

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525061	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/28/2025
NAME OF PROVIDER OR SUPPLIER  Lincoln Park Nursing and Rehab LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  1700 C A Becker Dr Racine, WI 53406	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure 2 of 4 residents (R1 and R5) was free from physical abuse. R2 is known to have physical aggression towards residents and staff and was observed to have escalating behaviors. The facility did not ensure R1 was free from abuse by another resident (R2) residing in the facility.</p> <p>On 4/17/25, at 6:45 AM, facility staff observed R2 strike R1 in the arm twice while in the common area.</p> <p>On 4/20/25, facility staff observed R2 strike R1 in the back with a wet floor sign. R2 and R1 were separated by facility staff and escorted to separate units within the facility. Approximately 10 minutes later at 12:50 AM, R2 sought out R1, and R2 hit R1 multiple times in the head with the wet floor sign. R1 sustained a subdural hematoma (a pool of blood between the brain and its outermost covering often associated with a traumatic brain injury) and required an Intensive Care Unit (ICU) stay as a result of being hit in the head by R2 from the wet floor sign.</p> <p>The facility's failure to keep R1 free from physical abuse created a finding of Immediate Jeopardy that began on 4/17/25.</p> <p>On 5/12/25, at 3:52 PM, Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Regional Nurse-C, and Corporate Consultant-E were informed of the Immediate Jeopardy. The Immediate Jeopardy was removed on 5/12/25. The deficient practice continues at a scope and severity (S/S) of a D (potential for harm/isolated) as the facility continues to implement their action plan and based upon the additional example related to R5 and R6.</p> <p>R5 alleges that R6 hit and pinched them in the smoking courtyard. The facility did not prevent this occurrence of abuse or future negative interactions between the residents.</p> <p>Findings include:</p> <p>Surveyor reviewed the facility's Policy and Procedure, Abuse, Neglect and Exploitation, last reviewed 1/5/24, which documents:</p> <p>It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Prospective residents will be screened to determine whether the facility has the capability and capacity to provide the necessary care and services for each resident admitted to the facility.</p> <p>*An assessment of the individual's functional and mood/behavioral status, medical acuity, and special needs will be reviewed prior to admission.</p> <p>*The facility will make individual determinations in consideration of current staffing patterns, staff qualifications, competency and knowledge, clinical resources, physical environment, and equipment.</p> <p>Existing staff will receive annual education through planned in-services and as needed.</p> <p>The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves:</p> <p>*Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms.</p> <p>*The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.</p> <p>*Addressing features of the physical environment that may make abuse, neglect, exploitation, and misappropriation of resident property more likely to occur.</p> <p>*Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors.</p> <p>The facility will have written procedures to assist staff in identifying the different types of abuse - mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services .</p> <p>An immediate investigation is warranted when allegation or suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.</p> <p>*Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not destroying evidence).</p> <p>*Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause.</p> <p>*Providing complete and thorough documentation of the investigation.</p> <p>The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to:</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R2's Quarterly MDS documents R2 has fluctuating behaviors for disorganized thinking, delusions, and wandering. R2 requires supervision for dressing, bathing, and putting on shoes. R2 is independent with transferring and walking. R2 was documented as having a BIMS of 2 indicating R2 has severe cognitive impairment.</p> <p>R2' care plan documents:</p> <p>R2 has episodes of aggression (date initiated 4/20/25).</p> <p>Interventions include:</p> <p>*Attempt to separate R2 from other residents or staff that R2 has been aggressive with (date initiated 4/20/25).</p> <p>*Monitor R2's whereabouts at all times (date initiated 4/20/25).</p> <p>*Try to redirect resident before he becomes too agitated (date initiated 4/20/25).</p> <p>R2 has a mood and behavior problem related to vascular dementia, unspecified severity, with other behavioral disturbance (example being sexually inappropriate with female residents, exposing self, and poor impulse control). Monitor psychosocial well-being due to peer-to-peer altercation on 4/17 and 4/20. Refusing staff to clean R2's room or letting staff assist R2 in getting dressed. Aggressive behaviors noted towards staff, accepting redirection on 4/1. R2 will refuse medications at times; Risks and benefits explained. R2 will refuse to have lab work done; Risks and benefits explained. (Date initiated 12/11/24).</p> <p>Interventions include:</p> <p>*Provide a calm and safe environment to allow R2 to express feelings as needed (date initiated 12/11/24).</p> <p>*Provide R2 with area for decreased stimulation as needed for negative behaviors (date initiated 12/11/24).</p> <p>*1:1 (one on one supervision from staff) initiated and maintained upon return to regular ambulation/wandering (date initiated 4/20/25).</p> <p>*Encourage activated POA to participate in care planning period discuss and review alternate placement options that is a more appropriate setting for R2's progression of disease process (date initiated 4/17/25).</p> <p>*Set up another care conference with POA and psychiatry Nurse Practitioner (NP)-H to collaborate and care planning which is scheduled on 4/22/25 (date initiated 4/17/25).</p> <p>*Activities interview R2 and family to determine interest to care plan meaningful activities. Activities department monitor participation (date initiated 4/21/25).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>*Collaborate with MD, psych services, pharmacist, Adult Protective Services (APS), ombudsman, parole officer (PO), social services, and Regional Field Operations Director (RFOD) (State Agency) regarding options/interventions/care planning (date initiated 4/21/25).</p> <p>*Request from POA/family information regarding R2's past period extended family support options, likes, dislikes, interests, triggers or trends. Implement any suggested recommendations if applicable and appropriate (date initiated 4/22/25).</p> <p>*Anticipate and meet R2's needs. Continue to monitor for triggers and any trends (date initiated 12/13/24).</p> <p>*Monitor for any aggressive/intrusive behaviors and report to provider (date initiated 4/11/25).</p> <p>*Monitor psychosocial well-being: mood, behavior, sleep pattern, appetite and usual activities of choice. Report any alterations and notify provider to determine if any other interventions are recommended (date initiated 4/11/25).</p> <p>*Praise any indication of R2's progress/improvement in behavior (date initiated 2/24/25).</p> <p>*Provide a program of activities that is of interest and accommodates R2's status. Continue to offer nonpharmacological interventions to distract and detour negative incidents. Example: offer snacks, ice cream, chocolates, engage in conversation of preferences, offer meaningful activities and walk while talking about guitars and music (date initiated 12/11/24).</p> <p>*Utilize psych services if provider deems necessary (date initiated 4/11/25).</p> <p>R2 uses psychotropic, antidepressant medications related to vascular dementia with behaviors, psychosis, and depression. R2 regularly refuses medications (date initiated 3/8/24).</p> <p>Interventions include:</p> <p>*Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift (date initiated 3/8/24),,</p> <p>R2 has a potential psychosocial well-being problem related to resident-to-resident altercation (date initiated 4/17/25).</p> <p>Interventions include:</p> <p>*Attempt to remove and redirect R2 when other residents are calling out to prevent R2 from feeling the need to protect other residents (date initiated 4/17/25).</p> <p>*Initiate referrals as needed or increase social relationships (date initiated 4/17/25).</p> <p>*Monitor/document R2's usual response to problems, how R2 makes own decisions, expects others to control problems or leaves to fate, or luck (date initiative 4/17/25).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>*When conflict arises, remove R2 to a calm safe environment and allow to vent/share feelings (date initiated 4/17/25).</p> <p>Surveyor reviewed R2's Care Area Assessments (CAA)s dated 1/29/25, which document the following:</p> <p>Delirium CAA - R2 has dementia with no acute change in mental status.</p> <p>Cognitive loss/Dementia CAA- R2 has vascular dementia impacting R2's cognitive status at present requiring reminders frequently. R2 is here for long term care due to vascular dementia requiring frequent redirection due to behavior issue and has been refusing medications despite encouragement. R2's condition at present is complicated by recent influenza A which R2 was placed on strict droplet precaution. R2 is mostly independent for R2's ADLs and up ad lib. R2 is able to verbalize needs and wants, when given time. Needs anticipated by staff to maintain safety. Staff to redirect R2 as needed and follow plan of care.</p> <p>Behavioral Symptoms CAA - R2 has vascular dementia with psychosis/behavior triggering this CAA for behavioral symptoms as R2 continues having behavior issue at present. R2 is here for long term care due to vascular dementia requiring frequent redirection due to behavior issue and has been refusing medications despite encouragement. R2's condition at present is complicated by recent influenza A which R2 was placed on strict droplet precaution. R2 is mostly independent with ADL's and up ad lib. R2 is able to verbalize needs and wants, when given time. Needs anticipated by staff to maintain safety. Staff to redirect R2 as needed and follow plan of care.