physically abusive behavior. Approach: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Avoid over stimulation (e.g. noise, crowding, other physically aggressive residents. Divert resident's behavior by assisting resident to activities or to a quiet area for redirection of conversations. Maintain a calm environment and approach to the resident. Remove from group activities when behavior is unacceptable. On 10/23/24 at approximately 10:00 AM, a review of Resident #158's Behavioral/Intervention Monthly Flow Records revealed the following: October 2023 Behavioral/Intervention Monthly Flow Record: 10/03/23: Intermittent behaviors, interventions ineffective 10/04/23: Intermittent behaviors: interventions ineffective 10/05/23: Intermittent behaviors, interventions ineffective 10/06/23: intermittent behaviors, interventions ineffective 10/07/23: intermittent behaviors, interventions ineffective 10/08/23: Intermittent behaviors, interventions ineffective 10/09/23: intermittent behaviors, interventions ineffective 10/10/23: intermittent behaviors, interventions ineffective 10/11/23: intermittent behaviors, interventions ineffective 10/23/23: intermittent behaviors, interventions ineffective 10/24/23: Intermittent behaviors, interventions ineffective 10/25/23: Intermittent behaviors, interventions ineffective 10/26/23: Intermittent behaviors, interventions ineffective 10/29/23: Intermittent behaviors, interventions ineffective 10/30/23: Intermittent behaviors, interventions ineffective November 2023 Behavioral/Intervention Monthly Flow Record: 11/08/24: No behaviors documented. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/29/23: Continuous behaviors, interventions ineffective. On 10/23/24 at 12:19 PM an interview was conducted with the facility Assistant Director of Nursing (ADON) who stated the facility nurses complete the Behavioral/Intervention Monthly Flow Records. On 10/23/24 at 12:56 PM, an interview was conducted with the facility Director of Nursing (DON). At that time, the DON acknowledged on the Behavioral/Intervention Monthly Flow Records: 1. When a behavior was documented, the outcomes of interventions attempted Resident #158's behaviors were unchanged or worsened. 2. Interventions documented were ineffective 3. The facility was unable to provide further documentation of any interventions attempted were performed to keep other residents safe. 4. Interventions of the behavioral care plan were not resident centered. 5. That the occurrence on 11/08/23 had not been reported or investigated. 50552

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 49465 Based on record review and staff interview, the facility failed to notify the State Ombudsman of a discharge to the hospital. This failed practice was found true for (1) one of (2) two residents reviewed for hospitalization s during the Long-Term Care Survey Process. Resident identifier: #49. Facility Census 58. Findings included: a) Resident #49 A record review on 10/23/24 at 1:30 PM revealed that Resident #49 had been transferred out to the hospital for an extended stay on 08/04/24. Further record review revealed that no notification had been sent to the state Ombudsman. During an interview on 10/23/24 at 2:52 PM, the Licensed Social Worker (LSW) stated, No, I did not send notification to the Ombudsman. I did not know that we had to do that.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45173 Based on record review and staff interview, the facility failed to develop the care plan which includes all diagnoses for Resident #54, Resident #15 and Resident #16; and implement the care plan for Resident #15 and Resident #29. This was true for four (4) of 18 residents reviewed during the survey process. Resident Identifiers: #54, #15, #16 and #29. Facility Census: 58. Findings Included: a) Resident #54 On 10/22/24 at 1:00 PM, the care plan was reviewed for Resident #54. The care plan did not include the following diagnoses: --Vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. --Pain, unspecified --Shortness of Breath --Hyperlipidemia, unspecified --Hypomagnesemia --Hypokalemia --Other peripheral vertigo, unspecified ear --Hypertensive heart and heart failure --Chronic Kidney Disease --Unspecified Atrial Fibrillation --Gastro-esophageal reflux disease without esophagitis On 10/22/24 at 1:25 PM, Registered Nurse (RN) #66 stated, I don't use big words .it has to be simple and easy to understand .I don't always add the diagnosis usually a description. On 10/22/24 at 3:15 PM, the Administrator was notified regarding the care plan not including specific diagnoses. The Administrator stated, I understand what you are telling me. b1) Resident #15 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/22/24 at 1:45 PM, the care plan was reviewed for Resident #15. The care plan did not include the following diagnoses: --Constipation, unspecified --Hypothyroidism, unspecified --Chronic Obstructive Pulmonary Disease (COPD), unspecified --Hyperlipidemia --Unspecified systolic (congestive) heart failure --Obstructive sleep apnea --Methicilin susceptible Staphylococcus aureus infection as the cause of diseases classified elsewhere (History of) --Non-ST elevation (NSTEMI) myocardial infarction On 10/22/24 at 