STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345008	A. BUILDING ______ B. WING ______	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL AT MYERS PARK, LLC	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An onsite recertification and complaint investigation survey was conducted from 01/14/25 through 01/17/25. The survey team returned onsite on 01/29/25 for a new complaint investigation and collected additional information offsite 01/30/25 through 01/31/25. The survey team again returned onsite on 02/06/25, 02/07/25, and 02/10/25 to conduct a new complaint investigation and collected additional information offsite on 02/11/25 and 02/12/25. Therefore, the exit date was changed to 02/12/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # WXGK11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 01/14/25 through 01/17/25 to conduct an unannounced recertification and complaint investigation survey. Event ID: WCGK11. The survey team returned onsite on 01/29/25 for a new complaint investigation and collected additional information offsite 01/30/25 through 01/31/25. The survey team returned onsite on 02/06/25, 02/07/25, and 02/10/25 to conduct a new complaint investigation, collect additional information offsite on 02/11/25 and 02/12/25 and perform an extended survey. Therefore, the exit date was changed to 02/12/25. The following intakes were investigated NC00223612, NC00223398, NC00223967, NC00225151, NC00225462, NC00225675, NC00225901, NC00226083, NC00226348, NC00226476, NC00226542, NC00226553, NC00226789, NC00226897, and NC00226873. 28 of the 45 allegations resulted in deficiency.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 02/26/2025

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.

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F 000	Continued From page 1 Intakes NC00226873, NC00226897, NC00226789, NC00226553, NC00226542, NC00226476, NC00226348, NC00226083 resulted in Immediate Jeopardy. Immediate jeopardy was identified at: CFR 483.12 at tag F600 at scope and severity of J. CFR 483.12 at tag F607 at scope and severity of K. CFR 483.25 at tag F689 at scope and severity of J. The tags F600, F607, and F689 constituted Substandard Quality of Care. A extended survey was completed. Immediate Jeopardy for F600 began on 01/27/25 and is present and ongoing. Immediate Jeopardy for F607 began on 01/27/25 and is present and ongoing. Immediate Jeopardy for F689 began on 01/21/25 and is present and ongoing.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		3/4/25

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F 578	Continued From page 2 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to have effective systems in place for communicating changes in resident code status for 1 of 22 residents reviewed for advanced directives (Resident #25). The findings included:	F 578	1. It is the intention of Myers Park Nursing Center to ensure residents Most forms are updated following hospitalizations, quarterly, or annually as indicated or discussed with the party responsible. 2. This alleged deficient practice has the potential to affect all residents who	

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Resident #25 was admitted to the facility on 7/10/23. His diagnoses included cerebral infarction due to unspecified occlusion or stenosis of bilateral carotid arteries, diabetes mellitus due to an underlying condition with hypoglycemia, and chronic obstructive pulmonary disease.

Resident #25 resided on the second floor of the facility and a review of his physical advance directive, a Medical Orders for Scope of Treatment (MOST) form stored in a folder in a filing cabinet at the second-floor nurse's station, dated 12/13/24 indicated cardiopulmonary resuscitation (CPR/Full Code) status.

A review of Resident #25's physical Do Not Resuscitate (DNR) form, signed on 1/3/25 was completed. The DNR form was stored with the MOST form, signed on 12/13/24, in a folder in a filing cabinet at the second-floor nurse's station.

The electronic medical record (EMR) resident profile indicated Resident #25's code status as DNR.

A review of Resident #25's EMR nursing progress notes revealed he transitioned to Hospice/end of life care on 1/3/25 and his code status was changed from a CPR/Full Code to DNR on the same date.

An interview was conducted on 1/16/25 at 3:39 PM with the Medical Records Coordinator. He stated when a code status changed for a current resident, he would receive the information after a care plan meeting occurred and the care plan was updated. He stated he did not update the EMR for Resident #25's code status change and he was unaware of the change in status and was

F 578

resident in the facility.
Resident #25 MOST form was reviewed. Resident was assessed on 1/3/2025 by 2 physicians for advanced directives. Physician orders were implemented to reflect current plan of care.
100% audit of MOST forms was completed by the administrator/designee on 1/23/2025. Any identified discrepancy was immediately corrected.

3. The Administrator re- educated the Social Services Director, Medical Records Director, and clinical staff on 1/17/2025 regarding the requirements of completing and maintaining an accurate MOST form at least annually and following hospitalizations, quarterly, or annually as indicated or discussed with the responsible party.

4. Facility Director of Nursing or designee will perform medical record audits of new admissions, readmissions, and those residents on the MDS assessments schedule, as well as 5 random weekly for 6 weeks. Audit findings will be reported to QAPI committee monthly and additional interventions implemented as indicated to maintain ongoing compliance.

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unaware a care plan meeting occurred.

An interview on 1/17/25 at 9:55 AM with the Social Worker (SW) revealed she was responsible for updating the care plan when a code status changed for a current resident in the facility. She stated Resident #25's MOST form on file indicated a CPR/Full Code status and there had been discussion about transitioning his care to Hospice. The SW was unaware Resident #25 had transitioned to Hospice on 1/3/25 and was unaware of the code change status to DNR and did not have a care plan meeting. She stated she did not have the ability to change any code status alerts in the EMR and nursing was responsible for updating that information.

An interview was conducted on 1/17/25 at 11:31 AM with the Director of Nursing (DON). She stated the DNR order took effect on 1/3/25 for Resident #25 and the MOST form was not rewritten to reflect the code status change. She stated the Medical Records Coordinator, and the SW were responsible for updating the documents in the chart and the care plan, respectively and she was unsure why they were not informed of Resident #25's code status change. The DON explained Unit Manager #1 updated Resident #25's resident profile code status to DNR in the EMR. She stated nurses typically looked at the alert banner profile in the EMR for code status.

An interview with Unit Manager #1 on 1/17/25 12:11 PM revealed she updated the alert banner profile in the EMR to reflect the DNR code status for Resident #25, but the Medical Records Coordinator was responsible for uploading the copies of any new MOST or DNR form to the EMR and was unsure if that had been completed.

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F 578	Continued From page 5 An interview with the Administrator on 1/17/25 at 2:07 PM revealed she expected the physical DNR and MOST forms to reflect the same code status and was not sure how the physical MOST and DNR forms did not reflect the same status.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		3/4/25

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F 580	Continued From page 6 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, Nurse Practitioners (NP) and staff interviews, the facility failed to notify the physician details of a resident abuse incident that caused a resident to fall to the floor and hit his head. After NP #2's assessment a physician's order was provided for transfer to the hospital for evaluation to rule out head trauma, intracranial hemorrhage (bleeding), or other pathology. This occurred for 1 of 1 resident reviewed for notification (Resident #84). The findings included: Resident #84 was admitted to the facility on 11/22/24 with diagnoses including Alzheimer's disease and dementia. The admission Minimum Data Set (MDS) dated 11/29/24 revealed Resident #84's cognition was	F 580	1.Resident #84's NP #2 was notified of physical altercation resulting in fall with potential for injury including possible head injury on 1/27/25 at approximately 430pm. Resident #84 was sent to the hospital at approximately 7pm and returned to the facility with no identified injury. NP #1 was made aware of the physical altercation on 1/28/25 to update on the incident being a result of physical altercation and that resident #84 was seen at ER and returned with no noted injury. 2. Residents who reside in the facility have the potential to be affected. 3. Facility policy "Change in condition Notification", was reviewed by regional nurse on 2/17/25 with no revisions implemented.	

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severely impaired, and he was not taking anticoagulant or antiplatelet medications and had no history of falls.

An incident report dated 1/27/25 at 10:50 AM revealed Nurse #6 observed Resident #84 being "tossed out of the room" by another resident into the hallway floor landing on his left side and left facial area. Nurse #6 noted there were no injuries observed at the time of the incident and Resident #84 was alert, confused, oriented to person, and ambulatory without assistance.

Review of neuro check documentation revealed the first check was started on 1/27/25 at 10:55 AM and indicated Resident #84 refused vital signs, was alert, had a headache, and there were no signs of seizure, ear/nose drainage, or vomiting. Neuro checks continued from 12:16 PM until 5:45 PM and indicated Resident #84 was at the hospital.

During a phone interview on 1/30/25 at 11:22 AM Nurse #6 revealed on 1/27/25 she witnessed Resident #64 take both hands and lift Resident #84 off the ground and throw him out of his room and he fell onto the floor. Nurse #6 revealed she heard a noise that "sounded like a crack" and saw Resident #84's head hit the floor. After the fall she did not see any obvious injuries but Resident #84 told her his left arm and head hurt and would not let her touch or assess him and was guarding his left arm. NP #1 was notified, and she (Nurse #6) was asked to tell what happened and stated she reported "Resident #84 was thrown to floor."

An interview was conducted on 1/29/25 at 5:18 PM with NP #1. NP #1 revealed on 1/27/25

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The DON/designee will provide education to facility nurses regarding F580 and facility policy regarding notification of change. Education will be completed by 2/26/2025. This education will reiterate the importance and need for thorough reporting of all incidents.
4. Audits of 5 resident's EMR will be completed by DON/designee to review that appropriate notifications are completed and documented appropriately for identified change in resident condition. Audits will be completed weekly for 6 weeks.

Results of audits will be presented to QAPI Committee for review, recommendation, and oversight.

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around 11:00 AM he was called and told "an aggressive altercation" occurred and Resident #84 and was being monitored. NP #1 revealed his guidance was if the nurse thought Resident #84 needed to be evaluated she could send him to the emergency room. NP #1 revealed no specific details were provided about abuse and he was not notified Resident #84 fell and hit his head on the floor. NP #1 revealed if he was notified Resident #84 hit his head on the floor he would have requested the resident be sent to the emergency room for evaluation.

During a phone interview on 1/30/25 at 4:12 PM the Administrator revealed she spoke with NP #1 who revealed on 1/27/25 at approximately 11:00 AM or 11:30 AM he was informed of an altercation, but it was not expressed if it was physical or verbal. He spoke with Nurse #6 and was told nothing about a fall or Resident #84 hit his head. NP #1 instructed the nurse if she felt something was wrong to send Resident #84 out for evaluation and use her nursing judgement and let him know if that was what she chose to do.

Review of NP #2's follow-up note dated 1/27/25 revealed Resident #84 was reviewed for head injury and arm pain after nursing reported he fell around 10:50 AM. NP #2 noted Resident #84 fell as a result of resident abuse when Resident #64 forcefully lifted him into the air and threw him out of his room. Resident #84 landed on his left side and a cracking sound was heard and he hit his head on the floor. NP #2 noted neuro checks were started and during the evening Resident #84 was arousable but would not open his eyes and minimally responded to questions. NP #2's assessment revealed Resident #84 had no deformities or visible signs of mal-alignment or

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dislocation and appeared at baseline for the diagnosis of dementia. NP #2 recommended sending him to the emergency department for evaluation to rule out head trauma, intracranial hemorrhage, or other pathology.

During an interview on 1/29/25 at 4:48 PM NP #2 revealed she was at the facility around 4:30 PM on 1/27/25 when Nurse #6 told her "she saw Resident #84 fall and hit his head on the floor." NP #2 revealed when she assessed Resident #84 on 1/27/25 he was groggy but had no deformities or obvious physical injury, but she was concerned about him being thrown onto the floor and sent him to the emergency department for an evaluation of injury.

A review of the emergency department summary revealed on 1/27/25 Resident #84 was evaluated due to a previous fall. A CT (computed tomography) scan (a three dimensional imaging of the body) of the head and neck and a chest x-ray showed no abnormalities or injuries, and Resident #84 was discharged back to the facility in stable condition.

A follow-up phone interview was conducted on 1/31/25 at 2:21 PM with the Administrator. The Administrator revealed she expected the same information was shared with NP #1 when he was notified about the resident abuse incident and include Resident #84 fell and hit his head.

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F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		3/4/25

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including

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but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and

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1. The wheelchair armrest for resident

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interviews with residents and staff, the facility failed to maintain wheelchairs for 2 of the 2 residents reviewed for mobility device (Resident #38 and Resident #87) and window blinds in good repair in 1 of 8 rooms (Room 105) on 1 of 6 halls.

The findings included:

1.a. Resident #38 was admitted to the facility on 11/20/24.

The admission Minimum Data Set (MDS) assessment dated 11/27/24 revealed Resident #38 was coded with moderately impaired cognition and impairment on one side of lower extremity.

During an observation conducted on 01/14/25 at 11:12 AM, Resident #38 was seen sitting in a wheelchair in his room wearing a short sleeve shirt. The padded left armrest of the wheelchair had an area of approximately 2 inches by 5 inches of the covering that was torn, cracked, and ripped with sharp edges. Resident #38's left arm was seen contacting the area of disrepair on the armrest during the observation.

An interview was conducted with Resident #38 on 01/14/25 at 11:16 AM. He stated he could not recall how long the left armrest of his wheelchair had been in disrepair. He stated it would be nice if someone in the facility could fix it as soon as possible.

During a joint observation of Resident #38's wheelchair in conjunction with an interview conducted on 01/15/25 at 1:01 PM with Nurse Aide (NA) #8 and Nurse #5, the left armrest for Resident #38's wheelchair remained in disrepair.

F 584

#38 was replaced by the maintenance director on 1/17/2025.
The window blinds in resident #38's room were replaced by the maintenance director on 1/17/2025.
The wheelchair armrest for resident #87 was replaced by the maintenance director on 1/17/2025.
2. A 100% audit was completed by the therapy director on 1/17/2025 to observe each wheelchair to ensure armrests in good repair without need for replacement. Identified concerns were reported to the LNHA and maintenance director for repair/replacement.
The maintenance director completed a 100% audit of resident rooms on 1/17/2025 to observe window blinds. Identified broken blinds were replaced by the maintenance director on 1/17/2025.
3. Education was provided on 1/17/2025 to facility staff by the LNHA regarding reporting of identified broken or wheelchair armrests and of noted broken window blinds to the maintenance director.
The maintenance director was educated by the LNHA on 1/17/2025 regarding the repair of wheelchair armrests and monitoring and replacing window blinds timely.
4. The therapy director will audit 10 wheelchairs weekly for 6 weeks to observe for any armrests needing repair. The maintenance director will check window blinds in 10 rooms weekly for 6 weeks to ensure blinds are in good repair and replaced timely as needed.
Audit results will be reviewed in QAPI and

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F 584	Continued From page 12 Nurse #5 assessed Resident #38's left arm immediately and confirmed the areas of skin exposed to the armrest in disrepair were intact. An interview conducted with NA #8 and Nurse #5 revealed they had provided care for Resident #38 frequently in the past few weeks and did not notice the left armrest of Resident #38's wheelchair was in disrepair. They acknowledged that the left armrest needed to be replaced immediately as it could cause skin irritation. b. The census records indicated Resident #38 had been staying in Room 105 since he was admitted to the facility on 11/20/24. The admission MDS assessment dated 11/27/24 revealed Resident #38 was coded with moderately impaired cognition and adequate vision. During an observation conducted on 01/14/25 at 11:14 AM, the window blinds in Room 105 could not be rolled up or down nor flip open or closed as needed as the rod and the cord controlling the blinds were missing. The blinds remained open all the time. An interview was conducted with Resident #38 on 01/14/25 at 11:16 AM. Resident #38 stated the blinds had been in disrepair since he moved into this room last November. He could not control the blinds as it would not roll up and down, or open and close as needed. He felt like someone was watching him when he was in his room. During a joint observation of the window blinds in Room 105 in conjunction with an interview conducted on 01/15/25 at 1:01 PM with NA #8 and Nurse #5, the window blinds in Room 105	F 584	adjustments made as indicated to maintain ongoing compliance.	

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remained in disrepair. An interview conducted with NA #8 revealed she did not notice the window blinds in Room 105 were broken until the morning of the interview. However, she did not notify any maintenance staff or initiate a work order for the maintenance department. She acknowledged that the window blinds in Room 105 needed to be replaced immediately. Nurse #5 stated she did not notice the window blinds in Room 105 were broken and added they needed to be fixed immediately.

2. Resident #87 was admitted to the facility on 12/13/24.

The admission MDS assessment dated 12/20/24 revealed Resident #87 was coded with moderately impaired cognition.

During an observation conducted on 01/14/25 at 11:49 AM, Resident #87 was seen sitting in the wheelchair in her room. The left side of the wheelchair did not have an armrest in place. Resident #87 was observed resting her left arm on top of the metal frame of the wheelchair while sitting in the wheelchair.

An interview was conducted with Resident #87 on 01/14/25 at 11:51 AM. She stated she could not recall how long the left armrest of her wheelchair had been missing. She added it was very uncomfortable for her as she had to rest her left arm on the metal frame of the wheelchair when sitting in it. She wanted the wheelchair to be fixed as soon as possible.

During a subsequent observation conducted on 01/15/25 at 9:05 AM, the left armrest of Resident #87's wheelchair remained missing.

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During a joint observation of Resident #87's wheelchair in conjunction with an interview conducted on 01/15/25 at 1:01 PM with NA #8 and Nurse #5, the left armrest on Resident #38's wheelchair remained missing. An interview conducted with NA #8 and Nurse #5 revealed they had provided care for Resident #87 frequently in the past few weeks, but did not notice the left armrest on Resident #87's wheelchair was missing. They acknowledged that the left armrest needed to be fixed immediately as it could cause skin irritation.

An interview was conducted with the Maintenance Director on 01/15/25 at 3:25 PM. He stated he had just assumed his position in the facility about 10 days ago. He walked through the entire building at least once daily on a regular basis to identify repair needs. The Maintenance Director indicated he also depended on the nursing staff to report repair needs either verbally or with work order. He acknowledged that the armrests for Resident #38's and Resident #87's wheelchair and the window blinds for Room 105 were in disrepair and needed to be replaced immediately.