</p> <p>Surveyor reviewed R2's behavior task list dated 4/8/25 - 5/8/25, which documents:</p> <p>4/19/25 at 4:56 PM - wandering</p> <p>4/30/25 at 4:56 AM - wandering and rejection of care</p> <p>Surveyor reviewed R2's Medication Administration Record (MAR) which documents R2 is prescribed Seroquel for dementia with behavioral disturbance, Depakote for dementia, Keppra for seizures, and Paxil for depression. Surveyor notes the following missed medications for R2:</p> <p>January 2025 MAR documents the following:</p> <p>*R2 took Seroquel and Paxil one time on 1/10/25.</p> <p>*R2 took Depakote three times on 1/2/25, 1/10/25, and 1/12/25. Surveyor notes R2 took Depakote three times out of 62 opportunities in the month of January 2025.</p> <p>*R2 took Keppra 4 times on 1/2/25, 1/7/25, 1/10/25, and 1/16/25. Surveyor notes R2 took Keppra four times out of 62 opportunities in the month of January 2025.</p> <p>February 2025 MAR documents the following:</p> <p>*R2 took Depakote 21 times out of 56 opportunities.</p> <p>*R2 took Paxil 12 times out of 28 opportunities.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>*Surveyor reviewed the facility self-report dated 4/17/25, which documents the following:</p> <p>On 4/17/25, at 6:45 AM, R2 and R1 were documented as wandering the halls throughout the facility and becoming agitated and combative with staff throughout the night. R1 and R2 were in the common area when R1 approached R2. Facility staff attempted to redirect both R1 and R2 however, were unsuccessful. R2 then struck R1 in the right upper arm twice. R2 and R1 were separated. Staff performed skin and pain assessments on both R1 and R2 that were unremarkable. Facility staff contacted the police, NHA, DON, MD, POA's, MCO's (Managed Care Organizations), and Hospice. Surveyor notes facility staff did not contact Parole Officer (PO)-F, who is R2's parole officer. Facility staff interviewed R1 and R2. Neither resident recalled the incident where R2 struck R1 in the right upper arm twice. The facility self-report documents cameras were reviewed, staff statements obtained, and resident statements obtained. The facility self-report documents care plans were updated.</p> <p>*Surveyor reviewed the police report dated 4/17/25, at 7:03 AM, which documents the following:</p> <p>R1 and R2 were in the living room/day room when R1 suddenly stood up and stated what did you say to R2 and aggressively approached R2. R2 then struck R1 in R1's upper right arm. Staff immediately separated the two. The police officer observed R1 who appeared to be fine. Both R2 and R1 are low functioning and the facility states that neither residents would understand what the police was talking about if the police officer were to interview them. Facility staff was advised to file the report to build a paper trail for documentation purposes. For this reason, no incident report will be completed.</p> <p>*Surveyor reviewed the self-report incident notes dated 4/17/25, which documents the following:</p> <p>R2 struck a peer in the upper arm when R2's peer raised their voice to another resident. R2 states R2 was protecting another resident from R1. R2 has no complaints of discomfort and has no alterations to skin integrity that can be seen. R2 is refusing a full skin assessment which is unremarkable. Mood, behavior, sleep pattern, and unusual activities of choice are being monitored for at least 72 hours. R2 remains at baseline. R2's psychosocial well-being and physical status monitoring is ongoing. R2's care plan has been reviewed and updated. The care team will continue to anticipate R2's needs and monitor for any changes.</p> <p>*Surveyor reviewed the incident description on the facility self-report dated 4/17/25, which documents the following:</p> <p>Prior to the incident, R1 had been wandering the halls and in and out of rooms throughout the night, very agitated. R1 then aggressively approached another resident near the nurses' station, staff was unable to redirect and R2 then struck R1 in the right upper arm twice. Resident description documents, he got in my face. Immediate action taken documents, R1 was given PRN Ativan after non-pharmacological interventions were not effective.</p> <p>*Surveyor reviewed staff statement from Licensed Practical Nurse (LPN)-X, dated 4/17/25, which documents the following:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R1 was observed wandering hallways and becoming agitated and combative with staff throughout the night. While sitting in front of the nurses' station, R1 aggressively got up and approached R2. R2 then struck R1 in the right upper arm area, twice. R1 and R2 were immediately separated and redirected with the nurse. PRN Ativan was immediately administered without any difficulty. There was no redness/swelling noted to the area however, scattered old bruises were noted throughout R1's bilateral upper extremities. R1 denied any pain. Range of motion was within normal limits. Assistant Director of Nursing (ADON) and DON were notified by staff, POA for R1 was called and notified of the incident, as well as Hospice.</p> <p>*Surveyor reviewed incident notes dated 4/17/25, which documents the following:</p> <p>R1 is monitored by the care team for any delayed injuries from the resident-to-resident altercation. R1's psychosocial well-being is also monitored for at least 72 hours. R1's mood, behavior, appetite, sleep pattern, and unusual activities of choice are unchanged. R1 denies any pain or discomfort. There are no alterations in skin integrity. The care team has notified the provider and all responsible parties. There are no new orders received and there are no recommendations. The care plan is reviewed and updated. R1 is agreeable to spending free time in the lounge across from the NHA office as it is a much calmer environment with less stimuli. R1 did state that R1 needs a quieter environment to decrease agitation/anxiety. R1 is doing well in this area of preference. The care team will continue to anticipate R1's needs and monitor for any changes.</p> <p>*Surveyor reviewed staff statement from Certified Nursing Assistant (CNA)-V which documents R1 was really restless and confused wandering all night walking in and out of resident rooms and redirected. He was aggressive physically and verbally, abusive towards staff. CNA-V found R1 in a room standing over a resident around 4:00 AM. CNA-V asked R1 what R1 was doing. R1 responded stating R1 was helping the people. CNA-V told R1 that wasn't needed, that is what staff are there for and asked R1 to leave the resident's room with CNA-V because it was not R1's room. R1 told CNA-V no and grabbed something off the table. CNA-V asked R1 to give it to CNA-V, and R1 responded stating it was not R1's and R1 punched CNA-V twice and told CNA-V to leave R1 alone. CNA-V eventually got R1 to walk toward the door and got outside the door. R1 grabbed CNA-V's hand and pulled CNA-V's fingers apart. CNA-V got their hand loose, stepped back, and closed the door. When CNA-V opened the door back up, R1 was gone. CNA-V went to report what happened to the nurse when CNA-V observed R1 again by the nursing station. R1 was walking past R2. CNA-V was close enough to see both R1 and R2, but not to hear them. R1 said something to R2, and R1 stopped, they started to argue, and punches were thrown. Staff immediately intervened and separated R1 and R2. CNA-V does not know who threw the first punch. R2's behavior all night was normal. R2 wandered how R2 usually does, but did not bother anybody.</p> <p>Surveyor reviewed staff statement from CNA-W dated 4/17/25, which documents around 5:50 AM, R1 approached R3 in the TV area and told R3 to shut up because R3 was doing his usual screaming. R2 then told R1, don't talk to R3 like that. R1 walked closer to R2 with R1's fist bald (sic) up punching, R2 swung back at R1 a few times. CNA-W was trying to step in between without being hit. CNA-W separated R1 and R2.</p> <p>On 5/7/25, at 12:53 PM, Surveyor attempted to interview R3 who declined to answer questions.</p> <p>On 5/7/25, at 12:56 PM, Surveyor interviewed CNA-P who indicates R3 has severe cognition concerns, and will oftentimes yell out, but R3's yelling out is not directed at anyone.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Surveyor reviewed staff statement from RN-N, which documents R2 spends most nights walking around the facility. R2 does go to the long-term care side also. At one-point last night, RN-N had to go over to the long-term care side to look for an item and saw R2 sitting in the lounge by the nursing station. RN-N does not recall what time that was but R2 appear (sic) to be by themselves. R1 spent a lot of time over on the rehab unit last night. RN-N did not witness or hear any incident between R1 and R2. When R1 was on the rehab unit, R1 was being intrusive going near or inside other resident rooms. RN-N had to administer a resident Xanax because it made her anxious. RN-N did not personally see R1 going into other rooms, but that was what RN-N was told by the resident and other staff.</p> <p>*Surveyor reviewed incident notes dated 4/19/25, which documents the following:</p> <p>The care team continues to monitor R2's behaviors and any identifiable trends to mitigate any future untoward incidents. Non-pharmacological interventions are ongoing. The only identifiable trigger is that R2 believes R2 is protecting others, therefore when a peer appears to be distressed, R2 goes into protection mode. The care team will continue to anticipate R2's needs and monitor for any changes.</p> <p>Surveyor reviewed the facility self-report dated 4/20/25, which documents the following:</p> <p>*On 4/20/25, around 12:50 AM, R2 hit R1 in the back of the head with a wet floor sign resulting in R1 falling and causing injury. Staff immediately intervened and separated R1 and R2 to maintain safety and conducted nursing assessments. R1 was sent to the hospital for evaluation and treatment. R2 was also sent out to be evaluated by psych and to be admitted inpatient to get R2 the assistance needed. R2 was sent back to the facility from the hospital without a psych work up and without notice. Facility staff notified NHA, DON, POAs, MD, Hospice, R2's PO (parole officer), APS (adult protective services), ombudsman, and police. R1 sustained injuries as a result of the incident. R1 remained in the hospital. R1 is pending upcoming discharge.