STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675756	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsburg Village Healthcare Campus	941 Scotland Dr Desoto, TX 75115

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to provide housekeeping and maintenance services necessary to maintain a safe, sanitary, orderly, and comfortable interior for six (Residents #2, #3, #4 #5 #6 and #7) of six residents reviewed for safe clean homelike environment. 1. The facility failed to ensure Residents #2, and #3 did not have soiled briefs in the trash cans in their rooms. 2. The facility failed to ensure Residents #2, #4, and #5 had clean privacy curtains in their rooms. 3. The facility failed to ensure the ceiling vents Resident #5, #6 and #7's rooms were clean. These failures could affect residents and place them at risk for not having a safe and sanitary homelike environment. Findings included: 1. Review of Resident #2's Face Sheet, dated 04/18/24, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included cerebral ischemia (common mechanism of acute brain injury that results from impaired blood flow to the brain). Review of Resident #2's MDS assessment, dated 03/18/24, revealed the resident had a BIMS score of 10 indicating moderate cognitive impairment. Observation and interview on 04/18/24 at 11:10 AM with Resident #2 in her room revealed the resident was on her bed. A soiled brief with fecal matter observed in the trash can. Some dried brown stains were observed on the resident's privacy curtain. Resident#2 stated the brief was changed during wound care by the nurse, but she was not aware it was put in the trash can. She stated her curtain was all stained, and she did not like the way it looked. She stated she would like somebody to wash it. 2. Review of Resident 3's EHR revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included hypertension (high blood pressure) and obesity (excessive fat deposits that can impair health) (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's MDS assessment, dated 03/19/24, revealed the resident had a BIMS score of 15 indicating cognitive intact. Observation and interview on 04/18/24 at 11:10 AM with Resident #2 in her room revealed resident was on her bed. A soiled brief was observed in the trash can. The resident revealed she had changed herself in the morning when she was preparing to go for therapy. She stated she decided to put the brief in the trash can by the door, because if she kept it in the trash can in the bathroom the CNAs did not empty it and would leave it for the housekeepers. 3. Review of Resident #5's face sheet, dated 04/18/24, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Resident #5's diagnoses included bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration) and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). Review of Resident #5's MDS assessment, dated 04/02/24, revealed the resident had a BIMS score of 00 indicating severe cognitive impairment. Observation on 04/18/24 at 12:01 PM with Resident #5 in her room in the memory care unit revealed the ceiling vent was dusty, and there were black marks on the ceiling around the vent opening. 4. Review of Resident #6's Face Sheet, dated 04/18/2024, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included Unspecified dementia (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems) and Unilateral primary osteoarthritis, left knee (a condition in which the natural cushioning between joints cartilage wears away). Review of Resident #6's MDS assessment, dated 03/28/2024, revealed the resident had a BIMS score of 03 indicating severe cognitive impairment. Observation on 04/18/24 at 12:09 PM revealed Resident #6's room on the memory care unit had a privacy curtain with brown stains, and the vents in the room were dusty with black marks on the ceiling round the ventilation opening. 5. Review of Resident #4's Face Sheet, dated 04/18/24, revealed the resident was an [AGE] year-old female admitted to the facility on [DATE].The resident's diagnoses included Unspecified dementia (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems) and hypertension (high blood pressure). Review of Resident #4's MDS assessment, dated 03/28/2024, revealed the resident had a BIMS score of 00 indicating severe cognitive impairment. Observation on 04/18/24 at 12:30 PM of Resident #4's room in the memory care unit revealed the privacy curtain in the room had brown stains. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of Resident #7's face sheet, dated 04/18/24, revealed the resident was an [AGE] year-old male admitted to the facility on [DATE]. Resident #7's diagnoses included Chronic systolic (congestive) heart failure (a condition in which the left ventricle of your heart was weak) and Muscle weakness (happens when full effort doesn't produce a normal muscle contraction or movement). Review of Resident #7's MDS assessment, dated 03/25/24, revealed the resident had a BIMS score of 10 indicating moderate cognitive impairment. Observation and interview on 04/18/24 at 1:09 PM in Resident #7's room revealed he pointed out that the ceiling vent was dusty and there were black marks on the ducts. He stated his expectation was the housekeepers should have wiped the ducts when cleaning the room, and they did not. Resident #7 stated he felt if action was not taken the dust might continue to accumulate, and it might affect him in the future. Observation and interview with CNA C, who was assigned to Residents #2 and #3, on 04/18/24 at 11:15 AM revealed there were soiled briefs in the trash cans in both residents' rooms and a stained privacy curtain for Resident #2. She stated she had been to both rooms earlier, and she did not see the briefs in the trash cans. She stated briefs were not supposed to be left in the room after incontinence care. She stated they should be put in a plastic bag and put in the barrel outside the rooms on the hallway. She stated she was aware if the curtains were dirty or stained, she should notify the housekeepers, but she had not noticed the stains. She stated leaving soiled briefs in the room could cause contamination. She stated she had done training on incontinence care. Observation and interview with LVN A on 4/18/24 at 11:38 AM, revealed he was the one who provided incontinence care to Resident #2 during wound care. He stated he was in a hurry to go and observe breakfast in the dining room and that was how he left the soiled brief in the trash can. LVN stated