STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. Building B. Wing	09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
City View Multicare Center	5825 West Cermak Road Cicero, IL 60804

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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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on observation interview and record review, the facility failed to follow their Facility Outside Community Pass Privileges Policy and allow residents on the seventh floor assessed to have green pass privileges to be able to access common areas on the second floor for three (R39, R40, R41) of three residents reviewed for resident rights. Findings include: R39 was admitted to the facility on [DATE] with diagnoses of hypertension, diabetes type II and schizoaffective disorder. R39's brief interview for mental status score dated 8/18/22 documents a score 15/15 which indicates cognitively intact. R39's physician orders dated 6/10/22 document green pass. R39's community survival skills dated 8/18/22 documents: Resident appears to be capable of outside pass privileges. On 9/1/22 at 3:23PM, R39 who was alert and oriented at time of interview stated staff have to escort resident to the second-floor store. Resident is not allowed to go on other units within the building. R39 stated it makes him feel bad. On 9/6/22 at 356PM, V1(Administrator) stated Residents should not be escorted throughout the building or to access the second floor. V1 was unaware that was occurring only on the seventh floor. V1 stated it should not be taking place unless there is an active concern for safety. On 9/1/22 at 3:11PM, V65 (security) and V66 (security) stated all residents on the seventh floor are unable to go to other units in the building unless they are escorted by staff. Residents are not allowed to access the second-floor store or smoking area unless staff is present due to behaviors. (continued on next page)

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 - Few	Facility Outside community pass privileges policy undated reviewed by surveyor on 8/31/22 documents: Green pass- Resident may go out of the community independently and return within curfew hours. Yellow pass- resident who may go out in the community with a responsible party has been deemed appropriate by the IDT and return within designated time limit- residents will be given 2-hour Yellow pass initially and gradually increase. Red pass- residents who have violated facility policy or a resident who cannot go out in the community independently due to cognitive inabilities, degree and severity of mental Illinois, addiction history and present addictive behaviors, community safety skills, psychiatric status, ability to follow the rules and procedures, maintenance of appropriate grooming and hygiene. R40 was admitted to the facility on [DATE] with diagnoses of adjustment disorder, hypertension and hyperlipidemia. R40's brief interview for mental status score dated 8/18/22 documents a score 15/15 which indicates cognitively intact. On 9/1/22 at 3:20PM, R40 who was alert and oriented at time of interview stated staff have to escort the resident to the second-floor store. The resident is not allowed to go on other units within the building. R40 stated it makes him feel like a kid and he doesn't understand it. R40's physician orders dated 6/9/22 document green pass. R40's community survival skills dated 7/20/22 documents: Resident appears to be capable of outside pass privileges. On 9/6/22 at 3:56PM, V1(Administrator) stated residents should not be escorted throughout the building or to access the second floor. V1 was unaware that was occurring only on the seventh floor and stated it should not be taking place unless there is an active concern for safety. On 9/1/22 at 3:11PM, V65 (security) and V66 (security) stated all residents on the seventh floor are unable to go to other units in the building unless they are escorted by staff. Residents are not allowed to access the second-floor store or smoking area unless staff is present due to behaviors. R41 was admitted to the facility on [DATE] with diagnoses of schizoaffective disorder and major depressive disorder. R41's brief interview for mental status score dated 7/7/22 documents a score 15/15 which indicates cognitively intact. On 9/1/22 at 3:04PM, R41 who was alert and oriented at time of interview stated staff have to escort resident to the second-floor store. The resident is not allowed to go on other units within the building. R41 stated he is mad and does not understand why he can leave the building unsupervised but not go to the second floor unsupervised. R41's physician orders dated 6/10/22 document green pass. R41's community survival skills dated 9/2/22 documents: Resident appears to be capable of outside pass privileges. On 9/6/22 at 3:56PM, V1(Administrator) stated residents should not be escorted throughout the building or to access the second floor. V1 was unaware that was occurring only on the seventh floor and stated it should not be taking place unless there is an active concern for safety. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/1/22 at 3:11PM, V65 (security) and V66 (security) stated all residents on the seventh floor are unable to go to other units in the building unless they are escorted by staff. The residents are not allowed to access the second-floor store or smoking area unless staff is present due to behaviors.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on interview and record review, the facility failed to follow their advance directives policy by not assisting residents who are unable to make decisions to obtain guardianship for four (R43, R45, R4, R46) of four residents reviewed for decisions and guardianship. Findings include: R43 was admitted to the facility on [DATE] with a diagnoses of schizoaffective disorder, cognitive communication deficit, and hypotension. R43's brief interview for mental status score dated 7/4/22 documents a score 3/15 which indicates cognitively impaired. R43's medical record did not document any power of attorney paperwork or guardian paperwork. On 9/7/22 at 2:47PM, V17 Psychiatric Rehabilitation Service Director (PRSD) stated resident advance directives are evaluated upon admission and annually. Resident decision making is based on the brief interview for mental status score. A score below 11 would be cause for concerns and would require notification to doctor to determine decisional capabilities which would be initiated by social services. Once the doctor is aware they would complete the form and request for state guardian or guardianship. V17 stated he was not at the facility at the time the residents were initially assessed. Facility policy titled Advance Directives Policy and Procedures undated documents: The facility provides to all residents the right to accept or refuse medical and surgical treatment and at the resident's option, formulate an advance directive. Determine upon admission whether resident or legal representative has an advanced directive and if not, determine whether the resident or legal representative wishes to formulate an advance directive. Periodically assess the resident for decision-making capacity and invoke the health care agent or legal representative if the resident is determined not to have decision making capacity. Identify primary decision maker. If the resident has not executed advance directives or is incapacitated, the facility will advise the resident or legal representative regarding the right to establish an advance directive R45 was admitted to the facility on [DATE] with a diagnosis of dementia, schizophrenia, and dysphagia. R45's brief interview for mental status score dated 7/8/22 documents a score 3/15 which indicates cognitively impaired. R45's face sheet documents R45 as responsible party. R45 medical record did not document any power of attorney paperwork or guardian paperwork. On 9/7/22 at 2:47PM, V17 (PRSD) stated resident advance directives are evaluated upon admission and annually. Resident decision making is based on the brief interview for mental status score. A score below 11 would be cause for concerns and would require notification to doctor to determine decisional capabilities which would be initiated by social service. Once the doctor is aware they would complete form and would request for state guardian or guardianship. V17 stated he was not at the facility at the time the residents were initially assessed. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R4 was admitted to the facility on [DATE] with diagnoses of dysphagia, schizophrenia, and altered mental status. R4's brief interview for mental status score dated 8/15/22 documents a score 0/15 which indicates cognitively impaired. R4's face sheet documents R4 as responsible party. R4 medical record did not document any power of attorney paperwork or guardian paperwork. On 9/7/22 at 2:47PM, V17 (PRSD) stated resident advance directives are evaluated upon admission and annually. Resident decision making is based on the brief interview for mental status score. A score below 11 would be cause for concerns and would require notification to doctor to determine decisional capabilities which would be initiated by social service. Once the doctor is aware they would complete form and would request for state guardian or guardianship. V17 stated he was not at the facility at the time the residents were initially assessed. R46 was admitted to the facility on [DATE] with diagnoses of dementia, dysphagia, schizophrenia and major depressive disorder. R46's brief interview for mental status score dated 7/13/22 documents a score 0/15 which indicates cognitively impaired. R46's face sheet documents R46 as responsible party. R46 medical record did not document any power of attorney paperwork or guardian paperwork. On 9/7/22 at 2:47PM, V17 (PRSD) stated resident advance directives are evaluated upon admission and annually. Resident decision making is based on the brief interview for mental status score. A score below 11 would be cause for concerns and would require notification to doctor to determine decisional capabilities which would be initiated by social service. Once the doctor is aware they would complete form and would request for state guardian or guardianship. V17 stated he was not at the facility at the time the residents were initially assessed.