3:15 PM, the Administrator was notified regarding the care plan not including specific diagnoses. The Administrator stated, I understand what you are telling me. b2) Resident #15 On 10/22/24 at 1:45 PM, the care plan was reviewed for Resident #15. One (1) of the care plan interventions under the focus area of behavioral symptoms was not followed. A documented event happened between 09/13/24-09/15/24 which was reported to all State agencies on 09/16/24. Resident #15 became upset verbally and physically. Licensed Practical Nurse (LPN) #73 did not follow the interventions of maintain a calm environment and approach to the resident and when the resident becomes physically abusive, STOP and try task later. Do not force to do task. On 10/23/24 at 1:15 PM, the Administrator stated, the nurse should have came back later regarding the breathing treatment .I agree this escalated Resident #15's behavior. c) Resident #16 On 10/22/24 at 2:00 PM, the care plan was reviewed for Resident #16. The care plan did not include the following diagnoses: --Unspecified systolic (congestive) heart failure --Iron deficiency anemia secondary to blood loss (chronic) --Chronic atrial fibrillation, unspecified --Arteriosclerotic heart disease of native coronary artery without angina pectoris (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Peripheral vascular disease, unspecified --Chronic Obstructive Pulmonary Disease, unspecified --Hyperlipidemia, unspecified --Hypothyroidism, unspecified --Pain, unspecified --Gastro-esophageal reflux disease without esophagitis --Hypokalemia --Solitary pulmonary nodule --Constipation, unspecified --Methicillin resistant Staphylococcus aureus infection, unspecified site (History of) --Non-ST elevation (NSTEMI) myocardial infarction (History of) On 10/22/24 at 3:15 PM, the Administrator was notified regarding the care plan not including specific diagnoses. The Administrator stated, I understand what you are telling me. d) Resident #29 During the initial observation on 10/21/24 at 12:29 PM, there was found to be a white board in Resident #29's room. Written on the white board was Moon boots on at all times Further observation of Resident #29 lying in bed revealed she did not have her moon boots on. A record review on 10/21/24 at 1:30 PM, revealed a care plan for Resident #29 that read as follows: Focus: At risk for pressure ulcers related to requiring assistance with bed mobility and incontinence of bladder and bowel. [NAME] score shows risk for skin breakdown. History of an unstageable pressure ulcer on right heel. Intervention: Moon boots to be worn at all times. Remove for bathing. An observation of 10/21/24 at 1:55 PM, showed Resident #29 up to a Geri chair, being assisted with lunch. Resident #29 was not wearing moon boots. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/21/24 at 1:57 PM, Nurse Aide (NA) #24 stated, Yes she should have them on. I don't even know where they are. Let me look in her closet. 49465

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49466 Based on record review and staff interview, the facility failed to promptly develop and update Resident #37's care plan to include hospice-specific interventions and care coordination with the hospice provider. This deficiency led to an incomplete care plan lacking essential guidance for staff on the resident's end-of-life needs, creating a risk for inconsistent care delivery and unmet needs. Resident Identifier: #37. Facility Census: 58. Findings Included: a) Resident #37 During an annual recertification survey on 10/22/24, at 11:50 AM, this surveyor observed Resident #37, who was admitted on [DATE] with a BIMS score of 4, indicating severe cognitive impairment. The resident, currently receiving hospice care, responded only with nonverbal sounds, demonstrating limited capacity to participate in care planning. A review of Resident #37's medical records revealed the individualized care plan did not contain hospice-specific interventions or documentation reflecting coordinated services with the hospice provider. Key elements necessary for thorough care coordination, such as pain management protocols, emotional support resources, and end-of-life preferences, were notably absent from the Medication Administration Record (MAR), Treatment Administration Record (TAR), Continuity of Care Documentation, and the Care Plan. On 10/23/24, at 10:07 AM, the surveyor questioned the Director of Nursing (DON) regarding the tracking and integrating hospice care details. The DON provided a binder containing hospice-related documentation, including the resident's face sheet and treatment notes from the hospice provider. However, this information had not been integrated into the facility's care documentation for Resident #37, and the DON acknowledged that hospice coordination details were maintained exclusively in the binder, not within the resident's facility care plan. The individualized care plan lacked documented hospice services, logistical information, and hospice-specific interventions critical to the resident's end-of-life care. Furthermore, the MAR included only the contact information for the hospice provider, with no further entries addressing coordinated hospice care. The absence of hospice-specific interventions and documentation of care coordination does not meet the standards established under F657, which require prompt and precise updates to the care plan. This oversight presents a risk for inconsistent care delivery, particularly in addressing Resident #37's end-of-life needs, potentially impacting the resident's quality of care and well-being.