he was aware he was not supposed to leave a soiled brief in the trash can. He stated he was supposed to put it on plastic bag and then put it in the barrel outside the room on the hallway. He stated he had not checked on Resident #3's room but revealed staff had been leaving soiled briefs in the trash cans, and they needed to be trained on the importance of not leaving soiled briefs in the trash can. He stated the risk of leaving soiled briefs in the room was contamination. He stated he had done an in-service on incontinence care and disposal of soiled briefs. Observation and interview with CNA D, who was assigned to Residents #4, #5, and #6, on 04/18/24 at 12:11 PM revealed she had observed the privacy curtains were stained. CNA D revealed she was aware if curtains were dirty or stained, she should notify housekeeping, but she had not because she was busy. Observation and interview with Housekeeper I on 04/18/24 at 1:12 PM revealed the rooms vents were dusty. He stated it was his responsibility and other housekeepers to clean the vent ducts as they cleaned the rooms. He stated he was supposed to let the maintenance department know in case they were dirty for cleaning. Housekeeper I, stated the vents do not look good. He stated there was no schedule for dusting, they were supposed to dust daily as they clean the rooms, but he has not dusted the vents for some time, and he did not have any reason for not dusting. He stated it was also the housekeepers' responsibility to check on curtains. If they were dirty, they should notify maintenance to remove them, so they could be taken to the laundry to be washed. He stated the risk of having dusty vents was that it could affect resident with allergies and also residents were entitled to a clean and safe homelike environment. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Maintenance Director on 04/18/24 at 2:47 PM revealed he had one of his staff who was responsible for ensuring the curtains and the ventilation ducts were clean. He stated the vents were supposed to be removed cleansed and painted at times and other times they only required dusting. He stated he did not like how the ceiling vents looked. He stated he did not manage to see the curtains, but he was informed three privacy curtains were stained, and they were removed by his assistant. He stated he would take full responsibility for the vents and curtains being dirty, and he would be working closely with the staff to ensure they were cleansed. He stated the risk of the ceiling vents being dusty was that if they blew on residents they could be affected, especially those allergic to dust. He also stated residents were entitled to clean and safe environment. Interview with Assistant Maintenance Director on 04/18/24 at 3:00 PM revealed he was responsible for the curtains and air vents with help from the housekeepers, but there was no schedule of when to clean them. He stated he did go to the rooms to check how they looked, and he was notified by the director they did not look good. He stated he was notified of the stained curtains, and he saw three were stained. He stated he had to remove them for the housekeepers to wash them. He stated he did not have any reason why the vents and curtains were dirty. He stated residents were entitled to a clean and safe environment. He stated he was notified by the housekeepers if they needed to be changed or washed. Interview with the DON on 04/18/24 at 3:44 PM revealed her expectation was that staff performing incontinence care should put soiled briefs in a plastic bag, get them out of the room, and dispose of them in the barrels outside the room. She stated they should not leave soiled briefs in the room to prevent contamination and to control odors. The DON stated she had provided an in-service on incontinence care. Review of the facility's Resident Room Cleaning policy dated November 2021 reflected: PURPOSE: To provide a clean, attractive, and safe environment for residents, visitors, and staff. .K. Heater/ A/C Unit - wipe top and all sides, check top vents for accumulation of dust or debris; remove built-up dirt under the unit, sweep, and damp mop. J. Windows - clean window tracks and check curtains/blinds for soiling. Report any soiled blinds or curtains to the Housekeeping Supervisor

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on interview and record review, the facility failed to ensure residents had the right to be free from abuse for 1 (Resident #11) of 6 residents reviewed for abuse. The facility failed to supervise and protect Resident #11 from Resident #12, who had a diagnosis of dementia with a behavioral disturbance and was acting out on auditory hallucinations to hit other residents. On 04/02/24, Resident #11 was found on the floor, crying with bloody nostrils, while Resident #12 was standing over her yelling in an aggressive manner. The noncompliance was identified as PNC. The IJ began on 03/27/24 and ended on 04/03/24. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Finding included: Review of Resident #11's face sheet, dated 04/18/24, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included dementia (a condition characterized by the gradual decline of memory, language, and other cognitive abilities). Review of Resident #11's quarterly MDS assessment, dated 03/15/24, reflected she had a BIMS score of 00, indicating sever cognitive impairment. Further review revealed Resident #11 had not had any physical or verbal behaviors directed towards others. Review of Resident #11's undated care plan reflected: Care Area/Problem: *Fall Risk [04/03/24: Updated], Related To: Fall 4/2/24 .[sic]. Review of Resident #11's Psychiatric Periodic Evaluation, dated 03/21/24, reflected under History of Present Illness: Today, resident is seated in the TV room alert and oriented x1 in no distress or discomfort. She is pleasantly confused and collateral information is gathered from Medical records adn staff. Per satf, residenthas been calm with less aggression and is redirectable [sic] Review of Resident #11's hospital records, dated 04/05/24, reflected the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Chief complaint: Domestic Violence .