STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145439	A. Building B. Wing	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accolade Healthcare of Savoy	302 West Burwash Savoy, IL 61874

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40385 Based on observation, interview, and record review the facility failed to promote residents' dignity by failing to ensure residents were served meals at the same time, ensure staff did not stand over residents while providing feeding assistance, ensure staff did not enter without knocking before entering a resident's bathroom, ensure staff provide assistance with dressing and shaving, and ensure staff removed institutional identification (hospital bracelets) and gait belts for 12 (R56, R42, R70, R92, R50, R86, R47, R104, R96, R91, R215, R14) of 24 residents reviewed for dignity in the sample list of 99. Findings include: The facility's undated Resident Rights, Privacy and Dignity policy documents: The resident has the right to be treated with respect and dignity and care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility may encourage and assist the residents to dress in their own clothes, rather than hospital type gown and appropriate footwear for the time of the day and individual preferences. Resident's appearance should be consistent with his or her choice. The facility must promote resident's independence and dignity while dining: c. Staff standing over residents while assisting them to eat. The facility's undated Quality of Life-Dignity policy documents: Residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etc. (etcetera). Resident's private space and property shall be respected at all times. a. Staff will knock and request permission before entering resident's rooms. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.) On 8/29/22 the following occurred: At 11:33 AM R56, R42, R70, R92, R50, R86, R47, R104 and R96 were sitting in the lounge on the 2nd floor. Lunch meal trays were delivered to the 2nd floor. At this time R56 and R42 were served their meals and began eating. At 11:40 AM R70 stated I'm hungry, hungry, hungry. R70 did not have R70's meal, and was sitting directly beside R42. At 11:45 AM R92's meal was served. At 11:50 AM R42 finished R42's meal and left the lounge. R70 stated (R42) already finished eating and left. I'm hungry. I haven't ate yet. Why haven't I ate yet? At 11:54 AM V27 Certified Nursing Assistant (CNA) collected R42's and R56's meal trays. R70 asked V27 about R70's meal tray and R70 said R70 was hungry. V27 told R70 your (R70's) food is coming. At 12:02 PM a second meal tray cart was delivered to the 2nd floor and distributed down the [NAME] Hall. At this time R50's meal was served. V23 Licensed Practical Nurse (LPN) was standing and feeding R50. R70 stated sure would be nice to get something to eat. I (R70) haven't had anything to eat. V23 told R70 that V23 will check on R70's meal tray. At 12:07 PM R86's meal was served. R70 continued to repeatedly ask about R70's meal. At 12:11 PM (38 minutes after meal trays were served to R56 and R42) meal trays were delivered to R47, R104, R96 and R70. On 9/1/22 at 11:40 AM V3 Infection Preventionist stated: Staff should not be standing while feeding residents. Staff should serve meal trays for residents sitting in dining areas together and then distribute trays by hall. 2.) On 8/31/22 at 12:45 PM V42 Central Supply Clerk entered R91's bathroom, and did not knock before entering. R91 was sitting on the toilet in view of V42. V42 stated Oh my, I'm sorry. I didn't know you were in here. On 9/1/22 at 9:15 AM V3 Infection Preventionist confirmed staff are expected to knock before entering resident rooms and bathrooms. 35046 3.) On 8/30/22 at 10:00 AM, R215 was sitting in a wheelchair. R215 was wearing a hospital gown and had a fall risk bracelet and hospital band on his wrist. R215 stated, I don't know why they haven't taken it off and I am not sure why I'm not dressed. R215 was noted to have an overgrowth of facial hair and stated he doesn't usually wear a beard and is not sure why they don't shave him. R215 stated he would like to be shaved and dressed. 4.) On 8/29/22 at 11:11 AM, R14 was propelling self around the common area by the nurses' station. R14 had a bright yellow fall risk band on his wrist and bright yellow gait belt around waist. At that time, V35 Licensed Practical Nurse stated, I am not sure why (R14) is wearing a fall risk band. It was applied at the hospital and should be taken off.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to notify the resident's physician and family of significant weight loss for three (R13, R70, R95) of twelve residents reviewed for nutrition in the sample list of 99. Findings include: The facility's Change in a Resident's Condition or Status policy with a revised date of December 2016, documents the facility will promptly notify the resident, resident's physician, and resident's representative of changes in a resident's physical, emotional, and mental condition. 1.) R13's Minimum Data Set (MDS) dated [DATE] documents R13 has severe cognitive impairment, R13 is not on a prescribed weight loss regimen, and R13 has had a weight loss of 5% or more in one month or 10% or more in six months. R13's undated weight log documents R13's weights and identified significant weight loss as follows: 118.6 lbs. (pounds) on 4/27/22, 118.7 lbs. on 5/3/22, 109.7 lbs. on 5/9/22 (7.58 % loss), 103.6 lbs. on 5/12/22 (5. 56% loss in 4 days), 103 lbs. on 5/24/22 (6.11 % loss from 5/9/22), and 101 lbs. on 8/22/22 a 10% loss since 4/27/22. R13's Nutrition Note dated 5/26/2022 at 9:50 recorded by V47 Registered Dietitian documents R13 was evaluated for wounds and weight loss noted. R13's weight is down 15 lbs. since R13 admitted in late April 2022. R13 has a low BMI (Body Mass Index) of 18.8, adjusted for left above knee amputation. V47 requested to change multivitamin to multivitamin with minerals, offer double protein at breakfast, a frozen nutritional supplement once daily, whole milk at meals, and change diet from Low Concentrated Sweets to regular. R13's Dietary Note dated 7/21/2022 at 12:04 recorded by V47 documents V47 requested to add ice cream with lunch. There is no documentation in R13's medical record that R13's family and physician were notified of R13's significant weight loss in May and August 2022. 2.) R70's MDS dated [DATE] documents R70 has severe cognitive impairment, is not on a prescribed weight loss regimen, and has a weight loss of 5% or more in the last month or 10 % or more in the last six months. R70's undated weight log documents R70's weights as follows: 121.3 lbs. on 4/11/22, 110.4 lbs. on 6/14/22 (8.99 % loss since 4/11/22), 103.2 lbs. on 7/31/22 (6.52 % loss since 6/14/22), and 107 lbs. on 8/31/22. R70's Nutrition Note dated 4/21/2022 at 1:19 PM by V47 RD documents R70 was reviewed for weight loss, R70 has history of fluid issues and receives a diuretic. This note documents a recommendation to add whole milk and juice with all meals. R70's Nutrition Note dated 8/11/2022 at 1:56 PM by V47 documents: R70 was reviewed for weight loss at 1, 3, and 6 months and R70 has a healing stage III wound. V47 recommended a frozen nutritional supplement once daily to provide an additional 290 kilocalories and 9 grams of protein. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There is no documentation that R70's family and physician were notified of weight loss in June and July 2022. 3.) R95's MDS dated [DATE] documents R95 has severe cognitive impairment, is not on a prescribed weight loss regimen, and has a weight loss of 5 % or more in 1 month or 10 % or more in 6 months. R95's undated weight log documents R95's weights as follows: 136.7 lbs. on 5/31/22 and 6/8/22, and 129.8 lbs. on 7/7/22 and 8/2/22 (5.05 % loss). R95's Nutrition Notes dated 7/21/22, 3/7/22, 2/26/22, and 9/9/21 and recorded by V47 RD, do not document an estimate of R95's calorie, protein, nutrient, and fluid needs. There are no documented thorough/complete nutritional assessments in R95's medical record since 7/24/21. R95's Nutrition Note dated 7/21/2022 at 11:35 AM documents R95 was reviewed for weight loss for the past month, and R95's BMI remains low at 21. 6 with a goal of 23. R95's diet includes a nutritional shake 120 cc (cubic centimeters) four times daily. V47 suggested adding a frozen nutritional supplement for additional kilocalories. There is no documentation in R95's medical record that R95's family and physician were notified of significant weight loss in July 2022. On 9/6/22 at 9:15 AM V3 Infection Preventionist stated family and physician notification of significant weight loss should be documented in a nursing note. On 9/6/22 at 10:43 AM V3 stated V3 did not find documentation of family and physician notification for weight loss for R13, R70, and R95.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 32853 Identified failures require more than one deficient practice statement. A.) Based on interview and record review the facility failed to ensure R52, R64, and R88 were not to subjected mental, verbal, and physical abuse by R46. This failure puts these residents at risk for severe, life threatening, and potentially fatal injuries. R46, R52, R64 and R88 are four of seven residents reviewed for abuse in the sample list of 99. This failure resulted in an Immediate Jeopardy. While the immediacy was removed on 9/7/22, the facility remains out of compliance at severity level 2. While the facility continues to develop and implement measures for each identified resident to address tendencies and triggers that could lead to physical aggression towards others. Findings include: The facility's Abuse Prevention Program policy with an effective date of 11/28/17 documents, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to resident or families, or within their hearing distance, regardless of an individuals' age, ability to comprehend, or disability. Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention (77 Ill. Adm. Code 300.330). Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment (42 CFR 483.12 Interpretive Guidelines). Pre-Admission Screening of Potential Residents. The facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal convictions. For residents who are identified offenders, the facility shall incorporate the Identified Offender Report and Recommendation Report into the identified offender's plan of care including the security measures listed. Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of resident including, but not limited to, the separation of the residents. R46's Face Sheet dated 8/19/22 documents an admitted [DATE]. R46's Admission Minimum Data Set (MDS) dated [DATE] documents diagnoses including Schizophrenia, Wernicke's Encephalopathy, Alcohol Abuse with Intoxication and Unspecified Mood Disorder. This MDS documents a BIMS (Brief Interview for Mental Status) score of 9/15 indicating moderately impaired cognition. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R46's Care Plan dated 6/20/22 documents R46 has a history of criminal behavior and documents a care plan updated 8/26/22 that since admission R46 has had some aggressive behaviors towards others with interventions to promote safety, intervene when inappropriate behavior is observed. This Care Plan documents R46 is a wanderer and (R46) goes in other resident's rooms and can be difficult to redirect with a revision date of 6/27/22. R46's Nurse's Notes in June 2022 documents R46 curses and yells at residents and staff and goes into other residents' rooms and gets agitated and does not want to leave easily. R46's Nurse's Notes in July 2022 documents R46 was physically and verbally abusive to staff. R46's Nurse's Notes in August 2022 continue to document verbal abuse and being combative with staff. R46's Nurse's Note dated 8/26/22 at 2:55 PM, documents R46 was sent to a Psychiatric hospital. R46's Nurse's Note dated 8/26/22 at 4:20 PM documents R46 was being issued a 30-day discharge notification due to recent incidents and behaviors which were affecting other residents. a.)1.) The facility's Preliminary Incident Investigation Report dated 8/19/22 at 12:20 PM, documents (R46) were ambulating in (R46's) wheelchair behind (R52) and (R64). (R46) said f*** you (expletive) and (R64) responded by saying the same to (R46). (R46) then propelled (R46's) wheelchair towards (R52) and (R64) and they fell to the ground. The residents were separated, and (R46) is being monitored 1:1 (one to one) pending orders received for (R46) to be sent out for evaluation. Following nurse assessments of the residents, no injuries were noted for any of the three residents. Residents will be monitored for signs and symptoms of distress. Physicians and POAs (Power of Attorneys) were notified. R46's Nurse's Note dated 8/19/22 at 12:20 PM, R46 became agitated with two other female residents (R52, R64). R46 was in a wheelchair on R46's way back from the dining room. (R52 and R64) were ambulating back from lunch. R46 was heard yelling F*** you to (R52 and R64). One of the female residents yelled F*** you back to R46. R46 sped up the wheelchair and hit (R52 and R64) directly knocking them to the ground. R46 stated that they deserved it, they shouldn't talk to R46 like that. R46 on 1:1 supervision from time of incident. On 9/1/22 at 9:42 AM, V14 LPN (Licensed Practical Nurse) stated V14 witnessed R46 run R46's wheelchair into R52 and R64 on 8/19/22 and knock them to the ground. V14 stated V14 heard bickering and cuss words being yelled and V14 saw R46 plow R46's wheelchair towards R52 and R64 and knock them to the ground. V14 stated when R52 and R64 were on the ground they were yelling cuss words at R46 and calling R46 a SOB (Son of a B****) (expletive). V14 stated V14 separated R46, R52 and R64. V14 stated V14 asked R46 why R46 knocked R52 and R64 down and R46 told V14 that they were making fun of R46 and R46 told V14 that R46 would do it again. V14 stated R46 stayed with V25 Social Services Director after the incident. R52's Order Summary Report dated 8/30/22 documents diagnoses including Major Depressive Disorder, Cerebral Infarction and Unspecified Dementia without Behavioral Disturbance. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R52's Nurse's Note dated 8/19/22 at 12:20 PM, documents fall was witnessed and occurred in the hallway. R52 was ambulating back from the dining room and the reason for the fall was evident. Another resident knocked R52 over. R52 was ambulating down the hallway and a male resident (R46) yelled F*** you and R52 yelled it back. This prompted (R46) to speed toward R52 in R46's wheelchair knocking R52 to the ground. V14 LPN/writer witnessed the fall. No head trauma. Parties separated. Nursing Assessment completed. Vital signs recorded. No complaints of pain. Able to move all extremities. Assisted to standing with two assists. Able to ambulate back to room without difficulty. R52's BIMS Evaluation dated 8/19/22 documents a score of 9/15 indicating moderately impaired cognition. R64's Order Summary Report dated 8/30/22 documents diagnoses including Alzheimer's Disease, Unspecified Dementia with Behavior Disturbances and Anxiety Disorder. R64's Nurse's Note dated 8/19/22 at 2:05 PM, documents at 12:20 PM R64 was ambulating back to room from dining room, talking with roommate. Another male resident (R46) became agitated, yelled F*** you at R64, R64 yelled it back. This prompted R46 to speed toward R64 in R46's wheelchair knocking R64 to the ground. V14/writer witnessed fall. No head trauma. Parties separated. Nursing assessment completed. Vital signs recorded. No complaints of pain. Able to move all extremities. Assisted to standing with two assists. Able to ambulate back to room without difficulty. Primary Care Provider notified. POA notified. R64's BIMS Evaluation dated 8/19/22 documents a score of 3/15 indicating severely impaired cognition. a.)2.) The facility's Preliminary Incident Investigation Report dated 8/30/22 documents the incident happened on an unknown date. (R88) stated another resident (R46) called me a f***ing b**** (expletives) and double fist hit my nose so bad around a month ago. R88's Order Summary Report dated 8/31/22 documents diagnoses including Transient Cerebral Ischemic Attack and Repeated Falls. This Order Summary documents an order for Clopidogrel (Plavix/Anticoagulant) 75 mg (milligrams), one tablet by mouth once a day related to Cerebral Infarction with a start date of 5/18/21. R88's Nurse's Note dated 8/30/22 at 2:50 PM, documents (R88) reported to Administrator (V1) that a month or so ago, another resident called me F---in b---- and double fist hit my nose so bad. (R88) reported that (R88) still felt pain on (R88's) nose bridge every now and then from the alleged incident. R88's BIMS Evaluation dated 7/14/22 documents a score of 10/15 indicating moderately impaired cognition. On 8/30/22 at 11:12 AM, during resident council meeting, R32 reported there was a physical altercation R32 witnessed that occurred between two residents in R32's room but asked to identify the residents and details in private. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/30/22 at 12:20 PM, (R32) requested the State Survey Agency come with R32 to R32's room after resident council meeting finished at this time. R32 stated R46 punched (R88) right in the face. R32 stated R32 witnessed this occur as it occurred right inside the doorway to R32's room. R32 stated R88 and R32 were in R32's room talking when R46 entered the doorway of R32's room. R32 stated R88 asked R46 to please move so R88 could leave R32's room and that is when R46 punched R88 with a closed fist. R32 stated R88's glasses went flying across the floor in R32's room and R88 started crying. R32 stated R46 got very hostile when this happened. On 8/30/22 at 1:25 PM, (R88) stated the picture the State Survey Agency showed R88 was R46. R88 stated R46 called R88 a fat f***ing b**** (expletives) a few different times. R88 stated around a month ago, R46 hit R88 so hard across the nose that R88 glasses fell off R88's face. R88 stated R88 hurt so bad and R88 was experiencing headaches and dizziness that R88 still gets from time to time since R46 hit R88. R88 stated R88 developed a little bruising to R88's nose. R88 stated R88 started crying and was afraid that R46 would come at R88 again. R88 stated, nothing would surprise (R88) with what (R46) could or would do to anyone in the facility. At this time R88 became tearful and began sobbing and crying again. R88 stated the facility would be stupid to ever let that f***ing a**hole (expletives) back in. R88 stated, (R88) just wants to feel safe. 8/30/22 at 1:41 PM, (R32) stated R32 is, very much so afraid of (R46) and that R46 has a bad temper. On 8/30/22 at 1:55 PM, (R88) began crying when discussing R46 hitting R88 across the nose. R88 stated R46 doubled up (R46) fist and hit R88 right across the nose. R88 stated, (R88) never hurt so bad as R88 did after R46 hit R88 with a closed fist. R88 stated it felt like R88's nose was split in half and R88's nose began bleeding after R46 hit R88. R88 stated R88 notified the staff nurses who R88 could not identify. R88 stated R88 nose still bleeds a little from time to time when R88 blows it. R88 stated staff had even taken stuff to clean R88's blood from R88's nose. R88 stated R88's nose still hurts. R88 agreed to go to the hospital for testing and/or radiology testing if the doctor says R88 needs to. On 8/30/22 the facility provided a list of interviewable residents on the second floor of the facility which also indicates all of the residents that could potentially be affected by R46's aggressive behavior. An Immediate Jeopardy situation was identified on 8/30/22. The Immediate Jeopardy was identified to have begun on 8/19/22 when the facility failed to ensure interventions were implemented related to R46's aggressive behaviors to prevent R46 from deliberately assaulting R52 and R64. On 9/2/22 at 11:23 AM, V1 Administrator was notified of the Immediate Jeopardy situation. On 9/6/22 at 1:05 PM, the surveyor confirmed through record review and interview that the facility took the following actions to remove the Immediate Jeopardy: 1.) R52 and R64 were interviewed. An initial abuse allegation report was completed on 8/19/22 by V24 Corporate Administrator and the final abuse investigation was completed on 8/26/22 by V1 Administrator for the incident of 8/19/22. R52 and R64 were assessed and monitored. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	2.) R88 was interviewed. An initial abuse allegation report was completed on 8/30/22 by V1 and a final abuse investigation was completed on 9/2/22 for an allegation reported on 8/30/22. 3.) R46 was involuntarily discharged to a Psychiatric hospital on 8/26/22 with paperwork completed by V3 Nurse Manager and a 30-day Discharge was issued to R46 on 8/26/22 completed by V1 Administrator. 4.) On 9/7/22, V25 Social Services Director and V34 Social Services Assistant completed a review of residents and identified residents who were predisposed to physical violence and the identified residents were assessed and evaluated for their ability to safely co-exist with other residents. 5.) All facility staff, including contracted agency staff, to complete training on abuse prevention policy and how to recognize triggers to prevent resident to resident abuse. This action was initiated on 9/2/22 and completed by V1 Administrator and V24 Corporate Administrator. 40385 B.) Based on interview and record review the facility failed to prevent a resident-to-resident altercation for two (R89, R95) of seven residents reviewed for abuse in the sample list of 99. Findings include: b.)1.) The facility's Abuse Prevention Program dated November 28, 2017, documents: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The facility's Final Incident Investigation Report dated 9/2/22 documents the following: On 8/28/22 staff observed R95 attempt to inappropriately touch another resident R89. V12 Certified Nursing Assistant (CNA) initially reported that V12 witnessed R95 touch R89 on R89's private (genital) area. V12 intervened and separated R95 from R89. V12 later clarified to local police that R95 was attempting to grab and unbutton R89's pants, and R89 was shaking and pushing R95 away with both of R89's hands. R95's hands were touching and grabbing towards R89's private (genital) area. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	R95's undated Diagnosis List documents R95 has diagnosis of Bipolar Disorder. R95's Minimum Data Set (MDS) dated [DATE] documents R95 has severe cognitive impairment, requires supervision of one staff person for locomotion on R95's unit. R95's Care Plan revised on 5/5/22 documents R95 has the potential to be physically aggressive towards other residents and has a history of a physical altercation with another resident. R95's Care Plan revised on 5/31/22 documents R95 has a behavior problem of exposing R95's self in R95's room and inappropriately touching female staff. This care plan includes an intervention Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. R95's Nursing Note dated 10/22/2021 at 11:51 PM documents R95 appeared in the common area wearing only an incontinence brief and shirt. R95 was asked what R95 was doing and replied that R95 wanted some. R95 was told that R95 was inappropriate and redirected back to R95's room. R95's Nursing Note dated 8/28/2022 at 2:24 PM documents R95 was touching a female resident (R89) and trying to unbutton her pants. R89's undated Diagnosis List documents R89 has a diagnosis of Alzheimer's Disease. R89's MDS dated [DATE] documents R89 is rarely/never understood, has short- and long-term memory impairment, R89's Care Plan dated 6/17/22 documents R89 is at risk for abuse and neglect per the facility's assessment tool. R89's Nursing Note dated 8/28/2022 at 2:39 PM documents R89 was sent to the hospital for evaluation after R89 was touched in groin area by another male resident (R95). On 8/29/22 at 3:56 PM V22 Licensed Practical Nurse (LPN) stated: R95 has made sexual comments to staff and residents while passing them in the hallway. R95 would say things such as you can come sit on my lap, or I'll help you undo your pants. This has been an ongoing behavior. We try to keep a close eye on R95 and have R95 near the nurse's station. R95 does wander at times. On 8/30/22 at 9:38 AM V12 CNA stated: On 8/28/22 around 1:50 PM, R95 was in the television room facing the window, and R89 was facing the television. R95 had R89's hands on R89 trying to unbutton R89's pants. R89 is nonverbal. R89 used R89's hands to try and push R95's hands off of R89, while R95 continued to attempt to unbutton R89's pants. V12 immediately separated R95 from R89. R95 is confused, and during incontinence care has made sexual comments in regards to female staff's breasts. On 8/31/22 at 3:30 PM V39 LPN stated: About a month ago during shift change, V39 saw R89 and R95 in the television room. R95's back was facing V39, and R95's arm was near R89. V39 was not able to see R95's hands. V39 approached R95, and R95 acted startled and said I'm not doing anything. It (the situation) didn't sit well with me (V39). R95 and R89 were immediately separated. V39 reported the incident to V13 Previous Administrator, and V13 told V39 it sounds like two residents with Dementia. After that incident, whenever V39 worked V39 had the female residents sit in the hallway for monitoring. R95 required close supervision.

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Accolade Healthcare of Savoy	302 West Burwash Savoy, IL 61874

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32853 Based on observation, interview and record review the facility failed to protect R52, R64, R89, and R99 from potential/further abuse pending investigation, following witnessed instances of physical, sexual, and mental/verbal abuse by R46 and V31. These failures impact six of seven residents (R46, R52, R64, R89, R95, R99) reviewed for abuse in the sample list of 99. Findings include: The facility's abuse policy documents, The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. This will be done by: immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property; VI. Protection of Residents. The facility will take steps to prevent potential abuse while the investigation is underway. Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of residents including, but not limited to, the separation of the residents. Accused individuals not employed by the facility will be denied unsupervised access to the residents during the course of the investigation. Supervisors shall immediately inform the administrator or person designated to act in the administrator's absence of all reports of incidents, allegations or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property. Upon learning of the report, the administrator or a designee shall initiate an incident investigation. 1.) R46's Admission Record/Face Sheet documents R46 was admitted to the facility on [DATE]. R46's Admission Minimum Data Set (MDS) dated [DATE] documents diagnoses including Schizophrenia, Wernicke's Encephalopathy, Alcohol Abuse with Intoxication and Unspecified Mood Disorder. This MDS documents a BIMS (Brief Interview for Mental Status) score of 9/15 indicating moderately impaired cognition. The facility's Preliminary Incident Investigation Report dated 8/19/22 at 12:20 PM, documents circumstances of the alleged incident: Resident (R46) was ambulating in (R46's) wheelchair behind (R52) and (R64). (R46) said 'f*** you' (expletive) and (R64) responded by saying the same to (R46). (R46) then propelled (R46's) wheelchair towards (R52) and (R64), and they fell to the ground. The residents were separated, and (R46) is being monitored 1:1 (one to one) pending orders received for (R46) to be sent out for evaluation. R46's Nurse's Note written by V14 Licensed Practical Nurse (LPN) dated 8/19/22 and written at 1:53 PM, documents the incident between R46, R52 and R64 and documents R46 was placed on 1:1 supervision at this time from time of incident. R46's Nurse's Note written by V43 Registered Nurse (RN) on 8/19/22 at 3:03 PM documents V45, R46's Physician, gave an order to send R46 to the hospital for evaluation. V43 wrote in R46's Nurse's Notes the same day, 8/19/22 at 8:29 PM that R46 returned from the hospital with no new orders. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V44 LPN wrote in R46's Nurse's Notes on 8/20/22 at 1:35 PM, writer did 1:1's with (R46) and documents that R46 came out of R46's room to mingle for a little. On 8/29/22 at 1:06 PM, V1 Administrator confirmed that when they document 1:1 monitoring they are meaning the resident is on 15 minutes checks. 