STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345388	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWN HAVEN HEALTH AND REHABILITATION	**620 TOM HUNTER ROAD , CHARLOTTE, North Carolina, 28213**

(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
E0000	Initial Comments A recertification and complaint survey were conducted on 06/16/25 through 06/20/25. The facility was notified of Immediate Jeopardy on 06/24/25 and the credible allegation was validated on 07/01/25. Additional information was obtained offsite on 07/02/25 through 07/03/25 therefore the exit date was changed to 07/03/25. The facility was found in compliance with the requirement at CFR 483.73, Emergency Preparedness. Event ID # GT1B11	E0000		
F0000	INITIAL COMMENTS A recertification and complaint survey were conducted on 06/16/25 through 06/20/25. The facility was notified of Immediate Jeopardy on 06/24/25 and the credible allegation was validated on 07/01/25. Additional information was obtained offsite on 07/02/25 through 07/03/25 therefore the exit date was changed to 07/03/25. The following intakes were investigated: 864092, 864137, 864142, 864140, and 864139. Event ID# GT1B11. 1 of the 8 complaint allegations resulted in a deficiency. Immediate Jeopardy was identified at: CFR 483.15 at tag F627 at a scope and severity of J. Immediate Jeopardy began on 05/18/25 and was removed on 06/27/25.	F0000		
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:	F0552	F552 – Right to be informed/make treatment decisions 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #88(discharged 5/18/2025) is no longer a resident in the facility.	07/30/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0552 SS = D	Continued from page 1 §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and resident, Medical Director and staff interviews, the facility failed to have documentation that the resident was informed in advance of the risks and benefits for the use of Chlordiazepoxide HCl (a psychotropic medication used to treat the symptoms of alcohol withdrawal) for 1 of 6 residents (Resident #88) reviewed for psychotropic medications. Findings included: Resident #88 was admitted to the facility on 11/8/23 and discharged on 5/18/25 with diagnoses which included anxiety, depression, and alcohol dependence with unspecified alcohol-induced disorder. A review of the quarterly Minimum Data Set (MDS) assessment dated 2/15/25 revealed Resident #88 was cognitively intact. A review of a Medical Director progress note dated 5/14/25 revealed Resident #88 was seen for alcohol use. The note indicated he left the facility to consume alcohol, which was against the protocol of the facility and Resident #88 agreed on 5/14/25 to be treated within the facility for his alcohol withdrawal symptoms. A review of Resident #88's physician's orders dated 5/14/25 revealed an order for Chlordiazepoxide HCl (Librium) to be given in a tapered dose over the course of five days. Day one (5/15/25) dose was two 25 milligram (mg) capsules to be given every six hours, day two dose (5/16/25) was two 25mg capsules every eight hours, day three dose (5/17/25) was two 25mg capsules every 12 hours, and day four and five dose on	F0552	Continued from page 1 (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; Quality review was conducted by Director of Clinical Service/designee on 7/23/2025 on 100% of all current residents on psychotropic medications to ensure the informed consent was signed for administration and the resident and or responsible party was informed of the risks and benefits for the use of the psychotropic medication to ensure no one else is being affected by the deficient practice. No additional affected residents were identified. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur; On 7/23/2025, the Regional Director of Clinical Services educated the Director of Nursing on the regulations. regarding residents right to be informed and make treatment decisions. Director of clinical services was also educated on ensuring that the Resident(s)/ Resident Representative receiving psychotropic medication has an informed consent completed prior to initiation of or change in dosage of the medication. On 7/23/25, the Director of Nursing, Nurse Managers and or administration educated licensed nurses on residents right to be informed and make treatment decisions to include ensuring that the Resident(s)/ Resident Representative receiving psychotropic medication have an informed consent completed prior to initiation of or change in dosage of the medication. The Director of Nursing or Nurse Managers will educate licensed nurses who were not educated on 7/23/25 prior to working their next scheduled shift. Newly hired staff will be educated in orientation by the Director of Nursing or Nurse Managers. During Morning Clinical Meeting all orders will be reviewed Monday to Friday to ensure that any newly ordered Psychotropic medication or changes in medication have the appropriate informed consent	

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F0552 SS = D	Continued from page 2 5/18/25 and 5/19/25 was for two 25mg capsules one time a day for two days. A physician's order dated 5/14/25 to "monitor resident every shift for signs and symptoms of alcohol withdrawal syndrome...tremors, shaking, anxiety, nausea, vomiting, headaches, elevated heart rate, sweating, irritability, confusion, insomnia, nightmares and high blood pressure. Notify MD if/when observed every shift for AWS (alcohol withdrawal symptoms). If aggression or violent behavior observed call 911." A review of Resident #88's EMR revealed consent forms for Buspirone (a medication used to treat anxiety) and Escitalopram (a medication used to treat major depressive disorder and generalized anxiety disorder) both dated 11/8/24 and signed by Resident #88. The EMR revealed no written consent form for Chlordiazepoxide HCl. A telephone interview with Resident #88 on 6/24/25 at 11:17 AM revealed Resident #88 stated he did not sign anything agreeing to the Chlordiazepoxide HCl and didn't recall agreeing to the treatment. A telephone interview with the Medical Director occurred on 7/3/25 at 3:02 PM. He stated he educated Resident #88 in person with Family Member #1 over the phone on all side effects of Chlordiazepoxide HCl. He discussed the possible side effects of Chlordiazepoxide HCl and the possible side effects of taking Chlordiazepoxide HCl and drinking alcohol. The Medical Director stated Resident #88 agreed to the treatment plan because of the severity of the situation and the consequences of bringing alcohol in the facility and endangering himself and others. An interview with the DON on 6/20/25 at 10:35 AM revealed she was a part of the conversation when Resident #88 was told about the medication plan. The DON stated she did not recall Resident #88 signing anything regarding the treatment plan. An interview with the Administrator on 6/20/25 at 11:22 AM revealed he set up a meeting with Resident #88, Family Member #1, and the Medical Director to discuss a treatment plan. The Administrator did not recall Resident #88 signing for the treatment. The Administrator stated the Medical Director put Resident #88 on Librium and it would help with his alcohol withdrawal symptoms. The Administrator stated the Medical Director suggested taking his privileges away to leave the building	F0552	Continued from page 2 signed. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place; The Director of Clinical Services/designee will conduct a quality review of new admissions and all psychotropic medication orders weekly x 4 weeks, and then every 2 weeks x 2 months to ensure consent is obtained upon admission, new order and/or change in dosage. ADHOC QAPI conducted 7/18/25 with the Interdisciplinary Team and Facility Medical Provider to discuss overall survey results and citations. The Executive Director will introduce the plan of correction to the Quality Assurance Performance Improvement Committee on 8/19/25. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Clinical services, Assistant Director of Clinical Services, Unit Manager, Director of Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, Minimum Data Set Nurse, and a minimum of one direct care giver. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly x 3 or until the committee determines substantial compliance has been met. Date of Compliance : (7/30/2025)	
F0561 SS = D	Self-Determination	F0561	F561–Resident rights Self Determination	07/30/2025

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F0561 SS = D	Continued from page 3 CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff, resident, family member, and Medical Director interviews, the facility failed to allow a resident's choice regarding leave of absence (LOA) for 1 of 1 resident (Resident #88) reviewed for self-determination. Findings included: Resident #88 was admitted to the facility on 11/8/23 and discharged on 5/18/25 with diagnoses which included anxiety, depression, and alcohol dependence with unspecified alcohol-induced disorder. A review of the quarterly Minimum Data Set (MDS) assessment dated 2/15/25 revealed Resident #88 was cognitively intact and was not coded for any behaviors. Additionally, Resident #88's annual MDS assessment	F0561	Continued from page 3 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #88(discharged 5/18/25) no longer resides at this facility. (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; Quality review of 100% of current residents conducted on 7/23/25 by Executive Director/designee to ensure residents and/or their responsible party are allowed a personal choice regarding their leave of absence, and the facility is abiding by their choice. No additional affected residents were identified. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not re-occur; On 7/23/2025, the Regional Director of Clinical Services educated the Director of Nursing on the regulations regarding residents having the right to have a choice regarding their leave of absence from the facility as well as the residents' right to refuse treatment, medications, or services. Should a resident refuse treatment, medications, or services, staff will document the refusal and that the resident was informed of the possible risks vs. benefits of their refusal, update the resident's care plan indicating their refusal and notify the provider and the responsible party. Resident preferences will continue to be reviewed during the resident's base line care plan review, at least quarterly, and as needed, per facility protocol by the interdisciplinary team in collaboration with the resident and or resident representative. When the resident and/or resident representative decides to take a leave of absence from the facility the interdisciplinary team will collaborate with the resident /representative to identify the resident's needs are addressed and permit resident to sign out,	