[Resident #11] .presents to the ED with epistaxis [Bleeding from the nostril, nasal cavity or nasopharynx] secondary to an assault which occurred prior to arrival by another fell ow nursing home resident. EMS brought patient from facility and reports that they found patient on the ground bleeding from bilateral nares [the external openings in human nose that leads to the nasal cavity] . Patient endorses facial pain and neck pain . and Discussed case with [hospital doctor]. Reviewed CT and states that current fracture is benign and non displaced (meaning the bone cracked in only one place and remained aligned without shifting). And Final diagnoses: epistaxis due to trauma, facial pain, assault, maxillary fracture (a break in the upper jaw bone) , left side, initial encounter for closed fracture. Review of Resident #12's face sheet, dated 04/18/24, reflected she was a [AGE] year-old female who admitted to the facility on [DATE] and discharged on [DATE]. Her diagnoses included depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a group of mental illnesses that cause constant fear and worry), senile degeneration of the brain (the mental deterioration (loss of intellectual ability) that is associated with or the characteristics of old age), and dementia with behavioral disturbance (a condition characterized by the gradual decline of memory, language, and other cognitive abilities). Review of Resident #12's quarterly MDS assessment, dated 03/08/24, reflected she had a BIMS score of 00, indicating severe cognitive impairment. Further review revealed Resident #12 had not had any physical or verbal behaviors directed towards others. Review of Resident #12's physician's orders, printed 04/18/24 , reflected the following: Transfer to hospital for increased aggression and psych evaluation with a start date of 04/03/24. Review of Resident #12's undated care plan reflected: Care Area/Problem: *Behavioral Changes, Evidence By: Behavioral Aggression, angry/aggressive behavior .Interventions: Frequent visual checks, Maintain behavior log .[sic]. And Physically Aggressive, Related To: Altercation 3/27/24, Altercation 3/28/24 x2, Altercation 3/29/24, Altercation 03/30/24 .Interventions: 15min monitoring . Review of Resident #12's Psychiatric Periodic Evaluation, dated 03/26/24, reflected under History of Present Illness: .[Resident #12] is being seen for follow up, medication check and to monitor for staff c/o of increased anxiety, aggression and irritability .Per staff, resident has been walking up and down the hallway hitting other residents with her doll and getting aggressive and unredirectable. resident is posing a risk to self and others and staff is having to monitor her 1:1. I have instructed staff to continuously monitor and redirect resident. [sic] Review of Resident #12's progress notes reflected the following entries: - On 03/13/24 written by ADON Y, Resident noted with increased agitation, routine buspar administered per orders , redirected to activities, psych NP notified. - On 03/21/24 written by LVN X, Resident is exhibiting aggressive behaviors, constant redirecting by staff noted. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On 03/27/24 written by ADON W, 0930- Resident walking past nurse's station and physically hit another resident on the side of the head with her hand unprovoked. Resident continued walking down hallway and threw garment down while yelling out. - On 03/27/24 written by ADON W, 0939- contacted [Psych NP]. Received new telephone orders .for aggression and agitation .Initiated increased monitoring. - On 03/27/24 written by ADON W, 0955- Contacted patient's [family member], [Resident #12's RP] for update and consent for new medication orders. [Resident #12's RP] refused medications at this time. States, Because [Resident #12] hit someone today yall want to drug her up with medications? No. Don't give her anything. I'm coming up there. Attempted to educate on medications and increased aggression. [Resident #12's RP] continued to refuse treatment. Notified DON. [sic] - On 03/27/24 written by ADON W, 1600 [4:00 PM]- New order per [NP V]: Collect UA .for increased agitation . - On 03/27/24 written by LVN U, 7:30pm- Resident was involved in altercation with another resident. She was swinging her baby doll at the other resident hitting her in the face. Residents were separated. Resident was assessed and no injuries were observed. - On 03/28/24 written by LVN T, Pt is continuing to have random outburst where she is aggressive and agitated for no apparent reason. Pt outburst are not directed towards any individual but general to whomever .Later that day around 10:30 Pt hit a random resident for no reason and walk off afterwards. will continue to monitor. [sic] - On 03/29/24 written by NP Z, .Patient with dementia with agitation and behaviors. Patient resides on memory care unit. She is uncooperative with care .Had an incident where she was aggressive towards another resident for no reason . - On 03/29/24 written by LVN S, 0900:) Resident observed standing in the hallway near her room yelling and making threats at other resident walking in the hallway. Staff re-directed resident and escorted the other residents to their destination. 0930:) Resident observed hitting a male resident with a closed fist in his chest while walking past him in the hallway. Staff re-directed patient and escorted the male resident to his destination. No injuries noted. Management contacted resident's [family member] to notify of behaviors and also requested the [family member] to come into facility to discuss a treatment plan to reduce/prevent these episodes. - On 03/30/24 written by LVN T, Pt was walking down the hallway to hit another resident with her baby doll. Family and MD was noticed will continue to monitor. [sic] - On 04/02/24 written by LVN U, Resident is having auditory hallucinations, she stated her [family member] is telling her to hit other residents. - On 04/02/24 written by LVN R, resident noted with aggression towards other residents, RP contacted and made aware of situation stated [NAME] wanted to speak with social worker at this time. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On 04/02/24 written by ADON Y, Spoke to NP regarding family refusal to allow psych treatment, per NP attempted to call family on multiple attempts with no return call or answer. Resident observed with no behaviors at this time per NP if aggressive behaviors send to ER for further psych evaluation. - On 04/02/24 written by LVN U, Resident was involved in an altercation with another resident. Resident was found standing over another resident while they were on the floor and yelling at them. - On 04/03/24 written by ADON W, 0140- New order to send to [hospital] for increased and psych evaluation. Review of Resident #12's social services notes reflected the following: - On 04/01/24 written by the SW, Call placed to the [family member] and RP for the resident in order to discuss the increased aggression by the resident toward the other residents on the unit. The residents current medical status was discussed and the resident currently has a UTI that is on the second day of treatment . - On 04/02/24 written by the SW, Report received from the Unit staff that the resident continues to be a danger to the other residents on the Memory Unit due to increasing aggression toward residents on the unit. This resident has initiated two physical altercations towards other residents and is stating her [family member] is telling her to 'get them'. The resident has verbalized Auditory Hallucinations and admits to acting out as a result of the voices and commands she believes she is hearing. Medication management has been attempted but the residents' [family member] continues to refuse any attempts at medical intervention. The resident will be referred again for Inpatient psychiatric evaluation for stabilization due to increasing physical aggression and Auditory Hallucinations. [sic]. Review of Resident #12's Individual Resident Monitoring Nurse Visual Checks revealed they were started on 03/27/24 and ended on 03/29/24. Staff were documenting where the resident was seen every 15 minutes . Interview via phone on 04/18/24 at 12:37 PM with RN P revealed the incident between Residents #12 and #11 occurred during her shift. RN P said she turned the corner and Resident #11 was on the floor and Resident #12 was standing over her. RN P said she found the residents like this outside of Resident #12's room. RN P said as she got closer to the two residents, she noticed that Resident #11 was bleeding from her nostrils, and she kept putting her head down as if she was traumatized from what happened. RN P said Resident #11 could not and did not vocalize anything due to her cognitive condition. RN P said she rendered first aid to Resident #11 but when the bleeding did not stop the doctor was notified and she was sent to the hospital. RN P said Resident #12 just kept saying she was tired of this but was unharmed. RN P said she worked PRN, and this was her first time working on the unit in a while, but she was told that Resident #12 had become aggressive in the last week or so towards other residents. RN P said she was not told what to do during her shift to care for Resident #12 and her increased behaviors. RN P said neither Residents #11 or #12 were her residents at the time, but she heard Resident #11 whining and moaning which was what made her go around the corner to see what was happening. RN P said she was not sure how Resident #11 ended up on the floor. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 04/18/24 at 1:17 PM with LVN R revealed she had only recently started working with Resident #12. LVN R said Resident #12 was showing physical aggression towards other residents by randomly hitting other residents. LVN R said she was not told to do anything specifically regarding Resident #12's increased behaviors. LVN R was able to explain what to do when there was a resident-to-resident altercation. LVN R was able to explain the facility's abuse and neglect policies and how to handle a resident with behaviors. Interview on 04/18/24 at 2:44 PM with LVN U revealed she cared for Resident #12 who normally had moods but recently had a UTI that caused her to go on a rampage and wanted to hit and fight everyone. LVN U said she heard yelling in the direction of Resident #12's room where both Residents #11 and #12 were. LVN U said she went to see what happened and saw Resident #11 on the floor and Resident #12 yelling and standing over her. LVN U said she assessed Resident #11 who had a nosebleed which kept bleeding, so she was sent to the hospital for further treatment. LVN U said she was able to look through the window of the closed double doors where the residents were on the other side of the door, and it looked like Resident #12 was fighting with Resident #11 and that it appeared Resident #12 hit Resident #11. LVN U said Resident #11 was crying and was unable to say what happened due to her cognitive condition. LVN U said Resident #12 was yelling but did not sustain any injuries. LVN U said Resident #12 was on observations before this incident which meant staff were documenting where she was every 15 minutes. LVN U said Resident #12 was not currently on every 15-minute checks at the time of this incident though. LVN U said she knew that other staff had contacted the psych doctor who ordered medications, but the family refused them. LVN U said she tried making sure to keep a close eye on Resident #12 because of the increase in behaviors because she had heard Resident #12 had been hitting people lately. LVN U was able to explain the facility's abuse and neglect policies, how to handle a resident with behaviors, and what to do when there was a resident-to-resident altercation. Interview on 04/18/24 at 3:37 PM with ADON W revealed she cared for Resident #12 as her nurse before becoming the unit manager. ADON W said Resident #12 started having outbursts where she was assaulting other residents on the unit. ADON W said Resident #12's attacks were random and unprovoked. ADON W said Resident #12 told her that [Resident #12's family member] was telling her to do these things. ADON W said Resident #12 was being frequently monitored and at one point was on every 15-minute checks by staf f. ADON W said staff communicated with the psych doctor to make medication adjustments for Resident #12, but her family refused it. ADON W said she was not here for the incident between Resident #11 and #12 but heard that Resident #12 hit Resident #11 who fell to the floor. ADON W said Resident #11 was sent to the hospital and returned with a facial fracture. ADON W was able to explain the facility's abuse and neglect policies, how to handle a resident with behaviors, and what to do when there was a resident-to-resident altercation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 04/18/24 at 4:09 PM with the Administrator revealed Resident #12 was a challenge who started having an increase in behaviors and outbursts. The Administrator said he tried to get psych involved in Resident #12's care, but the family was adamant that they would not allow for any medication adjustments. The Administrator said he told Resident #12's family if her behaviors continued, they