STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515183	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pocahontas Center	5 Everett Tibbs Road Marlinton, WV 24954

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49650 Based on observation and staff interview the facility failed to provide a dignified dining experience for a resident while assisting them to eat. This was a random opportunity of discovery during the long term care survey process and was true for Resident #7. Resident Identifier: #7. Facility Census: 67. Findings include: a) Resident #7 On 07/29/24 at 1:56 PM, Registered Nurse (RN) #26 was observed standing over Resident #7 on the left side of the resident's bed as she was assisting him to eat. It was observed Resident #7 had a laptop sitting on the over the bed table along with his dinner tray. It was further observed there was an empty chair available to use sitting at the right side of the bed. On 07/29/24 at approximately 1:55 PM, during an interview with Clinical Reimbursement Coordinator Registered Nurse (CRC RN) #32 she stated RN #26 is new and should not be doing that. On 07/29/24 at approximately 1:57 PM, during an interview with RN #26 she agreed she should not be standing over the resident but was concerned with his computer being on the over the bed table with the dinner tray. RN #26 then stated she would move the empty chair to the right of the bed so she could assist the resident with his meal while being seated in the chair.

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 50552 Based on record review and staff interview the facility failed to ensure Resident #60 had documentation related to the provision of information provided to Resident #60 and/or Resident #60's representative related to advanced directives. This was true for 1 (one) of 7 (seven) residents reviewed in the Long Term Survey Process. Resident identifier: Resident #60. Facility Census: 67. Findings include: a) Resident #60 On 07/29/24 at 11:47 AM, a record review was conducted for Resident #60 revealing the absence of an Advanced Directive. On 07/31/24 at 4:24 PM, an interview was conducted with Employee #33. At this time, Employee #33 acknowledged no documentation was present to show Resident #60 and/or Resident #60's representative had been provided information related to implementing an Advanced Directive and the facility did not have documentation of an Advanced Directive for Resident #60. Employee #33 stated a call had been placed to Resident #60's representative and Resident #60's representative wanted Resident #60 to remain a Do Not Resuscitate (DNR) at this time. In addition, Employee #33 stated a care plan meeting had been scheduled for Resident #60 in which Resident #60's representative would be attending to review and discuss this further.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45171 Based on observation and staff interview the facility failed to provide the Resident the right to a safe, clean, comfortable and homelike environment. Resident Identifier: Room #A1-1 and B9-1. Facility Census: 67 Findings Include: a) Room A1-1 On 07/29/24 at 9:56 AM, it was observed that room A1-1 had two (2) soiled privacy curtains in the room. One had a brown substance on it and the other had a brown substance and red spots. On 07/30/24 at 10:21 AM, it was observed and noted that the curtains were still in the room. This was confirmed with Registered Nurse #28 and Corporate Clinical Lead on 07/30/24 at 10:03 AM. b) Unit B room [ROOM NUMBER] A During a tour of the facility on 07/29/24 at approximately 9:08 AM of Unit B, the bed side night stand for room [ROOM NUMBER] A was observed to have one third (1/3) of the top surface laminate to be torn off leaving rough edges and the underneath particle board exposed. During an interview with Registered Nurse (RN) #28 on 07/29/24 at approximately 9:30 AM, RN #28 agreed that the surface exposed from the laminate missing was not safe for the resident as it left rough areas that could potentially cause skin tears and that is wasn't pleasant for a home like environment. 49650

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 50551 Based on resident interview, record review and staff interview, the Facility failed to ensure that residents can anonymously report a grievance. This was discovered during the resident council meeting and has the potential to affect all residents currently residing in the facility. Facility Census: 67. Findings include: a) On 07/30/24 at 2:15 PM during the resident council meeting, resident council members reported they are unable to file a grievance anonymously. b) On 07/31/24 at approximately 2:30 PM, in an interview with the admissions director she stated, I'm going to be honest, the residents will usually give the grievances to me or the administrator. We don't really have a place to put them anonymously. c) On 07/31/24 at 2:45 PM, review of Policy Titled Grievance/Concern, stated the facility has the responsibility to maintain confidentiality of all information associated with grievances, for example, the identity of the patient for those grievances submitted anonymously.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - 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** 50552 Based on record review and staff interview the facility failed to ensure residents were free from abuse from other residents. Beginning on 04/19/23 Resident #20 began displaying physical, verbal and sexually abusive behaviors towards residents and staff. A review of the record found at least 20 noted incidents of such behavior. The abusive behavior was not consistently reported as required, the physician and responsible party was not consistently notified, the victims were not consistently identified, and interventions were not consistently put into place to prevent the abuse from reoccurring. Resident #20 still currently resides at the facility and has had documented episodes of said behaviors as recent as 07/05/24. The State Agency (SA) determined this put more than a limited number of Residents currently residing in the facility at risk for immediate serious harm and/or death and constitutes an Immediate Jeopardy (IJ) situation. The facility was notified of the IJ at 2:09 PM on 07/30/24. The abatement plan of correction (POC) was submitted and accepted by the state agency at 4:07 PM on 07/30/24. The POC read as follows: F600 Resident #20 was placed on one to one on 07/30/24 at 2 PM All residents of the facility have the potential to be affected. The Director of Nursing (DON)/designee interviewed residents with Brief Interview for Mental Status (BIMS) of 7 (seven) or below if the resident permitted for potential sexual, verbal and physical abuse on 07/30/24 with any corrective action immediately upon discovery. Re-education was provided by the Director of Nursing (DON)/designee to all employees on 07/30/24 to ensure allegations of sexual, verbal, physical abuse are identified, immediate intervention put in place to prevent reoccurrence, immediately reported to the appropriate states agencies and thoroughly investigated. A post-test to validate understanding. Any employees ot available during this time frame will be provided re-education, including post-test upon the beginning of next shift to work. New employees will be provided education, including post-test during orientation by the DON/designee. The Director of Nursing (DON)/designee will monitor progress notes starting on 07/30/24 to ensure that allegations of sexual, verbal, physical abuse have been correctly identified, reported in a timely manner and appropriate intervention put in place to prevent the reoccurrence daily across all shifts for 2 (two) weeks including weekends and holidays, then 3 (three) times a week for 2 weeks then randomly thereafter. Results of monitors will be reported by the Director of Nursing (DON)/designee monthly to the Quality Improvement Committee (QIC) for any additional follow-up and or in-servicing until the issue is resolved, then randomly thereafter as determined by the QIC committee. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 07/31/24 at 4:31 PM after interviews with staff to confirm the receipt of and understanding education and observation of the implementation of the abatement POC, the IJ was abated. The IJ started on 07/30/24 and ended on 07/31/24. Resident identifier: Resident #20, Resident #22, Resident #62. Facility Census: 67 Findings Include: a) Resident #20 On 07/29/24 at approximately 3:15 PM, a review of the facility reported incidents (FRI), it was discovered a FRI had been submitted for Resident #22. During the review of this FRI, it was noted on 07/02/24 at 6:15 PM, Resident #20 was witnessed grabbing Resident #22's breast. Nurse Aide (NA) #62 and NA #40 witnessed the incident, separated and redirected the residents, and immediately reported the incident to Licensed Practical Nurse (LPN) #20. A review of the FRI revealed the following 5 (five) day was submitted as a summary of the incident and read as follows: On July 2, 2024 at approximately 6:15 PM, Resident #20 was witnessed grabbing Resident #22's breast. NA #62 and NA #40 witnessed the incident, separated and redirected the residents, and immediately reported to LPN #20. Resident #22 is a [AGE] year-old female resident who was admitted to (Name of Facility) on September 13, 2017. The resident has diagnoses of dementia, Alzheimer's disease, unspecified psychosis and wandering. Resident #22 is ambulatory, frequently wanders and ambulates about the facility ad lib. The resident does not retain the capacity to make healthcare decisions and her son is the health care surrogate and conservator. Resident #20 is a [AGE] year-old male resident who was admitted to (Name of Facility) September 9, 2022. The resident has diagnoses of dementia and Alzheimer's disease. Resident #20 has a history of sexual behaviors and inappropriately touching other residents, visitors and staff. The resident utilizes a wheelchair and independently locomotion about the facility ad lib. Resident #20 does not retain capacity to make health care decisions and his daughter is Medical Power of Attorney (MPOA). A head-to-toe check was performed on Resident #22 following the incident on 07/02/24 and no injuries or skin issues were observed. The resident did not exhibit any emotional or psychological distress or change in behaviors. Resident #20 was immediately placed under every 15 minute checks for 72 hours following the incident. A urinalysis was collected during the evening of 07/02/24 and was negative for Urinary Tract Infection. Meditelecare Psych was notified of the incident on 07/02/24 and evaluated the resident in house on 07/03/24. A recommendation to increase Celexa to 30 milligrams (mg) by mouth daily. This recommendation was reviewed with Medical Director and orders were completed. All interviewable residents were interviewed. One resident did say Resident #20 touched her leg but was not in a sexual way, no other residents had any concerns. This was reported to all appropriate agencies. The perpetrator was placed on every 15 minute checks. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-- 08/16/23 at 11:49 PM. attempting to go into a female residents room, grabbing at another female resident. Trying to kick and hit this nurse. Cursing and yelling. No physician or POA notification documented. -- 08/16/23 at 3:53 PM. Nursing staff witnessed resident groping another female residents private area and grabbing her butt. The female resident attempted to walk away from resident, but was grabbed by the waist and continuously being groped at her private areas and butt. Nursing staff yelled the residents name to attempt to gain his attention. Resident did let the female resident go, but attempted to scoot in his wheelchair attempting to grab at female resident as she continued to walk away. When nursing staff arrived to the resident, he was assisted in his wheelchair away from the female resident. Nursing staff attempted to redirect resident, but resident yelled Shut the fuck up and go to hell. Nursing administrator was notified of the occurrence and did speak with resident with an RN as a witness. On call psych notified and was set up with an apt for tomorrow morning. Order to call PMH on call provider. Spoke with Summer, and she states she will speak with provider and call back. After speaking with PMH provider, order to continue with current medications, keep Psych apt tomorrow and continue to monitor and redirect additional behaviors. -- 08/16/23 at 06:52 PM. Kitchen staff reported to nursing staff that she was in the kitchen wrapping silverware when she heard a female yelling help help when kitchen staff went to see what the issue was, she witnessed resident groping a female resident, touching her breast and private areas. States resident had female resident pinned where she could not get away from him. When the kitchen staff was able to get to the female resident, resident did let her pass by. Administrator notified of occurrence. No physician or POA notification documented. -- 08/17/23 at 11:24 AM. Resident refused a.m. medications. Resident cussing at nurse when trying to administer medications. Resident attempting to touch visitors. No physician or POA notification documented. -- 08/17/23 at 7:26 PM. Resident had behaviors this PM. touching and inappropriate touching of female residents and staff. Dr. (Last name of physician) in new orders. #1 Increase Celexa to 40 milligrams (mg) by mouth every day. POA informed of behaviors and medication changes. -- 08/18/23 at 10:52 AM. eINTERACT Summary for Providers noted Resident #20 was demonstrating physical aggression, verbal aggression and other behavioral symptoms. In addition, it stated, Resident making sexual gestures and vulgar comments to staff and residents. Redirected, unsuccessful. Resident was placed on one on one and behaviors continued. No physician or POA notification documented. -- 08/26/23 at 04:55 PM. Staff found resident at the supply door, blocking exit of female resident, he would not let her get away from him. One on one in place for safety of residents. Resident redirected to another area of building and offered coffee. No physician or POA notification documented. -- 08/26/23 at 07:19 PM. Resident attempting to isolate female resident and not allow them to leave his presence. Staff observed this behavior and intervened on behalf of female resident, providing her with egress. No physician or POA notification documented. --09/13/23 at 09:22 AM. Physical behaviors, directed towards others occurs daily or almost every day. Verbal behaviors, directed towards others occurs daily or almost every day. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-- 10/16/23 at 09:06 PM. Escalation of inappropriate behavior, grabbing at staff and other residents, masturbating in front of staff, sexual comments, picking his pants leg up to show his penis. No physician or POA notification documented. -- 02/25/24 at 08:50 PM. Resident chasing women down the hall yelling come back here, hit another resident . cursing at staff. No physician or POA notification documented. -- 05/18/24 at 12:12 PM. Certified Nursing Assistant (CNA) reported to nursing that resident grabbing staff and a resident and making lewd comments. Redirected resident will report to oncoming shift. No physician or POA notification documented. -- 06/02/24 at 10:00 PM. resident chasing women residents, trying to grab them inappropriately and trying to touch staff inappropriately. No physician or POA notification documented. -- 07/05/24 at 08:30 PM. resident continues to make sexual comments to staff and argue with residents. No physician or POA notification documented. In addition to the above mentioned documentation, Resident #20's diagnosis list, orders and care plan was reviewed. On 07/30/24 at approximately 10:00 AM, a review of the investigation conducted by facility staff related to the incident that occurred on 07/02/24 in regards to Resident #22 was conducted which revealed interviews with all licensed nursing staff. In review of the interviews, the question Are you aware of sexual abuse occurring at this facility? was answered No by all licensed nursing staff. No interviews of CNA's were present. These interviews were conducted by RN #33. On 07/30/24 at approximately 11:30 AM, a review of the facility Policy and Procedure entitled, Abuse Prohibition was performed. This policy and procedure was noted to state that the facility will implement an abuse prohibition program through screening of potential hires, training of employees, prevention of occurrences, identification of possible incidents or allegations which need investigation, investigation of incidents and allegation, protection of residents during investigations and reporting of incidents, investigations and Center response to the results of their investigations. In addition the policy and procedure states that the facility will identify, correct and intervene in situations in which abuse, neglect, and/or misappropriation of resident property is more likely to occur. Furthermore this policy and procedure states that all suspected abuse must be reported to the physician and the resident's family. The policy and procedure also states that the facility who has identified a resident who has in any was threatened or attacked another will be removed from the setting or situation and investigation will be completed. That immediately upon [NAME] information concerning a report of suspected or alleged abuse, mistreatment or neglect, the Administrator or designee will perform the following: 1. Report the allegation involving abuse (physical, verbal, sexual, mental) not later than 2 (two) hours after the allegation is made. 2. Report allegations to the appropriately state and local authority(s) involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of resident property, not later that 2 (two) hours after the allegation is made. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Initiate an investigation within 24 hours of allegation of abuse. 4. The Center will protect residents from further harm during the investigation. On 07/30/24 at 12:38 PM, an interview was conducted with RN #28 who acknowledged she was aware of Resident #20's verbal, physical and sexual behaviors, stating that Resident #20 self propels in his wheelchair and that it is absolutely best to keep eyes on him. On 07/30/24 at approximately 12:45 PM, an interview was conducted with RN #30 who acknowledged she was aware of Resident #20's verbal, physical and sexual behaviors. On 07/30/24 at approximately 01:10 PM, an interview was conducted with RN #32 who stated that she attends the facility morning clinical meeting and acknowledged she was aware of Resident #20's behaviors because it had been discussed. On 07/30/24 at approximately 01:20 PM, an interview was conducted with Resident #62. At this time, Resident #62 stated that she is afraid of Resident #20. Resident #62 reported that Resident #20 had a reputation of touching women. Resident #62 stated she had reported Resident #20 had entered her room one night and touched her leg and tried to get into bed with her. Resident #62 further stated that when she asked Resident #20 to leave he refused, Resident #62 stated she then called the nurse who came and got Resident #20. Resident #62 reported that she has witnessed Resident #20 touching other residents in the breast and groin area. On 07/30/24 at 01:33 PM, an interview was conducted with RN #33, who was documented as having performed the investigation into the incident involving Resident #20 and Resident #22 When this Surveyor questioned RN #33. This Surveyor asked why the interviews she conducted stated no licensed nursing staff were aware of sexual abuse occurring in the facility when 2 (two) RN's interviewed today stated they were. RN #33 responded, I can't answer why they would each tell us something different. This Surveyor then asked RN #33 if she questioned CNA's and other facility staff related to witnessing abuse by Resident#20 due to CNA's reporting the incident. RN #33 responded I didn't interview CNA's or other staff to see if they witnessed abuse by Resident #20. At this time, RN #33 verbalized she had been in her current position for approximately 1.5 years and that she, among other RN's, were responsible for reading the facility progress notes prior to morning clinical meeting and she is unaware of the above documented allegations of abuse by Resident #20. The corporate Clinical Lead Nurse was present for this interview. Immediately upon discovering the above mentioned occurrences of abuse placed Resident #20 on one to one observation. On 07/30/24 at 2:39 PM, an interview with the facility corporate Clinical Lead Nurse was conducted, in which she acknowledged the following: 1. The facility was unable to identify the resident's in the above mentioned progress notes. 2. No investigations had been performed related to these incidents. 3. No follow-up assessments had been conducted to assess for the psychosocial well-fare of these residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. These incidents had not been reported or investigated by the facility as indicated in the facility Policy and Procedure entitled Abuse Prohibition. 5. Resident #20 frequently refused medication for his behavioral disturbances. 6. The facility policy and procedure entitled, Abuse Prohibition had not been implemented in this occurrences. 7. The facility failed to notify the physician and POA for all occurrences. 8. The facility failed to keep the residents safe from verbal, physical and sexual abuse. 8. These incidents and the verbal, sexual and physical abuse had not been taken to Quality Improvement Committee (QIC). No further information was provided prior to the end of the survey.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50552 Based on record review and staff interview the facility failed to implement the policy and procedure entitled, Abuse Prohibition. This failed practice has the potential to affect more than a limited number of residents. Resident identifier: Resident #20, Resident #22, Resident #62. Facility census: 67. Findings include: a) Resident #20 On 07/29/24 at approximately 3:15 PM, a review of the facility reported incidents (FRI), it was discovered a FRI had been submitted for Resident #22. During the review of this FRI, it was noted on 07/02/24 at 6:15 PM, Resident #20 was witnessed grabbing Resident #22's breast. Nurse Aide (NA) #62 and NA #40 witnessed the incident, separated and redirected the residents, and immediately reported the incident to Licensed Practical Nurse (LPN) #20. A review of the FRI revealed the following 5 (five) day was submitted as a summary of the incident and read as follows: On July 2, 2024 at approximately 6:15 PM, Resident #20 was witnessed grabbing Resident #22's breast. NA #62 and NA #40 witnessed the incident, separated and redirected the residents, and immediately reported to LPN #20. Resident #22 is a [AGE] year-old female resident who was admitted to (Name of Facility) on September 13, 2017. The resident has diagnoses of dementia, Alzheimer's disease, unspecified psychosis and wandering. Resident #22 is ambulatory, frequently wanders and ambulates about the facility ad lib. The resident does not retain the capacity to make healthcare decisions and her son is the health care surrogate and conservator. Resident #20 is a [AGE] year-old male resident who was admitted to (Name of Facility) September 9, 2022. The resident has diagnoses of dementia and Alzheimer's disease. Resident #20 has a history of sexual behaviors and inappropriately touching other residents, visitors and staff. The resident utilizes a wheelchair and independently locomotion about the facility ad lib. Resident #20 does not retain capacity to make health care decisions and his daughter is Medical Power of Attorney (MPOA). A head-to-toe check was performed on Resident #22 following the incident on 07/02/24 and no injuries or skin issues were observed. The resident did not exhibit any emotional or psychological distress or change in behaviors. Resident #20 was immediately placed under every 15 minute checks for 72 hours following the incident. A urinalysis was collected during the evening of 07/02/24 and was negative for Urinary Tract Infection. Meditelecare Psych was notified of the incident on 07/02/24 and evaluated the resident in house on 07/03/24. A recommendation to increase Celexa to 30 milligrams (mg) by mouth daily. This recommendation was reviewed with Medical Director and orders were completed. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	All interviewable residents were interviewed. One resident did say Resident #20 touched her leg but was not in a sexual way, no other residents had any concerns. This was reported to all appropriate agencies. The perpetrator was placed on every 15 minute checks. Skin checks were performed on all non-interviewable residents. No signs of abuse were identified. The care plan of both residents were reviewed and updated to reflect changes. On 07/29/24 at 7:41 PM, a record review was conducted for Resident #20 which revealed multiple entries of documentation related to Resident #20's behaviors of verbal, physical and sexual aggression towards facility staff and other residents residing in the facility. The following documentation was noted to be dated for 05/08/23 at 06:44 PM: Resident yelling and was rude to staff and other residents this afternoon. Redirected and resident continued to yell. Further review of Resident #20's medical record revealed escalating behavioral disturbances. The following notes were present in Resident #20's medical record: -- 04/19/23 at 9:09 AM. Resident was in dinning room with other resident talking vulgar to her. Kept telling her he wanted her pussy. Female resident removed from situation and Resident #20 was told he can not talk to other residents that way. Will continue to monitor closely. No physician or POA notification documented. -- 04/22/23 at 2:00 PM. Resident was removed from dining room for threatening to hit another resident. Resident was in hallway in WC and started yelling cuss words, saying I don't give a fuck, I'll knock the hell outta you. When nurse ask resident what was wrong, He replied I don't give a fuck. Resident was ask to stop cussing and to go to his room to cool off for his safety and others. No physician or POA notification documented. --. 