During an interview conducted with the Director of Nursing (DON) on 01/16/25 at 1:57 PM. She expected all the wheelchairs and window blinds to be in good repair all the time to prevent skin irritation and protect residents' privacy.

An interview was conducted on 01/17/25 at 10:12 AM with the Administrator. The Administrator expected all the staff to be more attentive to the residents' living environment and mobility devices when providing care to ensure all the repair needs would be communicated to the

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F 584	Continued From page 15 maintenance department in a timely manner. It was her expectation for all the window blinds and wheelchairs to be in good repair all the time.	F 584		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews with the Nurse Practitioners, resident, and staff the facility failed to protect Resident #84's right to be free of physical abuse perpetrated by Resident #64. On 1/27/25 Resident #84, who was cognitively impaired and had wandering behaviors, entered the room of Resident #64 who was also cognitively impaired. Nurse #6 heard Resident #64 yell at Resident #84 to get out of his room followed by Resident #64 taking both of his hands to "lift" Resident #84 off of the ground and "throw him" out of his room. Resident #84 fell to the floor hitting his head and Nurse #6 stated she heard a noise that sounded like a "crack". Resident #84 reported pain to his	F 600	1. Resident #84 is no longer a resident of the facility. Resident #64 was placed on increased monitoring of every 30 minutes via nurse aides and hourly via licensed nurse on 01/28/25. As a result of a secondary resident to resident involving resident #18, resident #64 was escalated to a 1 on 1 supervision during wake hours via nurse aide or designee effective 2/1/25 and q 30 min by nurse aides and q1 hour by nurse while resting. On 2/5/25, the NP for resident #64 also started the resident on Seroquel 25mg daily for behavior management and diagnosis of adjustment disorder with depressed mood. Resident	3/4/25

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left arm and head and was evaluated at the hospital with no acute injuries. There was a high likelihood of Resident #84 suffering serious physical harm as a result of the physical abuse. A reasonable person would have experienced feelings such as fear, intimidation, anxiety, and/or withdrawal as a result of being abused in their home environment. Additionally, the facility also failed to prevent resident to resident abuse when Resident #64 shoved Resident #18. The deficient practice occurred for 2 of 3 (Resident #84 and Resident #18) reviewed for abuse.

Immediate jeopardy began on 1/27/25 when the facility failed to protect a cognitively impaired resident right to be free of abuse when Resident #84 wandered into the room of cognitively impaired Resident #64 who used physical force to throw Resident #84 to the floor. Immediate jeopardy remains present and on-going.

Example 2 is being cited at a scope and severity of "D."

The findings included:

1) Resident #64 was admitted to the facility on 4/18/23 with diagnoses including cerebral infarction (stroke) and cognitive communication deficit.

The care plan last reviewed on 11/20/24 revealed Resident #64 had the potential to be physically aggressive related to poor impulse control and had attempted to throw a chair in the dining room. Interventions included analyzing times of day, places, circumstances, triggers, and what de-escalated behavior and document.

F 600

#64 was seen by the pysch provider on 2/13/25. Education was initiated by Licensed Nursing Home Administrator (LNHA)/designee related to types of abuse including resident to resident altercations, abuse identification, abuse prevention, and maintaining resident safety, with all nursing home staff on 1/28/25. Education included scenarios and quizzes for demonstration of staff competency. Education further included redirecting residents, monitoring for and identifying precipitating behaviors that could lead to possible resident to resident altercations. This education includes agency staff and newly hired employees via the facility orientation process. No staff will work after 2/7/2025 without having had this education.

2. The facility has determined that all residents have the potential to be affected. Residents on the dementia unit were assessed for injuries and/or physical indicators of abuse by the DON, Unit Manager, and licensed nursing staff on 1/28/25. Interviewable residents were interviewed by the DON, Unit Manager, and licensed nursing staff or designee on 1/28/25 regarding feeling safe while residing in the facility and feeling safe in the presence of other residents. No additional findings were identified.

3. Interviewable residents on the dementia units were educated on 2/19/25 on the facility□s zero tolerance of abuse and the residents ability to communicate concerns or allegations to the facility□s abuse coordinator. Education was provided by the facility□s clinical

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The quarterly Minimum Data Set (MDS) dated 12/12/24 assessed Resident #64's cognition was moderately impaired. He had no upper or lower extremity range of motion impairment, did not use a device for mobility, and was able to transfer and walk independently without assistance from staff. Resident #64's height and weight was 68 inches and 184 pounds. There were no physical or verbal behaviors directed towards others during the lookback period.

A review of Resident #64's Medication Administration Record (MAR) revealed behaviors were monitored each day, evening, and night shift. Behaviors being monitored included agitation/pacing/yelling, and danger to self or others. From 1/1/25 through 1/26/25 the nurses documented 0 to indicate no behaviors were present. On 1/27/25 day shift Nurse #7 documented 0 to indicate no behaviors were present.

Resident #84 was admitted to the facility on 11/22/24 with diagnoses including Alzheimer's disease and dementia.

The admission MDS dated 11/29/24 revealed Resident #84's cognition was severely impaired, and he had demonstrated physical and verbal behaviors directed towards others, rejection of care, and wandering behaviors for 1 to 3 days during the lookback period. Resident #84's height and weight was 69 inches and 148 pounds. There was no mobility device identified on the MDS and Resident #84 was dependent on staff for walking. The MDS indicated Resident #84 was not taking anticoagulant or antiplatelet medications.

The care plan last reviewed on 1/16/25 identified

F 600

consultants.
Education was provided by the Psych provider/designee with all nursing home staff on recognizing early warning signs of aggression, de-escalation strategies, preventing escalation in clinical settings, ensuring staff are trained in crisis management and having a safety plan. No staff will work after 2/25/25 without having this education.
Nursing Home Administrator (LNHA)/designee related to types of abuse including resident to resident altercations, abuse identification, abuse prevention, and maintaining resident safety, with all nursing home staff on 1/28/25. Education included scenarios and quizzes for demonstration of staff competency. Education further included redirecting residents, monitoring for and identifying precipitating behaviors that could lead to possible resident to resident altercations. This education includes agency staff and newly hired employees via the facility orientation process. No staff will work after 2/7/2025 without having had this education.
4. The Administrator/designee will audit 10 staff per week for 4 weeks, 5 staff per week for 4 weeks and 3 staff per week for 4 weeks on abuse prevention, identification, reporting, and managing behaviors competency via written quiz. Audit results will be reviewed in QAPI and adjustments made to plan as indicated to maintain ongoing compliance.

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Resident #84 wandered related to being disoriented to place. Interventions included to intervene as needed to protect the rights and safety of others and to remove from situations to another location as needed.

A review of Resident #84's MAR revealed behaviors were being monitored each day, evening, and night shift. Behaviors being monitored included agitation/ pacing/yelling, uncooperative, and wandering. On 1/10/25 and 1/13/25 the nurse documented during day shift agitation/pacing/yelling, uncooperative, and wandering behaviors were present. On 1/27/25 during day shift Nurse #6 documented behaviors of agitation/pacing/yelling, uncooperative, and wandering were present.

A review Resident #84's current physician orders revealed he was not taking anticoagulant or antiplatelet medications.

A review of an incident report dated 1/27/25 at 10:50 AM revealed Nurse #6 observed Resident #84 being "tossed out of the room" by another resident into the hallway floor landing on his left side and she unable to obtain assessment due to Resident #84 was guarding his body. Nurse #6 noted there were no injuries observed at the time of the incident and Resident #84 was alert, confused, oriented to person, ambulatory without assistance, and the predisposing factor was he wandered.

A review of the progress note created on 1/27/25 at 5:29 PM by Nurse #6 revealed she was the assigned nurse for Resident #84 and at 10:50 AM was at the medication cart and observed the door to Resident #64's room was open, and Resident

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#84 was "tossed out of the room." Nurse #6 documented she observed Resident #84 fall to the floor and land on the left side of his body and the left side facial area. Resident #84 landed in front of Nurse #6, and she heard Resident #84's body make an audible sound. The note indicated Nurse #6 told what happened in detail to the Director of Nursing (DON) and Unit Manager #5. Nurse #6 observed Unit Manager #5 contact Nurse Practitioner (NP) #1 by phone and Nurse #6 answered their questions. Neuro checks were implemented and DON assisted Resident #84 with a bed bath and the Unit Manager and DON assumed plan of care. At 4:45 PM Nurse #6 updated NP #2 and a verbal order was provided to transfer Resident #84 to the emergency room for evaluation and rule out possible head trauma.

Review of the neuro check documentation for Resident #84 revealed the following: the first check was started on 1/27/25 at 10:55 AM and indicated vital signs were refused, Resident #84 was alert and Nurse #6 was unable to assess his upper and lower extremity motor function. Headache was checked yes, and no was checked for signs of seizure, ear/nose drainage, or vomiting. Neuro checks continued from 12:16 PM until 5:45 PM and indicated Resident #84 was at the hospital.

During a phone interview on 1/30/25 at 11:22 AM Nurse #6 revealed on 1/27/25 she was working on the secured unit on the third floor and witnessed the altercation between Resident #64 and Resident #84. Nurse #6 revealed she heard Resident #64 yell out, "Get out my room, I told you to get out." Nurse #6 revealed she saw Resident #64 take both hands and lift Resident #84 off the ground and throw him out of his room

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F 600	Continued From page 20 and he fell to the floor, and she heard a noise that "sounded like a crack and saw Resident #84's head hit the floor." Both residents were separated, and Resident #64 stayed in his room. After the fall she did not see any obvious injuries but Resident #84 told her his left arm and head hurt but would not let her touch or assess him and was guarding his left arm. She revealed Nurse #7 stayed with Resident #84 while she went to find the Administrator or DON. The DON and Unit Manager #5 came to the secured unit on the third floor. Nurse #6 revealed she attempted to administer acetaminophen for pain but Resident #84 spit it out and the DON administered olanzapine (an antipsychotic medication) and took Resident #84 to a room and gave him a bed bath. She revealed Unit Manager #5 notified NP #1 and she (Nurse #6) was asked to tell what happened and stated she reported "Resident #84 was thrown to floor." Nurse #6 revealed she heard Unit Manager #5 tell NP #1, "the nurse thought the resident was hurt and was thrown on the floor." Nurse #6 revealed when NP #2 came to the facility she updated her on what happened, and an order was provided to send Resident #84 to emergency room for further evaluation. During an interview on 1/29/25 at 11:29 AM Nurse #7 revealed she was working on the secured unit on the third floor where the altercation between Resident #64 and Resident #84 occurred on 1/27/25 but she did not witness the incident. Nurse #7 revealed she was at the opposite end of hallway from Resident #64's room when she heard Nurse #6 scream "he threw him on the floor." Nurse #7 revealed when she looked up, she saw Resident #84 on the floor in the hallway by Resident #64's room door. Nurse #7 revealed	F 600		

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Resident #84 was scooting himself on the floor and around the corner of the nurse station away from Resident #64's room. Nurse #7 revealed she heard Resident #84 say he broke my arm and would not let anyone touch him. Nurse #7 revealed when she asked Resident #64 what happened he did not say anything about the incident but did say he was okay.

During an interview on 1/29/25 at 3:59 PM Nurse Aide (NA) #10 revealed she worked on the secured unit on the third floor where the altercation between Resident #64 and Resident #84 occurred on 1/27/25 but she did not witness the incident. NA #10 revealed she did observe Resident #84 on the floor by the nurse station near the room of Resident #64 and was told by a nurse, she could not recall by name, that Resident #64 picked up and threw Resident #84 to the floor. NA #10 revealed she stood by Resident #84 to ensure there was no contact until the DON, Unit Manager #5, and Nurse #6 assessed the resident. NA #10 described Resident #84 had wandering behaviors prior to the altercation and would wander into other resident rooms and she would redirect him.

During an interview and observation on 1/29/25 at 10:54 AM and 3:53 PM the entry door to Resident #64's room was kept closed. Resident #64 was observed sitting on the edge of the bed and was able to self-transfer and walk in and out of his room without assistance from staff. Resident #64 revealed a resident had entered his room and would not leave after he told him, "you got to go." Resident #64 revealed the resident did not say anything but would not leave and he used physical force to get him out of his room. Resident #64 demonstrated he used both hands

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F 600	Continued From page 22 to lift up and throw the resident out of the room onto the floor. Resident #64 revealed the resident he threw was not doing anything to make him feel threatened or afraid and repeated, "it was time for him to go." Resident #64 confirmed he did not ask a staff member for help and stated he did not need help from anyone. Resident #64 revealed that if someone came into his room and would not leave when asked, he would use physical force to get them out and did not need help getting someone out of his room. A review of the nurse progress note created on 1/29/25 at 1:43 PM by Unit Manager #5 was a late entry for 1/27/25 at 11:30 AM. The note revealed the Unit Manager #5 was called to the secured unit on the third floor to assess Resident #84. Unit Manager #5 and the DON noted Resident #84 was sitting on the floor near the nurse station and the assigned nurse (Nurse #6) stated "Resident #84 had an unwitnessed fall." Unit Manager #5 noted Resident #84 refused assistance from staff and was assessed by the DON. Unit Manager #5 contacted NP #1 and was instructed to notify the assigned nurse (Nurse #6) to send Resident #84 out to the hospital if needed. Unit Manger #5 noted she was instructed to provide additional 30-minute checks for the NA staff and hourly checks for the nurses for Resident #84. An interview was conducted on 1/29/25 at 4:26 PM with Unit Manager #5. Unit Manager #5 revealed she was asked by Nurse #6 to come to the secured unit and when she arrived saw Resident #84 sitting on the floor and he did not want anyone to touch or help him. Unit Manager #5 revealed Resident #84 got up off the floor without help and walked to his room with the	F 600		

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DON who provided incontinence care. Unit Manager #5 revealed she was told by Nurse #6, she heard a noise that "sounded like a boom" but did not see anything. Unit Manager #5 revealed 1/28/25 was the first time she heard Resident #64 threw Resident #84 to the floor. She revealed Resident #84 was not capable of describing what happened and she did assess Resident #64, and he told her he did not want anyone in his room but did not tell what happened.

A review of a nurse's progress note created on 1/28/25 at 8:01 PM by the DON was a late entry for 1/27/25 at 11:30 AM. The note revealed the DON was called to the secured unit on the third floor to assess Resident #84. The DON and Unit Manager #5 saw Resident #84 on the floor near nursing station. The DON asked Nurse #6 what happened and was told Resident #84 had an unwitnessed fall to the floor. Resident #84 refused vital signs and assistance from staff. The DON noted Resident #84 eyes were reactive to light, grips were equal, and cognitive status was at baseline with no signs of distress or complaints. Resident #84 got up off the floor without assistance and walked with the DON. The DON noted there were no visible injuries, and no change in physical, emotional, or social state at the time of assessment.

During an interview on 1/29/25 at 5:35 PM the DON revealed on 1/27/25 she received a text to come to the third-floor unit immediately during her morning meeting. The DON revealed when she arrived on the unit she saw Resident #84 sitting on his buttocks with his back against the wall and around the corner of the nurse station located near the room of Resident #64. Nurse #6 told her Resident #84 had an unwitnessed fall and she did

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not know what happened. The DON revealed Resident #84 would not let her touch him but was able to get up from the floor without assistance and walk and appeared at his baseline. The DON revealed when she asked what happened, Resident #84 stated "I fell." The DON revealed Resident #84 had a history of wandering behaviors and when she checked on Resident #64, he was sitting on the edge of the bed in his room and she asked Resident #64 if someone had been in his room, and he denied that. The DON revealed she asked Nurse #6 to fill out a statement on 1/27/25 but did not get it before leaving that day. The DON revealed she was not made aware of a physical altercation involving Resident #64 and Resident #84 until 1/28/25 after reviewing Nurse 6's note and incident report during their morning meeting.

An interview was conducted on 1/29/25 at 5:18 PM with NP #1. NP #1 revealed on 1/27/25 around 11:00 AM he was called and informed there was altercation between residents and named Nurse #6 was who he spoke with. NP #1 revealed he was told an "aggressive altercation" occurred and Resident #84 was administered olanzapine and was being monitored and was calm. NP #1 revealed his guidance was if the nurse thought Resident #84 needed to be evaluated, she could send him to the emergency room. NP #1 revealed no specifics were provided about the altercation and he could not confirm Resident #64 threw Resident #84 to the floor. NP #1 revealed he was not notified that a fall occurred during the altercation or that Resident #84's head hit the floor and if told that information he would have requested to send the resident to the emergency room for evaluation.

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A review Resident #84's medical record revealed NP #2 documented a follow-up note dated 1/27/25 that revealed Resident #84 was being reviewed for head injury and arm pain. NP #2 noted nursing reported around 10:50 AM Resident #84 wandered into another resident's room and was forcefully lifted into the air and thrown from out of the room. Resident #84 landed on his left side and a cracking sound was heard and he hit his head on the floor. NP #2 noted neuro checks were started and during the evening Resident #84 was arousable but would not open his eyes and minimally responded to questions. NP #2 assessed Resident #84 had no deformities or visible signs of malalignment or dislocation and appeared at baseline for the diagnosis of dementia. NP #2 recommended Resident #84 be transferred to the emergency department for evaluation to rule out head trauma, intracranial hemorrhage, or other pathology.

A physician's order dated 1/27/25 at 5:00 PM provided directions to send Resident #84 to the emergency room for evaluation to rule out head trauma.

A review of the emergency department summary revealed on 1/27/25 Resident #84 was evaluated due to a previous fall. A CT (computed tomography) scan (a three-dimensional imaging of the body) of the head and neck and chest x-ray showed no abnormalities or injuries, and Resident #84 was discharged back to the facility in stable condition.

