STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675595	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Beaumont	2660 Brickyard Rd Beaumont, TX 77703

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 25115

36214

Based on observation, interview, and record review, the facility failed to ensure residents the right to be free from abuse for 2 of 6 residents (Residents #Unnamed & Resident #4) reviewed for abuse.

1. On 08/02/24 Resident #1 was grabbing Resident #Unnamed breasts.

2. On 08/25/24 Resident #1 touched Resident #4's breast.

On 10/05/24 at 4:40 p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 10/06/24, the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of the Plan of Removal.

These failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress.

Findings included:

1. Record review of a face sheet dated 09/23/24 indicated Resident #1 was [AGE] years old, initially admitted to facility on 03/07/24 and readmitted to facility on 09/09/24. His diagnoses included dementia (loss of cognitive functioning), delusional disorder (a mental health condition that causes unshakable beliefs in something that's untrue), hypertension (condition in which the force of the blood against the artery walls is too high), dysphagia (difficulty swallowing) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).

Record review of Resident #1's care plan with revision dated 04/24/24 indicated Resident #1 had inappropriate sexual behaviors; resident seeks to satisfy his sexual desires. Interventions included to firmly approach resident that behaviors are not acceptable and document conversations and actions of resident; inform direct caregivers on methods to assist them in handling resident behaviors while providing care; monitor whereabouts of resident and keep distance from others; provide diversional activities and redirect when behaviors happen and document.

(continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a quarterly MDS assessment dated [DATE] indicated Resident #1 was usually able to make himself understood and usually understands others. He had a BIMS of 08 (moderately impaired cognitively). He exhibited no behaviors over the 7 days look back period. He required supervision or moderate assistance for most ADLS. He was frequently incontinent of bladder and bowel. Record review of Resident #1's progress note authored by previous DON R indicated on 08/02/24 at 8:42 a. m., Resident #1 was in the dining room this morning grabbing other resident's breast when nurse tried to redirect him, he stated let me see your pussy. Nurse informed him that this kind of behavior would not be accepted. Nurse phoned MD and made him aware of situation. Received one time order for lorazepam 1 milligram IM for agitation. Record review of an unsigned 24-hour report indicated: 08/02/24 08:42 a.m. - Behavior Note Resident #1 was in the dining room this morning grabbing other resident breasts. When SN tried to redirect him, he stated, Let me see your pussy. SN informed him that this kind of behavior would not be accepted. SN phoned MD and made him aware of the situation. Received on time order for Lorazepam 1 mg IM for agitation. 08/02/24 10:21 a.m. - Social Services SSD sent referral over to behavioral unit at local hospital per DON who said to refer Resident #1 due to behavior displayed. Spoke with rep who said that he would need to be transported to the ER to be assessed. SSD said she would speak to the ADON/DON on how to proceed. 08/02/24 11:29 a.m. - Behavior Note Resident has been extremely inappropriate to staff and other residents sexually. Speaking graphically lewd and grabbing resident's breasts, then laughing and leering. Unable to redirect. DON notified. 08/02/24 12:32 a.m. - Nurses Note Resident #1 sent to hospital ER for psych evaluation due to inappropriate sexual behavior. Record Review of Resident #1's behavior monitoring log indicated on 08/02/24 Resident #1 was monitored hourly from 9:00 a.m. until 12:30 p.m. Record review of Resident #1's progress note authored by LVN Q on 08/05/24 at 12:55 p.m., indicated the behavioral hospital called to inform facility that Resident #1 did not meet criteria for extended stay and the unit was full. Resident #1 would be transferred back to the facility (on 08/05/24). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's psychiatric assessment note dated 08/05/24 and completed by NP AA indicated Resident #1 was seen for a hospital follow up visit for exhibiting anxiety symptoms and hypersexual behaviors toward female peers and staff. Psych treatment plan included to start Resident #1 on Rivastigmine (used for the treatment of mild to moderate Alzheimer's disease) 1.5 mg daily for inappropriate sexual behaviors in dementia, utilize behavioral interventions to manage episodic behaviors, redirect as needed and provide support and encouragement to increase positive interactions and socialization, and follow up in 4 weeks or as needed. Record review of Resident #1's progress note authored by LVN Q on 08/07/24 at 7:10 a.m. indicated Resident #1 continued to speak sexually inappropriately to staff. Resident #1 appeared exhausted, and shower was given to calm resident. Record review of Resident #1's behavior monitoring log did not indicate Resident #1 had any increased monitoring after discharge from behavioral hospital on 08/05/24. During an observation and interview on 09/30/24 at 11:45 a.m., Resident #1 was sitting up in wheelchair in secure unit dining room. He said he did not recall the incident involving him inappropriately touching other residents that happened on 08/02/24. Resident #1 said that he knew that he was not supposed to touch or hit other residents or staff. Resident #1 was observed trying to stand up without assistance and staff intervened and redirect him by providing activities. Resident #1 was one of 6 residents in the dining room. During an interview on 09/30/24 at 1:00 p.m., the Administrator said there was no incident report for Resident #1's sexually inappropriate behaviors on 08/02/24. During an interview on 09/30/24 at 2:48 p.m., LVN Q said she was the CN on duty on 08/02/24 and vaguely recalled the incident with Resident #1 touching another female resident's breast. She said she recalled that the incident was in the dining room of the secure unit, and he touched the female's breast and was laughing and leering. He was unable to be redirected, and when removed from the area by staff he was talking sexually to staff and grabbing at their breast. She said that she notified the DON and MD. She said Resident #1 was monitored until he was transferred to a local hospital for evaluation for placement into their behavioral unit. She said she did not recall the female's name that he touched inappropriately. She said that she was in the unit covering for the CNA when the incident occurred, and it was not witnessed by other staff. During an interview on 09/30/24 at 3:30 p.m., the previous DON R said she was the active DON at the facility on 08/02/24. She recalled the incident with Resident #1 touching another female resident's breast. She said she was called to the secure unit that morning after breakfast and the CN reported that Resident #1 had touched another female resident's breast and was laughing and leering and was unable to be redirected and when removed from the area by staff he was talking sexually to staff and grabbing at their breast. She said she told the CN to keep Resident #1 on one-to-one monitoring and that she requested the SW to contact a local behavioral hospital for a transfer due to the behavior. She said that she notified all department heads (including the Administrator) during the 9:00 am morning meeting that day. She said Resident #1 was monitored until he was transferred to a local hospital for evaluation for placement into their behavioral unit. She said she did not recall the female resident's name that Resident #1 touched inappropriately. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 09/30/24 at 3:55 p.m., previous the Administrator S she said she was the active Administrator on 08/02/24. She said she was not notified of Resident #1 touching another female resident's breast on 08/02/24. She said that was considered sexual abuse. During an interview on 09/30/24 at 4:00 p.m., the ADON said she did not recall the incident with Resident #1 touching another female resident's breast on 08/02/24. She said she was aware that would be considered sexual abuse. The ADON said she notifies the Administrator/Abuse Prevention Coordinator immediately by phone/text of any allegation of abuse. The ADON said residents with behaviors were monitored and incidents were reported to the MD/NP. If MD ordered, resident would be transferred behavioral hospital for evaluation and treatment. During an interview on 10/05/24 at 9:41 a.m., CNA E said she had never observed Resident #1 touch any residents or staff inappropriately. She said she was never told he needed to be monitored closely due to inappropriate sexual touching. She said she knew he talked inappropriately to staff, and he had said many lewd comments to her. During an interview on 10/05/24 at 9:44 a.m., CNA CC said Resident #1 always talked sexually to staff and he had said some vulgar things to her, but she was never told he had sexually/inappropriately touched another resident. 2. Record review of a face sheet dated 10/05/24 indicated Resident #4 [AGE] years old, initially admitted to the facility 03/13/24 and readmitted on [DATE]. Her diagnosis included dementia (loss of cognitive functioning), cognitive communication deficit (a difficulty with communication caused by disruption to cognition, or brain processes like attention, memory, and Problem solving), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #4 was usually understood and sometimes understands others. She had a BIMS of 08 (moderately impaired cognitively). She exhibited no behaviors over the 7 days look back period. She required moderate assistance for most ADLS. She was always incontinent of bladder and frequently incontinent of bowel. Record review of a care plan last revised 07/19/24 for Resident #4 did not indicate she had been touched inappropriately on 08/25/24. Record review of an incident report dated 08/25/24 at 7:45 a.m. and signed by RN U indicated CNA heard Resident #4 yell, let go of my titty. CNA saw Resident #1 grabbing Resident #4's breast and reported the incident to her. Record review of an incident report dated 08/25/24 at 11:18 a.m. and signed by RN U indicated CNA reported to her that she saw Resident #1 touch a female resident on her breast. Residents were separated. Calls placed to notify ADON, NP, and RN T (previous Abuse Coordinator) and resident's FM UU. Resident #1 was on every 30-minute monitoring. Record review of a behavior monitoring log indicated Resident #1 was monitored hourly from 08/25/24 at 8:00 a.m. to 08/27/24 at 10:00 p.m. There was no documentation of further monitoring. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a progress note dated 08/28/24 at 9:22 a.m. authored by previous MDS Coordinator DD indicated call placed to responsible party of Resident #1 to inform that Resident #1 has been having changes in behavior, both inappropriate sexual behaviors and aggressive behavior. Resident has been accepted to a behavioral hospital. RP said OK, thank you. Record review of a progress note dated 08/28/24 at 10:33 a.m. authored by the ADON indicated Resident #1 left facility with transportation company in route to behavioral hospital. During an interview on 09/25/24 at 10:21 a.m. RN T said she was made aware of the incident between Resident #1 and Resident #4. She said staff reported to her (the acting abuse coordinator) Resident #1 and Resident #4 were sitting at a dining table on the secure unit. Staff reported Resident #4 said Resident #1 grabbed her. Resident #1 denied he grabbed Resident #4's breast. She said both residents had low BIMS scores and there was no willful intent. During an interview on 09/25/24 at 12:15 p.m., CNA BB said she was getting all the residents into the dining room for the breakfast meal. She said it looked like Resident #1 was touching Resident #4's breast and then he reached for the coloring book and crayons that was on the dining table. She said she told Resident #1 he did not need to be so close to the ladies and he moved away. She said she advised RN U of the incident. She said RN U called the abuse coordinator. She said Resident #4 did not say anything. She said Resident #1 said he did not touch Resident #4's breast. He said he was reaching for the crayons. During an interview on 9/27/2024 at 4:00 pm, RN U said that on 8/25/2024 a CNA reported to her that Resident #1 touched a female resident on her breast. RN U said Resident #1 was separated from the female resident, assessed and behavioral monitoring initiated. RN U said she reported the incident to the ADON, NP/MD, AC (RN T) and RP. RN U said that Resident #1 was placed on behavioral monitoring for the incident until the AC (RN T) completed an abuse investigation. RN U said that there were 2 CNAs working the secure unit on 8/25/2024 to provide behavioral monitoring for the incident until the AC (RN T) completed an abuse investigation. RN U said if residents had behaviors that facility staff notify the NP/MD and place the residents on behavioral monitoring, depending on the MD orders and/or severity of the behavior's resident may be sent out to behavioral hospital for evaluation and treatment. She said Resident #1 was monitored q15 minutes. During an observation and interview on 10/05/24 at 9:39 a.m., Resident #4 was sitting in her wheelchair in the dining room of the secure unit. She was appropriately dressed and well-groomed. She was unable to answer questions about the incident and just repeated words spoken to her. During an interview on 10/05/24 at 3:55 p.m., the Administrator said that she was not the active Administrator/Abuse Coordinator at the time of the incidents with Resident #1 touching another female resident's breast on 08/02/24 or on 08/25/24 when Resident #1 touched Resident #4's breast. She said her expectation for incidents involving resident to resident abuse was for the residents to be separated and the aggressor to be placed on one-on-one monitoring for the protection of other residents. She said her expectation was care plans be updated when incidents occur, but the current MDS nurse worked remotely and might not have been aware of the incidents. She said the possible negative outcome of not protecting the residents could be physical, emotional, or psychological harm of the residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the undated facility's Abuse and Neglect policy indicated .It is the policy of the facility to administer care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation. III. Prevention: Have procedures to: provide residents, families, and staff information on how and to whom they may report concerns, incidents and grievances without fear of retribution; and provide feedback regarding the concerns that have been expressed. Identify, correct and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur. Establish a safe environment that supports consensual sexual relationship. Develop and implement policy on abuse, neglect, theft, exploitation, and misappropriation of property. Deployment of sufficient and trained staff to deal with behaviors in the units. Identification, assessment, care planning for intervention, and monitoring of residents with needs and behaviors that might lead to conflicts or neglect. The supervisions of staff to identify inappropriate behaviors . ensuring health and safety of residents .VI. Protect residents from physical and psychosocial harm during investigations. 1. If the allegation of abuse involves 2 or more residents, they will all be immediately separated for the protection of all residents involved and those potentially affected by the abuse. 2. Affected residents will be assessed for injury. 3. Attending physician will be notified. a. This includes but not limited to full assessment of physical and psychosocial well-being; sending resident to hospital if needed; depending on circumstance, keep resident on 1:1, assign a female/male depending on the accusation/allegation. This was determined to be an Immediate Jeopardy (IJ) on 10/05/24 at 4:40 p.m. The Administrator was notified. The Administrator was provided the IJ template on 10/05/24 at 4:45 p.m. The Facility's Plan of Removal for Immediate Jeopardy was accepted on 10/06/24 at 1:50 p.m. and reflected the following: Action: On 10/05/24 R1 was immediately placed on q 15-minute checks for close monitoring for further behaviors. R1 will remain on q 15-minute checks until IDT team meets in 30 days and reevaluate his behaviors for medical adjustment and determine if R1 will remain on q 15-minute checks or can be discontinued. If Res #1 has additional behaviors, he will be placed one-on-one until psychiatric services can reevaluate his behaviors. Res #1 was placed on q 15 minutes checks due to the recurrent behaviors that require closer monitoring. Charge nurse/nurse managers Immediately assessed R2 and the rest of the residents in the secure unit for possible mental, physical, or sexual abuse, no additional mental health needs were identified, nor any suspected physical abuse found at this time. 0 out of 10 residents were affected. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administrator/abuse coordinator Immediately reeducated all staff 100% completion on Abuse & Neglect policy for types of abuse (physical, sexual, mental, verbal, neglect, exploitation, and misappropriation) through verbal in-service and written test. Staff were also reeducated for the identification, and intervention in a situation in which abuse, neglect, exploitation and/or misappropriation of resident property is more likely to occur. This education included protecting and/or removing the resident from the situation, as well as who the abuse coordinator is, when to report, and how to report abuse. Staff were reeducated to stay with the aggressor one-on-one until further instruction from the abuse coordinator and/or until the evaluation or further intervention. on 10/05/24 the Administrator, reeducated 100% of staff on behavioral management policy which included resident to resident abuse in regard to residents exhibiting sexual behaviors towards other and steps to do and approach the situation. Reeducation was provided for the staff with instructions for proper documentation for the behavior monitoring log through verbal in-service with monitoring log attached. Staff were reeducated through verbal in-servicing, tests, and questionnaires. On 10/05/24 MDS nurse immediately reviewed and updated care plan to reflect sexually inappropriate behaviors. The MDS nurse will review all incident reports related to sexual behaviors to make sure interventions were in place, for the floor staff to be able to see in electronic health record (EHC). Administrator/and or designee will reeducate floor staff to review Kardex in PCC (EHC) for updated interventions for each resident. On 10/06/24 at 11:48 a.m., the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: During interviews conducted on 10/06/24 from 11:05 a.m. though 3:48 p.m. included LVN EE 6:00 a.m. - 6:00 p.m. weekends, LVN FF (6:00 a.m. to 6:00 p.m.) weekends, LVN B (6:00 a.m. 2:00 p.m.), LVN GG (2:00 p.m. to 10:00 p.m.), LVN HH (10:00 p.m. to 6:00 a.m.), LVN X (10:00 p.m. to 6:00 a.m.), MA J (6:00 a.m. to 2:00 p.m & 2:00 p.m. to 10:00 p.m., CNA CC (6:00 a.m. to 2:00 p.m.), CNA E (6:00 a.m. to 2:00 p.m.), CNA JJ (6:00 a.m. to 2:00 p.m.), CNA KK (6:00 a.m. to 2:00 p.m.), CNA LL (6:00 a.m. to 2:00 p.m.), CNA D (2:00 p.m. to 10:00 p.m.), CNA MM (2:00 p.m. to 10:00 p.m.), CNA NN (10:00 p.m. to 6:00 a.m.), and CNA OO (10:00 p.m. to 6:00 a.m.), CNA PP (10:00 p.m. to 6:00 a.m.), Dietary Aide QQ, Housekeeper RR, Occupational Therapist SS, Staffing LVN TT and ADON who worked all shifts. Staff were able to identify the Abuse Coordinator as the administrator. Staff indicated they were to report allegations of abuse and neglect immediately to the Administrator and were able to give examples of physical, verbal, sexual abuse and immediate intervention procedures. They were able to state immediate actions to take when an allegation was made and/or identified, such as immediately removing residents from the situation and stay with the aggressor one-on one until further instruction from the Abuse Coordinator. They verbalized proper documentation of behavior monitoring logs. CNA CC and CNA E said they were now aware of Resident #1's sexual behaviors and the resident was to be monitored q15 minutes. They said they documented every 15 minutes on Resident #1's behavior monitoring log. CNA CC and CNA E said they were in-serviced on abuse/neglect and gave examples of physical, verbal, and sexual abuse. They said the Administrator was the Abuse Coordinator and they would immediately report any abuse/neglect allegations to the Administrator. CNA CC and CNA E gave examples of immediate interventions they would take when an allegation or made incuding removing residents from the situation and staying with the aggressor one on one until the Administrator was notifed and gave further instruction. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 10/06/24 at 3:55 p.m., the Administrator said she had conducted in-services with all staff addressing the facility abuse/neglect policy and initiating one-on-one monitoring with the aggressor until they were given further instructions on monitoring. She had addressed the different types of abuse and staff had passed a written test. She said she instructed staff on documentation in behavior monitoring logs. She in-serviced staff on the facility's behavioral management policy which included resident abuse. She said staff were required to pass behavioral management test. She said Resident #1's care plan had been updated and a q15 minute monitoring was required by staff until the IDT meeting in 30 days to re-evaluate his behaviors. During an observation and interview on 10/06/24 at 1:15 p.m., Resident #1 was in the TV room with CNA E with no sexual behaviors noted. CNA E said she was assigned to monitor Resident #1 because he was being monitored q15 minutes for sexual behaviors and she was observed documenting the checks on his behavioral monitoring log. Record review of behavioral monitoring logs for Resident #1 indicated he was being monitored by staff every 15 minutes beginning on 10/05/24 at 6:00 p.m. to monitor for sexually inappropriate behaviors. Record review of a check off list of secured unit residents indicated all residents on the secure unit were assessed by charge nurses and the ADON. Record review of nursing assessments completed by the ADON and charge nurses for Resident #4 and all other secure unit residents indicated all residents were assessed for physical and psychosocial changes on 10/05/24. There was no evidence of sexual abuse noted on the assessments. Record review of Resident #1's care plan indicated it was updated on 10/05/24 and included he exhibiting unwanted sexual behaviors with interventions of referral to psychiatric services and increased monitoring for behaviors and changes in mental status. Record review of Resident #4's care plan indicated it was updated on 10/05/24. Record review of facility incident/accident reports indicated no other incidents of inappropriate sexual behaviors. Record review of quiz results, dated 10/05/24 and 10/06/24, indicated all staff passed the quiz regarding abuse, neglect, reporting, and one-on-one monitoring. Record review of a list of all facility staff used for tracking the required in-service training on abuse/neglect, behavioral monitoring, and behavioral management indicated all facility staff had received the in-service training in person or by phone. The Administrator was informed the IJ was removed on 10/06/24 at 3:58 p.m. The facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put in place.