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49465 Based on record review and staff interview, the facility failed to provide treatment and care in accordance with professional standards of practice. Resident #23 refuses all AM and PM medications and has had no physician intervention since 05/24. In addition the facility failed to offer hospice to Resident #158. This failed practice was found true for (2) two of 18 sample residents reviewed during the long term care survey process. Resident identifier: #23 and #158. Facility Census 58. Finding Included: a) Resident #23 A record review on 10/21/24 at 2:06 PM, revealed Resident #23 had multiple notes from 05/24 to present of refusing AM and PM medications. The notes also revealed Resident #23 was educated on the risk of refusing the medications; however Resident #23's Brief Interview for Mental Status (BIMS) score is 99. Further record review revealed Resident #23 was ordered the following medications: Famotidine 20 Milligrams (mg) one time a day at 9:00 AM. Levothyroxine 112 mcg one time a day at 9:00 AM. Lipitor 10 mg one time a day at 9:00 PM. Metoprolol tartrate 25 mg every 12 hours at 9:00 AM and 9:00 PM. A review of Resident #23's care plan on 10/22/24 at 3:15 PM, revealed the following care plan for refusal of medications: Focus: Wanders in/out of other residents rooms at times. Says Oh Lord frequently. Occasionally will take others' belongings. Also frequently refuses medications and is verbally and physically abusive with care. The only intervention related to refusing medications reads as follows: Encourage to take medications. Explain importance of taking medications. May mask taste in ice cream or applesauce or food/drink if necessary. Implemented on 07/10/2024. An interview on 10/22/24 at 2:45 PM, Licensed Practical Nurse (LPN) #58 stated, I crush her meds in applesauce. She just refuses them. A record review on 10/22/24 at 3:00 PM revealed Resident #23's blood pressure had been high 44 times since 06/01/24. No physician intervention was noted. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further record review revealed the only physician note addressing the refusal of medications is from 05/20/24 reads as follows: (Doctor named) notified of resident refusing medications. He stated to continue to attempt to give medications and to document when resident refuses them. Risk and benefits explained to the resident of the medications and importance of taking them. POA also notified of resident refusing medications. Further record review of Resident #23's Medication Administration Records (MAR) from 06/2024 to present revealed Resident #23 had refused her medications everyday. During an interview on 10/22/24 at 3:56 PM, the Assistant Director of Nursing (ADON) agreed there are no notes in the chart to say what we are doing about resident refusing meds for a long period of time. She then stated, Let me see if I can find anything else. No further evidence was provided by the end of the survey. b) Resident #158 On 10/22/24 at approximately 2:30 PM, a review of the Facility Reported Incident was completed which revealed Resident #158 bumped Resident #30's wheelchair with a physical altercation occurring with Resident #30 having sustained bruising to the top of the left hand and left elbow as a result of this altercation. On 10/22/24 at 3:08 PM, a medical record review was completed for Resident #158 which revealed the following diagnoses and medications: Diagnoses included Hallucinations, Vascular Dementia with other behavioral disturbance, Alzheimer's disease, Major depressive disorder recurrent, Delusional disorders, and Anxiety. In addition to the following documentation: 12/18/2023 4:20 PM New order received from Dr. for Roxanol 0.25 mg sublingual Chirrs for pain, medication is currently on order from pharmacy, resident previously taking Tramadol 50 mg BID for pain this does not appear to be controlling residents pain as exhibited by resident hollering out more frequently as well as moaning/facial grimacing when being transferred or repositioned in bed. MPOA made aware and is in agreement with this change in patients plan of care. Tramadol to be discontinued once Roxanol is received from pharmacy. 12/19/2023 4:25 PM Resident continues on Cephalexin for UTI. Resident tolerates the medication without difficulty. no adverse reaction noted at this time. fluids are frequently offered and encouraged. Resident has had no c/o pain or discomfort from recent fall. Resident is currently resting in bed. call light and fluids are within reach. Nursing (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/20/2023 1:55 AM Resident continues on Cephalexin for UTI. No adverse reactions noted this shift. Resident has been yelling out this shift. Has been receiving Roxanol as scheduled is somewhat effective. Spit out most of hs medication. 