would have to consider an inpatient psych facility next. The Administrator said after the first incident Resident #12 was placed on frequent checks and staff were monitoring her consistently. The Administrator said regarding Resident #11 and #12's incident, he was told that they had an altercation and had to send Resident #11 to the hospital because she had a maxillary fracture. The Administrator said Resident #12 was also taken to the hospital for a psychological evaluation, The Administrator said staff could not see what happened between the two residents to determine if Resident #12 pushed or hit Resident #11. The Administrator said Resident #12 had six incidents with other residents in a short period of time from 03/27/24 to 04/02/24. The Administrator said he had tried to send Resident #12 out multiple times related to the behaviors, requested a care conference with her family, had her on every 15-minute checks, and asked staff to redirect her. The Administrator said Resident #12 was not on every 15-minute checks the entire time she was having behaviors, including when she had the incident with Resident #11 on 04/02/24. The Administrator said he thought the behaviors were due to Resident #12 having a UTI at the time of the incidents and she was being treated for that. The Administrator said he continued notifying the psych doctor of Resident #12's behaviors but since the family refused any additional medication adjustments there was nothing to be done. The Administrator said all staff assigned to the unit were responsible for making sure all residents were safe. The Administrator said the purpose of making sure residents were safe was the facility's due diligence to monitor them and try to prevent any accidents/incidents. The Administrator said the risk of not keeping residents safe was that they can have injuries from resident-to-resident altercations. The Administrator was able to explain the facility's abuse and neglect policies, how to handle a resident with behaviors, and what to do when there was a resident-to-resident altercation. Interview on 04/18/24 at 4:26 PM with the SW revealed Resident #12 all of a sudden had a violent streak with multiple physical altercations with other residents. The SW said Resident #12 was actually hitting and fighting people. The SW said he was in the process of getting Resident #12 set up to go to a psych hospital when she was sent to the hospital to try and get an evaluation regarding her medications. The SW said Resident #12's family members refused any medication adjustments from the facility's doctors which would have helped to lessen Resident #12's aggressive behaviors. The SW said Resident #12 reported hearing her dead family members voices telling her to hit and beat people up. The SW said Resident #12 could not go to a psych facility originally because she had been diagnosed with a UTI that she was being treated for. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 04/18/24 at 5:15 PM with the DON revealed the situation with Residents #11 and #12 was not witnessed. The DON said staff observed Resident #11 on the floor and she had an injury which was a facial fracture. The DON said Resident #12 was found standing over Resident #11 who did not have any injuries. The DON said the facility had tried to send Resident #12 out for a psych evaluation, but no facility would take her since she was being treated for a UTI. The DON said the psych doctor had also tried to make medication adjustments for Resident #12, but the family refused them all. The DON said staff were monitoring Resident #12 for her increased aggressive behaviors and were monitoring her every 15 minutes while she still had seven incidents with other residents in a short span of time. The DON said the facility also took her dolls away from her so that she could not use them to continue hitting others with them. The DON said the facility only had Resident #12 on every 15-minute checks from 03/27/24 to 03/29/24. The DON said Resident #12 did not have any noted aggressive behaviors past 03/30/24 so there was no need to continue every 15-minute checks. The DON said the entire nursing department made the decision to keep a resident on every 15-minute checks or not. The DON said the facility was not going to keep Resident #12 on every 15-minute checks for too long of a time. The DON said staff were supposed to be monitoring the residents on the unit in general and separating them if there were any altercations that occurred. Follow-up interview on 05/06/24 at 1:52 PM with ADON W revealed Resident #12's situation taught the facility the harm of delay. ADON W said the facility thought they had intervened and tried things before sending Resident #12 out because they knew the family truly did not want that. ADON W said now the facility understands that they have to think of all the other residents in the facility. ADON W said there were not any current residents on the memory care unit who had aggressive tendencies or any behaviors right now. Follow-up interview on 05/06/24 at 2:27 PM with the DON revealed there were not any current residents on the memory care unit who had aggressive tendencies or behaviors right now. The DON said Resident #11 has not had any changes in her behavior after the incident on 04/02/24. Follow-up interview on 05/06/24 at 3:07 PM with the Administrator revealed there were not any current residents on the memory care unit who had aggressive tendencies or behaviors right now. The Administrator said Resident #11 has not had any changes in her behavior after the incident on 04/02/24. Review of a census, dated 05/06/24, revealed Resident #12 was not a resident of the facility. Review of the facility's Incident Report log from 04/06/24 to 05/06/24 revealed there were no altercations with injuries amongst the residents. Review of the facility's training in-service form, dated 04/03/24, revealed all staff were trained regarding abuse, neglect, exploitation, misappropriation of resident property and resident to resident behaviors. Review of the facility's training in-service form, dated 04/20/24, revealed all staff were trained regarding abuse, neglect, exploitation, misappropriation of resident property and fall prevention/fall management. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy, revised February 2020, and titled Behavior Management reflected: .A. Anticipating Behaviors: 1. Staff is responsible for preempting behavior problems before they occur. 