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 36214 Based on observation, interview and record review the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 2 of 6 residents (Resident #4 and Resident #Unnamed) reviewed for abuse and neglect. 1. The facility failed to implement their written policies and procedures to prevent sexual abuse and potential further sexual abuse by Resident #1 when Resident #1 grabbed Resident #Unnamed's breast. 2. The facility failed to implement their written policies and procedures to prevent sexual abuse and potential further sexual abuse by Resident #1 when Resident #1 touched Resident #4's breast. On 10/05/24 at 4:40 p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 10/06/24, the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of the Plan of Removal. These failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings include: 1. Record review of a face sheet dated 09/23/24 indicated Resident #1 was [AGE] years old, initially admitted to facility on 03/07/24 and readmitted to facility on 09/09/24. His diagnoses included dementia (loss of cognitive functioning), delusional disorder (a mental health condition that causes unshakable beliefs in something that's untrue), hypertension (condition in which the force of the blood against the artery walls is too high), dysphagia (difficulty swallowing) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #1's care plan with revision dated 04/24/24 indicated Resident #1 had inappropriate sexual behaviors; resident seeks to satisfy his sexual desires. Interventions included to firmly approach resident that behaviors are not acceptable and document conversations and actions of resident; inform direct caregivers on methods to assist them in handling resident behaviors while providing care; monitor whereabouts of resident and keep distance from others; provide diversional activities and redirect when behaviors happen and document. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #1 was usually able to make himself understood and usually understands others. He had a BIMS of 08 (moderately impaired cognitively). He exhibited no behaviors over the 7 days look back period. He required supervision or moderate assistance for most ADLS. He was frequently incontinent of bladder and bowel. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675595	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/06/2024
NAME OF PROVIDER OR SUPPLIER: Harmony Care at Beaumont		STREET ADDRESS, CITY, STATE, ZIP CODE: 2660 Brickyard Rd Beaumont, TX 77703	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's progress note authored by previous DON R indicated on 08/02/24 at 8:42 a.m., Resident #1 was in the dining room this morning grabbing other resident's breast when nurse tried to redirect him, he stated let me see your P---. Nurse informed him that this kind of behavior would not be accepted. Nurse phoned MD and made him aware of situation. Received one time order for lorazepam 1 milligram IM for agitation. Record review of an unsigned 24-hour report indicated: 08/02/24 08:42 a.m. - Behavior Note Resident #1 was in the dining room this morning grabbing other resident breasts. When SN tried to redirect him, he stated, Let me see your pussy. SN informed him that this kind of behavior would not be accepted. SN phoned MD and made him aware of the situation. Received on time order for Lorazepam 1 mg IM for agitation. 08/02/24 10:21 a.m. - Social Services SSD sent referral over to behavioral unit at local hospital per DON who said to refer Resident #1 due to behavior displayed. Spoke with rep who said that he would need to be transported to the ER to be assessed. SSD said she would speak to the ADON/DON on how to proceed. 08/02/24 11:29 a.m. - Behavior Note Resident has been extremely inappropriate to staff and other residents sexually. Speaking graphically lewd and grabbing resident's breasts, then laughing and leering. Unable to redirect. DON notified. 08/02/24 12:32 a.m. - Nurses Note Resident #1 sent to hospital ER for psych evaluation due to inappropriate sexual behavior. Record Review of Resident #1's behavior monitoring log indicated on 08/02/24 Resident #1 was monitored hourly from 9:00 a.m. until 12:30 p.m. Record review of Resident #1's progress note authored by LVN Q on 08/05/24 at 12:55 p.m., indicated the behavioral hospital called to inform facility that Resident #1 did not meet criteria for extended stay and the unit was full. Resident #1 would be transferred back to the facility (on 08/05/24). Record review of Resident #1's behavior monitoring log did not indicate Resident #1 had any increased monitoring after discharge from behavioral hospital on 08/05/24. During an observation and interview on 09/30/24 at 11:45 a.m., Resident #1 was sitting up in wheelchair in secure unit dining room. He said he did not recall the incident involving him inappropriately touching other residents that happened on 08/02/24. Resident #1 said that he knew that he was not supposed to touch or hit other residents or staff. Resident #1 was observed trying to stand up without assistance and staff intervened and redirect him by providing activities. Resident #1 was one of 6 residents in the dining room. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 09/30/24 at 2:48 p.m., LVN Q said she was the CN on duty on 08/02/24 and vaguely recalled the incident with Resident #1 touching another female resident's breast. She said she recalled that the incident was in the dining room of the secure unit, and he touched the female's breast and was laughing and leering. He was unable to be redirected, and when removed from the area by staff he was talking sexually to staff and grabbing at their breast. She said that she notified the DON and MD. She said Resident #1 was monitored until he was transferred to a local hospital for evaluation for placement into their behavioral unit. She said she did not recall the female's name that he touched inappropriately. She said that she was in the unit covering for the CNA when the incident occurred, and it was not witnessed by other staff. During an interview on 09/30/24 at 3:30 p.m., the previous DON R said she was the active DON at the facility on 08/02/24. She recalled the incident with Resident #1 touching another female resident's breast. She said she was called to the secure unit that morning after breakfast and the CN reported that Resident #1 had touched another female resident's breast and was laughing and leering and was unable to be redirected and when removed from the area by staff he was talking sexually to staff and grabbing at their breast. She said she told the CN to keep Resident #1 on one-on-one monitoring and that she requested the SW to contact a local behavioral hospital for a transfer due to the behavior. She said that she notified all department heads (including the Administrator) during the 9:00 am morning meeting that day. She said Resident #1 was monitored until he was transferred to a local hospital for evaluation for placement into their behavioral unit. She said she did not recall the female resident's name that Resident #1 touched inappropriately. During an observation on 10/05/24 at 9:35 a.m., Resident #1 was in his wheelchair alone in the hallway of the secure unit. During an observation and interview on 10/05/24 at 9:41 a.m., CNA E was in the dining room of the secure unit with 5 residents. She said she had never observed Resident #1 touch any residents or staff inappropriately. She said she was never told he needed to be monitored closely due to inappropriate sexual touching. During an observation and interview on 10/05/24 at 9:44 a.m., CNA CC was in the dining room of the secure unit with 5 residents. She said Resident #1 always talked sexually to staff and he had said some vulgar things to her, but she was never told he had sexually/inappropriately touched another resident or to monitor him closely. 2. Record review of a face sheet dated 10/05/24 indicated Resident #4 [AGE] years old, initially admitted to the facility 03/13/24 and readmitted on [DATE]. Her diagnosis included dementia (loss of cognitive functioning), cognitive communication deficit (a difficulty with communication caused by disruption to cognition, or brain processes like attention, memory, and Problem solving), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #4 was usually understood and sometimes understands others. She had a BIMS of 08 (moderately impaired cognitively). She exhibited no behaviors over the 7 days look back period. She required moderate assistance for most ADLS. She was always incontinent of bladder and frequently incontinent of bowel. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a care plan last revised 07/19/24 for Resident #4 did not indicate she had been touched inappropriately on 08/25/24. Record review of an incident report dated 08/25/24 at 7:45 a.m. and signed by RN U indicated CNA heard Resident #4 yell, let go of my titty. CNA saw Resident #1 grabbing Resident #4's breast and reported the incident to her. Record review of an incident report dated 08/25/24 at 11:18 a.m. and signed by RN U indicated CNA reported to her that she saw Resident #1 touch a female resident on her breast. Residents were separated. Calls placed to notify ADON, NP, and RN T (previous Abuse Coordinator) and resident's FM UU. Resident #1 was on every 30-minute monitoring. Record review of a behavior monitoring log indicated Resident #1 was monitored hourly from 08/25/24 at 8:00 a.m. to 08/27/24 at 10:00 p.m. There was no documentation of further monitoring. Record review of a progress note dated 08/28/24 at 9:22 a.m. authored by previous MDS Coordinator DD indicated call placed to responsible party of Resident #1 to inform that resident has been having changes in behavior, both inappropriate sexual behaviors and aggressive behavior. Resident has been accepted to a behavioral hospital. Record review of a Behavior Monitor Post an Incident in-service dated 8/28/24 indicated, Immediately after an incident involving resident with physical, verbal, or sexual aggression, the CN will place the resident on monitoring checks, and fill out the from q 1 hr, q 30 min, q 15 min. Call provider and supervisor to notify them of incident. They will continue monitoring checks until the IDT can review the incident and place further interventions. During an interview on 09/25/24 at 10:21 a.m. RN T said she was made aware of the incident between Resident #1 and Resident #4. She said staff reported to her (the acting abuse coordinator) Resident #1 and Resident #4 were sitting at a dining table on the secure unit. Staff reported Resident #4 said Resident #1 grabbed her. Resident #1 denied he grabbed Resident #4's breast. She said both residents had low BIMS scores and there was no willful intent. During an interview on 09/25/24 at 12:15 p.m., CNA BB said she was getting all the residents into the dining room for the breakfast meal. She said it looked like Resident #1 was touching Resident #4's breast and then he reached for the coloring book and crayons that was on the dining table. She said she told Resident #1 he did not need to be so close to the ladies and he moved away. She said she advised RN U of the incident. She said RN U called the abuse coordinator. She said Resident #4 did not say anything. She said Resident #1 said he did not touch Resident #4's breast. He said he was reaching for the crayons. During an interview on 9/27/2024 at 4:00 pm, RN U said that on 8/25/2024 a CNA reported to her that Resident #1 touched a female resident on her breast. RN U said Resident #1 was separated from the female resident, assessed and behavioral monitoring initiated. RN U said she reported the incident to the ADON, NP/MD, AC (RN T) and RP. RN U said that Resident #1 was placed on behavioral monitoring for the incident until the AC (RN T) completed an abuse investigation. RN U said that there were 2 CNAs working the secure unit on 8/25/2024 to provide behavioral monitoring for Resident #1, but one-on-one monitoring was not initiated. She said Resident #1 was monitored q15 minutes. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on 10/05/24 at 9:39 a.m., Resident #4 was sitting in her wheelchair in the dining room of the secure unit. She was appropriately dressed and well-groomed. She was unable to answer questions about the incident and just repeated words spoken to her. During an interview on 10/05/24 at 3:55 p.m., the Administrator said that she was not the active Administrator/Abuse Coordinator at the time of the incidents with Resident #1 touching another female resident's breast on 08/02/24 or on 08/25/24 when Resident #1 touched Resident #4's breast. She said her expectation for incidents involving resident to resident abuse was for the residents to be separated and the aggressor to be placed on one-on-one monitoring for the protection of other residents. She said the facility policy on abuse and neglect addressed protecting residents from harm during the investigation of the incident and placing the resident on one-on-one monitoring. She said the facility abuse policy was not followed for the incidents involving Resident #1. She said the possible negative outcome of not performing one-on-one monitoring of the resident and protecting the other residents could be physical, emotional, or psychological harm of the residents. She said her expectation was care plans be updated when incidents occur, but the current MDS nurse worked remotely and might not have been aware of the incidents. Record review of the undated facility's Abuse and Neglect policy indicated .It is the policy of the facility to administer care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation. III. Prevention: Have procedures to: provide residents, families, and staff information on how and to whom they may report concerns, incidents and grievances without fear of retribution; and provide feedback regarding the concerns that have been expressed. Identify, correct and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur. Establish a safe environment that supports consensual sexual relationship. Develop and implement policy on abuse, neglect, theft, exploitation, and misappropriation of property. Deployment of sufficient and trained staff to deal with behaviors in the units. Identification, assessment, care planning for intervention, and monitoring of residents with needs and behaviors that might lead to conflicts or neglect. The supervisions of staff to identify inappropriate behaviors . ensuring health and safety of residents .VI. Protect residents from physical and psychosocial harm during investigations. 1. If the allegation of abuse involves 2 or more residents, they will all be immediately separated for the protection of all residents involved and those potentially affected by the abuse. 2. Affected residents will be assessed for injury. 3. Attending physician will be notified. a. This includes but not limited to full assessment of physical and psychosocial well-being; sending resident to hospital if needed; depending on circumstance, keep resident on 1:1, assign a female/male depending on the accusation/allegation. This was determined to be an Immediate Jeopardy (IJ) on 10/05/24 at 4:40 p.m. The Administrator was notified. The Administrator was provided the IJ template on 10/05/24 at 4:45 p.m. The Facility's Plan of Removal for Immediate Jeopardy was accepted on 10/06/24 at 1:50 p.m. and reflected the following: Action: (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/05/24 R1 was immediately placed on q 15-minute checks for close monitoring for further behaviors. R1 will remain on q 15-minute checks until IDT team meets in 30 days and reevaluate his behaviors for medical adjustment and determine if R1 will remain on q 15-minute checks or can be discontinued. If Res #1 has additional behaviors, he will be placed one-on-one until psychiatric services can reevaluate his behaviors. Res #1 was placed on q 15 minutes checks due to the recurrent behaviors that require closer monitoring. Charge nurse/nurse managers Immediately assessed R2 and the rest of the residents in the secure unit for possible mental, physical, or sexual abuse, no additional mental health needs were identified, nor any suspected physical abuse found at this time. 0 out of 10 residents were affected. Administrator/abuse coordinator Immediately in-service all staff 100% completion on Abuse & Neglect policy. for types of abuse (physical, sexual, mental, verbal, neglect, exploitation, and misappropriation) through verbal in-service and written test. Staff were also reeducated for the identification, and intervention in a situation in which abuse, neglect, exploitation and/or misappropriation of resident property is more likely to occur. This education included protecting and/or removing the resident from the situation, as well as who the abuse coordinator is, when to report, and how to report abuse. Staff were reeducated to stay with the aggressor until further instruction from the abuse coordinator and/or until the evaluation or further intervention. on 10/05/24 the Administrator, reeducated 100% of staff on behavioral management policy which included resident to resident abuse in regard to residents exhibiting sexual behaviors towards other and steps to do and approach the situation. Reeducation was provided for the staff with instructions for proper documentation for the behavior monitoring log through verbal in-service with monitoring log attached. Staff were reeducated through verbal in-servicing, tests, and questionnaires. On 10/05/24 MDS nurse immediately reviewed and updated care plan to reflect sexually inappropriate behaviors. The MDS nurse will review all incident reports related to sexual behaviors to make sure interventions were in place, for the floor staff to be able to see in electronic health record (EHC). Administrator/and or designee will reeducate floor staff to review Kardex in PCC (EHC) for updated interventions for each resident. On 10/06/24 at 11:48 a.m., the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During interviews conducted on 10/06/24 from 11:05 a.m. though 3:48 p.m. included LVN EE 6:00 a.m. - 6:00 p.m. weekends, LVN FF (6:00 a.m. to 6:00 p.m.) weekends, LVN B (6:00 a.m. 2:00 p.m.), LVN GG (2:00 p.m. to 10:00 p.m.), LVN HH (10:00 p.m. to 6:00 a.m.), LVN X (10:00 p.m. to 6:00 a.m.), MA J (6:00 a. m. to 2:00 p.m & 2:00 p.m. to 10:00 p.m., CNA CC (6:00 a.m. to 2:00 p.m.), CNA E (6:00 a.m. to 2:00 p.m.), CNA JJ (6:00 a.m. to 2:00 p.m.), CNA KK (6:00 a.m. to 2:00 p.m.), CNA LL (6:00 a.m. to 2:00 p.m.), CNA D (2:00 p.m. to 10:00 p.m.), CNA MM (2:00 p.m. to 10:00 p.m.), CNA NN (10:00 p.m. to 6:00 a.m.), and CNA OO (10:00 p.m. to 6:00 a.m.), CNA PP (10:00 p.m. to 6:00 a.m.), Dietary Aide QQ, Housekeeper RR, Occupational Therapist SS, Staffing LVN TT and ADON who worked all shifts. Staff were able to identify the Abuse Coordinator as the administrator. Staff indicated they were to report allegations of abuse and neglect immediately to the Administrator and were able to give examples of physical, verbal, sexual abuse and immediate intervention procedures. They were able to state immediate actions to take when an allegation was made and/or identified, such as immediately removing residents from the situation and stay with the aggressor one-on one until further instruction from the Abuse Coordinator. They verbalized proper documentation of behavior monitoring logs. CNA CC and CNA E said they were now aware of Resident #1's sexual behaviors and the resident was to be monitored q15 minutes. They said they documented every 15 minutes on Resident #1's behavior monitoring log. CNA CC and CNA E said they were in-serviced on abuse/neglect and gave examples of physical, verbal, and sexual abuse. They said the Administrator was the Abuse Coordinator and they would immediately report any abuse/neglect allegations to the Administrator. CNA CC and CNA E gave examples of immediate interventions they would take when an allegation or made incuding removing residents from the situation and staying with the aggressor one on one until the Administrator was notifed and gave further instruction. During an interview on 10/06/24 at 3:55 p.m., the Administrator said she had conducted in-services with all staff addressing the facility abuse/neglect policy and initiating one-on-one monitoring with the aggressor until they were given further instructions on monitoring. She had addressed the different types of abuse and staff had passed a written test. She said she instructed staff on documentation in behavior monitoring logs. She in-serviced staff on the facility's behavioral management policy which included resident abuse. She said staff were required to pass behavioral management test. She said Resident #1's care plan had been updated and a q15 minute monitoring was required by staff until the IDT meeting in 30 days to re-evaluate his behaviors. During an observation and interview on 10/06/24 at 1:15 p.m., Resident #1 was in the TV room with CNA E with no sexual behaviors noted. CNA E said she was assigned to monitor Resident #1 because he was being monitored q15 minutes for sexual behaviors and she was observed documenting the checks on his behavioral monitoring log. Record review of behavioral monitoring logs for Resident #1 indicated he was being monitored by staff every 15 minutes beginning on 10/05/24 at 6:00 p.m. to monitor for sexually inappropriate behaviors. Record review of a check off list of secured unit residents indicated all residents on the secure unit were assessed by charge nurses and the ADON. Record review of nursing assessments completed by the ADON and charge nurses for Resident #4 and all other secure unit residents indicated all residents were assessed for physical and psychosocial changes on 10/05/24. There was no evidence of sexual abuse noted on the assessments. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's care plan indicated it was updated on 10/05/24 and included he exhibiting unwanted sexual behaviors with interventions of referral to psychiatric services and increased monitoring for behaviors and changes in mental status. Record review of Resident #4's care plan indicated it was updated on 10/05/24. Record review of facility incident/accident reports indicated no other incidents of inappropriate sexual behaviors. Record review of quiz results, dated 10/05/24 and 10/06/24, indicated all staff passed the quiz regarding abuse, neglect, reporting, and one-on-one monitoring. Record review of a list of all facility staff used for tracking the required in-service training on abuse/neglect, behavioral monitoring, and behavioral management indicated all facility staff had received the in-service training in person or by phone. The Administrator was informed the IJ was removed on 10/06/24 at 3:58 p.m. The facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put in place.