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F0561 SS = D	Continued from page 4 dated 11/15/24 revealed participating in his favorite activities and participating in outdoor activities were very important to him. A review of Resident #88's care plan last reviewed on 2/27/25, revealed he was non-compliant with the facility's rules on alcohol and management routinely confiscated alcohol from him. Interventions included not allowing Resident #88 to bring alcoholic beverages into the facility, encouraging peer bonds, and monitoring for symptoms of alcohol use. In addition, Resident #88's care plan indicated he had a history of alcohol and substance abuse, and staff reported the presence of alcohol intoxication and illegal substances at the facility. Interventions included educating Resident #88 on facility policies on consumption of alcohol, explaining the facility's responsibility for all resident's safety, and reporting any occurrences or suspicions to facility administration. A review of a nursing progress note written by Nurse #3 on 4/26/25 revealed, in part, Resident #88 was observed seated in the smoking courtyard and drinking a beer. Resident #88 was approached and made aware of the facility alcohol policy and that his room and backpack needed to be searched and he began to get agitated, and said, "leave me alone." Resident #88 wheeled himself to his room and upon searching, nine cans of beer were taken from his backpack, and five empty cans from his bedside drawer. Resident #88 also had a strong smell of alcohol on his breath. A review of a nursing progress note written by Nurse #3 on 5/5/2025 revealed Resident #88 returned from LOA and a smell of alcohol was noticed. Resident #88 was made aware of the facility alcohol policy. His backpack was searched, and several cans of beer were taken away. A review of a Medical Director progress note dated 5/14/25 revealed Resident #88 was seen for alcohol use. The note indicated he left the facility to consume alcohol, which was against the protocol of the facility and Resident #88 agreed on 5/14/25 to be treated within the facility for his alcohol withdrawal symptoms. A review of Resident #88's physician's orders dated 5/14/25 revealed an order for chlordiazepoxide HCl to be given in a tapered dose over the course of five days. Day one (5/15/25) dose was two 25 milligram (mg) capsules to be given every six hours, day two dose (5/16/25) was two 25mg capsules every eight hours, day three dose (5/17/25) was two 25mg capsules every 12 hours, and day four and five dose on 5/18/25 and	F0561	Continued from page 4 exit the facility and return and sign back into the facility. On 7/23/25, the Director of Nursing, Nurse Managers and or administration educated licensed nurses on the regulations regarding residents having the right to have a choice regarding their leave of absence from the facility as well as the residents' right to refuse treatment, medications, or services. Should a resident refuse treatment, medications, or services, staff will document the refusal and that the resident was informed of the possible risks vs. benefits of their refusal, update the resident's care plan indicating their refusal and notify the provider and the responsible party. Director of Nursing or Nurse Managers will educate licensed nurses who were not educated on 7/23/25 prior to working their next scheduled shift. Newly hired staff will be educated in orientation by the Director of Nursing or Nurse Managers. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place; The Executive Director/designee will conduct a quality review of 5 resident care plans to ensure their rights regarding having a leave of absence from the facility are honored and reflected in their plan of care, on each unit weekly x 4 weeks, and then every 2 weeks x 2 months. ADHOC QAPI conducted 7/18/25 with the Interdisciplinary Team and Facility Medical Provider to discuss overall survey results and citations. The Executive Director will introduce the plan of correction to the Quality Assurance Performance Improvement Committee on 8/19/25. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Clinical services, Assistant Director of Clinical Services, Unit Manager, Director of Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, Minimum Data Set Nurse, and a minimum of one direct care giver. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly x 3 or until committee determines substantial compliance has been met.	

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F0561 SS = D	Continued from page 5 5/19/25 was for two 25mg capsules one time a day for two days. A physician's order dated 5/14/25 to "monitor resident every shift for signs and symptoms of alcohol withdrawal syndrome...tremors, shaking, anxiety, nausea, vomiting, headaches, elevated heart rate, sweating, irritability, confusion, insomnia, nightmares and high blood pressure. Notify MD if/when observed every shift for AWS (alcohol withdrawal symptoms). If aggression or violent behavior observed call 911." An additional review of Resident #88's physician's orders included an order written on 5/14/25 revoking Resident #88's LOA privileges due to poor safety awareness and risk of injury associated with ongoing behaviors due to alcohol dependency. A review of a social work progress note written on 5/14/25 by the SW revealed, in part, she spoke with Resident #88 and his family member regarding his alcohol use in the facility and when he left the facility. Resident #88 and his family member were made aware that this behavior would no longer be tolerated at the facility. He was informed that an order was written by the Medical Director that Resident #88 was no longer allowed to leave the facility due to excessive drinking and coming back intoxicated. The note further revealed that if Resident #88 left the facility it would be considered Against Medical Advice (AMA), and he would be discharged. "Resident #88 and his family member understood." An interview with the Medical Director on 6/19/25 at 12:46 PM revealed that Resident #88 posed a threat to other residents and staff and was combative towards employees and other residents in the building. He stated Resident #88 was using alcohol in and out of the facility and it was decided he was no longer allowed to leave the facility on 5/14/25 during a meeting with Resident #88, Family Member #1 (over the phone), and the Director of Nursing (DON). A second telephone interview with the Medical Director occurred on 7/3/25 at 3:02 PM. He stated he educated Resident #88 in person with Family Member #1 over the phone on all side effects of Chlordiazepoxide HCl. He discussed the possible side effects of Chlordiazepoxide HCl and the possible side effects of taking Chlordiazepoxide HCl and drinking alcohol. The Medical Director stated Resident #88 agreed to the treatment plan because of the severity of the situation and the consequences of bringing alcohol in the facility and endangering himself and others. A nursing progress note written by Unit Manager #1 on	F0561	Continued from page 5 Date of Compliance : (7/30/2025)	

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F0561 SS = D	Continued from page 6 5/18/25 revealed, in part, she was notified by the facility receptionist that Resident #88 left the facility against medical advice and he was observed leaving facility grounds and headed towards a main road. The note further revealed Resident #88 and his emergency contact (Family Member #1) were previously notified that his LOA was revoked due to unsafe health practices and poor safety awareness and if he left facility grounds it was against medical advice and would result in a discharge from the facility. It was a discharge from the facility against medical advice. Resident #88 repeatedly violated facility policies related to consuming alcohol on facility property and sneaking alcohol into his room and management repeatedly confiscated the alcohol. A review of Resident #88's electronic medical record (EMR) revealed no signed agreement or consent by Resident #88 or Family Member #1 agreeing to the revocation of LOA. An interview with the Receptionist on 7/3/25 at 11:17 AM revealed she was informed by Unit Manager #1 on 5/16/25 about the agreement the facility made with Resident #88 about not leaving the facility. The Receptionist stated Resident #88 was in the front lobby of the facility on 5/18/25 as another resident's family member was moving items out of the facility. She stated she reminded Resident #88 of the agreement he had with the facility, and he stated he wanted to go out to the store and not to "put a hand on him." The Receptionist stated she told Resident #88 she would never do that to him and when the other resident's family member went out the front door, Resident #88 followed him out. An interview with Unit Manager #1 on 6/19/25 at 1:48 PM revealed she was working on 5/18/25 when Resident #88 left the building. She stated he and Family Member #1 understood after a meeting with the administration that he was not allowed to leave the facility due to his alcohol use. A telephone interview with Resident #88 on 6/24/25 at 11:17 AM revealed he did not sign anything agreeing to the medication they put him on or not leaving the facility and didn't recall agreeing to the treatment. Resident #88 stated "When they told me I couldn't leave it made me feel like I was in jail." An interview with the DON occurred on 6/20/25 at 10:35 AM and revealed Resident #88 had a history of drinking alcohol outside of the facility for quite some time but he started to bring the alcohol on campus. The DON stated staff found beer in the courtyard and in his	F0561		

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F0561 SS = D	Continued from page 7 room. The DON explained the facility tried to discharge him to an adult care home and tried to get him into an alcohol detox program, but he refused. The DON stated the Medical Director started him on medication to curb his withdrawal symptoms and his leave of absence privileges from the facility were revoked on 5/14/25. An interview with the Administrator occurred on 6/20/25 at 11:22 AM and revealed Resident #88 signed himself out of the facility daily to drink and panhandle on the street which he had witnessed in the past. He explained Resident #88 started to drink alcohol in his room and other places on campus and staff had to come in and remove the alcohol in the weeks leading up to 5/18/25. The Administrator stated he contacted law enforcement to assist in searching Resident #88's room for alcohol. He stated the Medical Director decided it was too risky for Resident #88 to leave the facility campus and prescribed some medication that would help with alcohol withdrawal symptoms. He additionally stated Resident #88's privileges to leave the building were taken away on 5/14/25. The Administrator stated Resident #88 received education from himself and the Medical Director on 5/14/25 that if he left the facility, they would not take him back and it would be considered an AMA discharge.	F0561		
F0627 SS = J	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would	F0627	F627 –Inappropriate discharge 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #88 was discharged involuntarily without a post discharge plan and necessary resources for medical and non-medical services to ensure a safe and orderly discharge. Resident #88 currently does not reside in facility (discharged 5/18/25). (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; On 06/24/25, the Minimum Data Set Nurse and Director of Nursing conducted a quality review of current resident's care plans to verify that the care plan accurately reflected the resident's current preference for discharge. Residents who desire to be discharged will be assisted by the interdisciplinary team to ensure that discharge planning meets the resident's	07/30/2025

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F0627 SS = J	Continued from page 8 otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by-	F0627	Continued from page 8 preference, and that care has been coordinated to ensure a safe discharge. On 06/24/25, the Executive Director conducted a quality review of residents that have been discharged from the facility within the last 30 days to ensure safe discharge. The Executive Director reviewed discharged residents EMR, contacted the residents and or resident representative to ensure the resident needs were met upon discharge. No discrepancies noted. No additional affected residents were identified. On 06/24/25, the Minimum Data Nurse and Director of Nursing conducted a quality review of current resident's medication record to identify other residents on Librium; No additional residents identified. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur; On 06/24/25, the Regional Vice President of Operations educated the Executive Director on proper discharge to include immediate discharge, 30-day discharge and residents who discharge the facility Against Medical Advice (AMA). On 6/24/2025, the Regional Director of Clinical Services and/or Regional Vice President of Operations educated the Executive Director and Director of Nursing on the regulations. regarding discharge planning and the facility protocols to promote a safe resident centered plan. Resident discharge plans will continue to be reviewed during the resident's base line care plan review, at least quarterly, and as needed, per facility protocol by the interdisciplinary team in collaboration with the resident and or resident representative. When the resident and/or resident representative changes the discharge plan, the interdisciplinary team will collaborate with the resident / representative to identify the resident's needs, identify potential locations, and will facilitate a safe discharge for the resident. The residents' medical record will contain documentation of discharge instructions and education (i.e., care needs, medication administration, follow-up appointments) provided to the resident/ resident representative. The On June 26, 2025, Executive Director educated the interdisciplinary team on the facility policy for discharge planning and the policy on interdisciplinary	

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F0627 SS = J	Continued from page 9 (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.	F0627	Continued from page 9 discharge planning. On 06/24/25, the Director of Nursing, Nurse Managers and or administration educated licensed nurses on safe and orderly discharge to include medication administration, monitoring, equipment needs, services needed, shelter, food, and hydration. The Director of Nursing or Nurse Managers will educate licensed nurses who were not educated on 06/24/25 prior to working their next scheduled shift. Newly hired staff will be educated in orientation by the Director of Nursing or Nurse Managers. The facility social worker's last day of employment with the facility was June 20, 2025. The facility has hired a social worker that is scheduled to begin work on July 7, 2025. During the social worker's orientation, education will be provided by Director of Nursing or designee to the social worker on discharge planning requirements and protocols to promote safe a discharge for the resident. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place; The Executive Director/designee will conduct quality review of facility initiated discharges weekly x 4 weeks, then every 2 weeks x 2 months, and then monthly x 1 year ADHOC QAPI conducted 7/18/25 with the Interdisciplinary Team and Facility Medical Provider to discuss overall survey results and citations. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly x 2 or until committee determines substantial compliance has been met.	