</p> <p>*Surveyor reviewed the clinical chart review which documents the following:</p> <p>R1 sustained a subdural hematoma (a type of bleeding in which a pool of blood between the brain and its outermost covering occurs, often associated with a traumatic brain injury). R2 was placed on a 1:1 in the facility indicating one staff member is always with R2. Specific 1:1 instruction for R2 is provided to the 1:1 assigned staff. The care team is currently working with the provider, pharmacist, psych services, APS, ombudsman, POA, medical director, and PO to get R2 properly placed, so R2 can receive the services needed. R2 remains unwilling to take medications as ordered.</p> <p>*Surveyor reviewed staff statement from CNA-Y which documents, CNA-Y was doing rounds, heard a commotion, walked down the hall and saw R2 hitting R1 with a wet floor sign. CNA-Y and another aid both ran towards the incident to break it up and R2 walked in one direction and R1 walked in the other direction.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Surveyor reviewed staff statement from LPN-X which documents, R1 was wandering in and out of rooms, agitating other residents; unable to be redirected. Loud banging noise and yelling heard from unit 4 hall, and R1 was observed on R1's knees on the floor holding R1's face with a large amount of blood dripping from R1's face. R2 was separated from R1 and while walking away with the wet floor sign in hand, R2 admitted that R2 hit R1 several times. Large bumps were noted to the back of R1's head and behind left ear area along with the left side of the face and forehead. R1 was not cooperative with assessment from staff. Seems to be a laceration to left side of upper lip and an approximate 4-centimeter skin tear and redness to the left elbow area, tender to touch. While R1 was being seen by paramedics, R1 turned around and punched LPN-X in the arm/face while attempting to block R1's hit. R1 was placed on the stretcher by the paramedics and taken to the ER.</p> <p>Surveyor reviewed a second staff statement from LPN-X which documents, it was later reported to LPN-X that R1 was struck in the back with the wet floor sign by R2, observed by staff nurse and CNAs. Prior to incident, R1 had bee</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the Facility did not ensure 1 allegation of resident to resident abuse, involving R5 and R6, of 3 allegations reviewed was reported to the police as a possible suspicion of a crime.</p> <p>R5 made an allegation that R6 hit and pinched them. The Facility reported that the police were called, however, there is no record or documentation to support this occurred.</p> <p>Findings include:</p> <p>Surveyor reviewed the Facility Reported Incident dated 4/9/2025 that documents on 4/7/25 around 4:30pm, R5 alleged R6 hit R5 in the courtyard. Residents immediately separated and assessments conducted on both residents. No injuries obtained. Police notified. Investigation started.</p> <p>Surveyor reviewed the investigation documentation provided by the facility. Surveyor requested the police report involving R5's allegation of abuse from the police department and documentation of the call being made from the Nursing Home Administrator (NHA)-A. The Records Specialist from the [NAME] Police Department reported that there were no calls for service to the address of the facility for the dates of 4/6/25 to 4/8/25.</p> <p>On 5/12/25, at 11:12am, Surveyor interviewed NHA-A regarding the police being contacted. Per NHA-A they cannot locate the sticky note with the documentation of the police call.</p> <p>On 5/12/25, at 3:52pm, during the exit meeting with the facility, Surveyor relayed concern that there is no documentation or evidence that the police were called regarding the allegation of abuse.</p> <p>No additional information was provided regarding the notification of the police regarding R5's allegation of abuse on 4/7/25.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the Facility did not update the comprehensive person-centered care plan for 2 (R5, R6) of 5 residents to meet a resident's medical, nursing and psychosocial needs that are identified in the comprehensive assessment.</p> <p>* R5 and R6's care plans were not thoroughly updated after a resident to resident altercation to prevent potential further abusive situations. Additionally, R5 and R6's care plan and smoking assessment are not consistent for interventions.</p> <p>Findings include:</p> <p>The Facility Policy titled Care Plans- Comprehensive revised 11/26/16, documents (in part):</p> <p>Policy Statement</p> <p>An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident.</p> <p>Policy Interpretation and Implementation .</p> <p>2. The comprehensive care plan is based on a thorough assessment that includes strengths, goals, life history and preferences, but is not limited to, the MDS (minimum data set).</p> <p>3. Each resident's comprehensive care plan after each assessment including both the comprehensive and quarterly review assessments is designed to:</p> <ul style="list-style-type: none"> <li>a. Incorporate identified problem areas and goals for desired outcomes;</li> <li>b. Incorporate risk factors associated with identified problems;</li> <li>c. Build on the resident's strength;</li> <li>d. Reflect the resident's expressed preferences, wishes regarding care and treatment goals including a desire to return to the community;</li> <li>e. Reflect treatment goals, timetables and objectives in measurable outcomes;</li> <li>f. Identify the professional services that are responsible for each element of care;</li> <li>g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels;</li> <li>h. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and</li> <li>i. Reflect currently recognized standards of practice for problem areas and conditions .</li> </ul> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are added to the care plan.</p> <p>5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers. It is recognized that care planning individual symptoms or Care Area Triggers in isolation may have little, if any, benefit for the resident.</p> <p>6. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decision making. No single discipline can manage the task in isolation. The resident's physician (or primary healthcare provider) is integral to this process .</p> <p>8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.</p> <p>9. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans:</p> <p>a. When there has been a significant change in the resident's condition;</p> <p>b. When the desired outcome is not met;</p> <p>c. When the resident has been readmitted to the facility from a hospital stay; and</p> <p>d. At least quarterly .</p> <p>The Facility Policy titled Smoking Policy-Residents revised December 2011, documents (in part):</p> <p>Policy Statement</p> <p>This facility shall establish and maintain safe resident smoking practices.</p> <p>Policy Interpretation and Implementation .</p> <p>7. The staff shall consult with the Attending Physician and the Director of Nursing Services to determine any restrictions on a resident's smoking privileges.</p> <p>8. Any smoking related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues.</p> <p>9. The facility may impose smoking restrictions on residents at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>10. Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking.</p> <p>11. The staff will review the status of a resident's smoking privileges periodically, and consult as needed with the Director of Nursing Services and the Attending Physician.</p> <p>12. Smoking articles for residents with independent smoking privileges:</p> <p>a. Residents who have independent smoking privileges shall be permitted to keep cigarettes, pipes, tobacco, or other smoking articles in their possession.</p> <p>b. Residents may only keep disposable safety lighters. All other forms of lighters, including matches, shall be prohibited .</p> <p>13. Smoking articles for residents without independent smoking privileges:</p> <p>a. Residents without independent smoking privileges may not have or keep any types of smoking articles, including cigarettes, tobacco, etcetera, except when they are under direct supervision .</p> <p>c. Anyone who provides smoking supervision to residents shall be advised of any restrictions/concerns and the plan of care related to smoking.</p> <p>14. Staff members and volunteer workers shall not purchase and/or provide any smoking articles for residents unless approved by the charge nurse .</p> <p>R5 was admitted to the facility on [DATE] with pertinent diagnoses that include type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood), morbid obesity (body mass index (BMI) of 40 or higher), chronic obstructive pulmonary disease (lungs become inflamed, damaged and narrowed), bipolar disease (mental health condition causes extreme mood swings that include emotional highs, called mania, and lows, known as depression), insomnia (common sleep disorder that can make it hard to fall asleep or stay asleep), spinal stenosis (a narrowing of the spinal canal, stenosis can cause pressure on your spinal cord), and anxiety disorder (persistent, excessive fear or worry in situations that are not threatening).</p> <p>R5's Quarterly Minimum Data Set (MDS) with an assessment reference date of 3/31/25, documents a Brief Interview for Mental Status (BIMS) score of 15, indicating that R5 is cognitively intact. R5's MDS documents a patient depression questionnaire (PHQ-9) score of 08, indicating mild depression. The MDS documents that R5 is understood and understands others and has clear speech. R5 was assessed to have no behaviors exhibited during the look back period. The MDS documents a high risk drug, categorized as antidepressant, is taken by R5. R5 is responsible for self.