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 47879 Based on interviews and record review, the facility failed to ensure that all alleged violations involving abuse were reported, but not later than 2 hours after the allegation is made, if the events that cause the allegation involves abuse or result in serious bodily injury, to the State Survey Agency, for 2 of 6 residents (Resident #Unnamed and Resident #4) reviewed for reporting allegations of abuse. The facility failed to report an allegation of sexual abuse to the State Agency when it was reported on 08/02/24 that Resident #1 touched Resident #Unnamed breasts. The facility failed to report an allegation of sexual abuse to the State Agency when it was reported on 08/25/24 that Resident #1 touched Resident #4's breast. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: 1. Record review of a face sheet dated 09/23/24 indicated Resident #1 was [AGE] years old, initially admitted to facility on 03/07/24 and readmitted to facility on 09/09/24. His diagnoses included dementia (loss of cognitive functioning), delusional disorder (a mental health condition that causes unshakable beliefs in something that's untrue), hypertension (condition in which the force of the blood against the artery walls is too high), dysphagia (difficulty swallowing) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #1's care plan with revision dated 04/24/24 indicated Resident #1 had inappropriate sexual behaviors; resident seeks to satisfy his sexual desires. Interventions included to firmly approach resident that behaviors are not acceptable and document conversations and actions of resident; inform direct caregivers on methods to assist them in handling resident behaviors while providing care; monitor whereabouts of resident and keep distance from others; provide diversional activities and redirect when behaviors happen and document. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #1 was usually able to make himself understood and usually understands others. He had a BIMS of 08 (moderately impaired cognitively). He exhibited no behaviors over the 7 days look back period. He required supervision or moderate assistance for most ADLS. He was frequently incontinent of bladder and bowel. Record review of Resident #1's progress note authored by previous DON R indicated on 08/02/24 at 8:42 a. m., Resident #1 was in the dining room this morning grabbing other resident's breast when nurse tried to redirect him, he stated let me see your pussy. Nurse informed him that this kind of behavior would not be accepted. Nurse phoned MD and made him aware of situation. Received one time order for lorazepam 1 milligram IM for agitation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an unsigned 24-hour report indicated: 08/02/24 08:42 a.m. - Behavior Note Resident #1 was in the dining room this morning grabbing other resident breasts. When SN tried to redirect him, he stated, Let me see your pussy. SN informed him that this kind of behavior would not be accepted. SN phoned MD and made him aware of the situation. Received on time order for Lorazepam 1 mg IM for agitation. 08/02/24 10:21 a.m. - Social Services SSD sent referral over to behavioral unit at local hospital per DON who said to refer Resident #1 due to behavior displayed. Spoke with rep who said that he would need to be transported to the ER to be assessed. SSD said she would speak to the ADON/DON on how to proceed. 08/02/24 11:29 a.m. - Behavior Note Resident has been extremely inappropriate to staff and other residents sexually. Speaking graphically lewd and grabbing resident's breasts, then laughing and leering. Unable to redirect. DON notified. 08/02/24 12:32 a.m. - Nurses Note Resident #1 sent to hospital ER for psych evaluation due to inappropriate sexual behavior. Record Review of Resident #1's behavior monitoring log indicated on 08/02/24 Resident #1 was monitored hourly from 9:00 a.m. until 12:30 p.m. Record review of Resident #1's progress note authored by LVN Q on 08/05/24 at 12:55 p.m., indicated the behavioral hospital called to inform facility that Resident #1 did not meet criteria for extended stay and the unit was full. Resident #1 would be transferred back to the facility (on 08/05/24). Record review of Resident #1's psychiatric assessment note dated 08/05/24 and completed by NP AA indicated Resident #1 was seen for a hospital follow up visit for exhibiting anxiety symptoms and hypersexual behaviors toward female peers and staff. Psych treatment plan included to start Resident #1 on Rivastigmine (used for the treatment of mild to moderate Alzheimer's disease) 1.5 mg daily for inappropriate sexual behaviors in dementia, utilize behavioral interventions to manage episodic behaviors, redirect as needed and provide support and encouragement to increase positive interactions and socialization, and follow up in 4 weeks or as needed. Record review of Resident #1's progress note authored by LVN Q on 08/07/24 at 7:10 a.m. indicated Resident #1 continued to speak sexually inappropriately to staff. Resident #1 appeared exhausted, and shower was given to calm resident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress/behavioral note authored by LVN Q on 08/14/24 at 8:55 p.m. indicated Resident #1 in his room observed crawling out of bed laying on back and asking the nurse to put your pu**y on me, let's do sex [NAME]. Resident then crawled back into bed by himself as nurse was assisting him with his covers, he grabbed her breast and squeezed it hard. Record review of Resident #1's psychiatric assessment note completed by psych NP AA on 08/20/24 indicated Resident #1 had no new instances of inappropriate sexual behaviors reported. Psych treatment plan included to continue current plan, utilize behavioral interventions to manage episodic behaviors, redirect as needed and provide support and encouragement to increase positive interactions and socialization. Record review of Resident #1's progress note authored by RN U on 08/25/24 at 7:46 a.m. indicated CNA BB reported to RN supervisor that Resident #1 touched a female resident on her breast. Resident #1 was separated from the female resident. The ADON, the NP, the AC, and the RP notified of the incident. Resident #1 was placed on monitoring. Record review of Resident #1's progress note authored by RN U on 08/25/24 at 12:43 p.m. indicated Resident #1 continued to be monitored following incident. Record review of Resident #1's progress/nurses' note authored by RN T/Abuse Coordinator on 08/26/24 at 11:44 p.m., indicated Resident #1 was interviewed regarding the incident that was reported over the weekend. Resident #1 denied touching the other resident inappropriately. He stated Resident #4 was close by when he reached for something. Resident #1 was calm and cooperative, and no behaviors observed. Resident #1 continued to reside in secure unit. Record Review of Resident #1's behavior monitoring log indicated on 08/25/24 to 08/27/24 Resident #1 was monitored hourly from 08/25/24 at 9:00 a.m. until 08/27/24 at 10:00 p.m. There was no documentation of further monitoring. Record review of Resident #1's Medical Professional note authored by NP Y on 09/10/24 indicated Dx: Dementia - patient impaired, memory, cognitive function. It is medically necessary to have care in a nursing home long term care facility setting in order to assist with ADLS and IADLS. It is necessary to refill and continue dementia and psychotropic medication including Memantine 5 mg and have frequent re-direction and re-orientation by staff. Resident readmitted from behavioral hospital. Resident with no active behaviors at this time. Record review of Resident #1's progress note authored by LVN B on 09/17/24 at 8:27 a.m. indicated Resident #1 hit the CNA (unidentified) in the face while passing breakfast trays and was being verbally aggressive towards everyone around him. LVN B administered prn Lorazepam injection and notified the MD, the Administrator, and the RP. Record review of Resident #1's psychiatric assessment note dated 09/17/24 and completed by NP AA indicated Resident #1 had no new instances of inappropriate sexual behaviors reported. Resident having increased agitation and slapped a staff member. Psych treatment plan included to add Rivastigmine/Risperdal to 0.5 mg tablet 1 tablet by mouth 2 times per day, utilize behavioral interventions to manage episodic behaviors, redirect as needed and provide support and encouragement to increase positive interactions and socialization, and follow up in 4 weeks or as needed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/25/24 at 12:15 p.m., CNA BB said she was getting all the residents into the dining room for the breakfast meal. She said it looked like Resident #1 was touching Resident #4's breast and then he reached for the coloring book and crayons that was on the dining table. She said she told Resident #1 he did not need to be so close to the ladies and he moved away. She said she advised RN U of the incident. She said RN U called the abuse coordinator. She said Resident #4 did not say anything. She said Resident #1 said he did not touch Resident #4's breast. He said he was reaching for the crayons. She said she did not see him grab or fully touch Resident #4's breast. During an interview on 9/26/2024 at 4:00 pm, RN U said that on 8/25/2024 a CNA reported to her that Resident #1 touched a female resident on her breast. RN U said Resident #1 was separated from the female resident, assessed, and behavioral monitoring initiated. RN U said she reported the incident to the ADON, the NP/MD, the AC (RN T), and the RP. RN U said that Resident #1 was placed on behavioral monitoring for the incident until the AC (RN T) completed an abuse investigation. RN U said that there were 2 CNA working the secure unit on 8/25/2024 to provide behavioral monitoring of Resident #1. RN U said if residents had behaviors that facility staff notify the NP/MD and place the residents on behavioral monitoring, depending on the MD orders and/or severity of the behavior's resident may be sent out to behavioral hospital for evaluation and treatment. During an observation and interview on 09/30/24 at 11:45 a.m., Resident #1 was sitting up in wheelchair in secure unit dining room. He said he did not recall the incident involving him inappropriately touching other residents that happened on 08/02/24. Resident #1 said that he knew that he was not supposed to touch or hit other residents or staff. Resident #1 was observed trying to stand up without assistance and staff intervened and redirect him by providing activities. Resident #1 was one of 6 residents in the dining room. There was no inappropriate touching observed. During an interview on 09/30/24 at 1:00 p.m., the surveyor requested the Administrator provide an incident report for Resident #1's sexual inappropriate behaviors documented on 08/02/24. The administrator said there was no incident report completed on 08/02/24 or no incident report completed for this incident. During an interview on 09/30/24 at 2:48 p.m., LVN Q said she was the CN on duty on 08/02/24 and vaguely recalled the incident with Resident #1 touching another female resident's breast. She said she recalled that the incident was in the dining room of the secure unit, and he touched the female's breast and was laughing and leering. He was unable to be redirected, and when removed from the area by staff, he was talking sexually to staff and grabbing at their breast. She said that she notified the DON and the MD. She said Resident #1 was monitored until he was transferred to a local hospital for evaluation for placement into their behavioral unit. She said she did not recall the female's name that he touched inappropriately. She said that she was in the unit covering for the CNA when the incident occurred, and it was not witnessed by other staff. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/30/24 at 3:30 p.m., DON R said she was the active DON at the facility on 08/02/24. She recalled the incident with Resident #1 touching another female resident's breast. She said she was called to the secure unit that morning after breakfast and the CN reported that Resident #1 had touched another female resident's breast and was laughing and leering. He was unable to be redirected, and when removed from the area by staff, he talked sexually to staff and grabbed at their breast. She said she told the CN to keep Resident #1 on one-to-one monitoring and that she requested the SW to contact a local behavioral hospital for a transfer due to the behavior. She said that she notified all department heads (including the Administrator) during the 9:00 am morning meeting that day. She said Resident #1 was monitored until he was transferred to a local hospital for evaluation for placement into their behavioral unit. She said she did not recall the female resident's name that Resident #1 touched inappropriately. During an interview on 09/30/24 at 3:55 p.m., the previous Administrator S said she was the active Administrator on 08/02/24. She said she was not notified when Resident #1 touched another female resident's breast on 08/02/24. She said that was considered sexual abuse and was required to be reported to the state agency within 2 hours. She said that if she was notified of the sexual abuse allegation, she would have reported it. During an interview on 09/30/24 at 4:00 p.m., the ADON said she did not recall the incident when Resident #1 touched another female resident's breast on 08/02/24. She said she was aware that would be considered sexual abuse and would have to be reported to the state agency within 2 hours of the incident. The ADON said she notified the Administrator/Abuse Coordinator immediately by phone/text of any allegation of abuse so it can be reported to the state agency within 2 hours. The ADON said residents with behaviors were monitored and incidents were reported to the MD/NP and orders followed. She said the possible negative outcome of not protecting the residents could be physical, emotional, or psychological harm of the residents. Record review of TULIP intakes for Resident #1 and facility reported intakes did not indicate any reports from the facility on 08/02/24. 2. Record review of a face sheet dated 10/05/24 indicated Resident #4 [AGE] years old, initially admitted to the facility 03/13/24 and readmitted on [DATE]. Her diagnosis included dementia (loss of cognitive functioning), cognitive communication deficit (a difficulty with communication caused by disruption to cognition, or brain processes like attention, memory, and Problem solving), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Record review of a quarterly MDS assessment dated [DATE] indicated Resident #4 was usually understood and sometimes understands others. She had a BIMS of 08 (moderately impaired cognitively). She exhibited no behaviors over the 7 days look back period. She required moderate assistance for most ADLS. She was always incontinent of bladder and frequently incontinent of bowel. Record review of a care plan dated 07/19/24 for Resident #4 did not indicate she had been touched inappropriately on 08/25/24. Record review of an incident report dated 08/25/24 at 7:45 a.m. and signed by RN U indicated CNA heard Resident #4 yell, let go of my titty. CNA saw Resident #1 grabbing Resident #4's breast and reported the incident to her. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an incident report dated 08/25/24 at 11:18 a.m. and signed by RN U indicated CNA reported to her that she saw Resident #1 touch a female resident on her breast. Residents were separated. Calls placed to notify ADON, NP, and RN T (previous Abuse Coordinator) and resident's FM UU. Resident #1 was on every 30-minute monitoring. Record review of a behavior monitoring log indicated Resident #1 was monitored hourly from 08/25/24 at 8:00 a.m. to 08/27/24 at 10:00 p.m. There was no documentation of further monitoring. Record review of a progress note dated 08/28/24 at 10:33 a.m. authored by the ADON indicated Resident #1 left facility with transportation company in route to behavioral hospital. Record review of TULIP intakes for Resident #1 and Resident #4 facility reported intakes did not indicate any reports from the facility on 08/25/24. During an interview on 09/25/24 at 10:21 a.m. RN T said she was made aware of the incident between Resident #1 and Resident #4. She said staff reported to her (the acting abuse coordinator) Resident #1 and Resident #4 were sitting at a dining table on the secure unit. Staff reported Resident #4 said Resident #1 grabbed her. Resident #1 denied he grabbed Resident #4's breast. She said both residents had low BIMS scores and there was no willful intent, so the incident was not reported to the State Agency. During an interview on 09/25/24 at 12:15 p.m., CNA BB said she was getting all the residents into the dining room for the breakfast meal. She said it looked like Resident #1 was touching Resident #4's breast and then he reached for the coloring book and crayons that was on the dining table. She said she told Resident #1 he did not need to be so close to the ladies and he moved away. She said she advised RN U of the incident. She said RN U called the abuse coordinator. She said Resident #4 did not say anything. She said Resident #1 said he did not touch Resident #4's breast. He said he was reaching for the crayons. During an interview on 9/27/2024 at 4:00 pm, RN U said that on 8/25/2024 a CNA reported to her that Resident #1 touched a female resident on her breast. RN U said Resident #1 was separated from the female resident, assessed and behavioral monitoring initiated. RN U said she reported the incident to the ADON, NP/MD, AC (RN T) and RP. RN U said that Resident #1 was placed on behavioral monitoring for the incident until the AC (RN T) completed an abuse investigation. RN U said that there were 2 CNAs working the secure unit on 8/25/2024 to provide behavioral monitoring for the incident until the AC (RN T) completed an abuse investigation. RN U said if residents had behaviors that facility staff notify the NP/MD and place the residents on behavioral monitoring, depending on the MD orders and/or severity of the behavior's resident may be sent out to behavioral hospital for evaluation and treatment. She said Resident #1 was monitored q15 minutes. During an observation and interview on 10/05/24 at 9:39 a.m., Resident #4 was sitting in her wheelchair in the dining room of the secure unit. She was appropriately dressed and well-groomed. She was unable to answer questions about the incident and just repeated words spoken to her. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/05/24 at 3:55 p.m., the Administrator said that she was not the active Administrator/Abuse Coordinator at the time of the incidents with Resident #1 touching another female resident's breast on 08/02/24 or on 08/25/24 when Resident #1 touched Resident #4's breast. She said her expectation for incidents involving resident to resident abuse was for the residents to be separated and the aggressor to be placed on one-on-one monitoring for the protection of other residents. She said the possible negative outcome of not protecting the residents could be physical, emotional, or psychological harm of the residents. Record review of the undated facility's Abuse and Neglect policy indicated .It is the policy of the facility to administer care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation. III. Prevention: Have procedures to: provide residents, families, and staff information on how and to whom they may report concerns, incidents and grievances without fear of retribution; and provide feedback regarding the concerns that have been expressed. Identify, correct and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur. Establish a safe environment that supports consensual sexual relationship. Develop and implement policy on abuse, neglect, theft, exploitation, and misappropriation of property. Deployment of sufficient and trained staff to deal with behaviors in the units. Identification, assessment, care planning for intervention, and monitoring of residents with needs and behaviors that might lead to conflicts or neglect. The supervisions of staff to identify inappropriate behaviors . ensuring health and safety of residents .VI. Protect residents from physical and psychosocial harm during investigations. 1. If the allegation of abuse involves 2 or more residents, they will all be immediately separated for the protection of all residents involved and those potentially affected by the abuse. 2. Affected residents will be assessed for injury. 3. Attending physician will be notified. a. This includes but not limited to full assessment of physical and psychosocial well-being; sending resident to hospital if needed; depending on circumstance, keep resident on 1:1, assign a female/male depending on the accusation/allegation. Record review of the facility's Abuse and Neglect policy dated June 2023 indicated . All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's Designee. All allegations of abuse will be reported to DADS immediately after the initial allegation is received.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 25115 Based on interviews and record review the facility failed to ensure they had a full time DON and failed to ensure there was an RN for 8 consecutive hours 7 days a week for 1 of 1 facility reviewed for DON and RN coverage. The facility did not have a full-time DON as of 08/16/24. The facility did not have RN coverage for 8 consecutive hours on from 09/16/24 through 09/20/24, 09/23/24 through 09/25/24, 09/27/24, and 09/30/24. These failures could place residents at risk of lack of nursing oversight and a higher level of care. Findings included: Record review of staff hours from 08/01/24 through 09/30/24 indicated there was no DON in the facility from 08/16/24 through 09/30/24. Record review of staff hours from 08/01/24 through 09/30/24 indicated there was no RN coverage on 09/16/24, 09/17/24, 09/18/24, 09/19/24, 09/20/24, 09/23/24, 09/24/24, 09/25/24, 09/26/24, 09/27/24, and 09/30/24. During an interview on 09/25/24 at 9:00 a.m., the Administrator said the facility did not have a current DON, however she was in the process of hiring a DON. She said there was no DON in the facility since 08/16/24. The Administrator said she had some days with no RN coverage. She said she was not made aware that she could use agency staff for RN coverage. During an interview on 09/25/24 at 2:28 p.m., RNC T said the facility did not have a DON as of 08/16/24. She said the facility was actively looking for a DON through recruiting. She said the facility also utilized a staffing agency. She said she was not aware the facility did not have RN coverage as required. She said the medical records staff was doing the scheduling but her (medical records staff) last day was 09/20/24. She said the risks of not having a DON or RN coverage was it placed residents at risk of not having focused assessments when there was a change of condition. During an interview on 09/30/24 at 4:30 p.m. the Administrator said she was not aware she could use agency nurses to fill RN coverage until she spoke to RNC P on 09/30/24. They submitted a request for RN coverage through the staffing agency on 09/30/24 but she had not received notification an RN was obtained as of 4:30 p.m. on 09/30/24. She said the facility did not have a policy for the DON or RN coverage. She said the facility followed the federal guidelines.