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F0627 SS = J	Continued from page 10 §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the	F0627		

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F0627 SS = J	Continued from page 11 determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff, resident, family member, Medical Director and Adult Protective Services (APS) Social Worker (SW) interviews, the facility failed to provide a safe and orderly discharge for 1 of 3 residents reviewed for discharge (Resident #88). Resident #88 was being treated in the facility with Chlordiazepoxide HCl (a medication used to treat the symptoms of alcohol withdrawal also known as Librium) for a known history of alcohol abuse and received a	F0627		

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F0627 SS = J	Continued from page 12 dose a short time before exiting the facility on 5/18/25 at approximately 10:51 AM. The Medical Director wrote orders for Resident #88 to be monitored every shift for symptoms of alcohol withdrawal syndrome, such as tremors, shaking, anxiety, nausea, vomiting, headaches, elevated heart rate, sweating, irritability, confusion, insomnia, nightmares and high blood pressure the same day the Chlordiazepoxide HCl was initiated. Consuming alcohol while taking Chlordiazepoxide HCL could cause nausea and/or vomiting. When Resident #88 returned to the facility on 5/18/25 he begged staff to let him back in but, he was not allowed to re-enter the facility. There were no documented assessments of Resident #88 when he returned to the facility. Unit Manager #1 offered Resident #88 his belongings and medications to include the remaining Chlordiazepoxide HCL and Metoprolol (a medication used to lower blood pressure), which he refused except for his cigarettes. Resident #88 also refused to sign the Against Medical Advice (AMA) document. Unit Manager #1 failed to notify Emergency Medical Services (EMS) or have Resident #88 transferred to a higher level of care for ongoing monitoring when notified he had exited the facility or when he returned. Unit Manager #1 called law enforcement at 12:08 PM because staff wanted Resident #88 banned from the facility. Resident #88 did not have a planned discharge location, and no ongoing monitoring arranged. He was seen at the local convenience store, homeless, by staff members on 5/19/25 and 5/20/25 and no staff members offered assistance to Resident #88. In addition, Resident #88 was an amputee, mobile in a wheelchair, had no other source of money or resources, and did not have supplies for urinary incontinence. Resident #88 was found intoxicated by the APS SW at the convenience store on 5/20/25 and was taken to the hospital for chest pain and palpitations as well as left lower extremity pain due to a fall from his wheelchair. Resident #88 remailed homeless and a second hospitalization occurred on 5/29/25 and Resident #88 received intravenous antibiotics in the emergency department (ED) for left leg cellulitis (a bacterial infection involving the inner layers of the skin) and was discharged on 5/30/25 with a prescription for oral antibiotics. The third hospitalization was on 6/4/25 and Resident #88 presented with complaints of worsening left lower leg pain with erythema (redness) and edema (swelling) times one week. He was admitted to the hospital and treated with intravenous antibiotics for cellulitis for a wound on his left leg and monitored for alcohol withdrawal. Resident #88 declined placement in a skilled nursing facility and discharged AMA on 6/16/25 stating he was going to the “street”. Immediate jeopardy began on 5/18/25 when Resident #88	F0627		

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F0627 SS = J	Continued from page 13 was not permitted to return to the facility after a brief leave of absence. Immediate jeopardy was removed on 6/27/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education. Findings included: Resident #88 was admitted to the facility on 11/8/23 with diagnoses which included hypokalemia, protein-calorie malnutrition, anxiety, depression, alcohol dependence with unspecified alcohol-induced disorder, and absence of right leg below the knee. Resident #88 and discharged on 5/18/25. Review of quarterly Minimum Data Set (MDS) assessment dated 2/15/25 revealed Resident #88 was cognitively intact and was independent with Activities of Daily Living (ADLs) but needed supervision assistance with shower transfers. Resident #88 was not coded for any behaviors. The MDS further revealed he utilized a prosthetic limb for a below the knee amputation of his right leg and had occasional urinary incontinence. The MDS indicated he was not coded for any discharge planning to the community. A review of Resident #88's care plan last reviewed on 2/27/25 revealed he was non-compliant with the facility's rules on alcohol and management routinely confiscated alcohol from him. Interventions included not allowing Resident #88 to bring alcoholic beverages into the facility, encouraging peer bonds, and monitoring for symptoms of alcohol use. In addition, Resident #88's care plan indicated he had a history of alcohol and substance abuse, and staff reported the presence of alcohol intoxication and illegal substances at the facility. Interventions included educating Resident #88 on facility policies on consumption of alcohol, explaining the facility's responsibility for all resident's safety, and reporting any occurrences or suspicions to facility administration. Resident #88's care plan also indicated he wished to remain a long-term resident at the facility. Interventions included evaluating his motivation to return to the community, encouraging him to discuss feelings and concerns with impending discharge, and monitoring for and address episodes of anxiety, fear, distress. The care plan further revealed Resident #88 had occasional bladder incontinence due to impaired mobility. Interventions included cleaning peri-area with each incontinence episode, using disposable briefs per	F0627		

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F0627 SS = J	Continued from page 14 manufacturer's recommendation and have staff check and change during care rounds and as needed, and monitoring and documenting for signs and symptoms of a urinary tract infection. A review of Resident #88's Electronic Medical Record (EMR) was conducted. It revealed Resident #88 was given a 30-day discharge notice signed by the Administrator on 3/25/25. The reason for discharge was selected as "your health has improved sufficiently so that you no longer need the services provided by the facility." The discharge location was to a lower level of care in an adult care home. An interview with the Social Worker (SW) on 6/19/25 at 2:45 PM revealed she originally gave Resident #88 a 30-day discharge notice to an adult care home on 3/25/25, but he did not qualify due to his payor source and so the discharge could not take place. The SW stated the Administrator spoke to Resident #88 and his family member regarding not coming back to the facility if he went out to drink alcohol. A review of a Social Work Progress note written by the SW on 4/10/25 indicated she had a conversation with Resident #88 about three programs for alcohol detoxification. Resident #88 refused to participate, and SW informed him that if he didn't go to a detoxification program, then he would be discharged to a homeless shelter. No further formal discharge planning was noted in Resident #88's EMR after 4/10/25. An interview with the SW occurred on 6/20/25 at 1:40 PM. She stated the facility did not pursue any discharge planning to a homeless shelter after the discharge notice to an adult care home failed. She stated Resident #88 did not want to go to a homeless shelter and he wanted to stay at the facility. The SW stated she told him that he could not stay at the facility and continue drinking alcohol. A review of a Psychiatric-Mental Health Nurse Practitioner (NP) progress note dated 4/8/25 revealed, in part, reports of Resident #88's alcohol confiscation in the past were noted. Despite this, Resident #88 denies any sleep disturbances and was on melatonin. During the visit, the Psychiatric-Mental Health NP expressed concern about the risk of withdrawal, but no tremors, diaphoresis, or agitation were observed during the visit. Recommended nursing staff to use the Clinical Institute Withdrawal Assessment for Alcohol (instrument used by medical professionals to assess and	F0627		

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F0627 SS = J	Continued from page 15 diagnose the severity of alcohol withdrawal) to assess for withdrawal symptoms every four to six hours and continue to monitor closely for any signs of alcohol withdrawal. Staff was educated on the risks of withdrawal and the importance of monitoring symptoms. Consider referral to supportive therapy if Resident #88 declined formal rehab. A review of a nursing progress note written by Nurse #3 on 4/26/25 revealed, in part, Resident #88 was observed seated in the smoking courtyard and drinking a beer. Resident #88 was approached and made aware of the facility alcohol policy and that his room and backpack needed to be searched and he began to get agitated, and said, "leave me alone." Resident #88 wheeled himself to his room and upon searching, nine cans of beer were taken from his backpack, and five empty cans from his bedside drawer. Resident #88 also had a strong smell of alcohol on his breath. A review of a Licensed Clinical Social Worker's (LCSW) note dated 5/1/25 revealed Resident #88 was being seen for the first time to assess possible psychotherapeutic need due to disturbances of potential alcohol abuse and mental health concerns by staff. The LCSW's note read in part that Resident #88 was not a danger to himself or others and that he was self-medicating with alcohol. Resident #88 agreed to psychotherapy sessions and will focus most sessions on rapport building until Resident #88 felt more comfortable to communicate his needs in an effective manner. A review of a nursing progress note written by Nurse #3 on 5/5/2025 revealed Resident #88 returned from leave of absence (LOA) and a smell of alcohol was noticed. Resident #88 was made aware of the facility alcohol policy. His backpack was searched, and several cans of beer were taken away. A review of a nursing progress note written by Nurse #12 on 5/8/2025 revealed, in part, Resident #88 was able to make needs known to staff. Resident #88 was noted with a can of beer and the smell of alcohol on his breath. Resident #88 was educated on facility protocol on having alcohol in his personal possession and was educated on the need to confiscate his beverage. He became upset stating, "I can have that. You can't tell me what to do." Resident #88 was encouraged to speak with management on protocol and showed signs of intoxication. The Director of Nursing (DON) was made aware. A review of a Medical Director progress note dated 5/14/25 revealed Resident #88 was seen for alcohol use.	F0627		

