STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675142	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcliff Health Center	3403 S Vine Ave Tyler, TX 75701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19401 Based on interview and record review the facility failed to ensure a resident was treated with dignity and respect for 1 of 8 residents reviewed for dignity. (Resident #3) Resident #3 was the victim of humiliation due to Resident #2 being allowed to urinate on him for two nights. The staff were aware of the first incident on 3/30/24 and allowed Resident #2 to continue to reside in the room with Resident #3 and a second incident occurred on 3/31/24. This failure caused a resident to be humiliated and dehumanized. Findings included: Record review of Resident # 3's face sheet with no date indicated he was a [AGE] year-old male admitted to the facility on [DATE]. Some of his diagnoses were high blood pressure, anxiety, depression, stroke and paralysis, unsteadiness on feet, and lack of coordination. Record Review of Resident #3's quarterly MDS assessment dated [DATE] indicated the resident was cognitively intact. The resident had functional limitations in range of motion of the upper and lower extremities and used a walker to assist with mobility. The resident required partial to moderate assistance with most ADLs. He required supervision with transfers and mobility. Record review of Resident #3's Care Plan dated 2/8/24 indicated a Problem of potential communication deficit related to cognition and late effects related to stroke. The resident had unclear speech but was usually understood and understood others. Some of the approaches were to allow for quality time to communicate, be sensitive to non verbal communication, and do not rush. A Problem of the resident required assistance with ADLs due to decreased mobility and altered mentation due to stroke and right sided hemiplegia. Some of the approaches were assist with ADLs as needed. Record review of Resident #3's nursing note dated 3/30/24 at 3:55 a.m. indicated roommate (Resident #2) got up and walked over to Resident #3's side of the room. Once by Resident #3's bed Resident #3 said Resident # 2 took off his brief with feces and began urinating all over his side of the room and on his belongings. The nurse cleaned the area and separated the residents. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Actual harm Residents Affected - Few	Resident #2 Record review of Resident # 2's face sheet indicated he was an [AGE] year-old male admitted to the facility on [DATE]. Some of his diagnoses were dementia, unsteadiness on feet, repeated falls, adult failure to thrive, depression with anxiety, and Parkinson's disease(disorder of the central nervous system that affects movements, often including tremors). The sheet indicated he was discharged on [DATE]. Record review of Resident #2's Brief Interview for Mental Status indicated he had severe cognitive impairment. Record review of Resident #2's Care Plan dated 3/28/24 reflected he had Problems of Pressure Ulcer and DNR status only. Record review of Resident #2's nursing notes indicated: On 3/30/24 at 3:55 a.m. Resident was found walking in the hall with brief off and wearing only a shirt outside his room. The nurse assisted the patient to his wheelchair for safety. Upon entering the room, a brief with feces was on the floor in front of the roommate's (Resident #3) bed. There were also two piles of feces around the roommate's bed and large amounts of urine all over the roommates belonging. The roommate reported Resident #2 walked over to his side of the room and took off his brief and used the restroom all over his side of the room. The nurse cleaned up the area and Resident #2 was brought to the nurse's station for monitoring due to confusion and inability to redirect. On 3/30/24 at 10:25 p.m. Resident #2 refused to stay in bed. Staff brought him to the nurse's station due to fall risks and attempt to get out of chair. On 3/31/24 at 4:17 p.m. Resident #2 had increased anxiety and restlessness. The nurse was monitoring at the nurse's station most of the shift. Resident had a fall; he was being monitored by all staff. The resident went over to roommates' side while he was in bed and urinated all over the bed, sheets, and blankets. The aide got it all cleaned up and the resident cleaned and brought to the nurse's station. During an interview on 4/2/24 at 3:50 p.m. CNA B said she worked with Resident #2 trying to get out of bed and had frequent falls. She said on 3/30/24 Resident #2 urinated and defecated all on his roommates' side of the room. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/2/24 at 4:00 p.m. Resident #3 had a speech impairment and was hard to understand. He would start to say something and stop as if gathering his thoughts, and then apologize. Resident #3 said his roommate (Resident #2) got up at night and had BM all over the floor on his side of the room on 3/30/24 at 4:00 a.m. in the morning. Resident #3 said Resident #2 urinated all over him and on his side of the room. Resident #3 said he asked Resident #2 to stop, and he did not until he was finished. He said he asked the staff to move Resident #2 and they said they could not. He said they told him he had to wait until Monday, 4/1/24 to ask to have Resident #2 moved to another room. He said they gave him the call light and told him to pull the light if anything happened again. Resident #3 said nothing happened for a while, so he had let his guard down. He said it happened again on Sunday, 3/31/24 morning. Resident #3 said Resident #2 urinated all over him and his bed. He said he pulled the call light, and the staff came but Resident #2 had done his business by the time they got there. During an interview on 4/3/24 at 7:46 a.m. the ADON said Resident #2 was admitted from home on 3/26/24. She said they were told he had been aggressive with the family members at home. The ADON said during the short time he was at the facility he would not sit down; he had a very unsteady gait and frequent falls. When he was redirected, he would become agitated and was placed on an antianxiety medication as needed. She said she had received a call on the morning of 3/30/24 about 4:00 a.m. saying Resident #2 had walked to his roommate's (Resident #3) side of the room and took off his brief and urinated in Resident #3's shoes and defecated in his chair. She said the room was cleaned by staff. She said they had told her Resident #3 was upset. She said the staff questioned her about moving Resident # 2 but they did not have any empty rooms on that unit. She said they had empty rooms in the building just not on that unit. The ADON said when they move a resident from one unit to the other, they required administrative approval. She said the nurse called the physician and received an order for an antipsychotic medication. The ADON said as far as she knew that type of incident had only occurred once. She was not aware of the second incident on 3/31/24. The ADON said Resident #2 had spent the night in that room with Resident # 3 on 3/30/24 and 3/31/24. During an interview on 4/3/24 at 8:00 a.m. Resident #3 said he did not remember the exact time of the second incident with Resident #2. He just knew that it happened two times. He said he was upset and felt humiliated to be treated like he was a bathroom. He said he had asked the staff to move Resident #2 the first time but was told he had to wait until Monday, 4/1/24 when the Administrator was in the building. During an interview on 4/3/24 at 9:35 a.m. LVN C said during the day she kept Resident #2 at the nurse's station. He did not spend much time in the room because he was a high fall risk. He was constantly trying to get up and would be verbally aggressive. She said Resident #3 did not want Resident #2 in the room with him because he wet all over him and his bed. LVN C said Resident #3 was upset and he was usually very calm and easy going. During an interview on 4/3/24 at 9:56 a.m. the RNC said when she arrived on 4/1/24, Resident #3 was in the hallway waiting to talk to Administrator. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/3/24 at 10:07 a.m. Administrator said Resident #3 was waiting on her when she arrived on 4/1/24. Resident #3 said his roommate Resident #2 had defecated on his chair and urinated all over his side of the room. The Administrator said Resident #3 did not say a whole lot to her but was pretty upset. She said they had gone into morning meeting and decided to move Resident #2 in a room by himself on a different hall. She said she did not know until today there were two incidents with Resident #2. During a telephone interview on 4/5/24 at 11:31 a.m. RN D (weekend nurse) said Resident #2 told her it happened again Resident #2 urinated all over him. She said she had asked Resident #2 what had happened, and he could not tell her. RN D said the first time the incident had happened they discussed moving Resident #2 to another room, but they did not have a single room that they could put him in on that hall. She said Resident #3 was upset and did not like it, but said he understood. The RN said during the day and evening hours they kept Resident #2 at the nurse's station. She said the incidents would be in the middle of the night or about 4 or 5 in the morning. She said Resident #3 said he wanted to know who to report his concerns to and he was told the Administrator would be back on 4/1/24. Record review of the facility's Resident [NAME] of Rights dated January 2004 indicated Each the Resident [NAME] of Rights must provide that each resident in the personal care facility has the right to be treated with respect, consideration, and recognition of his or her dignity and individuality. A resident shall receive personal care and private treatment in a safe and decent living environment.