07/28/23 at 12:52 PM. Resident refused care this a.m. Resident cussing at staff and residents, calling them names. Resident redirected and situation resolved. No physician or POA notification documented. -- 08/13/23 at 12:07 PM. Resident has been obnoxious to the staff and residents. Resident has hassled a resident multiple times by following, stomping his feet near her, verbally aggravating and asking for a kiss from her. He has badgered staff for coffee, milk and sugar throughout the morning not waiting for staff to meet his request before growing louder and more commanding. No physician or POA notification documented. -- 08/13/23 at 4:18 PM. Resident was observed by this nurse to be making rude and inappropriate hand gestures and sounds as a young, teenage girl visiting in the facility. He continued to talk about this teenager, attempting to get another resident to engage in conversation about what he wanted to do to her, and on and on. This nurse interrupted the conversation, telling the resident to stop the conversation, that it was not appropriate and not accepted. No physician or POA notification documented. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-- 08/15/23 at 09:34 PM. Resident has been very rude and disrespectful this eves caught grabbing an other resident breast. When confronted became very angry cursing staff. Then asked CNA to suck his Dick. Then he asked CNA repeatedly if she wanted to party. Resident was educated on this and asked to go to his room. At this time resting quietly. Will continue to monitor closely. No physician or POA notification documented. -- 08/16/23 at 11:49 PM. attempting to go into a female residents room, grabbing at another female resident. Trying to kick and hit this nurse. Cursing and yelling. No physician or POA notification documented. -- 08/16/23 at 3:53 PM. Nursing staff witnessed resident groping another female residents private area and grabbing her butt. The female resident attempted to walk away from resident, but was grabbed by the waist and continuously being groped at her private areas and butt. Nursing staff yelled the residents name to attempt to gain his attention. Resident did let the female resident go, but attempted to scoot in his wheelchair attempting to grab at female resident as she continued to walk away. When nursing staff arrived to the resident, he was assisted in his wheelchair away from the female resident. Nursing staff attempted to redirect resident, but resident yelled Shut the fuck up and go to hell. Nursing administrator was notified of the occurrence and did speak with resident with an RN as a witness. On call psych notified and was set up with an apt for tomorrow morning. Order to call PMH on call provider. Spoke with Summer, and she states she will speak with provider and call back. After speaking with PMH provider, order to continue with current medications, keep Psych apt tomorrow and continue to monitor and redirect additional behaviors. -- 08/16/23 at 06:52 PM. Kitchen staff reported to nursing staff that she was in the kitchen wrapping silverware when she heard a female yelling help help when kitchen staff went to see what the issue was, she witnessed resident groping a female resident, touching her breast and private areas. States resident had female resident pinned where she could not get away from him. When the kitchen staff was able to get to the female resident, resident did let her pass by. Administrator notified of occurrence. No physician or POA notification documented. -- 08/17/23 at 11:24 AM. Resident refused a.m. medications. Resident cussing at nurse when trying to administer medications. Resident attempting to touch visitors. No physician or POA notification documented. -- 08/17/23 at 7:26 PM. Resident had behaviors this PM. touching and inappropriate touching of female residents and staff. Dr. (Last name of physician) in new orders. #1 Increase Celexa to 40 milligrams (mg) by mouth every day. POA informed of behaviors and medication changes. -- 08/18/23 at 10:52 AM. eINTERACT Summary for Providers noted Resident #20 was demonstrating physical aggression, verbal aggression and other behavioral symptoms. In addition, it stated, Resident making sexual gestures and vulgar comments to staff and residents. Redirected, unsuccessful. Resident was placed on one on one and behaviors continued. No physician or POA notification documented. -- 08/26/23 at 04:55 PM. Staff found resident at the supply door, blocking exit of female resident, he would not let her get away from him. One on one in place for safety of residents. Resident redirected to another area of building and offered coffee. No physician or POA notification documented. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-- 08/26/23 at 07:19 PM. Resident attempting to isolate female resident and not allow them to leave his presence. Staff observed this behavior and intervened on behalf of female resident, providing her with egress. No physician or POA notification documented. --09/13/23 at 09:22 AM. Physical behaviors, directed towards others occurs daily or almost every day. Verbal behaviors, directed towards others occurs daily or almost every day. -- 10/16/23 at 09:06 PM. Escalation of inappropriate behavior, grabbing at staff and other residents, masturbating in front of staff, sexual comments, picking his pants leg up to show his penis. No physician or POA notification documented. -- 02/25/24 at 08:50 PM. Resident chasing women down the hall yelling come back here, hit another resident . cursing at staff. No physician or POA notification documented. -- 05/18/24 at 12:12 PM. Certified Nursing Assistant (CNA) reported to nursing that resident grabbing staff and a resident and making lewd comments. Redirected resident will report to oncoming shift. No physician or POA notification documented. -- 06/02/24 at 10:00 PM. resident chasing women residents, trying to grab them inappropriately and trying to touch staff inappropriately. No physician or POA notification documented. -- 07/05/24 at 08:30 PM. resident continues to make sexual comments to staff and argue with residents. No physician or POA notification documented. In addition to the above mentioned documentation, Resident #20's diagnosis list, orders and care plan was reviewed. On 07/30/24 at approximately 10:00 AM, a review of the investigation conducted by facility staff related to the incident that occurred on 07/02/24 in regards to Resident #22 was conducted which revealed interviews with all licensed nursing staff. In review of the interviews, the question Are you aware of sexual abuse occurring at this facility? was answered No by all licensed nursing staff. No interviews of CNA's were present. These interviews were conducted by RN #33. On 07/30/24 at approximately 11:30 AM, a review of the facility Policy and Procedure entitled, Abuse Prohibition was performed. This policy and procedure was noted to state that the facility will implement an abuse prohibition program through screening of potential hires, training of employees, prevention of occurrences, identification of possible incidents or allegations which need investigation, investigation of incidents and allegation, protection of residents during investigations and reporting of incidents, investigations and Center response to the results of their investigations. In addition the policy and procedure states that the facility will identify, correct and intervene in situations in which abuse, neglect, and/or misappropriation of resident property is more likely to occur. Furthermore this policy and procedure states that all suspected abuse must be reported to the physician and the resident's family. The policy and procedure also states that the facility who has identified a resident who has in any was threatened or attacked another will be removed from the setting or situation and investigation will be completed. That immediately upon [NAME] information concerning a report of suspected or alleged abuse, mistreatment or neglect, the Administrator or designee will perform the following: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Report the allegation involving abuse (physical, verbal, sexual, mental) not later than 2 (two) hours after the allegation is made. 2. Report allegations to the appropriately state and local authority(s) involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of resident property, not later that 2 (two) hours after the allegation is made. 3. Initiate an investigation within 24 hours of allegation of abuse. 4. The Center will protect residents from further harm during the investigation. On 07/30/24 at 12:38 PM, an interview was conducted with RN #28 who acknowledged she was aware of Resident #20's verbal, physical and sexual behaviors, stating that Resident #20 self propels in his wheelchair and that it is absolutely best to keep eyes on him. On 07/30/24 at approximately 12:45 PM, an interview was conducted with RN #30 who acknowledged she was aware of Resident #20's verbal, physical and sexual behaviors. On 07/30/24 at approximately 01:10 PM, an interview was conducted with RN #32 who stated that she attends the facility morning clinical meeting and acknowledged she was aware of Resident #20's behaviors because it had been discussed. On 07/30/24 at approximately 01:20 PM, an interview was conducted with Resident #62. At this time, Resident #62 stated that she is afraid of Resident #20. Resident #62 reported that Resident #20 had a reputation of touching women. Resident #62 stated she had reported Resident #20 had entered her room one night and touched her leg and tried to get into bed with her. Resident #62 further stated that when she asked Resident #20 to leave he refused, Resident #62 stated she then called the nurse who came and got Resident #20. Resident #62 reported that she has witnessed Resident #20 touching other residents in the breast and groin area. On 07/30/24 at 01:33 PM, an interview was conducted with RN #33, who was documented as having performed the investigation into the incident involving Resident #20 and Resident #22 When this Surveyor questioned RN #33. This Surveyor asked why the interviews she conducted stated no licensed nursing staff were aware of sexual abuse occurring in the facility when 2 (two) RN's interviewed today stated they were. RN #33 responded, I can't answer why they would each tell us something different. This Surveyor then asked RN #33 if she questioned CNA's and other facility staff related to witnessing abuse by Resident#20 due to CNA's reporting the incident. RN #33 responded I didn't interview CNA's or other staff to see if they witnessed abuse by Resident #20. At this time, RN #33 verbalized she had been in her current position for approximately 1.5 years and that she, among other RN's, were responsible for reading the facility progress notes prior to morning clinical meeting and she is unaware of the above documented allegations of abuse by Resident #20. The corporate Clinical Lead Nurse was present for this interview. Immediately upon discovering the above mentioned occurrences of abuse placed Resident #20 on one to one observation. On 07/30/24 at 2:39 PM, an interview with the facility corporate Clinical Lead Nurse was conducted, in which she acknowledged the following: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The facility was unable to identify the resident's in the above mentioned progress notes. 2. No investigations had been performed related to these incidents. 3. No follow-up assessments had been conducted to assess for the psychosocial well-fare of these residents. 4. These incidents had not been reported or investigated by the facility as indicated in the facility Policy and Procedure entitled Abuse Prohibition. 5. Resident #20 frequently refused medication for his behavioral disturbances. 6. The facility policy and procedure entitled, Abuse Prohibition had not been implemented in these occurrences. 7. The facility failed to notify the physician and POA for all occurrences. 8. The facility failed to keep the residents safe from verbal, physical and sexual abuse. 8. These incidents and the verbal, sexual and physical abuse had not been taken to Quality Improvement Committee (QIC). No further information was provided prior to the end of the survey.

