STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455477	A. Building B. Wing	06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Jackson Healthcare Center	413 Garland Dr Lake Jackson, TX 77566

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38530 Based on observation, interview and record review, the facility failed to ensure residents were free from neglect for 1 of 8 residents (CR #2) were reviewed for neglect. The facility admitted CR #2 to the facility after identifying he required services of one on one supervision of two staff which they were unable to provide. The facility failed to train staff how to care for CR #2 who had diagnosis of autism and required behavior management. The facility failed to provide CR #2 with the behavior management and supervision he required which resulted in CR #2 physically assaulting Resident #1. After being admitted to the facility for approximately 13 hours the facility had to call the police to physically restrain and remove CR #2 from the facility due to staff inability to care for him and protect CR #2 from himself, other residents, and staff. These failures placed residents at risk of abuse, neglect, decline in health, and being displaced or hospitalized . Findings include: Record review of CR #2's facesheet revealed a [AGE] year-old male admitted to the facility on [DATE] and discharged on [DATE]. CR #2's condition listed upon discharge was unstable. Further review of the facesheet listed no diagnoses. Record review of CR #2's hospital records dated 4/19/21 revealed he was admitted to the hospital on 3/24/21 for possible seizures. Further review of the hospital record revealed CR #2 had a medical history of seizures and mental retardation. CR #2 hospital notes dated 3/28/21 revealed he had autism which required supportive care, monitoring for safety, and case management consult for placement as he was unable to return to group home and family unable to care for him. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of CR #2's hospital notes dated 3/29/21 - 4/19/21 revealed, note dated 3/29/21 indicated CR #2 needed behavioral management and was to be started on Seroquel and Risperdal and was going to transfer CR #2 for behavioral health. Hospital note dated 3/30/21 indicated CR #2's behavior improved with medications. Hospital notes dated 3/31/21 - 4/8/21 indicated CR #2 required monitoring and supportive care for autism and 1 on 1 supervision for behavioral health. Hospital note dated 4/9/21 revealed in part, . yesterday around 6pm patient with severe agitation and aggression kicking and hurting staff, multiple medications Geodon, Haldol, and Ativan given to calm patient down currently patient is in bilateral wrist restraints still trying to get out of bed very aggressive agitated, per RN still eating and taking medications added Klonopin to medication regimen we will continue to monitor the patient, discussed with nursing staff and case management will initiate transfer to behavioral health hospital . Hospital notes dated 4/10/21 revealed CR #2 had a sitter at bedside and continued with increased agitation and aggression. Risperdal was discontinued and started on Seroquel. Resident was awaiting bed availability to be transferred to behavioral hospital. Hospital note dated 4/11/21 revealed CR #2 continued with sitter at bedside and increased agitation and aggression. Haldol was given which did not help. Resident was evaluated and not a candidate for behavioral hospital. Hospital notes dated 4/12/21 - 4/15/21 revealed CR #2 continued to have on and off agitation and aggression and require sitters at bedside. Resident behaviors were noted to be secondary to underlying mental disorder. Hospital note dated 4/16/21 - 4/19/21 revealed CR #2 required 2 sitters at bedside, had autism with behavioral problems, and was uncooperative with medications/labs/and treatment. Record review of CR #2's facility progress note dated 4/19/21 at 6:21PM, the DON noted in part, .Received resident via stretcher per ambulance transport. Resident admitted to the facility . diagnosis: seizures. Past medical history of autism. Full code. Awake, alert. Nonverbal. Drooling. Agitation and combativeness noted. Unable to be redirected. Non-compliant . Stage II pressure ulcer to sacrum. Unable to measure due to non - compliance . abrasion noted to right and left knee. Multiple scratches to upper extremity . decubitus ulcer noted to left heel. Unable to measure due to non-compliance. Adult brief in place . Tolerates medications crushed in apple sauce. Resident non-compliant. Resident began striking staff members with his fists and began scratching, kicking, biting, and grabbing staff members by their clothing and hair. Distraction and redirection unsuccessful. Resident continues to ambulate on and off without assistance. Resident proceed to take all items off of medication cart and throw them at staff. Resident attempted to pull his bed out of his room. Resident's safety ensured. NP phoned on ipad facetime and observed resident's behavior. New order to send resident to ER if behavior persists. Writer phone resident's RP and allowed him to hear RP voice. Resident began to lie face down on the floor and refused to get up with assistance. Resident proceeded to ambulate around the unit with bowel movement in brief and took it off. Resident refused to allow staff to help change his clothes into clean clothes. Writer administered some nightly medication from ER kit to which resident ingested and tolerated well. Staff member currently in resident room one on one to ensure safety. Bed locked in low position . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 4/20/21 at 5:00PM, the DON said CR #2 was a new admit and was combative and aggressive where they were unable to orientate him. She herself along with other staff members were unable to redirect him. She called the NP show her his behavior and she said if CR #2 did not calm down to send him out. The DON said they did end up calling 911 last night (4/19/21) around 11PM but by the time the police came out the resident had calmed down because they were able to administer some medication to him. The DON said she left the faciity on ce he had calmed down around 1:00AM. The DON said she was next contacted at around 7:07AM per her phone records and staff reported CR #1 was fighting staff again and trying to leave the building. She said she could hear them trying to redirect him without restraining him. She told the staff to go ahead and call 911 again. The DON the staff were not trained to handle a resident like CR #2, and they were not trained to physically restrain residents. She said since staff were unable to restrain him, they did their best to keep him safe and to try and stabilize him by moving things out of his way, offering snacks, and trying to walk with him. The DON said the staff were repeatedly hit, scratched, bitten, had their hair pulled, etc. by CR #2. The DON said she did not have experience with caring for resident's like CR #2 and tried her best to manage his behaviors. The DON said she saw in CR #1's hospital clinicals he had diagnoses of mental retardation and autism and said he was admitted to the facility after remaining in the hospital for about a month and a half. The DON said the clinicals from the hospital also indicated CR #1 had behavioral problems and required 2 hospital nurses to watch him so he would not hurt himself. The DON said because of his age, diagnoses, and requirement of 2 staff to supervise him he was inappropriate to be in the facility. The DON said the facility had a corporate team that handled admissions and the facility did not have a say in admitting the resident. The DON said she was forwarded CR #2 clinicals from the corporate admission team (the hospital records reviewed above) and when she saw the residents age, diagnoses and notes regarding behavior, she voiced the resident was inappropriate for the facility to the Administrator and CR #2 was admitted anyways. The DON said CR #2's behaviors were far worse than what they expected and when EMS transported the resident into the facility, they questioned why he was being admitted there because he was not their typical resident. The DON said when she got to the facility on [DATE] the cops were already there with CR #2 restrained. The DON said the staff were upset when she arrived because the police had to aggressively restrain CR #2 and they felt bad he had to be treated that way. Interview on 4/20/21 at 5:30PM, the Administrator said CR #2 was admitted into the facility on [DATE] after she had already left for the day. She said staff called her when CR #2 arrived and said he was in the building fighting the staff. The administrator said she called the corporate auditor who reviewed CR #2's before he was admitted , and the auditor told her CR #2 was autistic and would be combative because he does not like strangers. The Administrator said the DON did tell her before CR #2 arrived he required 1 on 1 supervision in the hospital but did not know he required 2 nurses to supervise him. The Administrator said she was not fully told of CR #2's behaviors and needs before he was admitted . The administrator said when CR #2 arrived, and they saw the magnitude of his behaviors the DON contacted the doctor and the doctor said to send the resident out. The Administrator said the last call she got was before 9PM and she did not hear anything after that, so she thought CR #2 was out of the building and did not know he stayed in the building overnight until around 7AM the next morning. The administrator said the next morning (4/20/21) the DON called her and said CR #2 was still in the building fighting staff. She said she called corporate auditor again and she said the resident just does not want to be touched. She said the staff had called 911. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of CR #2's progress notes dated 4/20/21 at 3:46AM, LVN C noted, Resident was up at the nurse's station resisting to go back to his room. Tried several times to redirect, unable to follow direction. Went to Resident #1's room, and pulled her head trying to yank her out of her bed and he was naked. This surely made her upset because she was up most part of the night talking to herself. Patient was finally taken to his room but was up moving the bed and other furniture around. He finally went to another room after all the commotion and slept. Resident is in stable condition. Will continue to monitor. Unable to take vital signs due to combative behavior. Interview on 6/3/21 at 12:26PM, LVN C said she worked from 10pm - 6am on 4/19/21. LVN C said CR #2 was moving up and down the halls when she came in and he was supposed to be on the quarantine hall (C Hall). LVN C said CR #2 had a nurse's aide to try and monitor him one on one but when nurse aides were busy with other residents he would try and leave out of the hall. LVN C said she was at the nurse's station when she saw CR #2 naked come off C Hall and walk very fast past the nurse's station and into Resident #1's room. LVN C said before she could even react CNA A and CNA B went running into the room behind him and redirected him out. LVN C said she could not tell what happened in the room, she just saw he was naked and had gotten very close to Resident #1. LVN C said she did not ask the CNA's what happened but overheard them talking about it and was not sure if CR #2 touched Resident #1. LVN C said she put in her notes what she heard but did not see what had happened inside the room. LVN C said she was not the nurse assigned to Resident #1, so she had not assessed her. LVN C said Resident #1 was laughing to herself and talking to herself all night after that and she never does that. LVN C said she thought Resident #1 might have seen CR #2 was naked and that's why she was acting the way she did the rest of the night. LVN C said after they got CR #2 out of Resident #1's room he was still in the hallway sitting on the floor and would grab and scratch at people, so they were dodging him. LVN C said when she came in, she did not know how bad CR #2's behaviors were. She said CR #2 had a nurse one on one with him during the day but overnight they were unable to keep one on one supervision for him because they had other residents to care for. LVN C said at the end of her shift she just put in her notes and left because things were so hectic overnight with CR #2. LVN C said she had not contacted the Administrator or DON overnight because she knew they were already aware of CR #2's behaviors. LVN C said they were not able to supervise him or watch him one on one overnight like they did during the day. LVN C said they had a CNA to stay with him, but she would have to leave to do some other work and CR #2 would come over to the other side of the hall. LVN C said just knew he had to stay overnight, and they were to manage him until the morning, but they were not given any instructions or training on how to deal with his behaviors. LVN C said CR #2 was not appropriate for the facility because of his age and diagnosis but she knew corporate had accepted the resident and there was nothing she could do. LVN C said she had never experienced anything like this before and did not know what to do but to just try and make it through her shift. LVN C said she had received training over abuse neglect and said she would report situations of abuse/neglect to the Administrator. LVN C said she was overwhelmed by the night and forgot to tell anyone about what happened. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 6/3/21 at 1:05PM, CNA A said she worked from 6pm - 6am on 4/19/20. CNA A said CR #2 came into the facility very unhappy. She said when he came in, she was told he was being watched by two people at all times while in the hospital. CNA A said there was 2 paramedics, 2 nurses, 1 medication aide, and 2 CNA's in CR #2 room trying to keep him in room and redirect him when he got to the facility. They were unable to assess him or get his vitals because of his combativeness. CNA A said the first few hours she stayed on C hall with CR #2 by herself and tried to keep him from leaving the hall. She said he wandered constantly and kept trying to leave off of the hall. CNA A said CR #2 eventually fell asleep and she left off the hall to check on other residents. CNA A said during the time no one was with him he woke up and came off of C hall and they were unable to get him to go back. CNA A said he spent most of the night sitting on the floor naked by the nurse's station. CNA A said CR #2 was standing in the doorway of C Hall and suddenly took off straight into Resident #1's room and went straight for her. She said CR #2 went over to Resident #1 and had her by the head trying to pull her out of the bed while he was naked. She said CNA B and LVN D went into first and redirected CR #2 away and was able to get him to let go of her. They then redirected CR #2 out of Resident #1's room. CNA A said Resident #1 top half of body (head, shoulders, and stomach) were hanging out of the bed. She said Resident #1 has a low bed and mat that is kept next to her bed so her top half of body was resting on the mat when she came in, she adjusted Resident #1 back in bed. CNA A said Resident #1 made a screaming noise when the incident happened, and she was restless the rest of the night but overall, she appeared okay and did not seem to have any injuries. CNA A said around 4AM they were able to get CR #2 back onto C-hall. CNA A said they did not know what to do or how to handle CR #2. She said CR #2 destroyed C Hall by turning over TV's, moving dressers, overflowing water in bathrooms, etc. CNA A said CR #2 kept trying to choke, scratch, and bite her when she was on C hall with him. CNA A said when CR #2 was admitted the EMS staff were confused as to why the resident was coming there because CR #2 was not the type of resident they had there. CNA A said the nurse (LVN C) did not do much to help with CR #2 overnight because she appeared to be very scared of CR #2. She said there was an agency nurse there as well overnight who tried to help but she did not know what to do either. CNA A said she questioned coming back to work after the night and said it was chaos all night long. CNA A said there was 3 CNA's in the facility until about 10PM but overnight they only had two CNA's, herself and CNA B, and two nurses, LVN C and the agency nurse . Phone interview attempted on 6/3/21 at 1:03PM with CNA B. He did not answer, and voicemail was left. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 6/3/21 at 2:44PM, LVN D said she was an agency nurse who came to work in the facility on 4/19/20 6pm - 6am. LVN D said she had come in a little late so when she arrived CR #2 was already there and staff were trying to deal with him. LVN D said CR #2 was naked with feces all over him and he kept coming on and off of C hall and they were trying to keep him on C hall. She said the DON called 911 and they came out, but they did not take the resident and said they needed to call someone else. LVN D said LVN C came in around 9 or 10 and the DON left after LVN D got there. LVN D said CR #2 slept for about 15 minutes and got up and started pushing the bed against the door, pulling the dressers out of the rooms, throwing supplies everywhere, and had feces everywhere. LVN D said she was down the hall when she heard the CNA's calling CR #2's name. She said when she looked what was going on, they were already bringing CR #2 out of Resident #1's room. LVN D said she did not know if CR #2 touched Resident #1 because they were already bringing him out when she got to the room and she did not ask. LVN D said Resident #1 was restless for the rest of the night and was calling out. She said the other staff she was usually like that so she was not sure if it was a change for her. LVN D said she did not know if CR #2 had touched Resident #1 because when she looked at her, she had a bump with skin missing on her chin but did not know if it was from the interaction with CR #2. LVN D said they were not given any special instruction on how to deal with CR #2 or how to redirect him. She said they were told by the DON to keep an eye on him and make sure he did not mess with the other residents. LVN D said everyone was checking on him the whole night. LVN D said she had been a nurse for [AGE] years and hadn't seen anything like that before. LVN D said she felt bad for the DON, because the DON had said she didn't know why they brought CR #2 there. LVN D said she felt the DON tried to do everything she could, but no one knew how to handle CR #2 and voiced she did not think CR #2 should have been admitted there. LVN D said CR #2 was still up on C hall when she left for her shift in the morning. Record review of CR #2's progress notes dated 4/20/21 at 9:39AM revealed, Resident wandering halls at 6:45AM with no clothing on. Provided animal crackers, he threw them at the staff. Provided fruit punch, he threw it at the staff. When resident was approached to attempt to be dressed, he scratched and bit CNA's. Resident urinated on the floor. Resident got out of the building through the back door into the street still unclothed at 7:00AM. CNA ushered him back inside where he shortly got out again. 911 was called at 7:30AM. Resident scratched CNA C on the chest and tugged on her shirt collar. Police arrived on the scene at 7:45AM, resident was placed on the ground outside and handcuffed. An officer placed him inside the building. A sergeant created a case number. Resident placed in a brief. Resident was provided pudding to eat, he spit it out. Resident was placed in a wrap at 9:10AM, still in handcuffs. Resident was hand fed oatmeal cookies and a bottle of sprite. 9:37AM EMT's transported him to the hospital. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 6/3/21 at 3:18PM, CNA C said she worked the 6am - 6pm shift on 4/19/21 and 4/20/21. CNA C said CR #2 was admitted towards the end of her shift on 4/19/21. She said EMS brought him in and placed him on the bed and he immediately tried getting up and walking around and would not stop trying so they let him get up. CNA C said they were told he was autistic and required some redirection. She said they were initially doing okay with redirecting him but then he became very aggressive towards staff and would throw the snacks they tried to provide him. CNA C said she left around 9pm and the night CNA (CNA A) took over watching him. CNA A said she returned the next morning for work (4/20/21) and got a crazy report about CR #2 overnight. CNA A said it was reported to her CR #2 was up all night wandering the halls and had pooped everywhere and spread feces on the wall. She said it was also reported CR #2 had gotten into Resident #1's room overnight and tried to remove her helmet from her head. CNA A said when she got onto C hall CR #2 was awake walking around roaming the hall. CNA A said CR #2 had wandered out an exit door at the end of C hall and was running around outside. She said they heard the door alarm and ran out behind him chasing him around outside. CNA C said CR #2 grabbed the collar of her scrubs and she was finally able to guide him back inside while he was holding on to her. She said once they got him back inside, he continued to attempt to run back outside and they tried blocking the doorway with a chair to detour him from the door, but he was able to get back outside again. She said CR #2 grabbed her by her collar again and she tried guiding him inside again, but he became very violent and was attempting to claw at her neck. CNA C said she had scratches and bites on her from CR #2. CNA C said as CR #2 was clawing at her neck the cops arrived and they had to tackle CR #2 and cuff him. CNA C said she was very upset CR #2 had to be handled like that because of his condition he did not know what he was doing or what was going on. CNA C added when CR #2 was admitted on [DATE] she heard the DON trying to explain to corporate CR #2 should not be admitted because the facility would be unable to meet his needs, but she said CR #2 came to the facility anyway. Record review of Resident #1's facesheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: hypertension, pruritis, vitamin deficiency, abnormal weight loss, muscle wasting and atrophy, and depersonalization - derealization syndrome. Record review of Resident #1's quarterly MDS dated [DATE] revealed a staff assessment for mental status which reflected Resident #1 had short- and long-term memory problems and her cognitive skills were severely impaired. Resident #1 was totally dependent on staff for transfer, eating, toilet use, and personal hygiene. Record review of Resident #1's progress notes dated 4/20/21 at 3:30AM, LVN D noted, Resident was in bed resting when another resident entered her room and tried to lay in her bed, resident was stopped by staff did not enter her bed, resident redirected out of room, has small red area to left lower face. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview on 4/20/21 at 4:00PM, the police officer said the facility had called the police the morning of 4/20/21 because they had a resident (CR #2) there who was assaulting staff. He said when he arrived CR #2 was physically assaulting a staff and had to be physically restrained. The officer said once inside the facility, he observed CR #2 had destroyed the inside of the facility. The officer said it was vaguely mentioned CR #2 had put another resident in a head lock but they did not seem to have much information about it. The officer said the staff main complaint was the resident was admitted to the facility yesterday (4/19/21) and facility administration tried to stop the admission because the facility was unable to care for someone like him but their corporate had already approved the admission and they had to admit the resident. He said the staff voiced that they did not know what to do or how to care for the resident. The officer had concerns that the CR #2 was admitted to the facility and they were not equipped to care for a resident with aggressive behaviors. The officer said this was not the first time the facility had to call the police for admitting a resident they could not care for and hoped something would happen to the facility so this would stop happening Interview on 4/20/21 at 5:10PM, the DON said she did not know of any incident with CR #2 entering Resident #1's room. The DON said no one called her overnight and it was not mentioned when she was called the next morning or when she got to the facility. The DON was notified by surveyor the officer who responded to the facility on [DATE] regarding CR #2, was told by facility staff that CR #2 had another resident in a head lock overnight and the staff also reported the facility was forced by corporate to accept CR #2 and they did not know what to do or how to handle the resident. The DON said she was not sure what the officer was referring to and said he did not mention anything to her about that when she got to the facility that morning. The DON said she had not been told of CR #2 having any interactions with other residents just the staff. The DON reviewed notes entered by the overnight nurses (LVN C and LVN D). The DON said the staff should have informed her and the administrator