A review Resident #64's medical record revealed NP #2 documented a follow-up note dated 1/27/25 that revealed nursing reported Resident

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#64 was the aggressor in an incident after Resident #84 wandered into his room. The NP noted Resident #64 forcefully removed Resident #84 from the room. NP #2 noted the incident was isolated and Resident #64 was calm and stable and being monitored by staff with no further incidents with other residents. NP# 2 recommended to continue 1:1 monitoring for 12 hours.

During an interview on 1/29/25 at 4:48 PM NP #2 revealed she was at the facility around 4:30 PM on 1/27/25 when she was told the details of an altercation between Resident #64 and Resident #84. NP #2 revealed Nurse #6 told her Resident #84 had wandered into Resident #64's room and Resident #64 threw him out. NP #2 revealed Nurse #6 stated "she saw Resident #84 flying out room and was lifted off the floor and she heard a crack and saw Resident #84 hit his head." NP #2 revealed she spoke with Resident #64, and he confirmed he picked Resident #84 up and threw him to the floor. NP #2 stated when she assessed Resident #84 on 1/27/25 he was groggy but had no deformities or any obvious physical injury, but she was concerned about him being thrown onto the floor and sent him out for evaluation of injury.

A phone interview was conducted on 1/31/25 at 2:23 PM with the Administrator. The Administrator revealed she became aware of the physical abuse altercation between Resident #64 and Resident #84 the next morning on 1/28/25 during their clinical morning meeting after reading Nurse #6's notes. The Administrator revealed staff had just received training and were expected to inform her or the DON of any situation between residents and she would start the investigation and determine if abuse occurred. The

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Administrator revealed based on the information in the medical records it appeared Resident #64 actions were willful.

The Administrator was notified of IJ on 02/06/25 at 8:30 PM.

The facility provided the following credible allegation of immediate jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

-The facility failed to have an effective system in place to prevent resident to resident abuse and ensure the safety of all residents.

-On 1/27/2025 Resident #84 entered the room of resident #64. Per witness documentation from Nurse #6, Resident #64 could be heard saying, "I told you to get out of here." Per Nurse #6 documentation, Resident #64 was visualized to take both hands and pick Resident #84 up off the ground and 'throw' Resident #84 to the floor resulting in Resident #84 hitting his head on the floor. Resident #84 was assessed and assisted from the floor to his feet and proceeded to his own room receiving toileting and incontinence care provided by the Director of Nursing (DON). Fall assessments and neuro checks were initiated to be completed by licensed nurse as directed by the Director of Nursing on 1/27/25. Later in the shift Resident #84 was sent to Emergency Room (ER) for full evaluation per Nurse Practitioner (NP) orders to ensure no physical injury. Resident #84 returned to the facility with no negative findings. It was noted that the nurse's notes stated resident #84 had left arm

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pain and the hospital had not completed an x-ray of the arm, and an order was obtained for an x-ray. On 1/28/25, the order was changed to stat (now or as soon as possible) as the x-ray company had not yet come. Resident #84 demonstrated unrelated behaviors becoming combative with care resulting in discharge on 1/28/25 to the hospital for psych evaluation. On 1/29/25 Resident #84 returned to facility and continued to demonstrate escalating behaviors with emergency medical staff and facility staff. Resident #84 again was discharged from the facility for psych evaluation. Resident #84 remains out of the facility at this time.

-Police were notified of this resident-to-resident abuse and reported to facility for statements on 01/28/25. No actions were taken by the police. Resident #64 was assessed by police and determined to not be at risk to self or others.

-Residents on the dementia unit were assessed for injuries and/or physical indicators of abuse by the DON, Unit Manager, and licensed nursing staff on 1/28/25. Interviewable residents were interviewed by the DON, Unit Manager, and licensed nursing staff on 1/28/25 regarding any witnessed physical altercations, witnessed abuse, and feelings of safety while residing in the facility. No additional findings were identified. Documentation is maintained by the Administrator in the physical copy of the investigation file.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

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-Resident #64 was placed on increased monitoring of every 30 minutes via nurse aides and hourly via licensed nurse. This directive was received by the Administrator and Director of Nursing on 1/28/25. Resident #64's orders and care plans were reviewed and updated by the DON and Unit Manager on 1/28/25 to reflect 30-minute checks by nurse aides and hourly checks by licensed nurses. Staff providing care were made aware of aforementioned care plan modification on 1/28/25 by the DON and Unit Manager. Resident #64 remains in need of skilled care related to assistance required with activity of daily living (ADL), inability to self-manage medications, and cognitive impairments that result in behaviors such as wandering completed by the Director of Nursing on 2/8/25. As a result of a secondary resident to resident involving Resident #18, Resident #64 was escalated to a 1 on 1 supervision during wake hours via nurse aide or designee effective 2/1/25. This was directed by the Director of Nursing and Administrator on 2/1/25. This will continue until deemed safe to reduce or eliminate by a psych provider or until discharge.

-Education was initiated by Licensed Nursing Home Administrator (LNHA)/designee related to types of abuse including resident to resident altercations, abuse identification, abuse prevention, and maintaining resident safety, with all nursing home staff on 1/28/25. Education included scenarios and quizzes for demonstration of staff competency. Education further included redirecting residents, monitoring for and identifying precipitating behaviors that could lead to possible resident to resident altercations. This education includes agency staff and newly hired employees via the facility orientation process. No

F 600

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staff will work after 2/7/2025 without having had this education. Licensed Nursing Home Administrator (LNHA) or designee will maintain compliance with tracking education requirements.

-Additional ongoing whole nursing home staff education is being coordinated by the Regional Director of Operations on 2/8/25 with Telos psych providers or designee related to dealing with difficult behaviors and monitoring interventions, to be completed monthly with all staff. First education in this series will be conducted on 2/17/25.

The facility Administrator assumes responsibility for the immediate jeopardy removal plan. The date of the immediate jeopardy removal is 2/9/25.

The survey team attempted to conduct a validation of the immediate jeopardy removal on plans on 2/10/25. The facility had failed to update Resident #64's care plan to reflect 30-minute Nurse Aide checks and hourly Nurse checks. The facility failed to collaborate with the psychaitric provider for montly on-going education that was supposed to start on 02/17/25. The facility failed to have Resident #64 assessed by a psychiatric provider before reducing his one-on-one supervision. The immediate jeopardy removal date of 2/9/25 was not able to be validated.

2. Resident #64 was admitted to the facility on 4/18/2023 with diagnoses which included depression and alcohol related dementia (brain damage from alcohol abuse) and adjustment disorder with depressed mood (mental health disorder that can occur as a response to stressful life events).

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Review of the Electronic Medical Record (EMR) revealed Resident #64 was last seen for psychiatric services (psychotherapy) on 10/29/2024.

A quarterly Minimum Data Set (MDS) dated 12/12/2024 revealed Resident #64 was moderately cognitively impaired with no behaviors, rejections of care, or wandering.

A care plan dated 1/7/2025 revealed Resident #64 had the potential to be physically aggressive related to poor impulse control. Resident #64 was to have psychiatric/psychogeriatric (mental health services) consulted as needed.

Resident #18 was admitted to the facility on 7/16/2022 with diagnoses which included vascular dementia.

A quarterly Minimum Data Set (MDS) dated 1/7/2025 revealed Resident #18 was severely cognitively impaired. Resident #18 was coded as "behavior of this type occurred daily" for wandering. Resident #18 had no impairment of her upper and lower extremities and did not utilize assistive devices. Resident #18 was coded as "independent" for walking.

A care plan dated 1/13/2025 revealed Resident #18 was an elopement risk, wanderer, with interventions which included staff were to address wandering behavior by walking with Resident #18 and redirecting Resident #18 from inappropriate areas.

A nurse's note dated 2/1/2025 at 12:21 pm, authored by the Unit Manager #4, revealed she

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F 600	Continued From page 32 was sitting at the nurse's station when she heard Resident #64 saying "get out of here, get out of here." As Unit Manager #4 got up to redirect the residents, Resident #64 was observed shoving Resident #18 as she was proximal to Resident #64's door. Unit Manager #4 immediately intervened and stepped between the two residents. Resident #64 went into his room and slammed the door. Unit Manager #4 redirected Resident #18. Resident #18 walked over to the common area then proceeded to walk back towards Resident 64's room. Resident #64 came out of his room as Resident #18 started walking and antagonized Resident #18 by saying "walk over here, walk over here" with a grin on his face and his fist balled up. Unit Manager #4 continued to redirect Resident #18 and attempted to reeducate Resident #64 on peer-to-peer interactions with no effect. Resident #64 told Unit Manager #4 to "yeah go call the police, yeah I will do it again." Unit Manager #4 made the supervisor aware at 12:14 pm, called the Administrator at 12:15 pm, and contacted the Nurse Practitioner (NP) at 12:34 pm. Unit Manager #4 reported the event to Nurse #3 at 1:10 pm. An interview was conducted on 2/10/2025 at 11:19 am with Unit Manager #4. Unit Manager #4 stated she was charting at the nurse's station on 2/1/2025 when she heard Resident #64 say get out of here, get out of here." Unit Manager #4 stated when she went to get up, she witnessed Resident #64 shove Resident #18. Unit Manager #4 was unable to recall if Resident #64 shoved Resident #18 using one hand or two hands. Unit Manager #4 stated the shove did not cause Resident #18 to lose balance or fall. Unit Manager #4 stated the shove seemed as though	F 600		

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it was to have Resident #18 go the other way. Unit Manager #4 stated she educated Resident #64 and told him not to place his hands on anyone else. Unit Manager #4 stated Resident #64 was placed on one-on-one supervision immediately. Unit Manager #4 stated she contacted the supervisor, Guardian, and NP as well.

A nurse's note dated 2/1/2025 at 2:14 pm, authored by Nurse #3, revealed she had been notified by another nurse Resident #64 had pushed another resident. Resident #64 was separated and one-on-one care during wake hours was initiated until further notice. One-hour checks were to be completed by the nurse and 30-minute checks were to be completed by Nurse Aides (NAs) while Resident #64 was sleeping. Nurse #3 documented per supervisor, a new order for lorazepam 1 milligram (mg) was to be administered every 6 hours as needed and would be placed in the system by a physician.

An initial allegation report dated 2/1/2025, completed by the Administrator, revealed the facility reported an allegation due to resident-to-resident physical altercation involving Resident #64. The facility became aware of the incident on 2/1/2025 at 12:14 pm and notified law enforcement at 12:54 pm. Resident #64 was placed on one-on-one supervision while awake and hourly nursing checks with every 30-minute NA checks while Resident #64 was asleep.

A five-day investigation report dated 2/7/2025 revealed the Administrator had completed an investigation and determined Resident #64 pushed Resident #18. Resident #18 was not injured, did not fall, and there were no bruises.

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An interview was conducted on 2/10/2025 at 11:38 am with NA #10. NA #10 stated she worked on the memory care unit on 2/1/2025 and was on the unit, sitting as a post near the elevators (to watch residents and ensure they did not go down the elevator). NA #10 stated she did not witness the incident between Resident #64 and Resident #18. NA #10 stated she was told by a nurse, name unknown, to sit with Resident #64 one-on-one. NA #10 stated Resident #64 was calm the remainder of the time she was assigned to him and stated she had taken him out to smoke after the incident to help calm his nerves. NA #10 stated she was not aware of any other instances where Resident #64 had been aggressive with other residents. NA #10 stated Resident #64 was able to ambulate independently and made his needs known. NA #10 stated Resident #18 frequently wandered and would attempt to go in other resident's rooms. NA #10 stated Resident #64 would get agitated when other residents would try to wander into his room but stated she had never witnessed him shoving anyone before.

An interview was conducted on 2/10/2025 at 11:46 am with Nurse #3. Nurse #3 stated she was not on the memory care unit when the event between Resident #64 and Resident #18 occurred. Nurse #3 stated when she arrived back on the memory care unit, Resident #64 and Resident #18 were already separated. Nurse #3 stated she assessed Resident #18 for pain and injuries following the incident and stated Resident #18 was okay.

An interview was conducted on 2/10/2025 at 12:17 pm with NP #2. NP #2 stated she had

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been called over the weekend by a facility staff member regarding the incident with Resident #64 and Resident #18. NP #2 stated she had made the recommendation to place Resident #18 on one-on-one supervision.

An observation was conducted on 2/10/2025 at 3:43 pm of Resident #64. Resident #64 was observed awake, sitting on the side of his bed, and no longer had a one-on-one sitter. Resident #64 appeared calm.

An observation was conducted on 2/10/2025 at 11:03 am of Resident #18. Resident #18 was observed lying in bed. Resident #18 did not answer questions.

An interview was conducted on 2/10/2025 at 4:19 pm with the Director of Nursing (DON). The DON stated she had made aware of the incident involving Resident #64 and Resident #18 on 2/1/2025. The DON stated Resident #64 was immediately placed on one-on-one supervision.

Follow-up interviews have been requested with the Director of Nursing (DON) and have not been successful.
An interview was conducted on 2/11/2025 at 1:20 pm with the Administrator. The Administrator stated she was made aware of the incident that involved Resident #64 and Resident #18 on 2/1/2025 at 12:14 pm. The Administrator stated she was told Unit Manager #4 was sitting at the nurse's station adjacent from Resident #64's room when she heard Resident #64 say for someone to not go into his room. The administrator stated she was told when Unit Manager #4 got up she saw Resident #64 shoveResident #18. The Administrator stated

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F 600	Continued From page 36 Resident #18 was assessed for injuries and had no injuries and did not fall because of the incident. The Administrator stated Resident #64 was immediately placed on one-on-one supervision, the NP, and family were notified. The Administrator stated Resident #64 remained on one-on-one supervision until 2/10/2025.	F 600		
F 607 SS=K	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and	F 607		3/4/25

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(2) of the Act.
This REQUIREMENT is not met as evidenced by:
Based on record reviews, and staff and Resident interviews, the facility failed to implement their abuse policy in the area of protection following an incident of resident-to-resident physical abuse placing 33 of 33 other residents residing on the secured unit at risk of suffering abuse perpetrated by Resident #64. On 01/27/25 Nurse #6 witnessed Resident #64 "lift" Resident #84 off the floor and "throw him" out of Resident #64's room. Resident #84 fell to the floor, hit his head, and Nurse #6 heard a noise that sounded like a crack. The facility implemented 30-minute monitoring checks for Resident #64 on 01/28/25. The 30-minute monitoring checks were not effective in preventing further abuse. On 02/01/25 as Resident #18 was ambulating past Resident #64's room, Resident #64 pushed Resident #18. Following the incident, Resident #64 balled up his fist and stated to Resident #18, "walk over here" and "I will do it again."

Immediate Jeopardy began on 01/27/25 when protective measures were not immediately implemented to protect other residents from further abuse after Nurse #6 witnessed Resident #64 physically abuse Resident #84. Immediate Jeopardy was unable to be removed and is present and ongoing.

The findings included:

Review of the facility's Abuse, Neglect and Exploitation policy dated 11/01/2020 indicated the facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. The policy

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1. Resident #84 is no longer a resident of the facility. Resident #64 was placed on increased monitoring of every 30 minutes via nurse aides and hourly via licensed nurse on 01/28/25. As a result of a secondary resident to resident involving resident #18, resident #64 was escalated to a 1 on 1 supervision during wake hours via nurse aide or designee effective 2/1/25 and q 30 min by nurse aides and q1 hour by nurse while resting. On 2/5/25, the NP for resident #64 also started the resident on Seroquel 25mg daily for behavior management and diagnosis of adjustment disorder with depressed mood. Resident #64 was seen by the pysch provider on 2/13/25. Resident #18 was assessed by her assigned nurse for any skin or pain concerns and no concerns were identified. Education was initiated by Licensed Nursing Home Administrator (LNHA)/designee related to types of abuse including resident to resident altercations, abuse identification, abuse prevention, and maintaining resident safety, with all nursing home staff on 1/28/25. Education included scenarios and quizzes for demonstration of staff competency. Education further included redirecting residents, monitoring for and identifying precipitating behaviors that could lead to possible resident to resident altercations. This education includes agency staff and newly hired employees via the facility orientation process. No staff will work after 2/7/2025 without having

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listed examples of protection that included: increased supervision of the alleged victim and residents; and room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator. The policy specified that protection was not limited to those examples.

Resident #64 was admitted to the facility on 04/18/23.

A review of Resident #64's quarterly Minimum Data Set (MDS) assessment dated 12/12/24 revealed the Resident's cognition was moderately impaired and did not use a device for mobility and was able to transfer and walk independently without assistance from staff.

A review of an Incident Report dated 01/27/25 at 10:50 AM revealed Nurse #6 observed Resident #84 being tossed out of the room by another resident (Resident #64) into the hallway floor landing on his left side. Nurse #6 noted there were no injuries observed at the time of the incident and Resident #84 was alert, confused, oriented to person, and ambulatory without assistance.

During a telephone interview on 01/30/25 at 11:22 AM Nurse #6 revealed on 01/27/25 she was working on the secured unit on the third floor and heard Resident #64 yell out, "Get out my room, I told you to get out." Nurse #6 revealed she saw Resident #64 take both hands and lift Resident #84 off the ground and throw him out of his room. Resident #84 fell to the floor, and she (Nurse #6) heard a noise that sounded like a crack and saw Resident #84's head hit the floor. Both residents were separated, and Resident #64 stayed in his room. She revealed Nurse #7 stayed with

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had this education.
2. The facility has determined that all residents have the potential to be affected. Residents on the dementia unit were assessed for injuries and/or physical indicators of abuse by the DON, Unit Manager, and licensed nursing staff on 2/1/25. Interviewable residents were interviewed by the DON, Unit Manager, and licensed nursing staff and/or designees on 2/1/25 regarding feeling safe while residing in the facility and feeling safe in the presence of other residents. No additional findings were identified.
3. Interviewable residents on the dementia units were educated on 2/19/25 on the facility’s zero tolerance of abuse and the residents ability to communicate concerns or allegations to the facility’s abuse coordinator. Education was provided by the facility’s clinical consultants.
Education was provided by the Psych provider/designee with all nursing home staff on recognizing early warning signs of aggression, de-escalation strategies, preventing escalation in clinical settings, ensuring staff are trained in crisis management and having a safety plan. No staff will work after 2/25/25 without having this education.
Nursing Home Administrator (LNHA)/designee related to types of abuse including resident to resident altercations, abuse identification, abuse prevention, and maintaining resident safety, with all nursing home staff on 1/28/25. Education included scenarios

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Resident #84 while she went to find the Administrator or the Director of Nursing (DON). DON and Unit Manager #5 came to the secured unit on the third floor.