12/20/2023 7:59 AM Spoke with Dr about increasing Roxanol from Q4 to Q2, Dr . agreed POA notified 12/21/2023 9:16 AM Res. unable to take her medications. Dr. notified. New order to d/c meds except for Ativan and Roxanol. 12/21/2023 12:17 PM Resident moaning out and restless in bed, family at bedside and spoke with LPN (LPN name) about resident being uncomfortable . Last administration of Morphine Concentrate 0.25 ml less than an hour. Dr. notified and new order to increase dose to 0.5 ml. Family aware of change. 12/22/2023 8:21 PM Resident continues on Roxanol every 2 hours. Resident noted to be restless and sitting up in her bed this morning during 8 am dose. PT/TO in the resident's room with the recording nurse when resident stated she wanted to get up in wheelchair. Prior to getting up in wheelchair resident drank one cup of coffee, one cup of water, and ate a container to applesauce without difficulty. PT/TO assisted the resident up to wheelchair. Resident helped by standing when transferring to wheelchair. Resident self-propelling some while up in wheelchair. Resident place backed to bed after a few hours. Resident rested well after being up. Roxanol seems to be controlling the resident's pain and discomfort. Resident currently resting in bed with family at bedside. 12/22/2023 10:45 PM Resident continues on Roxanol every 2 hours. Resident noted to be restless but calmed after a position change in bed. Roxanol seems to be controlling the resident's pain and discomfort. Resident currently resting in bed with family members at bedside. 12/23/2023 10:38 PM Roxanol 0.5mls continues as ordered q 2 hrs. Resident seems comfortable. Family was at bedside earlier. 12/25/2023 5:02 PM Called to room by family, resident noted to be absent of vital signs, auscultation revealed no breath sounds or heart sounds, Dr. notified, time of death 1658, family remains at bedside. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/23/24 at approximately 9:00 AM, a review of Resident #158's care plan was completed which revealed the following care plan: PROBLEM: Code status GOAL: Residents wishes will be followed during stay. INTERVENTIONS: Allergies: ASA, PCN, Sulfa, Cipro, Ciprodex Does not have decision making capacity Limited Additional interventions IVF for defined trail period of 10 days. No tube feeding. No further documentation of a care plan addressing end of life care was identified. On 10/23/24 at 12:56 PM, an interview was conducted with the facility Director of Nursing (DON). At time, the DON acknowledged: 1. The facility has no policy and procedure related to the provision of Hospice services. 2. While the facility does have a contract with a local hospice provider, the facility failed to inform Resident #158 of this service. 3. Resident #158 was not offered hospice services. 4. No further documentation of end of life care was provided. 50552

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. 49466 50552 Based on record review and staff interview the facility failed to identify, treat, monitor, and manage the resident's pain to the extent possible in accordance with the comprehensive assessment and care plan, current professional standards of practice, and the resident's goals and preferences. This is due to the facility ' s failure to implement a formal pain assessment process and develop a comprehensive, individualized pain management plan. This was true for 1 (one) of 2 (two) resident's reviewed for the Long Term Care Survey Process. Resident identifier: Resident #158. Facility census: 58. Findings included: a) Resident #158 On 10/22/24 at approximately 2:30 PM, a review of the Facility Reported Incident (FRI) was completed which revealed Resident #158 bumped Resident #30's wheelchair with a physical altercation occurring with Resident #30 having sustained bruising to the top of the left hand and left elbow as a result of this altercation. On 10/22/24 at 03:08 PM, a medical record review was completed for Resident #158 which revealed the following diagnoses and medications: Diagnoses: 1. Hallucinations 2. Vascular Dementia with other behavioral disturbance 3. Alzheimer's disease 4. Major depressive disorder recurrent, 5. Delusional disorders 6. Anxiety Medications: 1. Xanax 0.5 milligrams (mg) 1/2 tablet by mouth twice a day 2.Lamictal 200 mg 1 tablet by mouth at bedtime 3. Zyprexa 2.5 mg 1 tablet by mouth once a day (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Mirtazapine 7.5 mg 1 tablet by mouth at bedtime In addition to the following documentation: 12/18/2023 04:20 PM New order received from Dr. for Roxanol 0.25 mg sublingual Q4hrs for pain, medication is currently on order from pharmacy, resident previously taking Tramadol 50 mg BID for pain this does not appear to be controlling residents pain as exhibited by resident hollering out more frequently as well as moaning/facial grimacing when being transferred or repositioned in bed. MPOA made aware and is in agreement with this change in patients plan of care. Tramadol to be discontinued once Roxanol is received from pharmacy. 