about what happened so they could investigate and report. The DON also said the facility overnight staff could have called 911 if they felt other residents were at risk from CR #2's behavior. The DON said she was going to contact the nurses and begin investigating what happened overnight with CR #2 and Resident #1. The DON said she did not know if the residents were assessed and did not see any documentation of an assessment. The DON said she would immediately have Resident #1 assessed for injuries and stated Resident #1 always wears a helmet because of her fall risks. The DON said there was supposed to be a CNA with CR #2 all night one on one. Interview on 4/20/21 at 5:35PM, the administrator said she did not know of CR #2 having any interactions with Resident #1 overnight. The Administrator reiterated she did not know CR #2 had remained in the building overnight until she was called the following morning. She said she would also begin to investigate and said the nursing staff should have informed them. The Administrator said the protocol was for the staff to immediately separate the two residents, assess them and document assessment, notify herself, the DON, the physician and the RP's about what had happened and proceed from there with investigating and reporting requirements. The Administrator said she did not know if the nurse had assessed the residents or if there were any injuries. Observation and interview on 4/20/21 at 6:00PM, Resident #1 was lying in bed. Resident #1 was unable to speak or answer any surveyor questions. She was wearing a helmet which was removed by staff for head to toe assessment. Residents arms, neck, face, chest, and head were observed with no obvious markings or injuries. Resident had a small spot on her chin which looked like a facial bump that had been scratched or picked with. The DON who was assisting with assessment said the bump was not a new mark for the resident and said it was skin irritation from Resident #1 wearing a mask and she may have picked with it causing the bump to bleed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Jackson Healthcare Center	413 Garland Dr Lake Jackson, TX 77566

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Observation and interview on 4/20/21 at 6:15PM, the DON was observed to call the NP and notify her Resident #1 was involved in an incident the previous night where CR #2 may have tried to pull her out of bed. The NP ordered for them to monitor Resident #1. The DON also informed the NP that the nurses were trying to reach Resident #1's RP to inform them of the incident as well. Interview on 6/18/21 at 11:35PM, the corporate staff said corporate had an admissions team that handled facility admissions. She said any referral the come in for the facility, central intake would review the clinicals and determine whether the resident was appropriate. The corporate staff said she reviewed CR #1's clinicals for him to be admitted and found him to be appropriate to be at the facility. She said per her notes, CR #2 was admitted to the hospital from a group home because he was having seizures. She said the records indicated CR #2 had developed a sacral pressure ulcer while in the hospital and he was non-verbal. The corporate staff said the records did indicate he had some agitation when he was admitted to the hospital, but he was provided medication to manage it. The Corporate staff denied knowing CR #2 required one on one supervision before he was admitted . She said if she knew, they would have been unable to admit CR #2 because it was against their policy to admit someone who required one on one supervision and said CR #2 would of needed to go at least 24 hours without needing one on one supervision in order for them to admit him. The corporate staff said once the facility found out CR #2 required one on one supervision; they should have cancelled the admission. The corporate staff was told the DON had voiced concerns about CR #2 being inappropriate and she said she was not sure who the DON or facility voiced their concerns to at corporate, but it was not her. The corporate staff said if she approved someone to be admitted and the facility has concerns, they are supposed to formerly submit a concern through e-mail. She ended by saying if the facility felt they could not care for CR #2 they should have denied the admission. Interview on 6/22/21 at 2:22PM, the hospital social worker said she attempted to contact the facility for CR #2 to return to the facility and was told he could not return because they were unable to care for him at the facility. The hospital social worker said the facility was aware of CR #2's diagnoses, behaviors and supervision needs before he was admitted on [DATE], so she questioned why they had previously accepted the resident. The hospital social worker said all of CR #2's information regarding his behaviors and supervision were included in clinicals provided to the facility to review before he was admitted . Record review of facility Admission Criteria policy (Revised December 2016) revealed in part, .Our facility will admit only those residents whose medical and nursing care needs can be met . 1. The objective out admission criteria policy are to: a. provide uniform criteria for admitting residents to the facility; b. admit residents who can be cared for adequately by the facility . e. assure that the facility receives appropriate medical and financial records prior to or upon the residents admission . 6. Residents will be admitted to this facility as long as their nursing and medical needs can be met adequately by the facility . 10. The acceptance of residents with certain conditions or needs may require authorization or approval by the Medical Director, Director of Nursing Services, and/or the Administrator. 12. The Administrator, through the Admissions Department, shall assure that the resident and the facility follow applicable admission policies . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility Abuse Prevention Program (Revised May 2020) revealed in part, . 2. Our residents have the right to be free from abuse, neglect, misappropriation of resident's property and exploitation . 5. Our facility will not condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect to their supervisor or to the Director of nursing services immediately . Recognizing signs and symptoms of abuse/neglect . 2. Neglect as defined at 483.5, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress . Further review of the policy revealed in part, . b. Signs of Actual physical neglect: vi. Inadequate provision of care . ix. Leaving someone unattended who needs supervision . 1. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect .

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38530 Based on observation, interview and record review, the facility failed to implement written policies and procedures to investigate allegations of abuse for 2 (CR #2 and Resident #1) of 8 residents reviewed for abuse. CR #2 physically assaulted Resident #1 and facility staff failed to assess residents and to report to abuse coordinator, resident responsible party, and physician after an allegation/incident of abuse. This failure placed all residents at risk of subsequent abuse. Findings included: Record review of the facility Abuse Prevention Program policy (Revised May 2020) revealed in part, . To aid in abuse prevention, all personnel are report any signs and symptoms of abuse/neglect to their supervisor or to the director of nursing . 1. The nurse will assess the individual and document related findings. Assessment data will include: a. Injury assessment; b. pain assessment; c. current behavior; d. patients age and sex; e. all current medications; f. other platelet inhibitors; g. vitals signs; h. behavior over the last 24 hours; j. all active diagnoses; k. any recent labs . 1. All alleged violations of abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the Administrator, or his/ her designee, to the following persons or agencies as required: b. the Resident's Representative of record; d. The resident's attending physician; and e. the facility medical director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment will be reported immediately, but no later than: 3. 2 hours if the alleged violation involves abuse OR had resulted in serious bodily injury . d. if the alleged abuse involves another resident, the accused resident representative and attending physician will be informed of the alleged abuse incident and that there may be restrictions on the accused resident's ability to visit other resident rooms unattended . Record review of CR #2's facesheet revealed a [AGE] year-old male admitted to the facility on [DATE] and discharged on [DATE]. CR #2's condition listed upon discharge was unstable. Further review of the facesheet listed no diagnoses. Record review of CR #2's hospital records dated 4/19/21 revealed he was admitted to the hospital on 3/24/21 for possible seizures. Further review of the hospital record revealed CR #2 had a medical history of seizures and mental retardation. CR #2 hospital notes dated 3/28/21 revealed he had autism which required supportive care, monitoring for safety, and case management consult for placement as he was unable to return to group home and family unable to care for him. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR #2's facility progress note dated 4/19/21 at 6:21PM, the DON noted in part, .Received resident via stretcher per ambulance transport. Resident admitted to the facility . diagnosis: seizures. Past medical history of autism. Full code. Awake, alert. Nonverbal. Drooling. Agitation and combativeness noted. Unable to be redirected. Non-compliant . Stage II pressure ulcer to sacrum. Unable to measure due to non - compliance . abrasion noted to right and left knee. Multiple scratches to upper extremity . decubitus ulcer noted to left heel. Unable to measure due to non-compliance. Adult brief in place . Tolerates medications crushed in apple sauce. Resident non-compliant. Resident began striking staff members with his fists and began scratching, kicking, biting, and grabbing staff members by their clothing and hair. Distraction and redirection unsuccessful. Resident continues to ambulate on and off without assistance. Resident proceed to take all items off of medication cart and throw them at staff. Resident attempted to pull his bed out of his room. Resident's safety ensured. NP phoned on ipad facetime and observed resident's behavior. New order to send resident to ER if behavior persists. Writer phone resident's RP and allowed him to hear RP voice. Resident began to lie face down on the floor and refused to get up with assistance. Resident proceeded to ambulate around the unit with bowel movement in brief and took it off. Resident refused to allow staff to help change his clothes into clean clothes. Writer administered some nightly medication from ER kit to which resident ingested and tolerated well. Staff member currently in resident room one on one to ensure safety. Bed locked in low position . Record review of CR #2's progress notes dated 4/20/21 at 3:46AM, LVN C noted, Resident was up at the nurse's station resisting to go back to his room. Tried several times to redirect, unable to follow direction. Went to Resident #1's room, and pulled her head trying to yank her out of her bed and he was naked. This surely made her upset because she was up most part of the night talking to herself. Patient was finally taken to his room but was up moving the bed and other furniture around. He finally went to another room after all the commotion and slept. Resident is in stable condition. Will continue to monitor. Unable to take vital signs due to combative behavior. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/3/21 at 12:26PM, LVN C said she worked from 10pm - 6am on 4/19/21. LVN C said CR #2 was moving up and down the halls when she came in and he was supposed to be on the quarantine hall (C Hall). LVN C said CR #2 had a nurse's aide to monitor him but when nurse aides were busy with other residents he would try and leave out of the hall. LVN C said she was at the nurse's station when she saw CR #2, who was naked, come off C Hall and walk very fast past the nurse's station and into Resident #1's room. LVN C said before she could even react CNA A and CNA B went running into the room behind him and redirected him out. LVN C said she could not tell what happened in the room, she just saw he was naked and had gotten very close to Resident #1. LVN C said she did not ask the CNA's what happened but overheard them talking about it and was not sure if CR #2 touched Resident #1. LVN C said she put in her notes what she heard but did not see what had happened inside the room. LVN C said she did not assess Resident #1 because she was not assigned to her. LVN C said Resident #1 was laughing to herself and talking to herself all night after that and she never does that. LVN C said she thought Resident #1 might of saw CR #2 was naked and that's why she was acting the way she did the rest of the night. LVN C said after they got CR #2 out of Resident #1's room he was still in the hallway sitting on the floor and would grab and scratch at people, so they were dodging him. LVN C said when she came in, she did not know how bad CR #2's behaviors were. She said CR #2 had a nurse one on one with him during the day but overnight they were unable to keep one on one supervision for him because they had other residents to care for. LVN C said at the end of her shift she just put in her notes and left because things were so hectic overnight with CR #2. LVN C said she had not contacted the Administrator or DON overnight because she knew they were already aware of CR #2's behaviors. LVN C said she had been trained on abuse/neglect and said she was to notify the Administrator of situations of abuse/neglect. LVN C said she left at the end of her shift and forgot to say anything about what happened with Resident #1 because it was such a hectic night. She also said she was not sure if CR #2 had touched Resident #1. Interview on 6/3/21 at 1:05PM, CNA A said she worked from 6pm - 6am on 4/19/20. CNA A said CR #2 came into the facility very unhappy. She said when he came in, she was told he was being watched by two people at all times while in the hospital. CNA A said there was 2 paramedics, 2 nurses, 1 medication aide, and 2 CNA's in CR #2 room trying to keep him in room and redirect him when he got to the facility. They were unable to assess him or get his vitals because of his combativeness. CNA A said the first few hours she stayed on C hall with CR #2 by herself and tried to keep him from leaving the hall. She said he wandered constantly and kept trying to leave off of the hall. CNA A said CR #2 eventually fell asleep and she left off the hall to check on other residents. CNA A said during the time no one was with him he woke up and came off of C hall and they were unable to get him to go back. CNA A said he spent most of the night sitting on the floor naked by the nurse's station. CNA A said CR #1 was standing in the doorway of C Hall and suddenly took off straight into Resident #1's room and went straight for her. She said CR #2 went over to Resident #1 and had her by the head trying to pull her out of the bed while he was naked. She said CNA B and LVN D went into first and redirected CR #2 away and was able to get him to let go of her. They then redirected CR #2 out of Resident #1's room. CNA A said Resident #1 top half of body (head, shoulders, and stomach) were hanging out of the bed. She said Resident #1 has a low bed and mat that is kept next to her bed so her top half of body was resting on the mat when she came in, she adjusted Resident #1 back in bed. CNA A said Resident #1 made a screaming noise when the incident happened, and she was restless the rest of the night but overall, she appeared okay and did not seem to have any injuries. CNA A said the abuse coordinator was the Administrator, CNA A denied speaking to the Administrator about the incident with CR #2 and Resident #1 but said the nurses were aware of what had happened and thought they had taken care of it. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Phone interview attempted on 6/3/21 at 1:03PM with CNA B. He did not answer, and voicemail was left. Interview on 6/3/21 at 2:44PM, LVN D said she was an agency nurse who came to work in the facility on 4/19/20 6pm - 6am. LVN D said she was down the hall when she heard the CNA's calling CR #2's name. She said when she looked what was going on, they were already bringing CR #2 out of Resident #1's room. LVN D said she did not know if CR #2 touched Resident #1 because they were already bringing him out when she got to the room and she did not ask. LVN D said Resident #1 was restless for the rest of the night and was calling out. She said the other staff she was usually like that so she was not sure if it was a change for her. LVN D said she did not know if CR #2 had touched Resident #1 because when she looked at her, she had a bump with skin missing on her chin but did not know if it was from the interaction with CR #2. LVN D said she did not report the incident to anyone because she did not know what had happened or if Resident #1 was touched by CR #2. Interview on 6/3/21 at 3:18PM, CNA C said she worked the 6am - 6pm shift on 4/19/21 and 4/20/21. CNA A said it was reported to her by CNA A, CR #2 was up all night wandering the halls and had pooped everywhere and spread feces on the wall. She said it was also reported CR #2 had gotten into Resident #1's room overnight and tried to remove her helmet from her head. Record review of Resident #1's facesheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: hypertension, pruritis, vitamin deficiency, abnormal weight loss, muscle wasting and atrophy, and depersonalization - derealization syndrome. Record review of Resident #1's quarterly MDS dated [DATE] revealed a staff assessment for mental status which reflected Resident #1 had short- and long-term memory problems and her cognitive skills were severely impaired. Resident #1 was totally dependent on staff for transfer, eating, toilet use, and personal hygiene. Record review of Resident #1's progress notes dated 4/20/21 at 3:30AM, LVN D noted, Resident was in bed resting when another resident entered her room and tried to lay in her bed, resident was stopped by staff did not enter her bed, resident redirected out of room, has small red area to left lower face. Interview on 4/20/21 at 4:00PM, the police officer said the facility had called the police the morning of 4/20/21 because they had a resident (CR #2) there who was assaulting staff. He said when he arrived CR #2 was physically assaulting a staff and had to be physically restrained. The officer said once inside the facility, he observed CR #2 had destroyed the inside of the facility. The officer said it was vaguely mentioned CR #2 had put another resident in a head lock but they did not seem to have much information about it. The officer said the staff main complaint was the resident was admitted to the facility yesterday (4/19/21) and facility administration tried to stop the admission because the facility was unable to care for someone like him but their corporate had already approved the admission and they had to admit the resident. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/20/21 at 5:10PM, the DON said she did not know of any incident with CR #2 entering Resident #1's room. The DON said no one called her overnight and it was not mentioned when she was called the next morning or when she got to the facility. The DON was notified by surveyor the officer who responded to the facility on [DATE] regarding CR #2, was told by facility staff that CR #2 had another resident in a head lock overnight and the staff also reported the facility was forced by corporate to accept CR #2 and they did not know what to do or how to handle the resident. The DON said she was not sure what the officer was referring to because she had not been told of CR #2 having any interactions with other residents just the staff. The DON reviewed notes entered by the overnight nurses (LVN C and LVN D). The DON said the staff should have informed her and the administrator about what happened so they could investigate and report. The DON also said the facility overnight staff could have called 911 if they felt other residents were at risk from CR #2's behavior. The DON said she was going to contact the nurses and begin investigating what happened overnight with CR #2 and Resident #1. The DON said she did not know if the residents were assessed and did not see any documentation of an assessment. The DON said she would immediately have Resident #1 assessed for injuries and stated Resident #1 always wears a helmet because of her fall risks. Interview on 4/20/21 at 5:35PM, the administrator said she did not know of CR #2 having any interactions with Resident #1 overnight. She said she would also begin to investigate and said the nursing staff should have informed them. The Administrator said the protocol was for the staff to immediately separate the two residents, assess them and document assessment, notify herself, the DON, the physician and the RP's about what had happened and proceed from there with investigating and reporting requirements. The Administrator said she did not know if the nurse had assessed the residents or if there were any injuries. The Administrator said she was the abuse coordinator. Observation and interview on 4/20/21 at 6:00PM, Resident #1 was lying in bed. Resident #1 was unable to speak or answer any surveyor questions. She was wearing a helmet which was removed by staff for head to toe assessment. Residents arms, neck, face, chest, and head were observed with no obvious markings or injuries. Resident had a small spot on her chin which looked like a facial bump that had been scratched or picked with. The DON who was assisting with assessment said the bump was not a new mark for the resident and said it was skin irritation from Resident #1 wearing a mask and she may have picked with it causing the bump to bleed. Observation and interview on 4/20/21 at 6:15PM, the DON was observed to call the NP and notify her Resident #1 was involved in an incident the previous night where CR #2 may have tried to pull her out of bed. The NP ordered for them to monitor Resident #1. The DON also informed the NP that the nurses were trying to reach Resident #1's RP to inform them of the incident as well.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38530 Based on interview and record review, the facility failed to develop and/or implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet residents' mental and psychosocial needs for 2 of 8 Residents (CR #1 and CR #3) reviewed for comprehensive care plans, in that: CR #3 was not care planned for pressure ulcers she admitted to the facility with. CR #3 was not care planned for the receiving anticoagulation medications and risks associated with the medication. These failures placed residents at risk of their care and needs not being met. Findings include: Record review of CR #3's facesheet revealed a female admitted to the facility on [DATE] and discharged to the hospital on 6/15/21. Her diagnoses included: iron deficiency anemia, candidiasis, iron deficiency anemia, abnormal coagulation, enterocolitis due to clostridium difficile, chronic obstructive pulmonary disease, atrial fibrillation, heart failure, and hypertension. Record review of CR #3's admission MDS dated [DATE] revealed a BIMS score of 10 out of 15 indicating moderate impaired cognition. Further review of the MDS revealed CR #3 was at risk for developing pressure ulcers and had one stage one pressure injury, one stage two pressure injury that was present upon admission, and one stage 3 pressure injury that was present upon admission. MDS noted CR #3 received skin and ulcer treatments of pressure injury care, application of non-surgical dressing, and application of ointments/medications. The MDS revealed CR #3 received anticoagulant medications every day within the last 7 days of the MDS. Record review of CR #3's care plan revealed a focus area dated 4/30/21 for pressure sores/skin care. The care plan revealed one intervention for the focus are which was dated 4/30/21 and noted the intervention was preventative measure. Further review of the care pressure sore care plan revealed further interventions were not added to care plan until 6/22/21 which was after CR #3's discharge to the hospital on 6/15/21. Record review of CR #3's care plan initiated on 4/30/21 revealed no mention of her use of anticoagulant medications and interventions regarding the use of the medication. Wounds/Skin issues Record review of CR #3's physician order dated 4/29/21 revealed an order for nystatin powder; 100,000 unit/gram for topical application twice a day. Order was discontinued on 6/2/21. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR #3's wound management assessment dated [DATE] revealed she had a pressure ulcer to her right heel that was present upon admission. Further review of the assessment revealed her heel wound was a stage I and had measurements of 1.3cm X 2.5cm. Record review of CR #3's physician order dated 5/4/21 revealed wound treatment order for right heel, clean with normal saline/wound cleanser. Apply: (skin prep) cover with dressing once a day. Order was discontinued on 5/26/21. Record review of CR #3's physician order dated 5/4/21 revealed wound treatment order for sacrum, clean with normal saline/wound cleanser. Apply: (collagen) cover with dry dressing once a day. Order was discontinued on 5/12/21. Record review of CR #s's physician order dated 5/12/21 revealed wound treatment order for right buttock, clean with normal saline/wound cleanser. Apply: (barrier cream) cover with dressing once a day. Order was discontinued on 5/26/21. Record review of CR #3's physician order dated 5/12/21 revealed wound treatment order for left buttock, clean with normal saline/wound cleanser. Apply: (collagen) and cover with dressing once a day. Order was discontinued on 5/26/21. Record review of CR #3's progress notes dated 5/21/2021 at 2:10 PM revealed in part, Resident presents with irritation under the left breast, right ankle. Irritation is red with a circle pattern. Will write in the notebook for physician to inspect . Record review of CR #3's physician order dated 5/26/21 revealed wound treatment order for right heel, clean with normal saline/wound cleanser. Apply: (Calcium Alginate and Santyl). Cover with dry dressing once a day. Order was discontinued on 6/15/21. Record review of CR #3's physician order dated 5/26/21 revealed wound treatment order for right buttock, clean with normal saline/wound cleanser. Apply: (Collagen) Cover with dry dressing once a day. Order was discontinued on 6/15/21 Record review of CR #3's physician order dated 5/26/21 revealed wound treatment order for left buttock, clean with normal saline/wound cleanser. Apply: (Calcium alginate and Santyl) Cover with dry dressing once a day. Order was discontinued on 6/15/21. Record review of CR #3's progress notes dated 5/31/2021 at 12:42 PM revealed, Resident presents with new skin openings on the lower posterior right extremity. Measurements as follows 2.5cmX0.5cm then 3 small round wounds at 0.5cm diameter. All the wounds are 0.1cm deep. Wound bed tissue is white slough tissue. No bleeding observed, weeping of yellow clear liquid is observed. 4x4 gauze bandage placed over affected area. Resident denies pain or discomfort at site. Resident did complain of right hip pain and given prn Tylenol. Will continue to monitor. Record review of CR #3's physician order dated 6/2//21 revealed an order for nystatin powder; 100,000 unit/gram for topical application under bilateral breast twice a day. Order was discontinued on 6/10/21. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR #1's NP progress note dated 6/10/21 revealed in part, .New wound on her buttocks have been identified. There are 2 1cm X 1cm pressure injuries to right buttocks, one 3cm x 1cm to left buttocks and 1 1cm X 2cm to left buttocks. Left buttocks pressure injury are confluent with each other and all area unstageable, wound beds covered with slough. Right heel unstageable pressure injury or reassessment appears to be blanchable redness . Record review of CR #3's progress notes dated 6/12/2021 at 3:25 PM revealed, Resident has open areas to the lower posterior right extremity. Measurements #1 2.5cm X 1 cm then 3 small round wounds at 0.5cm diameter. All the wounds are 0.1cm deep. Wound bed tissue is white slough tissue. No bleeding observed, cleansed with normal saline, pat dried and covered with gauze bandage. Left heel has open area with partial visible scab Resident denies pain or discomfort at site. On call for physician notified waiting for return call. Record review of CR #3's progress notes dated 6/12/21 at 3:40PM revealed, on call provider returned call for open areas to bilateral extremities. New orders received for Left heel & right lower extremity apply Santyl with daily dressing changes. Record review of CR #3's physician order dated 6/12/21 revealed wound treatment order for left heel, clean with normal saline/wound cleanser. Apply: (Santyl) Cover with dry absorbent dressing once a day. Order was discontinued on 6/15/21. Record review of CR #3's physician order dated 6/12/21 revealed wound treatment order for right posterior lower extremity, clean with normal saline/wound cleanser. Apply: (Santyl) Cover with primary dressing and secure with dry absorbent dressing once a day. Order was discontinued on 6/15/21. Record review of CR #3's wound management assessment dated [DATE] for pressure ulcer to right heel revealed wound was a stage III and had measurements of 1.4cm X 1.5cm X 0.1cm. Record review of CR #3's progress notes dated 6/15/2021 at 6:15 PM revealed in part, .Per wound physician areas appear to be fungal related with order to consult primary care physician and provided treatment as ordered: cleanse with ns pat dry and apply nystatin. Skilled nurse to monitor and assess skin daily for any changes noted. Physician notified and in facility seen and examined resident with new order to send to ER for further evaluation and treatment as indicated. Resident has recently had a decline in functional ability evident by altered mental status with encephalopathy and volume deficit, accompanied by loose dark stools. Bowl sound normoactive x4 quad with no distention noted. discoloration to skin is in the abdominal fold inner/lateral thighs and travel down her lower extremities with blood flow noted to lower extremities (dorsal). Resident displays symptoms of itching noted by scratching with risk for infection due to patient digging in her brief, unable to redirect and patient teaching would not be effective due to altered mental capacity . All noted wound treatments are to continue with current plan of care. RP notified via phone of hospital transfer with no answer voicemail left for her to contact the facility . Resident transferred to hospital . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR #3's physician progress note dated 6/15/21 revealed in part, .Staff report over the last day or so she has had a change in her mental status. She is less alert with her communication. She has eaten her stool according to nursing. Her issues with intertrigo (inflammation caused by skin-to-skin friction, most often in warm, moist areas of the body, such as the groin, between folds of skin on the abdomen, under the breasts, under the arms or between toes) has worsened. She has a lesion to left heal and bilateral presacral buttocks areas. She has also areas to her left flank and near ankle on right foot that appears like granuloma annular (a skin condition that causes raised reddish or skin-colored bumps (lesions) in a ring pattern) . Interview on 6/22/21 at 12:39PM, wound doctor said CR #3 had wounds she had been treating since she admitted on her heel, sacral and buttocks. She said wounds had been stable/ healing, not deteriorating. She said she noticed resident had some lesions all over her body that she wasn't sure what they were and thought they might be fungal. She had only recently noticed them and told the facility to have the physician take a look at them because she felt resident may need some type of prescribed ointment a physician would have to order because the wounds did not appear pressure related . Anticoagulant medication Record review of CR #3's physician order dated 4/29/21 revealed an order for warfarin tablet; 2.5mg; 1 tablet; take every night, hold if INR > 4 and contact physician. Order was discontinued on 5/6/21. Record review of CR #3's physician order dated 5/6/21 revealed an order for warfarin tablet; 5mg; 1 tablet once a day, hold if INR > 4. Order was discontinued on 5/13/21. Record review of CR #3's INR lab dated 5/11/21 revealed a critical level of 6.4. Reference range was 2.0 - 3.5. Record review of CR #3's progress notes dated 5/13/2021 at 7:34 AM revealed, Lab company called this morning to notify critical lab value of INR at 6.4. Physician notified of this and placed order to hold the warfarin for the weekend and do a repeat INR on Monday. Will pass on to oncoming nurse. Record review of CR #3's physician order dated 5/13/21 revealed an order noting, pending Monday INR. Dose will be restarted when physician visits depending on INR value. Record review of CR #3's INR lab dated 5/18/21 revealed a high level of 4.1. Reference range was 2.0 - 3.5. Record review of CR #3's physician order dated 5/20/21 revealed an order for warfarin tablet; 3mg; 1 tablet once a day at 5:00PM, hold if INR > 4. Order was discontinued on 5/28/21. Record review of CR #3's physician order dated 5/20/21 revealed an order for warfarin tablet; 1mg; 0.5 tablet once a day at 5:00PM, hold if INR > 4. Order was discontinued on 5/28/21. Record review of CR #3's INR lab dated 5/27/21 revealed a critical level of 9.1. Reference range was 2.0 - 3.5. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR #1's NP progress note dated 5/27/21 revealed NP added an addendum on 5/28/21 at 8:35PM which noted in part, .Warfarin also discontinued for INR 9.1 and nursing instructed to watch for bleeding. Will start on Eliquis when INR < 3 in order to avoid INR fluctuations associated with other medications . Record review of CR #3's progress notes dated 5/28/2021 at 5:53 PM revealed in part, .PT/INR results in elevated . NP notified new orders dc warfarin and next lab draw, draw CBC . Record review of CR #3's INR lab dated 5/30/21 revealed a critical level >10. Reference range was 2.0 - 3.5. Record review of CR #3's INR lab dated 6/3/21 revealed a low level of 1.8. Reference range was 2.0 - 3.5. Record review of CR #3's INR lab dated 6/6/21 revealed a low level of 1.5. Reference range was 2.0 - 3.5. Record review of CR #3's progress notes dated 6/07/2021 at 3:34 PM revealed, PT 17.8, INR 1.5 NP notified, will place orders in electronic record for Eliquis. Record review of CR #3's physician order dated 6/8/21 revealed an order for Eliquis (apixaban) tablet; 5mg; 1 tablet twice a day at 8:00AM and 8:00PM. Order was discontinued on 6/14/21. Record review of CR #3's INR lab dated 6/10/21 revealed a level of 2.1. Reference range was 2.0 - 3.5. Record review of CR #3's care plan initiated on 4/30/21 revealed no mention of her use of anticoagulant medications and interventions regarding the use of the medication. Interview on 6/21/21 at 7:09 PM, CR 3's RP said CR #3 was in the hospital not doing well and said her kidneys were shutting down. CR #'3's RP said she did not find out CR #3 had developed multiple wounds and lesions on her body until she got to the hospital and said no one from the facility had informed her. The RP said she was called on 6/15/21 and was told CR #3 was going to the hospital for a skin fungal infection under breast, under stomach and partially on buttocks. Resident got to the hospital and had all kinds of complications. CR #3's RP said CR #3 had a wound to her heel and had some internal bleeding, her kidneys were failing, and her liver had severe cirrhosis. The RP said the hospital was going to try one last thing with giving her dialysis treatment but the doctors at the hospital told them to be prepared the treatment will most likely not work and the resident would soon pass away. Interview on 6/22/21 at 2:22PM, the hospital social worker said CR #3 was admitted to the hospital on 6/15/21 and was diagnosed with an upper GI bleed (bleeding that occurs anywhere in the esophagus, the stomach, or the upper part of the small intestine) along several other issues. The hospital social worker said the records did not indicate why CR #3 had the bleed. The hospital social worker said she saw documentation CR #3 passed away in the hospital from multi organ failure. Notes indicated dialysis was attempted but was unsuccessful. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/22/21 at 4:27PM, CR #3's physician said CR #3 was on coumadin and her INR had gotten really high, so he put her on apixaban. The physician said a nurse said CR #3 had some dark stool. The NP had looked at the stool and did not feel like it looked like bloody stools and did not have a high concern about it. The physician said CR #3 had issues with rashes under her breast and he ordered Nystatin and it got worse. The physician said she then developed some areas on her ankles and peri area. The physician said CR #3 admitted to the facility with stage 3 renal failure which he monitored with routine labs checking her renal function which did not show any significant changes. The physician said there are several things that could have caused CR #3 to have an upper GI bleed and she was at risk due to her use of anticoagulants which is why they monitored her INR's closely. Interview on 6/25/21 at 5:30PM, the DON said the facility usually had an order in place in the MAR to monitor for side effects of anticoagulant but after she reviewed CR #3's record it revealed she did not have the order in her record. The DON said the order was missed for CR #3 and should have been in there. The DON said there should have also been an area in the care plan for CR #3's use of anticoagulants and for her wounds/skin issues. The DON said the facility was monitoring CR #3's wounds/skin and her use of anticoagulant medication along with providing treatment for both.The DON said the care plan should be updated immediately / within 24 hours of a new problem/care area being identified for residents and any nurse was able to update the care plan. Interview on 6/25/21 at 5:35PM, the MDS Nurse said she was responsible for developing and updating the care plans. She said she had just started in the facility a month ago and the facility had care plan issues before she started. The MDS Nurse said she had been trying to go through each resident's care plan and update it to reflect all residents needs and said she had not gotten to CR #3's care plan yet. Record review of the facility care plan policy (October 2019) revealed in part, . the resident care plan must be reviewed after each assessment, as required by 483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions . The IDT must evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's goals, preferences, strengths, problems, and needs . The care plan competition date must be either later than or the same date as the CAA competition date, but no later than 7 calendar days after the CAA competition date. The MDS competition date must be earlier than or the same date as the as the care plan competition date . Resident's preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38530 Based on interview, and record review, the facility failed to review and revise the person-centered care plan to reflect current condition for 1 of 8 residents (CR #1) reviewed for comprehensive care plans, in that: CR #1's care plan was not updated to reflect him receiving hospice services/care. CR #1 care plan was not updated to include for diagnoses of dysphagia and his inability to eat or drink. These failures placed residents at risk of their care and needs not being met. Findings include: Record review of CR #1's facesheet revealed an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] and discharged on [DATE] to a hospital. His diagnoses included: hypertension, dementia with behavioral disturbances, cognitive communication deficit, dehydration, dysphagia, nutritional deficiency, hypotension, aphasia, shortness of breath, and encounter for palliative care. Further review of the facesheet revealed CR #1 was a full code. Record review of CR #1's quarterly MDS dated [DATE] revealed staff assessment of cognitive patterns was completed which indicated he had short term and long-term memory problems and his cognition was severely impaired. Further review of the MDS revealed CR #1 required extensive assistance with bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. Record review of CR #1's care plan with problem start date of 5/19/21 revealed he had swallowing problems related to cognitive deficit. Care Plan interventions were not created until 6/23/21 (after resident's discharge to hospital on 6/11/21). Interventions included: assess for dehydration, monitor and record intake of food, monitor for signs of malnutrition., Record review of CR #1's care plan with problem start date of 6/2/21 revealed he was on hospice services and continued to be full code. Care plan indicated interventions were not created until 6/23/21 (after resident's discharge to hospital on 6/11/21). Interventions included: assure comfort measures are being provided, discuss with POA code status and the importance of DNR, give medications as ordered, resident is NPO at the time offer toothettes or mouth swabs to provide oral care, provide pain management as needed, provide preacher/priest if needed. Record review of CR #1's progress notes dated 5/21/2021 at 1:20PM revealed the NP placed an order to send resident to ER for lethargy and inability to swallow. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR #1's progress notes dated 6/02/2021 at 5:44 AM revealed in part, .resident arrived to facility by ambulance via stretcher, resident stable vital signs within normal limits (WNL) bp-132/77 pulse-88 resp-20 temp-98.5 o2 97 % on room air, lung sounds clear, respiration even and unlabored, abdomen soft and non-distended, bowel sounds active in all four quads, no tenderness noted, skin intact-warm and dry to touch resident without complaints of pain . Record review of CR #1's hospice nurse note dated 6/2/21 at 11:00AM revealed his vitals were: temp 98.7, blood pressure (BP) 135/80, pulse 95, O2 Saturation (O2 sat) 92%, Respiration (Resp) 19. The note further revealed there was no imminence of death. He had abnormal breath sounds that were diminished. Record review of CR #1's physician orders dated 6/2/21 revealed he was admitted to hospice with the diagnoses of Alzheimer's disease. Record review of CR #1's physician orders dated 6/2/21 revealed he received pureed diet and nectar thin liquids. Record review of CR #1's progress notes dated 6/04/2021 at 12:45 PM, the DON noted, .Resident swallowing assessed and resident unable to swallow or masticate food properly. New telephone order received from Hospice nurse to make resident NPO. Legal guardian notified. NP notified in facility. Dietary manager and staff aware as well . Record review of CR #1's physician order dated 6/4/21 revealed resident was NPO status at all times. Interview on 6/18/21 at 10:57AM, the NP said CR #1 was sent to the hospital on 5/21/21 because he was having issues with swallowing. The NP said they were considering getting a peg tube placed on CR #1 but making him an appointment was taking too long given he was unable to eat or drink. She said he was transferred to the hospital instead thinking he would get a peg tube placed there but he returned to the facility on hospice. The NP said she last saw CR #1 on 6/4/21 which is when she learned he had returned to the facility and was on hospice. The NP said CR #1 was unable to swallow so he was not eating or drinking. She said the resident was still full code and was told the hospice agency was working with CR #1's guardian on getting a DNR. The NP said since CR #1 was now on hospice the facility would usually notify the hospice agency if he had a change in condition. She was not aware CR #1 was sent to the hospital on 6/11/21 or why . Record review of progress notes dated 6/07/2021 at 11:15 AM, LVN A noted, . spoke with hospice nurse in relation to NPO and blisters to back. Per nurse okay to discontinue medications and she will attempt to come by today or tomorrow to assess . Record review of CR #1's progress notes dated 6/9/2021 at 12:00 PM, the DON noted, .Writer assessed resident and notified hospice nurse to come and assess resident in facility. Writer requested order to resume feedings at this time. New telephone order received to start puree pleasure feeds with nectar thickened liquids. Floor nurse aware. No answer at this time from guardian. Dietary notified . Record review of CR #1's physician orders dated 6/9/21 revealed order for NPO status was discontinued and order for pureed diet with nectar thickened liquids were started. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR #1's progress notes dated 6/9/21 at 3:48 PM revealed, .Nurse attempted to feed resident but was unsuccessful dysphagia noted. Hospice nurse notified in facility and she assessed patient. No distress noted . Interview on 6/18/21 at 1:00PM, the DON said CR #1 had not eaten or drank anything since 6/3/21 and on 6/9/21 the hospice agency still had not obtained a DNR for CR #1 and she was concerned of the resident starving. She said she asked the hospice nurse if they could try feeding the resident again and she gave order to restart pureed diet. She said staff attempt the feed CR #1 but were unsuccessful as the resident was not alert enough to swallow. The DON said there were no further attempts to feed CR #1 . Interview on 6/18/21 at 1:40PM, the hospice nurse said when she last saw CR #1 on Thursday (6/10/21) he was actively transitioning. He was not alert and was minimally responsive, and she felt he had about 72 hours left to live. He wasn't responding and had not been able to eat or drink in quite some time. The hospice nurse said he had no bowel sounds and his heart sounded weak and distant. She observed CR #1 taking shallow breaths which all gave indication he was in his final days and at that time they still did not have a DNR. The hospice nurse said the hospice agency was still working on getting the DNR with CR #1's guardian but it was taking some time due to guardianship procedures. The hospice nurse said since CR #1 was on hospice they did not provide any type of IV fluid therapy. The hospice nurse said CR #1 was transferred to the hospital on Friday (6/11/21) but she did not see him that day and said an on-call nurse saw him on 6/11/21. The hospice nurse said since CR #1 was discharged to the hospital they began to provide treatment to the resident, and he had to be discharged from hospice services. Record review of CR #1's progress notes dated 6/11/2021 at 10:52 PM revealed CR #1 was transferred to the hospital because he was unstable, and his vitals were unstable. Resident left the faciity on [DATE] at 9:03 PM. Further review of resident record and note revealed no recorded vitals. Interview on 6/24/21 at 11:30AM, CR #1's guardian said when CR #1 was in the hospital on 5/21/21 the decision was made along with CR #1's family to admit CR #1 to hospice care and get a DNR. The guardian said there was some complications with obtaining the DNR, so the process was delayed and once the proper paperwork was obtained from the hospital there was still some agency procedures, he had to go through to get the DNR finalized. The guardian said he was told on 6/4/21 CR #1 had stopped eating but he was stable. The guardian said he was informed CR #1 became unstable on 6/11/21 so he was transferred to the hospital because his agency was still working on the DNR. Interview on 6/17/21 at 4:24PM, CR #1's family said they visited on 6/11/21 and found him in bed with his mouth open and his lips and tongue were completely dried and cracked and had developed sores inside his mouth. She said they were upset because the resident in the room by himself gasping for air and a hospice nurse was not there. The family said the hospice nurse was called and a hospice nurse came to the facility to assess CR #1 and he was transferred to the hospital. The family said the facility was letting CR #1 die in the facility because he had not eaten or drank in days even though he was still full code. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/25/21 at 5:30PM, the DON said CR #1's care plan should have been updated to reflect he was on hospice services as soon as he readmitted on hospice and the resident care plan should have also reflected his dysphagia. The DON stated interventions were in place for CR #1's receiving hospice care and he was being monitored since he was unable to eat or drink. The DON said the care plan should be updated immediately / within 24 hours of a new problem/care area being identified for residents and any nurse was able to update the care plan. Interview on 6/25/21 at 5:35PM, the MDS Nurse said she was responsible for developing and updating the care plans. She said had just started in the facility a month ago and the facility had care plan issues before she started. The MDS Nurse said she had been trying to update to go through each resident's care plan and update it to reflect all residents needs and said she had not gotten to CR #1's care plan yet. Record review of the facility care plan policy (October 2019) revealed in part, . the resident care plan must be reviewed after each assessment, as required by 483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions . The IDT must evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's goals, preferences, strengths, problems, and needs . The care plan competition date must be either later than or the same date as the CAA competition date, but no later than 7 calendar days after the CAA competition date. The MDS competition date must be earlier than or the same date as the as the care plan competition date . Resident's preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan .

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38530 Based on interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 8 residents (CR #1) reviewed for quality of care. The facility failed to monitor CR #1 by not checking his blood pressure and pulse for 8 days. CR #1 was unable to eat or drink due to dysphagia and was not provided any form of nutrition or hydration for 8 days. The facility failed to identify CR #1 had a change in condition for 2 days as the hospice agency documented CR #1 began showing signs of imminent death and facility continued to document resident was stable. Two days after the hospice agency identified CR #1 was showing signs of imminent death, they again identified another change in condition of CR #1's vitals becoming unstable. The facility nurse failed to complete an assessment of CR #1 after the change in condition was identified by hospice nurse. CR #1 was transferred to the hospital and he was diagnosed with acute renal failure secondary to dehydration and severe sepsis. CR #1 was treated in the hospital with bolus fluids and IV antibiotics until DNR was obtained and then deceased on e week later in the hospital. This failure could place residents at risk of not receiving timely care, health complications and decline in functioning. Findings included: Record review of CR #1's face sheet revealed an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] and discharged on [DATE] to a hospital. His diagnoses included: hypertension, dementia with behavioral disturbances, cognitive communication deficit, dehydration, dysphagia, nutritional deficiency, hypotension, aphasia, shortness of breath, and encounter for palliative care. Further review of the face sheet revealed CR #1 was a full code. Record review of CR #1's quarterly MDS dated [DATE] revealed staff assessment of cognitive patterns was completed which indicated he had short term and long-term memory problems and his cognition was severely impaired. Further review of the MDS revealed CR #1 required extensive assistance with bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. Record review of CR #1's care plan with problem start date of [DATE] revealed he had swallowing problems related to cognitive deficit. Care Plan interventions were not created until [DATE] (after resident's discharge to hospital on [DATE]). Interventions included: assess for dehydration, monitor and record intake of food, monitor for signs of malnutrition, (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of CR #1's care plan with problem start date of [DATE] revealed he was on hospice services and continued to be full code. Care plan indicated interventions were not created until [DATE] (after resident's discharge to hospital on [DATE]). Interventions included: assure comfort measures are being provided, discuss with POA code status and the importance of DNR, give medications as ordered, resident is NPO at the time offer toothettes or mouth swabs to provide oral care, provide pain management as needed, provide preacher/priest if needed. Record review of CR #1's progress notes dated [DATE] at 1:20PM revealed the NP placed an order to send resident to ER for lethargy and inability to swallow. Record review of CR #1's progress notes dated [DATE] at 5:44 AM revealed in part, .resident arrived to facility by ambulance via stretcher, resident stable vital signs within normal limits (WNL) bp-,d+[DATE] pulse-88 resp-20 temp-98.5 o2 97 % on room air, lung sounds clear, respiration even and unlabored, abdomen soft and non-distended, bowel sounds active in all four quads, no tenderness noted, skin intact-warm and dry to touch resident without complaints of pain . Record review of CR #1's physician orders dated [DATE] revealed he was admitted to hospice with the diagnoses of Alzheimer's disease. Record review of CR #1's hospice nurse note dated [DATE] at 11:00AM revealed his vitals were: temp 98.7, blood pressure (BP) ,d+[DATE], pulse 95, O2 Saturation (O2 sat) 92%, Respiration (Resp) 19. The note further revealed there was no imminence of death. He had abnormal breath sounds that were diminished. Record review of CR #1's physician orders dated [DATE] revealed he received pureed diet and nectar thin liquids. Record review of CR #1's progress notes dated [DATE] at 5:21 AM revealed, patient is currently resting in bed without complaints or complications all vital signs stable and WNL, will continue to monitor. Will pass to oncoming nurse. Record review of CR #1's vitals dated [DATE] revealed a blood pressure of ,d+[DATE] and pulse 88. Record review of CR #1's MAR and vitals revealed CR #1's blood pressure and pulse were no longer recorded after [DATE]. Record review of CR #1's [DATE] MAR and vitals revealed the facility only continued to check CR #1's O2 saturation, temperature, and respirations after [DATE] due to COVID monitoring. Record review of CR #1's COVID - 19 monitoring dated [DATE] revealed from 6am - 2pm his O2 saturation was 92%, lung sounds clear, respirations 16, and temperature 98.0. From 2pm - 10pm his O2 saturation was 92%, lung sounds clear, respirations 16, and temperature 98.0. From 10pm - 6am his O2 saturation was 92%, lung sounds clear, respirations 16, and temperature 98.0. Interview on [DATE] at 1:15PM, the MDS nurse said CR #1's blood pressure and pulse stopped being checked after [DATE] because he was a hospice patient and the hospice agency monitored his vitals. MDS nurse was asked for facility policy regarding care of hospice residents and she asked to consult with the DON regarding why the vitals for CR #1 stopped being recorded. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on [DATE] at 2:30PM, the DON said the facility policy did not state the facility should no longer monitor resident on hospice services. The DON said CR #1 vitals stopped being checked because the order to check his vitals were attached to his medication orders for metoprolol tartrate. She said CR #1's medications were unable to be provided after [DATE] because he was unable to swallow and therefore the staff were not recording his blood pressure and pulse and the order to administer the medication and check his blood pressure and pulse were discontinued officially on [DATE]. The DON said it was an error and facility should have continued to monitor and record CR #1's blood pressure and pulse even if he was a hospice resident. The DON said CR #1's O2 sat, temp, and resp continued to be check due to COVID - 19 monitoring order still being in place. Record review of CR #1's [DATE] MAR revealed order started on [DATE] for metoprolol tartrate tablet 25mg to be administered once a day had special instruction to hold for BP less than ,d+[DATE], heart rate less than 60. The MAR further revealed CR #1's BP and pulse were not checked on [DATE], [DATE], [DATE], and [DATE] and the medication was not administered. Order was discontinued on [DATE]. Record review of CR #1's progress notes dated [DATE] at 12:45 PM, the DON noted, .Resident swallowing assessed and resident unable to swallow or masticate food properly. New telephone order received from Hospice nurse to make resident NPO. Legal guardian notified. NP notified in facility. Dietary manager and staff aware as well . Record review of CR #1's physician order dated [DATE] revealed resident was NPO status at all times. Record review of CR #1's progress notes dated [DATE] at 2:09 PM, the DON noted, .NP in facility at this time and verbal order received to consider obtaining paperwork to change resident's full code status to DNR. Hospice nurse notified via phone and states they are working to obtain a DNR for resident. Will follow - up with social services . Interview on [DATE] at 10:57AM, the NP said CR #1 was sent to the hospital on [DATE] because he was having issues with swallowing. The NP said they were considering getting a peg tube placed on CR #1 but making him an appointment was taking too long given he was unable to eat or drink. She said he was transferred to the hospital instead thinking he would get a peg tube placed there but he returned to the facility on hospice. The NP said she last saw CR #1 on [DATE] which is when she learned he had returned to the facility and was on hospice. The NP said CR #1 was unable to swallow so he was not eating or drinking. She said the resident was still full code and was told the hospice agency was working with CR #1's guardian on getting a DNR. The NP said since CR #1 was now on hospice the facility would usually notify the hospice agency if he had a change in condition and for orders. The NP said the physicians did not typically give orders for hospice residents because the hospice agency would be responsible for giving orders for the residents care. She was not aware CR #1 was sent to the hospital on [DATE] or why. Record review of CR #1's COVID - 19 monitoring dated [DATE] revealed from 6am - 2pm his O2 saturation was 96%, lung sounds clear, respirations 17, and temperature 98.2. From 10pm - 6am his O2 saturation was 97%, lung sounds clear, respirations 20, and temperature 98.5. Record review of CR #1's COVID - 19 monitoring dated [DATE] revealed from 2pm - 10pm his O2 saturation was 98%, lung sounds clear, respirations 18, and temperature 98.2. From 10pm - 6am his O2 saturation was 98%, lung sounds clear, respirations 18, and temperature 98.2. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of CR #1's COVID - 19 monitoring dated [DATE] revealed from 6am - 2pm his O2 saturation was 96%, lung sounds clear, respirations 20, and temperature 98.2. From 2pm - 10pm his O2 saturation was 95%, lung sounds clear, respirations 18, and temperature 98.4. From 10pm - 6am his O2 saturation was 94%, lung sounds clear, respirations 18, and temperature 98.6. Record review of progress notes dated [DATE] at 11:15 AM, LVN A noted, . spoke with hospice nurse in relation to npo and blisters to back. Per nurse okay to discontinue medications and she will attempt to come by today or tomorrow to assess . Record review of CR #1's progress notes dated [DATE] at12:36 PM, LVN A noted, .Resident in room supine position in bed, alert and unable to communicate needs, no groaning or moaning noted at this time. Vital signs stable . Record review of CR #1's COVID - 19 monitoring dated [DATE] revealed from 6am - 2pm his O2 saturation was 95%, lung sounds clear, respirations 18, and temperature 98.4. From 2pm - 10pm his O2 saturation was 95%, lung sounds clear, respirations 18, and temperature 98.4. From 10pm - 6am his O2 saturation was 95%, lung sounds clear, respirations 18, and temperature 98.2 . Record review of CR #1's hospice nurse note dated [DATE] at 2:00PM revealed his vitals were: temp 98.4, BP ,d+[DATE], pulse 99, O2 sat 91%, Resp 19. The note further revealed there was no imminence of death. He had abnormal breath sounds that were diminished. Record review of CR #1's progress notes dated [DATE] at 5:32 AM, LVN B noted, .patient is currently resting in bed without complaints or complications all vital signs stable and within normal limits. Will continue to monitor. Will pass to oncoming nurse . Record review of CR #1's COVID - 19 monitoring dated [DATE] revealed from 6am - 2pm his O2 saturation was 95%, lung sounds clear, respirations 14, and temperature 98.4. From 2pm - 10pm his O2 saturation was 95%, lung sounds clear, respirations 14, and temperature 97.7. From 10pm - 6am his O2 saturation was 95%, lung sounds clear, respirations 16, and temperature 98.4 . Record review of CR #1's progress notes dated [DATE] at 12:00 PM, the DON noted, .Writer assessed resident and notified hospice nurse to come and assess resident in facility. Writer requested order to resume feedings at this time. New telephone order received to start puree pleasure feeds with nectar thickened liquids. Floor nurse aware. No answer at this time from guardian. Dietary notified . Record review of CR #1's hospice nurse note dated [DATE] at 1:30PM revealed his vitals were: temp 99.1, BP ,d+[DATE], pulse 113, O2 sat 86%, Resp 19. The note further revealed there was imminence of death due to coolness of skin, decreased fluid/food intake, decreased level of consciousness, decreased urine output, increased fatigue, and increased respiratory distress. Resident was noted to have a decreased level of consciousness which included confusion, lethargy, and responds to painful stimuli. Record review of CR #1's physician orders dated [DATE] revealed order for NPO status was discontinued and order for pureed diet with nectar thickened liquids were started. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of CR #1's progress notes dated [DATE] at 3:48 PM revealed, .Nurse attempted to feed resident but was unsuccessful dysphagia noted. Hospice nurse notified in facility and she assessed patient. No distress noted . Interview on [DATE] at 1:00PM, the DON said CR #1 had not eaten or drank anything since [DATE] and on [DATE] the hospice agency still had not obtained a DNR for CR #1 and she was concerned of the resident starving. She said she asked the hospice nurse if they could try feeding the resident again and she gave order to restart pureed diet. She said staff attempt the feed CR #1 but were unsuccessful as the resident was not alert enough to swallow. The DON said there were no further attempts to feed CR #1. The DON said since CR #1 was on hospice they would not give order for IV fluids or peg tube. The DON said she kept being told they were close to getting CR #1's DNR. Record review of CR #1's progress notes dated [DATE] at 5:27 AM, LVN B noted, .patient is currently resting in bed without complaints or complications all vital signs stable and within normal limits. Will continue to monitor. Will pass to oncoming nurse . Record review of CR #1's COVID - 19 monitoring dated [DATE] revealed from 6am - 2pm his O2 saturation was 95%, lung sounds clear, respirations 16, and temperature 98.1. From 2pm - 10pm his O2 saturation was 95%, lung sounds clear, respirations 16, and temperature 98.1. From 10pm - 6am his O2 saturation was 95%, lung sounds clear, respirations 16, and temperature 98.1 . Record review of CR #1's hospice nurse note dated [DATE] at 12:30PM revealed his vitals were: temp 97.1, BP ,d+[DATE], pulse 101, O2 sat 87%, Resp 19. The note further revealed there was imminence of death due to absent bowel function, coolness of skin, cyanosis (a bluish discoloration of the skin resulting from poor circulation or inadequate oxygenation of the blood) decreased fluid/food intake, decreased level of consciousness, decreased urine output, increased respiratory distress. Interview on [DATE] at 1:40PM, the hospice nurse said when she last saw CR #1 on Thursday ([DATE]) he was actively transitioning. He was not alert and was minimally responsive, and she felt he had about 72 hours left to live. He wasn't responding and had not been able to eat or drink in quite some time. The hospice nurse said they made many attempts to try and feed CR #1, but he was not alert enough to eat or drink and would have been unable to swallow. The hospice nurse said he had no bowel sounds and his heart sounded weak and distant. She observed CR #1 taking shallow breaths which all gave indication he was in his final days and at that time they still did not have a DNR. The hospice nurse said the hospice agency was still working on getting the DNR with CR #1's guardian but it was taking some time due to guardianship procedures. The hospice nurse said since CR #1 was on hospice they did not allow for any type of IV fluid therapy or peg tube and said if the resident was provided that kind of treatment he would be discharged from hospice. The hospice nurse said CR #1 was transferred to the hospital on Friday ([DATE]) but she did not see him that day and said an on-call nurse saw him on [DATE]. The hospice nurse said since CR #1 was discharged to the hospital they began to provide treatment to the resident, and he had to be discharged from hospice services. Record review of CR #1's COVID - 19 monitoring dated [DATE] revealed from 6am - 2pm his O2 saturation was 95%, lung sounds clear, respirations 18, and temperature 98.4. From 2pm - 10pm his O2 saturation was 96%, lung sounds clear, respirations 18, and temperature 98.4. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of CR #1's progress notes dated [DATE] at 10:52 PM revealed CR #1 was transferred to the hospital because he was unstable, and his vitals were unstable. Resident left the faciity on [DATE] at 9:03 PM. Further review of resident record and note revealed no recorded vitals. Record review of CR #1's progress notes and assessments revealed no detailed assessment of CR #1 on [DATE] with evidence of the resident being unstable and unstable vitals. Interview on [DATE] at 11:30AM, CR #1's guardian said when CR #1 was in the hospital on [DATE] the decision was made along with CR #1's family to admit CR #1 to hospice care and get a DNR. The guardian said there was some complications with obtaining the DNR, so the process was delayed and once the proper paperwork was obtained from the hospital there was still some agency procedures, he had to go through to get the DNR finalized. The guardian said he was told on [DATE] CR #1 had stopped eating but he was stable. The guardian said he was informed CR #1 became unstable on [DATE] so he was transferred to the hospital because his agency was still working on the DNR. Interview on [DATE] at 4:24PM, CR #1's family said they visited on [DATE] and found him in bed with his mouth open and his lips and tongue were completely dried and cracked and had developed sores inside his mouth. She said they were upset because the resident in the room by himself gasping for air and a hospice nurse was not there. The family said the hospice nurse was called and a hospice nurse came to the facility to assess CR #1 and he was transferred to the hospital. The family said the facility was letting CR #1 die in the facility even though he was still full code. Interview on [DATE] at 3:21PM, LVN A said she worked 6am - 6pm on [DATE]. LVN A said she recalled CR #1's family coming in to visit and they were upset because a hospice nurse was not at his bed side. LVN A said the hospice agency did not provide crisis care and she was not sure if the hospice nurse had come in or not that day to see CR #1. LVN A said she felt CR #1 was stable through her shift and did not observe a change in condition in him. LVN A said CR #1 had not been eating or drinking and he was not alert but had been that way since he readmitted . LVN A said she did not see any indications CR #1 was actively transitioning. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on [DATE] at 3:16PM, LVN B said she worked 6pm - 6am on [DATE]. LVN B said she heard the family had come in earlier to visit CR #1 and were upset. LVN B said the family was already gone when she came in for her shift, so she wasn't sure what had happened when they visited earlier. LVN B said she rounded on CR #1 when she came in for her shift and his vitals were stable and he was stable. LVN B said she did call the hospice nurse to come and check on CR #1 because she saw notes, they were trying to get the hospice nurse to come in and assess the resident. LVN B said an on - call hospice nurse came in around 8:00PM and told them they do not do crisis care. She said the on-call hospice nurse inquired about what her vitals were for CR #1, but she told the on-call hospice nurse they needed to check the resident and get their own vitals. LVN B said the hospice nurse assessed CR #1 and reported he did not think CR #1 was going to make it through the night because he had become unstable. LVN B said CR #1 was still listed as a full code so she called the physician who gave the order to transfer CR #1 to the ER. LVN B was asked where she documented the vitals, she said she collected, and she said she documented under the vitals tab in their electronic record. LVN B was asked what CR #1's vitals were when they became unstable because there was no documentation in her transfer note of what they were. LVN B said she did not know what his vitals were upon his transfer or when he became unstable because the on-call hospice nurse was the one who had checked them and said he was unstable. LVN B said she just recorded in her note what the on-call hospice nurse told her and relayed it to the physician. LVN B said surveyor would have to check with the on - call hospice nurse to know his vitals. Phone interview attempted on [DATE] at 1:58PM with hospice agency to identify and interview on - call hospice nurse from [DATE], a message was left with no return phone call. Interview on [DATE] at 2:30PM, the DON said the facility nursing staff should have documented and checked CR #1's vital upon his transfer to hospital or when change in condition was noted. The DON said it was her understanding CR #1 was stable and he had a change in condition the night of [DATE] by his vitals becoming unstable and increased lethargy. She said the hospice on - call nurse was contacted to come assess and confirmed CR #1 was transitioning. She said the facility nurse (LVN B) then contacted the facility physician to have him transferred to the hospital. The DON was asked about the difference in assessments because hospice nurse indicated through interview and her notes CR #1 had a change in condition and was actively transitioning on [DATE]. The DON said there have been times they do not agree with the nurse's assessment of residents and disagreed the resident was actively transitioning when the hospice nurse noted he was. The DON said she did not know why the CR #1's facility recorded O2 sat were significantly different than the hospice nurses recorded O2 sat but said she knew the staff were checking it. The DON said the facility should still monitor hospice residents by assessing them and monitoring vitals, if they have a change in condition the hospice agency should be notified and their orders would be followed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of CR #1's hospital records dated [DATE] revealed in part, . at this time patient is a full code. Nursing home was concerned as patient was not responding and appeared to be very ill, patient was brought to the emergency department and noted to be febrile (having or showing the symptoms of a fever), tachycardic (heart rate over 100 beats per minute) . Emergency department provider wishes to admit for severe sepsis, aspiration pneumonia, and acute renal failure . Further review of the hospital record revealed upon assessment CR #1 had metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood. It is not caused by a head injury), severe sepsis, acute hypoxic respiratory failure secondary to aspiration pneumonia with history of dysphagia/advanced end-stage dementia, acute renal failure likely secondary to dehydration and severe sepsis. CR #1 was treated in the hospital since he was full code and was provided bolus sepsis fluids and IV antibiotics. Interview on [DATE] at 12:00PM, CR #1's family said the DNR was finally finalized while he was in the hospital and he passed away the morning of [DATE]. Record review of facility change in resident's condition or status policy (Revised February 2021) revealed in part, . prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the SBAR Communication Form . The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status . Record review of facility Hospice program policy (Revised [DATE]) revealed in part, .In general, it is the responsibility of the facility to meet the residents personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. These include: c. Notifying hospice of the following . (1) a significant change in the residents physical, mental, social, or emotional status. (2) clinical complications that suggest a need to alter the plan of care. (3) a need to transfer the resident from the facility for any condition (4) the resident's death .