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F0627 SS = J	Continued from page 16 The note indicated he left the facility to consume alcohol, which was against the protocol of the facility and Resident #88 agreed on 5/14/25 to be treated within the facility for his alcohol withdrawal symptoms. An additional review of Resident #88's physician's orders included an order written on 5/14/25 revoking Resident #88's leave of absence (LOA) privileges due to poor safety awareness and risk of injury associated with ongoing behaviors due to alcohol dependency. A review of a social work progress note written on 5/14/25 by the SW revealed, in part, she spoke with Resident #88 and his family member regarding his alcohol use in the facility and when he left the facility. Resident #88 and his family member were made aware that this behavior would no longer be tolerated at the facility. He was informed that an order was written by the Medical Director that Resident #88 was no longer allowed to leave the facility due to excessive drinking and coming back intoxicated. The note further revealed that if Resident #88 left the facility it would be considered Against Medical Advice (AMA), and he would be discharged. “Resident #88 and his family member understood.” A review of Resident #88's physician's orders dated 5/14/25 revealed an order for chlordiazepoxide HCl to be given in a tapered dose over the course of five days. Day one (5/15/25) dose was two 25 milligram (mg) capsules to be given every six hours, day two dose (5/16/25) was two 25mg capsules every eight hours, day three dose (5/17/25) was two 25mg capsules every 12 hours, and day four and five dose on 5/18/25 and 5/19/25 was for two 25mg capsules one time a day for two days. A review of Resident #88's May Medication Administration Record (MAR) from 5/1/25 until 5/18/25 revealed Resident #88 received Chlordiazepoxide HCl on 5/15/25 two 25 milligram (mg) capsules every six hours, on 5/16/25 two 25mg capsules every eight hours, on 5/17/25 two 25mg capsules every 12 hours, and on 5/18/25 two 25mg capsules at 9:00 AM. A physician’s order dated 5/14/25 to “monitor resident every shift for signs and symptoms of alcohol withdrawal syndrome...tremors, shaking, anxiety, nausea, vomiting, headaches, elevated heart rate, sweating, irritability, confusion, insomnia, nightmares and high blood pressure. Notify MD if/when observed every shift for AWS (alcohol withdrawal symptoms). If aggression or violent behavior observed call 911.”	F0627		

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F0627 SS = J	Continued from page 17 A review of Resident #88's May MAR from 5/15/25 to 5/17/25 revealed Resident #88's vital signs were documented every shift and were all within normal limits. A nursing progress note written by Unit Manager #1 on 5/18/25 revealed, in part, she was notified by the facility Receptionist that Resident #88 left the facility AMA, and he was observed leaving facility grounds and headed towards a main road. The note further revealed Resident #88 and his emergency contact (Family Member #1) were previously notified that his LOA was revoked due to unsafe health practices and poor safety awareness. Should resident leave facility grounds it would be against medical advice. It was a discharge from the facility against medical advice. Resident #88 repeatedly violated facility policies related to consuming alcohol on facility property and sneaking alcohol into his room and management repeatedly confiscated the alcohol. An interview with Unit Manager #1 on 6/19/25 at 1:48 PM revealed she was working on 5/18/25 when Resident #88 left the facility. She stated he and Family Member #1 understood after a meeting with administration 5/14/25 that he was not allowed to leave the facility due to his alcohol use. She stated she was alerted by the Receptionist on 5/18/25 that Resident #88 left the facility and she reminded him when he came back that he would be leaving AMA and not allowed to come back into the facility. Unit Manager #1 stated she called Resident #88's family member (Family Member #1) after she was notified Resident #88 left by the Receptionist to let her know he had left the facility, and he was not allowed back in. She asked Family Member #1 to come get his belongings. Unit Manager #1 stated she called APS and law enforcement when he returned but did not call an ambulance for evaluation. The Unit Manager #1 did not state if Resident #88 was assessed when he returned to the facility. A second interview with Unit Manager #1 on 6/20/25 at 12:35 PM revealed Resident #88 did not immediately come back after leaving the facility on 5/18/25. She stated she called his family member (Family Member #1) and asked if she could come gather his belongings. Unit Manager #1 stated Family Member #1 called Resident #88 and he returned to the facility. She stated Resident #88 had already violated the agreement, and she would not let Resident #88 back into the facility. She stated Resident #88 begged to come back and stated he did not have anything to drink while he was gone. Unit Manger #1 stated she called law enforcement when he returned to the facility, and they arrived and found Resident	F0627		

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F0627 SS = J	Continued from page 18 #88 sitting on the porch at the facility. She stated law enforcement let him know he was not allowed back on the property as it would be considered trespassing. Unit Manager #1 stated she was instructed on what to do if Resident #88 left on a weekend by the Administrator and the DON. Unit Manager #1 indicated she saw Resident #88 on 5/19/25 and 5/20/25 at the convenience store but did not stop and check on him and added multiple staff members also reported seeing him in the convenience store parking lot. Unit Manager #1 stated she did not call an ambulance when Resident #88 returned to the facility because he would have refused to get in an ambulance. A review of the facility's sign-in and out logbook at the receptionist desk revealed Resident #88 was signed out by the receptionist on 5/18/25 at 10:51 AM. An interview with the Receptionist on 7/3/25 at 11:17 AM revealed she was informed by Unit Manager #1 on 5/16/25 about the agreement the facility made with Resident #88 about not leaving the facility. The Receptionist stated Resident #88 was in the front lobby of the facility on 5/18/25 as another resident's family member was moving items out of the facility. She stated she reminded Resident #88 of the agreement he had with the facility, and he stated he wanted to go out to the store and not to "put a hand on him." The Receptionist stated she told Resident #88 she would never do that to him and when the other resident's family member went out the front door, Resident #88 followed him out. She stated she immediately called Unit Manager #1 and signed Resident #88 out on the facility sign in and out logbook at 10:51 AM. The Receptionist stated she got in her car and followed him to the main road, and he was at the bus stop. The Receptionist indicated that while she was in her car she asked Resident #88 to come back to the facility. She stated Resident #88's phone rang a few minutes later and he started back to the facility. The Receptionist stated when she returned to the building, Unit Manager #1 asked where she found Resident #88. She stated Resident #88 made it to the bus stop across the street on the main road, not too far from the facility. The Receptionist stated she was unsure of the time she got back to the facility, but by the time she returned and used the restroom, Resident #88 was outside on the porch and Unit Manager #1 was speaking to him. She stated residents could sign out in a logbook at the nurse's desk, but she did not always know if they did sign out, so she signed the book at the receptionist desk to keep track of all the residents coming and going. She stated that is why she signed Resident #88 out on 5/18/25 and put "removed" in the return time slot as he did not come back inside the	F0627		

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F0627 SS = J	Continued from page 19 facility. An additional review of Resident #88's EMR revealed no documented vital signs or any assessment of Resident #88 by nursing staff before he exited the facility on 5/18/25 or after he returned to the facility on 5/18/25. A review of Resident #88's AMA form in the EMR dated 5/18/25 revealed no signature. The signature line where Resident #88 would have signed was filled in by Unit Manger #1 with the statement "Resident refused to sign." The AMA form included the signatures of Unit Manager #1 and another nurse. A review of a police report dated 5/18/25 was reviewed and revealed law enforcement arrived at the facility at 12:36 PM for a disturbance with a suspect on scene and indicated Resident #88 was at the front door of the facility. In addition, the report revealed facility staff wanted Resident #88 banned from the property. An interview with the SW on 6/19/25 at 11:34 AM revealed Resident #88 would often go off campus and buy 12 to 24 cans of beer and drink them. She stated the facility staff started finding empty beer cans in his room as he drank alcohol on facility grounds and off campus. The SW stated she investigated detoxification programs for Resident #88 and initially he was willing to participate. She stated when a detoxification program came to evaluate him at the facility, he refused to participate in the program. She further explained the Administrator eventually told Resident #88 he was not allowed to leave the facility and if he did, he could not return. The SW explained on 5/18/25, Resident #88 followed a visitor out the front door and when he came back later, the weekend staff would not allow him to come back into the facility. The SW stated an APS SW was working with Resident #88 after his discharge from the facility for placement and resources. An interview with Resident #88's Family Member #1 occurred on 6/19/25 at 9:29 AM. She stated Resident #88 left the facility on 5/18/25 and when he came back, the staff would not let Resident #88 back in the facility. The Family Member stated Resident #88 did not have access to his belongings, medicine, or anything. She explained that after Resident #88 was not allowed back into the facility, he became homeless and had been in and out of the hospital for several weeks. The Family Member explained that an APS Social Worker found Resident #88 on the streets and was working with him to locate a new facility.	F0627		

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F0627 SS = J	Continued from page 20 Additional interviews with Family Member #1 were attempted on 6/23/25 at 3:10 PM and 6/24/25 at 11:12 AM but were unsuccessful. A telephone interview with Resident #88 on 6/24/25 at 11:17 AM revealed he tried to get back into the building after leaving on 5/18/25. He stated the facility staff called law enforcement on him for trespassing while he was sitting on the porch in front of the facility. Resident #88 stated he did not sign anything agreeing to the medication they put him on or not leaving the facility and didn't recall agreeing to the treatment. He stated he hung out at the convenience store until the APS SW found him a few days later and did not recall going anywhere else after the discharge from the facility. Resident #88 stated, "When they told me I couldn't leave it made me feel like I was in jail. Them not letting me back in made me mad. It was a f---ing G-- D--- joke that they left me out on the porch. I was only gone 30 minutes-not enough time to do anything." Resident #88 also stated Family Member #1 paid for him to have a phone, but he had no other source of money or resources. An interview with the Medical Director on 6/19/25 at 12:46 PM revealed that Resident #88 posed a threat to other residents and staff and was combative towards employees and other residents in the building. He stated Resident #88 was using alcohol in and out of the facility and it was decided he was no longer allowed to leave the facility on 5/14/25 during a meeting with Resident #88, Family Member #1 (over the phone), and the DON. The Medical Director stated he worked closely with a pharmacist to initiate a course of chlordiazepoxide HCl as it was not a medication used often in long term care. He stated this medication acted as a central nervous system depressant and helped with the symptoms of alcohol withdrawal. The Medical Director stated the medication required constant monitoring during the five-day course of medication. He stated Resident #88 was ultimately a threat to himself and would have had the expectation for the facility staff to call Emergency Management Services (EMS) and have him sent to the hospital for evaluation if he came back to the facility in an unsafe manner such as being intoxicated. The Medical Director stated the facility did not dump him out of the facility; they attempted to treat his alcohol detoxification as it was their medical responsibility. A second telephone interview with the Medical Director occurred on 6/24/25 at 11:43 AM. He explained that Chlordiazepoxide HCl blocked side effects of alcohol	F0627		