</p> <p>Resident to Resident altercation:</p> <p>Surveyor reviewed the Facility Reported Incident dated 4/9/2025 that documents on 4/7/25 around 4:30pm, R5 alleged R6 hit R5 in the courtyard. Residents immediately separated and assessments conducted on both residents. No injuries obtained. Police notified. Investigation started.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor reviewed the Verification of Investigation with the Date of Finding: 4/7/25 that documents within the Summary of Factual Investigative Findings: The care plan has been reviewed and updated. The care team, residents and all parties that were notified are agreeable to the current plan of care. The Plan of Care Update section for R5 and R6 documents Resident provided verbal education of facility rules including to not engage in inappropriate name calling with other residents and to not use the courtyard at the same time as the other resident. Resident counseled to use the courtyard door closest to assigned unit.</p> <p>R5's care plan documents: The resident has a psychosocial wellbeing problem that was initiated on 04/07/2025.</p> <p>The goal is the resident will have no indications of psychosocial wellbeing problem by/through review. (Surveyor noted indications of and definition of what a psychosocial wellbeing problem is for R5 is not specified. Surveyor noted this is an intervention on another care plan for R5 initiated 11/29/24 after a previous resident to resident altercation).</p> <p>Date Initiated: 04/08/2025, Target Date: 07/07/2025</p> <p>Interventions include:</p> <ul style="list-style-type: none"> <li>- Consult with: Pastoral care, Social services, Psych (psychology) services, Other:</li> </ul> <p>Date Initiated: 04/08/2025</p> <ul style="list-style-type: none"> <li>- Encourage participation from resident who depends on others to make own decisions.</li> </ul> <p>Date Initiated: 04/08/2025</p> <ul style="list-style-type: none"> <li>- Initiate referrals as needed or increase social relationships: (Specify) (Surveyor noted this is not individualized for R5).</li> </ul> <p>Date Initiated: 04/08/2025</p> <ul style="list-style-type: none"> <li>- When conflict arises, remove residents to a calm safe environment and allow to vent/share feelings.</li> </ul> <p>Date Initiated: 04/08/2025</p> <p>R5's care plan documents: R5 has a mood problem r/t dx of Bi-polar disorder, hx (history) metabolic encephalopathy, anxiety, depression, history of missing or losing items -Verbally abusive to staff and other residents</p> <ul style="list-style-type: none"> <li>-loud and disruptive</li> <li>-Invasive to others</li> <li>-problems sleeping</li> </ul> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>11-29-24 Monitor psychosocial wellbeing due to peer-peer altercation.</p> <p>12-1-24 Peer-peer that was initiated on 04/27/2020.</p> <p>Interventions include:</p> <ul style="list-style-type: none"> <li>- SLEEP: Evaluate resident for possible sleeping pattern changes and intervene as appropriate.</li> </ul> <p>Date Initiated: 06/09/2020</p> <ul style="list-style-type: none"> <li>- Administer medications as ordered.</li> </ul> <p>Date Initiated: 04/27/2020</p> <ul style="list-style-type: none"> <li>- Attempt to find out the reason or cause for any anxiety; listen to resident to resolve or discuss areas of upset.</li> </ul> <p>Date Initiated: 04/27/2020</p> <ul style="list-style-type: none"> <li>- Encourage R5 to express feelings. Provide support and reassurance.</li> </ul> <p>Date Initiated: 04/27/2020</p> <ul style="list-style-type: none"> <li>- Encourage R5 to participate in activities of choice. R5 enjoys adult coloring, tending to R5's plants and collecting stuffed animals.</li> </ul> <p>Date Initiated: 04/27/2020</p> <ul style="list-style-type: none"> <li>- Engage in relaxation techniques such as deep breathing, grounding in order to reduce anxiety and increase coping</li> </ul> <p>Date Initiated: 04/27/2020</p> <ul style="list-style-type: none"> <li>- R5 chooses to use west courtyard door to void conflict between other residents.</li> </ul> <p>Date Initiated: 01/02/2025</p> <ul style="list-style-type: none"> <li>- R5 is encouraged to keep items of high value secured in locked drawer in room</li> </ul> <p>Date Initiated: 01/02/2025</p> <ul style="list-style-type: none"> <li>- Monitor R5 for changes in behavior such as; expressions of sadness, lack of energy, withdrawn, worry, anxiety, flight of ideas, fast talking and movements.</li> </ul> <p>Date Initiated: 08/24/2020</p> <ul style="list-style-type: none"> <li>- Provide redirection when inappropriate behaviors exhibited; document behaviors</li> </ul> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Date Initiated: 01/02/2025</p> <p>- Re-offer assistance with a referral for behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.)</p> <p>Date Initiated: 04/27/2020</p> <p>- Work on skills to regulate emotions properly in an effort to reduce making negative statements such as I just want to die.</p> <p>Date Initiated: 10/27/2020</p> <p>Surveyor noted that the intervention of R5 chooses to use west courtyard door to void conflict between other residents was already initiated on 01/02/2025 and was not effective on 4/7/25 to mitigate conflict that occurred in the courtyard. Surveyor noted the care plan initiated on 4/7/25 is not relevant to the situation of an allegation of abuse.</p> <p>On 5/8/25, at 3:21pm, Surveyor interviewed Social Services (SS)-D regarding what was done after the alleged altercation between R5 and R6 on 4/7/25. SS-D stated that the care plan was updated, and residents were put into separate settings. Staff were advised to supervise R5 and R6 for further issues.</p> <p>On 5/12/25, at 9:27am, Surveyor interviewed Unit Manager (UM)-U who was working when the alleged incident between R5 and R6 occurred. UM-U stated that staff are aware of the issues between R5 and R6. For care plan interventions it was decided that they would keep R5 and R6 apart and use encouragement to help R5 and R6 remain calm.</p> <p>On 5/12/25, at 11:12am, Surveyor interviewed Director of Nursing (DON)-B regarding when a care plan should be updated and was told after a situation occurs. Surveyor asked what was being done to prevent another incident between R5 and R6. Nursing Home Administrator (NHA)-A replied that the residents were educated on policies, options related to other facilities were discussed and it was reinforced that R5 and R6 should go to the courtyard at staggered times so don't run into each other. Surveyor asked if these were added to the care plan and NHA-A replied would have to check.</p> <p>Surveyor noted the interventions staff mentioned of separate settings and keeping R5 and R6 apart were not added to R5's care plan.</p> <p>Surveyor reviewed the Facility Reported Incident dated 4/9/2025 that documents on 4/7/25 around 4:30pm, R5 alleged R6 hit R5 in the courtyard. Residents immediately separated and assessments conducted on both residents. No injuries obtained. Police notified. Investigation started.</p> <p>Surveyor reviewed the Verification of Investigation with the Date of Finding: 4/7/25 that documents within the Summary of Factual Investigative Findings: The care plan has been reviewed and updated. The care team, residents and all parties that were notified are agreeable to the current plan of care. The Plan of Care Update section for R5 and R6 documents Resident provided verbal education of facility rules including to not engage in inappropriate name calling with other residents and to not use the courtyard at the same time as the other resident. Resident counseled to use the courtyard door closest to assigned unit.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor noted that the new Plan of Care Update interventions were not initiated on R6's care plan. Surveyor noted R6's pertinent care plans and interventions were reviewed and none were new on 4/7/25 or after.</p> <p>R6's care plan R6 has a behavior problem issue: Resident chooses not to allow wound care/care/use/wear colostomy supplies, O2, refuses care/showers, refuses appointments/consults, refuses to have weights obtained, uncooperative w/appointments if attends, verbally aggressive w/staff/others, makes racial statements about staff/others, dislikes staff/others, combative w/staff/others @ times, hoards uncovered food, soiled towels/washcloths, throws stool soiled towels/wash cloths against walls, resistive cleaning of room, makes false accusations about staff and other residents was initiated: 08/29/2022. The pertinent intervention of R6 chooses to use east courtyard door to void conflict between other residents was initiated on: 12/19/2023.</p> <p>Surveyor noted that the intervention of R6 chooses to use east courtyard door to void conflict between other residents was initiated on 12/19/23 and did not mitigate conflict that occurred in the courtyard.</p> <p>Surveyor noted while reviewing R6's care plan that 05/23/2024 was the last time an intervention pertinent to R6's behaviors was added to R6's care plan, that is 11 months without new interventions on R6's care plan and no new interventions were noted after the 4/7/25 incident.</p> <p>On 5/8/25, at 3:21pm, Surveyor interviewed Social Worker (SW)-D regarding what was done after the alleged altercation between R5 and R6 on 4/7/25. SW-D stated that the care plan was updated, and residents were put into separate settings. Staff were advised to supervise R5 and R6 for further issues.</p> <p>On 5/12/25, at 9:27am, Surveyor interviewed Unit Manager (UM)-U who was working when the alleged incident between R5 and R6 occurred. UM-U stated that staff are aware of the issues between R5 and R6. For care plan interventions it was decided that they would keep R5 and R6 apart and use encouragement to help R5 and R6 remain calm.</p> <p>On 5/12/25, at 11:12am, Surveyor interviewed Director of Nursing (DON)-B regarding when a care plan should be updated and was told after a situation occurs. Surveyor asked what was being done to prevent another incident between R5 and R6. Nursing Home Administrator (NHA)-A replied that the residents were educated on policies, options related to other facilities were discussed and it was reinforced that R5 and R6 should go to the courtyard at staggered times so don't run into each other. Surveyor asked if these were added to the care plan and NHA-A replied would have to check.