During an interview on 01/29/25 at 11:29 AM and 02/10/25 at 12:45 PM Nurse #7 revealed she was working on the memory care unit where the incident between Resident #64 and Resident #84 occurred on 01/27/25. The Nurse reported after the incident she stayed with Resident #84 who was still in the floor outside of Resident #64's room while Nurse #6 went downstairs to get the DON and Administrator. Nurse #7 stated while she was with Resident #84, Resident #64 did not come out of his room. The Nurse explained that she did not know what system was put in place immediately following the incident to monitor Resident #64 but stated around 3:00 PM that same day the DON came up to the unit and asked where the papers were (meaning the hourly monitoring sheets) for Resident #64. Nurse #7 informed her (the DON) that she did not know anything about Resident #64 being on hourly monitoring and initiated the hourly monitoring sheets herself at that time.

An interview was conducted with Nurse Aide (NA) #10 on 02/07/25 at 1:11 PM who reported after the incident with Resident #84 on 01/27/25, Resident #64 was on every 30-minute checks.

During an interview on 01/29/25 at 5:35 PM and 02/06/25 at 3:40 PM the DON revealed on 01/27/25 Nurse #6 told her Resident #84 had an unwitnessed fall and she did not know what happened. The DON revealed she was not made aware of a physical abuse incident involving Resident #64 and Resident #84 until 01/28/25

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and quizzes for demonstration of staff competency. Education further included redirecting residents, monitoring for and identifying precipitating behaviors that could lead to possible resident to resident altercations. This education includes agency staff and newly hired employees via the facility orientation process. No staff will work after 2/7/2025 without having had this education.

4. The Administrator/designee will audit 10 staff per week for 4 weeks, 5 staff per week for 4 weeks and 3 staff per week for 4 weeks on abuse prevention, identification, reporting, and managing behaviors competency via written quiz. Audit results will be reviewed in QAPI and adjustments made to plan as indicated to maintain ongoing compliance.

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after reviewing Nurse #6's note and incident report during their morning meeting. The DON indicated that after administration found out about the incident on 01/28/25, they decided to include Resident #64 in on every 30-minute observation checks done by the nurse aides and hourly checks done by the nurses to protect the other residents from Resident #64.

During an interview on 01/29/25 at 10:54 AM and 3:53 PM Resident #64 demonstrated how he used both hands to lift and throw Resident #84 out of the room onto the floor. Resident #64 revealed that if someone came into his room and would not leave when asked he would use physical force to get them out and did not need help getting someone out of his room.

A nurse's note dated 2/1/2025 at 12:21 pm, authored by the Unit Manager #4, revealed she was sitting at the nurse's station when she heard Resident #64 saying "get out of here, get out of here." As Unit Manager #4 got up to redirect the residents, Resident #64 was observed shoving Resident #18 near to Resident #64's door. Unit Manager #4 immediately intervened and stepped between the two residents. Resident #64 went into his room and slammed the door. Unit Manager #4 redirected Resident #18. Resident #18 walked over to the common area then proceeded to walk back towards Resident 64's room. Resident #64 came out of his room as Resident #18 started walking and antagonized Resident #18 by saying "walk over here, walk over here" with a grin on his face and his fist balled up. Unit Manager #4 continued to redirect Resident #18 and attempted to reeducate Resident #64 on peer-to-peer interactions with no effect. Resident #64 told Unit Manager #4 to

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"yeah go call the police, yeah I will do it again."

During an interview with Unit Manager #4 on 02/06/25 at 11:13 AM she confirmed she witnessed the incident between Resident #64 and Resident #18 on 02/01/25. The Unit Manager explained that as she was charting at the nursing desk, she heard Resident #64 say get out of here twice. When she looked up, she saw Resident #64 standing in the doorway to his room facing the hallway and saw Resident #18 walk past the doorway in front of Resident #64. She continued to explain that Resident #64 put his hand(s) (she could not remember if he used one or two hands) out as if to redirect Resident #18 from going into his room. The Unit Manager reported that Resident #18 did not lose her balance or fall she was just redirected. When the Unit Manager was asked why she wrote "shoving" in her nurses' notes the Unit Manager stated, "I guess I should not have used that word." The Unit Manager stated after the incident she made sure Resident #18 was redirected and she instructed Resident #64 not to put his hands on the other residents. She stated she reported the incident to the administration and Resident #64 was put on one to one (1:1) supervision and he was still on the 1:1 monitoring.

During an interview with NA #10 on 02/07/25 at 1:11 PM she reported that she was assigned to stay with Resident #64 for a 1:1 monitoring for that current shift. She explained that the 1:1 monitoring started on 02/01/25 after the incident with Resident #18. The NA also reported Resident #64's roommates were moved to other rooms after the incident on 02/02/25 with Resident #18.

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Multiple observations were made of ambulatory residents on the secured Memory Care Unit on 02/06/25 at 12:45 PM, 02/07/25 at 1:08 PM, 02/10/25 PM at 1:20 PM and 02/10/25 at 2:15 PM. Ambulatory residents were walking about the unit in the hallways and in and out of resident rooms. There were residents around Resident #64's room but they were being monitored by the nursing staff. On every observation, Resident #64 was either lying on his bed and or he was being monitored with a 1:1 observation from a nurse aide.

An interview was conducted with the Administrator and Director of Nursing on 02/06/25 at 3:40 PM. The DON explained that after the incident on 01/27/25 between Resident #64 and Resident #84 they included Resident #64 in the already established routine monitoring checks for the wandering residents for every 30-minute checks by the nurse aides and hourly checks by the nurses. When asked how the incident happened if all the wandering residents (that would include Resident #84) were being monitored that frequently, and the DON stated the aides must have been busy giving patient care and the Nurse must not have been watching. The DON continued to explain that Resident #64 was currently under 1:1 supervision since the 02/01/25 incident with Resident #18 and both of Resident #64's roommates were moved to other rooms. Both the DON and the Administrator were asked how the second incident between Resident #64 and Resident #18 happen if Resident #64 was being monitored every 30 minutes and every hour by the staff and the Administrator stated during the first incident on 01/27/25 she felt the intervention was appropriate to include Resident #64 in the every 30 minute and hourly checks but,

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in retrospect, she indicated she should have put Resident #64 on 1:1 monitoring on 01/28/25 after she was more informed of the incident between Resident #64 and Resident #84 on 01/27/25.

The Administrator was notified of Immediate Jeopardy on 02/07/25 at 11:51 AM.

The facility provided the following Credible Allegation of immediate jeopardy removal.

o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

- The facility failed to follow their policy about protecting residents and ensuring safety from Resident #64 from 1/27/25 through 2/1/25.
- Resident #64 was placed on every 30-minute checks on the morning of 1/28/25 due to physical abuse with resident #84 in which it was reported that that he picked up and threw resident #84 resulting in a fall. The abuse altercation occurred when resident #84 who has wandering behaviors entered Resident #64's room and Resident #64 yelled at him to get out. The hourly checks were initiated by the Director of Nursing (DON) and nursing assistants were assigned on 1/28/25 mid-morning.
- On 2/1/25, the Licensed Nursing Home Administrator (LNHA) and DON were notified at 12:15 pm by the Unit manager (UM) of the resident-to-resident abuse in which resident #64 pushed resident #18.
- The Nurse Practitioners (NP's) for Residents #64 and #18 were each notified at 12:34 pm by the UM of physical altercation between resident #64 and resident #18. The on-call NP for resident #64 was further updated by his assigned nurse at

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approximately 1:10 pm. A new order was received for Resident #64 from the NP for as needed (PRN) Ativan to be used for any additional/further signs of agitation.
- Resident #18 was assessed by her assigned nurse for any skin or pain concerns and no concerns were identified. Both assessments were completed by Resident #18's assigned nurse on 2/1/25 and documented into the EMR at approx. 2:40 pm by her assigned nurse who completed the assessments.
- Residents on the dementia unit were assessed for injuries and/or physical indicators of abuse by the DON, Unit Manager, and licensed nursing staff on 2/1/25. Interviewable residents were interviewed by the DON, Unit Manager, and licensed nursing staff and/or designees on 2/1/25 regarding any witnessed physical altercations, witnessed abuse, and feeling of safety while residing in the facility. No additional findings were identified. Documentation is maintained by the Administrator in the physical copy of the investigation file.

o Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

- At approximately 12:15 pm on 2/1/25, Resident #64 was placed on 1:1 supervision via nurse aides or designee during wake hours until further notice and 1-hour checks by nurse and 30-minute checks by nursing assistant or designee to be completed while resident is sleeping.
- On 2/5/25, a follow up call to the NP for resident #64 was placed by the DON and new orders were received for labs and psych consult due to escalated behaviors over the past week. On

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2/5/25, the NP for resident #64 also started the resident on Seroquel (antipsychotic medication) 25 mg daily for behavior management and diagnosis of adjustment disorder with depressed mood. The psych consult remains pending due to the physician being out with illness, however, his following Nurse Practitioner has seen and assessed Resident #64 on 2/3/25, 2/4/25, 2/5/25 and again 2/8/25. A follow-up call will be made regarding the psych consult to determine the date they will be in to further evaluate.

A Root Cause Analysis was completed on 2/3/25 by the LNHA and the DON with input from Interdisciplinary Team (IDT) and consultants in an effort to determine the cause for resident #64's behaviors that escalated beginning 1/27/25. With the initial incident, it was felt that the resident was angry that resident #84 wandered into his room and did not leave when he told him to. With the second incident on 2/1/25, resident #18 was walking past resident #64's doorway when he yelled at her to stay out of his room and pushed her. A request was made to the NP for acute work-up i.e. labs, psych consultation for resident #64 to determine if any acute illness may be process and to determine if any type of psychosis may be occurring that needed to be further addressed as well. It was discussed with resident #64 regarding placing a stop sign banner across his doorway that could possibly hinder other residents from entering his room, but he refused for this intervention. It was determined that resident #64 became agitated with other residents he did not know and/or whom he felt were entering his room. Failure of staff to redirect wandering residents resulted in abuse situation.

Resident #64 was placed on 1:1 supervision on

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2/1/25 at 12:15 pm by his nurse. This supervision was assigned to nursing assistant or designee with oversight by the resident's assigned nurse daily and the DON monitoring that 1:1 supervision is assigned and in place daily until such a time that Medical Doctor (MD) deems that resident #64 is no longer a risk for physical altercation.

The facility's policy titled Abuse, Neglect, and Mistreatment was reviewed by the administrator on 1/28/25 with no changes indicated at that time. The abuse policy was reviewed again by the LNHA and the regional clinical consultant on 2/7/25 and no changes were made at that time. The clinical consultant reviewed the abuse policy again on 2/8/25 and corrected verbiage in section VI, section C to alleged perpetrator. The abuse policy is specific to protection as noted:

VI. Protection of Resident

The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to:

A. Responding immediately to protect the alleged victim and integrity of the investigation.

B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed.

C. Increased supervision of the alleged perpetrator and residents.

D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged

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perpetrator.

E. Protection from retaliation.

F. Providing emotional support and counseling to the residents during and after the investigation, as needed.

Verbal education was provided by the Regional Director of Operations and Regional Clinical Consultant on 1/28/25 to LNHA and DON regarding procedures of thoroughly completing an investigation of alleged abuse, unusual events, monitoring for and identifying precipitating behaviors that could lead to possible resident to resident altercations and ensuring protection for all residents. This education also included the importance of thorough communication with the team, adequately obtaining of timely statements, and appropriate use of IDT meetings to review any incidents and/or concerns that may have occurred during the day.

Nurse aides and licensed nurses received education from the Licensed Nursing Home Administrator/Designee on 02/08/25 that included direction to stay with the aggressive resident to promote and maintain safety for other residents within the facility. No nurse aide or licensed nurse will work after 2/8/25 without having had this education. The Licensed Nursing Home Administrator will be responsible to track the completion of this education.

- On a phone call on 2/3/25, The regional director of operations and the regional clinical consultant reiterated to the LNHA and the Director of Nursing the responsibility that is expected for monitoring and ensuring safety and protection to

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the facility residents. Understanding was verbalized by the LNHA and Director of Nursing.

- Immediate verbal education was initiated by LNHA/designee related to types of abuse including resident to resident altercations, abuse identification, abuse prevention, abuse reporting, and maintaining resident safety, with all nursing facility staff on 1/28/25. Education included scenarios and quizzes for demonstration of staff competency. Education further included redirecting of residents, monitoring for and identifying precipitating behaviors that could lead to possible resident to resident altercations. Education further reiterated the responsibility of the staff to promote and protect each resident. This education is for all nursing facility staff and includes agency staff and newly hired employees via the facility orientation process. No staff will work after 2/7/2025 without having had this education. The LNHA will be responsible to track the completion of this education.

- Additional ongoing whole nursing home staff education is being coordinated by the Regional Director of Operations on 2/8/25 with psych providers or designee related to dealing with difficult behaviors and monitoring interventions, to be completed monthly with all staff. First education in this series will be conducted on 2/17/25.

The facility administrator assumes responsibility for the immediate jeopardy removal plan.

The alleged date of the immediate jeopardy removal is 2/9/25.

The facility's credible allegation of Immediate

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F 607	Continued From page 49 Jeopardy was unable to be validated on 02/10/25. The facility was unable to explain why the Ativan order that was ordered after the resident-to-resident abuse on 02/01/25 was never entered into Resident #64's electronic health record. The Ativan was never entered as an order or received by Resident #64 at the facility. The facility failed to provide evidence that the Regional Director of Operations collaborated with the psych provider or designee to coordinate training on 02/08/25. The Administrator stated that the collaboration had not occurred and would not occur until at least 02/13/25. Resident #64 was not seen by a psychiatry provider due to illness and the following medical visits on 02/03/25, 02/04/25, 02/04/25 and 02/06/25 were not done by a psych provider. They were done by a medical nurse practitioner. The facility did not have sufficient evidence to remove the immediate jeopardy, and it remains present and ongoing.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 609		3/4/25

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abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews with staff and the resident the facility failed to implement their abuse policies and procedures in the area of reporting immediately to the Administrator an allegation of resident abuse, after Nurse #6 witnessed a resident (Resident #64) use physical force to remove another resident (Resident #84) from his room resulting in fall; and failed to include an accurate date of when the facility became aware of the incident on the initial 24-hour report; and failed to identify resident abuse occurred and provide details of the incident that caused Resident #84 to fall in the initial 24-hour report. The facility also failed to follow their abuse policy and procedure by not immediately reporting an allegation of resident-to-resident sexual abuse to the Administrator (Resident #82 and Resident #88). The deficient practice affected 2 of 3 residents reviewed for abuse.

The findings included:

1. The therapy director will audit 10 wheelchairs weekly for 6 weeks to observe for any armrests needing repair. The maintenance director will check window blinds in 10 rooms weekly for 6 weeks to ensure blinds are in good repair and replaced timely as needed.
Audit results will be reviewed in QAPI and adjustments made as indicated to maintain ongoing compliance.
2. The therapy director will audit 10 wheelchairs weekly for 6 weeks to observe for any armrests needing repair. The maintenance director will check window blinds in 10 rooms weekly for 6 weeks to ensure blinds are in good repair and replaced timely as needed.
Audit results will be reviewed in QAPI and adjustments made as indicated to maintain ongoing compliance.
3. The therapy director will audit 10 wheelchairs weekly for 6 weeks to

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1. Review of the facility's "Abuse, Neglect, and Exploitation" policy dated 11/01/20 included reporting all alleged violations to the Administrator within specified timeframes immediately but no later than two hours after the allegation was made, if the events that caused the allegation involve abuse. The policy and procedures did not include to provide sufficient information and details describing the allegation when preparing the initial 24-hour report.

Resident #64 was admitted to the facility on 4/18/23 with diagnoses including cerebral infarction (stroke) and cognitive communication deficit.

The quarterly Minimum Data Set (MDS) assessment dated 12/12/24 revealed Resident #64's cognition was moderately impaired.

Resident #84 was admitted to the facility on 11/22/24 with diagnoses including Alzheimer's disease and dementia.

The admission MDS assessment dated 11/29/24 revealed Resident #84's cognition was severely impaired.

a. During an interview on 1/29/25 at 10:54 AM Resident #64 revealed he used both hands and physically picked up a resident (Resident #84) and threw him out of his room and onto the floor.

A progress note created on 1/27/25 at 5:29 PM by Nurse #6 revealed at 10:50 AM she observed Resident #64's room door was open and saw Resident #84 being "tossed out of the room." Resident #84 fell to the floor and land on the left

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observe for any armrests needing repair.
The maintenance director will check window blinds in 10 rooms weekly for 6 weeks to ensure blinds are in good repair and replaced timely as needed.
Audit results will be reviewed in QAPI and adjustments made as indicated to maintain ongoing compliance.
4. The therapy director will audit 10 wheelchairs weekly for 6 weeks to observe for any armrests needing repair.
The maintenance director will check window blinds in 10 rooms weekly for 6 weeks to ensure blinds are in good repair and replaced timely as needed.
Audit results will be reviewed in QAPI and adjustments made as indicated to maintain ongoing compliance.

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side of his body and the left side of his face. The note indicated Nurse #6 told the Director of Nursing (DON) what happened.