40385 2.) The facility's abuse allegation investigative files from March 2022-August 2022 were reviewed. The only documented abuse allegation between R89 and R95 was for an incident that occurred on 8/28/22. The facility's Final Incident Investigation Report dated 9/2/22 documents the following: On 8/28/22 staff observed R95 attempt to inappropriately touch another resident R89. V12 Certified Nursing Assistant (CNA) initially reported that V12 witnessed R95 touch R89 on R89's private (genital) area. V12 intervened and separated R95 from R89. V12 later clarified to local police that R95 was attempting to grab and unbutton R89's pants, and R89 was shaking and pushing R95 away with both of R89's hands. R95's hands were touching and grabbing towards R89's private (genital) area. R95 was placed on 15-minute checks. R95's undated diagnosis list documents R95 has a diagnosis of Bipolar Disorder. R95's Minimum Data Set (MDS) dated [DATE] documents R95 has severe cognitive impairment, requires supervision of one staff person for locomotion on R95's unit. R95's Care Plan revised on 5/5/22 documents R95 has the potential to be physically aggressive towards other residents and has a history of a physical altercation with another resident. R95's Care Plan revised on 5/31/22 documents R95 has a behavior problem of exposing R95's self in R95's room and inappropriately touching female staff. R95's Nursing Note dated 10/22/2021 at 11:51 PM documents R95 appeared in the common area wearing only an incontinence brief and shirt. R95 was asked what R95 was doing and replied that R95 wanted some. R95 was told that R95 was inappropriate and redirected back to R95's room. R95's Nursing Note dated 8/28/2022 at 2:24 PM documents R95 was touching a female resident (R89) and trying to unbutton her pants. R95 was transferred to the local emergency room and returned to the facility on [DATE] at 8:48 PM. R95 was transferred to an inpatient psychiatric hospital on 8/29/22 at 2:00 PM. R95's 15 Minute Sign Off for 1:1 Supervision form documents R95 was checked on at 15-minute intervals from 8/28/22 at 8:00 PM until 2:00 PM on 8/29/22. R95's undated census report documents R95 resides on the 2nd floor of the facility. On 8/29/22 at 10:54 AM R95 was lying in bed, and there were no staff present in R95's room. On 8/29/22 at 3:56 PM V22 Licensed Practical Nurse (LPN) stated: R95 has made sexual comments to staff and residents while passing them in the hallway. R95 would say things such as you can come sit on my lap, or I'll help you undo your pants. This has been an ongoing behavior. We try to keep a close eye on R95 and have R95 near the nurse's station. R95 does wander at times. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/30/22 at 9:38 AM V12 CNA stated: On 8/28/22 around 1:50 PM, R95 was in the television room facing the window, and R89 was facing the television. R95 had R89's hands on R89 trying to unbutton R89's pants. R89 is nonverbal. R89 used R89's hands to try and push R95's hands off of R89, while R95 continued to attempt to unbutton R89's pants. V12 immediately separated R95 from R89. R95 is confused, and during incontinence care has made sexual comments in regard to female staff's breasts. On 8/31/22 at 3:30 PM V39 LPN stated: About a month ago during shift change, V39 saw R89 and R95 in the television room. R95's back was facing V39, and R95's arm was near R89. V39 was not able to see R95's hands. V39 approached R95, and R95 acted startled and said I'm not doing anything. It (the situation) didn't sit well with me (V39). R95 and R89 were immediately separated. V39 reported the incident to V13 Previous Administrator, and V13 told V39 it sounds like two residents with Dementia. V39 did not report the incident to anyone else. On 8/31/22 at 4:15 PM V1 Administrator confirmed there is no investigative file or report of an allegation of abuse between R95 and R89 prior to 8/28/22. V1 stated: After the incident on 8/28/22 R95 was placed on one-to-one supervision until R95 transferred to the psychiatric hospital on 8/29/22. We do not provide continuous one to one, our one to one is 15-minute checks. The Preliminary Incident Investigation Report dated 8/31/22 documents On 8/31/22 V39 verbalized an incident, a while ago, between residents (R95) and (R89) of what seems to be inappropriate interaction. V39 stated that R95's back was towards V39, and V39 observed R95's arm to be moving back and forth on what seemed like R89's lap. V39 immediately reported to V13 Previous Administrator, and V13 told V39 that the conclusion was two dementia residents having behaviors. This report documents an investigation was initiated. 35510 3.) The facility's verbal abuse allegation investigation for R99 and V31, Certified Nursing Assistant (CNA) documents the incident occurred on 8/18/22 at 8:00 AM. V31, CNA's Copy of Timecard Report dated 8/18/22 to 8/24/22 documents V31 worked as follows: 8/18/22 6:16 AM to 8:54 AM and 9:15 AM to 11:51 AM. 8/22/22 6:06 AM to 9:15 AM. On 9/6/22 at 10:35 AM, V32, Housekeeper stated V32 overheard V31, Certified Nursing Assistant (CNA) speaking in a negative tone to R99 on 8/18/22 between 6:30 AM and 8:00 AM. On 9/6/22 at 11:50 AM, V1, Administrator stated the facility should not have allowed V31, CNA to continue working on 8/18/22 after R99's alleged verbal abuse against V31. V1 Administrator stated V31 was to have been suspended pending the completion of the investigation and should not have worked on 8/22/22 either. V1 stated the investigation was completed 8/24/22. On 9/8/22 at 3:30 PM, V1, Administrator stated staff are not hired nor always scheduled to work the same unit and have the potential to work throughout the facility.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32853 Based on interview and record review the facility failed to develop an initial baseline care plan for one of 24 residents (R74) reviewed for care plans in the sample list of 99. Findings include: The facility's Care Plan Process policy dated 6/2015 documents, 2. The admitting nurse initiates the interim care plan, under Observations labeled initial Care plan. 3. The remainder of the interdisciplinary team will assess the resident within 72 hours of admission and add any issues to the initial care plan to address any immediate care needs. R74's Admission Minimum Data Set (MDS) dated [DATE] documents R74 was admitted to the facility on [DATE] with diagnoses including Fractures and Other Multiple Traumas, Anemia, Unspecified Fall and history of TIA (Transient Ischemic Attack). R74's MDS documents R74 had one fall in the last month and had one fall resulting in a fracture in the last six months. R74's Care Plan does not have any fall interventions until 8/6/22 when an actual fall took place. R74's initial Fall Risk assessment dated [DATE] documents R74 is at risk for falls and has had 1-2 falls in the last three months. On 9/6/22 at 10:10 AM, V21 MDS/CPC (Minimum Data Set/Care Plan Coordinator) confirmed there was no initial baseline care plan initiated for R74's falls.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 32853 Based on observation, interview and record review the facility failed to develop and implement a Comprehensive Care Plan for falls, bilateral hearing aide use, nutrition, weight loss and anticoagulant medication use for four of 24 residents (R74, R21, R101, R70) reviewed for Care Plans in the sample list of 99. Findings include: The facility's Care Plans-Comprehensive policy with a revised date of 1/2011 documents, An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 2. A comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS (Minimum Data Set). 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. incorporate risk factors associated with identified problems; g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels; 4. Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are added to the care plan. 5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem areas(s), rather than addressing only symptoms or triggers. 7. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS). 8. Assessment of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. 1. R74's Admission Minimum Data Set (MDS) dated [DATE] documents R74 was admitted to the facility on [DATE] with diagnoses including Fractures and Other Multiple Traumas, Anemia, Unspecified Fall and history of TIA (Transient Ischemic Attack). This MDS documents R74 had one fall in the last month and had one fall resulting in a fracture in the last six months. This MDS's Care Area Assessment Summary documents the trigger for Falls and documents Falls should be carried over to R74's Care Plan. R74's Fall Risk Assessments dated 7/1/22, 7/14/22, 8/6/22 and 8/25/22 all document R74 is at risk for falls. R74's Care Plan documents the first mention of a fall risk is dated 8/6/22 with the first fall intervention dated 8/6/22. R74's Nurse's Notes dated 8/6/22 at 7:00 AM documents R74 was found on the floor in R74's room. On 9/6/22 at 10:10 AM, V21 MDS/CPC (Minimum Data Set/Care Plan Coordinator) confirmed there was no comprehensive Care Plan developed for falls on admission or even after the admission MDS was completed for R74. V21 confirmed the first fall documentation on R74's Care Plan is after R74 fell at the facility on 8/6/22. Surveyor: [NAME], [NAME] (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R21's Order Summary Report dated 8/1/21-9/30/22 documents R21's medication orders including Xarelto (Anticoagulant) 20mg (milligrams) by mouth in the evenings for a diagnosis of Deep Vein Thrombosis. R21's Care Plans dated 2/16/22 does not document a Care Plan for R21's use of Anticoagulation medication and side effects to monitor for. R21's Progress Notes dated as follows documents: 7/17/22 at 7:48pm document R21 was actively bleeding from R21's right front tooth, pressure was applied and mouth rinsed with cool water and that bleeding continues. 7/17/22 at 8:37am documents to apply gauze and pressure until bleeding stops as needed to upper right tooth and monitor R21. On 9/6/22 at 11:50am, V1, Administrator confirmed V1 did not see a Care Plan for R21's Anticoagulation medication. The facility's Anticoagulation Clinical Protocol policy dated October 2015 documents the staff and physician will identify and address potential complications in individuals receiving anticoagulation. The staff and physician will monitor for possible complications in individuals who are being anticoagulated and manage related problems. 