12/19/2023 04:25 PM Resident continues on cephalexin for UTI. Resident tolerates the medication without difficulty. no adverse reaction noted at this time. fluids are frequently offered and encouraged. Resident has had no c/o pain or discomfort from recent fall. Resident is currently resting in bed. call light and fluids are within reach. Nursing 12/20/2023 01:55 AM Resident continues on cephalexin for UTI. No adverse reactions noted this shift. Resident has been yelling out this shift. Has been receiving Roxanol as scheduled is somewhat effective. Spit out most of hs medication. 12/20/2023 07:59 AM Spoke with Dr about increasing Roxanol from Q4 to Q2, Dr . agreed MPOA notified 12/21/2023 09:16 AM Res. unable to take her medications. Dr. notified. New order to d/c meds except for Ativan and Roxanol. 12/21/2023 12:17 PM Resident moaning out and restless in bed, family at bedside and spoke with LPN (LPN name) about resident being uncomfortable . Last administration of Morphine Concentrate 0.25 ml less than an hour. Dr. notified and new order to increase dose to 0.5 ml. Family aware of change. 12/22/2023 08:21 PM (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident continues on Roxanol every 2 hours. Resident noted to be restless and sitting up in her bed this morning during 8 am dose. PT/OT in the resident's room with the recording nurse when resident stated that she wanted to get up in wheelchair. Prior to getting up in wheelchair resident drank one cup of coffee, one cup of water, and ate a container to applesauce without difficulty. PT/OT assisted the resident up to wheelchair. Resident helped by standing when transferring to wheelchair. Resident self-propelling some while up in wheelchair. Resident place backed to bed after a few hours. Resident rested well after being up. Roxanol seems to be controlling the resident's pain and discomfort. Resident currently resting in bed with family at bedside. 12/22/2023 10:45 PM Resident continues on Roxanol every 2 hours. Resident noted to be restless but calmed after a position change in bed. Roxanol seems to be controlling the resident's pain and discomfort. Resident currently resting in bed with family members at bedside. 12/23/2023 10:38 PM Roxanol 0.5mls continues as ordered q 2 hrs. Resident seems comfortable. Family was at bedside earlier. 12/25/2023 05:02 PM Called to room by family, resident noted to be absent of vital signs, auscultation revealed no breath sounds or heart sounds, Dr. notified, time of death 1658, family remains at bedside. On 10/23/24 at approximately 9:00 AM, a review of Resident #158's care plan was completed which revealed the following care plan: PROBLEM: Pain. Resident states/exhibits pain related to arthritis, as evidenced by yelling out at times, grimacing at times, and will make verbal statements of pain at times. GOAL: Resident will state/exhibit relief of pain with interventions offered through next review. INTERVENTIONS: Pain med (Roxanol) as ordered for pain. Document effectiveness. Monitor for side effects. Assess pain relief techniques from resident/family and implement non-pharmaceutical measures when possible (gentle rubbing, massage, warm bath, soothing music) Position resident for comfort and reposition as needed. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of policy and procedure entitled, Pain Management was then completed, which revealed that all patients shall be assessed upon admission and at regular intervals when they voice complaints of pain or non-verbal signs of pain are noted. Assessment of pain should include location, duration, radiation, precipitating and alleviating factors. The physician, primary/charge inures and patient and/or significant others shall collaborate to develop the plan of pain management and the ongoing reassessment of plan. In addition, this policy and procedure reviews Methods of Pain Control and lists them as the following: A. Comfort Measure 1. repositioning 2. massage 3. application of cold or heat B. Behavioral Interventions 1. relaxation 2. distraction 3. imagery C. Medication Alternatives 1. non-steroidal 2. anti-inflammatory 3. narcotics (topical, by mouth, intramuscularly and intravenously) On 10/23/24 at 11:00 AM, a review of Resident #158's Medication Administration Record was conducted which revealed no documentation of pain levels. On 10/23/24 at approximately 12:18 AM, an interview was conducted with the Director of Nursing (DON). At that time, the DON states We only document pain if the resident is getting and as needed pain medication. If the pain medication is scheduled, we don't ask the resident's their pain levels. At that time, this Surveyor asked if non-pharmacological interventions were attempted with resident's prior to using pain medication. The DON responded, Yes. This Surveyor reviewed Resident #158's documentation with the DON who acknowledged no use of non-pharmacological interventions for Resident #158 was documented.