| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| BEAR MOUNTAIN HEALTH AND REHABILITATION | 500 BEAVERDAM ROAD ASHEVILLE, NC 28804 |

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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 5/5/25 through 5/9/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 724S11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 5/5/25 through 5/9/25. Event ID# 724S11. The following intakes were investigated: NC00230008, NC00219376, NC00220171, NC00225592, NC00228534, NC00223591, NC00222206, NC00218960, NC00217445.<br><br>8 of the 27 complaint allegations resulted in deficiency. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, | F 550 | | 6/4/25 |

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

Electronically Signed | 05/31/2025

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| F 550 | Continued From page 1<br>severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to promote care in a dignified manner for 1 of 2 residents who were assisted with meals (Resident #2). Staff were observed standing beside the resident's bed while feeding assistance was provided.<br><br>The finding included:<br><br>Resident #2 was admitted to the facility on 01/03/22 with diagnoses including dysphagia and malnutrition.<br><br>The quarterly Minimum Data Set (MDS) assessment dated 02/07/25 coded Resident #2 | F 550 | 1.The facility failed to promote care in a dignified manner for 1 of 2 residents who were assisted with meals (Resident #2). Staff members were observed standing beside the residents bed while feeding assistance was provided. Quarterly MDS assessment dated 2/7/25 coded Resident #2 as cognitively intact. The assessment also indicated resident #2 was dependent on staff for eating and receiving mechanically altered diet. During breakfast observation on 5/7/25 from 9:01am to 9:10am, resident #2 was observed seated at approximately 45-degree angle in her bed. Nurse Aide | |

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| F 550 | Continued From page 2<br>with intact cognition. The assessment indicated Resident #2 was dependent on staff for eating and receiving a mechanically altered diet.<br><br>During a continuous breakfast observation on 05/07/25 from 9:01 AM to 9:10 AM, Resident #2 was observed seated at approximately 45-degree angle in her bed. Her breakfast tray was brought into the room by Nurse Aide (NA) #1 and placed on top of the overbed table in front of Resident #2. NA #1 stood on the left side of the bed. She set up the tray and started feeding Resident #2 while she was standing and not at eye level with Resident #2. A folding chair was available in the room and NA #1 did not use it.<br><br>An interview was conducted with Resident #2 on 05/07/25 at 9:20 AM. She stated that she did not like the staff to stand over her when receiving feeding assistance.<br><br>During an interview conducted on 05/07/25 at 9:30 AM, Unit Manager #1 (UM) stated all the NAs had received training in feeding and it was her expectation for the NAs to sit at eye levels with the residents when providing feeding assistance. She could not explain why it happened but stated she would notify the Administrator immediately.<br><br>An interview was conducted with NA #1 on 05/07/25 at 10:11 AM. She explained she had worked at different nursing facilities and received conflicting trainings related to feeding assistance, and it confused her. She did not know it was a dignity issue by not sitting at eye level beside the resident while providing feeding or eating assistance. | F 550 | #1 delivered breakfast tray to room and placed it on top of bedside table in front of resident #2. Nurse Aide #1 stood up on the left side of bed while feeding resident #2. Due to nurse aide #1 standing, she was not eye level with resident #2 during feeding. A folding chair was available in the room, and nurse aide #1 did not use it. Upon notification of deficient practice Nurse Aide #1 was immediately educated on resident dignity and ensuring that you are at eye level with a resident when providing feeding assistance.<br><br>2.Current facility residents requiring feeding assistance are at risk of being affected by the deficient practice. On 5/28/2025 the Director of Nursing (DON) completed an audit of all residents being assisted with their meal to ensure the nurse aides are seated at eye level of residents during meal. No other areas of concern identified.<br><br>3.The measures that have been put into place to ensure the deficient practice does not recur are as follows: Education was completed by the DON and Staff Development Coordinator (SDC) by 6/3/2025 to current facility and agency nurse aides and licensed nurses on the facilities policy regarding dignity and providing dignity while assisting residents during meal service. Newly hired facility and agency nurse aides and licensed nurses and staff not educated by 6/4/2025 will be educated upon hire or prior to working their next scheduled shift. | |

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| F 550 | Continued From page 3<br>During an interview conducted on 05/07/25 at 10:51 AM, the Administrator expected nursing staff to pay attention to residents' dignity when providing care or feeding assistance. The Administrator indicated she would re-train all the nursing staff to ensure all dependent residents who needed feeding assistance would receive it with dignity.<br><br>An interview was conducted with the Director of Nursing (DON) on 05/8/25 at 10:59 AM. She expected all nursing staff to focus on dignity issues when providing care or feeding assistance. | F 550 | 4.The DON or SDC will complete observations of 5 residents who require assistance with feeding during meals for twice a week for four weeks, then weekly for four weeks, then biweekly for 4 weeks to ensure residents dignity is being upheld during assistance with meal service. The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement Committee. Data will be brought by DON or Staff Development Coordinator to review at the monthly Quality Assurance Performance Improvement meeting.<br><br>5. Date of compliance: 6/4/2025 | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)(h)(i)(j)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br><br>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>§483.20(i) Certification.<br>§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.<br>§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>§483.20(j) Penalty for Falsification. | F 641 | | 6/4/25 |