2. At onset of anxiousness, agitation, or any behavior that signifies the resident is having difficulty, staff is responsible for immediately attempting to rule any unmet needs .[sic]. Review of the facility's policy revised 02/12/20, and titled Abuse, Neglect and Exploitation and Misappropriation of Resident Property reflected: .Each resident has the right to be free from abuse, neglect, exploitation, misappropriation of resident's property, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse, neglect, exploitation, misappropriation of resident's property by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, resident representative, friends, or other individuals. On 05/06/24 at 5:05 PM the Administrator was informed an Immediate Jeopardy was determined to have existed from 03/27/24 to 04/02/24. The IJ was determined to have been removed on 04/03/24 due to the facility's implemented actions that corrected the non-compliance prior to the beginning of the investigation.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain good personal hygiene for 6 (Residents #1, #2, #8, #9, #10, #13) of 6 residents reviewed for ADL care. The facility failed to provide incontinence care to Residents #1, #2, #8, #9, #10, #13 every 2 hours and as needed. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life. Findings include: 1. Review of Resident #2's Face Sheet, dated 04/18/24, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included cerebral ischemic (common mechanism of acute brain injury that results from impaired blood flow to the brain). Record review of Resident #2's Care Plan dated 02/16 /24, reflected the following: Goal: Resident will be assisted with incontinence to ensure social acceptance over the next 90 days . Approach: Check resident every two hours and assist with toileting as needed . Review of Resident #2's MDS assessment, dated 03/18/24, revealed the resident had a BIMS score of 10 indicating moderate cognitive impairment. The MDS assessment indicated Resident #2 required moderate assistance with toileting and personal hygiene. Observation and interview on 04/21/24 at 7:30 AM revealed LVN H providing Resident #2 with incontinence care. LVN H washed her hands, put on gloves, and explained the procedure to Resident #2. She unfastened the resident's brief, which was wet with urine. The resident stated the last time she was changed was at 11:00 PM during her nighttime medication administration. Resident #2 stated she only got changed once at night and after that she had to wait until morning. She was observed to have a dressing on her coccyx (a small triangular bone at the base of the spinal column in human) dated 04/18/24. 2. Review of Resident #10's face sheet, dated 04/21/24, revealed the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included hypertension (high blood pressure) and cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain). Review of Resident #10's MDS Quarterly Assessment, dated 01/15/24, reflected a BIMS score of 0, which indicated severe cognitive impairment. Further review reflected Resident #10 needed substantial/maximal assistance from staff in regard to activities of daily living. Review of Resident #10's care plan, dated 02/07/24, reflected the following: Goal: Resident will be assisted with incontinence to ensure social acceptance over the next 90 days Approach: Check resident every two hours and assist with toileting as needed . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 04/21/24 at 7:35 AM revealed RN G providing Resident #10 with incontinence care. RN G washed his hands, put on gloves, and unfastened the resident's brief. Resident #10 had on two briefs and was heavily urine soaked. Resident #10 stated he requested the night staff to put two briefs on him because he was a heavy wetter, and staff took a long to come and change him at night. His skin was intact. 3. Record review of Resident #1's face sheet dated 04/21/2024 reflected Resident #1 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included altered mental status and hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side (Paralysis of partial or total body function on one side of the body). Record review of Resident #1's Comprehensive MDS assessment dated [DATE] reflected, Resident #1's BIMS score of 0, which indicated Resident #1 was unable to complete the interview. The MDS assessment indicated Resident #1 required moderate assistance with toileting and personal hygiene. Record review of Resident #1's Care Plan dated 03/03 /24, reflected the following: Goal: Resident will be assisted with incontinence to ensure social acceptance over the next 90 days . Approach: Check resident every two hours and assist with toileting as needed . Observation and interview on 04/18/24 at 10:57 AM with Resident #1 and his Power of Attorney revealed the resident's room had a urine odor smell. According to them, since last night, the resident only had his brief changed once. The Power of Attorney stated the resident was always wet at around that time, and she visited him 3 times a week in the morning. Observation on 04/21/24 at 8:10 AM revealed RN G providing Resident #1 with incontinence care. RN G washed his hands, put on gloves, and explained the procedure to Resident #1. He then unfastened the resident's brief, and Resident #1 had on two briefs which were heavily soaked wiht urine. The resident could not remember when he was changed last, and he did not know he was wearing two briefs. 4. Review of Resident #8's face sheet, dated 04/21/24, revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included acute respiratory failure (a serious condition that makes it difficult to breathe), muscle wasting and atrophy and congestive heart failure (long-term condition in which heart could not pump blood well enough to meet body's needs). Review of Resident #8's MDS Quarterly Assessment, dated 03/26/24, reflected a BIMS score of 0, which indicated severe cognitive impairment. Further review reflected Resident #8 needed substantial/maximal assistance from staff in regard to activities of daily living. Review of Resident #8's care plan, dated 04/03/24, reflected the following: Goal: Resident will be assisted with incontinence to ensure social acceptance over the next 90 days Approach:Check resident every two hours and assist with toileting as needed . Observation and interview on 04/18/24 at 5:30 PM revealed MA/CNA K providing Resident #8 witih incontinence care. The resident was heavily soaked with urine. Resident #8 stated the last time she had a brief change was before breakfast. She stated she had been complaining, and it had been all the same. The resident's skin was observed intact. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/21/24 at 7:50 AM with LVN revealed he washed his hands, put on gloves, and explained the procedure to Resident#8. He unfastened the resident's brief, and the brief was heavily soaked with urine. Resident #8 stated the last time she had her brief changed was at 8:00 PM. Her skin was intact. 5. Review of Resident #9's face sheet, dated 04/21/24, revealed the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included acute kidney failure (occurs when kidneys suddenly become unable to filter waste products from the blood) and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). Review of Resident #9's MDS Quarterly Assessment, dated 01/15/24, reflected a BIMS score of 0, which indicated severe cognitive impairment. Further review reflected Resident #9 dependent with staff in regard to activities of daily living. Review of Resident #9's care plan, dated 04/10/24, reflected the following: Goal: Resident will be assisted with incontinence to ensure social acceptance over the next 90 days Approach: Check resident every two hours and assist with toileting as needed . Observation and interview on 04/21/24 at 7:52 AM revealed LVN F revealed he washed hands, put on gloves, and unfastened the resident's brief. Resident #9 had on two briefs, which were heavily urine soaked with fecal matter in the briefs. Resident #9 was not a good historian, and she could not tell when she was last changed. The resident's skin was intact. 6. Review of Resident #13's face sheet, dated 04/21/24, revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included hypertension (high blood pressure) and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). Review of Resident #13's MDS Quarterly Assessment, dated 02/06/24, reflected a BIMS score of 03, which indicated severe cognitive impairment. Further review reflected Resident #13 needed substantial/maximal assistance from staff in regard to activities of daily living. Review of Resident #13's care plan, dated 02/07/24, reflected the following: Goal: Resident will be assisted with incontinence to ensure social acceptance over the next 90 days Approach: Check resident every two hours and assist with toileting as needed . Observation and interview on 04/21/24 at 7:58 AM with LVN A revealed he washed his hands, put on gloves, and unfastened the resident's brief. Resident #13's brief was heavily soaked with urine. Resident #13 stated her brief was not changed overnight. The resident's skin was observed intact. Interview on 04/21/24 at 9:00 AM with LVN X, who was the night charge nurse, revealed he was not aware the CNAs, who worked on night shift, were not changing the residents. He stated he would see CNAs on the hallway with barrels, and he thought they were going room to room changing the residents. He stated he did his rounds, but he was not checking whether the residents were wet. He stated when the morning staff came, he gave them report at the desk. He stated he was not aware that his CNA had left before the on-coming shift crew arrived. He stated he was aware staff were supposed to check resident every two hours and ensure they were dry to prevent skin issues and infections like urinary tract infections. LVN X stated they should not put double briefs on residents. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/21/24 at 9:16 AM with CNA L revealed she came to work late, and she did not meet the night crew. She stated when she reported in the morning most of the time the resident were soaked and wet, and she had reported it to her nurses. She stated she was aware they were supposed to do rounds every two hours and as needed. CNA L stated they had been given training of not putting residents two briefs and rounding every two hours. Interview with on 04/21/24 at 10:31 AM with LVN F, who was the day shift nurse, revealed when he reported there was an odor in some rooms. He stated when he reported in the morning, he did not meet the night shift CNA. He stated residents were being left wet by night shift on weekends, and he had once reported to the management, but he could not recall when. He stated the risk of putting two briefs and leaving residents wet for a long time was that they would be predisposed to skin irritation and urinary tract infections. Interview on 04/21/24 at 10:35 AM with the DON revealed her expectation was that the staff perfomed rounds every two hours and as needed. She stated the nurses were responsible for monitoring the CNAs during their shifts. She stated staff should not double the briefs on residents, and she had educated the staff and also the family members. She stated the risk of not performing every two hours rounds and doubling the briefs was that it could lead to skin issues and infections. The DON stated she had done training with staff on providing incontinence care every two hours and not leaving the soiled briefs in the trash cans in residents' rooms. Interviews were attempted with night shift staff on 04/21/24 via telephone calls, but the calls were not successful. Record review revealed the facility had completed training on timely ADL care/incontinence care, making rounds every 2 hours and as needed, and skin integrity: no double briefing on 03/26/24. Record review of the facility's policy Perineal care revised April 2024, reflected the following: . Staff will provide perineal care in accordance with the standard of practice to prevent skin breakdown and infection.