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F0627 SS = J	Continued from page 21 detoxification. He explained if someone undergoing Chlordiazepoxide HCl treatment started drinking, it would make them physically sick-throwing up and nauseated. The Medical Director explained the combination of drinking alcohol on Chlordiazepoxide HCl would not make a person confused, the alcohol itself could cause confusion. He stressed the importance of vital sign monitoring during Chlordiazepoxide HCl treatment and looking for any symptoms such as sweating, nervousness, or shaking. The Medical Director stated when Resident #88 was not allowed back into the facility, there would be no way monitoring could occur without hospitalization. A third telephone interview with the Medical Director occurred on 7/3/25 at 3:02 PM. He stated he educated Resident #88 in person with Family Member #1 over the phone on all side effects of Chlordiazepoxide HCl on 5/14/25. He discussed the possible side effects of Chlordiazepoxide HCl and the possible side effects of taking Chlordiazepoxide HCl and drinking alcohol. The Medical Director stated Resident #88 agreed to the treatment plan because of the severity of the situation and the consequences of bringing alcohol in the facility and endangering himself and others. An interview with the APS SW on 6/20/25 at 9:27 AM revealed she was assisting Resident #88 with ongoing services since his discharge from the facility on 5/18/25. She stated Resident #88 was currently homeless and had been hospitalized three times on 5/20/25, 5/29/25, and 6/4/25. The APS SW stated the facility called on 5/18/25 and filed a report. She stated she called the facility on 5/19/25 and 5/20/25 multiple times to ask staff additional questions about Resident #88's discharge from the facility with no response. She stated she drove to the facility on 5/20/25 to get clarification on Resident #88's appearance as the person she saw at the convenience store had a darker skin tone and it was reported to her that Resident #88 was Caucasian. The APS SW stated she met with the DON and the Administrator when she arrived at the facility, and they explained multiple staff members and the Administrator had seen Resident #88 at the convenience store when they were driving to work on 5/20/25. The APS SW stated Resident #88 was hanging out at the convenience store since his discharge on 5/18/25 until 5/20/25 when she found him intoxicated and dirty in the convenience store parking lot without any medications, supplies, or his belongings. She stated he was hospitalized for an abrasion on his leg and discharged the following day on 5/21/25. The APS SW explained that after his discharge from the second hospitalization on 5/30/25, she found him at another convenience store	F0627		

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F0627 SS = J	Continued from page 22 further up the road, still homeless and without resources. The APS SW stated Resident #88 did not have the money to pay for the antibiotic he was prescribed for cellulitis in his leg. The APS SW stated he was admitted to another hospital on 6/4/25 and was admitted for a significant wound infection in his leg. A review of the hospital records dated 5/20/25 revealed Resident #88 arrived at the emergency department (ED) via emergency medical services (EMS) complaining of chest pain and palpitations as well as left lower extremity pain. EMS stated he fell out of his wheelchair and sustained an abrasion to his left lower extremity. A fresh abrasion was noted to the anterior left shin. Resident #88 did undergo an extensive workup for his complaint of his leg pain and chest pain and no abnormalities warranting a hospital admission were noted. The record indicated Resident #88 was homeless with a history of alcohol dependence and chronic alcohol use disorder. Resident #88 had a below the knee amputation with a history of hypertension and chronic osteomyelitis. Additionally, the note revealed Resident #88 stated he was not in a shelter. The Physician documented Resident #88 was found to be mildly hyponatremic (low sodium) and hypokalemic (low potassium). It was noted the hyponatremia was likely secondary to beer ingestion and Resident #88 was given oral potassium as well as a multivitamin. The note further indicated Resident #88 reported he had been living in a nursing home for about one year and they "kicked me out on Sunday". Patient was obviously intoxicated and slurring his words and was a very poor historian. In addition, Resident #88's hospital records revealed his blood ethanol level was 128mg/dl (an ethanol level of 50mg/dl or above was considered intoxicated). The Physician further documented because Resident #88 was homeless and intoxicated, he was not discharged on 5/20/25 but kept in the ED and allowed him to metabolize the alcohol and see clinical case management in the morning to get resources to a homeless shelter and a bus pass to facilitate transportation to the shelter. Resident #88 was discharged the following day on 5/21/25 with no prescriptions. A review of the hospital records dated 5/29/25 indicated Resident #88 presented to the ED with a chief complaint of left lower extremity swelling and reported redness and swelling to his left lower extremity for several days. Resident #88 denied a fever, chills, dyspnea, abdominal pain, nausea or vomiting. The ED Physician documented Resident #88 had a previous right lower extremity amputation and prosthesis. The ED Physician noted Resident #88 had a few abrasions to his	F0627		

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F0627 SS = J	Continued from page 23 left knee and lateral leg from where he fell from his wheelchair several days ago. Pitting edema of the left lower leg was observed as well as poor hygiene. Resident #88 stated he had been drinking beer today. Resident #88's blood ethanol level was not obtained. Resident #88 received intravenous antibiotics for left leg cellulitis and was discharged on 5/30/25 with an order for 500mg of Cephalexin (antibiotic), one capsule to be taken four times a day for seven days for cellulitis of left lower extremity. Review of ED provider notes dated 6/4/25 indicated Resident #88 presented complaining of worsening left lower leg pain with erythema (redness) and edema (swelling) times one week. Pulses were intact and range of motion was normal. Resident #88's blood ethanol level was 93mg/dl. Resident #88 was admitted to the hospital and treated with intravenous antibiotics for cellulitis for a wound on his left leg and monitored for alcohol withdrawal. The history and physical documented on 6/5/25 noted Resident #88 had a past medical history significant for essential hypertension, history of chronic alcohol dependence, ongoing alcohol and tobacco use, status post right BKA, homelessness, and mild protein calorie malnutrition. Resident #88 had been doing quite very well until about a week ago when he started noticing increasing redness and pain in the left leg area. The Physician documented Resident #88 denied having any injury, but he had some scabs which he tried to remove at which time he started having the redness. Resident #88 denied having any chest pain or shortness of breath or nausea or vomiting or abdominal pain. He has been having throbbing kind of pain in the left leg which he ranks as a 7-8/10 intensity. The doppler ultrasound of the legs did not show any evidence of deep vein thrombosis but significant erythema was observed. He was recently seen in the emergency room on 5/29/2025 at which time he was prescribed Keflex, but he has not been taking the medications. On 6/16/25 Resident #88 met with the hospital Case Manager and stated he no longer wanted to go to a long-term care facility and requested to be discharged. Resident #88 confirmed he planned to return to the "street". The Case Manager was able to provide a medication voucher for a one-month supply and noted the APS SW was made aware of Resident #88's decision. Resident #88 discharged AMA from the hospital on 6/16/25 and was known to be homeless. An interview with the DON occurred on 6/20/25 at 10:35 AM and revealed Resident #88 had a history of drinking alcohol outside of the facility for quite some time but he started to bring the alcohol on campus. She stated staff found beer in the courtyard and in his room. The	F0627		

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F0627 SS = J	Continued from page 24 DON explained the facility tried to discharge him to an adult care home and tried to get him into an alcohol detoxification program, but he refused. She stated the Medical Director started him on medication to curb his withdrawal symptoms and his leave of absence privileges from the facility were revoked on 5/14/25. The DON stated she was not at the facility on 5/18/25 when Resident #88 left but stated Unit Manager #1 called and explained on 5/18/25 he signed out of the facility and left the campus even though he had physician's orders to stay at the facility. She stated he knew that if he left, it would be AMA. She stated Unit Manager #1 tried to give Resident #88 his belongings, but he only took his cigarettes and refused to sign the AMA form. The DON stated she could not recall if Resident #88 signed any document agreeing to the plan but knew he had been educated because she was part of the meeting. The DON stated she did not have the expectation that Unit Manager #1 should have called an ambulance on 5/18/25 because she knew Resident #88 would refuse treatment and he was not in any acute distress to her knowledge. An interview with the Administrator occurred on 6/20/25 at 11:22 AM and revealed Resident #88 signed himself out of the facility daily to drink and panhandle on the street which he had witnessed in the past. He stated they attempted a discharge notice to an adult care home, but Resident #88 refused to disclose his financial information. The Administrator stated they also attempted to send him to an alcohol treatment program for detoxification and Resident #88 refused when they came to evaluate him. He explained Resident #88 started to drink alcohol in his room and other places on campus and staff had to come in and remove the alcohol in the weeks leading up to 5/18/25. The Administrator stated he contacted law enforcement to assist in searching Resident #88's room for alcohol. He stated the Medical Director decided it was too risky for Resident #88 to leave the facility campus and prescribed some medication that would help with alcohol withdrawal symptoms. He additionally stated Resident #88's privileges to leave the building were taken away on 5/14/25. The Administrator stated Resident #88 received education from himself and the Medical Director on 5/14/25 that if he left the facility, they would not take him back and it would be considered an AMA discharge. The Administrator stated he reminded Resident #88 again after the meeting that if he left the facility, it would be considered an AMA discharge. He stated after he was discharged on 5/18/25, APS was able to pick him up as a client. The Administrator stated he thought APS might be able to convince him to go to the hospital for treatment. The APS SW came to the facility on 5/20/25 asking for clarification on	F0627		

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F0627 SS = J	Continued from page 25 what Resident #88 looked like as the person she saw had a darker skin tone and Resident #88 was reported to APS as Caucasian. The Administrator stated he verified Resident #88 as having a darker skin tone and explained he saw Resident #88 at the convenience store on his way into work on 5/20/25 but did not intervene. The Administrator clarified on 5/18/25, Resident #88 did not come back into the building but asked to come back inside.	F0627		
F0641 SS = A	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §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. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (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 (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. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by:	F0641		07/30/2025