During a phone interview on 1/30/25 at 11:22 AM Nurse #6 revealed on 1/27/25 she witnessed Resident #64 use physical force and throw Resident #84 onto the floor causing him to fall and hit his head. Nurse #6 revealed she reported to the DON Resident #84 was thrown to the floor by Resident #64. Nurse #6 stated she received abuse training and was told to report immediately and that's what she did.

During an interview on 1/29/25 at 5:35 PM the DON revealed on 1/27/25 while in her morning meeting she received a text from Nurse #6 to immediately come to the secured memory care unit. The DON revealed when she arrived on the unit she saw Resident #84 sitting on the floor and was told by Nurse #6 "he had an unwitnessed fall, and she did not know what happened." The DON revealed she was not aware of the details about an abuse incident that Resident #64 used physical force to remove Resident #84 from his room had caused the fall until 1/28/25, after reviewing Nurse #6's documentation of the incident. She revealed Nurse #6's statement was put under the Administrator's door after hours and the incident report signed after hours on 1/27/25 at 6:08 PM and she saw those notes on 1/28/25 during the morning meeting. The DON revealed Nurse #6 should have reported resident abuse at the time she was asked about the fall on 1/27/25.

During a phone interview on 1/30/25 at 4:12 PM the Administrator revealed she asked Nurse #6 why she did not report the allegation of resident abuse immediately to her. She revealed staff

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recently received education to immediately report abuse and aware they need to contact the Administrator first and if she cannot be reached notify the DON. The Administrator revealed Nurse #6 told her she followed the chain of command.

b. A review of the initial 24-hour allegation fax cover sheet revealed the report was sent to the State Agency on 1/28/25 at 11:15 AM. The allegation report revealed the date the facility became aware of the incident was 1/27/2025 at 11:12 AM.

A phone interview was conducted on 1/30/25 at 4:12 PM and 5:41 PM with the Administrator. The Administrator confirmed the date she became aware of the details of the abuse incident involving Resident #64 and Resident #84 was on 1/28/25 during the morning meeting. The Administrator revealed the date on the initial 24-hour allegation report indicating the facility became aware on 1/27/25 was incorrect and an error on her part and should have been 1/28/25.

c. A review of the initial 24-hour allegation report revealed it did not identify resident abuse occurred. The report was completed by the Administrator and indicated a resident to resident physical altercation occurred without details describing Resident #84 was physically thrown by Resident #64 causing Resident #84 to fall and hit his head on the floor.

During an interview on 2/7/25 at 12:38 PM the Administrator revealed after reading nurses' progress notes she should have identified resident abuse on the initial 24-hour report. The Administrator revealed the initial 24-hour report did not contain sufficient details describing the

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incident of resident abuse because she did not want to be late in reporting to the State Agency.

2. An undated facility policy titled, Abuse, Neglect and Exploitation, read in part: "all alleged violations will be reported to the Administrator within specified timeframes: a) Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury."

Resident #82 was admitted to the facility on 08/31/2024.

The admission Minimum Data Set (MDS) dated 09/07/24 assessed Resident #82 as severely cognitively impaired.

Resident #88 was admitted to the facility on 11/09/2023.

The quarterly Minimum Data Set (MDS) dated 08/09/24 assessed Resident #88 as severely cognitively impaired.

A nursing progress note dated 10/16/24 at 10:54 PM written by Nurse #1 in Resident #88's electronic medical record (EMR) revealed Resident #82 was discovered in Resident #88's room. Resident #88's pants were all of the way down to his ankles; Resident #82 was leaned over onto Resident #88's lap. The note revealed the Nurse Aide (NA #1) was not aware of what took place because the lights were off when she entered the room. NA #1 separated both residents and redirected Resident #82 back to

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F 609	Continued From page 55 her room. A nursing progress note dated 10/16/24 at 10:54 PM written by Nurse #1 in Resident #82's (EMR) revealed Resident #82 was discovered in another resident's room during rounds sitting on the bed fully clothed with no signs of distress. She was redirected and taken to her designated sleeping area. Review of Resident #82 and Resident #88's EMR revealed there was no indication that the Director of Nursing (DON) and/or Administrator were notified. On 01/17/25 at 8:45 AM a telephone interview was conducted with Nurse #1. Nurse #1 stated it was difficult to remember the situation due to the length of time that had passed since the incident on 10/16/24. She stated she did recall a Nurse Aide (NA #1) coming to her and stating Resident #82 was found in Resident #88's room and Resident #88's (male resident) pants were down but the female resident (Resident #82) was fully clothed. Nurse #1 stated she told NA #1 to leave a statement, but NA #1 left the next morning without writing a statement for the facility. Nurse #1 thought she had called the former Director of Nursing to let her know about the incident but didn't think she was supposed to let the Administrator know. Nurse #1 stated she did not recall any more details about the incident and stated, "I wrote a note about what happened". The interview revealed she had since taken care of both Resident #82 and Resident #88 following the incident and had not witnessed any sexual behaviors from either resident. On 01/17/25 at 9:55 AM a telephone interview	F 609		

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F 609	Continued From page 56 was attempted with Nurse Aide (NA) #1. The surveyor did not receive a return phone call. NA #1 was an agency employee and no longer worked in the facility. On 01/16/25 at 2:12 PM an interview was conducted with the Social Worker. She stated she was unaware of any incident on 10/16/24 involving Resident #82 and Resident #88. On 01/17/25 at 9:37 AM a telephone interview was attempted with the former Director of Nursing. The surveyor did not receive a return phone call. On 01/17/25 at 10:04 AM an interview was conducted with the Administrator. During the interview she stated she was unaware of any incident involving Resident #82 and Resident #88. After reviewing the nursing progress note's written by Nurse #1 on 10/16/24 the Administrator stated Nurse #1 should have immediately notified her of the incident and an investigation should have been initiated into what had occurred. The Administrator stated the facilities abuse prevention policy was not followed because she was unaware of the situation. She stated the nursing progress note had been missed during nursing audits and not discussed in interdisciplinary team meetings.	F 609		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		3/4/25

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F 657	Continued From page 57 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to update a care plan to indicate do not resuscitate (DNR) status (Resident #25) and failed to update a care plan to reflect the use of an electronic wander guard alarm (a device that residents wear to trigger an alarm in unsafe areas) (Resident #63) for 2 of 3 residents reviewed for care plans. The findings included: 1. Resident #63 was admitted to the facility on 09/23/23 with diagnoses that included Alzheimer's disease, heart failure and seizure disorder.	F 657	1. The MDS coordinator updated the care plan for Resident #63 on 2/11/25 and Resident 25 on 1/9/2025. 2. Residents residing within the facility have the potential to be affected by this practice. 3. The facility's MDS team and Interdisciplinary Team attended an in-service presented regarding reviewing and updating care plans timely for any identified changes in resident needs by the nurse consultant on 2/26/25. 4.Audits of 5 resident's EMR will be completed by DON/designee to review that appropriate notifications are	

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The quarterly Minimum Data Set (MDS) assessment dated 11/13/24 revealed Resident #63 had severe cognitive impairment and wandering behaviors were not indicated on the MDS.

The MDS indicated a wander/elopement alarm was used daily.

A review of Resident #63's physician orders dated 01/29/25 revealed an order to check electronic monitoring device via testing machine every shift and to visually check electronic monitoring device every shift.

Resident #63's wandering care plan last revised on 02/10/25 did not include the use of the electronic monitoring device as an intervention.

During an interview with the MDS Coordinator on 02/10/25 at 3:05 PM the Coordinator explained that she was responsible for adding the new interventions to the care plans which would go over onto the Kardex (a care guide) for the nurse aides to see and follow. She indicated the wander guards were normally care planned. The MDS Coordinator reviewed Resident #63's care plan and acknowledged the wander guard was not on the care plan and stated he did have a wandering care plan. The Coordinator stated she did not remember discussing a wander guard for Resident #63.

On 3:43 PM on 02/10/25 interviews were conducted with Nurse Aide #3 and Nurse Aide #13 simultaneously. The Nurse Aides were asked how they knew when a new intervention was started for the residents, and they explained that when an intervention was added to the care plan

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completed and documented appropriately for identified change in resident condition.
Audits will be completed weekly for 6 weeks.
Results of audits will be reviewed in QAPI and adjustments made to plan as indicated to maintain ongoing compliance.

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it automatically comes over to the Point of Care (Kardex) charting system for the Nurse Aides to see and sign off on.

An interview was conducted with the Director of Nursing (DON) on 02/10/25 at 5:25 PM. The DON indicated that Resident #63 had severe cognitive impairment and was a wanderer on the Memory Care Unit. She explained that he needed a wander guard alarm to keep him safe. When the DON was informed that the wander guard was not on Resident #63's care plan she stated she did not know that it was not on there and it needed to be added to the care plan.

During an interview with the Administrator on 02/10/25 at 6:10 PM she stated Resident #63 was a wanderer and needed a wander guard alarm which should be care planned.
Based on record review and staff interviews, the facility failed to update a care plan to indicate do not resuscitate (DNR) status for 1 of 3 residents reviewed for care plans (Resident #25).

The findings included:

2. Resident #25 was admitted to the facility on 7/10/23. His diagnoses included cerebral infarction due to unspecified occlusion or stenosis of bilateral carotid arteries, diabetes mellitus due to an underlying condition with hypoglycemia, and chronic obstructive pulmonary disease.

A review of Resident #25's electronic medical record (EMR) nursing progress note revealed he transitioned to Hospice/end of life care on 1/3/25 and his code status was changed from a CPR/Full Code to DNR on the same date.

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A review of Resident #25's physical Do Not Resuscitate (DNR) revealed the form was signed on 1/3/25.

A review of the most recent quarterly Minimum Data Set (MDS) dated 12/13/24 revealed Resident #25 was severely cognitively impaired.

There was no current care plan indicating do not resuscitate.

An interview was completed with the MDS Nurse on 1/17/25 at 10:32 AM revealed she did not update the care plan when a resident code status changed. She explained that the Social Worker (SW) was tasked with updating the care plan.

An interview with the SW occurred on 1/17/25 at 9:55 AM. She explained she was tasked with updating care plans quarterly or whenever they needed to be updated. The SW indicated the care plans used to be updated by the MDS Nurse and the process had changed many months ago. She stated she attempted to schedule a care plan meeting for Resident #25 last quarter but was unable to explain why she was unsuccessful. The SW stated she was aware a change in code status and transition to Hospice care was discussed for Resident #25, but she was not informed by nursing that the change had been made, and the care plan was not revised or updated.

An interview with the DON on 1/17/25 at 11:32 AM revealed Resident #25's care plan should have been updated when his code status changed from CPR/Full Code to DNR by the SW.

An interview with the Administrator on 1/17/25 at

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F 657	Continued From page 61 2:07 PM revealed she expected Resident #25's care plan to be updated timely.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide nail care for 1 of 3 residents (Resident #65) reviewed for activities of daily living. The findings included: Resident #65 was admitted to the facility on 07/02/24 with diagnoses which included cerebrovascular accident (stroke), diabetes mellitus, dementia, and Alzheimer's disease. Resident #65's Care Area Assessment for activities of daily living (ADL) dated 07/16/24 revealed she needed assistance from staff with all activities of daily living due to her diagnoses of dementia and Alzheimer's disease. Staff were to anticipate the needs of the resident. Resident #65's quarterly Minimum Data Set (MDS) assessment dated 10/08/24 revealed she was severely cognitively impaired and required substantial to maximal assistance with all activities of daily living (ADL) except eating in which she required set up. There were no behaviors, and no rejection of care noted on her assessment.	F 677	1. Nail care was provided for resident # 65 on 1/16/2025. Education was provided on 2/26/2025 to Nurse Aides by DON/designee regarding care of residents fingernails inspection of fingernails and timely provision of nail care. 2. The facility has determined that all residents have the potential to be affected. DON and the clinical managers completed an assessment of each residents nails on 1/16/2025. Any identified issues were corrected at the time of the assessments. 3. Education was provided by the DON/designee to facility nurse aides and nurses on 1/16/2025 regarding provision of personal care, including nail care to all residents. No nurse aides or nurses will work after 2/26/2025 without education. Education included the inspection of nails routinely and not just on shower days and the importance of cleaning hands and nails thoroughly. 4. The DON/designee will observe 5 residents weekly for 6 weeks to ensure nail care is provided appropriately and	3/4/25

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Resident #65's care plan last revised on 10/22/24 revealed she had a focus area for an ADL self-care performance deficit related to recent hospitalization, decline in functional transfers, ADL and mobility. The goal was for Resident #65 to improve ability to safely and efficiently perform eating tasks with supervision or touching assistance to ensure adequate nutrition, hydration, perform upper and lower body dressing with supervision or touching assistance by the next review date of 04/14/25. The interventions included in part:

- Encourage resident to participate to the fullest extent possible with each interaction.
- Encourage the resident to use the call bell to call for assistance.
- Monitor/document/report prn any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function.
- Praise all efforts at self-care.
- Therapy evaluation and treatment as per Medical Doctor orders.

An observation on 01/14/25 at 3:07 PM of Resident #65 revealed her sitting in the dining area in her wheelchair coloring and watching TV. The resident was oriented to person only and her nails on both hands were noted to have brown colored debris under all nails on both hands. The resident was unable to answer when the last time she washed her hands or had her hands washed by staff.

An observation on 01/15/25 at 1:37 PM of Resident #65 revealed her sitting in the dining area in her wheelchair at a table with another resident watching TV. The resident's nails on

F 677

that resident’s nails are clean.
The LNHA will observe 3 residents weekly for 6 weeks to ensure nail care is provided appropriately and resident’s nails are clean.
Audit results will be reviewed in QAPI and adjustments made to plan as indicated to maintain ongoing compliance.

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both hands were noted to have brown colored debris under all nails on both hands.

An interview on 01/16/25 at 2:31 PM with Nurse Aide (NA) #4 revealed she had assisted with care for Resident #65 on 01/15/25. She stated she had not noticed the resident having brown debris under the resident's nails. NA #4 did not offer to clean Resident #65's fingernails.

An observation on 01/16/25 at 2:39 PM of Resident #65 revealed her sitting in the dining area in her wheelchair working on a puzzle. The resident's nails on both hands were noted to have brown colored debris under all nails on both hands.

An interview on 01/16/25 at 2:45 PM with NA #2 revealed she was assisting with care for Resident #65 during the 7:00 AM to 3:00 PM shift on 01/16/25 and had assisted with her care on 01/14/25 during the 7:00 AM to 3:00 PM shift. NA #2 stated she had not noticed Resident #65 having brown colored debris underneath her fingernails. She further stated Resident #65 received her showers on the 3:00 PM to 11:00 PM shift on Mondays and Thursdays and she was not responsible for her shower today. NA #2 did not offer to clean Resident #65's fingernails.

An observation and interview was conducted with Unit Manager #1 on 01/16/25 at 3:15 PM. UM #1 confirmed she was assigned to care for Resident #65 during the 7:00 AM to 3:00 PM shift on 01/16/25 and when shown the resident's dirty fingernails she stated that she had already seen them and discussed with NA #3 they needed to give her a good shower on the 3:00 PM to 11:00 PM shift today (01/16/25). UM #1 stated

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Resident #65's fingernails were dirty and needed to be cleaned and stated she had already discussed with NA #3 that they would give her a good shower on the 3:00 PM to 11:00 PM shift. UM #1 stated when she noticed things like dirty fingernails or long fingernails or any issue with the residents she tried to get them taken care of right away. UM #1 did not offer to clean the resident's fingernails prior to her scheduled shower on 2nd shift.

An interview on 01/17/25 at 9:40 AM with NA #3 revealed she had taken care of Resident #65 during the 3:00 PM to 11:00 PM shift on 01/16/25. She stated she and Unit Manager (UM) #1 had given Resident #65 a shower and had trimmed and cleaned her fingernails on both hands. NA #3 said UM #1 had noticed her fingernails being dirty while she was caring for her on 01/16/25 and had asked if NA #3 would assist her in giving Resident #65 a good shower on 01/16/25 during the 3:00 PM to 11:00 PM shift. NA #3 further stated she had not noticed Resident #65's dirty fingernails until UM #1 had brought it to her attention and stated she had not offered to clean her fingernails when it had been brought to her attention because she knew she and UM #1 were going to be giving Resident #65 a shower on 2nd shift.