</p> <p>Surveyor noted the interventions staff mentioned of separate settings and keeping R5 and R6 apart were not added to R6's care plan.</p> <p>On 5/12/25, at 3:52pm, during the exit meeting with the facility, Surveyor relayed concern of lack of new care plan interventions added after R6 allegedly hit and pinched R5.</p> <p>No additional information was provided regarding R6's care plan interventions being updated after the allegation of abuse occurred on 4/7/25 to prevent future incidences.</p> <p>Smoking Assessments and Care Plan Interventions:</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R5's care plan documents: R5 is a smoker.</p> <ul style="list-style-type: none"> <li>- supervised smoker R/T (related to) unsafe behavior.</li> <li>- refuses follow supervised smoking time</li> <li>- resistive to supervised smoking and refuses to allow staff to hold material.</li> </ul> <p>- chooses not to follow facility designated smoking location, including doors to enter or exit courtyard as well as smoking policy that was initiated: 04/28/2021.</p> <p>Interventions include:</p> <ul style="list-style-type: none"> <li>- Instruct R5 about smoking risks and hazards and about smoking cessation aids that are available.</li> </ul> <p>Date Initiated: 04/28/2021</p> <ul style="list-style-type: none"> <li>- Instruct R5 about the facility policy on smoking: locations, times, safety concerns.</li> </ul> <p>Date Initiated: 04/28/2021</p> <ul style="list-style-type: none"> <li>- R5 can smoke SUPERVISED.</li> </ul> <p>Date Initiated: 04/28/2021</p> <ul style="list-style-type: none"> <li>- Monitor oral hygiene.</li> </ul> <p>Date Initiated: 04/28/2020</p> <ul style="list-style-type: none"> <li>- Notify charge nurse immediately if it is suspected R5 has violated facility smoking policy.</li> </ul> <p>Date Initiated: 04/28/2021</p> <p>Surveyor noted interventions have not been updated since 4/28/2021.</p> <p>On 1/10/25, a Smoking Risk Evaluation was completed for R5. Under Risk Category it is marked that R5 has known history of or current demonstration of unsafe smoking, giving R5 a score of 1. Per the evaluation with a score 1 or greater, risk/IDT (interdisciplinary team) team will review for additional care planning. For the question Is supervision needed? the answer selected is safe to smoke with supervision. For the question Is resident safe to keep any/all smoking materials? the answer selected is yes. For the question Material Storage: the answers selected are resident can keep lighter/matches and resident can keep cigarettes, cigarette materials .</p> <p>Surveyor noted the assessment indicates conflicting information in that it is assessed R5 needs supervision to smoke but that R5 can keep their smoking materials. There is not additional documentation on the assessment to explain assessment responses.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/12/25, at 8:34am, Surveyor interviewed Registered Nurse (RN)-S who stated that they try to supervise all smokers but R5 screams about it, won't allow it.</p> <p>On 5/12/25, at 9:27am, Surveyor interviewed Unit Manager (UM)-U regarding the smoking area and if there is supervision. UM-U stated that if a resident needs help someone should be out there with them.</p> <p>On 5/12/25, at 9:45am, Surveyor interviewed R5 about smoking. R5 stated they are not supervised when they go outside to smoke. R5 stated that the facility needs to have more supervision in the smoking area because one lady drops her cigarette butts on the ground then blames R5 and another lady calls R5 the N and B words. Surveyor asked if there were assigned times to smoke with supervision would R5 go out then and was told no, R5 wants to go when R5 wants.</p> <p>Surveyor noted R5's care plan and smoking assessment both indicate R5 needs supervision, however R5 is not supervised to smoke and is allowed to keep their smoking materials.</p> <p>R6's care plan documents R6 is a smoker (supervised), however, Resident chooses not to follow facility designated smoking times as well as smoking policy that was initiated: 04/22/2022.</p> <p>Interventions include:</p> <ul style="list-style-type: none"> <li>- Resident's smoking materials to be secured by facility staff.</li> </ul> <p>Date Initiated: 11/22/2023</p> <ul style="list-style-type: none"> <li>- Instruct resident about the facility policy on smoking: locations, times, safety concerns.</li> </ul> <p>Date Initiated: 04/22/2022</p> <ul style="list-style-type: none"> <li>- Notify charge nurse immediately if it is suspected resident has violated facility smoking policy.</li> </ul> <p>Date Initiated: 06/13/2022</p> <ul style="list-style-type: none"> <li>- Resident chooses not to follow facility designated smoking times as well as smoking policy.</li> </ul> <p>Date Initiated: 12/19/2023</p> <ul style="list-style-type: none"> <li>- The resident requires SUPERVISION while smoking.</li> </ul> <p>Date Initiated: 11/22/2023</p> <p>Surveyor noted interventions had not been updated since 11/22/2023.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/26/24, a Smoking Risk Evaluation was completed for R6. Under Risk Category it is marked that R6 has dexterity problem(s) that could affect smoking, Resident wears oxygen and explain other documents: Cannot always open door but can use door bell to alert staff, giving R6 a score of 2. Per the evaluation with a score 1 or greater, risk/IDT (interdisciplinary team) team will review for additional care planning. For the question Is supervision needed? the answer selected is safe to smoke without supervision. For the question Is resident safe to keep any/all smoking materials? the answer selected is yes. For the question Material Storage: the answer selected is resident can keep cigarettes, cigarette materials .</p> <p>Surveyor noted the smoking assessment indicates risks related to R6's smoking but indicates R6 can smoke &amp; keep materials without supervision. However, R6's care plan indicates R6 requires supervision. Surveyor noted R6's smoking assessment has not been updated/documented as reviewed since 4/26/24.</p> <p>On 5/8/25, at 10:33am, Surveyor observed R6 in the dining room, R6 was not wearing oxygen, which the smoking assessment indicated R6 wore. Surveyor interviewed R6 and asked if they were a smoker to which R6 responded yes. Surveyor asked if they keep their own materials and was told yes, Surveyor asked if they went to the smoking area with supervision and was told R6 is independent and needs no help.</p> <p>On 5/12/25, at 9:27am, Surveyor interviewed Unit Manager (UM)-U regarding the smoking area and if there is supervision. UM-U stated that if a resident needs help someone should be out there with them.</p> <p>Surveyor noted R6's care plan indicates R6 requires supervision and smoking materials are to be secured by facility staff. R6's smoking assessment resulted in a score of 2 yet was coded to not need supervision to smoke and is allowed to keep their smoking materials.</p> <p>On 5/12/25, at 3:52pm, during the exit meeting with the facility, Surveyor relayed concern regarding R5 and R6's care plan and smoking assessments being contradictory.</p>		

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<p>F 0745</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility did not ensure 4 (R1, R2, R5, and R6) of 6 residents reviewed received medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.</p> <p>R1 has a diagnosis of Alzheimer's Disease, alcohol abuse, and impaired cognitive function with behaviors demonstrated upon admission. The facility did not obtain information prior to admission that would have been pertinent to understanding R1's behaviors and how to address them. The facility failed to assess R1's behaviors. The facility did not develop and implement individualized psychosocial interventions to address R1's behavior pattern based on assessments and behavior demonstrated in the facility, thus leaving residents residing in the facility vulnerable and at risk.</p> <p>R2 has a diagnosis of psychosis, vascular dementia, and major depressive disorder with behaviors increasing after admission. The facility failed to assess R2's behaviors. The facility did not develop and implement psychosocial interventions to address R2's behavior pattern based on assessments and behavior demonstrated in the facility, thus leaving residents residing in the facility vulnerable and at risk.</p> <p>Review of R2 indicates as early as 1/12/25, R2 was engaging in aggressive behaviors with other residents in the facility and becoming more difficult to care for. Documentation and interviews with Psychiatric Nurse Practitioner (NP)-H indicated as early as January 2025, the facility was aware of R2's increased behaviors and refusals to take medications. Psychiatry NP-H indicated R2's refusals to take medications, Depakote in particular, would have an impact on R2's dementia symptoms along with his behavior symptoms.</p> <p>R1 and R2 engaged in an altercation that resulted in R1 being sent to the hospital with a subdural hematoma.</p> <p>The facility's failure to assess and treat R1 and R2's behaviors created a finding of Immediate Jeopardy, which began on 1/12/25. The facility failed to assess R1 and R2's needs and social history to determine their trauma background in order to treat and complete resident centered plans of care to provide proper care and address behavior concerns. On 5/12/25, at 3:52 PM, Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Regional Nurse-C, and Corporate Consultant-E were informed of the Immediate Jeopardy. The Immediate Jeopardy was removed on 5/12/25. The deficient practice continues at a scope and severity of a D (potential for harm/isolated) related to the additional example regarding R5 and R6 and as the facility continues to implement its action plan.</p> <p>R5 and R6 engaged in multiple resident to resident altercations starting 4/7/25. The facility did not assess R5 and R6's psychosocial needs following the altercations or assess behavioral changes and needs post altercations.