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F0641 SS = A	Continued from page 26 Based on record review and staff interviews, the facility failed to accurately code the discharge status on a Minimum Data Set (MDS) Assessment for 1 of 1 resident reviewed for discharge (Resident #90). The findings included: Resident #90 was admitted to the facility on 3/26/25. Review of the discharge Minimum Data Set (MDS) Assessment dated 4/11/25 indicated Resident #90 was discharged to a short-term general hospital. Review of a nursing progress note dated 4/11/25 indicated Resident #90 was discharged home with family. An interview with the MDS Nurse #1 on 6/19/25 at 11:46 AM was conducted. She stated the discharge MDS for Resident #90 should have been coded as discharged home. The MDS Nurse #1 stated Resident #90 was admitted from the hospital and discharged home. An interview with the Director of Nursing (DON) on 6/20/25 at 10:34 AM revealed the correct areas should have been selected for admission and discharge on the MDS. During an interview with the Administrator on 6/20/25 at 11:21 AM he indicated the MDS should be completed accurately.	F0641		
F0657 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. (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.	F0657	F657/ – Care plan timing and revision 1)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident # 23 care plan was reviewed and revised for completion and accuracy by Minimum Data Set (MDS) Coordinator on 6/19/25. 3) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; Quality Review was conducted on 7/21/25 for all residents to ensure comprehensive care plan completion. MDS staff to ensure all comprehensive care plans are	07/30/2025

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F0657 SS = D	Continued from page 27 (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 record review and staff interviews, the facility failed to develop an individualized person-centered comprehensive care plan in the areas of dialysis, Activity of Daily Living (ADL), insulin use, (Resident #23) for 1 of 20 residents reviewed for comprehensive care plans. The findings included: Resident #23 was admitted to the facility on 4/7/25 with diagnoses of end stage renal disease, encephalopathy, and diabetes. A review of the admission Minimum Data Set (MDS) dated 4/14/25 indicated Resident #23 needed supervision to total assistance with ADL's. Resident #23 was also coded for insulin use, and dialysis. The MDS did not indicate Resident #23 exhibited any behaviors or rejection of care. The Care Area Assessment (CAA) on 4/14/25 indicated Resident #23 had a care area of ADL functional/rehab potential triggered. The CAA also indicated that Resident #23's ADL functional/rehab potential care area was addressed in the care plan. A review of Resident #23's electronic medical record (EMR) revealed a physician's order for dialysis three times a week. The EMR further revealed physician orders for Humalog injection solution (an insulin medication used to manage blood sugar levels), 100 unit/mg to be given subcutaneously before meals and at bedtime.	F0657	Continued from page 27 developed, completed and accurately reflect residents' plan of care. Review was completed on 7/21/25 and concluded that no other deficiencies noted requiring completion and/or revision at this time. 3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not re-occur; MDS staff was re-educated by the Regional MDS Coordinator on 7/21/25 on the RAI process and the components of this regulation with emphasis on the requirements for accuracy and timely development and completion of care plans within 7 days of completion of the comprehensive assessment for all residents. Newly hired MDS staff will be educated by MDS Educator/Regional MDS/Designee on the RAI process and components of this regulation during orientation. 4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place; The Director of Clinical Services/MDS/designee to conduct quality review new admitted residents care plans x 4 weeks, and then every 2 weeks x 2 months then PRN as indicated.. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly by The Director of Clinical Services/MDS/designee to conduct quality review. Quality Review schedule modified based on findings. 5. Date of compliance 7/30/25.	

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F0657 SS = D	Continued from page 28 A review of Resident #23's care plan as of 5/26/25 revealed there was no care area in place for insulin use, behaviors, dialysis, or ADL functioning. An interview with MDS Nurse #1 on 6/19/25 at 11:18 AM revealed staff nurses completed the initial, baseline care plan and then the MDS Nurses were responsible for completing the comprehensive care plan. MDS Nurse #1 stated former MDS Nurse #2 left the facility in May 2025 and Resident #23's comprehensive care plan was overlooked. MDS Nurse #1 stated she should have reviewed all new admissions to make sure all residents had a comprehensive care plan. An interview with the Director of Nursing (DON) on 6/20/25 at 10:28 AM revealed the comprehensive care plan was developed from the MDS and interdisciplinary team meetings, which occur weekly. She had the expectation Resident #23 would have a comprehensive care plan that addressed all his needs completed in the appropriate time frame. An interview with the Administrator on 6/20/25 at 11:19 AM revealed he had the expectation that Resident #23 would have a more thorough care plan.	F0657		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff and physician interviews, the facility failed to transcribe an order of lorazepam gel (a medication used to treat anxiety) from the hospital discharge record to the electronic medical record (EMR) for Resident #23. Additionally, the failed to report a low heart rate of 46 (normal heart rate is 60 to 100 beats per min) to the medical provider prior to surveyor stopping Nurse #9 from administering Metoprolol (medication that lowers heart rate and blood pressure) to Resident #41. The facility also failed to follow an order to remove a lidocaine (topical pain medication) patch at bedtime	F0658	F658 Services Provided Meet Professional Standards (1)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. On 6/17/25 order was clarified by Nurse Manager with Medical Director, obtained and transcribed for resident #23 to the resident's facility EMR. On 6/18/25 order was updated in PCC by Nurse Practitioner providing directions with administration hold parameters for resident #41 to hold administration of hypertensive medication if HR & BP fall outside of parameters. On 7/18/28 order was given by Medical Director to Director of Clinical services to remove lidocaine patch and document removal of patch at bedtime or after 12 hours for resident #79.	07/30/2025

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F0658 SS = D	Continued from page 29 for Resident #79. This was for 3 of 5 residents reviewed for professional standards of practice. The findings included: 1. A review of Resident #23's hospital discharge summary dated 4/7/25 listed lorazepam gel .5mg/ml to be applied to the neck or wrist topically every 24 hours as needed. Resident #23 was admitted to the facility on 4/7/25 with diagnoses of end stage renal disease, depression, and diabetes. A review of the admission Minimum Data Set (MDS) dated 4/14/25 indicated Resident #23 was cognitively intact. A review of a nursing progress note dated 4/30/25 read, in part, that Resident #23 was soiled and refused to allow staff to provide care. Three attempts at hygiene were made and Resident #23 started to swing his fists on both nurse and nurse aide, striking both staff members on the arm and hand while repeating "No, no I'm going to wear this. I'm not taking this off." A review of a Psychiatric-Mental Health Nurse Practitioner (PMHNP) progress note dated 5/20/25 revealed, in part, Resident #23 was currently managed with lorazepam gel as needed for anxiety, which was well-tolerated without reported side effects. Plan to continue current lorazepam gel as needed regimen. Staff to maintain safety and provide supportive measures. Psychotherapy was recommended as an adjunct treatment. Staff to closely monitor mood and behaviors, given Resident #23's history of non-compliance with medication. A review of an additional nursing progress note dated 6/16/25 revealed Resident #23 swung at Nurse Aide #1 with his fist and towel attempting to hit her. He was upset about her throwing away his blue bag. Writer attempted to calm Resident #23 and he refused his medications. A review of Resident #23's Medication Admission Record (MAR) from April, May, and June 2025 was completed. Lorazepam gel was not listed as a medication from 4/7/25 until 6/16/25. A review of an additional Psychiatric-Mental Health Nurse Practitioner (PMHNP) progress note dated 6/17/25 revealed a new order for fluoxetine (a medication used to treat depression) and a new order for lorazepam gel 0.5 milligram (mg)-1mg every 6 hours as needed for	F0658	Continued from page 29 (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; On 7/22/25 Nurse Managers conducted quality review of current residents' medication admission records in last 90 days conducted to ensure all medications are transcribed as ordered to residents EMR. No additional affected residents were identified. Quality review of current residents receiving extended-release hypertensive medications conducted on 7/21/25 by unit manager/designee to ensure appropriate parameters are in place on medication orders to hold if results fall outside of parameters. Any observations noted were reviewed with the Medical Provider for clarification and addressed as directed. Quality review was conducted on 7/21/25 of active residents requiring use of lidocaine patches to ensure orders reflect removal after 12 hours and documentation of removal DCS/designee. Any observations noted were reviewed with the Medical Provider for clarification and addressed as directed. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur; On 7/23/25, the Regional Director of Clinical Services educated the Director of Nursing on the regulations regarding ensuring services provided or arranged by the facility as outlined by the resident's comprehensive care plan meet professional standards of quality. To ensure that all admitting residents' discharge medication admission records will reviewed prior to admission and medications will be transcribed as ordered to the residents' electronic medical record. The facility medical provider will review medications, clarify any orders and provide any necessary medication administration parameters for nursing to follow. If, nursing identifies any abnormalities they will be reported to the medical provider to obtain further	

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F0658 SS = D	Continued from page 30 agitation/aggression was added. A review of Resident #88's electronic medical record (EMR) revealed a PMHNP order written on 6/17/25 for lorazepam gel 0.5mg-1mg every 6 hours as needed for agitation/aggression with a maximum dose of 3 milliliters (mL)/3 doses in 24 hours and to hold for sedation. An interview with the PMHNP on 6/19/25 at 10:28 AM revealed Resident #23 became agitated and physically aggressive when staff tried to clean or adjust anything in his room. The PMHNP indicated that in her note on 5/20/25, the reference to the lorazepam gel was from a previous order at Resident #23's old facility. She stated the previous facility staff stated the lorazepam gel was effective for his anxiety. The PMHNP stated she was not aware Resident #23 ever had an order for the lorazepam gel at his current facility. An interview with the Medical Director on 6/19/25 at 12:41 PM revealed he was not aware of the lorazepam gel order when Resident #23 was admitted. He stated he would have wanted a discussion with the facility about the lorazepam gel. The Medical Director stated he would have probably referred to the PMHNP to see if the medication was appropriate for Resident #23. An interview with Nurse #4 on 6/19/25 at 3:37 PM revealed she did not recall admitting Resident #23 on 4/7/25 but stated when a new admission arrived at the facility, nursing had 24 hours to process the admission. She stated sometimes the task of adding the medications to EMR was delegated to the nurse by the unit manager. She did not recall an order for lorazepam gel for Resident #23. An interview with the Director of Nursing (DON) on 6/20/25 at 10:23 AM revealed Resident #23 had a history of combative behaviors but since he was admitted he was not combative but refused care. She stated the medications were put in the EMR by the admitting nurse and the discharge summary would be given to the provider and the provider could then decide to add or take away any medications or treatments. The DON had the expectation that the lorazepam gel would have been added to the MAR because it was a continued medication on the hospital discharge summary. She stated if there was a question about a medication listed, she had the expectation the admitting nurse would contact the provider for clarification. An interview with the Administrator on 6/20/25 at 11:13 AM revealed Resident #23 became agitated when he	F0658	Continued from page 30 directives regarding medication administration or treatment. Nurses will follow physicians' orders as directed, administering medications and providing treatments as the orders is written and appropriately signing off on the medication record once completed. On 7/23/25, the Director of Nursing, Nurse Managers and or administration educated licensed nurses on ensuring services provided or arranged by the facility as outlined by the resident's comprehensive care plan meet professional standards of quality. To ensure that all admitting residents' discharge medication admission records will reviewed prior to admission and medications will be transcribed as ordered to the residents' electronic medical record. The facility medical provider will review medications, clarify any orders and provide any necessary medication administration parameters for nursing to follow. If, nursing identifies any abnormalities they will be reported to the medical provider to obtain further directives regarding medication administration or treatment. Nurses will follow physicians' orders as directed, administering medications and providing treatments as the orders is written and appropriately signing off on the medication record once completed. The Director of Nursing or Nurse Managers will educate licensed nurses who were not educated on 7/23/25 prior to working their next scheduled shift. Newly hired staff will be educated in orientation by the Director of Nursing or Nurse Managers. 4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place; The Director of Clinical Services/designee to conduct quality review of 5 resident medication admission records weekly x 4 weeks, and then every 2 weeks x 2 months then PRN as indicated. The Director of Clinical Services/designee to conduct quality review of 5 resident's medication admission records to ensure calibrations are completed and appropriately documented weekly x 4 weeks, and then every 2 weeks x 2 months. ADHOC QAPI conducted 7/18/25 with the Interdisciplinary Team and Facility Medical Provider to discuss overall survey results and citations.	