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| F 641 | Continued From page 4<br>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of Preadmission Screening and Resident Review (PASARR) and high-risk drug classes usage that involved anticoagulant, antipsychotic, and opioid medications for 3 of the 7 sampled residents (Residents #11, #24, and #52).<br><br>Findings included:<br><br>a. Resident #11 was admitted to the facility on 11/16/24 with diagnoses that included high blood pressure and peripheral vascular disease.<br><br>A review of the Medication Administration Records (MAR) for January 2025 revealed Resident #11 did not receive any anticoagulant throughout the month. Instead, the MAR indicated that he received 1 tablet of enteric-coated aspirin 81 milligrams (mg) by mouth once daily since 01/20/25.<br><br>The quarterly MDS assessment dated 01/30/25 coded Resident #11 with intact cognition. The | F 641 | 1.The facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of Preadmission Screening and Resident Review (PASRR) and high-risk drug classes usage that involved anticoagulant, antipsychotic, and opioid medications for 3 of 7 sampled residents (Residents #11, #24, and #52). Modifications were completed on identified assessments and submitted.<br><br>2.Current facility residents are at risk of being affected by the deficient practice. On 5/27/2025, the Regional Director of Clinical Reimbursement (RDCR) completed an audit of MDS assessments completed for the past 30 days to ensure anticoagulants, antipsychotics, opioid medication, and PASRR to are coded correctly. Findings included four residents identified with anticoagulant coding issues. These were corrected by MDS modifications by RDCR.<br><br>3.The measures that have been put into | |

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| F 641 | Continued From page 5<br>Medication section of the MDS indicated Resident #11 had received anticoagulant during the 7-day assessment periods.<br><br>b. Resident #24 was admitted to the facility on 10/26/22 with diagnoses that included cerebral infarction and bipolar disorder.<br><br>Resident #24's medical record revealed he had completed PASARR Level II assessment on 03/25/24.<br><br>A review of the annual MDS assessment dated 09/20/24 revealed the Identifying Information section indicated Resident #24 had not been evaluated by PASARR Level II and determined to have a serious mental illness and/or mental retardation or a related condition.<br><br>The quarterly MDS assessment dated 02/14/25 assessed Resident #24 with intact cognition. The Medication section indicated Resident #24 had received anticoagulant, antipsychotic, and opioid during the 7-day assessment periods.<br><br>A review of the MAR for February 2025 revealed Resident #24 did not have any order to receive anticoagulant, antipsychotic, or opioid throughout the month.<br><br>c. Resident #52 was admitted to the facility on 9/26/24 with diagnoses which included cerebrovascular accident.<br><br>Review of Resident #52's physician's orders revealed an order dated 9/27/24 for Aspirin 81 mg by mouth daily. | F 641 | place to ensure the deficient practice does not recur are as follows: Education was provided to the Minimum Data Set (MDS) coordinator and Interdisciplinary Team (Administrator, Director of Nursing, Staff Development Coordinator, Unit Managers, Social Worker) by the RDCR on accurate coding of anticoagulants, antipsychotics, opioids, and PASRRs on MDS assessments prior to submission. The education was completed by 6/3/2025. New facility Minimum Data Set (MDS) nurses and Interdisciplinary Team (IDT) members and staff not educated by 6/4/2025 will be educated upon hire and prior to working their first shift.<br><br>4.The Regional Director of Clinical Services, Director of Nursing, Vice President of Clinical Operations, or designee will audit 5 resident MDS assessments to ensure anticoagulants, antipsychotics, opioid, and PASRRs are coded correctly, twice weekly for four (4) weeks, then weekly for four (4) weeks, then bi-weekly for four (4) weeks. Deficient practices identified in these audits will be corrected immediately. The results of this audit will be presented by the Minimum Data Set coordinator (MDS) during the Quality Assurance Performance Improvement committee meetings for 3 months and changes will be made to the plan as necessary to maintain compliance.<br><br>5. Date of compliance: 6/4/25 | |

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| F 641 | Continued From page 6<br>Resident #52 significant change Minimum Data Set (MDS)assessment dated 3/14/25 indicated she had severe cognitive impairment and was dependent on staff for most activities of daily living. The MDS coded Resident # 52 for high-risk drug class for anticoagulant use.<br><br>During an interview conducted on 05/06/25 at 1:18 PM, the MDS Coordinator acknowledged that the coding of anticoagulant for Resident #11, Resident #24, and Resident #52 were incorrect. She explained it was due to her perception of considering aspirin as an anticoagulant, and it was her oversight. She confirmed Resident #24 had completed a PASARR Level II assessment on 03/25/24. She could not explain why she coded Resident #24 as never been evaluated by Level II PASARR in the annual MDS assessment dated 09/20/24. She added it was an error to code Resident #24 as receiving anticoagulant, antipsychotic, and opioid for the quarterly MDS assessment dated 02/14/25 as he was not receiving any of the above medications during the 7-day assessment periods.<br><br>During an interview conducted on 05/08/25 at 10:59 AM, the Director of Nursing (DON) stated it was her expectation for all the MDS assessments to be coded accurately according to the established medication categories.<br><br>An interview was conducted with the Administrator on 05/07/25 at 10:51 AM. She stated it was her expectation for the MDS Coordinator to code all MDS assessments correctly before submission. | F 641 | | |
| F 644 SS=D | Coordination of PASARR and Assessments<br>CFR(s): 483.20(e)(1)(2) | F 644 | | 6/4/25 |

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| F 644 | Continued From page 7<br><br>§483.20(e) Coordination.<br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and medical record review, the facility failed to refer a resident with newly diagnosed serious mental illnesses for Pre-Admission Screening and Annual Resident Review (PASARR) Level II screening for 1 of 2 residents reviewed for PASARR (Resident #36).<br><br>The findings included:<br><br>A review of Resident #36's medical records revealed he had a PASRR Level I evaluation completed in 2023.<br><br>Resident #36 was admitted to the facility on 03/13/24 with diagnoses including bipolar disorder. | F 644 | 1.The facility failed to issue Pre-Admission Screening and Resident Review Level (PASRR) two for Resident #36 on the admission date of 3/13/24 with new onset diagnosis of bipolar disorder documented in his medical records. The PASRR screen was entered on 5/6/2025 by the Vice President of Clinical Operations and resident #36 was issued a Level 2 PASRR on 5/9/2025.<br><br>2.Current facility residents with a new mental health diagnosis are at risk of being affected by the deficient practice. The Social Worker (SW) audited current facility residents to ensure all residents with mental health diagnosis have | |