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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** 50552 Based on record review and staff interview the facility failed to report to the appropriate state agencies as listed in the policy and procedure entitled, Abuse Prohibition. This failed practice has the potential to affect more than a limited number of residents. Resident identifier: Resident #20, Resident #22, Resident #62. Facility census: 67. Findings include: a) Resident #20 On 07/29/24 at approximately 3:15 PM, a review of the facility reported incidents (FRI), it was discovered a FRI had been submitted for Resident #22. During the review of this FRI, it was noted on 07/02/24 at 6:15 PM, Resident #20 was witnessed grabbing Resident #22's breast. Nurse Aide (NA) #62 and NA #40 witnessed the incident, separated and redirected the residents, and immediately reported the incident to Licensed Practical Nurse (LPN) #20. A review of the FRI revealed the following 5 (five) day was submitted as a summary of the incident and read as follows: On July 2, 2024 at approximately 6:15 PM, Resident #20 was witnessed grabbing Resident #22's breast. NA #62 and NA #40 witnessed the incident, separated and redirected the residents, and immediately reported to LPN #20. Resident #22 is a [AGE] year-old female resident who was admitted to (Name of Facility) on September 13, 2017. The resident has diagnoses of dementia, Alzheimer's disease, unspecified psychosis and wandering. Resident #22 is ambulatory, frequently wanders and ambulates about the facility ad lib. The resident does not retain the capacity to make healthcare decisions and her son is the health care surrogate and conservator. Resident #20 is a [AGE] year-old male resident who was admitted to (Name of Facility) September 9, 2022. The resident has diagnoses of dementia and Alzheimer's disease. Resident #20 has a history of sexual behaviors and inappropriately touching other residents, visitors and staff. The resident utilizes a wheelchair and independently locomotion about the facility ad lib. Resident #20 does not retain capacity to make health care decisions and his daughter is Medical Power of Attorney (MPOA). A head-to-toe check was performed on Resident #22 following the incident on 07/02/24 and no injuries or skin issues were observed. The resident did not exhibit any emotional or psychological distress or change in behaviors. Resident #20 was immediately placed under every 15 minute checks for 72 hours following the incident. A urinalysis was collected during the evening of 07/02/24 and was negative for Urinary Tract Infection. Meditelecare Psych was notified of the incident on 07/02/24 and evaluated the resident in house on 07/03/24. A recommendation to increase Celexa to 30 milligrams (mg) by mouth daily. This recommendation was reviewed with Medical Director and orders were completed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-- 08/26/23 at 07:19 PM. Resident attempting to isolate female resident and not allow them to leave his presence. Staff observed this behavior and intervened on behalf of female resident, providing her with egress. No physician or POA notification documented. --09/13/23 at 09:22 AM. Physical behaviors, directed towards others occurs daily or almost every day. Verbal behaviors, directed towards others occurs daily or almost every day. -- 10/16/23 at 09:06 PM. Escalation of inappropriate behavior, grabbing at staff and other residents, masturbating in front of staff, sexual comments, picking his pants leg up to show his penis. No physician or POA notification documented. -- 02/25/24 at 08:50 PM. Resident chasing women down the hall yelling come back here, hit another resident . cursing at staff. No physician or POA notification documented. -- 05/18/24 at 12:12 PM. Certified Nursing Assistant (CNA) reported to nursing that resident grabbing staff and a resident and making lewd comments. Redirected resident will report to oncoming shift. No physician or POA notification documented. -- 06/02/24 at 10:00 PM. resident chasing women residents, trying to grab them inappropriately and trying to touch staff inappropriately. No physician or POA notification documented. -- 07/05/24 at 08:30 PM. resident continues to make sexual comments to staff and argue with residents. No physician or POA notification documented. In addition to the above mentioned documentation, Resident #20's diagnosis list, orders and care plan was reviewed. On 07/30/24 at approximately 10:00 AM, a review of the investigation conducted by facility staff related to the incident that occurred on 07/02/24 in regards to Resident #22 was conducted which revealed interviews with all licensed nursing staff. In review of the interviews, the question Are you aware of sexual abuse occurring at this facility? was answered No by all licensed nursing staff. No interviews of CNA's were present. These interviews were conducted by RN #33. On 07/30/24 at approximately 11:30 AM, a review of the facility Policy and Procedure entitled, Abuse Prohibition was performed. This policy and procedure was noted to state that the facility will implement an abuse prohibition program through screening of potential hires, training of employees, prevention of occurrences, identification of possible incidents or allegations which need investigation, investigation of incidents and allegation, protection of residents during investigations and reporting of incidents, investigations and Center response to the results of their investigations. In addition the policy and procedure states that the facility will identify, correct and intervene in situations in which abuse, neglect, and/or misappropriation of resident property is more likely to occur. Furthermore this policy and procedure states that all suspected abuse must be reported to the physician and the resident's family. The policy and procedure also states that the facility who has identified a resident who has in any was threatened or attacked another will be removed from the setting or situation and investigation will be completed. That immediately upon [NAME] information concerning a report of suspected or alleged abuse, mistreatment or neglect, the Administrator or designee will perform the following: (continued on next page)

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	515183	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pocahontas Center	5 Everett Tibbs Road Marlinton, WV 24954

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Report the allegation involving abuse (physical, verbal, sexual, mental) not later than 2 (two) hours after the allegation is made. 2. Report allegations to the appropriately state and local authority(s) involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of resident property, not later that 2 (two) hours after the allegation is made. 3. Initiate an investigation within 24 hours of allegation of abuse. 4. The Center will protect residents from further harm during the investigation. On 07/30/24 at 12:38 PM, an interview was conducted with RN #28 who acknowledged she was aware of Resident #20's verbal, physical and sexual behaviors, stating that Resident #20 self propels in his wheelchair and that it is absolutely best to keep eyes on him. On 07/30/24 at approximately 12:45 PM, an interview was conducted with RN #30 who acknowledged she was aware of Resident #20's verbal, physical and sexual behaviors. On 07/30/24 at approximately 01:10 PM, an interview was conducted with RN #32 who stated that she attends the facility morning clinical meeting and acknowledged she was aware of Resident #20's behaviors because it had been discussed. On 07/30/24 at approximately 01:20 PM, an interview was conducted with Resident #62. At this time, Resident #62 stated that she is afraid of Resident #20. Resident #62 reported that Resident #20 had a reputation of touching women. Resident #62 stated she had reported Resident #20 had entered her room one night and touched her leg and tried to get into bed with her. Resident #62 further stated that when she asked Resident #20 to leave he refused, Resident #62 stated she then called the nurse who came and got Resident #20. Resident #62 reported that she has witnessed Resident #20 touching other residents in the breast and groin area. On 07/30/24 at 01:33 PM, an interview was conducted with RN #33, who was documented as having performed the investigation into the incident involving Resident #20 and Resident #22 When this Surveyor questioned RN #33. This Surveyor asked why the interviews she conducted stated no licensed nursing staff were aware of sexual abuse occurring in the facility when 2 (two) RN's interviewed today stated they were. RN #33 responded, I can't answer why they would each tell us something different. This Surveyor then asked RN #33 if she questioned CNA's and other facility staff related to witnessing abuse by Resident#20 due to CNA's reporting the incident. RN #33 responded I didn't interview CNA's or other staff to see if they witnessed abuse by Resident #20. At this time, RN #33 verbalized she had been in her current position for approximately 1.5 years and that she, among other RN's, were responsible for reading the facility progress notes prior to morning clinical meeting and she is unaware of the above documented allegations of abuse by Resident #20. The corporate Clinical Lead Nurse was present for this interview. Immediately upon discovering the above mentioned occurrences of abuse placed Resident #20 on one to one observation. On 07/30/24 at 2:39 PM, an interview with the facility corporate Clinical Lead Nurse was conducted, in which she acknowledged the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The facility was unable to identify the resident's in the above mentioned progress notes. 2. No investigations had been performed related to these incidents. 3. No follow-up assessments had been conducted to assess for the psychosocial well-fare of these residents. 4. These incidents had not been reported or investigated by the facility as indicated in the facility Policy and Procedure entitled Abuse Prohibition. 5. Resident #20 frequently refused medication for his behavioral disturbances. 6. The facility policy and procedure entitled, Abuse Prohibition had not been implemented in this occurrences. 7. The facility failed to notify the physician and POA for all occurrences. 8. The facility failed to keep the residents safe from verbal, physical and sexual abuse. 8. These incidents and the verbal, sexual and physical abuse had not been taken to Quality Improvement Committee (QIC). No further information was provided prior to the end of the survey.

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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** 50552 Based on record review and staff interview the facility failed to imvestigate allegations of abuse as listed in the policy and procedure entitled, Abuse Prohibition. This failed practice has the potential to affect more than a limited number of residents. Resident identifier: Resident #20, Resident #22, Resident #62. Facility census: 67. Findings include: a) Resident #20 On 07/29/24 at approximately 3:15 PM, a review of the facility reported incidents (FRI), it was discovered a FRI had been submitted for Resident #22. During the review of this FRI, it was noted on 07/02/24 at 6:15 PM, Resident #20 was witnessed grabbing Resident #22's breast. Nurse Aide (NA) #62 and NA #40 witnessed the incident, separated and redirected the residents, and immediately reported the incident to Licensed Practical Nurse (LPN) #20. A review of the FRI revealed the following 5 (five) day was submitted as a summary of the incident and read as follows: On July 2, 2024 at approximately 6:15 PM, Resident #20 was witnessed grabbing Resident #22's breast. NA #62 and NA #40 witnessed the incident, separated and redirected the residents, and immediately reported to LPN #20. Resident #22 is a [AGE] year-old female resident who was admitted to (Name of Facility) on September 13, 2017. The resident has diagnoses of dementia, Alzheimer's disease, unspecified psychosis and wandering. Resident #22 is ambulatory, frequently wanders and ambulates about the facility ad lib. The resident does not retain the capacity to make healthcare decisions and her son is the health care surrogate and conservator. Resident #20 is a [AGE] year-old male resident who was admitted to (Name of Facility) September 9, 2022. The resident has diagnoses of dementia and Alzheimer's disease. Resident #20 has a history of sexual behaviors and inappropriately touching other residents, visitors and staff. The resident utilizes a wheelchair and independently locomotion about the facility ad lib. Resident #20 does not retain capacity to make health care decisions and his daughter is Medical Power of Attorney (MPOA). A head-to-toe check was performed on Resident #22 following the incident on 07/02/24 and no injuries or skin issues were observed. The resident did not exhibit any emotional or psychological distress or change in behaviors. Resident #20 was immediately placed under every 15 minute checks for 72 hours following the incident. A urinalysis was collected during the evening of 07/02/24 and was negative for Urinary Tract Infection. Meditelecare Psych was notified of the incident on 07/02/24 and evaluated the resident in house on 07/03/24. A recommendation to increase Celexa to 30 milligrams (mg) by mouth daily. This recommendation was reviewed with Medical Director and orders were completed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	All interviewable residents were interviewed. One resident did say Resident #20 touched her leg but was not in a sexual way, no other residents had any concerns. This was reported to all appropriate agencies. The perpetrator was placed on every 15 minute checks. Skin checks were performed on all non-interviewable residents. No signs of abuse were identified. The care plan of both residents were reviewed and updated to reflect changes. On 07/29/24 at 7:41 PM, a record review was conducted for Resident #20 which revealed multiple entries of documentation related to Resident #20's behaviors of verbal, physical and sexual aggression towards facility staff and other residents residing in the facility. The following documentation was noted to be dated for 05/08/23 at 06:44 PM: Resident yelling and was rude to staff and other residents this afternoon. Redirected and resident continued to yell. Further review of Resident #20's medical record revealed escalating behavioral disturbances. The following notes were present in Resident #20's medical record: -- 04/19/23 at 9:09 AM. Resident was in dinning room with other resident talking vulgar to her. Kept telling her he wanted her pussy. Female resident removed from situation and Resident #20 was told he can not talk to other residents that way. Will continue to monitor closely. No physician or POA notification documented. -- 04/22/23 at 2:00 PM. Resident was removed from dining room for threatening to hit another resident. Resident was in hallway in WC and started yelling cuss words, saying I don't give a fuck, I'll knock the hell outta you. When nurse ask resident what was wrong, He replied I don't give a fuck. Resident was ask to stop cussing and to go to his room to cool off for his safety and others. No physician or POA notification documented. --. 