</p> <p>Findings include:</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. Surveyor notes the Facility Assessment documents, the facility may accept residents with dementia, residents who may develop dementia, which may include common diseases such as psychiatric and mood disorders, psychosis with hallucinations and delusions, impaired cognition, mental disorder depression, bipolar disorder, schizophrenia, PTSD, anxiety disorder, and behaviors that require interventions.</p> <p>Surveyor reviewed R1 and R2's medical record which documents the following:</p> <p>R1 is a [AGE] year-old resident who was admitted to the facility on [DATE]. R1's diagnoses include seizures, Alzheimer's Disease, alcohol abuse, fall, and laceration to the scalp.</p> <p>R1's Discharge Minimum Data Set (MDS) completed on 4/20/25, documents R1 has severe impaired cognitive concerns, short term memory problems, rejection of care concerns, wandering, physical behaviors, and verbal behaviors. R1 requires substantial/maximal assistance with toileting hygiene, showering, and dressing. R1 is independent with transferring and walking. R1 does not require assistive devices while ambulating and ambulates throughout the facility independently. R1 was documented as having a Brief Interview for Mental Status (BIMS) score of 3, indicating that R1 has severe cognitive impairment.</p> <p>On 5/8/25, at 9:51 AM, Surveyor interviewed Assisted Living Facility (ALF) Executive Director-J, ALF Director of Wellness-K, and ALF Assistant Executive Director-L. ALF Director of Wellness-K indicates R1 resided at the ALF for a couple of years. ALF Director of Wellness-K described R1 with severe dementia, PTSD (Post Traumatic Stress Disorder) related to being in the military, delusions of gunfire that were war related, and experiencing hallucinations. ALF Director of Wellness-K stated R1 will calm down immediately after R1 feels safe. ALF Director of Wellness-K indicated R1 was a modest individual and did not like private parts exposed. R1 was a two person assist with one person providing cares, while the other person would assist with calming R1 down during cares. ALF Director of Wellness-K indicated R1 did not like cares being provided by the opposite sex. ALF Director of Wellness-K stated the facility did not reach out to the ALF and records were not requested by the facility. ALF Director of Wellness-K stated she wished the facility would have reached out to them so she could provide report and history along with interventions that would help with some of R1's behaviors. Surveyor noted the facility did not reach out to R1's previous residence (ALF), who could have provided vital information with R1's care plan, behavior monitoring, and treatment plan.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 5/7/25, at 3:29 PM, Surveyor interviewed Hospice Manager of Clinical Services-M who stated she is familiar with R1 who displays behaviors, refusals of care, and displays behaviors with people of the same sex. Hospice Manager of Clinical Services-M stated her team was the only one that could provide cares to R1 as he was familiar with them. Hospice Manager of Clinical Services-M stated Hospice did a lot of work with R1's psychotropic medications to help manage R1's behaviors. Hospice Manager of Clinical Services-M indicated R1 was prescribed Ativan due to R1 consistently wandering which was part of the reason why R1 would have altercations with the same sex. Hospice Manager of Clinical Services-M stated in the times where R1 could not be redirected, Ativan was administered. Hospice Manager of Clinical Services-M stated the referral for admission to the facility came from the hospital. Hospice Manager of Clinical Services-M stated Hospice does not make those type of referrals and Hospice was told by the hospital, R1 was accepted into the facility. Hospice Manager of Clinical Services-M stated Hospice received a phone call on 4/16/25, indicating R1 was being transferred out of the hospital and into the facility. Hospice Manager of Clinical Services-M indicated R1 was redirectable once you got to know R1. Surveyor noted the facility did not reach out or speak with Hospice prior to accepting R1 into the facility. Surveyor noted Hospice had vital information to help guide R1's plan of care with the potential to decrease behaviors with information and interventions the facility was unaware of.</p> <p>On 5/13/25, at 9:36 AM, surveyor spoke with R1's Activated Power of Attorney (APOA) who reported R1 had many behaviors while living at his previous residence, at the ALF. R1 displayed behaviors that were both verbal and physical with other residents while living at the ALF. R1's APOA stated the facility must have accepted R1 blindly because the admission happened so fast and other facilities typically did not accept R1 after interviewing R1. R1's APOA indicated the facility must have accepted him without performing an interview and the facility must not have talked with the nurses at the hospital. R1's APOA indicated R1 has significant PTSD due to training in war and being in the [NAME] Corps. R1 also served time in prison back in 1976. R1 also has a history with alcohol and drug abuse with most recent use approximately two years ago. R1's APOA indicated R1 may have schizophrenia and has never been properly diagnosed. R1 experiences hallucinations and has previously experienced homelessness. Surveyor noted the facility did not reach out to R1's APOA to obtain pertinent psychosocial information that may be beneficial with providing a personalized plan of care and treatment for behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 5/7/25, at 1:16 PM, Surveyor interviewed Admissions-I who stated she will receive a request for a new admission to the facility and will review the admission paperwork. Admissions-I indicated she will look for red flags such as financials, safe discharge planning, and behaviors. Admissions-I then stated the facility does not have a memory care unit or a unit for residents who elope, and indicated the facility tries to keep it simpler. Admissions-I indicated the facility will get surprises where residents will change after they are admitted. Admissions-I indicated criminal background checks are performed to determine safety risk on all new residents. Admissions-I stated diagnosis and behaviors that are charted will determine if the resident has memory concerns. Admissions-I indicated she has had it happened with one resident recently who was admitted with Hospice care that was not appropriate. Surveyor asked Admissions-I who she was referring to, and Admissions-I indicated R1 was under Hospice care, and everything was good. R1 went to the hospital with behaviors, and behaviors had improved. Admissions-I indicated R1 had a sitter and restraints in the hospital prior to admission. Admissions-I stated the facility got a referral from Hospice and R1's sister-in-law could no longer care for R1. Admissions-I stated Hospice records were reviewed and R1 was accepted based on the Hospice records. Admissions-I indicated she visited R1 in the hospital who displayed agitation, wrist restraints, had a sitter out in the hallway, and described R1 as a restless fish out of water. Admissions-I stated she went back a 2nd time to the hospital and R1 was much calmer, social, talking, asked about lunch, and asked about going home. Admissions-I indicated R1 was 48 hours without restraints or a sitter at the time of her 2nd visit to the hospital. Admissions-I indicated R1 was not wandering in the hospital and started wandering in the facility right away after admission. Surveyor then asked Admissions-I why R1 had a sitter in the hospital, Admissions-I indicated R1 had a sitter due to being aggressive and getting out of bed.</p> <p>Surveyor noted Admissions-I did not receive the referral from Hospice. This was confirmed with an interview with Hospice Manager of Clinical Services-M. Surveyor also noted Admissions-I had already accepted the admission to the facility for R1 prior to visiting R1 in the hospital.</p> <p>R1's care plan documents:</p> <p>R1 is an elopement risk/wanderer related to Alzheimer's Disorder (date initiated 4/17/25).</p> <p>Interventions include:</p> <p>*Photo on wander list (date initiated 4/21/25).</p> <p>*Staff aware of R1's wander risk (date initiated 4/17/25).</p> <p>*Wander alert personal safety device applied to right wrist (date initiated 4/21/25).</p> <p>Surveyor notes 2 of the 3 interventions were initiated 1 day after R1 was discharged from the facility on 4/20/25. Surveyor also notes the intervention indicating R1 wearing the wander alert device on the R1's right wrist was initiated after R1 was discharged from the facility.</p> <p>R1 has potential to be physically or verbally aggressive related to history of alcohol abuse and Alzheimer's Disease with poor impulse control. Verbal aggression occurred 4/16/25, 4/17/25, 4/19/25, and 4/20/25. Physical aggression occurred 4/17/25, 4/19/25, and 4/20/25 (date initiated 4/22/25).</p> <p>Interventions include:</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>*Administer medications as ordered. Monitor/document for side effects and effectiveness (date initiated 4/22/25).</p> <p>*Assess and address for contributing sensory deficits (date initiated 4/22/25).</p> <p>*Provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, and encourage seeking out of staff member when agitated (date initiated 4/22/25).</p> <p>*Monitor/document/report as needed (PRN) any signs/symptoms of R1 posing a danger to self and others (date initiated 4/22/25).</p> <p>Surveyor notes this care plan was initiated 2 days after R1 discharged from the facility on 4/20/25.</p> <p>R1 has a mood problem related to Alzheimer's Disease (date initiated 4/16/25).</p> <p>Interventions include:</p> <p>*Provide a calm and safe environment to allow R1 to express feelings as needed (date initiated 4/22/25).</p> <p>*Provide R1 with area for decreased stimulation as needed (date initiated 4/22/25).</p> <p>Surveyor notes these interventions were initiated 2 days after R1 discharge from the facility on 4/20/25.