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| F 644 | Continued From page 8<br>A review of Resident #36's list of cumulative diagnoses revealed a new diagnosis of bipolar disorder with an onset date of 03/13/24 was documented in his medical record.<br><br>A review of physician's order dated 03/14/24 revealed Resident #36 had an order to receive 1 tablet of Depakote 500 milligrams (mg) delayed release by mouth 2 times daily for mood symptoms related to bipolar disorder.<br><br>The annual Minimum Data Set (MDS) assessment dated 03/18/25 coded Resident #36 with intact cognition. The Section A1500 indicated he was not currently considered by the state PASARR Level II process to have a serious mental illness and/or intellectual disability or a related condition.<br><br>During an interview conducted on 05/06/25 at 9:16 AM, the MDS Coordinator confirmed the facility had failed to refer Resident #36 for a PASARR Level II evaluation according to the annual MDS assessment dated 03/18/25. She stated Resident #36 was diagnosed with bipolar disorder during admission and should have a PASARR Level II evaluation. She added the referral was typically handled by the Social Services Director (SSD).<br><br>An interview was conducted with the SSD on 05/06/25 at 11:03 AM. She confirmed she was responsible for reviewing medical records of newly admitted residents and making a referral for PASARR evaluation as indicated. She acknowledged that Resident #36 should have a referral for PASARR Level II screening as he was diagnosed with bipolar disorder during admission. She could not explain why Resident #36 was | F 644 | completed a Pre-admission Screening and Resident Review (PASRR) for level 2 evaluation. Identified issues were addressed and PASRR screenings were submitted for review. Audit was completed on 5/28/2025.<br><br>3.The measures that have been put into place to ensure the deficient practice does not recur are as follows: Interdisciplinary Team (IDT) including the Administrator, Director of Nursing, Staff Development Coordinator, Unit Managers, and Social Worker were educated by the Regional Director of Clinical Services on ensuring a residents with a mental illness, development/intellectual delay, or related concern has a PASRR screen submitted to the North Carolina Medicaid Uniform Screening Tool (NC MUST) website for Level 2 PASRR screening. This education was completed on 5/26/2025. Newly hired Interdisciplinary Team (IDT) including the Administrator, Director of Nursing, Staff Development Coordinator, Unit Managers, and Social Worker or staff not educated by 6/4/2025 will be educated upon hire or prior to next scheduled shift by Administrator, Regional Director of Clinical Services, or designee.<br><br>4.The SW or Administrator will audit five residents for new mental health diagnosis and need for Pre-admission Screening and Resident Review (PASRR) twice weekly for four (4) weeks, then weekly for four (4) weeks, then bi-weekly for four (4) weeks. Any deficient practice identified in these audits will be corrected immediately. | |

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| F 644 | Continued From page 9<br>overlooked and attributed the error as an oversight.<br><br>During an interview conducted on 05/06/25 at 11:48 AM, the Corporate MDS Director stated Resident #36 was admitted with bipolar disorder should be referred for a PASARR Level II evaluation. It was his expectation for the SSD to follow the regulation guidance to ensure a referral for PASARR Level II evaluation was in place as indicated.<br><br>An interview was conducted with the Administrator on 05/07/25 at 10:51 AM. She stated the regulation guidance should be followed and a request for a PASRR Level II evaluation should be made when a resident was diagnosed with a new serious mental health condition such as bipolar disorder.<br><br>During an interview conducted on 05/08/25 at 10:59 AM, the Director of Nursing (DON) expected the SSD to follow the established guidelines to coordinate PASARR Level II as indicated in a timely manner. | F 644 | The results of this audit will be presented by the Administrator during the Quality Assurance Performance Improvement committee meetings for 3 months and changes will be made to the plan as necessary to maintain compliance.<br><br>5.Date of compliance: 6/4/2025 | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and Medical Director (MD), resident and staff interviews, the facility failed to readjust | F 658 | 1.The facility failed to deliver Resident #36 medications at the requested new time per Resident #36 request and | 6/4/25 |

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| F 658 | Continued From page 10<br>medication orders after those orders had been updated which resulted in the resident missing one dose of five medications for 1 of 1 resident reviewed for pharmacy services (Resident #36).<br><br>The finding included:<br><br>Resident #36 was admitted to the facility on 03/13/24 with diagnoses including stroke, insomnia, and bipolar disorder.<br><br>The quarterly Minimum Data Set (MDS) assessment dated 04/04/25 coded Resident #36 with intact cognition. The assessment indicated Resident #36 had adequate hearing and vision with clear speech.<br><br>During the initial interview conducted with Resident #36 on 05/05/25 at 1:13 PM, he stated he disliked nursing staff waking him up around midnight at times to administer his medications.<br><br>A review of medication administration records (MAR) on 05/05/25 revealed Resident #36 had the following 5 active physician's orders to receive medications once daily at either 8:00 PM or 10:00 PM:<br>1. Atorvastatin 20 milligrams (mg), 1 tablet by mouth once daily at 10 PM for cholesterol.<br>2. Depakote delay release 500 mg, 2 tablets by mouth once daily at 10 PM for bipolar disorder.<br>3. Ezetimibe 10 mg, 1 tablet by mouth once daily at 10 PM for cholesterol control.<br>4. Melatonin 3 mg, 3 tablets by mouth once daily at 10 PM for insomnia.<br>5. Trazodone 50 mg, 2 tablet by mouth once daily at 8 PM for sleep.<br><br>An interview was conducted with Unit Manager #2 | F 658 | Medical Director (MD) orders. The following five medications were not received by Resident #36 on the new ordered date for 5/6/25 by MD at 6:00pm: Depakote, Melatonin, Trazodone, Ezetimibe, and Atorvastatin. Upon notification of missed medications, the Director of Nursing (DON) notified the MD, completed a medication error report, and notified the resident.<br><br>2.Current facility residents with updated times on orders for medications are at risk of being affected by deficient practices. On 5/28/2025 the Director of Nursing completed an audit of current residents with updated medication orders to avoid any gaps when updated medication orders are placed by the Medical Director. No other areas of concern were identified. Audit was completed on 5/28/2025.<br><br>3.The following measures have been put in place to ensure the deficient practice does not recur, are as follows: All current facility and agency nurses and certified medication aides (CMA) will be educated on adjusting medication orders administration times and dates as needed when changing or updating medication orders to avoid creating any gaps in medication administration. Newly hired facility or agency licensed nurses and CMA's or facility or agency licensed nurses and CMA's not educated by 6/4/2025 will be educated upon hire or prior to working next scheduled shift.<br><br>4.The DON, Regional Director of Clinical | |