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on observations, interviews, and record review, the facility failed to ensure PRN orders for psychotropic drugs were limited to 14 days unless the attending physician or prescribing practitioner believed that it was appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record, and indicate the duration for the PRN order for 3 of 3 residents (Resident #s 1, 2, and 3) reviewed for pharmacy services. 1. The facility failed to ensure Residents #1, #2, and #3 had a stop date for PRN anti-anxiety and antipsychotic medications. 2. The facility failed to monitor Resident #1's behaviors for his prescribed Ativan during the months of August and [DATE]. These failures could place residents at risk of receiving unnecessary psychotropic medications and of not receiving the intended therapeutic benefits of their psychotropic medications. The findings included: Record review of a face sheet dated 09/23/24 indicated Resident #1 was [AGE] years old, initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. His diagnoses included dementia (loss of cognitive functioning), delusional disorder (a mental health condition that causes unshakable beliefs in something that's untrue), hypertension (condition in which the force of the blood against the artery walls is too high), dysphagia (difficulty swallowing), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #1's quarterly MDS dated [DATE] indicated he was usually understood and usually understood others and he had moderate cognitive impairment (BIMS score of 8). The MDS Antipsychotic Medication Review was incorrectly completed and indicated no antipsychotic medications received. Record review of Resident #1's care plan dated 03/27/24 (revised 05/17/24) indicated Resident #1 was taking psychotropic medications and was at risk for adverse reactions and acute episodes of disease process (depression anxiety, delusional disorder, and/or psychosis driven) related to behaviors. Interventions included check for adverse reactions and check for effectiveness of psychotropic medication. Record review of Resident #1's care plan dated 03/27/24 indicated Resident #1 had a potential for medication interaction/side effects related to receiving 9+ medications. Interventions included monthly pharmacy review. Record review of Resident #1's physician orders dated 08/11/24 indicated Ativan oral tablet 1 mg give 1 tablet every 8 hours as need for anxiety. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's physician orders dated 08/27/24 indicated Ativan Injection Solution 2 MG/ML inject 2 mg intramuscularly every 12 hours as needed for agitation. Record review of Resident #1's physician orders dated 08/24/24 indicated monitor for the following behaviors: itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression and refusing care. Document 'Y' if monitored an any of the following occurred. 'N if monitored and any of the above were not observed, select chart codeother/See Nurses Notes and progress note findings. Record review of Resident #1's MAR dated 08/2024 indicated he received Ativan injection 2 mg every 12 hours as needed for agitation on 08/27/24. Record review of Resident #1's MAR dated 08/2024 i indicated he received Ativan oral tablet 1 mg every 8 hours as needed 8 instances between 08/13/24 and 08/28/24. Record review of Resident #1's MAR dated 09/2024 in indicated he received Ativan injection 2 mg every 12 hours as needed for agitation on 09/18/24. Record review of Resident #1's narcotic control count sheets dated 09/24/24 indicated: Ativan injection 2 mg every 12 hours as needed on 09/13/24, 09/17/24, 09/18/24, and 09/19/24. Record review of Resident #1's MAR dated 08/2024 indicated he received Ativan oral tablet 1 mg every 8 hours as needed 20 instances between 09/09/24 and 09/20/24. Record review of Resident #1's pharmacy review dated 08/14/24 and completed by Pharmacist M indicated Ativan 1 mg every 8 hours prn from order date of August 11, 2024. Per CMS guidelines this med is not indicated prn past 14 days. Please dc this med or offer a benefit risk as to why this med is to continue prn. MD N signed (did not date) and indicated defer all psych meds to psychiatry team, please send this form to psychiatry team. Record review of Resident #1's electronic record and consent forms indicated there was no consent forms for Ativan. Record review of Resident #2's face sheet dated 09/30/24 indicated he was a [AGE] year-old male admitted on [DATE], and his diagnoses included schizoaffective disorder (chronic mental illness) and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). Record review of Resident #2's quarterly assessment MDS dated [DATE] indicated he rarely made himself understood, usually understood others, and had severe cognitive impairment (BIMS score of 2). His signs and symptoms of delirium included inattention and disorganized thinking. He received antipsychotic medications on a routine basis. The MDS did not include PRN antipsychotic medication use. Record review of Resident #2's care plan 07/07/23 (revised 07/23/23) indicated Resident #2 had the potential to be physically aggressive related to dementia. Interventions included administer medications as ordered. Monitor/document for side effects and effectiveness. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's care plan dated 04/13/23 indicated Resident #2 had diagnoses of impaired thought process related to dementia. Interventions included administer medications as ordered. Monitor/document for side effect and effectiveness. Record review of Resident #2's physician orders dated 08/09/24 indicated Ativan 2/MG/ML inject 1 ml intramuscularly every 6 hours as needed for agitation related to dementia. Record review of Resident #2's MAR dated 08/2024 indicated he received Lorazepam IM injection 1 ml intramuscularly every 6 hours as needed on 08/09/24 and twice on 08/28/24. Record review of the narcotic count sheet indicated Resident #2 received 1 IM at 9:00 a.m. and 1 IM at 6:30 p.m. on 08/28/24. Record review of monthy pharmacy reviews indicated there was no pharmacy recommendation review completed for Resident #2's prn IM Ativan (the last pharmacy review in the facility was 08/16/24). Record review of Resident #3's face sheet dated 09/30/24 indicated she was a [AGE] year old female, admitted on [DATE], and her diagnoses included dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), anxiety (feelings of fear, dread, uneasiness), major depressive disorder (a persistently low or depressed mood and a loss of interest in activities), and unspecified psychosis (collection of symptoms that happen when a person has trouble telling the difference between what's real and what's not). Record review of Resident #3's significant change MDS dated [DATE] indicated she was usually able to make herself understood, understood others, had severe cognitive impairment (BIMS score of 00), signs of delirium included inattention and disorganized thinking. She had physical and verbal behaviors directed at others that occurred 1 to 3 days. She had behavioral symptoms not directed at others that occurred 1 to 3 days. The MDS Antipsychotic Medication Review was incorrectly completed and indicated no antipsychotic medications received. Record review of Resident #3's care plan dated 07/07/23 (revised 07/23/23) indicated Resident #3 exhibited signs and symptoms of anxiety. Interventions included medications as ordered. Record review of Resident #3's physician orders dated 07/15/24 (discontinued 09/27/24) indicated Lorazepam Oral Tablet 1 MG give 1 tablet by mouth every 8 hours as needed. Record review of Resident #3's physician orders dated 09/29/24 indicated Lorazepam oral concentrate 1 mg/. 05 ml give 0.5 ml by mouth every 4 hours for anxiety. Record review of Resident #3's MAR dated 08/2024 indicated she received 1 mg oral Lorazepam every 8 hours as needed for agitation/anxiety for 24 instances from 08/01/24 through 08/29/24. Record review of Resident #3's MAR dated 09/2024 indicated she received 1 mg oral Lorazepam every 8 hours as needed for agitation/anxiety for 8 instances from 09/01/24 through 09/27/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's pharmacy review dated 08/14/24 and completed by Pharmacist M indicated Ativan 1 mg every 8 hours prn from order date of July 15, 2024. Per CMS guidelines this med is not indicated prn past 14 days. Please dc this med or offer a benefit risk as to why this med is to continue prn. MD N signed (did not date) and indicated defer all psych meds to psychiatry team, please send this form to psychiatry team. During an observation and interview on 09/23/24 at 12:29 p.m., Resident #1 was in the hospital and lying on a bed. There was a hospital staff sitter by the side of the bed. Resident #1 was speaking incoherently when asked how he was feeling. He had excessive drooling from the mouth and was making repeated attempts to leave the bed. He did not respond with coherent responses to questions regarding his medications. During an interview on 09/23/24 at 3:09 p.m., LVN V said she administered Resident #1, Resident #2, and Resident #3's antipsychotic and anti-anxiety medications that included routine and PRN, and IM and PO. She said she was required to monitor for side effects. She said side effects could include lethargy or increased behaviors. She said she did not know why Resident #1's behaviors were not monitored. She said she was not aware it was the responsibility of the nurse who obtained the order to ensure PRN was only prescribed for 14 days. During an interview on 09/23/24 at 3:21 p.m., the ADON said the QM pharmacist (she could not recall the name) had made the facility aware on 09/19/24 or 09/20/24 that Resident #1's PRN antipsychotic medications required a 14-day end date. She said she was not aware previously and she had not addressed the issues. She said the facility was advised to come up with a corrective action plan and include staff training. She said she had not completed an audit of residents' charts to address the issue of prn end dates because there was no DON or other ADON to assist. She said she was not aware Resident #1's behaviors were not being monitored in the EMR. During an interview on 09/25/24 at 9:21 a.m., LVN B said she administered Resident #1, Resident #2, and Resident #3's antipsychotic and anti-anxiety medications that included routine and PRN, and IM and PO. She said she was required to monitor for side effects. She said side effects could include lethargy or increased behaviors. She said she did not know why Resident #1's behaviors were not monitored. She said she was not aware it was the responsibility of the nurse who obtained the order to ensure the PRN was only prescribed for 14 days. She said she thought the PRN orders were standing orders. During an interview on 09/25/24 at 11:38 a.m., LVN Z said she administered routine PRN antipsychotics and antianxiety IM and PO medications to Residents #1, #2, and #3. She said she was required to monitor for side effects. She said side effects could include lethargy or increased behaviors. She said she did not know why Resident #1's behaviors were not monitored. She said she was not aware it was the responsibility of the nurse who obtained the order to ensure the PRN was only prescribed for 14 days. She said she thought the PRN orders were standing orders. During an interview on 09/25/24 at 12:36 p.m., psych NP AA said he did not review Residents #1, #2, or #3's PRN anti-psychotic or anti-anxiety medications per the pharmacy recommendations to add a 14-day end date because he was not given the pharmacy recommendations to review. He said monitoring was important for medications to ensure it was needed and working effectively. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/25/24 at 2:28 p.m. RNC T said she was made aware of by the QM pharmacist that PRN medications had to have a 14-day end date. She said she spoke to psych NP AA on 09/23/24 regarding the PRN antipsychotics. She said NP AA gave orders to discontinue the PRN antipsychotics and antianxiety medications and he would review them on his next visit to the facility. She said Pharmacist R gave all recommendations to the facility during his monthly reviews and she was not aware of why the recommendations were not addressed. She said she was not aware Resident #1's behavior monitoring in the EMR was not completed. She said it was ordered but was not populating in the EMR for the nurses to document. She said if the behavioral monitoring was not documented, the physician may not see the continued behaviors to determine if any treatment changes were needed. During an interview on 09/25/24 at 1:29 p.m., MD N said he was aware IM and PO orders for PRN Ativan and other antipsychotic and anti-anxiety PRN medications required a 14-day end date. He said all pharmacy recommendations related to antipsychotic and anti-anxiety medications were deferred to psych services. He said PRN Ativan IM or PO with 14-day renewals were usual standard orders. He said he was also the facility provider and medical director. He said he was not aware the correct pharmacy protocols were not being followed. He said monitoring was important for medications to ensure it was needed and working effectively. During an interview on 09/26/24 at 3:15 PM, LVN A said any resident on antipsychotics, antidepressants, or any mind-altering drug should be monitored for side effects and behaviors. She said that behaviors and side effects were documented on the MAR/TAR and if side effects and/or behaviors were identified those should be documented in the progress note. She said if resident identified to have behaviors that an assessment was completed and the MD notified and physicians orders followed which could include monitoring, referral to behavioral hospital, lab work, psych services evaluation, and/or transfer to local ER. She said she did not know there was no monitoring for behaviors for Resident # 1. She said residents on psychotropic medication prn (as needed) should have a stop date at 14-days or documentation from a physician of why it was necessary to continue beyond 14 days. She said that she did not know there was not a stop day on Resident #1, #2, and #3's prn psychotropic medications. She said not having a stop date on the prn psychotropic medications could cause ill effects or the resident to receive unnecessary medications. During an interview on 09/26/24 at 4:20 p.m., MA J said she did not administer prn psychotropic medications that the CN administers prn medications. She said that she does administer psychotropic and sedative/hypnotic medications if ordered routinely. She said that behaviors and side effects were documented on the MAR/TAR and if side effects and/or behaviors were identified those should be documented in the progress note. During an interview on 09/26/24 at 5:00 p.m., Pharmacist L said that he was the consulting pharmacist at the facility up until last month (August 16, 2024). During his visits to the facility, he reviewed resident's medications and provided the facility DON and the administrator a list of residents receiving psychotropic and sedative/hypnotic and consultant pharmacist/physician communication sheets to be provided to the physician. He said that the pharmacist/physician communication sheets identified MMR date and notations of residents receiving prn psychotropic drugs limited to 14 days and the physician was required to stop the psychotropic drug or offer a benefit risk as to why the medication was to continue prn. He said that the list of residents receiving psychotropic, and sedative/hypnotic included the resident name, medication class, medication, dose and direction, ordered date, last GDR date, and the next evaluation date. He said monitoring was important for medications to ensure it was needed and working effectively. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/30/24 at 12:30 p.m., LVN B said any resident who was on psychotropic medication, or any mind-altering medication should be monitored for side effects and behaviors. She said it was important to monitor for the side effects of the medication to see if it helped the resident or not. She said if she administers psychotropic medication prn that she documents on the MAR/TAR effectiveness, side effects, and behaviors. She said she did not know there was no monitoring for behaviors for Resident # 1. She said residents on psychotropic medication prn (as needed) should have a stop date at 14 days or documentation from a physician why it was necessary to continue beyond 14 days. She said that she did not know there was not a stop day on Resident #1, #2, and #3's prn psychotropic medications. She said not having a stop date on the prn psychotropic medications could cause the resident to receive unnecessary medications. During an interview on 09/30/24 at 1:30 p.m., LVN C said any resident who was on an antipsychotic, antidepressant, or any mind-altering medication should be monitored for side effects and behaviors. She said it was important to monitor for the side effects of the medication to see if it helped the resident or not. She said if she administers psychotropic medication prn that she documents on the MAR/TAR effectiveness, side effects, and behaviors. She said if the resident was not monitored, a side effect could be missed. She said residents on psychotropic medication prn (as needed) should have a stop date at 14 days or documentation from a physician why it was necessary to continue beyond the 14 days. During an interview on 09/30/24 at 4:00 p.m., the ADON said any resident on antipsychotics, antidepressants, or any mind-altering drugs should be monitored for side effects and behaviors. She said that the quality monitoring team had identified that the psychotropic drugs where not being stopped or reviewed by a physician after 14 days and that she was made aware of that on September 20th, 2024, the Friday prior to the investigator entering the facility (on 09/23/24). She said she had reviewed all the resident's currently on prn psychotropic drugs and stopped the drugs. She consulted the physician for new orders and medication regimen review including the prn psychotropic drug, dosage, last doses of the psychotropic drugs, and indications of why administered. She said she put in those orders in 09/24/24 for Residents #1, #2, and #3. She said it was important to monitor to see if the medication was effective and monitoring the behaviors to address them before they got out of hand. She said she was currently responsible to make sure the orders were there; however, it was every nurse's responsibility. She said the orders for monitoring Resident #1's behaviors were not generated onto the MAR/TAR because the schedule was not assigned at the time the order was written. She said monitoring was important for medications to ensure it was needed and working effectively. During an interview on 09/30/24 at 4:30 p.m., the Administrator said residents receiving prn psychotropic medication that it was important to monitor for side effects of medications and behaviors to look for negative side effects or negative behaviors. She said that resident's medication regimen should be free from unnecessary medications. She said that that MD giving orders for prn psychotropic medications would be asked for a stop date and/or reevaluation date (no longer than 14 days will be accepted for a stop date). She said staff had been recently in-serviced regarding no longer than 14 days for prn psychotropic medication and adding a stop date to these medications when ordered. She said the nurses should be putting in necessary orders but ultimately the DON was responsible for making sure stop dates on prn psychotropic medication, behaviors, and side effects of medications were monitored. She said that the ADON and the corporate nurse was currently reviewing the orders and behavioral monitoring since the facility did not currently have a DON. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's undated policy antipsychotic use in residents with dementia indicated Objective: To ensure the facility is in compliance with the CMS regulations for proper management of antipsychotic medication in residents with dementia, who have behavioral issues. Procedure: 1. Upon admission of a resident who is ordered an antipsychotic medication and has a diagnosis of dementia, the nursing supervisor/staff will obtain from the physician an approved diagnosis for the antipsychotic medication and a specific behavior for its use. d. The facility will obtain an informed consent, from the resident / power of attorney, and or healthcare representative, before an antipsychotic medication is administered. 3. The nursing supervisor/staff will initiate a behavior sheet with the specific behavior(s) for which the antipsychotic medication was prescribed, in accordance with the physicians wishes when he reviews the medication orders. 4. The behavior sheet will include resident specific non-pharmacological interventions for the resident. a. These non-pharmacological interventions can be obtained from family members, physician/psychiatrist (he/she was seeing prior to admission to the facility), or attending physician. 5. The behavior sheet will be filled out at the end of each shift with the number of episodes the resident had for that shift, non-pharmacological interventions that were used and the result. 6. The resident's medical record and behavior sheet will be reviewed at the monthly Behavioral IDT meeting. 8. Upon monthly review of resident medical records, the Consultant Pharmacist will make recommendations for dosage reductions/ adjustment of antipsychotic medications for residents with dementia in accordance with the CMS regulations and guidelines. a. This review will also include any other psychotropic medication(s), which is due for review by the attending/psychiatrist at this time. 9. The physician will review the dosage recommendations and determine at such time, if a dose adjustment is medically indicated or clinically contraindicated. a. The reason for the medication to continue to be medically indicated will be answered in the response section on the consultant's recommendation or in the physician's progress note. B The note should demonstrate that the physician has carefully considered the risk/benefit for the current dose and for it to continue. The documentation should also include; that past gradual dose reduction, failures, and why any changes would aggravate the resident's general medical condition, functional status, or psychiatric stability. 12. Documentation of all gradual dose reductions attempts, failures, or usefulness of non-pharmacologic interventions, will be maintained by the facility and consultant pharmacist, using tracking tools to monitor progression.