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 19401 Based on interview and record review, the facility failed to ensure a resident had the right to be free of abuse for 1 of 8 residents reviewed for abuse. (Resident #1) Resident #1 was intimidated, suffered pain and mental anguish, and forced to allow care against her will by CNA A on 3/11/24. CNA A refused to take no for an answer when Resident #1 told her she did not want to be transferred. CNA A pushed back at Resident #1's flailing hands and reached under her arms and transferred her against her will from her wheelchair to her bed. Resident #1 complained of back pain when she was transferred by CNA A. CNA A was hollering at Resident #1 and told her she was afraid for nothing. CNA A was close to Resident #1's face talking loudly in an intimidating manner. CNA A reached between Resident #1's legs to check if she was wet and the resident was begging her not to, but CNA A continued. The noncompliance was identified as past non-compliance (PNC). The IJ began on 3/11/24 and ended on 3/21/24. The facility had corrected the noncompliance before the survey began. The negative findings placed residents at risk of abuse, mental anguish, and pain. Findings included: Record review of Resident #1's face sheet with no date indicated she was a [AGE] year-old female admitted to the facility on [DATE]. Some of her diagnose were heart failure, anxiety disorder, high blood pressure, and left lower quadrant pain. Record review of Resident #1's MDS assessment dated [DATE] indicated she had severe cognitive impairment. She required substantial/maximal assistance with bed to chair transfer and toilet transfer. During an interview on 4/5/24 at 11:45 a.m. the MDS nurse said Resident #1's MDS indicated the resident required two people for transfer. Record review of Resident #1's Care Plan dated 2/22/24 indicated a Problem of the resident required assistance with transfers due to decreased mobility, weakness and altered mentation. She used a wheelchair for ambulation. Some of the approaches were do not force the resident to perform a care activity, call the resident's family for assistance with ADL issues. Transfer resident per instructions on resident assistant guide. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's nursing note dated 3/11/24 at 8:15 p.m. indicated a grievance was brought to the nurse by a family member. Resident #1 was immediately assessed to ensure she was safe, skin showed no signs of bruising, the resident was calm and in no distress at this time. Resident #1 did ask for a pain pill but later declined it. The incident was immediately reported to administrative staff. Record review of Resident #1's nursing note indicated a note recorded as late entry on 3/12/24 at 11:32 a.m. indicated on 3/11/24 at 7:47 p.m. this nurse receive report from the charge nurse concerning an incident with CNA and reviewed the video with the family member. The Family member said CNA A was rude and handled Resident #1 roughly. Resident #1 said she was not fearful and had no new complaints of pain. Signed by ADON. Record review of a Provider Investigation Report indicated on 3/11/24 at 8:15 p.m. the family member reported CNA A approached Resident #1 and would not take no for an answer when attempting to put her to bed. Resident #1 said she was afraid the aide would drop her. The family member stated CNA A manhandled Resident #1. The family member said Resident #1 told her CNA A was rough with her and would not take no for an answer. The investigation findings were confirmed. The agency aide was blocked from returning to the facility. Record review of an email dated 3/12/24 from the administrator to HHSC Complaint and Incident Intake mailbox indicated . The Agency aide (CNA A) was terminated from our building meaning she was placed on a do not return list. In the conversation with the family and watching the video, it was determined that the aide was unnecessarily loud, and rude to the resident . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of video provided by the family of Resident #1 dated 3/11/24 with a start time of 6:39 p.m. CNA A was seen in the room with Resident #1 sitting in the wheelchair adjacent to the bed. The aide told the Resident #1, Hold your arms up cause I'm not going to drop you. Resident #1 said, I do not want you to lift me, no, no, no. The aide was seen getting down in the resident's face saying, Hey, hey in a loud voice. CNA A was just about screaming at Resident #1 saying What's the problems? Resident #1 said, I don't want you to lift me. The aide said, Why? with hand gestures and her head was lowered down to the resident's face. Resident #1 said, I am afraid you will drop me. CNA A again loudly told Resident #1 I have never dropped you, I have put you in the bed before with no help. The aide told the Resident #1, Now don't start that today. You are fighting me. Resident #1 said repeatedly I am fighting you, I am fighting you, I am fighting you. The aide said, For what? Resident #1 and CNA A fumble back and forth a little, with CNA A moving her hands one way, and Resident #1 trying to block her hands another. Resident #1 begs her, Please don't do this to me. The resident is seen trying to flail her hands and CNA A pushed Resident #1's hands out of the way. CNA A reached under the resident's arms and lifted her to the bed. When the aide sits the resident on the bed she said, What was all of that for? You are in the bed honey. The resident said, You hurt my back. The aide turns Resident #1 around and put her legs in the bed, and told her that was uncalled for. The resident's knees are bent. CNA pulled Resident's house shoes off her feet. The back of the Resident #1's head was pressed into the headboard and the resident was on her bottom with her shoulders and in the air. The aide said, I don't have time for that, that was unnecessary, all of it, and walks out of the room. The aide came back in the room with a brief and gloves. The aide tells the resident ,You have cameras all in this room. I am not going to do anything to hurt you or me. Resident #1 asked her, What? the aide points to the camera and says loudly, You have cameras all over this room, I am not going to do anything to hurt you or me. So cut that out. CNA A was putting on her gloves. The video showed CNA A used gestures with lot of neck rolling back and forth, hand shaking, and shoulder jerking gestures as she gave her speech. The aide pulled Resident #1's legs apart and continued to do what she was doing as Resident #1 was saying, Please don't do that. CNA A told Resident #1, I am checking to see if you are wet. In a loud voice. CNA A put the brief on the table. Resident #1 asked, What is your name. The aide told her name. Resident # 1 asked, Why did you come in here and act that way? CNA A said, I did not come in here and act no way. I came in here to put you in the bed, and you started. She raised Resident #1's head up and told her to stretch her legs out, and the resident did so. The aide told her, You was doing all that hollering and screaming for no reason. Then she put a pillow behind the resident's head and then two. The resident said that was too many. The aide took one pillow out, rolled her bedside table over the bed. Walked out and turned off the light. Total time of the video 3 minutes and 4 seconds. During an interview on 4/3/24 at 1:15 p.m. in Resident #1's room the family member of Resident#1 said she was very upset by the things she saw on the video regarding CNA A and the treatment of Resident #1. She said she had brought that video to the attention of the facility staff and the aide was let go. During that interview Resident #1 said she remembered the incident and did not want to talk about it at all. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/5/24 at 11:07 a.m. the ADON said she saw the video regarding Resident #1. She said when CNA A walked in the room she was agitated, a little upset, and was working that hall by herself. The ADON said Resident #1 asked her if she was going to go and get help to transfer her. She said CNA A told her no. The ADON said Resident #1 wanted two people to transfer her but did not require two. She said Resident #1 told CNA A she needed go and get someone else because she did not want to fall. The ADON said CNA A told Resident #1 she had transferred her alone before. She said the aide proceeded to put Resident #1 on the bed without help and without incident. The ADON said when CNA A laid Resident #1 down there was no pillow, and she looked uncomfortable. She said CNA A left the room and came back. She said then CNA A put the pillow under Resident #1's head. The DON said it was not so much what the aide said to the resident, it was her tone of voice and her agitation. She said CNA A was in a disagreement with the resident and did not use a pleasant voice. The ADON said she had never seen any behaviors like that from CNA A before. She said during the incident CNA A told Resident #1 there was a camera in the room, so she was aware it was there. The ADON said when the family member talked to her initially there was no mention of abuse. The ADON said the family member said CNA A was rough and condescending. She said on the next day when the family member came back, the family member told the former DON it was abuse. During an interview on 4/5/24 at 11:40 