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| F 658 | Continued From page 11<br>(UM) on 05/06/25 at 2:58 PM. She stated Resident #36 voiced a complaint that morning about getting his medications late at night. After she had submitted his concerns in the doctor's communication log, the physician had approved to switch most of Resident #36's evening medications to around 6:00 PM and the orders had been updated.<br><br>A subsequent review of MAR on 05/07/25 revealed the above 5 active evening medication orders had been discontinued on 05/06/25 at around 10:30 AM. New orders for each of the 5 evening medication were in place and they would be started 05/07/25 at 6:00 PM. Resident #36 received the last dose of the above 5 medications on 05/05/25 at 8:00 PM and 10:00 PM respectively before the discontinuation, but did not receive any of the above 5 medications on 05/06/25 at 6:00 PM.<br><br>During an interview conducted on 05/07/25 at 5:45 AM, Resident #36 stated he had received some medications around 6:30 PM on 05/06/25. After that, he did not receive any more medications, and he went to sleep. He could not confirm whether he had received atorvastatin, depakote, trazodone, melatonin, or ezetimibe on 05/06/25 in the evening as he always took the pills without looking at them during medication pass. Resident #36 denied feeling any difference since 05/06/25 evening and stated he slept well on the night of 05/06/25. He added nursing staff notified him that they had changed his evening medications to an earlier hour, and he was very pleased with the changes. During the interview, Resident #36 appeared to be alert and oriented without showing any signs and symptoms of pain, distress, or other behavioral issues. | F 658 | Services, or designee will complete an audit on 5 residents for any updated medication orders to ensure no missed doses are occurring with the update twice weekly for four (4) weeks, then weekly for four (4) weeks, then bi-weekly for four (4) weeks. Any deficient practice identified in these audits will be corrected immediately. The results of this audit will be presented by the DON during the Quality Assurance Performance Improvement committee meetings for 3 months and changes will be made to the plan as necessary to maintain compliance.<br><br>5.Date of compliance: 6/4/2025 | |

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An interview was conducted on 05/07/25 at 5:48 AM with the Medication Aide #1 (MA) who provided care for Resident #36 from 7:00 PM on 05/06/25 to 7:00 AM on 05/07/25. She did not recall administering depakote, melatonin, trazodone, ezetimibe, or atorvastatin to Resident #36 as those medications did not appear on the computer during the evening medication pass on 05/06/25.

During an interview conducted on 05/07/25 at 5:55 AM, Nurse #1 confirmed Resident #36 did not receive depakote, melatonin, trazodone, ezetimibe, or atorvastatin on 05/06/25 in the evening. She stated those orders did not appear on the computer as they had been deleted, and the new orders would not be started until a day later on 05/07/25 in the evening. Nurse #1 indicated the new orders should be restarted on the same day on 05/06/25. Otherwise, those orders would not appear on the computer during the evening medication pass on 05/06/25.

During an interview conducted on 05/07/25 at 9:57 PM, Nurse #2 stated that he worked on 05/06/25 from 7 AM to 7 PM and confirmed he did not administer Depakote, melatonin, trazodone, ezetimibe, or atorvastatin to Resident #36 on 05/06/25 in the evening as those orders did not appear on the computer during the evening medication pass.

An interview was conducted with the Director of Nursing (DON) on 05/07/25 at 7:01 AM. She acknowledged that she was the nursing staff who had updated Resident #36's medication orders on 05/06/25 after she was made aware of the concerns brought up by Resident #36. She stated

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| F 658 | Continued From page 13<br>when she updated the orders, the computer would start the new orders on the next day as a default. She forgot to readjust those orders to avoid a gap after the new orders were in place on 05/06/25. She attributed the errors to her oversight.<br><br>An interview was conducted with the MD on 05/8/25 at 3:35 PM. She stated missing just one dose of depakote for bipolar disorder along with trazodone, ezetimibe, atorvastatin, and melatonin would not have any significant impact to Resident #36 behavior. It was her expectation for nursing staff to change or update approved medication orders correctly.<br><br>During an interview conducted on 05/07/25 at 10:51 AM, the Administrator expected nursing staff to stay focus and make readjustment as needed when changing or updating medication orders to avoid creating any gaps in medication administration. | F 658 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, and staff interviews, the facility failed to intervene effectively when two residents became agitated | F 689 | 1.The facility failed to closely monitor and intervene quickly between two residents arguing over the bears while in the front | 6/4/25 |