An interview on 01/17/25 at 12:53 PM with the Director of Nursing (DON) revealed she promoted daily grooming of residents when possible. The DON stated sometimes residents on the 300-hall were not able to be redirected for care and that was why they were utilizing an extra NA on the hall to help with redirecting residents that wandered and refused care. She further stated she expected all refusals to be documented and

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F 677	Continued From page 65 communicated to UM #1 so she can reapproach the residents. The DON indicated she expected all staff to make sure the residents were groomed daily. An interview on 01/17/25 at 2:30 PM with the Administrator revealed she could not understand why the residents were not being groomed immediately when issues of grooming were identified by staff. She stated they had provided education to all staff, and she expected the staff to be diligent with daily care of the residents especially on the 300-hall given their dementia and inability of most of them to care for themselves.	F 677		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, review of the transportation van training tutorial, and resident, Transportation Driver #1, Transportation Administrator, staff, and Nurse Practitioner interviews, the facility failed to ensure that Resident #336 who was cognitively intact, received dialysis services and was prescribed an anticoagulant, was safely transported back to the facility following dialysis on 01/21/25. Transportation Driver #1 who drove through a	F 689	1.1 A head-to-toe assessment was completed of resident #336 by nurse #24 with no injuries or abnormalities noted on 1/21/25. The facility provided a facility employed transportation assistant for all non-emergent transportations of residents. The facility employed transportation assistant will validate the driver's proper securement of the resident to prevent an incident.	3/4/25

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F 689	Continued From page 66 contract transportation company failed he failed to secure the lap and shoulder belt around Resident #336. During the transport, Transportation Driver #1 hit bumps in the road and Resident #336 was thrown from his wheelchair to the floor of the van. In addition, Transportation Driver #1 did not contact Emergency Medical Services for Resident #336 to be evaluated and when he was unable to assist Resident #336 back into his wheelchair, Transportation Driver #1 made the decision to leave Resident #336 on the floor of the van and transport him back to the facility. Resident #336 stated he was not injured. When Transportation Driver #1 returned to the facility Nurse #24 assessed Resident #336 for injuries and none were noted. Failing to secure the lap and shoulder belt around Resident #336 during transport and transporting Resident #336 back to the facility while he was on the floor of the van had the high likelihood of causing serious harm, or serious impairment. The facility also failed to complete an accurate safe smoking assessment for Resident #39 and have electronic monitoring devices in place for Resident #29 and Resident #76. In addition, the facility failed to provide supervision to Resident #63 who resided on the locked unit on the third floor of the facility and had a history of wandering from getting on the elevator unattended and going to the second floor of the facility where staff found him and returned him to the secured unit on the third floor. The deficient practices affected 5 of 5 residents reviewed for supervision to prevent accidents (Resident #336, Resident #39, Resident #29, Resident #76, and Resident #63). Immediate jeopardy began on 01/21/25 when Resident #336's lap and shoulder belt was not	F 689	1.2 The facility identified that any resident who is being transported non-emergently has the potential to be affected. All residents transported by this contract transportation company in the last 30 days were interviewed by the Administrator on 2/19/25 with no reporting of any incidents or failure to be buckled appropriately noted during these interviews. 1.3 The facility will provide a facility employed transportation assistant for all non-emergent transportation completed beginning 2/19/25. The facility employed transportation assistant will be trained on proper procedures to complete wheelchair and seatbelt securement and how to respond in an emergency including notifying emergency personnel and the facility following any incident, wreck or fall involving a resident at the facility while on the contract transportation vehicle, by the Administrator or designee using the facility's designated training video 'Securing a wheelchair in a handicap accessible van.' This training began 2/19/25. No facility employed transportation assistant will take part in transportation of residents after 2/20/25 without having this education. The transportation aide will monitor the contract transportation driver's procedures of securing the residents in the vehicle with proper use and positioning of the vehicle securements. The facility employed transportation assistant will remain with the resident throughout the transport, while at their destination, and again monitor the contract transportation driver's procedures for securing the	

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secured around him prior to transportation and he was thrown to the floor after Transportation Driver #1 hit "bumps" in the road. Immediate jeopardy is present and ongoing. Examples #2, 3a, 3b, and 4 are being cited a lower scope and severity of E.

The findings included:

1. Per the restraint system used on the transportation van training tutorial, in order to properly secure a resident in a wheelchair with the restraint system, Transportation Driver #1 needed to lock the resident's wheelchair after loading Resident #336 followed by utilizing the retractable securing hooks to Resident #336's wheelchair and ensuring that they are locked and prevented Resident #336's wheelchair from moving. Transportation Driver #1 should have then placed the lap and shoulder belt over Resident #336, ensuring the lap belt was snug across Resident #336's lap and the shoulder belt was across the front of Resident #336.

Resident #336 was admitted to the facility on 01/18/25 with diagnoses that included end stage renal disease.

Resident #336's admission Minimum Data Set assessment dated 01/25/25 revealed him to be cognitively intact with no delusions, behaviors or rejection of care. Resident #336 was coded as dependent on others for transfers and had impairments on both sides of his lower extremities. Resident #336 was also coded as taking an anticoagulant medication and receiving dialysis services.

Resident #336's physician orders revealed Eliquis Oral Tablet - 5 milligrams - Give one tablet by

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resident in the vehicle with the proper use and positioning of the vehicle securements on the return trip.
Regional Director of Operations completed training with the Administrator and Director of Nursing on 2/11/25 that all non-emergent transportation agency contracted with the facility must provide training credentials required of the vehicle operators and proof of completion by the vehicle operators. The Administrator must determine that all appropriate safety measures for securing residents during transports, are included in the transportation agencies' orientation training of employees. The transportation agency must provide sufficient evidence of each individual driver, in writing to the facility by 2/19/25. Without sufficient evidence of aforementioned training, no transportation of the nursing facility's residents will occur after 2/19/25. This will be validated by the Administrator or designee.
A form titled "Non-emergent Transportation Attestation," is to be completed by any transportation assistant/drivers of the contract transport company who will be transporting nursing facility residents effective 2/18/25 with each individual transport. The written form communicates safety expectations of the nursing facility including proper securement requirements maintained throughout the transportation. Additionally, the form states "In the event of any incident including but not limited to falls, the transportation assistant must notify emergency services for assistance via

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mouth two times a day for history of stroke. This physician order was dated 01/20/25.

Resident #336's care plan dated 01/20/25 revealed a care plan for receiving hemodialysis related to end stage renal disease. Resident was scheduled for dialysis on Tuesdays, Thursdays, and Saturdays.

The facility's fall incident report dated 01/21/25 at 6:00 PM revealed the following: "Transport Driver arrived stating resident had fell out of wheelchair and asking for assistance. Un-witnessed fall. Resident lying on right side in the floor of the transport van. Resident was laying beside his wheelchair in back. No signs of visual injury. Resident had complaints of right knee discomfort. Resident stated he did not hit his head. Aided resident back into his chair with the help of driver. This nurse asked driver to come in and write a statement and driver left without doing so. Resident stated upon returning to facility from dialysis, driver went over a speed bump when he got dispositioned in his wheelchair. Resident stated before he could get himself straightened back up in wheelchair, the driver then [stomped] on the brakes and resident fell forward out of wheelchair on transport van floor. Resident stated his right leg was slightly bent when he landed on the floor. Resident stated his seat belt was anchored around his wheelchair and not him. Resident stated van driver made an attempt away from premises to pick him up off the floor but was unsuccessful." An additional review of the incident report revealed Resident #336's vital signs were taken and were within normal limits. Per the incident report a complete body check was completed on Resident #336 and there were no signs of injury. Nurse #24 offered Resident

F 689

911. Please notify the facility after calling 911." The contract transportation assistant must sign and date the Non-emergent Transportation Attestation prior to removing the resident from the facility. This is maintained in a binder located at each facility nursing station. This form was reviewed with the facility employed transportation assistant including procedures in the event of an emergency on 2/19/25 by the Administrator and be ensured completion by the facility employed transportation assistant.
1.4 The Administrator/designee will complete 5 resident interviews weekly for 6 weeks for any residents transported non-emergently to determine if the resident experienced any incidents or transportation concerns.
The Administrator will complete 5 facility employed transportation assistant interviews weekly for 6 weeks to determine if drivers are accurately completing the 'Non-emergent Transportation Attestation,' properly securing residents throughout the transportation, and validating if any incidents occurred during non-emergent transportations.

2.1 A smoking assessment was completed of resident #39 on 1/17/25 and determined to require supervision from staff while smoking.
2.2 The facility identified that any resident who smokes has the potential to be affected. A review was completed of all resident safe smoking assessments on 1/17/25 by the Administrator/designee

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F 689	Continued From page 69 #336 an ice pack, but he declined. The incident report was written by Nurse #24. An interview with Resident #336 on 02/07/25 at 12:16 PM revealed he remembered the incident. He reported he had gone to dialysis and was supposed to be picked up around 4:00 PM on 01/21/25. He stated Transportation Driver #1 first loaded another resident (Resident #337) and then loaded him onto the transportation van. He stated when Transportation Driver #1 loaded him on the transportation van, he locked the wheels of his wheelchair, but instead of placing the lap belt around his body, he placed it around his wheelchair. Resident #336 stated he did not question Transportation Driver at that time because, "I thought he knew what he was doing". Resident #336 continued, stating as Transportation Driver #1 proceeded on to the facility, it felt as though Transportation Driver #1 hit a bump which jarred him from his wheelchair. Resident #336 stated before he could get resituated in his wheelchair. Transportation Driver #1 hit another bump which resulted in throwing him from the wheelchair onto the floor of the van. Resident #336 reported he called out for help and Transportation Driver #1 pulled over and unsuccessfully attempted to get him back into his wheelchair. Resident #336 stated Transportation Driver #1 then proceeded to tell him that they were only about 10 minutes from the facility and that he would get him off of the floor of the van when they returned to the facility. Resident #336 stated he remained on the floor of the van for the remainder of the drive and when they arrived back at the facility, a staff member came out and helped him get back into his wheelchair. Resident #336 reported that he was not injured in the event but reported he really did not like being	F 689	with no additional residents identified as needing increased assistance from what is currently provided. 2.3 Education of safe smoking practices, supervision of smoking and smoking policy was provided from the Administrator/designee on 2/26/2025 to the nurse aides, licensed nurses and smoking assistants. 2.4 The Administrator/designee will complete an audit of 5 safe smoking assessments weekly to identify appropriateness of supervision level for each resident. 3.1 The need for a wandering device for resident #29 and #76 was confirmed by the Administrator / designee on 1/17/25. Q30 minute checks by nurse aides and hourly checks by licensed nurses were initiated on resident #29 and #76 initiated on 1/17/25 until electronic wandering devices could be placed on the residents. Both residents received wandering devices placed on 1/18/25. 3.2 Any resident in need of an electronic wandering device is at risk of this deficient practice. A review of all residents requiring electronic wandering devices was completed by the Clinical Consultants and Director of nursing on 2/13/25 and validated for accurate placement on the resident. No other residents were identified as missing an electronic wandering device. 3.3 Education was provided from the Director of Nursing/designee to licensed nurses beginning 1/18/25 and 2/26/2025 on verifying placement and function of all residents requiring an electronic	

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F 689	Continued From page 70 left on the floor of the van while it was returning to the facility and that it was not a good first-time experience being transported by the transportation company. Resident #337's admission Minimum Data Set assessment dated 12/03/24 revealed he was cognitively intact. An interview with Resident #337 on 02/07/25 at 3:43 PM revealed he was on the transportation van the day Resident #336 fell. Resident #337 reported that Transportation Driver #1 loaded him [Resident #337] into the transportation van first and secured his wheelchair with four straps to his wheelchair and then placed a lap and shoulder belt over his midsection. He stated since he was loaded first, he could not see how Transportation Driver #1 loaded and secured Resident #336 in the transportation van. He stated at some point during transport, he heard Resident #336 state, "Help, I need help". Resident #337 reported when he heard Resident #336 call out for help, he asked Resident #336 if he was okay, and Resident #336 replied that he needed help. Resident #337 reported he could not see Resident #336 due to their placement in the van, so he relayed that message to Transportation Driver #1. Resident #337 stated Transportation Driver #1 pulled the van into a bank parking lot and checked on Resident #336 but was unable to either get Resident #336 resituated into his wheelchair or get him off of the floor, so Transportation Driver #1 got back into the driver's seat of the van and continued on to their destination. Resident #337 indicated he did not realize Resident #336 was in the floor of the van until Transportation Driver #1 got to the facility and retrieved a staff member to come out and	F 689	wandering device. 3.4 Director of Nursing/designee will audit 5 electronic wandering devices weekly for 6 weeks on residents deemed to have a need for electronic wandering device. This audit will validate placement and function of the electronic wandering device. 4.1 Resident #63 was placed on 1 on 1 supervision until electronic wandering device could be placed. On the same day 2/10/25, resident #63 had an electronic wandering device placed on the ankle and verified for function. 4.2 Any resident in need of an electronic wandering device is at risk of this deficient practice. A review of all residents requiring electronic wandering devices was completed by the Director of Nursing on 2/10/25 and validated for accurate placement on the resident. No other residents were identified as missing an electronic wandering device. 4.3 Education was provided from the Director of Nursing/designee to licensed nurses beginning 1/18/25 and 2/26/25 on verifying placement and function of all residents requiring an electronic wandering device. Additional education was completed by the Director of Nursing/designee to redirect residents who appear to be exit seeking or increasing in exit seeking behaviors. 4.4 Director of Nursing/designee will audit 5 electronic wandering devices weekly for 6 weeks on residents deemed to have a need for electronic wandering device. This audit will validate placement and function of the electronic wandering device.	

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assist him in getting Resident #336 back into his wheelchair. Resident #337 reported he did not feel any significant bumps in the road but that there were a few times where Transportation Driver #1 applied the brakes "a little hard".

An interview with Transportation Driver #1 on 02/10/25 at 11:09 AM via telephone revealed he was the transportation driver for Resident #336 and Resident #337 on 01/21/25. Transportation Driver #1 reported he loaded Resident #337 onto the van first, secured his wheelchair with four straps and then placed the lap belt around Resident #337's midsection and then loaded Resident #336 onto the van and repeated the same process. He reported he was driving both residents back to the facility and when he pulled into the facility's parking lot, he was notified by Resident #337 that Resident #336 needed assistance. Transportation Driver #1 stated he stopped and went to check on Resident #336 and noted that he had started to "slide out of his seat". Transportation Driver #1 reported he attempted to resituate Resident #336 back into his wheelchair but was unsuccessful. He stated he unlatched the lap belt and when he did, Resident #336 slid out of his wheelchair to the ground. Transportation Driver #1 stated Resident #336 landed on his bottom but could not recall if he was leaning to one side or the other. Transportation Driver #1 insisted that he was not aware of the issue until he was pulling into the facility's parking lot and denied pulling into any other parking lots or that Resident #336 was transported while he was on the floor. He continued, stating once he realized he could not get Resident #336 back into his wheelchair, he went and retrieved assistance from a staff member in the facility. Transportation Driver #1

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reported he received in-service trainings and was tested on competencies "a couple times a year" and had been reminded daily to ensure that when he was transporting clients, that their wheelchairs and the clients were secured before transporting them to their destinations. Transportation Driver #1 indicated if a client were to fall during transportation, he was supposed to immediately pull over and contact his supervisor. He also stated once he retrieved assistance from a facility staff member, they were able to get Resident #336 back into his wheelchair and off of the transportation van. He reported once Resident #336 was safely back into the facility, he knew he had to contact his supervisor but noticed that his phone was dead, so he immediately left the facility so he could charge his phone and contact his supervisor. He indicated he was unaware that the facility requested him to stay and complete a written statement of the incident.

Review of Transportation Driver #1's training revealed he was trained on defensive driving, along with how to secure resident's for transportation and the processes and policies in the event of an emergency.

Transportation Driver #1's written statement that was received by the facility on 01/22/25 at 12:00 PM, via email, to the attention of the Administrator read, in part: I am writing to provide an account of an incident that occurred at [facility]. I arrived at the facility between 5:15 PM and 5:30 PM. As I was pulling into the driveway, [Resident #337] informed me that [Resident #336] had slid out of his wheelchair. I did not hear about or observe the incident myself but immediately inquired about [Resident #336's] condition. I then entered the facility to request assistance. The nursing

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staff promptly responded and assisted in helping [Resident #336] back into his wheelchair. Once [Resident #336] was safely secured in his wheelchair, the nurse wheeled him back inside. I took [Resident #337] out of the van and subsequently left to notify my manager about the situation. Unfortunately, the office was closed, and my phone battery was dead. I made haste to get home so I could inform my manager, [Transportation Administrator], of the incident as quickly as possible.

An interview with the Transportation Administrator via telephone on 02/10/25 at 11:27 AM revealed she was made aware of the incident on 01/21/25 later that evening when Transportation Driver #1 contacted her. She said he reported to her that Resident #336 had slid out of his chair during transportation. She said she could not recall if Transportation Driver #1 reported he had slid completely out of the wheelchair or if he was only partially out of the wheelchair. She stated they provide training to all of their transportation drivers including proper securement of the clients and what to do in the event a client had a fall during transport. She stated her staff were trained to secure clients by hooking up four locking straps to the client's wheelchair and then placing the lap and shoulder belt over the client. Once that was complete, she expected her employees to "wiggle" the wheelchair to ensure it was fully secure. She continued, stating that if a client were to fall or have an emergency during transportation, she expected them to immediately pull over somewhere safe, check on the client, contact emergency services, and then notify her of the incident. She indicated she did not know if Transportation Driver #1 contacted emergency services at the time he was made aware that

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Resident #336 had slid out of his wheelchair.

An interview with Nurse #24 on 02/10/25 at 2:26 PM, revealed she was working on 01/21/25 and was near the lobby of the facility when Transportation Driver #1 entered the facility and stated "Help, help, a resident just fell in the van". She stated she ran outside and found Resident #336 who was lying flat on his side on the floor in the back of the transportation van. She questioned Transportation Driver #1 on how Resident #336 ended up in the floor and he reported to her that when he was trying to get Resident #336 out of the van, he slid out of his wheelchair and onto the floor. She stated his left leg was slightly bent and was between the wheels of his wheelchair underneath the seat. She stated she assessed and questioned Resident #336 who stated he had fallen during transport but was not injured and that he had not hit his head. She stated he did complain of some slight discomfort in his left foot or leg when she removed the wheelchair in order to get him off of the floor. She stated once she got Resident #336 off of the floor of the van and into his wheelchair, she questioned him as she took him into the facility, and he stated he had fallen during transport and was left on the floor of the van until they arrived at the facility. She stated he also informed her that Transportation Driver #1 had placed his lap belt around his chair and not his person, which resulted in him falling. Once she spoke with Resident #336 and ensured he was comfortable in his room, she immediately reported the fall to the Administrator. She reported she went back out to get a statement from Transportation Driver #1, but he refused and got into the transportation van and left the facility.

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An interview with Nurse Practitioner #1 on 02/10/25 at 5:08 PM via telephone call revealed Resident #336 was taking anticoagulant medication and there was a higher risk for internal bleeding following a fall.