07/28/23 at 12:52 PM. Resident refused care this a.m. Resident cussing at staff and residents, calling them names. Resident redirected and situation resolved. No physician or POA notification documented. -- 08/13/23 at 12:07 PM. Resident has been obnoxious to the staff and residents. Resident has hassled a resident multiple times by following, stomping his feet near her, verbally aggravating and asking for a kiss from her. He has badgered staff for coffee, milk and sugar throughout the morning not waiting for staff to meet his request before growing louder and more commanding. No physician or POA notification documented. -- 08/13/23 at 4:18 PM. Resident was observed by this nurse to be making rude and inappropriate hand gestures and sounds as a young, teenage girl visiting in the facility. He continued to talk about this teenager, attempting to get another resident to engage in conversation about what he wanted to do to her, and on and on. This nurse interrupted the conversation, telling the resident to stop the conversation, that it was not appropriate and not accepted. No physician or POA notification documented. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-- 08/15/23 at 09:34 PM. Resident has been very rude and disrespectful this eves caught grabbing an other resident breast. When confronted became very angry cursing staff. Then asked CNA to suck his Dick. Then he asked CNA repeatedly if she wanted to party. Resident was educated on this and asked to go to his room. At this time resting quietly. Will continue to monitor closely. No physician or POA notification documented. -- 08/16/23 at 11:49 PM. attempting to go into a female residents room, grabbing at another female resident. Trying to kick and hit this nurse. Cursing and yelling. No physician or POA notification documented. -- 08/16/23 at 3:53 PM. Nursing staff witnessed resident groping another female residents private area and grabbing her butt. The female resident attempted to walk away from resident, but was grabbed by the waist and continuously being groped at her private areas and butt. Nursing staff yelled the residents name to attempt to gain his attention. Resident did let the female resident go, but attempted to scoot in his wheelchair attempting to grab at female resident as she continued to walk away. When nursing staff arrived to the resident, he was assisted in his wheelchair away from the female resident. Nursing staff attempted to redirect resident, but resident yelled Shut the fuck up and go to hell. Nursing administrator was notified of the occurrence and did speak with resident with an RN as a witness. On call psych notified and was set up with an apt for tomorrow morning. Order to call PMH on call provider. Spoke with Summer, and she states she will speak with provider and call back. After speaking with PMH provider, order to continue with current medications, keep Psych apt tomorrow and continue to monitor and redirect additional behaviors. -- 08/16/23 at 06:52 PM. Kitchen staff reported to nursing staff that she was in the kitchen wrapping silverware when she heard a female yelling help help when kitchen staff went to see what the issue was, she witnessed resident groping a female resident, touching her breast and private areas. States resident had female resident pinned where she could not get away from him. When the kitchen staff was able to get to the female resident, resident did let her pass by. Administrator notified of occurrence. No physician or POA notification documented. -- 08/17/23 at 11:24 AM. Resident refused a.m. medications. Resident cussing at nurse when trying to administer medications. Resident attempting to touch visitors. No physician or POA notification documented. -- 08/17/23 at 7:26 PM. Resident had behaviors this PM. touching and inappropriate touching of female residents and staff. Dr. (Last name of physician) in new orders. #1 Increase Celexa to 40 milligrams (mg) by mouth every day. POA informed of behaviors and medication changes. -- 08/18/23 at 10:52 AM. eINTERACT Summary for Providers noted Resident #20 was demonstrating physical aggression, verbal aggression and other behavioral symptoms. In addition, it stated, Resident making sexual gestures and vulgar comments to staff and residents. Redirected, unsuccessful. Resident was placed on one on one and behaviors continued. No physician or POA notification documented. -- 08/26/23 at 04:55 PM. Staff found resident at the supply door, blocking exit of female resident, he would not let her get away from him. One on one in place for safety of residents. Resident redirected to another area of building and offered coffee. No physician or POA notification documented. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-- 08/26/23 at 07:19 PM. Resident attempting to isolate female resident and not allow them to leave his presence. Staff observed this behavior and intervened on behalf of female resident, providing her with egress. No physician or POA notification documented. --09/13/23 at 09:22 AM. Physical behaviors, directed towards others occurs daily or almost every day. Verbal behaviors, directed towards others occurs daily or almost every day. -- 10/16/23 at 09:06 PM. Escalation of inappropriate behavior, grabbing at staff and other residents, masturbating in front of staff, sexual comments, picking his pants leg up to show his penis. No physician or POA notification documented. -- 02/25/24 at 08:50 PM. Resident chasing women down the hall yelling come back here, hit another resident . cursing at staff. No physician or POA notification documented. -- 05/18/24 at 12:12 PM. Certified Nursing Assistant (CNA) reported to nursing that resident grabbing staff and a resident and making lewd comments. Redirected resident will report to oncoming shift. No physician or POA notification documented. -- 06/02/24 at 10:00 PM. resident chasing women residents, trying to grab them inappropriately and trying to touch staff inappropriately. No physician or POA notification documented. -- 07/05/24 at 08:30 PM. resident continues to make sexual comments to staff and argue with residents. No physician or POA notification documented. In addition to the above mentioned documentation, Resident #20's diagnosis list, orders and care plan was reviewed. On 07/30/24 at approximately 10:00 AM, a review of the investigation conducted by facility staff related to the incident that occurred on 07/02/24 in regards to Resident #22 was conducted which revealed interviews with all licensed nursing staff. In review of the interviews, the question Are you aware of sexual abuse occurring at this facility? was answered No by all licensed nursing staff. No interviews of CNA's were present. These interviews were conducted by RN #33. On 07/30/24 at approximately 11:30 AM, a review of the facility Policy and Procedure entitled, Abuse Prohibition was performed. This policy and procedure was noted to state that the facility will implement an abuse prohibition program through screening of potential hires, training of employees, prevention of occurrences, identification of possible incidents or allegations which need investigation, investigation of incidents and allegation, protection of residents during investigations and reporting of incidents, investigations and Center response to the results of their investigations. In addition the policy and procedure states that the facility will identify, correct and intervene in situations in which abuse, neglect, and/or misappropriation of resident property is more likely to occur. Furthermore this policy and procedure states that all suspected abuse must be reported to the physician and the resident's family. The policy and procedure also states that the facility who has identified a resident who has in any was threatened or attacked another will be removed from the setting or situation and investigation will be completed. That immediately upon [NAME] information concerning a report of suspected or alleged abuse, mistreatment or neglect, the Administrator or designee will perform the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Report the allegation involving abuse (physical, verbal, sexual, mental) not later than 2 (two) hours after the allegation is made. 2. Report allegations to the appropriately state and local authority(s) involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of resident property, not later that 2 (two) hours after the allegation is made. 3. Initiate an investigation within 24 hours of allegation of abuse. 4. The Center will protect residents from further harm during the investigation. On 07/30/24 at 12:38 PM, an interview was conducted with RN #28 who acknowledged she was aware of Resident #20's verbal, physical and sexual behaviors, stating that Resident #20 self propels in his wheelchair and that it is absolutely best to keep eyes on him. On 07/30/24 at approximately 12:45 PM, an interview was conducted with RN #30 who acknowledged she was aware of Resident #20's verbal, physical and sexual behaviors. On 07/30/24 at approximately 01:10 PM, an interview was conducted with RN #32 who stated that she attends the facility morning clinical meeting and acknowledged she was aware of Resident #20's behaviors because it had been discussed. On 07/30/24 at approximately 01:20 PM, an interview was conducted with Resident #62. At this time, Resident #62 stated that she is afraid of Resident #20. Resident #62 reported that Resident #20 had a reputation of touching women. Resident #62 stated she had reported Resident #20 had entered her room one night and touched her leg and tried to get into bed with her. Resident #62 further stated that when she asked Resident #20 to leave he refused, Resident #62 stated she then called the nurse who came and got Resident #20. Resident #62 reported that she has witnessed Resident #20 touching other residents in the breast and groin area. On 07/30/24 at 01:33 PM, an interview was conducted with RN #33, who was documented as having performed the investigation into the incident involving Resident #20 and Resident #22 When this Surveyor questioned RN #33. This Surveyor asked why the interviews she conducted stated no licensed nursing staff were aware of sexual abuse occurring in the facility when 2 (two) RN's interviewed today stated they were. RN #33 responded, I can't answer why they would each tell us something different. This Surveyor then asked RN #33 if she questioned CNA's and other facility staff related to witnessing abuse by Resident#20 due to CNA's reporting the incident. RN #33 responded I didn't interview CNA's or other staff to see if they witnessed abuse by Resident #20. At this time, RN #33 verbalized she had been in her current position for approximately 1.5 years and that she, among other RN's, were responsible for reading the facility progress notes prior to morning clinical meeting and she is unaware of the above documented allegations of abuse by Resident #20. The corporate Clinical Lead Nurse was present for this interview. Immediately upon discovering the above mentioned occurrences of abuse placed Resident #20 on one to one observation. On 07/30/24 at 2:39 PM, an interview with the facility corporate Clinical Lead Nurse was conducted, in which she acknowledged the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The facility was unable to identify the resident's in the above mentioned progress notes. 2. No investigations had been performed related to these incidents. 3. No follow-up assessments had been conducted to assess for the psychosocial well-fare of these residents. 4. These incidents had not been reported or investigated by the facility as indicated in the facility Policy and Procedure entitled Abuse Prohibition. 5. Resident #20 frequently refused medication for his behavioral disturbances. 6. The facility policy and procedure entitled, Abuse Prohibition had not been implemented in this occurrences. 7. The facility failed to notify the physician and POA for all occurrences. 8. The facility failed to keep the residents safe from verbal, physical and sexual abuse. 8. These incidents and the verbal, sexual and physical abuse had not been taken to Quality Improvement Committee (QIC). No further information was provided prior to the end of the survey.