3. On 08/29/22 10:55 AM R101 was in R101's bed. During attempt to talk with R101, it was noted R101's hearing aids were not in R101's ears. At this time there is a sign on R101's bedside table documenting R101 is fully blind and has hearing aids. R101 unable to see or communicate at this time. R101's Progress Notes dated 7/27/22 at 11:56pm document R101 has hearing aides. R101's Minimum Data Set (MDS) dated [DATE] does not document R101 requires hearing aids. R101's Care Plans dated 8/27/22 do not document a plan of care for R101's hearing aid use. On 9/6/22 at 11:50am, V1, Administrator confirmed R101 should have a plan of care for R101's hearing aid use. 40385 4. R70's Minimum Data Set (MDS) dated [DATE] documents R13 has severe cognitive impairment, is not on a prescribed weight loss regimen, and has a weight loss of 5% or more in the last month or 10 % or more in the last six months. R70's undated weight log documents R70's weights as follows: 121.3 lbs. on 4/11/22, 110.4 lbs. on 6/14/22 (8.99 % loss since 4/11/22), 103.2 lbs. on 7/31/22 (6.52 % loss since 6/14/22), and 107 lbs. on 8/31/22. R70's Care Plan revised on 7/17/22 does not include a problem area, goals, and interventions for nutrition or weight loss. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/7/22 at 11:30 AM V21 MDS/Care Plan Coordinator stated V21 assists with updating care plans. V21 stated nutrition and weight loss should be addressed on the resident's care plan. V21 confirmed R70 does not have a nutrition or weight loss care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 32853 Based on interview and record review the facility failed to update resident Care Plans with falls, nutrition and weight loss concerns. The facility failed to conduct a Care Plan meeting with a resident's family and failed to invite a resident to the resident's Care Plan meeting for four of 24 residents (R74, R100, R95, R13) reviewed for Care Plans in the sample list of 99. Findings include: The facility's Care Plans-Comprehensive policy with a revised date of 1/2011 documents, An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 7. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS). 8. Assessment of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. The facility's Care Planning-Interdisciplinary Team policy with a revised date of 11/2010 documents, 3. The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. 4. Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family. 1. R74's Admission Minimum Data Set (MDS) dated [DATE] documents R74 was admitted to the facility on [DATE] with diagnoses including Fractures and Other Multiple Traumas, Anemia, Unspecified Fall and history of TIA (Transient Ischemic Attack). This MDS documents R74 had one fall in the last month and had one fall resulting in a fracture in the last six months. This MDS's Care Area Assessment Summary documents the trigger for Falls and documents Falls should be carried over to R74's Care Plan. R74's Nurse's Notes document R74 was found on the floor in R74's room on 8/6/22 and on 8/25/22. R74's Care Plan provided by V1 Administrator on 8/29/22 documents one fall on 8/6/22 but does not document any other falls for R74. On 9/6/22 at 10:10 AM, V21 MDS/CPC (Minimum Data Set/Care Plan Coordinator) stated that V21 is aware that there is an issue with Care Plans being updated. V21 stated V21 has not had time to get to all of the Care Plans for the entire facility of 120 plus residents. 35046 2. On 8/29/22 at 11:56 AM, V36 (R100's Family Member) stated she has been here a month and he has not been to a care plan meeting. V36 stated he does not know the plan for his mom's (R100) discharge or the progress she has made. V36 stated he would like to know what is going on with her progress and plan of care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/31/22 at 3:02 PM, V21 Care Plan Coordinator stated the facility hasn't been having care plan meetings. V21 stated they should have had R100's care plan after her 5 Day/Admission Minimum Data Set assessment (MDS). R100's Electronic Medical Record documents R100's Admission MDS was completed on 8/3/22. 40385 3. R13's Minimum Data Set (MDS) dated [DATE] documents R13 has severe cognitive impairment, R13 is not on a prescribed weight loss regimen, and R13 has had a weight loss of 5% or more in one month or 10% or more in six months. R13's undated weight log documents R13's weights and identified significant weight loss as follows: 118.6 lbs. (pounds) on 4/27/22, 118.7 lbs. on 5/3/22, 109.7 lbs. on 5/9/22 (7.58 % loss), 103.6 lbs. on 5/12/22 (5. 56% loss in 4 days), 103 lbs. on 5/24/22 (6.11 % loss from 5/9/22), and 101 lbs. on 8/22/22 (a 10% loss since 4/27/22.) R13's Nutrition Note dated 4/28/22 at 12:48 PM recorded by V47 Registered Dietitian (RD) documents R13 was reviewed for recent admission, R13's BMI (Body Mass Index) was 21.6 and was adjusted for above knee amputation. This note, documents Will monitor for need to modify nutrition. R13's Nutrition Note dated 5/26/2022 at 9:50 recorded by V47 documents R13 was evaluated for wounds and weight loss noted. R13's weight is down 15 lbs. since R13 admitted in late April 2022. R13 has a low BMI of 18.8, adjusted for left above knee amputation. V47 requested to change multivitamin to multivitamin with minerals, offer double protein at breakfast, a frozen nutritional supplement once daily, whole milk at meals, and change diet from Low Concentrated Sweets to regular. R13's Dietary Note dated 7/21/2022 at 12:04 recorded by V47 documents V47 requested to add ice cream with lunch. R13's Care Plan dated 6/21/22 documents R13 has a potential nutritional problem secondary to wound healing and includes interventions to provide diet as ordered and Registered Dietitian to evaluate and make dietary changes as needed. This care plan has not been updated to include R13's significant weight loss and nutritional interventions. On 9/7/22 at 11:20 AM V21 MDS/Care Plan Coordinator stated nutrition and weight loss should be addressed on the care plan. V21 confirmed R13's care plan has not been updated to reflect R13's weight loss. 4. R95's MDS dated [DATE] documents R95 has severe cognitive impairment, is not on a prescribed weight loss regimen, and has a weight loss of 5 % or more in 1 month or 10 % or more in 6 months. R95's undated weight log documents R95's weights as follows: 136.7 lbs. on 5/31/22 and 6/8/22, and 129.8 lbs. on 7/7/22 and 8/2/22 (5.05 % loss). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R95's Nutrition Notes dated 7/21/22, 3/7/22, 2/26/22, and 9/9/21 recorded by V47 RD, do not document an estimate of R95's calorie, protein, nutrient, and fluid needs There are no documented thorough/complete nutritional assessments in R95's medical record since 7/24/21. R95's Nutrition Note dated 7/21/2022 at 11:35 AM documents R95 was reviewed for weight loss for the past month, and R95's BMI remains low at 21. 6 with a goal of 23. R95's diet includes a nutritional shake 120 cc (cubic centimeters) four times daily. V47 suggested adding a frozen nutritional supplement for additional kilocalories. There is no documentation that R95 was evaluated by V47 after 3/7/22 until 7/21/22. R95's Care Plan dated as revised on 8/27/21 documents R95's diet is regular and R95 is at risk for altered nutrition due to new admission to the facility. This care plan includes interventions that R95 will be reviewed by the RD as needed, and this care plan has not been updated to reflect R95's significant weight loss and nutritional interventions to address weight loss. On 9/7/22 at 11:20 AM V21 MDS/Care Plan Coordinator confirmed R95's care plan has not been updated to address R95's weight loss.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to identify and document a wound, adjust wound treatments, implement physician ordered wound treatments and interventions, schedule follow up Orthopedic appointments, and monitor weights as ordered for four (R13, R34, R215, R372) of 24 residents reviewed for quality of care in the sample list of 99. Findings include: 1.) On 8/29/22 at 10:18 AM V38 (R13's Family) stated R13 had a toe amputation a few months ago due to Diabetic wounds. V38 had visited several times where R13's wound dressings weren't on, and R13's wounds were uncovered/exposed. V38 stated R13 is supposed to wear a surgical boot. V38 removed R13's sock and R13's right foot was wrapped with a dressing dated 8/28/22. On 8/31/22 at 1:02 PM V38 stated V38 had previously requested an order for R13 for Vitamin E oil and a petroleum-based ointment, but the facility never implemented the treatment. R13's Minimum Data Set (MDS) dated [DATE] documents: R13 has severe cognitive impairment and requires extensive assistance of one staff person for toileting and dressing. R13's Physician's Orders dated 8/31/22 documents an order with a start date of 6/14/22 to apply moisture barrier to perineal area and buttocks every shift, an order to cleanse the 5th toe arterial wound, pat dry, apply Santyl ointment to wound, apply gauze moistened with 1/4 strength Dakin's solution, cover with an abdominal pad, and wrap with gauze twice daily and as needed, apply Betadine twice daily to the right 3rd and 4th toe wounds, and an order dated 6/20/22 for a surgical boot to the right foot to be worn with ambulation. R13's Wound Evaluation & Management Summaries recorded by V46 Wound Physician document: On 5/12/22 R13's right 5th toe arterial wound measured 1.5 cm (centimeters) long x 1.2 cm wide x no measurable depth. The wound was 100 % covered with black, necrotic tissue, and had gangrene. V46 ordered Betadine applied topically twice daily. On 8/25/22 R13's right 5th toe wound measured 3.5 cm x 2 cm x 1.2 cm and contained 20% necrotic tissue. R13's right 4th toe arterial wound measured 2 cm x 1.5 cm x no measurable depth, was 100 % necrotic with gangrene. R13's right 3rd toe arterial wound measured 1.2 cm x 1 cm, was 100 % necrotic with gangrene. R13's Skin assessment dated [DATE] documents R13 has Moisture Associated Skin Damage (MASD) that is no blanchable, an initial treatment was administered, and R13's family and physician were notified. There is no documentation of R13's MASD prior to 8/31/22, or that treatments were altered to treat R13's MASD. R13's May 2022 Treatment Administration