a.m. Administrator said she watched the video and did substantiate abuse regarding Resident #1. She said in her opinion the CNA was disparaging or offensive. She did not have a statement from CNA A. The Administrator said she took everything to the QA committee and spoke to the Medical Director regarding the abuse. She said she also completed in services on abuse and the resident's right to refuse. During an interview on 4/5/24 at 12:08 p.m. the RNC said she had watched the video regarding Resident #1 and it was abuse. She said they had in serviced staff to make sure if a resident said no then the staff were to honor their request and leave them alone. Record review of the facility Abuse policy dated April 2021 indicated Abuse of any kind against residents was strictly prohibited. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Physical abuse includes, but is not limited to hitting, slapping, biting, punching, or kicking. Corporal (physical) punishment used to control behavior is recognized as a form of abuse. Record review of the facility Quality Assurance Performance Improvement Committee Meeting dated 3/21/24 indicated during the meeting they spoke of abuse involving an agency staff, and on in service of staff when a resident says no they mean no. They spoke of resident rights and monitoring. All staff agreed to Inservice staff on Resident Rights and Reporting abuse. The form was signed by department heads and the Medical Director. Record review of the facility Provider investigation report dated 3/18/24 had the attached in services that indicated staff were in serviced on resident rights to refuse care, right to refuse medications, baths, eating, changing brief, and incontinent care. The in service indicated if a resident said no then walk away and get the nurse. Encouraging and coaxing the resident was acceptable to the point the resident said no. Do not argue with the resident. Also, an in service on abuse that indicated timely reporting of abuse, when to report, and who to report to. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews were conducted with facility staff regarding in services on abuse neglect and resident rights of when a resident says no it means on 4/5/24 between 12:56 p.m. through 1:45 p.m. with 8 CNAs and 4 LVNs. The staff interviewed were: At 12:56 p.m. CNA F At 12:59 p.m. CNA L At 1:10 p.m. LVN J At 1:04 p.m. CNA H At 1:07 p.m. CNA N At 1:17 p.m. LVN C At 1:23 p.m. CNA E At 1:27 p.m. LVN K At 1:34 p.m. CNA G At 1:32 p.m. LVN M At 1:38 p.m. CNA I At 1:45 p.m. CNA O Interviews indicated theses facility staff were knowledgeable about the facility abuse policy. They said they were in serviced on resident rights and when a resident said no that means do not force the resident to do something they did not want to do. They were also familiar with abuse, reporting in a timely manner, and who to report abuse to. The noncompliance was identified as PNC. The IJ began on 3/11/24 and ended on 3/21/24. The facility had corrected the noncompliance before the survey began.

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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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19401 Based on interview and record review the facility failed to implement an admission policy and did not disclose to a resident notice of special service limitations prior to admission for 1 of 3 residents reviewed for admission (Resident #2) Resident #2 was admitted to the facility and did not meet the facility admission criteria due to being a registered sex offender. This negative finding could have placed residents and family member at risk for possible abuse. Findings Included: Record review of Resident # 2's face sheet with no date indicated he was an [AGE] year-old male admitted to the facility on [DATE]. Some of his diagnoses were dementia, unsteadiness on feet, repeated falls, adult failure to thrive, depression with anxiety, and Parkinson's disease (disorder of the central nervous system that affects movements, often including tremors). The sheet indicated the resident was discharged from the facility on 4/1/24. Record review of Resident #2's Brief Interview for Mental Status Review indicated he had severe cognitive impairment. Record review of Resident #2's Care Plan dated 3/28/24 reflected he had Problems of Pressure Ulcer and DNR status only. Record review of Resident #2's nursing notes indicated: On 4/1/24 at 3:35 p.m. Resident #2 was being discharged home with all medications and belongings due to the resident not meeting criteria of the facility. The family will arrive and will transport the resident home. Signed by ADON. During an interview on 4/2/24 at 11:24 a.m. the family member said the facility admitted Resident #2 on 3/26/24. She said during the admission process she told the Director of Admissions that Resident #2 was a sex offender. She said she gave him the card of the person who he reported to. The family member said the Director said that was fine and she did not think anything of it. The family member said she went to visit Resident #2 on 4/1/24 and while she was there, they did not say anything about discharge. Then later they called to say because he was a sex offender he could not be in the facility. The family member said they gave them no warning at all just come and get him. She said the first plan was they were going to send him to the behavior hospital and the family was there waiting on him. Then they called back and said no they had to come and get him. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675142	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcliff Health Center	3403 S Vine Ave Tyler, TX 75701

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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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/24 at 2:32 p.m. the Director of Admissions said Resident #2 was admitted under false pretenses. He said the family put him and the facility in bad situation. The Director of Admissions said the family did not inform him Resident #2 was a sex offender. The older family member said she told him Resident #2 was a sex offender, but she had not. He said if she had done so the resident would never have been admitted . He said they often have families in the facility with their children. He said having a registered sex offender in the building put residents, families, and children at risk. He said according to their admission handbook and policy they could not admit a sex offender. The Director of Admissions said Resident #2 was having major behaviors, and he was only at the facility for a few days. He said the family member was visiting and she let everyone know that Resident #2 was a sex offender. The Director of Admissions said Resident #2 did not want to stay at the facility. During an interview on 4/2/24 at 3:55 p.m. the Administrator said the facility Admission Policy said they could not admit a sex offender. Resident #2 was admitted , and they did not know. On Monday 4/1/24 Resident #2's family member was at the nurse's station broadcasting that he was a sex offender. She said at that point she turned the discharge over to the Director of Admissions because he had admitted him. The Administrator said as far as she knew Resident #2 went home with family. During an interview on 4/3/24 at 7:46 a.m. the ADON said Resident #2 was admitted from home on 3/26/24. She said basically they found out Resident #2 was a sex offender and he had to go. He should not have been admitted in the first place. During an interview on 4/3/24 at 9:35 a.m. LVN C said on 4/1/24 the family member came to the facility and was at the nurses station talking about Resident #2 being a sex offender. She had gone to the Administrator and reported what the family said about Resident #2 being a sex offender. During an interview on 4/3/24 at 9:56 a.m. the RNC said she was at the nurse's station talking to Resident #2's family member when they said out of the blue, he was a registered sex offender. She said she told the Administrator, and she took it from there. She said to her knowledge no one knew. The RNC said the Director of Admissions said no one told him. She said it was in their admission policy they could not admit a sex offender. During an interview on 4/3/24 at 10:07 a.m. the Administrator said she was informed the family was at the nurse's station saying Resident#2 was a sex offender. She said when she questioned the Director of Admissions, he did not know Resident #2 was a sex offender. She said she in serviced the Admissions Director about their policy of not admitting residents with that type of background. She said there was a school less than mile away. She said residents were supposed to be checked prior to admission. She just knew their policy said they did not admit them. She said the RNC agreed per their policy they are not able to have him in the facility. She said she had turned the discharge over to the Director of Admissions because he had admitted him. Record review of an in-service training dated 4/1/24 over the Admissions Process of which to admit, how to admit and the Admission Policy. The in service indicated to check each resident on the website prior to admission. It was signed by the Director of Admissions. (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility Preadmission/Admission Criteria dated October 2017 indicated the facility will not accept those high-risk diagnostic category residents who have abusive behavior towards themselves and others. Those resident categories may include but are not limed to Registered Sex Offender.