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F0658 SS = D	Continued from page 31 returned to the facility from his dialysis treatments and became upset when people were near his belongings. He stated the provider would have clarified any order when they completed their initial visit. The Administrator had the expectation that the admitting nurse should have processed the lorazepam gel and called the provider for clarification. 2.Resident #41 was admitted to the facility on 7/1/21 with diagnosis that included hypertension (high blood pressure) and cerebral infarction (brain tissue dies due to lack of oxygen supply to the brain). A review of the quarterly Minimum Data Set (MDS) dated 5/5/2025 revealed Resident #41 was alert, disoriented to place, time, person, and event, speech was clear, and had a severe cognitive deficit. A review of the physician orders as of 6/18/25 revealed medication orders for: -Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 milligrams (MG) to give 1 tablet by mouth one time a day for hypertension dated 1/16/25. -Amlodipine Besylate Oral Tablet 10 MG, give 1 tablet by mouth one time a day for hypertension. Hold if systolic blood pressure is less than 110 dated 1/16/25 An observation and interview on 6/18/2025 at 8:43 AM revealed that Nurse #9 prepared morning medication that included Metoprolol 25 milligrams (mg) and Amlodipine 10 mg in two separate medication cups. She then stopped the Nurse Practitioner to ask if she should give the Amlodipine 10 mg if Resident #41's heart rate was 46 beats per minute (bpm). The Nurse Practitioner stated, Amlodipine would be okay to administer. Nurse #9 placed the Amlodipine tablet in the medicine cup with the Metoprolol 25 mg and proceeded to give the medications to Resident #41. Surveyor stopped Nurse #9 and asked if she should give the Metoprolol with a heart rate of 46 beats per minute. Nurse #9 stated, she did not have parameters to hold Metoprolol. The Nurse Practitioner stated, "You do not have to have parameters to know to hold Metoprolol for heart rate less than 60 beats per min (bpm)." Nurse #9 stated she did not know you had to check for heart rate if there were no parameters written. The Nurse Practitioner manually checked Resident #41's pulse by listening to his heart with her stethoscope. The Nurse Practitioner instructed Nurse #9	F0658	Continued from page 31 The Executive Director will introduce the plan of correction to the Quality Assurance Performance Improvement Committee on 8/19/25. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Clinical services, Assistant Director of Clinical Services, Unit Manager, Director of Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, Minimum Data Set Nurse, and a minimum of one direct care giver. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly x 3 or until committee determines substantial compliance has been met. Date of Compliance : (7/30/2025)	

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F0658 SS = D	Continued from page 32 to hold the Metoprolol for the day and wrote an order to not give Resident #41 Metoprolol 25 mg if his heart rated was less than 60 bpm. An interview with the Medical Director was completed on 6/19/25 at 1:00 PM. The Medical Director stated that Resident #41 should have had parameters for the Metoprolol. The Medical Director stated that Nurse #9 should not give Metoprolol with a heart rate of 46 beats per minute until she had notified the provider. An interview with the Director of Nursing (DON) was completed on 6/20/25 at 10:49 AM. The DON stated she would have contacted the provider to hold the medication. The DON reported that if a nurse was unsure of medication, Nurse #9 could have checked in Point Click Care to check information regarding medication information. 3.Resident #79 was admitted to the facility on 1/19/23 with a diagnosis of left knee pain and left knee contracture. A review of Resident #79's admission Minimum Data Set (MDS) assessment dated 5/25/25 revealed she was severely cognitively intact. She had pain almost constantly. Her pain affected her sleep and interfered with her daily activities almost constantly. Resident #79 rated her pain as a 10 on a zero to 10 scale with zero being no pain and 10 being the greatest pain. Resident #79’s active physician's orders as of 6/19/25 revealed a physician's order dated 12/27/23 for a lidocaine (topical pain medication) 5 percent (%) patch to be applied topically to Resident #79's left knee in the morning for pain and remove at bedtime. An observation on 6/18/25 at 9:30 AM revealed Nurse #11 removed the lidocaine patch from Resident #79’s left knee prior to administering the lidocaine patch to Resident #79’s left knee as ordered. Nurse #11 stated that “someone must have forgot to take the patch off last night.” Resident #79's June 2025 Medication Administration Record (MAR) revealed documentation indicating Nurse #10 signed she had removed the lidocaine 5% patch from	F0658		

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F0658 SS = D	Continued from page 33 Resident #79's left knee on 6/18/25 at 9:00 PM. The phone interview with Nurse #10 on 6/20/25 at 1:40 PM revealed that Nurse #10 could not remember if she had taken the lidocaine patch of Resident 79's left knee. Nurse#10 stated she must have signed off the medication record and forgot to take the lidocaine medication patch off Resident #79's left knee. An interview with the Medical Director was completed on 6/19/25 at 1:00 PM. The Medical Director stated that the lidocaine patch should not be on a resident longer than 12 hours because the absorption site would not be effective. Nurse #10 should have removed the patch at bedtime as ordered. An interview with the Director of Nursing (DON) was completed on 6/20/25 at 10:49 AM. The DON stated Nurse #10 should have followed the medication orders and removed the lidocaine patch form Resident #79's left knee as ordered.	F0658		
F0689 SS = D	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 observation, record review, and resident and staff interview, the facility failed to implement the smoking policy for storage of smoking supplies (cigarettes/lighter) for 2 of 3 residents sampled for supervision to prevent accidents (Resident #85 and Resident #13). The findings included: A review of the facility's undated Smoking Agreement, undated Smoke Break Rules and undated Designated	F0689	F689 – Free of Accident Hazards/Supervision/Devices 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Smoking materials were removed from resident #13 and resident #85 on 7/23/25 by Executive Director. The residents were educated on 7/23/25 on the facility policy and procedure related to smoking, designated resident smoking times and smoke break rules, and resident smoking agreement. (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; Executive Director/designee conducted a quality review of 100% current resident rooms that are smokers. On 7/23/25 with the residents' consent and in their presence. The executive Director searched the rooms to ensure rooms are free of accident hazards as it pertains to smoking materials.	07/30/2025