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| F 689 | Continued From page 14<br>and were yelling at each other in a common area. Resident #44 was cognitively impaired and had a history of violent behaviors caused Resident #229 to sustain a skin tear by hitting her on the hand with a cellphone. This deficient practice occurred for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #229).<br><br>The findings included:<br><br>Resident #44 was admitted to the facility on 9/29/22 with diagnoses that included: hemiplegia (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (stroke) affecting right dominant side, schizophrenia (psychiatric disorder), vascular dementia with mood disturbance, aphasia (brain disorder that affects the ability to communicate) following cerebral infarction, bipolar disorder (mood disorder), anxiety disorder, violent behaviors. Resident #44 was a current resident at the facility.<br><br>The quarterly minimum data set (MDS) dated 5/31/24 revealed Resident #44 had moderate cognitive impairment. The MDS documented she had no behavior or rejection of care.<br><br>Resident #44 had a care plan dated 8/27/23 and last revised on 7/28/24 that read: [Resident #44] has potential to be physically aggressive related to dementia, history of harm to others, and poor impulse control. A care plan intervention dated 8/28/23 read, when Resident #44 becomes agitated intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, if response is aggressive staff to walk calmly away and approach later.<br><br>Resident #229 was admitted to the facility on | F 689 | lobby of the facility on 7/28/2024. Resident #44 had a revised care plan on 7/28/2024 that states resident #44 has potential to be physically aggressive related to dementia, history of harm to others, and poor impulse control. It has been care planned in the past that resident #44 can become agitated and for staff to intervene before agitation escalates, guide away from the source of distress, engage in calm conversation. If resident #44 is to become aggressive with staff, then staff is recommended to calmly walk away and approach later. Resident #229 had a care plan dated for 9/11/2024, stating this resident has potential to be physically aggressive related to anger and poor impulse control. Resident #229 is also care planned to be known to throw items such as cups or dishes when attempting to get staffs attention. Additional care plan interventions recommended for resident #229 are for staff to intervene before agitation escalates, guide away from source of distress, and engage in calm conversation. If resident #229 is still aggressive in response, staff is to walk away and approach later.<br><br>2.Current facility residents are at risk of being affected by residents with care planned history of behaviors. On 5/28/2025 the Director of Nursing (DON) and Staff Development Coordinator (SDC) completed an audit of all residents who are care planned with aggressive behaviors and to ensure appropriate interventions are in place and available for facility and agency nursing staff including | |

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| F 689 | Continued From page 15<br>9/19/23 with diagnoses that included: hemiplegia following cerebral infarction affecting left non dominant side, adjustment disorder with mixed anxiety and depressed mood (psychiatric disorder). Resident #229 was discharged from the facility to another care facility on 1/24/25.<br><br>The quarterly minimum data set (MDS) dated 6/5/24 revealed Resident #229 was cognitively intact. The MDS documented that she had no behaviors or rejection of care.<br><br>Resident #229 had the following care plans in place:<br><br>-A care plan dated 10/19/23 that read, Resident #229 has potential to be verbally aggressive related to cognitive deficits. The care plan interventions included assessing her understanding of the situation, allowing time for her to express self and feelings towards the situation.<br><br>-A behavior problem care plan related to making false accusations dated 12/20/23. The behavior care plan interventions included intervening as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, remove from situation and take to an alternative location as needed.<br><br>- A care plan dated 9/11/24 that read Resident #229 has the potential to be physically aggressive r/t anger, poor impulse control, she will throw things such as cups and dishes when trying to get attention. The care plan interventions included providing physical and verbal cues to alleviate anxiety, giving positive feedback, assist verbalization of source of agitation, assist to set | F 689 | certified nursing assistants, licensed nurses, and certified medication aides to view on resident Kardex. Interventions not available on Kardex were added by DON, SDC, or designee.<br><br>3.The measures that have been put in place to ensure the deficient practice does not recur, are as follows: DON and SDC provided education on 5/28/2025 to current facility and agency nursing staff including certified nursing assistants, licensed nurses, and certified medication aides to 1) intervene as necessary when there is confrontation among residents to prevent any physical harm or mental anguish; 2) where to find care planned behaviors and interventions on Kardex; 3) how to respond if you visualize or hear residents becoming agitated. Newly hired facility and agency nursing staff including certified nursing assistants, licensed nurses, and certified medication aides and including certified nursing assistants, licensed nurses, and certified medication aides not educated by 6/4/2025 will be educated upon hire or prior to working their next scheduled shift.<br><br>4.The DON and SDC will complete observations of 5 residents twice weekly for 4 weeks, then weekly for 4 weeks, and biweekly for 4 weeks who are care planned to have aggressive behaviors to ensure they have appropriate interventions in place and they are available on the Kardex for staff to review. Any deficient practice identified in these audits will be corrected immediately. The | |

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| F 689 | Continued From page 16<br>goals for more pleasant behavior, encourage seeking out of staff member when agitated. Additional care plan interventions included when Resident #229 becomes agitated to intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, If response is aggressive, staff to walk calmly away, and approach later.<br><br>Review of a facility incident reported dated 7/28/24 completed by the Director of Nursing (DON) for Resident #229 revealed she had received a skin tear from another resident. The incident report indicated the other resident had a cell phone in her hand and struck Resident #229 on the right hand after Resident #229 had said don't open the door. The report indicated there was a misunderstanding and the other resident had thought Resident #229 was saying not to let her boyfriend in. The incident report revealed first aid was provided to Resident #229's right hand skin tear and both residents were separated.<br><br>An order dated 7/28/24 for Resident #229 read: Right hand, clean with normal saline, apply antibiotic ointment and cover with band aid daily until resolved for skin tear.<br><br>An interview was conducted on 5/5/25 at 11:04 AM with Resident #44. Resident #44 was asked if she recalled ever having any issues or an altercation with another resident at the facility. Resident #44 answered by shaking her head "no". Resident #44 declined to answer further questions.<br>Resident #229 was unable to be contacted for interview.<br><br>An interview with Nurse Aid (NA) #1 was | F 689 | results of this audit will be presented by the DON during the Quality Assurance Performance Improvement committee meetings for 3 months and changes will be made to the plan as necessary to maintain compliance<br><br>5.Date of compliance: 6/4/2025 | |