An interview with the Director of Nursing on 02/10/25 at 3:21 PM revealed all she could remember of the incident was she was completing her final round at the end of the day when Nurse #24 informed her that Resident #336 had fallen on the transportation van and that Transportation Driver #1 had "just left". She stated she immediately headed towards Resident #336's room and questioned Nurse #24 if she had assessed him for injury and taken his vital signs which Nurse #24 reported she had. The Director of Nursing reported she went to check on Resident #336 and found him resting comfortably in his room, in bed. She stated she asked him if he wanted to go to the hospital to be evaluated and Resident #336 declined, only asking for some warm blankets. The Director of Nursing reported the on-call provider and Resident #336's emergency contact were notified. She stated when she spoke with Resident #336 about what happened. He reported he had fallen during transport back from dialysis and when Transportation Driver #1 could not get him back into his wheelchair, he left him on the floor of the van and continued on to the destination. She reported it was not until 02/09/25 that she was aware that Resident #337 was on the transportation van at the time of the incident. She stated she went and spoke with Resident #337 at that time and he reported he provided the same information that Resident #336 provided, in that Resident #336 had fallen during transport, Transportation Driver #1 had pulled over and

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attempted to get him back in his wheelchair unsuccessfully, and then proceeded to continue on to the facility with Resident #336 still in the floor of the van. She reported there was absolutely no reason for Resident #336 to be left in the floor of the van while it was in transit to the facility. She stated Transportation Driver #1 should have stopped, called emergency services, and then notified the facility of the incident immediately. She continued, stating if Transportation Driver #1 would have done the bare minimum of contacting the facility, they would have been able to tell him that they were on their way but to go ahead and call emergency services.

An interview with the Administrator on 02/10/25 at 5:37 PM revealed she was in her office when a, now unknown, staff member notified her that Resident #336 had fallen on the transportation van. She reported Nurse #24 had responded to the fall and assessed Resident 336. She stated it was her understanding that Resident #336 was not injured. It was also reported to her that Nurse #24 had attempted to get Transportation Driver #1 to stay and provide a written statement of the events but that he had left the premises. The Administrator reported she immediately reached out to the transportation company via phone and email and expressed her displeasure with the events and demanded a written statement from Transportation Driver #1. She stated she heard back from the transportation company at 7:25 PM and was told they would get with Transportation Driver #1 and get his written statement and send it to her. She stated she did not hear back from the transportation company until 01/22/25 at 12:00 PM, when they emailed her Transportation Driver #1's written statement. She stated after

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the incident; she informed the transportation company that Transportation Driver #1 would not be allowed to provide any transportation for the facility. The Administrator reported she spoke with Resident #336 on the evening of 01/21/25 and he reported to her that he had fallen during transport and Transportation Driver #1 had tried to get him back in his wheelchair, unsuccessfully, and then left him in the floor for "another block" until they arrived at the facility. The Administrator reported since the incident that the facility had begun looking for other transportation companies to contract with to provide transportation to her resident but that the same transportation company was still providing transport to her resident. She indicated that it was unacceptable, and she expected transportation drivers to immediately pull over, check on the resident, call emergency services, and then notify the facility when a resident falls or has a medical emergency during transportation.

The Administrator was notified of immediate jeopardy on 02/10/25 at 6:06 PM.

The immediate jeopardy remains present and ongoing.

2. A review of the facility's Resident Smoking policy, last revised on 1/22/24, indicated residents who smoked would be further assessed using the Safe Smoking Assessment to indicate if a resident is safe to smoke at all. It also indicated any resident who was deemed unsafe to smoke independently would be supervised and would be allowed to smoke in designated areas, at designated times, and in accordance with his/her care plan.

Resident #39 was admitted to the facility on

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F 689	Continued From page 78 8/22/23 with diagnoses which included epilepsy, chronic kidney disease, and dementia. A review of Resident #39's Safe Smoking assessments since the last recertification on 7/26/24 was completed. The 8/15/24 assessment, completed by previous Unit Manager #2 indicated he was a supervised smoker. The assessment tool indicated that an answer of "Yes" to any history of smoking related incidents would require a resident must be at minimum a supervised smoker. Burning self, burning clothing, and dropping ashes on self were selected historical incidents for Resident #39. Another smoking assessment completed on 10/17/24 by previous Unit Manager #3 revealed Resident #39 was deemed to be an independent smoker. This assessment also indicated that an answer of "Yes" to any history of smoking related incidents would require a resident must be at minimum a supervised smoker. Burning self and dropping ashes on self were selected as historical incidents for Resident #39. Multiple attempts were made to contact previous Unit Manger #2 and previous Unit Manager #3 and were unsuccessful. A review of Resident #39's care plan, revised on 10/18/24, revealed he was an unsupervised smoker. The goal was for Resident #39 to not suffer injury from unsafe smoking practices through the review date. Interventions included observing clothing and skin for signs of cigarette burns and to notify the charge nurse immediately if it was suspected Resident #39 violated the facility smoking policy. A review of Resident #39's quarterly Minimum	F 689		

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Data Set (MDS) dated 12/10/24 revealed the resident was cognitively intact and needed supervision from staff for most activities of daily living (ADL). The MDS indicated Resident #39 utilized a wheelchair for mobility.

An observation on 1/14/25 at 4:26 PM revealed Resident #39 bent over in his wheelchair smoking a cigarette on the smoking porch. There was no staff present in the smoking area to supervise. The lit part of Resident #39's cigarette was touching his coat as his natural posture caused him to lean forward in his wheelchair. Cigarette ashes were present on the front of his coat. An ash collection container was located to the right of Resident #39 with multiple snuffed out cigarette butts.

An interview conducted with current Unit Manager #4 on 1/17/25 at 10:12 AM revealed she was new to the facility and did not complete the smoking assessment on 10/17/24 for Resident #39 the previous Unit Manger completed it. She stated the nurses on the floor are tasked with completing the smoking assessments quarterly. Unit Manager #4 stated a resident was deemed an independent or safe smoker if they met certain parameters in the assessment and didn't have any smoking related incidents. She was not aware of any concerns related to Resident #39 and smoking and he was able to smoke in the designated area at any time. If he was assessed as a supervised smoker, his smoking materials would be held on the nurse's cart, and someone would have to supervise him during designated supervised smoking times.

Interview conducted with the Director of Nursing (DON) on 1/17/25 at 11:08 AM revealed she was

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new to her position as DON and was working on safety issues with smoking at the facility. She stated that if there was any cause for concern regarding smoking for any resident, a smoking assessment could be completed by the Social Worker (SW) or any nurse immediately and assessments were not just completed quarterly. She indicated if there was a change in smoking status, the resident, any family, administration and provider would be notified. The DON stated she had concerns for Resident #39's safety due to his past history of behaviors and his posture but had not witnessed or heard of any concerning behaviors recently and stated he had been assessed as an independent smoker and could smoke at any time in the smoking area. She stated the use of smoking aprons was discussed for safety and stated Resident #39, as well as other residents could need an evaluation for a smoking apron. The DON further explained that management was reviewing smoking policies for resident safety, and they planned to discuss the smoking policy and possible changes to the policy with residents at their next Resident Council meeting for their input.

An interview with the Administrator on 1/17/25 at 2:04 PM revealed she expected staff to report any smoking concerns or a change of condition regarding a resident's ability to safely smoke to say something so an assessment could be completed. She stated smoking assessments were not just completed annually and quarterly, but whenever necessary if there was a cause for concern.

3.a. Resident #29 was admitted to the facility on 08/03/2017 and readmitted on 01/02/2021 with diagnosis including bipolar disorder.

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A quarterly Minimum Data Set (MDS) dated 12/13/24 revealed Resident #29 was severely cognitively impaired. He was coded for having a wander/elopement alarm used daily during the assessment period.

A review of the care plan revised on 01/05/25 revealed a focus area for elopement. Resident #29 was documented as a wanderer, disoriented to place and safety awareness. The goal was for Resident #29's safety to be maintained through the next review date. Interventions included an electronic signaling device as ordered.

An observation conducted on 01/15/25 at 1:11 PM of Resident #29 revealed he had no electronic signaling device in place.

3b. Resident #76 was admitted to the facility on 10/15/2024 with diagnosis including Alzheimer's disease and delirium.

A review of the care plan dated 10/21/24 revealed a focus area for elopement. Resident #76 was documented as an elopement risk/ wanderer. The goal was for Resident #76's safety to be maintained through the next review date. Interventions included an electronic signaling device as ordered.

An admission Minimum Data Set (MDS) dated 10/25/24 revealed Resident #76 was cognitively intact. He was coded for having a wander/elopement alarm used daily during the assessment period.

Resident #76's physician order dated 10/30/24 revealed an order to visually check electronic

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monitoring device to left wrist every shift.

An observation conducted on 01/15/25 at 12:50 PM of Resident #76 revealed he had no electronic signaling device in place. An interview conducted with Resident #76 during the observation revealed he had removed the electronic wandering device himself. He stated, "I'm going to get out of here, they can't lock me up like a prisoner".

On 01/16/25 at 10:53 AM an interview was conducted with Unit Manager #1. During the interview she stated Resident #29 and Resident #76 had physician orders for an electronic monitoring device and did not have one on. Unit Manager #1 stated the electronic monitoring devices were on backorder. She stated she had systems in place for increased monitoring overall for the entire memory care unit due to a shortage of electronic monitoring devices on the residents. The interview revealed the electronic monitoring devices were placed on the resident's ankle or wrist to signal to the alarm system if a resident was too close to the doors or elevator and prevent an elopement from the unit. Unit Manager #1 stated she had a Nurse Aide sit by the elevator doors because some of the residents on the unit did not have electronic monitoring devices and were a wandering risk. She stated to her knowledge neither Resident #29 or Resident #76 had attempted to elope from the memory care unit.

On 01/17/25 at 2:50 PM an interview was conducted with Nurse Aide (NA) # 3. During the interview she stated the staff had been instructed to sit at each elevator due to some of the residents not having a electronic monitoring

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device in place. NA #3 stated Resident #76 would often wander the unit, but she had not witnessed Resident #29, or Resident #76 leave the unit unless supervised by staff. She stated the NAs were supposed to fill out a 30-minute rounding form that included the where abouts of all residents in general on the unit.

On 01/16/25 at 12:04 PM an interview was conducted with the Director of Nursing (DON). During the interview she stated she started as the DON on 12/23/24 and had realized there were no electronic monitoring devices available for residents on the third floor of the facility (memory care unit). The DON stated she had been asking the Administrator on a consistent basis to order new electronic monitoring devices because it was a need for the unit due to residents wandering. She stated she found out the facility had placed an order in early December, but the devices were on back order and no additional order had been placed. The DON stated to her knowledge there had been no elopements on the unit due to no electronic monitoring devices in place.

On 01/16/25 at 11:46 AM an interview was conducted with the Administrator. She stated there were no extra electronic wandering devices in the facility to put on the residents. The interview revealed if a resident had an order, and was care planned for an electronic wandering device then they should have it on their body and in place. She stated there was an order placed on 12/02/24 for 3 electronic monitoring devices but did not realize the order was placed on backorder and the devices were never delivered. The Administrator stated she would be placing a new order for the devices and to ensure each resident with a physician order would have a device in

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place.

4. Resident #63 was admitted to the facility on 09/23/23 with diagnoses that included Alzheimer's disease, heart failure and seizure disorder. Resident #63 resided in the Memory Care Unit which is a secured unit on the third floor of the facility.

The care plan revised on 06/06/24 revealed Resident #63 was a "wanderer" due to being disoriented to place. The goal that he will be safe would be attained by utilizing interventions such as distracting the Resident by offering distraction with activities, ensuring the areas that the Resident is wandering in is safe and monitoring for fatigue and weight loss. There was no wander guard monitoring device on the care plan.

The quarterly Minimum Data Set (MDS) assessment dated 11/13/24 revealed Resident #63 had severe cognitive impairment and wandering behaviors were not indicated on the MDS. The MDS also indicated the Resident ambulated independently and wander/elopement alarm was used daily.

A review of Resident #63's physician orders dated 01/29/25 revealed an order to check electronic monitoring device via testing machine every shift and to visually check electronic monitoring device every shift.

A review of Resident #63's Medication Administration Record (MAR) for 01/2025 indicated an order dated 01/29/25 to visually check the electronic monitoring device right ankle every shift and check electronic monitoring device via testing machine every shift. The MAR

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indicated the electronic monitoring device was checked as present every day and every shift.

A review of Resident #63's MAR for 02/2025 indicated an order dated 01/29/25 to check the electronic monitoring device right ankle every shift and check electronic monitoring device via testing machine every shift. The MAR indicated the electronic monitoring device was checked as present every day and every shift except day shift on 02/06/25.

An interview and observation were made of Resident #63 on 02/07/25 at 1:08 PM. The Resident was standing in the middle of the floor in his room. Resident #63 answered to his name being called but could not follow verbal command. Observation of both ankles and wrists revealed there was no wander guard alarm on the Resident.

An observation was made on 02/10/25 at 1:15 PM of a sign posted on the back wall in the Providence Road elevator (one of two elevators that leads up to the Memory Care Unit) that stated "STOP" in a red stop sign and verbiage underneath the sign that stated "PLEASE SEE THE NURSE BEFORE ALLOWING OUR SECURED RESIDENTS ON THE ELEVATOR" in black capital letters. There was no sign posted on the front door of the elevator about the precaution.

An observation was made of the outside door and inside back wall of the Dartmouth Road elevator which leads up to the Memory Care Unit on 02/10/25 at 2:12 PM. There were signs posted that stated "STOP" in a red stop sign and verbiage underneath the sign that stated

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"PLEASE SEE THE NURSE BEFORE ALLOWING OUR SECURED RESIDENTS ON THE ELEVATOR" in black capital letters.

On 02/10/25 at 12:45 PM during an interview with Nurse #7 the Nurse reported that she was working on the second floor on 02/10/25 when around 7:39 AM she observed Resident #63 wandering around on the second floor near the nurses' station alone with no one attending him. The Nurse explained she sent a text message to the Director of Nursing (DON) to report her observation then called Nurse #5 who was working the Memory Care Unit at that time and reported her observation to the Nurse in which she responded that she would send a staff member down to get Resident #63. Nurse #7 continued to explain that approximately 5 minutes later Nurse Aide (NA) #11 who was scheduled to work on the Memory Care Unit came to the second floor nurses' station and assisted Resident #63 back upstairs to the Memory Care Unit. The Nurse reported that a few minutes after the NA left with Resident #63, the DON came to the second floor to collect statements from staff about Resident #63 being downstairs unattended. The Nurse stated she informed the DON that Resident #63 was observed to be walking up the long hall from the area of the Providence Road elevator. When asked how the Nurse thought Resident #63 got unattended to the second floor she indicated if his wander guard alarm did not sound on the Memory Care Unit then he could have ridden the elevator down with someone who did not know that the Resident should not be left unattended. The Nurse reported that there were a lot of new people at the facility and there were signs posted outside the elevator doors about patient safety.

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On 02/10/25 at 1:16 PM during an interview with Nurse Aide #12, the NA was working on the Memory Care Unit on first shift on 02/10/25 who explained that he was off the Unit when Resident #63 was found downstairs on the second floor. The NA continued to explain that a Hospice staff was on the Unit earlier that morning and the Resident could have rode the elevator down with that person. NA #12 stated Resident #63 had since had the wander guard placed on his ankle and was on a 1:1 monitoring with NA #11.

An observation of Resident #63 was made on 02/10/25 at 1:19 PM. The Resident was alert and walking up the hallway while being monitored by Nurse Aide #11. The NA asked Resident #63 to lift his pant leg up and the Resident could not follow through with the request. The NA had to lift the Resident's left pant leg to expose the wander guard was present on his ankle.

An interview and observation were conducted with Nurse Aide #11 on 02/10/25 at 1:20 PM. The NA was monitoring Resident #63 for the 1:1 protocol and explained that she went downstairs earlier that morning and as soon as she stepped off the elevator on the second floor the Resident was walking toward her and had already passed the nurses' station. The NA continued to explain that she asked Nurse #7 how Resident #63 got down to the second floor but neither of them knew how the Resident got downstairs by himself. NA #11 reported when she returned to the Memory Care Unit with Resident #63, she was told that she was changing assignments to monitor the Resident 1:1 for the rest of the shift. Soon afterwards the NA had to take Resident #63 to the podiatry clinic downstairs and one of the

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Unit Managers placed a wander guard on the Resident's left ankle.

During an interview with Nurse #5 on 02/10/25 at 1:35 PM the Nurse explained that earlier that morning she received a phone call from Nurse #7 who was working on the second floor, she found Resident #63 wandering around by himself and Nurse #5 needed to send someone down to get the Resident. The Nurse stated she notified Nurse Aide #8 who was the Resident's assigned care giver that day, that Resident #63 was found on the second floor, and she needed to go downstairs and get the Resident. NA #8 informed the Nurse that she had just sat Resident #63 down in the dining room and he was watching TV when she went to the supply closet to obtain some supplies to continue her morning care of the residents. The Nurse stated as the NA went to the Dartmouth Road elevator to obtain the Resident, she observed Nurse Aide #11 and Resident #63 getting off the elevator. Nurse #5 explained that she notified the Director of Nursing that Resident #63 was found downstairs on the second floor and the DON came to the Memory Care Unit when it was discovered that Resident #63 did not have his wander guard on either ankle. The Nurse reported that the staff searched the Resident's room and could not find the wander guard. Nurse #5 stated a new wander guard was placed on Resident #63 by one of the Unit Managers and he was placed on 1:1 monitoring with Nurse Aide #11. Nurse #5 continued to explain that she worked on the Memory Care Unit on Saturday 02/08/25 first shift and Resident #63 had his wander guard on during that shift. When Nurse #5 was asked how she thought Resident #63 got to the second floor she explained that since the wander guard alarm

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did not sound for the Resident, he must have ridden the elevator down with someone who did not know that the Resident could not be without attendance of staff. The Nurse reported only one person was on the unit that day which was a Hospice Aide, and she thought the DON had already obtained a statement from her about the incident.