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F0689 SS = D	Continued from page 34 Smoking Times documents, indicated that smoking materials and incendiary devices (something that is capable of causing a fire or designed to start a fire) would at no time be stored in the residents' rooms. Smoking materials would be secured by the facility including lighters, cigarettes and e-cigarettes. The policy indicated that all residents who smoked would be evaluated for smoking safety upon admission, quarterly, at the time of a change in condition or if staff had a concern that re-evaluation was necessary. 1. Resident #85 was admitted to the facility on 03/21/25 with diagnoses which included nicotine dependence. A safe smoking assessment dated 03/21/25 revealed Resident #85 was a safe smoker, and the facility stored his smoking materials. A review of Resident #85's admission Minimum Data Set (MDS) dated 03/28/25 revealed the resident was cognitively intact and independent for most activities of daily living (ADLs). The MDS indicated Resident #85 ambulated independently in the facility. A review of Resident #85's care plan, revised on 04/10/25, revealed he was an unsupervised smoker. The goal was for Resident #85 to smoke independently through the next review date. Interventions included instructing the resident about smoking risk and hazards, instruct the resident about the facility policy on smoking. An observation was conducted of Resident #85 on 06/17/25 at 11:03 AM. Resident #85 was observed ambulating out of the facility door into the smoking area. He sat down in a chair, pulled out a lighter and one pack of cigarettes from his left side shirt pocket. Resident #85 was observed to smoke one cigarette and when he was finished he placed the smoking materials back into his left side shirt pocket and reentered the facility. An observation and interview was conducted of Resident #85 on 06/18/25 at 2:57 PM. Resident #85 was observed lying in bed with Nurse Aide (NA) #4 at bedside. NA #4 proceeded to pull out two packs of cigarettes and one lighter from the resident's bedside top dresser drawer to show the surveyor Resident #85 kept his smoking supplies at his bedside. Resident #85 stated he had always kept his smoking supplies in his room since admission and was aware of the smoking agreement/policy. He stated nobody had ever mentioned to him that he could not keep supplies in his room.	F0689	Continued from page 34 Any concerns noted were addressed as identified. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not re-occur; On 7/23/25 the Regional Director of Clinical Services and/or Regional Vice President of Operations educated the Executive Director and Director of Nursing on the regulations regarding ensuring that the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents as it pertains to smoking. Residents must adhere to facility smoking policy and rules regarding smoking. Scheduled smoke break times and safe storage of all smoking supplies/material are a requirement and must be followed by all smoking residents, at no time should a resident store any smoking materials in their room. Family members were informed that any smoking material purchased for a resident must be turned into management or their nurse it can never be handed over to the resident. On 7/23/25, Executive Director educated the interdisciplinary team on the facility smoking policy and smoking agreement for residents. On 7/23/25, the Executive Director and or administration educated licensed nurses on the facility smoking policy, smoking agreement for residents and ensuring resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents as it pertains to smoking. The Executive Director or designee will educate all staff who were not educated on 7/23/25 prior to working their next scheduled shift. Newly hired staff will be educated in orientation by the Executive Director or designee. On 7/23/25 the facility smoking monitors and CNA's were educated on the policy and procedure as it relates to smoking, the smoke break rules and times, and expectations that they are to notify management if a resident is observed not complying with the smoking policy and rules. On 7/23/25 all smoking residents and their responsible parties were educated on the policy and procedure as it relates to smoking, provided a copy of the policy as	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0689 SS = D	Continued from page 35 An interview was conducted on 06/18/25 at 3:05 PM with NA #4. She stated she thought all residents in the facility were supposed to keep their smoking supplies in their assigned lockers located outside in the smoking area, however, when she asked Resident #85 about his smoking materials he stated to her he had the materials in his bedside dresser. NA #4 stated she was going to notify the nurse. On 06/17/25 at 12:10 PM an interview was conducted with the facility Smoking Monitor #1. He stated he had been hired solely for monitoring the residents in the facility who smoked. The interview revealed his job was to ensure the safety of the residents while smoking and ensure he (Smoking Monitor #1) was outside during the smoking times. He stated the facility had a locker to keep residents' smoking materials in, each resident was assigned a locker, however, some of the residents were not keeping their materials in the assigned locker such as Resident #85. The interview revealed he (Smoking Monitor #1) had a difficult time with some of the residents keeping their smoking supplies when they went back in the building. He indicated the residents called him a "snitch" if he told them to put the supplies in their assigned locker so he had gotten to the point that he didn't want to say anything to them. He stated he had told the Administrator the residents were keeping their smoking supplies several weeks prior but to his knowledge it was ok that the residents were keeping their smoking supplies because the residents were independent smokers. On 06/19/25 at 2:38 PM an interview was conducted with Unit Manager #1. During the interview she stated residents smoking supplies were supposed to be kept in the residents' lockers. The facility tried to keep the smoking supplies locked up however families would bring in materials without their knowledge. She stated Resident #85 was an independent smoker and she wasn't aware of him having his smoking materials in the room. The interview revealed the facility had Smoking Monitor #1 that was supposed to watch the residents place their smoking supplies into their lockers and to let staff know if a resident was non-compliant. She stated she had not been notified that Resident #85 was non-compliant. On 06/19/25 at 9:07 AM an interview was conducted with the Director of Nursing (DON). During the interview she stated Resident #85 was non-compliant with keeping his cigarettes in the assigned locker and family members would bring in smoking materials without the facilities knowledge. The DON stated she felt like the Smoking	F0689	Continued from page 35 well as copy of the smoke break rules with designated smoke break times and the smoking agreement. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place; The Executive Director/designee with consent of the resident and in the residents' presence, will conduct quality monitoring of 5 resident rooms on each unit to ensure rooms are free of accident hazards as it pertains to smoking materials twice weekly x 4 weeks, then weekly x 2 weeks then twice monthly and PRN as indicated. ADHOC QAPI conducted 7/18/25 with the Interdisciplinary Team and Facility Medical Provider to discuss overall survey results and citations. The Executive Director will introduce the plan of correction to the Quality Assurance Performance Improvement Committee on 8/19/25. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Clinical services, Assistant Director of Clinical Services, Unit Manager, Director of Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, Minimum Data Set Nurse, and a minimum of one direct care giver. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly x 3 or until committee determines substantial compliance has been met. Date of Compliance : (7/30/2025)	

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F0689 SS = D	Continued from page 36 Monitor #1 was helping with smoking compliance in the facility, but he needed to remind the residents to keep their smoking materials in their lockers. On 06/17/25 at 11:38 AM an interview was conducted with the Administrator. During the interview he stated he had multiple meetings with the residents about turning their smoking materials back in prior to re-entering the facility. He stated he had placed lockers in the smoking area and each resident had their own assigned key. The interview revealed he had attempted to confiscate materials, but the residents became upset. The facility had hired Smoking Monitor #1 to solely watch the residents during smoking times. He stated Resident #85 was non-compliant with the smoking policy, however it was a difficult situation because it would be hard to find him placement at another facility if they issued him a discharge notice for not following the smoking policy. Brown, Lynda 2. Resident #13 was admitted to the facility on 10/26/2023 with diagnoses which included incomplete paraplegia (partial paralysis of the lower body), chronic pain, orthostatic hypotension and generalized muscle weakness. Resident #13 was his own responsible party. He was in a private room and did not use oxygen. A smoking assessment dated 1/20/2025 revealed Resident #13 was a safe smoker. A review of Resident #13's care plan revised on 5/7/2025 revealed he was a safe smoker. The goal was that Resident #13 would not suffer any injury from unsafe smoking practices through the review date. Interventions included observing Resident #13's clothing and skin for signs of cigarette burns. A review of Resident #13's quarterly Minimum Data Set (MDS) assessment dated 5/7/2025 indicated the resident was cognitively intact and required maximum assistance with most Activities of Daily Living (ADL) and transfers from bed to wheelchair. The MDS indicated Resident #13 utilized a power wheelchair for mobility. On 6/17/2025 at 9:29 AM an interview with Resident #13 revealed he was a smoker. When asked what process he followed if he wished to smoke, he stated he asked staff to get him into his power wheelchair and he went to smoke. When asked if he stored his smoking materials	F0689		

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F0689 SS = D	Continued from page 37 and lighter with staff, he stated he handled that himself. When asked if he kept his smoking materials and lighter in his room, he stated he would not answer that question. An interview on 6/17/2025 at 10:02 AM with Nurse #3 indicated that Resident #13 generally kept his own smoking supplies (cigars and lighter) in his room. Nurse #3 stated Resident #13 was a safe smoker but did not comply with storing his smoking supplies in the lockers provided in the smoking area. An observation of Resident #13 on 6/17/2025 at 11:05 AM revealed approximately 12 cigars openly in view in a side pocket of the resident's backpack hanging on the back of his power wheelchair. Resident #13 was outside in the designated smoking area sitting in his power wheelchair next to a small table smoking a cigar in a safe manner. His lighter was on the table. An observation of Resident #13 on 6/18/2025 at 1:15 PM revealed the resident outside sitting in his power wheelchair near the front entrance while he waited on transportation. The cigars remained in open view in the side pocket of his backpack. He was not smoking at the time. On 6/17/2025 at 11:26 AM an interview with the Administrator revealed there were compliance issues with the smoking policy and the Administrator was working on these issues. He stated that the residents' family members brought in smoking materials, and it was difficult to monitor. The facility provided lockers for smoking materials, but most of the residents would not use the lockers. The facility hired Smoking Monitor #1 who had been working about 3 weeks. The Administrator stated he had called the Ombudsman for advice about the smoking issue and also held a Town Hall meeting that the Ombudsman attended to discuss the smoking policy with the residents. On 6/17/2025 at 12:14 PM an interview with Smoking Monitor #1 revealed that he worked 8:00 AM to 2:00 PM. He stated his job was to sit outside during the smoking times to monitor the residents. He stated the smoking times were 9:00 AM, 11:00 AM, 2:00 PM, 4:00 PM and 7:00 PM as unsupervised smoking was not permitted by the facility. He indicated he had tried get the residents to put their smoking materials and lighters in their lockers. He stated the residents were given a key to their individual locker and every day he asked the residents to use the lockers, but most became angry and just keep moving through the door back into the	F0689		

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F0689 SS = D	Continued from page 38 facility at the end of their smoke break. Smoking Monitor #1 estimated about 4 residents used the lockers. He stated he had been instructed not to confront Resident #13 about using his locker or relinquishing his smoking materials and lighter as Resident #13 would curse at staff. He stated Resident #13 kept his own cigars and lighter. On 6/17/2025 at 2:10 PM a telephone interview with the Ombudsman revealed that she had been in the building for another matter and had been invited to attend the Town Hall meeting. The Administration wanted to accommodate the residents who smoked as had recently received several new admissions from another facility and most were smokers. During the Town Hall meeting, not all of the residents who smoked were present. None of the residents had questions. The Administrator spoke with the Ombudsman twice over the phone requesting assistance with a new smoking plan as the old plan did not suit the new admissions. The Ombudsman stated she reviewed the residents' rights regarding smoking with the Administrator. She stated the facility's smoking policy would determine how the residents' smoking materials were managed. On 6/17/2025 at 2:15 PM an interview with Unit Manager #2 revealed Resident #13 kept his own smoking materials and lighter. She stated the facility tried to take his smoking materials in the past and store them with staff but was not successful as Resident #13 ordered more through delivery. She stated he was a safe smoker. On 6/18/2025 at 8:20 AM an interview with Nursing Aide #3 indicated Resident #13 basically did what he wanted to regarding smoking and kept his own smoking materials and lighter in his room. She stated he was a safe smoker. On 6/18/2025 at 9:20 AM an interview with Nurse #1 indicated Resident #13 kept his smoking materials and lighter in his room and did not comply with staff keeping his smoking materials in his locker in the smoking area. On 6/19/2025 at 3:15 PM an interview with the Social Worker indicated Resident #13 had a smoking assessment completed on admission and was found to be a safe smoker. He declined to sign a smoking agreement, and she stated there was not much she could have done about that. She indicated it was his right not to sign. The Social Worker stated she was aware he had his smoking supplies and lighter in his room. She stated Resident #13 ordered his smoking supplies and lighters through	F0689		

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F0689 SS = D	Continued from page 39 the mail and the facility could not search his packages. She indicated law enforcement had to be involved for the facility to search his room. She stated he stayed outside most of the day and had no incidents of smoking inside the facility. On 6/20/2025 at 10:57 AM an interview with the Director of Nursing (DON) indicated she was aware Resident #13 had his smoking materials and lighter in his room. She stated he ordered his own smoking materials and lighters and did not feel there was much the facility could do. He was non-compliant with almost everything and usually would not sign any documents including those related to smoking. On 6/20/2025 at 11:58 AM with the Administrator revealed he continued to work on the issues that existed around the residents smoking. Resident #13 was a challenging resident and had not complied with the smoking policy regarding turning his smoking materials and lighter over to staff.	F0689		