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conducted on 5/7/25 at 1:27 PM. NA #1 recalled the incident between Resident #44 and Resident #229 that occurred on 7/28/24. She reported there had been bears outside the facility main entrance door and several residents were gathered in the lobby watching the bears. NA #1 recalled she thought there had been a total of four residents in the lobby including Resident #44 and Resident #229. NA #1 reported she and NA #2 had been in the lobby also watching the bears at the time of the incident. She stated Resident #44 had been standing at the facility entrance glass door in the lobby with her boyfriend. NA #1 recalled Resident #229 had been sitting in her wheelchair at the back corner of the lobby diagonally to where Resident #44 was standing looking out the main door watching the bears. NA #1 explained Resident #229 had been agitated and scared of the bears. She recalled Resident #229 was yelling loudly "the bears were going to get inside and eat everybody." NA #1 reported Resident #44 yelled shut up at Resident #229, then Resident #229 yelled shut up back at Resident #44. She reported Resident #229 then continued to yell about the bears and Resident #44 yelled shut up again. NA #1 stated Resident #44 did not really talk but had a select vocabulary of words she could say and "shut up" was one of them. NA #1 recalled Resident #44 turned and began walking toward the back of the lobby, NA #1 stated she had thought Resident #44 was leaving and going back to her room. NA #1 stated that instead Resident #44 approached Resident #229 and swung at her using her left hand that was holding her cell phone. She reported Resident #229 put her hand up to protect her face and Resident #44 struck Resident #229 on the hand with the cell phone. NA #1 stated another staff member came and separated Resident #44

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and Resident #229, but she could not remember who the staff was. NA #1 reported she was aware Resident #44 had a history of aggressive behaviors and becoming easily agitated when someone did something she did not like or if she was provoked. NA #1 stated she thought Resident #229 yelling shut up at Resident #44 would be provoking. NA #1 reported everyone in the lobby was focused on the bears and excited about the bears at the time of the incident. NA #1 agreed she could have intervened when Resident #229 and Resident #44 had shown signs of agitation by yelling shut up, by verbally redirecting them, or removing Resident #229 who was scared and anxious about the bears. NA #1 reported she had been focused on the bears at the time like everyone else in the lobby because the bears were so close to the facility entrance and there were baby bears that she had not thought about it at the time.

An interview was conducted with NA #2 on 5/8/24 at 10:54 AM. NA #2 stated she recalled the incident between Resident #44 and Resident #229 that occurred on 7/28/24. She reported she had been in the lobby when the incident happened but did not see the incident happen. She recalled there had been maybe four Residents in the lobby at the time gathered and watching the bears that were outside the main facility entrance doors. She recalled there had been another staff member in the lobby and another staff member that had walked by the lobby, but she could not remember who the staff members were. NA #2 reported she heard Resident #44 and Resident #229 yell "shut up" back and forth. She thought they had said shut twice before the incident happened. She stated she could not remember all the details of the

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incident. NA #2 recalled Resident #44 walking toward the back of the lobby where Resident #229 had been sitting. NA #2 explained she had thought Resident #44 was going back to her room but instead she must have hit Resident #229. She stated she had not seen Resident #44 hit Resident #229 but heard Resident #229 say "she [Resident #44] hit me". NA #2 said she was not sure who had separated Resident #44 and Resident #229 after the incident, she reported it had been a staff member but did not remember who the staff member was. NA #2 stated she had never seen or heard of Resident #44 hit anyone before and did not know she was going to hit Resident #229. She reported at the time of the incident she had not worked at the facility long. NA #2 said she had heard Resident #44 say "shut up" up before but was not aware of Resident #44 having a history of aggressive or violent behaviors. She could not recall where Resident #44 had hit Resident #229.

An interview was conducted with Nurse #4 on 5/8/25 at 1:30 PM. He recalled the incident from 7/28/24 with Resident #44 and Resident #229. He remembered an NA came and got him from the nursing station and told him the two residents were arguing in the lobby about the bears or letting someone in or out of the building. Nurse #4 recalled the NA told him Resident #44 had "put hands" on Resident #229 and that it was an altercation they believed was physical. Nurse #4 said when he went to the lobby, he separated Resident #44 and Resident #229. Nurse #4 stated he assessed Resident #229 after the incident; he did not remember the skin tear on her hand. He said he just remembered Resident #229 was stuck on the bears and explaining the incident was not her fault. He recalled Resident

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#229 calmed down with reassurance. Nurse #4 explained he was aware of Resident #44's history of being easily agitated and having aggressive behaviors. He further explained Resident #44 was usually calm unless she was provoked. Nurse #4 said Resident #44 was provoked by direct confrontation such as someone cursing or arguing with her. He stated he had not seen Resident #44 on her own be the first aggressor without provocation. Nurse #4 indicated he reported the incident to the Director of Nursing (DON) and Resident #44 was placed on one-on-one staff supervision after the incident.

An interview was conducted on 5/7/25 at 3:44 PM with the DON. She recalled the incident between Resident #44 and Resident #229 that occurred on 7/28/24. The DON stated a staff member called her and reported the incident when it happened. She did not remember who the staff member was who called her. The DON remembered staff had called and told her bears had been outside the front entrance of the building. She said the staff told her Resident #44's boyfriend was outside and trying to get in through the main door. She explained the staff had said Resident #229 was yelling about the bears and had said "don't open the door" and that was when Resident #44 hit Resident #229 her with cell phone on the hand. The DON stated Resident #44 had become agitated when Resident #229 started yelling shut the door because Resident #229 maybe had thought her boyfriend was going to get eaten by the bears. The DON explained staff separated Resident #44 and Resident #229 after the incident and Resident #229 was placed on one-on-one staff supervision.