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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. 49650 Based on medical record review and staff interviews the facility failed to notify to the ombudsman of a resident transfer/discharge to the hospital. This was true for one (1) of three (3) residents reviewed for hospitalization s during the long term care survey process. Resident Identifiers: Resident #68. Facility Census: 67. Findings include: a) Resident #68 During a medical record review for Resident #68 on 07/30/24 at 7:30 AM it was identified the resident had a change in condition for abnormal vital signs and an order was received to transfer the resident out to the hospital on 05/03/24. With further review of the medical record a notification to the Ombudsman was not found During an interview with the facility Clinical Reimbursement Coordinator #32 on 07/31/24 at approximately 9:30 AM the CRC stated, the Ombudsman notification was a responsibility of the Social Worker who is out on medical leave. CRC #32 stated, this notification was not completed. She further stated she would reach out to the Ombudsman and initiate the notifications in the absence of the Social Worker.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 49650 Based on medical record review and staff interviews the facility failed to notify resident representatives of the bed hold policy at the time of transfer/discharge. This was true for two (2) of two (2) residents reviewed for transfers/discharges during the long term care survey process. Resident Identifiers: Resident #68 and Resident #51. Facility Census: 67. Findings include: a) Resident #68 During a medical record review for Resident #68 on 07/30/24 at 7:30 AM it was identified the resident had a change in condition for abnormal vital signs and an order was received to transfer the resident out to the hospital on 05/03/24. Further review of the medical record found the record was void of a bed hold notification to the medical power of attorney (MPOA) for this discharge. During an interview with the facility Admission Director (AD) #36 on 07/30/24 at 3:47 PM, the AD stated the bed hold notification had not been completed with this transfer and further stated it should have been but did not know why it wasn't. b) Resident #51 During a medical record review for Resident #51 on 07/29/24 at 10:47 AM, it was identified the resident had a change in condition for vomiting what appears to be blood, and an order was received to transfer the resident out to the hospital on 07/29/24. Futher review of the medical record found the record was void a bed hold notification for this resident transfer. On 07/31/24 at approximately 3:00 PM, a review of the policy and procedure entitled Discharge and Transfer was conducted, which revealed the facility must immediately inform in writing the resident and/or resident representative of a transfer in a language they are able to understand. On 07/31/24 at 3:30 PM, an interview was conducted with the facility Corporate Clinical Lead Nurse who acknowledged the bed hold notification had not been completed with this transfer and further stated it should have been but did not know why it wasn't. 50552

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 45171 Based on record review and staff interview the facility failed to coordinate with the appropriate State-designated authority, to ensure that individuals with a mental disorder, intellectual disability or a related condition receives care and services in the most integrated setting appropriate to their needs when completing/revising a Pre-Admission Screening and Resident Review (PASSR). This was true for three (3) of three (3) residents who had their PASSR's reviewed during the long term care survey process. Resident Identifiers: 57, 43, 16. Facility Census: 67. Findings Include: a) Resident #57 On 07/30/24 at 11:00 AM record review found Resident #57 had the following medical diagnosis: Schizoeffective Disorder Bipolar Type Onset 06/18/24 Unspecified Dementia Onset 10/06/23 Unspecified Psychosis Onset 10/06/23 Delirium Onset 06/18/24 Major Depressive Disorder Onset 10/06/23 Anxiety Disorder Onset 12/26/23 Review of the PASSR dated 06/13/24 found that the following medical diagnosis were not identified on the PASSR. Schizoeffective Disorder Bipolar Type Onset 06/18/24 Delirium Onset 06/18/24 Major Depressive Disorder Onset 10/06/23 Anxiety Disorder Onset 12/26/23 The above information was confirmed with Admissions Director on 07/30/24 at 12:00 PM who agreed that the additional medical diagnosis should be on the PASSR. b) Resident #43 On 07/30/24 at 11:30 AM record review found Resident #43 has the following medical diagnosis: (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dementia Onset 01/26/23 Post Traumatic Stress Disorder Onset 01/26/23 Paranoid Schizophrenia Onset 01/26/23 Delusional Disorders Onset 01/30/24 Review of the PASSR dated 01/26/24 found that the following medical diagnosis were not identified on the PASSR. Post Traumatic Stress Disorder Onset 01/26/23 Paranoid Schizophrenia Onset 01/26/23 Delusional Disorders Onset 01/30/24 The above information was confirmed with Admissions Director on 07/30/24 at 12:00 PM who agreed that the additional medical diagnosis should be on the PASSR. c) Resident #16 On 07/30/24 at approximately 09:00 AM, a review of Resident #16's medical record was conducted. During this review, Resident #16 was noted to have the following diagnoses: 1. Post Traumatic Stress Disorder, Chronic. Dated: 03/20/24. 2. Unspecified Dementia, mild with other behavioral disturbance. Dated: 03/20/24. 3. Schizoaffective Disorder, unspecified. Dated: 03/20/24. 4. Bipolar Disorder, unspecified. Dated: 03/20/24. 5. Major Depressive Disorder, single episode, unspecified. Dated: 03/20/24. In addition, a review of Resident #16's Preadmission Screening and Resident Review form (PASARR) dated 03/19/24 was conducted revealing the absence of the following diagnoses: 1. Post Traumatic Stress Disorder, Chronic. Dated: 03/20/24. 2. Bipolar Disorder, unspecified. Dated: 03/20/24. On 07/31/24 at 12:20 PM, an interview was conducted with the facility Corporate Clinical Lead Nurse who acknowledged that Resident #16's PASARR was inaccurate and a new one should have been completed and submitted to the appropriate state agency. 50552

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 50552 Based on record review and staff interview the facility failed to monitor potential triggers for a resident diagnosed with Post Traumatic Stress Disorder. This was true for 1 (one) of 1 (one) resident's reviewed for the Long Term Care Survey Process. Resident identifier: Resident #16. Facility census: 67. Findings include: a) Resident #16 On 07/30/24 at approximately 9:00 AM, a review of Resident #16's medical record was conducted. During this review, Resident #16 was noted to have the following diagnoses: 1. Post Traumatic Stress Disorder, Chronic. Dated: 03/20/24. 2. Unspecified Dementia, mild with other behavioral disturbance. Dated: 03/20/24. 3. Schizoaffective Disorder, unspecified. Dated: 03/20/24. 4. Bipolar Disorder, unspecified. Dated: 03/20/24. 5. Major Depressive Disorder, single episode, unspecified. Dated: 03/20/24. In addition, Resident #16 was noted to be receiving the following psychotropic medication: 1. Fluphenazine 2.5 milligrams (MG). Give 1 (one) tablet by mouth three times a day for schizoaffective disorder. 2. Seroquel 200 mg. Give 1 (one) tablet by mouth at bedtime for schizoaffective disorder. Furthermore, a review of Resident #16's medication administration record (MAR) was performed which revealed no behavior monitoring being performed for the above medication and or diagnoses. A review of Resident #16's care plan revealed no care plan related to Resident #16's Post Traumatic Stress Disorder. On 07/31/24 at approximately 10:30 AM, a review of the facility policy and procedure entitled Behaviors: Management of Symptoms revealed staff will monitor for and document in the medical record any exhibited behavioral symptoms. In addition, the facility policy and procedure entitled Trauma Informed Care revealed that the facility will: 1. Identify triggers which may re-traumatize residents with a history of trauma. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Implement trigger specific interventions to decrease the residents exposure to triggers which may re-traumatize the resident. 3. Identify ways to mitigate or decrease the effect of the trigger on the resident. 4. These triggers and trigger specific interventions will be added to the residents care plan. On 07/31/24 at 12:20 PM, an interview was conducted the facility Corporate Clinical Lead Nurse who acknowledged Resident #16 was not assessed for potential triggers and that no care plan for Post Traumatic Stress Disorder existed for Resident #16.

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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** 45171 Based on record review and staff interview the facility failed to revise care plan to be resident specific when the residents care needs changed. This was true for two (2) of 23 sampled residents reviewed during the long term care survey process. Resident Identifier: #25 and #44. Facility Census: 67 Findings Include: a) Resident #25 On 07/31/24 at 2:58 PM record review of the comprehensive care plan for Resident #25 found that it had not been revised when they no longer was insulin dependent. The care plan (created on 11/16/23) focus for diabetes states Resident #25 is insulin dependent when in fact her Lantus insulin was discontinued on 07/25/24. This was confirmed with the Corporate Clinical Lead #75 on 07/31/24 at 3:30 PM who agreed the care plan should have been revised accordingly. b) Resident #44 On 07/29/24 at 9:45 AM observation shows Resident #44 is a frail, small resident. She is unable to speak loud enough to be heard. She is laying in a fetal position with contractures observed. On 07/30/24 at 1:55 PM record review shows that Resident #44 is a [AGE] year old hospice resident as of 06/18/24. The Resident is bed bound and at end of life. The current care plan states: (Resident name) prefers to be self directed in her room but will attend some activities. .requested that she attend most or all out of room activities (Resident name) has an unstagable pressure injury Keep appointments with (local hospital) wound clinic as scheduled Resident requires assistance for ADLs related to . :Meals in the dining room Resident will remain able to feed herself through next quarter (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encourage and facilitate (Resident name) activity preference reading her kindle and Pocahontas Times. Administer diuretic as ordered Obtain skilled PT/OT evaluation to improve functional mobility PRN Based on the observations and record review the above care plan focuses are not resident specific for Resident #44. This was confirmed with the Corporate Clinical Lead #75 on 07/31/24 at 3:30 PM who agreed the care plan should have been revised accordingly.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 45171 Based on record review and staff interview the facility failed to follow Physician orders related to reporting elevated blood glucose levels. This was a random oppurtunity for discovery and was true for Resident #25. Resident Identifier: #25 Facility Census: 67 Findings Include: a) Resident #25 On 07/31/24 at 4:16 PM record review found, Resident #25 has the following orders: Monitor blood sugars twice weekly at 6:30 am. Notify Physician if less than (<) 60 or greater than (>)300 one time a day every Wednesday and Sunday for signs and symptoms of hyper or hypo glycemia diaphoresis changes of level of conscience. Documentation shows the following dates the blood glucose was out of range and not reported to the physician as ordered. 04/23/24 309 milligrams per deciliter (mg/dl 04/24/24 345 mg/dl 04/25/24 306 mg/dl 04/26/24 349 mg/dl The above information was confirmed on 08/01/24 at 9:00 AM with Corporate Clinical Lead #75 who agreed all of the elevated blood glucose levels should have been reported to the Physician. .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45171 Based on observation and staff interview the facility failed to ensure the resident environment of which it had control was as free from accident hazards as possible. The facility failed to maintain the dryer in a safe manner. This failed practice has the potential to affect all residents currently residing in the facility. Facility census: 67. Findings include: a) Facility On 08/01/24 at 9:40 AM, an observation of the laundry room was conducted. While observing the lint traps in the facility dryers they were noted to full and had overflowed with lint into the floor. On 08/01/24 at approximately 9:50 AM, a review of the facility Environmental Services Operations Manual section Laundry Operations was performed. During this review the section of the manual entitled Lint Screens stated lint screens must be brushed and cleaned after every load or every hour. In addition the section, Lint Screens states that if these lint screens are not brushed and cleaned as stated above the screen will become packed with lint and that when this occurs, the warm air moving through the system is blocked, raising the temperature in the lint basket causing a potential dangerous situation; i.e., where one spark on lint can cause a fire. On 08/01/24 at approximately 10:00 AM, Employee #72 acknowledged the lint traps were overflowing and it was a fire risk.