</p> <p>R1 has potential for a psychosocial well-being problem related to resident-to-resident incident on 4/17/25 and 4/20/25 (date initiated 4/17/25).</p> <p>Interventions include:</p> <p>*Encourage staff to redirect R1 and provide a calm quiet environment; remove high stimulation. R1 prefers the sitting area across from NHA office. To assess and monitor for any triggers or trends in behaviors to mitigate untoward incidents (date initiated 4/17/25).</p> <p>*Monitor mood, behavior, appetite, sleep pattern and usual activities of choice. Report any alterations to provider to determine if any additional interventions are needed (date initiated 4/18/25).</p> <p>*Monitor/document R1's usual response to problems: how R1 makes own changes and expects others to control problems or leaves to fate, or luck (date initiated 4/17/25).</p> <p>*Provide opportunities for R1 and family to participate in care. Continue non-pharmacological interventions to detour and distract from untoward behaviors (date initiated 4/17/25).</p> <p>*Upon readmission to the facility; schedule care conference with Power of Attorney (POA), Hospice, community care, and facility staff to communicate possible alternative placement equipped for residents with dementia (date initiated 4/20/25).</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>*When conflict arises, remove R1 to a calm safe environment and allow to vent/share feelings (date initiated 4/17/25).</p> <p>Surveyor reviewed R1's behavior task list dated 4/16/25 - 4/20/25, which documents:</p> <p>4/17/25 at 5:59 AM - wandering, yelling/screaming, kicking/hitting, pushing, grabbing, abusive language, threatening behavior, rejection of care</p> <p>4/19/25 at 3:54 PM - rejection of care</p> <p>Surveyor reviewed the incident description on the facility self-report dated 4/17/25, which documents the following:</p> <p>Prior to the incident, R1 had been wandering the halls and in and out of rooms throughout the night, very agitated. R1 then aggressively approached another resident near the nurses' station, staff was unable to redirect and R2 then struck R1 in the right upper arm twice. Resident description documents, he got in my face. Immediate action taken documents, R1 was given PRN Ativan after non-pharmacological interventions were not effective.</p> <p>Surveyor reviewed staff statement from Licensed Practical Nurse (LPN)-X, dated 4/17/25, which documents the following:</p> <p>R1 was observed wandering hallways and becoming agitated and combative with staff throughout the night. While sitting in front of the nurses' station, R1 aggressively got up and approached R2. R2 then struck R1 in the right upper arm area, twice. R1 and R2 were immediately separated and redirected with the nurse. PRN Ativan was immediately administered without any difficulty. There was no redness/swelling noted to the area however, scattered old bruises were noted throughout R1's bilateral upper extremities. R1 denied any pain. Range of motion was within normal limits. Assistant Director of Nursing (ADON) and DON were notified by staff, POA for R1 was called and notified of the incident, as well as Hospice.</p> <p>Surveyor reviewed staff statement from CNA-V which documents R1 was really restless and confused wandering all night walking in and out of resident rooms and redirected. He was aggressive physically and verbally, abusive towards staff. CNA-V found R1 in a room standing over a resident around 4:00 AM. CNA-V asked R1 what R1 was doing. R1 responded stating R1 was helping the people. CNA-V told R1 that wasn't needed, that is what staff are there for and asked R1 to leave the resident's room with CNA-V because it was not R1's room. R1 told CNA-V no and grabbed something off the table. CNA-V asked R1 to give it to CNA-V, and R1 responded stating it was not R1's and R1 punched CNA-V twice and told CNA-V to leave R1 alone. CNA-V eventually got R1 to walk toward the door and got outside the door. R1 grabbed CNA-V's hand and pulled CNA-V's fingers apart. CNA-V got their hand loose, stepped back, and closed the door. When CNA-V opened the door back up, R1 was gone. CNA-V went to report what happened to the nurse when CNA-V observed R1 again by the nursing station. R1 was walking past R2. CNA-V was close enough to see both R1 and R2, but not to hear them. R1 said something to R2, and R1 stopped, they started to argue, and punches were thrown. Staff immediately intervened and separated R1 and R2. CNA-V does not know who threw the first punch. R2's behavior all night was normal. R2 wandered how R2 usually does, but did not bother anybody.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Surveyor reviewed staff statement from CNA-W dated 4/17/25, which documents around 5:50 AM, R1 approached R3 in the TV area and told R3 to shut up because R3 was doing his usual screaming. R2 then told R1, don't talk to R3 like that. R1 walked closer to R2 with R1's fist bald (sic) up punching, R2 swung back at R1 a few times. CNA-W was trying to step in between without being hit. CNA-W separated R1 and R2.</p> <p>A second incident between R1 and R2 occurred three days later.</p> <p>Surveyor reviewed the facility self-report dated 4/20/25, which documents the following:</p> <p>On 4/20/25, around 12:50 AM, R2 hit R1 in the back of the head with a wet floor sign resulting in R1 falling and causing injury. Staff immediately intervened and separated R1 and R2 to maintain safety and conducted nursing assessments. R1 was sent to the hospital for evaluation and treatment. R2 was also sent out to be evaluated by psych and to be admitted inpatient to get R2 the assistance needed. R2 was sent back to the facility from the hospital without a psych work up and without notice. Facility staff notified NHA, DON, POAs, MD, Hospice, R2's PO, APS, ombudsman, and police. R1 sustained injuries as a result of the incident. R1 remained in the hospital. R1 is pending upcoming discharge.</p> <p>Surveyor reviewed staff statement from CNA-Y which documents, CNA-Y was doing rounds, heard a commotion, walked down the hall, and saw R2 hitting R1 with a wet floor sign. CNA-Y and another aid both ran towards the incident to break it up and R2 walked in one direction and R1 walked in the other direction.</p> <p>Surveyor reviewed staff statement from LPN-X which documents, R1 was wandering in and out of rooms, agitating other residents; unable to be redirected. Loud banging noise and yelling heard from unit 4 hall, and R1 was observed on R1's knees on the floor holding R1's face with a large amount of blood dripping from R1's face. R2 was separated from R1 and while walking away with the wet floor sign in hand, R2 admitted that R2 hit R1 several times. Large bumps were noted to the back of R1's head and behind left ear area along with the left side of the face and forehead. R1 was not cooperative with assessment from staff. Seems to be a laceration to left side of upper lip and an approximate 4-centimeter skin tear and redness to the left elbow area, tender to touch. While R1 was being seen by paramedics, R1 turned around and punched LPN-X in the arm/face while attempting to block R1's hit. R1 was placed on the stretcher by the paramedics and taken to the ER.</p> <p>Surveyor reviewed a second staff statement from LPN-X which documents, it was later reported to LPN-X that R1 was struck in the back with the wet floor sign by R2, observed by staff nurse and CNAs. Prior to incident, R1 had been wandering in and out of resident rooms. R2 had been telling staff that R1 killed R2's brother. Staff was attempting to keep the two separate, unsuccessful.</p> <p>The facility did not have pertinent information concerning R1's history and approaches that had been successful to help manage R1's behaviors, such as wandering into and out of other residents' rooms, upsetting them, and being physically aggressive. The initial care plans did not provide sufficient guidance to staff and care plans that were subsequently developed were developed after R1's admission to the hospital with a subdural hematoma that resulted after an altercation with another resident (R2).</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R2 is an [AGE] year-old resident who was admitted to the facility on [DATE]. R2's diagnoses include intracerebral hemorrhage (a type of stroke where bleeding occurs within the brain tissue), major depressive disorder, psychosis, vascular dementia (a form of dementia caused by damage to blood vessels in the brain, leading to reduced blood flow and oxygen delivery), seizures, and Transient Ischemic Attack (TIA) (temporary blockage of blood flow to the brain, causing similar symptoms to a stroke). R2's Quarterly MDS documents R2 has fluctuating behaviors for disorganized thinking, delusions, and wandering. R2 requires supervision for dressing, bathing, and putting on shoes. R2 is independent with transferring and walking. R2 was documented as having a BIMS of 2 indicating R2 has severe cognitive impairment.</p> <p>R2' care plan documents:</p> <p>R2 has episodes of aggression (date initiated 4/20/25).</p> <p>Interventions include:</p> <p>*Attempt to separate R2 from other residents or staff that R2 has been aggressive with (date initiated 4/20/25).</p> <p>*Monitor R2's whereabouts at all times (date initiated 4/20/25).</p> <p>*Try to redirect resident before he becomes too agitated (date initiated 4/20/25).</p> <p>R2 has a mood and behavior problem related to vascular dementia, unspecified severity, with other behavioral disturbance (example being sexually inappropriate with female residents, exposing self, and poor impulse control). Monitor psychosocial well-being due to peer-to-peer altercation on 4/17 and 4/20. Refusing staff to clean R2's room or letting staff assist R2 in getting dressed. Aggressive behaviors noted towards staff, accepting redirection on 4/1. R2 will refuse medications at times; Risks and benefits explained. R2 will refuse to have lab work done; Risks and benefits explained. (Date initiated 12/11/24).</p> <p>Interventions include:</p> <p>*Provide a calm and safe environment to allow R2 to express feelings as needed (date initiated 12/11/24).