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45173 Based on record review and staff interview, the facility failed to maintain an accurate and complete record for Resident #15's Physician's Orders for Scope of Treatment (POST) form, Resident #54's activity participation record, Resident #16's administration of the pneumococcal vaccination, and Resident #37's POST form. This was true for four (4) of 18 residents reviewed during the survey process. Resident Identifiers: #15, #54, #16, and #37. Facility Census: 58. Findings Included: a) Resident #15 On [DATE] at 11:00 AM, a record review was completed for Resident #15. The review found the POST form did not include the Preparer's signature and date. On [DATE] at 11:50 AM, the Administrator was notified and confirmed the POST form was incomplete. b) Resident #54 On [DATE] at 4:15 PM, a record review was completed for Resident #54. The review found the Activity Participation record dated ,d+[DATE] indicated the Resident was actively participating on the dates of [DATE] through [DATE]. Also, the date of [DATE] had expired written in. The resident was actively dying from [DATE] and expired on [DATE]. On [DATE] at 4:30 PM, an interview was held with the Activities Director #70. The Activities Director was asked, what does the A stand for? The Activities Director #70 stated, A means active. The Activities Director #70 was asked, do you think this document is correct regarding active participation when the resident was actively dying? The Activities Director #70 stated, I can't explain it. On [DATE] at 4:36 PM, the Administrator was notified and confirmed the documentation was incorrect. c) Resident #16 On [DATE] at 3:00 PM, a record review was completed for Resident #16. The review found no indication the resident had received a pneumococcal vaccination. Further review of the record, found under the documents tab, a document labeled Pneumococcal Vaccination and Temperature Record. This document included a signed physician's order to administer the pneumococcal vaccination. This document, also, included the lot number, expiration date, date and time of administration, site, temperature and the signature of the Nurse who administered the vaccination. However, this information was not documented under the immunization tab in the electronic medical record. On [DATE] at 3:30 PM, the Director of Nursing (DON) was notified and confirmed the information was not documented under the immunization tab. The DON stated, no one updated it, I'll fix it now. d) Resident #37 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:50 AM, this surveyor evaluated Resident #37 as part of the annual recertification survey. The resident, who is under hospice care, exhibited limited verbal communication, responding only with indistinct sounds. Admission records show an entry date of [DATE] and a Brief Interview for Mental Status (BIMS) score of 04, indicating severe cognitive impairment. During a review of the resident's chart, the surveyor noted that a signed Provider Orders for Scope of Treatment (POST) form was absent. Documentation of the resident's advance directive was limited to a general notation within the Continuity of Care Documentation, without a formalized directive. At approximately 12:00 PM, in response to a request for the completed POST form, the facility administrator provided a copy signed by the resident's Medical Power of Attorney (MPOA) on [DATE]. However, this form lacked a signature and date from the advising healthcare provider. The administrator confirmed that this was the only advance directive available on file, acknowledging the document's incomplete status. The absence of a healthcare provider's signature on Resident #37's POST form limits the facility's ability to fully honor the resident's healthcare preferences, potentially impacting the delivery of end-of-life care. This deficiency underscores the facility's obligation to maintain complete, accurate, and accessible resident records, as required by CMS standards, to safeguard the integrity of care for residents with cognitive impairments and end-of-life needs. d) Resident #37 On [DATE] at 11:50 AM, this surveyor evaluated Resident #37 as part of the annual recertification survey. The resident, who is under hospice care, exhibited limited verbal communication, responding only with indistinct sounds. Admission records show an entry date of [DATE] and a Brief Interview for Mental Status (BIMS) score of 04, indicating severe cognitive impairment. During a review of the resident's chart, the surveyor noted that a signed Provider Orders for Scope of Treatment (POST) form was absent. Documentation of the resident's advance directive was limited to a general notation within the Continuity of Care Documentation, without a formalized directive. At approximately 12:00 PM, in response to a request for the completed POST form, the facility administrator provided a copy signed by the resident's Medical Power of Attorney (MPOA) on [DATE]. However, this form lacked a signature and date from the advising healthcare provider. The administrator confirmed that this was the only advance directive available on file, acknowledging the document's incomplete status. The absence of a healthcare provider's signature on Resident #37's POST form limits the facility's ability to fully honor the resident's healthcare preferences, potentially impacting the delivery of end-of-life care. This deficiency underscores the facility's obligation to maintain complete, accurate, and accessible resident records, as required by CMS standards, to safeguard the integrity of care for residents with cognitive impairments and end-of-life needs. 49466