An interview was conducted with the

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| F 689 | Continued From page 21<br>Administrator and the Vice President of Operations (VPO) on 5/8/25 at 5:10 PM. The VPO reported everyone in the building was aware of Resident #44's behaviors. She stated Resident #44 was very quick and she felt like the staff responded quickly and were intervening from what staff had told them. The Administrator said shut up was a common phrase Resident #44 would use when she was agitated. The Administrator said maybe staff should have separated them but that she was not sure because they had been watching the bears. The Administrator said Resident #229 had a very minor injury after the incident on her hand that was superficial. She reported Resident #44 was placed on one-on one supervision after the incident, then monitoring was stepped down to every 15 minutes and then stepped down to every 30 minutes based on her having no further behaviors of incidents. | F 689 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that | F 690 | | 6/4/25 |

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| F 690 | Continued From page 22<br>catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interviews, the facility failed to keep a urinary catheter bag and drainage spout from touching the floor to reduce the risk of infection for 1 of 1 resident (Resident #62). This deficient practice occurred for 1 of 1 resident reviewed with a urinary catheter.<br><br>Findings included:<br><br>Resident #62 was admitted to the facility on 7/26/24 and had been re-admitted to the facility on 4/3/25. His diagnoses included chronic obstructive uropathy.<br><br>A significant change Minimum Data Set (MDS) assessment dated 2/6/25 indicated Resident #62 was never/rarely understood and his cognitive | F 690 | 1.The facility failed to maintain proper closure on the drainage valve of Resident #62s long term indwelling catheter bag. On 5/5/25 at 12:51pm the catheter drainage bag was observed resting on the floor. The drainage valve on the indwelling catheter was observed to be unsecure and resting on the floor as well by the state surveyor. It was care planned on 6/14/2024 that Resident #62s catheter bag and tubing be positioned below the level of the bladder and away from the entrance of room door. The catheter bag was checked and corrected immediately upon notification of issue on 5/5/2025 by Director of Nursing (DON).<br><br>2.Current facility residents with indwelling | |

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| F 690 | Continued From page 23<br>skills for daily decisions making were severely impaired. He was documented on the MDS as having an indwelling catheter.<br><br>Resident #62 had a care plan dated 6/14/24 for long term indwelling catheter. The care plan interventions included positioning the catheter bag and tubing below the level of the bladder and away from the entrance room door.<br><br>An order dated 4/3/25 read, indwelling urinary catheter related to chronic obstructive uropathy.<br><br>An observation was conducted on 5/5/25 at 11:15 AM of Resident #62 in his room in bed. He was observed to have an indwelling urinary catheter draining to a bedside drainage bag. The bedside drainage bag was observed positioned below bladder level and hanging on the bottom rail of the bed frame. The drainage valve of the catheter bag was observed to be unsecured and resting on the floor.<br><br>A follow up observation was conducted on 5/5/25 at 12:51 PM of Resident #62's indwelling urinary catheter drainage system. The bedside drainage bag was observed positioned below bladder level and hanging on the bottom rail of the bed frame. The drainage valve of the catheter bag was observed to be unsecured and resting on the floor.<br><br>An additional observation was conducted on 5/5/25 at 3:04 PM of Resident #62's indwelling urinary catheter drainage system. The bedside drainage bag was observed positioned below bladder level and hanging on the bottom rail of the bed frame. The catheter bag was observed on the floor beside the bed with the drainage | F 690 | catheters are at risk of being affected by the deficient practice. On 5/6/2025 the DON completed an audit of all residents who currently have indwelling catheters to ensure they maintain positioning below the bladder level and maintain a secured drainage valve on their catheter bag. No other areas of concern were identified. Audit completed on 5/6/2025.<br><br>3.The measures that have been put into place to ensure the deficient practice does not recur are as follows: The DON and Staff Development Coordinator (SDC) educated current facility and agency nursing staff including certified nursing assistants, licensed nurses, and certified medication aides on residents who require indwelling catheter bags. Positioning of catheter bags below bladder level and ensuring drainage valve is secured to reduce risk of infections. Newly hired nursing staff including certified nursing assistants, licensed nurses, and certified medication aides and staff including certified nursing assistants, licensed nurses, and certified medication aides not educated by 6/4/2025 will be educated upon hire or prior to working their next scheduled shift.<br><br>4.The DON, SDC, or designee will complete observations of residents who require indwelling catheter bags twice a week for four (4) weeks, then weekly for four (4) weeks, then bi-weekly for four (4) weeks to ensure residents requiring indwelling catheter bags are positioned appropriately with drainage valve secured. | |

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| F 690 | Continued From page 24<br>valve unsecured and on the floor.<br><br>An interview was conducted with Nurse Aide (NA) #3 on 5/5/25 at 3:20 PM. She said she was assigned to care for Resident #62 today. She reported she typically checked on his catheter throughout the shift but that it had been a busy day. NA #3 said she had not specifically checked his catheter bag today. She explained she had been in his room to provide care but had not looked at his catheter bag and had not noticed it had been on the ground or that the drainage valve was loose and on the ground. NA #3 stated she was taught urinary catheter drainage bags should be hung on the bed frame and positioned below the level of the bladder so urine could drain properly. NA #3 said the catheter drainage bag and the drainage valve should not be on the floor because it was unsanitary.<br><br>An interview was conducted with Nurse #3 on 5/5/25 at 13:35 PM. Nurse #3 reported he was Resident #62's assigned nurse today. He was not aware Resident #62's catheter drainage bag and drainage valve were on the floor. Nurse #3 said catheter bags and the drainage valve should not be on the floor because of contamination.<br><br>An interview was conducted with the Director of Nursing on 5/7/25 at 3:37 PM. The DON stated urinary catheter bags, and the drainage valve should be kept off the floor because of germs and to prevent contamination. The DON explained that urinary catheter bags should be hung on the side of the bed below the level of the bladder when a resident was in bed and the drainage valve should be secured.<br><br>An interview was conducted with the | F 690 | Any deficient practice identified in these audits will be corrected immediately. The results of these audits will be presented by the DON during the Quality Assurance Performance Improvement committee meetings for 3 months and changes will be made to the plan as necessary to maintain compliance<br><br>5.Date of compliance: 6/4/2025 | |