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 50552 Based on observation and staff interview the facility failed to ensure a resident who is incontinent of bladder received timely appropriate incontinence care. This was true for 1 (one) of 1 (one) residents reviewed for the Long Term Care Survey Process. Resident identifer: Resident #60. Facility Census: 67. Findings include: a) Resident #60 On 07/29/24 at 9:17 AM, an interview and observation was conducted with Resident #60. At this time Resident #60 indicated he was incontinent, stating Somebody was supposed to come clean me up, but I don't know how long before she gets here. This Surveyor asked Resident #60 if he had used his call bell to alert staff incontinence care was needed. Resident #60 stated he had, and some staff came in an turned it off and told me they would be back after the lunch trays were picked up At this time, this Surveyor walked out of Resident #60's room and spoke with Employee #43 who was outside of Resident #60's room. This Surveyor asked Employee #43 if she was taking care of Resident #60 to which Employee #43 acknowledged she was. This Surveyor informed Employee #43 Resident #60 was incontinent and needed care provided. Employee #43 acknowledged, she was aware Resident #60 was incontinent and waiting for incontinence care stating, We don't give peri-care unless its dire emergency during meal times, we are not allowed to have linen carts on the hallway at the same time the meal carts are on it. Let me check to see if the meal carts have been taken back to the kitchen. Once Employee #43 confirmed the meal carts were off the hallway, Employee #43 went to provide Resident #60 incontinence care. On 07/31/24 at 1:25 PM, an interview was conducted with the facility Corporate Clinical Lead Nurse. During this interview, the facility Corporate Clinical Lead Nurse acknowledged there was no facility policy and procedure prohibiting incontinence care being provided while the meal carts were on the floor and Resident #60 should have received prompt incontinence care when requested.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 50552 Based on record review and staff interview the facility failed to monitor potential triggers for a resident diagnosed with Post Traumatic Stress Disorder. This was true for 1 (one) of 1 (one) resident's reviewed for truama informed care during the Long Term Care Survey Process. Resident identifier: Resident #16. Facility census: 67. Findings include: a) Resident #16 On 07/30/24 at approximately 9:00 AM, a review of Resident #16's medical record was conducted. During this review, Resident #16 was noted to have the following diagnoses: 1. Post Traumatic Stress Disorder, Chronic. Dated: 03/20/24. 2. Unspecified Dementia, mild with other behavioral disturbance. Dated: 03/20/24. 3. Schizoaffective Disorder, unspecified. Dated: 03/20/24. 4. Bipolar Disorder, unspecified. Dated: 03/20/24. 5. Major Depressive Disorder, single episode, unspecified. Dated: 03/20/24. In addition, Resident #16 was noted to be receiving the following psychotropic medication: 1. Fluphenazine 2.5 milligrams (MG). Give 1 (one) tablet by mouth three times a day for schizoaffective disorder. 2. Seroquel 200 mg. Give 1 (one) tablet by mouth at bedtime for schizoaffective disorder. Furthermore, a review of Resident #16's medication administration record (MAR) was performed which revealed no behavior monitoring being performed for the above medication and or diagnoses. A review of Resident #16's care plan revealed no care plan related to Resident #16's Post Traumatic Stress Disorder. On 07/31/24 at approximately 10:30 AM, a review of the facility policy and procedure entitled Behaviors: Management of Symptoms revealed that staff will monitor for and document in the medical record any exhibited behavioral symptoms. In addition, the facility policy and procedure entitled Trauma Informed Care revealed that the facility will: 1. Identify triggers which may re-traumatize residents with a history of trauma. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Implement trigger specific interventions to decrease the residents exposure to triggers which may re-traumatize the resident. 3. Identify ways to mitigate or decrease the effect of the trigger on the resident. 4. These triggers and trigger specific interventions will be added to the residents care plan. On 07/31/24 at 12:20 PM, an interview was conducted the facility Corporate Clinical Lead Nurse who acknowledged that Resident #16 was not assessed for potential triggers and that no care plan for Post Traumatic Stress Disorder existed for Resident #16.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 49650 Based on facility record review and staff interview the facility failed to have Registered Nurse coverage for eight (8) consecutive hours daily. This was discovered through the long term care survey process and has the potentios to affect all residents currently resding in the facility. Facility Census: 67. Findings Include: a) No RN coverage. During a review of the staffing posting forms on 07/29/24 at approximately 6:30 PM the following staffing form for 03/18/23 did not have an RN on staff for the day. It was further observed that 04/09/23 had only 7.83 of the required eight (8) hours of RN coverage. During an interview with the Scheduler #88 on 07/30/24 at approximately 8:55 AM she agreed, there was no RN coverage for 03/18/23 and only 7.83 of the required eight (8) hours for 04/09/24.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 49650 Based on facility record review and staff interview the facility failed to complete staff evaluations. This was true for one (1) of five (5) staff evaluations reviewed during the long term care process. Identifier: Certified Nursing Assistant (CNA) # 61. Facility Census: 67. Findings Included: a) CNA #61 During a record review of the CNA's evaluation it is identified that CNA #61 was hired on 05/09/24 and the evaluation was completed by the DON on 06/27/24. However a small yellow post-it note was identified to be covering the signature line for CNA #61 and it stated (typed as written) employee missed to go over review with the [DON name] During an interview with the Scheduler #88, she agreed that the evaluation was incomplete and should have been completed with the staff member when she had returned to the facility.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 49650 Based on facility record review, observation and staff interview the facility failed to post the staffing posting form in a prominent location and failed to complete information on the form accurately. This was discovered through the long term care survey process and had the ability to affect more than a limited number of residents. Identifiers: Staffing Posting location, missing and inaccurate data. Facility Census: 67. Findings include: a) Staffing Posting location: On 07/29/24 at 08:32 AM during a tour of the front entrance, the staffing posting form was not identified to be posted in a prominent location for residents and visitors access to view. During interview with Admissions Director (AD) #36, she stated that normally it is posted at the door but it is also at the Director of Nursing (DON) office that is located at the end of the hall way near the nurses station. This location is not considered to be a prominent location as not all residents or visitors may go past the rooms they are in or visiting to go to the DON's office or nurses station. The AD #26 acknowledged that the posting should be at the front of the building for all visitors and staff to be able to view if needed. b) missing data or inaccurate data During a review of the staffing posting forms on 07/29/24 at approximately 6:30 PM the following staffing forms had the outlined missing or inaccurate data. *04/08/23 - The total number of direct care Certified Nursing Assistants (CNA) and the total number of CNA hours was inaccurate. Total number of CNA direct care staff posted was 11.04 and the total number of direct care CNA hours posted was 83.4. The actual direct care CNA 10 staff was 3 and the actual direct care CNA hours was 90.90. *04/08/23 - As with all the forms reviewed the direct care staff totals are reflected in decimals. The day shift Certified Nursing Assistants (CNAs) 5.23 and the evening shift CNA 3.81. The Licensed Practical Nurse evening shift is 2.56. The staff is not represented by a whole number and or total. *07/02/23 - The census was not included on the staffing posting form. *03/09/24 - The census was not included on the staffing posting form. *03/10/24 - The census was not included on the staffing posting form. *03/11/24 - The data included eight (8) hours for Administrative Nursing staff who did not provide direct care. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	*03/11/24 - The total number of direct care Registered Nursing (RN) staff and the total number of RN hours was inaccurate. Total number of RN direct care staff posted was 4 and the total number of direct care RN hours posted was 37.23. The actual direct care RN staff was 3 and the actual direct care RN hours was 29. 23. *07/05/24 - The data included eight (8) hours for Administrative Nursing staff who did not provide direct care. *07/05/24 - The total number of direct care Registered Nursing (RN) staff and the total number of RN hours was inaccurate. Total number of RN direct care staff posted was 7.06 and the total number of direct care RN hours posted was 33.17. The actual direct care RN staff was 1 and the actual direct care RN hours was 12. 50. During an interview with the facility Scheduler #88 on 07/30/24 at approximately 8:54 AM a review was completed of The Labor Classification/ Job Title section of the Centers for Medicare & Medicaid Services- Electronic Staffing Data Submission- Payroll-Based Journal- Long-Term Care Facility- Policy Manual Version 2.6. This section defines that the Labor Classification/Job Title Reporting shall be based on the employee' s primary role and their official categorical title. It is understood that most roles have a variety of non-primary duties that are conducted throughout the day (e.g., helping out others when needed). Facilities shall still report just the total hours of that employee based on their primary role. CMS recognizes that staff may completely shift primary roles in a given day. For example, a nurse who spends the first four hours of a shift as the unit manager, and the last four hours of a shift as a floor nurse. In these cases, facilities can change the designated job title and report four hours as a nurse with administrative duties, and four hours as a nurse (without administrative duties). The Scheduler #88 agreed that the data RN administrative staff should not be included on the staffing posting form as they were not direct care on those days. The Scheduler #88 also agreed that the data was missing for the census and that the data was incorrect for the total number of staff and staff hours. She further acknowledged that the decimals used to identify the staff did not reflect an accurate count of the total direct care staff in the building.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50551 Based on record review, resident interview and staff interview, the facility failed to provide medically necessary social services in the area of discharge planning and appointment of a healthcare decision maker. This was a random opportunity for discovery and true for resident #62 and #48. Facility Census: 67. Finding include: a) Resident #62 On 07/29/24 at 10:09 AM, an interview with Resident #62 was conducted. During this interview Resident #62, stated she hoped to go home. She states, she has capacity and is able to care for herself but she needs help finding a place to live. Resident states, the Social Worker has been out for a couple of months. Her last rental home had the heat out, water lines busted and she us unable to go back there. She states, she is [AGE] years old and would like to reside near her family. Resident stated she has been here since February when her ammonia levels where really high and the facility helped to save her life but now she is able to take care of herself, she would like to discharge from the facility. She stated, she has had her Social Security since June and needs assistance with getting housing. She stated, she had applied for one apartment and did not meet the requirements and then she became eligible for SSI last month so she now has an income. On 07/30/24 at 11:17 AM, a review of the last social services notes for Resident #62 were on 03/22/24 and 03/25/24 and they revealed the social worker was assisting the resident with planning for discharge at the time. Note revealed the following: a) Note on 3/25/24 Social Worker spoke with CRC to see if there were nursing needs that still needed to be completed for patient i.e. gastro appointment, other specialists. CRC sent SW and other team members an email indicating there were other appointments that needed to be made and followed up on between now and the next couple of months and patient was going to have another PASS R completed to request an extension for her stay through Medicaid. This would give her time to have f/u and perhaps have SSI approved, get applications in for housing, etc. b)The note dated 3/22/24, Social Worker spoke with patient re: DHHR application, patient said she had faxed her application in. Patient had not completed the housing application for (Name of Apartment complex) and SW provided additional information for (Name of additional Apartment Complex) application for housing and requested (First Name of Resident #62) bring to SW as soon as she completed to send applications out for her. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c) Social Services note dated 03/22/24 stated, Social Worker SW spoke with (First Name of Resident #62) regarding possible plans for discharge. She will be discontinued by therapy April 1, 2024 and can be discharged . SW was asking (First Name of Resident #62) if it was still an option for her to live with her friend (First name of Friend). She said that she did not have heat or running water, and the family did not know what they were going to do with the house yet. SW explained that if she this was the situation, this would not be a good option for her at this time and that she would need to start applying for other housing and resources, that most have a waiting list and even if she was waiting to hear from social security, she could explain this on applications and follow up with calls. SW explained that because she was being discharged from therapy April 1, 2024, this would give some time to apply for different housing, DHHR benefits. [NAME] became very upset, saying, You are mean. SW asked what was being done to have her say this and she responded that she had done all she knew to do. SW asked if she had completed housing application for (Name of Apartment Complex) and submitted, looked online for other possible housing. She said that she would not go to a homeless shelter and that she could just leave now if she chose to. SW agreed that she was able to make decisions on her own and she could leave if that was her choice, but recommended that she take steps to continue to search for temporary housing, follow up on social security and complete the housing applications and DHHR application for benefits. SW assisted resident contact her lawyer and SW left a message with her case manager to check status re: social security benefits. SW assisted (First Name of Resident #62) call SS office. SW provided DHHR fax number and (First Name of Resident #62) to complete application and have staff assist her fax the application. (First Name of Resident #62) had spoken with (First name of Residents Friend) and told her she could stay temporarily in the house as she waits to receive SSI benefits. SW continue to assist patient in dc planning. On 07/31/24 at 11:47 AM interview of Regional Clinical Lead #75 who reported that there is not currently a social worker on staff due to medical reasons. She is not sure how long she has been out but stated the admissions department was completing assessments. On 07/31/24 at 2:33 PM an interview with admissions director #36 revealed she is not a licensed social worker and has a background as a nurses assistant she spoke with resident this week to help her with application for housing. b) Resident #48 On 07/31/2024 at 11:50 AM a telephone interview with (First and Last name of Resident #48's niece), found the resident had regained capacity for a brief period of time and they don't call her as often now. Record review shows resident regained capacity and the capacity form was scanned in on 03/18/2024 supporting surrogate's statement of change in capacity status . However, a capacity statement dated 07/29/24 indicated the resident no longer has his capacity to make medical decisions. During an interview with the Admission's Director on 07/31/24 at 12:15 PM, she confirmed she was aware the resident had lost his capacity on 07/29/24. When asked who was making Resident #48's medical decisions now? She stated, I will have to check on that. In a later interview the Admissions Director confirmed she had just now contacted the residents niece and she agreed to be his surrogate as she was prior too him regaining his capacity in 03/2024. This action was not completed until after surveyor intervention. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50801

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 50552 Based on record review and staff interview the facility failed to monitor behaviors for a resident receiving psychotropic medication. This was true for 1 (one) of five (5) resident's reviewed for the care area of unnecessary medications during the Long Term Care Survey Process. Resident identifier: Resident #16. Facility Census: 67. Findings include: a) Resident #16 On 07/30/24 at approximately 9:00 AM, a review of Resident #16's medical record was conducted. During this review, Resident #16 was noted to have the following diagnoses: 1. Post Traumatic Stress Disorder, Chronic. Dated: 03/20/24. 2. Unspecified Dementia, mild with other behavioral disturbance. Dated: 03/20/24. 3. Schizoaffective Disorder, unspecified. Dated: 03/20/24. 4. Bipolar Disorder, unspecified. Dated: 03/20/24. 5. Major Depressive Disorder, single episode, unspecified. Dated: 03/20/24. In addition, Resident #16 was noted to be receiving the following psychotropic medication: 1. Fluphenazine 2.5 milligrams (MG). Give 1 (one) tablet by mouth three times a day for schizoaffective disorder. 2. Seroquel 200 mg. Give 1 (one) tablet by mouth at bedtime for schizoaffective disorder. Furthermore, a review of Resident #16's medication administration record (MAR) was performed which revealed no behavior monitoring being performed for the above medication and or diagnoses. On 07/31/24 at approximately 10:30 AM, a review of the facility policy and procedure entitled Behaviors: Management of Symptoms revealed staff will monitor for and document in the medical record any exhibited behavioral symptoms. On 07/31/24 at 12:20 PM, an interview was conducted the facility Corporate Clinical Lead Nurse who acknowledged, Resident #16 should be receiving behavioral monitoring should be documented in Resident #16's medical record. In addition, the facility Corporate Clinical Lead Nurse acknowledged there was no documentation related to this behavioral monitoring in Resident #16's medical record.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45171 Based on observation and staff interview the facility failed to act in accordance with currently accepted professional principles in accordance with expired medical supplies. This failed practice has the potential to affect more than a limited number of residents currently residing at the facility. Facility Census: 67 Findings include: a) On [DATE] at 8:46 AM observation of the medication/supply storage room found two (2) boxes of [NAME] (BD) Blood Transfer Devices (50 in each box) with an expiration date of ,d+[DATE]. b) On [DATE] at 8:46 AM observation of the medication/supply room found twenty (20) urinary catheters which have a past expiration date. Expired urinary catheters (20) 20 French 30 milliliter expired [DATE] 16 French 30 milliliter expired [DATE] X 2 20 French 30 milliliter expired [DATE] 20 French 30 milliliter expired [DATE] 22 French 30 milliliter expired [DATE] X 2 22 French 20 milliliter expired [DATE] 16 French 10 milliliter expired [DATE] X 10 22 French 5 milliliter 2 way expired [DATE] 22 French 10 milliliter expired [DATE] The above findings were confirmed with Registered Nurse #28 on [DATE] at 09:00 AM.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 50551 Based on resident interviews during resident council, and staff interview, the facility failed to ensure a substantial/nourishing snack was provided between the evening meal and breakfast. This had the ability to affect all residents who did not have a dietary order to receive an evening snack or the cognitive and/or physical ability to make their way to the nurse's station to request something to eat from the nourishment room. Facility Census 67. Findings include: a) On 07/30/24 at 2:12 PM during resident council, Residents #62 and #37 reported they are not offered bedtime snacks. They reported they have not had snacks for several weeks. Resident #2 and #24 reported that snacks are at the nurses station in the evening an they have had to ask for them. b) On 07/31/24 at 10:10 AM a review of Food and Nutrition Service Policies and Procedures revealed the following: -Food and Nutrition Services are to deliver snacks to nursing station at specific times. -Nursing or designated staff are to offer an evening snack to every resident. -Snacks are to be passed within 15 minutes or are stores properly at the nursing station. c) On 07/31/24 at 4:20 PM an interview with Registered Nurse #31 found nurse aids are supposed to take the snack cart from room to room and offer every resident a snack every evening.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50551 Based on observation, staff interview and review of records, the facility failed to ensure kitchen staff served food in a safe and sanitary manner. This failed practice had the potential to affect all residents who recieve nutrition from the facility's kitchen. Facility Census:67. Findings include: a)On 07/30/24 12:24 PM during an observation, staff failed to properly wash hands with soap and water or wear gloves before handling serving spoons. On 07/30/24 at 12:00 PM observed staff #77 exit office without washing hands or wearing gloves and handle serving spoons to District Manager #78 who then handed them to kitchen staff #15 to put into food in the serving line. Staff acknowledged this and washed hands, changed gloves and replaced serving spoons. On 07/31/24 at 3:03 PM Review of facility policy for food preparation stated All staff will practice proper hand washing techniques and glove use. B) Based on observation, staff interview and record review, the facility staff failed to wear beard restraints per current food code requirements. 0n 07/31/24 at 12:45 PM, Kitchen staff #2 and #3 were observed working on the serving line and did not wear beard restraints. Staff acknowledged and wore beard restraints. On 07/31/24 at 2:55 PM review of policy for Kitchen Staff Attire revealed the following: All employees wear approved attire for the performance of their duties. -All staff members will have their hair off the shoulders, confined in a hair net or cap and facial hair properly restrained.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 49650 Based on facility record review and staff interview the facility failed identify the required Certified Nurse Aide (CNA)/nursing competencies to meet the resident populations care needs. This was a random opportunity for discovery during the CNA/nursing competency review of the long term care survey process. This had the ability to affect more than a limited number of residents. Facility Census: 67. Findings Include: a) Facility assessment During a review of the facility assessment on 08/31/24 at approximately 10:30 AM it was identified the facility centered care areas of the resident population is outlined. It is further identified on page 20 of 43 of the facility assessment, under II. Staffing, Training, Services and Personnel that the required nursing competencies to meet the resident population care needs is outlined and under this header (typed as written) Staff Training/Competencies/Skill Sets each category/subcategory listed is marked as sufficient. During an interview with the Person in Charge (PIC) and an assisting Administrator #89 on 07/31/24 at approximately 8:36 AM the sufficient category and subcategory were questioned of whether or not those competencies are required to be completed. The PIC and Administrator #89 were not able to identify any competencies in the facility assessment that is required for the nursing staff to complete.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 31826 Based on record review and staff interview the facility failed to ensure Resident #16's medical record was complete and accurate. This was true for 1 (one) of 23 sampled residents reviewed during the Long Term Care Survey Process.Resident identifier: Resident #16. Facility Census: 67. Findings include: a) Resident #16 On 07/30/24 at approximately 09:00 AM, a review of Resident #16's medical record was conducted. During this review, Resident #16 was noted to have the following diagnoses: 1. Post Traumatic Stress Disorder, Chronic. Dated: 03/20/24. 2. Unspecified Dementia, mild with other behavioral disturbance. Dated: 03/20/24. 3. Schizoaffective Disorder, unspecified. Dated: 03/20/24. 4. Bipolar Disorder, unspecified. Dated: 03/20/24. 5. Major Depressive Disorder, single episode, unspecified. Dated: 03/20/24. In addition, Resident #16 was noted to be receiving the following psychotropic medication: 1. Fluphenazine 2.5 milligrams (MG). Give 1 (one) tablet by mouth three times a day for schizoaffective disorder. 2. Seroquel 200 mg. Give 1 (one) tablet by mouth at bedtime for schizoaffective disorder. Furthermore, a review of Resident #16's assessment entitled Social Determinants of Health, effective date 03/29/24, was performed which revealed under section C, number 4 (four), the facility Social Worker failed to note a diagnosis of Post Traumatic Stress Disorder. A review of Resident #16's care plan revealed no care plan related to Resident #16's Post Traumatic Stress Disorder. On 07/31/24 at 12:20 PM, an interview was conducted the facility Corporate Clinical Lead Nurse who acknowledged that Resident #16's assessment entitled Social Determinants of Health was incorrect

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50552 Based on observation and staff interview the facility failed to prevent infections through indirect contact transmission by storing clean resident clothing in the chemical closet of the laundry room. This failed practice has the potential to affect more than a limited number of residents. Facility census: 67. Findings include: a) Facility On 08/01/24 at 9:40 AM, an observation of the laundry room was conducted which revealed several items of personal resident clothing to be hanging in the chemical closet, which was located on the dirty side of the laundry room where soiled linen is brought to for laundering. These personal resident clothing items were in direct contact with the Rapid Multi-Surface Cleaner, this cleaner was confirmed to be used for the mops in the facility by Employee #72. In addition, this cleaning solution was noted to be stored on the floor. At this time, an interview was conducted with Employee #72 who stated she hangs personal resident clothing in this closet after the clothing is laundered and is is not labeled and not able to be directly delivered to the appropriate resident. Employee #72 states that she keeps the clothing in this closet and when a resident is missing an item, staff know to come check for it there. Furthermore, Employee #72 acknowledged the potential for the personal resident clothing items to be contaminated by the cleaner stored on the floor.