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F 0624 Level of Harm - Actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19401 Based on interview and record review the facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility for 1 of 3 residents reviewed for transfer/discharge. (Resident #2) The family of Resident #2 were told to come and get him without any prior notification or discharge planning for a safe and smooth discharge. The family of Resident #2 were told the resident would be admitted to the behavioral hospital for behavior issues and then transferred to another facility but instead spent about 24 hours in the ER. These negative findings could cause a resident to have no safe and comfortable place for discharge. Findings included: Record review of Resident # 2's face sheet indicated he was an [AGE] year-old male admitted to the facility on [DATE]. Some of his diagnoses were dementia, unsteadiness on feet, repeated falls, adult failure to thrive, depression with anxiety, and Parkinson's disease (disorder of the central nervous system that affects movements, often including tremors). The sheet indicated the resident was discharged from the facility on 4/1/24. Record review of Resident #2's Brief interview for Mental Status Review indicated he had severe cognitive impairment. Record review of Resident #2's Care Plan dated 3/28/24 reflected he had Problems of Pressure Ulcer and DNR status only. Record review of Resident #2's nursing notes indicated: On 4/1/24 at 1:02 p.m. received a new order to start mechanical soft diet. On 4/1/24 at 3:35 p.m. Resident #2 was being discharged home with all medications and belongings due to the resident not meeting criteria of the facility. The family will arrive and will transport the resident home. Signed by ADON (continued on next page)

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F 0624 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/2/24 at 11:24 a.m. the family member said the facility admitted Resident #2 on 3/26/24. She said during the admission process she told the Director of Admissions that Resident #2 was a sex offender. She said she gave him the card of the person who he reported to. The family member said the Director said that was fine and she did not think anything of it. The family member said she went to visit Resident #2 on 4/1/24 and they told her of the behaviors he had over the weekend urinating and defecating on the roommate and the roommate's things. She said while she was there, they did not say anything about discharge. Then later they called to say because he was a sex offender he could not be in the facility. The family member said they gave them no warning at all just come and get him. She said the first plan was they were going to send him to the behavior hospital and the family was there waiting on him. Then they called back and said no the family had to come and get him. She said she knew once they went to get him the facility would no longer be responsible for finding him a place to transfer. She said they were told they had all his belonging and medications ready for his discharge. She said the other family member went to get him. The Director of Admissions had told them everything was set up at the behavior hospital for Resident #2's admission. She said however when they got there, the hospital said they knew nothing about Resident #2 coming and would not admit him. He had been in the ER since yesterday with no place to go. During an interview on 4/2/24 at 2:32 p.m. the Director of Admissions said Resident #2 was admitted under false pretenses. He said the family put him and the facility in bad situation. the Director of Admissions said the family did not inform him Resident #2 was a registered sex offender. The older family member said she told him Resident #2 was a sex offender, but she had not. He said if she had done so the resident would never have been admitted . He said according to their admission handbook and policy they could not admit a sex offender. He said it puts their residents and family members at risk, especially if small children accompany the family. The Director of Admissions said Resident #2 had major behaviors, and he was only at the facility for a few days. He said on Resident #2's second night, he urinated on a man while he was in the bed and defecated in his shoe. The Director of Admissions said that happened on 3/31/24 and Resident #2 was discharged the next day. He said the family member was visiting and she let everyone know that Resident #2 was a sex offender. The Director of Admissions said Resident #2 did not want to stay at the facility. He said he helped the family with discharge by contacting the behavior hospital for admission. He said he called the hospital and helped him get set up there. He said the family told him before Resident #2 was admitted that he had an order to be admitted to Behavioral Hospital. The discharge plan was they would take Resident #2 to the hospital and once he was stable, they could find alternative placement. During a telephone interview on 4/2/24 at 2:59 p.m. the Director of Admissions called Resident #2's younger family member. The family member said she was told all they had to do was take Resident #2 to the hospital and he would be admitted . They said he was still in the ER. That family member was very upset with the Director of Admissions. The family member said she was told Resident #2's paperwork would be at the hospital. The family said when they got to the hospital the hospital staff had no idea Resident #2 was coming. She said Resident #2 had been evaluated and he had no medical reason to be admitted to the hospital and he did not qualify for a psychiatric admission. She said even if he had qualified, they did not have a bed. She said she picked Resident #2 up at the nurse's station, with his medications and belongings. She said she was not asked to sign anything, and the only discharge plan that was voiced to her was take the resident to the behavior hospital and all would be taken care of. She said she had tried to call the Director of Admissions several times for assistance but had not received a return call. (continued on next page)