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| F 690 | Continued From page 25<br>Administrator on 5/8/25 at 5:10 PM. The Administrator reported urinary catheter drainage bags, and the drainage valve should not be on the floor for infection control reasons. She explained the urinary drainage bag should be hung on the bed frame and positioned below the level of the bladder but should not be touching the floor. | F 690 | | |

| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # 345010 | MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | DATE SURVEY COMPLETE: 5/9/2025 |
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| **F 559** | Choose/Be Notified of Room/Roommate Change<br>CFR(s): 483.10(e)(4)-(6)<br><br>§483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.<br><br>§483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.<br><br>§483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff and resident interviews, the facility failed to provide written notification of a room change for 1 of 1 resident reviewed for notification of a change (Resident #66).<br><br>Findings included:<br><br>Resident #66 was admitted to the facility on 12/24/24. His diagnoses included cerebral infarction (stroke).<br><br>A quarterly Minimum Data Set (MDS) assessment dated 3/12/25 indicated Resident #66 was cognitively intact.<br><br>A review of Resident #66's census history in the electronic medical record revealed he was moved from room 202A to room 214B on 4/29/25.<br><br>There was no documentation in Resident #66's electronic medical record regarding a discussion about changing rooms, his agreement to the room change, or notification of the room change. There was not a written room change notice for Resident #66 in the medical record.<br><br>An interview was conducted on 5/5/25 at 1:13 PM with Resident #66. He stated he was not given notice or a choice about changing rooms. He reported he liked his old room and his prior roommate, he said he got along well with his prior roommate. Resident #66 explained he had not wanted to move rooms and was made to feel like he did not have a choice or option about moving and changing rooms. Resident #66 recalled the Admission Coordinator told him they needed his room for someone who was coming from the hospital. He said the facility had not given him any type of written notice for the room change. Resident #66 reported the Admission Coordinator came and talked to him about the room change and then he was moved that same day.<br><br>An interview was conducted with the Social Worker (SW) on 5/6/25 at 2:51PM. She said as far as she was aware there was not a written form that was provided to residents or family regarding room changes. The SW said she typically documented the room change notification in the resident's record but that if she was not here whoever talked to the resident or family could do it. She did not know why Resident #66 did not have |

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anything documented in his medical record about the room change. She said Resident #66 should have something documented in his medical record regarding the room change and him agreeing. The SW said she had not really been involved in Resident #66's room change and had not talked to him about it. She reported she had called Resident #66's family member after he had moved and let her know about the room change.

An interview was conducted with the Admission Coordinator on 5/6/25 at 3:05 PM. She stated she typically looked at rooms that were already open when she booked a new admission and decided on room placement. The Admission Coordinator explained sometimes she did have to move residents around to accommodate for the needs of a new admission resident. She reported that a resident returning to the facility after hospitalization needed a room closer to the nursing station so the nurses could watch him closer because he had sustained a bad fall prior to going to the hospital. The Admission Coordinator explained Resident #66's prior room bed 202A was located across from the nursing stations. She stated the decision to move Resident #66 had been made by the interdisciplinary team. She said residents were always spoken to about changing rooms before they were moved and the residents had to agree to the move. The Admission Coordinator stated she had talked to Resident #66 about changing rooms. She reported she explained why the facility needed him to move rooms and that he said it was fine. The Admission Coordinator said she had not filled out any room change paperwork or given Resident #66 anything in writing about the room change. The Admission Coordinator said Resident #66 consented to the room change and she was not aware he had not wanted to move. She reported she had not heard any complaints from Resident #66 about his room change since he had moved.

An interview was conducted on 5/7/25 at 3:22 PM with the Director of Nursing (DON). The DON said before a room change, someone from the interdisciplinary team will go and verbally talk to the resident involved in the room change and make sure they are okay with it. She stated residents were not moved unless they were agreeable to it. The DON reported that the facility did not give residents a written notice about room changes. The DON explained the facility had asked Resident #66 to change rooms because there had been a resident coming back from the hospital that needed to be close to the nursing station so the resident could be monitored. The DON said she had been told Resident #66 had agreed to move. The DON explained there was usually a note made in the electronic medical record to document the room change discussion and the residents agreeing to the room change. She did not know why Resident #66 did not have any documentation about the room change discussion in his medical record.

An interview was conducted with the Administrator and the Vice President of Operations (VPO) on 5/8/25 at 5:10 PM. The Administrator reported Resident #66 had been asked about the room change and he had said he was okay to move. She explained Resident #66 had not been forced to change rooms. The Administrator said the room change discussion and him agreeing should have been documented in Resident #66's electronic medical record. She reported a written notice for the room change should have been done. She was not sure why the administration staff did not know they needed to provide a written room change notice to Resident #66. The VPO said the SW had been trained and knew there was supposed to be a written notice given for room changes. The VPO operations said the SW had been educated and she was not sure why the SW did not do a written notice of room change for Resident #66's room change.

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