</p> <p>*Provide R2 with area for decreased stimulation as needed for negative behaviors (date initiated 12/11/24).</p> <p>*1:1 (one on one staff supervision) initiated and maintained upon return to regular ambulation/wandering (date initiated 4/20/25).</p> <p>*Encourage activated POA to participate in care planning period discuss and review alternate placement options that is a more appropriate setting for R2's progression of disease process (date initiated 4/17/25).</p> <p>*Set up another care conference with POA and psychiatry Nurse Practitioner (NP)-H to collaborate and care planning which is scheduled on 4/22/25 (date initiated 4/17/25).</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>*Activities interview R2 and family to determine interest to care plan meaningful activities. Activities department monitor participation (date initiated 4/21/25).</p> <p>*Collaborate with MD, psych services, pharmacist, Adult Protective Services (APS), ombudsman, parole officer (PO), social services, and Regional Field Operations Director (RFOD) (State Agency) regarding options/interventions/care planning (date initiated 4/21/25).</p> <p>*Request from POA/family information regarding R2's past period extended family support options, likes, dislikes, interests, triggers, or trends. Implement any suggested recommendations if applicable and appropriate (date initiated 4/22/25).</p> <p>*Anticipate and meet R2's needs. Continue to monitor for triggers and any trends (date initiated 12/13/24).</p> <p>*Monitor for any aggressive/intrusive behaviors and report to provider (date initiated 4/11/25).</p> <p>*Monitor psychosocial well-being: mood, behavior, sleep pattern, appetite, and usual activities of choice. Report any alterations and notify provider to determine if any other interventions are recommended (date initiated 4/11/25).</p> <p>*Praise any indication of R2's progress/improvement in behavior (date initiated 2/24/25).</p> <p>*Provide a program of activities that is of interest and accommodates R2's status. Continue to offer nonpharmacological interventions to distract and detour negative incidents. Example: offer snacks, ice cream, chocolates, engage in conversation of preferences, offer meaningful activities, and walk while talking about guitars and music (date initiated 12/11/24).</p> <p>*Utilize psych services if provider deems necessary (date initiated 4/11/25).</p> <p>R2 uses psychotropic, antidepressant medications related to vascular dementia with behaviors, psychosis, and depression. R2 regularly refuses medications (date initiated 3/8/24).</p> <p>Interventions include:</p> <p>*Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift (date initiated 3/8/24).</p> <p>*Consult with pharmacy and MD to consider dosage reduction when clinically appropriate at least quarterly (date initiated 3/8/24).</p> <p>*Educate R2/family/caregivers about risks, benefits and the side effects and/or toxic symptoms (date initiated 11/11/24).</p> <p>*Monitor/record occurrence for target behavior symptoms (date initiated 3/8/24).</p> <p>R2 has a potential psychosocial well-being problem related to resident-to-resident altercation (date initiated 4/17/25).</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interventions include:</p> <ul style="list-style-type: none"> <li>*Attempt to remove and redirect R2 when other residents are calling out to prevent R2 from feeling the need to protect other residents (date initiated 4/17/25).</li> <li>*Initiate referrals as needed or increase social relationships (date initiated 4/17/25).</li> <li>*Monitor/document R2's usual response to problems, how R2 makes own decisions, expects others to control problems or leaves to fate, or luck (date initiative 4/17/25).</li> <li>*When conflict arises, remove R2 to a calm safe environment and allow to vent/share feelings (date initiated 4/17/25).</li> </ul> <p>Surveyor reviewed R2's behavior task list dated 4/8/25 - 5/8/25, which documents:</p> <p>4/19/25 at 4:56 PM - wandering</p> <p>4/30/25 at 4:56 AM - wandering and rejection of care</p> <p>Surveyor reviewed R2's Medication Administration Record (MAR) which documents R2 is prescribed Seroquel for dementia with behavioral disturbance, Depakote for dementia, Keppra for seizures, and Paxil for depression. Surveyor notes the following missed medications for R2:</p> <p>January 2025 MAR documents the following:</p> <ul style="list-style-type: none"> <li>*R2 took Seroquel and Paxil one time on 1/10/25.</li> <li>*R2 took Depakote three times on 1/2/25, 1/10/25, and 1/12/25. Surveyor notes R2 took Depakote three times out of 62 opportunities in the month of January 2025.</li> <li>*R2 took Keppra 4 times on 1/2/25, 1/7/25, 1/10/25, and 1/16/25. Surveyor notes R2 took Keppra four times out of 62 opportunities in the month of January 2025.</li> </ul> <p>February 2025 MAR documents the following:</p> <ul style="list-style-type: none"> <li>*R2 took Depakote 21 times out of 56 opportunities.</li> <li>*R2 took Paxil 12 times out of 28 opportunities.</li> <li>*R2 took Keppra 22 times out of 56 opportunities.</li> <li>*R2 refused Seroquel throughout February 2025.</li> </ul> <p>March 2025 MAR documents the following:</p> <ul style="list-style-type: none"> <li>*R2 took Paxil seven times out of 31 opportunities.</li> <li>*R2 took Depakote 12 times out of 62 opportunities.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>*R2 took Keppra 12 times out of 62 opportunities.</p> <p>April 2025 MAR documents the following:</p> <p>*R2 took Paxil five times out of 30 opportunities.</p> <p>*R2 took Keppra 12 times out of 60 opportunities.</p> <p>*R2 took Depakote 10 times out of 60 opportunities.</p> <p>*R2 was prescribed Rexulti for dementia with a new order dated 4/21/25. Surveyor notes R2 took Rexulti two times out of nine opportunities in the month of April 2025.</p> <p>On 5/8/25, at 1:50 PM, Surveyor interviewed Psychiatry Nurse Practitioner (NP)-H who states she sees R2 every two to three months. Psychiatry NP-H indicated she was told R2 was not taking medications as prescribed as early as January 2025. Psychiatry NP-H stated R2 was not taking Depakote as prescribed and indicated dementia will worsen and behaviors will potentially worsen due to R2 not taking Depakote. Psychiatry NP-H stated things can set off R2 and some of these incidences are racially motivated. Psychiatry NP-H indicated she has not completed evaluations for possible triggers for R2 and is unsure if the facility performed evaluations for possible triggers. Psychiatry NP-H stated she does not think these evaluations to identify possible triggers are a standard of practice for any facility and then stated the facility will deal with the here and now. Psychiatry NP-H stated R2 had recent medication changes, and the facility is to contact her if R2's behaviors worsen, she would possibly adjust medications. Psychiatry NP-H indicated R2 is not a danger to themselves, however R2 is a danger to other residents within the facility if R2 is set off by another irritating factor to them. Psychiatry NP-H stated anybody can be that spark for someone with dementia. Psychiatry NP-H indicated she was not aware of R2's criminal history.</p> <p>The facility did not have a care plan that addressed R2's refusal to take medications. R2 did not consistently begin taking medications until May 2025 when R2's family member began administering them.</p> <p>(continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0745</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 5/8/25, at 2:57 PM, Surveyor interviewed Social Services-D who stated she is aware of the altercations between R2 and R1 that occurred on 4/17/25 and 4/20/25. Social Services-D states the facility has been in contact with R2's POA and family, with care conferences to discuss alternate facilities for R2. Social Services-D stated she was unaware that R2 had a parole officer, and the facility was made aware a couple of months ago when R2's parole officer showed up at the facility with a warrant for R2. Social Services-D indicated she is not aware of why R2 has a parole officer. Social Services-D indicated Admissions-I did not have knowledge of R2 having a parole officer. Social Services-D stated she was not sure what the plan is for the facility moving forward for verifying if residents are on parole with a new admission and directed Surveyor to speak with Admissions-I. Social Services-D indicated Admissions-I was in shock when she ran R2's name through the circuit courts and nothing came up. Social Services-D indicated R2 may have a parole officer due to R2 having convictions in another state. Social Services-D stated R2's care plan is updated to be monitoring R2, and the facility put a plan in for R2 being non-compliant with medications. Social Services-D indicated the facility has attempted to administer R2's medications in chocolate milk, yogurt, and other alternatives without success. Social Services-D stated family is coming in daily to administer R2's medications. Social Services-D indicated she is not sure what would happen if R2 assaults someone again and whether or not there is a plan. Social Services-D stated she feels R2's sister's hands are tied due to R2 getting turned down at other facilities for alternative placement. Social Services-D indicated the family is out of options and have stated numerous times family members will not take R2 home and care for R2 and POA told the facility that the facility can't tell the POA where to move his brother. Social Services-D indicated the facility then reminds R2's POA about the incident that occurred on 4/20/25. Social Services-D indicated she feels the facility should have known that R2 was on parole. Social Services-D indicated the facility tries to tell R2's family that the facility is not the proper setting for R2.</p> <p>Surveyor noted Social Services-D and Admission-I are not aware of why R2 has a parole officer, which helps determine resident needs and plan of care. Social Services-D indicated the facility does not have a plan of action moving forward for residents who are on parole, or if R2 were to display behaviors again including assaulting someone. Surveyor also noted, the facility was unable to indicate R2's previous conviction and ja</p>		