Record (TAR) documents the right 5th toe Betadine order was not implemented until the night shift on 5/16/22 (4 days after it was ordered.) This treatment is not signed out as administered on 5 days. R13's July 2022 TAR documents R13's right 3rd and 5th toe wound treatments are not signed out as administered on 7 days. R13's August 2022 TAR documents R13's right 3rd, 4th, and 5th toe wound treatments are not signed out as administered on 3 days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/29/22 at 3:50 PM R13 was self-propelling R13's wheelchair in the hallway. R13 was not wearing a boot on the right foot. On 8/31/22 at 3:12 PM R13 was sitting on the side of the bed with R13's right foot on the floor. R13 was not wearing a boot on the right foot. On 8/31/22 at 12:57 PM V38 told V12 Certified Nursing Assistant (CNA) that R13 needed assistance and that R13 was incontinent of bowel movement. V38 pulled down R13's incontinence brief which contained a small amount of bowel movement. R13's buttocks were red and excoriated. V38 stated the area had looked better on Sunday (8/28/22), but it looks worse today. On 8/31/22 at 1:02 PM V38 applied Vitamin E oil and a petroleum-based ointment. On 8/31/22 at 1:14 PM V12 CNA stated: R13's buttock excoriation was showing improvement, and last week it was not as red. Today it looks worse. The nurse (unidentified) was aware. We don't have access to barrier cream, it is given to us by the nurses to apply, but the nurses have to get an order first. On 8/31/22 at 3:39 PM V39 Licensed Practical Nurse (LPN) stated nothing has been reported about R13's buttock excoriation, and this is the first time V39 has heard about the excoriation. V39 administered R13's wound treatments to the right 3rd and 4th toe wounds, and 5th toe amputation wound. R13's 3rd and 4th toes were black indicating necrotic/dead tissue. R13's 5th toe was amputated, and there was a large wound with yellow and red tissue. There was tan drainage on the dressing. V39 stated the 5th toe wound has gotten larger and contains more yellow tissue. V39 cleansed the 5th toe wound, applied Santyl and gauze sponges, and wrapped R13's foot with gauze. V39 did not apply Dakin's-soaked gauze to the 5th toe wound. On 8/31/22 at 4:08 PM V39 assessed R13's buttocks. V39 stated the area looks like it is moisture associated that has flared back up. V39 stated V39 will get an order and apply barrier cream. V39 confirmed V39 did not apply Dakin's-soaked gauze to R13's right 5th toe wound. V39 stated V39 must have overlooked the Dakin's-soaked gauze in the order. On 9/01/22 at 3:22 PM V3 Infection Preventionist stated skin assessments are completed weekly by the nurses. The nurses should document skin issues, obtain a treatment order, and notify the physician if the treatment is not improving. V3 stated R13's right 4th toe wound was identified on 5/11/22, and the Betadine treatment was initiated on 5/16/22. V3 stated nurses should document their initials on the TAR when treatments are administered, and document resident refusals. V3 stated R13's surgical boot has been missing since last week. V39 confirmed there is no documentation of when R13's surgical boot is applied/removed. The facility's Wound Prevention Program dated February 2022 documents Notify the physician for any changes in the ski condition and obtain wound care treatment orders. Apply wound treatment as ordered by the physician. 2.) R34's MDS dated [DATE] documents R34 has short- and long-term memory loss. R34's Hospital Discharge Summary dated 8/10/22 documents R34 was diagnosed with a left wrist fracture. R34's discharge instructions document: A follow up for Orthopedic has been ordered for you. You will be contacted by the scheduling center for an appointment. Please schedule an appointment as soon as possible, If you do not receive a call within 2 days from now, please call the number below for an appointment. R34's Nursing Note dated 8/13/22 at 3:30 PM recorded by V39 Licensed Practical Nurse (LPN) documents R34 was not wearing the soft cast to the right wrist. The Physician was notified and gave orders to schedule an Orthopedic follow up visit on Monday (8/15/22) for a possible hard cast. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R34's Physician Orders Summary Report dated 8/30/22 documents an active order dated 8/13/22 to schedule R34's follow up Orthopedic appointment, and to discontinue the order once the appointment has been made and family is notified. R34's Nursing Note dated 8/30/2022 at 10:58 AM documents V29 (R34's Power of Attorney) was notified and agreed with scheduling an Orthopedic follow up appointment. R34's Nursing Note dated 8/30/22 at 12:14 PM documents R34's Orthopedic follow up appointment is scheduled for 9/19/22 at 2:30 PM, V34 Social Services Assistant spoke with R34's family on 8/25/22, and the family preferred that R34 not have a hard cast placed. There is no documentation that R34 was scheduled for an Orthopedic follow up appointment prior to 8/30/22, or that R34's family declined for R34 to have an Orthopedic follow up appointment. On 8/30/22 at 10:15 AM R34 was self-propelling R34's wheelchair in the hallway, using both hands. R34 was not wearing a soft cast or splint to R34's left arm. On 8/31/22 at 3:30 PM V39 LPN stated: V39 spoke with R34's family about the order for a follow up Orthopedic appointment due to R34 removing the soft splint cast. R34's family was in agreement with the appointment. I (V39) was off for a few days, and I (V39) guess no one followed up with making (R34) the ortho (Orthopedic) appointment. On 8/30/22 R 10:29 AM V23 LPN stated V11 Physician recommended R34 have a follow up Orthopedic appointment for a hard cast due to R34's noncompliance with wearing the soft cast. R34's family refused R34's follow up appointment, and it should be documented in a progress note. On 8/30/22 AT 10:38 AM V23 stated V23 spoke with R34's family to confirm their refusal of the follow up Orthopedic appointment. R34's family was in agreement to schedule R34's follow up appointment, and R34's family wants everything the Orthopedist can do for R34. 35046 3.) R215's hospital summary dated 8/20/22 documents R215 has a history of Congestive Heart Failure. R215's physician order dated 8/24/22 documents to obtain daily weights. Notify physician if weight gain of more than 3 lbs per day or more than 5 lbs in one week. R215's medical record does not document weights were done daily. R215's medical record from 8/24/22 to 9/8/22 daily weights were only completed on 8/30/22, 9/2/22, and 9/6/22. R215's Wound Evaluation Form documented by V46 Wound Physician documents R215 has a Diabetic wound to the right ankle. This form includes a recommendation for a calf high heel protector while in bed. On 8/31/22 at 11:28 AM, R215 was lying in bed on his right side. R215's legs were curled up and R215's feet were crossed. R215 was not wearing a calf high heel protector or any other type of heel protector. At that time, a calf high heel protector was lying on a three-drawer cabinet on the other side of the room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/31/22 at 11:45 AM, V35 Licensed Practical Nurse stated she was unaware of the recommendation and is not sure when R215 is supposed to be wearing the heel protector. V35 stated is unsure why R215's weights aren't getting completed. 42702 4.) R372's Orthopedic after care notes document a post operative appointment on 5/18/22. The post operative visit notes dated 5/18/22 document that R372 is to follow up with another post operative appointment and Xray on 6/29/22. R372's medical record does not document R372 attending any appointments on 6/29/22, nor does it document the appointment being rescheduled. Additionally, R372's medical record does not document an Xray being done. On 9/13/22 at 9:27AM, V21 Minimum Data Set Coordinator/Care Plan Coordinator stated, After a surgery like R372 had, she should have been seen by Orthopedics as ordered and have gotten an Xray. On 9/13/22 at 11:00 AM, V34 Social Services Assistant/Appointment Scheduler stated that she did not know about this appointment. On 9/13/22 at 12:00 PM, V1 Administrator confirmed that R372 did not attend this appointment and that the facility could not explain why this error occurred.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32853 Based on observation, interview and record review the facility failed to investigate fall occurrences and implement fall interventions for three of four residents (R74, R21, R17) reviewed for falls in the sample list of 99. Findings include: The facility's Falls Prevention Program policy with a revised date of 11/2017 documents, Fall prevention program will be implemented to ensure all resident's safety in the facility whenever possible. This program should include a measure that determines each resident's needs by assessing the risks for falls and implementing appropriate interventions to provide the necessary supervision, and assistive devices are utilized as necessary. Post Fall Incidents: 4. Identify the root causes of the fall incident, which could be related to the resident's current or declining medical condition or worsening behavior. 5. The staff will evaluate, and document falls that occur while the individual is in the facility, for example, when and where they happen, any observations of the events, etc. (etcetera). 6. For an individual who has fallen, staff will attempt to define possible root cause(s) of the fall. a. Causes refer to factors that are associated with or that directly result in a fall; for example, a balance problem caused by an old or recent stroke. b. Often, multiple factors in varying degrees contribute to a falling problem. 