On 02/10/25 at 1:45 PM an interview was conducted with Nurse Aide #8 who confirmed she was assigned to Resident #63 and explained that she had just sat Resident #63 down in the dining room to watch TV and went to the supply closet to obtain supplies to continue her care of the residents. She stated that approximately 5-7 minutes later when she opened the door to come out of the supply room Nurse #5 informed her that Resident #63 was found on the second floor by himself unattended and asked the NA to go downstairs and bring him back up but as she approached the Dartmouth Road elevator she saw that NA #11 had already brought Resident #63 back to the Unit. NA #8 reported that the Resident was supposed to have a wander guard on, but he did not have a wander guard on when he was brought back to the Unit. She stated if Resident #63 had a wander guard on then he would not have been able to get on the elevator because of the alarm sounding as he approached the elevator. The NA stated the Resident was put on 1:1 monitoring with NA #11 and the wander guard was replaced later that morning. NA #8 reported that she did not know how Resident #63 got downstairs unattended, but he should have had a wander guard on because of his wandering behavior.

An interview was conducted with Unit Manager #4

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on 02/10/25 at 3:30 PM. The Unit Manager explained that the Director of Nursing notified her earlier that day to put a wander guard on Resident #63 when he was at the podiatry clinic which she did. She stated the DON did not tell her why to put the wander guard on the Resident. The Unit Manager stated that she did not know that Resident #63 was found on the second floor earlier that morning unattended.

An interview was conducted with the Director of Nursing on 02/10/25 at 5:25 PM. The DON was asked what she knew of Resident #63 being found downstairs on the second floor earlier that day and the DON explained that she was notified that Resident #63 was wandering around and he had to have his wander guard replaced that day. The staff informed her that they were looking for his wander guard because he was wandering in and out of the rooms and near the doors and when they noticed it off, they replaced it. The DON stated she told someone through a text message circle to replace it and left one at the Reception Desk and told the receptionist to give it to whoever comes to get it, and Unit Manager #4 ended up replacing it. The DON reported Resident #63 was not found on the second floor because that would indicate he was lost. She stated the facility had a procedure when a resident was (missing) and it was to call a color code and there was not a code called that day to indicate a missing resident. When the DON was asked what the color code was for missing residents, she indicated she did not know and would have to get back with that information. The DON continued to explain that she was informed that Resident #63 was with an agency aide, but the DON found out later that it was a Hospice Aide because the Hospice Aide was the only

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non-staff member up on the Memory Care Unit earlier that day. She reported she had already called the Hospice Aide because the Hospice Aide was on the Memory Care Unit to get briefs to give care and she was the last person out of any doors from the Unit. The DON continued to explain that when she called the Hospice Aide the Aide informed her that there was no one on the elevator with her when she left the Memory Care Unit, that she was by herself. The DON was asked how was it possible that Resident #63 got to the second floor by himself without the wander guard alarm sounding to alert the staff and the DON explained that since Resident #63 did not have a wander guard on he must have went down the elevator but that he had to have been with someone who knew the code to the elevator because he was not cognitively intact to manage the code of the elevator, know the code of the elevator or push button #2 on the elevator to go to the second floor. She stated, "he just don't have it."

At 4:25 PM on 02/10/25 during an interview with the Hospice Aide she explained that she was up on the Memory Care Unit earlier that morning but when she went back down in the elevator there was no one with her on the elevator.

An interview was conducted with Nurse #8 on 02/11/25 at 1:04 PM. The Nurse confirmed she worked on the Memory Care Unit on third shift (11:00 PM - 7:00 AM) on 02/07/25 and 02/08/25. Nurse #8 explained that she checked both nights for the wander guard on Resident #63's ankle (could not remember which ankle) and the wander guard was on his ankle. The Nurse continued to explain that Resident #63 was usually awake and up all night walking the halls

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and often removed the wander guard. The Nurse reported it was not uncommon for her to have to replace the wander guard because Resident #63 often removed it from his ankle. The Nurse explained that she had reported it to the previous Unit Manager (who no longer worked at the facility), and she was trying to come up with a different plan for the Resident. Nurse #8 reported everybody was aware that Resident #63 removed the wander guard, even the Director of Nursing (DON), but she had not personally spoken to the DON about it. The Nurse explained that the only explanation she would have about how Resident #63 was found on the second floor unattended was that the Resident was not wearing the wander guard when he approached the elevator to sound the alarm or if he did not have the wander guard on, he must have road the elevator down to the second floor with someone who knew the code. The Nurse indicated Resident #63 was not cognitively intact enough to know the elevator code or to input the code by himself.

During an interview with Nurse # 3 on 02/11/25 at 4:45 PM the Nurse reported that she recently worked on the Memory Care Unit on 02/06/25 first shift (7:00 AM - 7:00 PM) and worked with Resident #63. She stated Resident #63 wandered around the unit independently and was easily redirected. Nurse #3 explained that when she checked the Resident's wander guard (monitoring device) during the shift, the wander guard was not on the Resident. She stated she did not report it, nor did she replace it because "everybody" knew, even the administrative staff. The Nurse stated she had mentioned it in the past to the Director of Nursing (DON) about not having the wander guards and the reply she got was "I will take care of it." The Nurse continued to explain

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F 689	Continued From page 93 that it was her understanding that there were not enough straps for the wander guards for everyone who needed them to have one. Nurse #3 stated she was not aware of whether Resident #63 was able to remove his wander guard. On 02/10/25 at 6:10 PM and 02/11/25 at 1:20 PM interviews were conducted with the Administrator who explained that she was not aware that Resident #63 had been found on the second floor wandering around unattended until this interview. The Administrator continued to explain that someone asked her for a wander guard, and she contacted the Maintenance Director to obtain a strap for the wander guard from a sister facility that was approximately 2 miles away and he was able to get one and they put it on him. She stated she found out who it was for, and she told the staff to put him on 1:1 monitoring until the wander guard got to the facility. The Administrator stated she did not know how Resident #63 got downstairs on the second floor. The Administrator indicated in the follow-up interview that she was still investigating how Resident #63 was able to get downstairs to the second floor because he can not press the buttons by himself. She stated as far as she knew the Resident was not unattended.	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		3/4/25

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F 812	Continued From page 94 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to remove expired food, remove food with signs of spoilage and label and date food items stored for use in 1 of 2 reach-in coolers. In addition, the facility failed to keep 2 of 3 nourishment rooms clean and free of food debris and ensure food items were labeled and dated, and leftover meal trays were not stored on the counters in the first and second floor nourishment rooms. These practices had the potential to affect food served to residents. The findings included: An initial tour of the main kitchen occurred 1/14/2025 at 10:10 AM with the Cook. a. Observation of the reach-in cooler revealed the following concerns: - one large opened plastic container of mayonnaise with an expiration date of 12/20/2024 - one large unopened container of coleslaw dressing with best by date of 8/23/2024 - two large, opened containers of barbeque sauce with expiration date of 12/28/2024	F 812	1. There were no Residents directly affected by the deficient practice. The open container of mayonnaise with an expiration date was immediately discarded on 1/14/2025. The unopened container of coleslaw dressing with the best by date of 8/23/2024 was immediately discarded on 1/14/2025. Both opened containers of barbeque sauce with and expiration date of 12/28/2024 was immediately discarded on 1/14/2025. The disposable bowls of yogurt, mushrooms, tomatoes and the box of turkey lunchmeat was disposed on 1/14/2025. On 1/16/2025 the refrigerator in the first-floor nourishment room was emptied and all items were discarded. The refrigerator was cleaned, and a cleaning schedule was implemented. Resident trays were removed from the counter and staff was reeducated on storage of meal trays in the nourishment room. On 1/16/2025 the second-floor nourishment room was cleaned. All meal	

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- three disposable bowls of yogurt on a tray not labeled or dated
- one large cardboard box of dark, discolored mushrooms
- one large cardboard box of tomatoes with white fuzzy matter on the tomatoes
- one opened box of turkey lunchmeat that was not labeled or dated

An interview with the Cook that had been at the facility for less than a month, was completed on 1/14/2025 at 10:20 AM. The Cook said he knew the expired items in the walk-in cooler should have been thrown out and that they were leftover from the previous kitchen staff. The Cook also said the food needed to be dated with an opened date and use by date.

b. On 1/16/25 at 10:39 AM the first-floor nourishment room was observed. Observations of the nourishment room revealed a resident's meal tray with a plate of half-eaten food dated 1/15/25 left on the counter. Food particles were observed in the sink. The refrigerator contained a Styrofoam box with meat patties inside with the date 1/2/2025 written on the outside. There was also a sausage, egg, and cheese prepackaged burrito in the refrigerator with a use by date of 12/24/2024 on the label. The inside of the refrigerator had food particles in it and spilled liquid.

An observation was completed on 1/16/2025 at 10:49 AM of the second-floor nourishment room and refrigerator. There were 2 meal trays with food on them from the night before. Both trays had meal tickets dated 1/15/2025 and were on the counter. The were food particles in the sink.

F 812

trays and food particles were removed from the counter tops and the sink. The staff was reeducated to call dietary for all meal trays immediately.

2. All residents were identified at risk for the deficient practice. The 24-hour report was reviewed for indication of gastrointestinal issues including vomiting, nausea and diarrhea no concerns were identified.

3. The Regional food service director reeducated the kitchen staff regarding discarding expired food items and ensuring that all items are dated.

The Director of Nursing/Designee reeducated nursing staff that nourishment refrigerators should be kept clean and free of food trays. The nursing staff was educated if there is food tray they must call dietary to pick them up immediately.

The Director of Nursing/Designee implemented a cleaning schedule for the panty refrigerators once weekly to ensure that the fridge is free of expired food items and free of debris.

4. The Administrator or designee will conduct weekly audit of the kitchen to monitor for expired or undated or unlabeled food items. The audit will be conducted daily x2 weeks and weekly x 4 weeks until substantial compliance is meet.

The Director of Nursing or designee will conduct a weekly round and document using the audit tool to ensure the nourishment room on all floors are free of meal tray, the refrigerators are clean and free of expired items. The audit will be conducted daily x 2 weeks and weekly x4

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	345008	A. BUILDING ______ B. WING ______	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL AT MYERS PARK, LLC	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 96 An interview was completed on 1/16/2025 at 10:52 AM with Nurse Aide (NA) #7. The NA stated the meal trays from the previous day should not be in the nourishment room. NA #7 explained sometimes after meals a meal tray would be placed in the nourishment room just until someone had the chance to take it downstairs to the kitchen or someone from dietary came upstairs to retrieve them. NA #7 said she was unsure of who was responsible for cleaning the nourishment rooms and refrigerators. An interview was completed on 1/16/2025 at 11:50 AM with the Dietary Manager (DM). The DM explained that he was made aware of expired items in the walk-in cooler and had reminded his staff that the walk-ins needed to be checked daily and make sure all foods were labeled with an open date and use by date. The DM further explained anything that was not labeled needed to be thrown out. The DM said that he had recently been made aware that the nourishment rooms were part of his responsibilities to include monitoring the refrigerators for expired food, temperature, and cleanliness. An interview was completed on 1/16/2025 at 12:14 PM with the Director of Nursing (DON). During the interview the DON said the responsibility of keeping the nourishment rooms clean and the refrigerators clean fell to dietary staff and nursing. The DON said third shift nursing should be checking the room for any trays and outdated food and throw it away and housekeeping should be cleaning the rooms and refrigerators daily. The DON also said it was also dietary's responsibility to check the refrigerators in the nourishment rooms for expired food and	F 812	weeks until substantial compliance is met. The results of the audit tools will be reported to the monthly Quality assurance meeting.	

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F 812	Continued From page 97 cleanliness. The DON said dietary was also responsible for checking the nourishment rooms for meal trays. An additional interview with the DON on 1/17/2025 at 12:50 PM revealed she had the expectation that her nursing staff, housekeeping, and dietary kept the nourishment rooms clean and free of expired food. An interview with the Administrator on 1/17/2025 at 1:55 PM revealed she had the expectation that the kitchen staff and managers followed their policies and procedures.	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove loose garbage, food, and debris from around 2 of 2 trash receptacles located outdoors, next to the kitchen exit. This practice had the potential to impact sanitary conditions and attract pests/rodents. The findings included: An observation of the outdoor trash receptacle area on 1/14/2025 at 9:45AM showed there were two dumpsters outside of the building and the second dumpster's top lid was open, and a clothing closet, bedside table, nightstand, eight wooden pallets were observed leaning up against the building and the dumpsters. Trash debris was also observed lying on the ground around the	F 814	1. No specific residents were identified as being affected. The area surrounding the dumpsters was cleaned on 1/17/2025 by facility maintenance and housekeeping. 2. Residents residing within the facility have the potential to be affected. 3. Education was provided to facility staff by the LNHA/designee regarding proper disposal of trash. Education included the need to keep the area surrounding the dumpsters clean and to report to maintenance if the dumpsters are noted to be full or lids unable to be closed. 4. Outside dumpster area will be monitored daily by maintenance/designee to ensure areas are kept appropriately	3/4/25

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F 814	Continued From page 98 dumpsters. A second observation of the dumpster area was made on 1/15/2025 at 12:34 PM. Furniture was observed in the same locations as the previous day. The side door on the dumpster was open and there was still food and garbage debris lying around the dumpsters. An interview was completed with the Director of Nursing (DON) on 1/17/2025 at 12:50 PM, she explained Maintenance, Housekeeping, and Nursing were all responsible for making sure the area around the dumpster was clean. The DON further explained the facility was in the process of refurbishing some of the rooms and the old furniture had been placed outside next to the dumpsters. The DON said she expected the dumpster doors to be always closed and the area clean. An interview with the Administrator on 1/17/2025 at 1:55 PM revealed she expected the trash receptacle area to be maintained according to the facility's policies and procedures, by keeping the doors to the dumpsters closed and debris picked up in the area. The Administrator explained the facility was in the process of ordering a larger dumpster for the furniture that was being thrown away.	F 814	clean. The LNHA/designee will complete audit 2 times weekly to ensure dumpster areas are clean and that waste is stored and removed appropriately. Audits will continue x6 weeks. Audit results will be reviewed in QAPI and adjustments made as indicated to maintain ongoing compliance.	
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care	F 851		3/4/25

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F 851	Continued From page 99 staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care	F 851		

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F 851	Continued From page 100 staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to electronically submit direct care staffing information based on payroll data to the Centers for Medicare and Medicaid (CMS) as required for quarter 4 of fiscal year (FY) 2024 (July 1 through September 30, 2024). The failure occurred for 1 of 4 quarters reviewed. The findings included: A review of the Payroll Based Journal (PBJ) Staffing Data report from the Certification and Survey Provider Enhanced Reports (CASPER) database revealed the facility failed to submit the required PBJ Staffing Data for the fourth quarter of FY 2024. The Administrator stated in an interview on 01/16/25 at 10:11 AM, that she was not aware of the PBJ staffing reporting error because the direct care staffing information was submitted to CMS by the Corporate team on a quarterly basis. The Administrator stated she would look into the issue	F 851	1. Residents were not directly impacted by the deficient practice. 2. All Residents have the potential to be affected by the deficient practice. 3. The policy and procedure titled Payroll Based Journal was reviewed and revised to indicate the facility administrator will be responsible to ensure submission of Payroll based journal to Centers for Medicaid and Medicare quarterly. The Director of Operations entered contract with a software company that allows for submission and validation of direct care staffing quarterly on 2/1/2025 to Centers for Medicaid and Medicare. The Facility Administrator and the Business Office Manager were educated on the submission of direct care staffing quarterly by the Director of Operations 4. The Director of Operations will audit using the submission confirmation to ensure that direct care staffing data is submitted to Centers for Medicare and	

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F 851	Continued From page 101 further as to why the error had occurred. An interview conducted on 01/16/25 at 11:27 AM with the Vice President of Operations revealed he was aware that the facility failed to electronically submit PBJ staffing data to CMS in the fourth quarter of FY 2024 after following up from the Administrator's interview. He stated the corporate office was responsible for submitting the PBJ staffing data for all the facilities in the corporation on a quarterly basis. The interview revealed the data sheet was created however just not submitted by the corporate office in error.	F 851	Medicaid (CMS) this audit will be conducted quarterly the week before the CMS deadline. The audit will be conducted quarterly x 4 quarters. Any concerns identified during the PBJ reporting will be reported to the QAPI committee quarterly.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345008	A. BUILDING: ______ B. WING ______	2/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) regarding mobility devices for 1 of 2 residents reviewed for mobility devices (Resident #38). Findings included: A review of the hospital discharge summary dated 11/20/24 revealed Resident #38 had completed a below the knee amputation (BKA) on 10/30/24. Resident #38 was admitted on 11/20/24 with diagnoses that included a right below the knee amputation. The admission MDS assessment dated 11/27/24 revealed Resident #38 had an impairment of the lower extremity on one side, and a walker as the only mobility device normally used. During an interview on 01/17/25 at 11:40 AM, Resident #38 stated he had a right BKA before being admitted to the facility on 11/20/24. He used a wheelchair as a mobility device for locomotion and denied he had ever walked with a walker since admission. An interview was conducted with the MDS Coordinator on 01/17/25 at 12:44 PM. She stated Resident #38 had a right BKA and she had never seen him walking with a walker. She confirmed the mobility devices on the MDS dated 11/27/24 for Resident #38 had been inaccurately coded. She added she should have checked wheelchair instead of walker as the mobility device for locomotion. During an interview conducted on 01/17/25 at 12:55 PM, the Director of Nursing stated it was her expectation for all the MDS assessments to be coded accurately.

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

The above isolated deficiencies pose no actual harm to the residents