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F 0624 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/2/24 at 3:07 p.m. the Director of Admissions said he did not say anything during the call because the family member was so upset but he did call and set up the admission for Resident #2. He said he had sent the facility's initial admission paperwork that did not have anything about him being a sex offender to the hospital. During a telephone interview on 4/2/24 at 3:10 p.m. the ER Hospital RN said Resident #2 was still in ER. The RN said she was familiar with the Director of Admissions said and no one told them Resident #2 was coming to the hospital. During a telephone interview on 4/2/24 at 3:15 p.m. the hospital SW said their policy was if the family picked up a Resident from the nursing home and brought them to the hospital then the facility was not responsible for taking the resident back. She said Resident #2 was seen by the psychiatric team, and it was determined he could not be committed to the hospital but be admitted on a voluntary basis. The SW said right now they were looking for placement for the resident and had no luck thus far. During an interview on 4/2/24 at 3:55 p.m. the Administrator said the facility Admission Policy said they could not admit a sex offender. Resident #2 was admitted , and they did not know. On Monday 4/1/24 Resident #2's family member was at the nurse's station broadcasting that he was a sex offender. She said at that point she turned the discharge over to the Director of Admission's because he had admitted him. The Administrator said as far as she knew Resident #2 went home with family. During an interview on 4/3/24 at 8:55 a.m. Resident #2's family member said they took Resident#2 back home yesterday evening on 4/2/24. The family member said they had to take him. She said they did not have a bed and they were still looking for a facility to transfer to. The family member said Resident #2 showed very little emotion because of his mental status but it was difficult for him to have to get adjusted to different environments. She said it was really hard on the family because they thought he had a safe place to live and the facility had basically thrown him out. During an interview on 4/3/24 at 7:46 a.m. the ADON said Resident #2 was admitted from home on 3/26/24. She said they were told he had been aggressive with the family members at home. The ADON said during the short time he was at the facility he would not sit down; he had a very unsteady gait and frequent falls. When he was redirected, he would become agitated and was placed on an antianxiety medication as needed. She said she had received a call on the morning of 3/30/24 about 4:00 a.m. saying Resident #2 had walked to his roommate's side of the room and took off his brief, urinated in his roommate's shoes, and defecated in his chair. She said the room was cleaned by staff. She said she thought the physician was involved in the discharge but after looking at the chart she did not see a discharge order. She said basically they found out Resident #2 was a sex offender and he had to go. He should not have been admitted in the first place. During an interview on 4/3/24 at 9:56 a.m. the RNC said she was at the nurse's station talking to Resident #2's family member when they said out of the blue he was a sex offender. She said she told the Administrator, and she took it from there. She said to her knowledge no one knew. The RNC said the Director of Admissions said no one told him. (continued on next page)

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F 0624 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/3/24 at 10:07 a.m. the Administrator said during morning meeting they were looking at moving Resident #2 to another room. She said she was informed the family was at the nurse's station saying Resident#2 was a registered sex offender on 4/1/24. She said their policy said they did not admit sex offenders. She said the RNC agreed per their policy they were not able to have him in the facility. She said she had turned the discharge over to the Director of Admissions because he had admitted him. Record review of the facility discharge /Transfer Policy dated December 2018 indicated a facility must establish, maintain and implement identical policies and practices regarding transfer and discharge provision of services for all individuals regardless of payor source. The facility must include documentation in the medical record to support the indication for transfer, who is responsible to make the documentation and the requirements for information that must be conveyed to the receiving provider at the time of transfer or discharge. Facility initiated transfer or discharge was one in which did not originate through a resident's verbal or written request was not in alignment with the residents' stated goals for care preferences. The determination for the facility-initiated transfer/discharge cannot be based on solely on the resident's status at the time of transfer. When the facility-initiated transfer/discharge meets the criteria under limited conditions for transfer, the facility will ensure the conditions was fully evaluated and documented in the medical record.