10. Collect and evaluate any information until either the cause of the falling is identified or can be speculated as to what was the resident trying to do causing the fall, or it is determined that the cause cannot be found or that finding a cause would not change the outcome or the management of falling and fall risk. Treatment/Management 1. Based on the preceding assessment, the staff and or physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. 2. If the underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment until falling reduces or stops or until a reason is identified for its continuation. Monitoring and Follow-Up If the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions. 1.) R74's Order Summary Report dated 8/30/22 documents diagnoses including Difficulty in Walking, Muscle Weakness and Cognitive Communication Deficit. R74's Minimum Data Set (MDS) dated [DATE] documents R74 requires extensive assistance of one staff for transfers and toileting and total dependence on one staff for walking in R74's room. R74's Census List dated 9/8/22 documents R74 was admitted to the facility on [DATE]. R74's Fall Risk Assessments dated 7/1/22, 7/14/22, 8/6/22 and 8/25/22 all document that R74 is at risk for falls. R74's MDS dated [DATE] documents R74 had one fall in the last month prior to admission and one fall with a fracture in the last six months prior to admission which triggered Falls on the CAAs (Care Area Assessments). The Assessment documents falls as a concern for R74 with instructions to proceed to care planning. R74's Care Plan does not document any fall interventions prior to 8/8/22. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/6/22 at 10:10 AM, V21 MDS/CPC (Minimum Data Set/Care Plan Coordinator) confirmed there was no initial fall care plan for R74 with no fall interventions developed until 8/6/22. 35510 2. R21's Care Plans dated 1/31/22 document R21 can potentially have a fall. There is no documentation of R21 sustaining falls and/or post fall intervention updates for R21's fall on 8/29/22. On 08/29/22 at 11:53 AM R21 fell forward out of R21's wheelchair. At this time V28, Activities Director was walking behind R21. V28 stated He threw himself on the floor out of the chair. R21's leg dropped after R21 had lifted it and R21 fell to the floor on R21's knees. V41, Assistant Director of Nursing (ADON) asked V28 if there were any additional witnesses to R21's fall. V28 stated there were no additional witnesses to R21's fall out of R21's wheelchair. On 09/01/22 at 09:36 AM R21 stated R21's back of leg bothers R21. R21 stated R21's leg slipped off as R21 tried to move R21's upper leg and R21's leg got stuck dropped and R21 fell . On 9/1/22, after speaking with R21 at 9:36 AM, V1, Administrator was notified of R21's fall that had occurred on 8/29/22 and that this fall was not documented in R21's medical records. V1 stated staff should complete an investigation into a report of a fall and document in the resident's medical records. On 9/6/22 at 11:50 AM, V1, Administrator stated the facility should not just assume or consider a fall a behavior without investigating and that is what V1 feels the facility potentially did for R21's fall. 42702 3) R17's undated diagnosis list documents the following diagnoses including Neuromuscular Dysfunction of Bladder, Generalized Anxiety Disorder, Cognitive Communication Deficit, Unspecified Psychosis, Hypothyroidism, Major Depressive Disorder, Urinary Tract Infections and Retention, Syncope, Congenital Hydrocephalus, Spinal Stenosis, and Dysphagia. R17's brief interview for mental status dated 5/17/22 documents R17 as moderately cognitively impaired. R17's progress notes dated 7/4/22, 7/14/22, 7/25/22, 9/1/22 document resident falls from the bed, identified as behaviors of throwing self onto floor. R17's care plan dated 4/23/21, documents, Increase activities of his choice when resident is exhibiting behaviors and intentionally putting himself on the floor. On 8/29/22 and 8/30/22 from 9:00 AM to 4:00 PM no group activities with residents were observed. During this survey; no 1:1 activities were observed including R17. On 8/30/22 at 11:00 AM, R17 stated that no one provided activities for him. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/22 at 10:00 AM and 2:00 PM, 8/30/22 at 9:30 AM and at 3:00 PM, 8/31/22 at10:30 AM and at 1:30 PM, 9/6/22 at 10:45 AM and at 3:30 PM and on 9/7/22 at 10:30 AM R17 was observed in his room, in bed. On 9/6/22 V22 Licensed Practical Nurse stated, They need to get him out of his bed. He is bored and that's why he keeps throwing himself out of bed. They used to do activities with everyone in the dining room but since COVID, (R17) and the others are just bored. They give them a paper and that's it. On 9/6/22 at 10:36 AM, V28 Activity Director stated, I haven't tried to get (R17) up for activities since March. I was told by V29 Administrator that I wasn't supposed to do group activities. I was doing 1:1 but (R17) is hard. I know that it is better for them to socialize. I was just doing what I was told.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35510 Based on observation, interview and record review, the facility failed to implement physician's orders for a urinary catheter, failed to develop and implement a plan of care related to the urinary catheter use. This failure affects one of four residents (R101) reviewed for urinary catheter use on the sample list of 99. Findings include: R101's Face Sheet documents R101 admitted to the facility on [DATE]. R101's Hospitalist Progress Note dated 7/26/22 documents R101 developed Acute Urinary Retention on 7/25/22 and a urinary catheter was placed. R101 is to follow-up with Urology as an outpatient. R101's urinary catheter was placed on 07/25/2022. (R101) will need Urology follow-up as an outpatient. This note also documents R101 is to follow-up with Urology for voiding study. R101's Post-Acute Care Transition Document dated 7/27/22 documents R101's urinary catheter as a Coude urinary catheter (slight curve near the insertion end of the urinary catheter tubing) size 14 french. This document also documents Discharge Instructions, Follow-up with Urology for voiding study. On 08/29/22 10:55 AM R101's urinary catheter tubing was red/brown. R101's Progress Notes dated 8/1/22 at 11:31 PM documents an order was received for a urinalysis to be obtained due to Hematuria. R101 to have f/u (follow-up) with Urology regarding Hematuria. R101's Order Summary Report dated 9/5/22 documents an order dated 8/1/22 to, Refer (R101) to Urology related to Hematuria. This report also documents to change R101's urinary catheter every four weeks but does not document R101's use of a Coude urinary catheter. There is no documentation R101 has had a follow-up appointment with a Urologist as ordered on admission as well as ordered on 8/1/22 by the facility. R101's Care Plans dated 8/27/27 document R101 has a urinary catheter due to Urinary Retention. These Care Plans do not document R101 has a Coude urinary catheter or size of R101's urinary catheter. These Care Plans also do not document R101's follow-up with a Urologist for voiding trials. On 9/8/22 at 1:00pm, V41, Assistant Director of Nursing (ADON) stated the facility did not call until 9/6/22 for an appointment for R101 at a local Urology clinic.

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F 0740 Level of Harm - Actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32853 Based on interview and record review the facility failed to comprehensively assess a resident's aggressive behaviors upon admission for one of one resident (R46) reviewed for behaviors in the sample list of 99. This failure has the potential to affect 65 residents (R36, R42, R164, R365, R47, R88, R109, R17, R79, R92, R37, R18, R69, R3, R71, R22, R366, R76, R9, R64, R49, R63, R30, R67, R60, R72, R40, R57, R105, R113, R50, R85, R54, R44, R86, R48, R38, R23, R96, R16, R104, R12, R2, R53, R20, R78, R70, R33, R59, R5, R34, R6, R82, R32, R81, R13, R103, R110, R56, R29, R91, R77, R95, R55, R165) residing on the second floor of the facility. Staff allowed R46 unsupervised access to residents who are unable to protect themselves from R46's behaviors. Findings include: The facility's Behavior Monitoring policy dated 10/2015 documents, Problematic behaviors will be identified and managed appropriately. The facility staff and Attending Physician will identify individuals with a history of impaired cognition (e.g., dementia, mental retardation), problematic behavior, or mental illness (e.g., bipolar disorder or schizophrenia). R46's Face Sheet dated 8/19/22 documents an admitted [DATE]. R46's Admission Minimum Data Set (MDS) dated [DATE] documents diagnoses including Progressive Neurological Conditions, Schizophrenia, Wernicke's Encephalopathy, Alcohol Abuse with Intoxication and Unspecified Mood Disorder. This MDS documents a BIMS (Brief Interview for Mental Status) score of 9/15 indicating moderately impaired cognition. R46's MDS dated [DATE] documents R46 had behaviors that put others at significant risk for physical injury, significantly intruded on the privacy of others, significantly disrupted care or living environment and wandering significantly intrudes on the privacy or activities of others. R46's Baseline Care Plan dated 6/20/22 documents the only behavioral concern was wandering. R46's Social Services Behavior Conditions Review dated 8/26/22 (after R46 was discharged to the Psychiatric hospital) documents R46's new or worsening behavior as aggressive behaviors towards staff and other residents. This Review documents R46 had exhibited physically aggressive behaviors towards residents. R46's Nurse's Progress Note dated 6/20/22 at 1:54 PM documented by V22 Licensed Practical Nurse (LPN) documents, (R46) having behaviors noted on this shift/ refusing medication. and (cussing) at nursing staff. NP (Nurse Practitioner) notified. Will continue to monitor. On 6/20/22 at 8:37 PM, V22 documents, (R46) noted having behaviors on this shift. (R46) was cursing/ yelling while (R46) was in (R46's) room. When staff tried to redirect (R46) continued to curse and yell. (R46) is now calm in bed call light within reach. Will continue to monitor. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Some	R46's Nurse's Progress Note dated 6/24/22 at 11:17 AM by V44 Licensed Practical Nurse (LPN) documents, (R46) has been trying to go to other (resident's) room with redirection. After being informed to not go into other (people's) (rooms) (R46) continued to do so. (R46) unplugged (R12's) air mattress and spilled water all over the floor. (R46) refused to come out by staff. (R46) was finally able to be redirected to (R46's) room. (R46) is now in (R46's) room in bed. Facility management notified. R12's Diagnosis Report dated 9/8/22 documents diagnoses including Quadriplegia and Tracheostomy status. On 7/8/22 at 4:25 PM, V4 LPN documents, (R46) Behavior: E) Hallucinations/Delusions/Psychosis 1) Able to redirect and refocus 3) Medication given 2) Keep redirecting every shift. On 7/14/22 at 9:33 PM, V44 documents, (R46) having behaviors this evening. (R46) was being physically and verbally abusive to staff. (R46) stated I will punch you and give you two black eyes to the writer. (R46) was redirected and was unsuccessful. (R46) started to become a threat to staff, (residents), and self. (R46) started to push and shove furniture. MD (Medical Doctor) notified. (R46) is to be sent to (hospital) for altered mental status evaluation. When paramedics arrived (R46) became aggressive with EMT (Emergency Medical Technicians) by telling them Bet nobody touches me and screaming. Notified (POA) and facility (Administrator). Will continue to monitor. On 8/11/22 at 7:03 PM, V4 documents, (R46) Behavior: B) Combative/hitting/kicking staff/resists care C) Crying/restlessness/agitated E) Hallucinations/Delusions/Psychosis 1) Able to redirect and refocus 3) Medication given 2) Keep redirecting every shift. On 8/19/22 at 1:53 PM, V14 LPN documents, (R46) became agitated with 2 other female residents (R52, R64). (R46) was in wheelchair on (R46's) way back from dining room. Female patients ambulating back from lunch in the 2 south dining room. Writer heard (R46) yell F*** you to (R52, R64). Writer began going toward the commotion. (R52, R64) yelled back F*** you. (R46) sped up his wheelchair and hit (R52, R64) directly knocking them to ground. Writer interviewed and separated all parties. (R46) stated they deserved it and they shouldn't talk to (R46) like that. PCP (Primary Care Provider) notified states to continue monitoring. emergency contact notified. (Administrator) and nurse managers notified. (R46) on 1-1 supervision at this time from time of incident. On 8/26/22 at 1:04 AM, V4 documents, (R46) Behavior: C) Crying/restlessness/agitated 1) Able to redirect and refocus 2) Keep redirecting. On 8/26/22 at 2:58 PM, V14 documents, (R46) left with transport for (Psychiatric) hospital in (the north) at (2:40 PM). Med list (medication list) and face sheet sent with. Writer reached out to (hospital) to give report, they stated they do not need a report just send (R46). R74's Order Summary Report dated 8/30/22 documents diagnoses including Cognitive Communication Deficit and Difficulty Walking. R74's Minimum Data Set (MDS) dated [DATE] documents diagnoses including Fractures and Other Multiple Trauma and History of TIAs (Transient Ischemic Attacks). R74's BIMS Evaluation dated 7/3/22 documents a score of 7/15 indicating moderately impaired cognition. (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Some	The facility's Preliminary Incident Investigation Report dated 8/25/22 at 6:22 PM, documents Employee reported suspicion of unusual event on 8/25/22 approximately 6:22 PM. (R74) was in (R74's) room with door blocked open by a wheelchair belonging to (R46). (R74's) wheelchair was between R74 and the other wheelchair. (R74) was lying on the floor and reported that (R74) had fallen. (R74) was undressed from waist down and soiled depend lying on (R74's) bed. No injury noted by nurse assessing the resident. Both residents (R46 and R74) were sent out for evaluation. Physicians and POA/emergency contacts notified. Police notified. (V15 Police Officer) arrived at facility to interview staff and residents. R74's Nurse's Note dated 8/25/22 at 5:00 PM, documents CNA (Certified Nursing Assistant) notified nurse that (R74) was on the ground, undressed from the waist down and (R46) was wrapped in (R74's) bed sheet. CNA told second nurse. Nurse notified administrator; statement given. Doctor contacted gave order to send out for assessment. POA notified. (R74) assessed. (R74) Vital Signs WNL (Within Normal Limits). No c/o (complaints of) pain. Sent (R74) to hospital to be assessed. On 8/29/22 at 3:55 PM, V5 Certified Nursing Assistant (CNA) stated on 8/25/22 around dinner time, 5:00 PM-6:30 PM, V5 noticed R46 standing at the nurse's station with no wheelchair with R46. V5 stated that V5 went to look for R46's wheelchair. V5 looked in a couple of rooms but then came to R74's room and the door would only open a small way.V5 stated that there were wheelchairs blocking the door and R74 was on the floor on the other side of the wheelchairs. V5 stated R74 had no clothes on from the waist down and R74's used incontinent brief was laying on the bed away from R74. V5 stated V5 could not fit through the opening without pushing the wheelchairs into R74 so V5 got the nurse (V6 Licensed Practical Nurse/LPN) and V6 was able to fit through the opening and climbed over the bed to get to the other side of the wheelchairs and rearranged things so V5 could come in and assist. V5 stated they got R74 up off the floor and dressed and during this time R46 returned to the room with R74's personal bed sheet wrapped around R46. V5 stated R46 was screaming at them to get out of R46's house. V5 stated after they got R74 up and R74's pants back on V5 left R74 with V6. V5 stated that R46 is a resident with high behaviors. V5 also stated that R46 is a highly disturbed man that is abusive, mean and nasty. On 9/8/22 at 10:30 AM, V25 confirmed that there was no behavior assessment completed for R46 upon admission. V25 stated that R46's behavior assessment was not completed until 8/26/22. The facility's Resident Room Roster provided on 8/30/22 documents 65 residents (R36, R42, R164, R365, R47, R88, R109, R17, R79, R92, R37, R18, R69, R3, R71, R22, R366, R76, R9, R64, R49, R63, R30, R67, R60, R72, R40, R57, R105, R113, R50, R85, R54, R44, R86, R48, R38, R23, R96, R16, R104, R12, R2, R53, R20, R78, R70, R33, R59, R5, R34, R6, R82, R32, R81, R13, R103, R110, R56, R29, R91, R77, R95, R55, R165) reside on the second floor.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35046 Based on interview and record review the facility failed to administer medications per physician's order for two of two residents (R215, R80) reviewed for significant medication errors on the sample list of 99. Findings include: 1) R215's hospital summary dated 8/20/22 documents R215 was hospitalized for Right Foot Gangrene with Cellulitis Osteomyelitis status post 4th and 5th digit amputation and followed by 2nd and 3rd metatarsal amputation with graft and Diabetes Mellitus type 2 Chronic with Neuropathy and Nephropathy. R215's Electronic Medical Record documents R215 was admitted to the facility on [DATE]. R215's physician orders documents orders dated 8/20/22 for Ertapenum Sodium 1 gram intravenously for right 4th and 5th toe amputation, Empagliflozin 20 milligrams every day for Diabetes Mellitus Type II, and Protonix (Gastric Acid Secretion Reducer) 40 milligrams every day for Gastrointestinal Reflux Disorder. R215's Medication Administration Record dated 8/1/2022 through 8/31/22 documents that R215 did not receive the physician ordered doses of Ertapenum Sodium (Antibiotic), Empagliflozin (Antihyperglycemic) 20 milligrams, or Protonix 40 milligrams on 8/21/22 and 8/22/22. R215's nurse's notes dated 8/21/22 and 8/22/22 documents, awaiting pharmacy. On 8/31/22 at 1:10 PM, V3 Registered Nurse Manager stated when R215 was admitted , R215's face sheet was not sent to the pharmacy as required so the pharmacy did not send R215's medications. V3 stated the nurse's on duty that weekend should have notified someone that R215 did not receive the medications from the pharmacy. 42702 2) R80's undated diagnosis sheet documents the following diagnoses including Metabolic Encephalopathy, Catatonic Schizophrenia, Stage four kidney disease, Chronic Atrial Fibrillation, Anxiety, Depression, Congestive Heart Failure, Atherosclerotic Heart Disease, Peripheral Vascular Disease, and History of Stroke. R80's hospital discharge/transfer notes dated 4/12/22 document R80 has a diagnoses of Paroxysmal Atrial Fibrillation (PAF) and takes Eliquis 5 milligrams twice a day for PAF. R80's care plan dated 8/27/22 documents that R80 is at risk for discolorations and bleeding due to anticoagulant medication for treatment of Atrial Fibrillation with Eliquis as the medication being used to treat. R80's August medication administration record documents Eliquis stopped on 8/7/22 and not resumed in the month of August. R80's September medication administration record documents no Eliquis given from September 1, 2022, through September 13, 2022. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/13/22 at 1:00 PM, V63 Medical Doctor stated, If (R80) was on Eliquis for Atrial Fibrillation, then she should be restarted on it. I was not the doctor who started her on this medication, nor did I stop it. On 9/13/22 at 2:54 PM, V61 Registered Nurse stated, (V62 Medical Doctor) wanted me to relay that the Eliquis should not have been stopped, should be restarted, and that the potential for harm is great with a moderate level of risk for Stroke recurrence. On 9/14/22 at 9:45AM, V1 Administrator stated that the facility could not determine why the Plavix had been stopped, but that they had received an order on 9/14/22 to restart the medication for R80.