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 2 (Resident #2 and #5) of 2 residents reviewed for pressure ulcer treatment. The facility failed to ensure Resident #2 and #5 received wound care according to physician orders. This failure could place the resident at risk of worsening wounds. Findings included: 1. Review of Resident #5's face sheet, dated 04/18/24, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Resident #5's diagnoses included bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration) and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). Review of Resident #5's MDS assessment, dated 04/02/2024, revealed the resident had a BIMS score of 00 indicating severe cognitive impairment and Resident #5 was at risk of developing pressure ulcers/injuries. Review of Resident #5's care plan, dated 04/10/24, indicated skin breakdown: At risk for/actual skin, Cleanse Wound every am shift (6am-2pm). Cleanse Wound as Needed as Needed Dislodged. She was care planned for open area will be healed over the next 90 days. Interventions: Treatments and dressings as ordered per physician. Review of Resident #5's physician orders revealed the following wound care orders, dated 04/10/24, reflected the following orders: Cleanse Wound every am shift (6am-2pm) WOUND OF THE RIGHT BUTTOCK: Cleanse with normal saline or wound cleanser pat dry. Apply mupirocin topical 2% and Santyl. Cover with a dry dressing daily. Cleanse Wound as Needed Dislodged WOUND OF THE RIGHT BUTTOCK: Cleanse with normal saline or wound cleanser, pat dry. Apply mupirocin topical 2% and Santyl. Cover with a dry dressing as needed. Review of Resident #5's Treatment Record for April 2024 indicated wound care was not provided on 04/17/24 and 04/18/24. Observation on 04/18/24 at 12:10 PM with CNA D revealed Resident #5 had a dressing on her coccyx dated 04/16/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 04/18/24 at 3:05 PM with LVN E, who was the Wound Care Nurse, revealed she was not responsible for performing wound care on the North Side. She stated the floor nurses were responsible for their residents since the wound care nurse was off duty. She assessed the resident and confirmed the dressing was dated 04/16/23. She stated failure to follow the doctor's orders could result in the wound getting worse and getting infected. She then prepared and disinfected the table, put supplies together, and she changed the resident's wound dressing. Interview on 04/18/24 at 5:20 PM with LVN B revealed she was not aware Resident #5's wound care was not performed by the 6:00 AM-2:00 PM shift, and the nurse had not told her during shift change. LVN B stated failure to perform wound care as indicated could worsen the wound and slow the healing. 2. Review of Resident #2's Face sheet, dated, 04/18/2024 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included cerebral ischemic (common mechanism of acute brain injury that results from impaired blood flow to the brain). Review of Resident #2's MDS assessment, dated 03/18/24, revealed the resident had a BIMS score of 10 indicating moderate cognitive impairment. Her Skin Conditions indicated she was at risk of developing pressure ulcers/injuries. Resident has open lesion. Review of Resident #2's care plan, dated 02/20/24, indicated skin breakdown: At risk for/actual skin, cleanse wound as needed if dislodged. She was care planned for open area will be healed over the next 90 days. Interventions: Treatments and dressings as ordered per physician. Review of Resident #2's physician orders revealed the following wound care orders, dated 04/03/24: Cleanse Wound every am shift (6am-2pm) NON-PRESSURE WOUND OF THE LEFT BUTTOCK: Cleanse wound with NS/WC, pat dry. Apply anapest and collagen sheet, then cover with a dry dressing daily. Review of Resident #2's Treatment Record for April 2024 indicated wound care was provided on 04/19/24 and 04/20/24. Observation on 04/21/24 at 11:25 AM with LVN A revealed him performing wound care. He washed his hands and put on gloves. He disinfected the table and let to dry. He removed the gloves and washed his hands. He explained the procedure to Resident #2. He put supplies together, washed his hands, put on gloves, and explained the procedure to Resident #2. He unfastened the resident's brief, and Resident #2's wound dressing was dated 04/18/24. He removed the old dressing, doffed his gloves, washed his hands, and put on new gloves. LVN A then cleansed the wound, patted it dry, doffed his gloves, washed his hands, and put on new gloves. The wound was healing with no signs of infection. LVN A next applied anapest, collagen sheet then covered the wound with a dry dressing. He then doffed his gloves and washed his hands. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/21/24 at 11:35 AM with LVN A revealed the dressing was dated 04/18/24. He stated he was responsible for performing wound care on 04/19/24 and 04/20/24, and he had not managed to perform wound care for all residents because there were many. He stated Resident #2's wound care was supposed to be done daily on the 6:00 AM-2:00 PM shift. He stated the risk of not performing wound care as per the doctor's order was that it could lead to the wound worsening. He stated he did not understand how he signed the treatment administration record as wound care was performed while it was not performed. He stated he understood signing without performing wound care could make the resident miss the treatment as per physicians' orders and could worsen the wound. Interview on 04/21/24 at 11:38 AM with the DON revealed the nursing staff knew they had to follow physician orders as they were written. The DON stated the facility had a Wound Care Nurse, but she was out. She stated they had requested for nurses on the floor to perform wound care on their halls. Staff nurses were responsible for wound care when the Wound Care Nurse was not available. The DON stated she was not aware that nurses were not performing wound care and were signing treatment administration records before administering care. She stated she would perform a wound sweep on all residents and ensure all the wounds were taken care of. She stated failure to follow the doctors' orders could result in the wounds worsening. She stated she was responsible for ensuring wound care was being provided. She stated she was responsible for monitoring that wound care was being provided. Interview on 04/22/24 at 11:40 AM with LVN N revealed she worked the 6:00 AM-2:00 PM shift with Resident #5. She stated she was aware the resident's wound care was supposed to be done, but the resident refused. She stated she had not notified the on-coming nurse, and she had not notified the management or documented in the progress notes. She stated failure to perform wound care as indicated could result in the the wound getting worse or getting infected. She stated she was also supposed to let the doctor know about the refusal. Review of the facility's current policy dated July 2018 titled, Treatment of Wounds: Dressing Changes-Performing reflected: . 1. Review orders and treatments and gather supplies. 2. Follow standard precautions and infection control methods depending on the appropriate type of transmission-based precautions. .4. Ensure all wound dressing products are completely removed with each dressing change if present