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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. 41758 Based on interview and record review, the facility failed to follow their Change in Resident's Condition Policy by not notifying the Psychiatrist of an attempted suicide for 1 of 3 (R23) residents reviewed for change in condition. Findings includes: On 8/30/22 at 4:26PM, V35 (nurse) stated, R23 was pacing all night. I did not call V48 (Psychiatrist) until the morning after, I found R23 hanging in the dining room. On 9/1/22 at 1:51PM, V48 stated, the facility is putting my name in the resident's chart. I was not called about R23's suicide attempt. I was not informed about R23 having a belt around his neck. I would have sent R23 to the hospital via 911. I was not aware of R23's pacing or any of R23's behaviors the night before R23's suicide attempt. I would have placed R23 on 1:1 monitoring. Nursing note dated 7/31/22 documents: At 2300 upon making rounds resident (R23) was noted to be absent from his bed, previous nurse (V16) stated R23 had returned from pass. R23 was observed hiding in the restroom on the first floor. R23 was escorted back to the floor by security. At 2320 this nurse (V35) assisted R23 to restroom and back to his room. 2330 R23 was observed pacing hallway quietly. 0030 R23 was observed in his bed laying quietly. 0130 R23 continues to pace hallway. 0230 CNA observed R23 pacing back and forth from his room to restroom. 0330 R23 continues to pace hallway. 0430 R23 observed standing in hallway. 0530 medication administered, R23 continues standing outside of room. 0630 R23 observed in dining room back left corner sitting quietly. 0640 Resident (R29) alerted this nurse (V35) to come in the dining room. Upon entering resident (R23) was noted with his belt wrapped around his neck on one end and the other around a pipe in the ceiling. R23 fell to floor. V35 (nurse) removed the belt from R23's neck. R23 was unresponsive to verbal stimuli. Sternal rub applied by V35, R23 took deep breath and began to make moaning sounds. V48 was contacted and order to send to hospital emergency room for psychiatric evaluation. Transportation called for pick up estimate time of arrival 60 minutes given. Hospital paperwork dated 7/31/22 documents: R23 was sent for psychological evaluation of suicidal ideation with a plan. R23 observed attempting to hang himself today. R23 tried to hang himself with a belt. Primary Impression: Suicide attempt. Change in resident's condition or status policy/procedure dated 6/26/22 documents: To ensure that the resident's attending physician and representative is notified of changes in the resident's condition and /or status.

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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** 41156 Based on interviews, and record reviews, the facility failed to follow their abuse policy and prevent incidents of sexual assault and resident to resident physical assault. This failure affected 6 residents (R11, R33, R4, R36, R23, R28) of 8 reviewed for abuse. These failures resulted in R11 making an allegation of rape being sent to the local hospital to be assessed and diagnosed with multiple external rectal tears and dark redness with impending bruising to distal vaginal opening. Findings Include: Facility reported incident dated 6/15/22 reads in part: R11 alleged inappropriate contact by R21. Conclusion: R11 stated that R11 went into R21's room to watch television and did not anticipate having sexual intercourse with R21. R11 stated that R11 and R21 began kissing and that they had intercourse in R21's bed. R11 stated she did not want to have intercourse with R21. R11 informed staff the next morning that R11 did not want to have intercourse with R21. R11 was sent out for medical evaluation and returned the same day with no new orders. R21 was interviewed and denies having sexual intercourse with R11. The facility is unable to substantiate the allegation made by R11. R11's Progress note dated 6/15/2022 at 9:00AM, reads in part: resident reported this AM to staff alleged abuse received from peer. Per resident I was in peers' room last night and was touched inappropriately. Hospital records reviewed and read in part: stated complaint: possible sexual assault. 6/15/22 at 12:12PM body assessment reads in part: abrasions to anus, redness to vaginal area, sexual assault 6/14/22, type of assault-anal penetration, last voluntary intercourse/sexual activity: last year, contraceptive used by penetration: no, skin inspection: abrasion, genital inspection: abrasion. 6/15/22 at 1:39PM reads in part: upon examination redness noted to vaginal area, small tears noted to rectal area in internal and external area, small blood noted on swab when anus was swabbed. 6/15/22 emergency room : pelvic exam shows dark redness to impending bruising to distal vaginal opening, also has multiple external rectal tears without bleeding. Police report dated 6/15/22 at 12:05PM, reads in part: Criminal Sexual Assault Investigation. V59 (Nurse) related that R11 claimed R11 was raped by R21. R11 related that R11 had messaged R21 and asked R21 if R21 wanted R11 to go to his room. Once inside R21's room, the two sat on the bed and R21 allegedly began kissing R11 on the mouth. R21 then removed R11's shorts and underwear and vaginally penetrated R11 with R21's penis. R11 did not say to stop or put up any resistance. R21 then began to anally penetrate R11 causing R11 pain where R11 then stated for R21 to stop. R11 stated R11 did not tell R21 to stop or prior to R21 penetrating R11 sexually. R11 stated R11 was once raped when R11 was younger so R11 just froze and did not say anything because R11 did not want R21 to hurt R11 physically. R21 stated that R11 agreed to go to R21's room to watch TV and further stated that R21 and R11 only watched television and that they did not have sex. R21 also stated that they did not kiss or did anything sexually. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Sexual assault kit picked up by the local police and turned into the lab. Results are still pending. Results not yet available at this time. On 9/7/22 at 12:00PM, V59 (nurse) stated that V59 remembers the time when R11 reported the incident that happened on 6/14/22. V59 cannot remember the complete details but remembers that R11 reported to her that R11 was raped by R21. On 8/26/22 at 1:30PM, V1 (Administrator) stated that R11 reported to the nurse that R11 was raped and stated it was a black man, and then mentioned the name of R21. Before the police came and before sending R11 out to the hospital, R11 was able to give more details about watching television and kissing with R21. Further investigation R11 reported that she went to R21's room, watched television, but it was not R11's intention to have sex with R21. R11 and R21 are both not available for interview. Both residents have been discharged . Facility reported incident dated 7/14/22 reads in part: R22 was physical towards co-peer R33. Conclusion: Per staff, they witnessed R22 wandering the dining room during mealtime as staff was trying to redirect R22 to his table, R22 was swinging his hands and accidentally bumped into R33. R22 is care planned for aggressive behavior with initial date of 1/6/21 and revision date of 7/8/22). The resident has a history of aggression (physical and verbal), inappropriate, and attention-seeking. R22's history includes conflicts/altercations with others, threatening behavior and verbal/physical aggression. R22's care plan interventions: Place resident on 72 hours well-being checks in order to monitor any mood and behavior changes and document accordingly (1/6/21). Remove resident from triggering environment. Motivate resident to exercise safety (initiated 11/27/21, revision on 8/31/22). Staff will monitor for aggressive behavior and redirect as necessary. O n 8/26/22 at 9:45AM, V20 (Assistant Administrator) stated that V20 investigated the incident. V20 stated that V20 asked the nurse assigned on the floor what happened. The nurse reported to V20 that R22 was walking around the unit pacing and accidentally bumped into R33. R22 was walking with his hands flaring and hit R33. The nurse immediately attended to the situation. The nurse separated residents immediately. The nurse completed an assessment on R33, no injury or pain noted. R22 was placed on one-to-one monitoring immediately. The incident was reported to [NAME] police. The incident was a physical altercation, and it was part of the seven types of abuse, and it is the resident rights to be free from abuse. We did our diligence in our part to report and investigate the incident. R22 has the behavior of flaring his hands. R33 was in a wheelchair, in the hallway when R22 passed by and accidentally hit R33. R22 has history of accidentally hitting other residents. V20 stated I cannot recall how many but more than one incident. During this incident, other staff were providing care with other residents and did not witness the resident-to-resident physical altercation. Only the nurse observed this incident. Prior to this incident, R22 was placed on one-to-one monitoring multiple times because of R22's aggressive behavior. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	When V20 was questioned about the location of the conflicts (reported to the state agency (SA)) V20 stated the incident happened in the hallway. V20 then stated I apologize, if the final report says dining room, then that was where the incident happened. We have lots of incidents and I probably confused it with another incident. On 8/26/22, V23 (Dementia Care Coordinator) stated I was in the facility the day of the incident. I believe it was the nurse that informed me that R33 reported to the nurse that R22 hit him. R33 is able to report if someone hit him. I believe R22 has a history of hitting other residents. I know we do close monitoring for R22 because of R22's aggressive behavior. This incident happened it the hallway, around the corner from R33's room. If someone hit R33, I know R33 is able to report it to staff. This is the first time I heard R33 report that a resident hit him. R33 did not have any other physical abuse allegation except for this incident. R33 was not hurt, no injuries and no reported pain. We are closely monitoring R22. V23 stated R22 has the tendency to swing R22's arms and hit others unintentional and unprovoked. On 8/30/22 at 12:20PM, R33 stated that 3 months ago someone hit him on the back of the head. Per R33, he was watching television in the dining room. R33 noticed R22 walking in the dining room, then R22 got close to R33, and before the staff can get to R22, R22 already hit R33. R22 was just walking everywhere, and no one was watching R22 at the time. R33 stated that R33 was not expecting that R22 would hit R33. R33 stated R22 hit me in the head and my ear was warm for a while and painful at the time of the he hit me, but the pain went away. Since the incident R33 have not been close to R22. On 8/26/22 at 2:15PM, V50 (LPN) stated I was doing rounds in the morning and R33 met me in front of R33's room and reported to me while pointing at R22 who at the time was coming out of the washroom. R33 stated R22 hit me in the head and I asked R22 what happened, R22 just muffled and walked away. I assessed R33, no pain and no injury. I monitored R33 then reported the incident to the administrator immediately. R22 wanders on the unit majority of the time, but I have not seen R22's hand swinging when walking. I am not aware of any history of R22 hitting another resident prior to this incident R33 is alert and oriented and able to report if something happens to R33. It was shift change at the time the incident happened, and I am pretty sure the other staff were doing patient care, there are no witnesses. Abuse Prevention Program with a revised date of 3/1/21, reads in part: It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility. The following procedures shall be implemented when an employee or agent becomes aware of abuse or neglect of a resident, or of an allegation of suspected abuse or neglect of a resident by a 3rd party. 41758 R4 has the diagnoses of schizophrenia and altered mental status. R4's Brief Interview for Mental Status dated 8/15/22 documents a score of zero which indicates severe impairment. R4's care plan initiated and revised on 2/21/22 documents: Comprehensive assessment reveals past trauma and or other factors that may increase R4's susceptibility to abuse/neglect. R4 presents with an alteration in ability to communicate related to mental illness as evidenced by being selective with when and who she will communicate with. On 8/24/22 at 3:40PM, R4 was unable to report any physical abuse occurred. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 8/24/22 at 3:41PM, R26 (R4's roommate) who was assessed to be alert and oriented to person place and time, stated R27 entered our room, standing at R4's bedside. R4 asked R27 to get out. R27 hit R4 in the face and head multiple times. R4 tried to fight back. R27 stopped hitting R4 on her own and left our room. I informed staff. On 8/24/22 at 3:21PM, V17 psychiatric rehabilitation service director (PRSD) stated, R27 was impulsive and difficult to deescalate. Both R4 and R27 have cognitive delays and were unable to report what happen. R27 has a history of being impulsive and physically/verbally aggressive. R27 became physically aggressive without any warning towards R4. On 8/24/22 at 3:30PM, V20 (assistant administrator) stated, R27 was standing at R4's bedside. R4 was trying to redirect R27. R27 made physical contact with R4. Nursing Note dated 7/29/22 documents: Resident (R4) received physical contact from her co-peer (R27) inside her room as per witness by roommate (R26). Observed resident (R4) had a small superficial scratch on her face.Incident report dated 7/29/22 documents: R4 received physical contact from co-peer (R27). R27 was physically aggressive towards peer (R4). Witness R26. Abuse Prevention Program revised 3/1/21 documents: It is the policy of this facility to prohibit and prevent resident abuse, neglect and exploitation, mistreatment and misappropriation of resident property and a crime against a resident in the facility. #4 Physical Abuse: Hitting, slapping, punching and kicking. R36 has the diagnosis of schizoaffective disorder and cognitive communication deficit. R36's brief interview for mental status dated 8/29/22 documents a score of fifteen which indicates cognitively intact. On 8/24/22 at 3:32PM, V17 (PRSD) stated, R27 is impulsive, physically and verbally aggressive. On 9/7/22 at 2:36PM, R36 was unable to articulate what happened related to the altercation with R27. On 9/7/22 at 3:16PM, V61 psychiatric rehabilitation services coordinator (PRSC) stated, I did a wellbeing check on R36. I asked R36 if she was ok, related to an alleged physical altercation with a co-peer (R27). On 9/7/22 at 3:32PM, V21 (nurse) stated, R27 was supposed to have hit R36. R27 has mental illness, unpredictable thoughts and actions. Sometimes things happen with the residents that is out of our/staff control. The incident with R27 and R36 that was unpredictable. I was called by staff (unable to recall who) to assess the situation. V21 stated use my charting as my factual statement. I assessed both R36 and R27 after an alleged physical altercation for alterations in skin. Incident report dated 7/21/22 documents: R36 allegedly received physical contact from peer (R27). No witnesses. Nursing note dated 7/21/22 documents: R36 observed within bedroom allegedly received physical contact from R2.7 Reportable dated 7/25/22 documents: R27 had physical contact towards her co-peer (R36). On 8/26/22 at 11:56AM, R23 who was assessed to be alert to person, place and time stated, I was hit by a staff member who was tall, ball head and black. I was sleeping and he (unknown staff) hit me. He monitored the hallway. (continued on next page)

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	145850	A. Building B. Wing	09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
City View Multicare Center	5825 West Cermak Road Cicero, IL 60804

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 8/30/22 at 3:14PM, V20 (assistant administrator) stated, R23 is alert and orient to person, place and time. R23 reported to V53 (nurse) that someone came into his room and hit him in the eye. R23 was unable to report who hit him and did not give a description. R23 has never accused anyone of hitting him prior to this incident. R23 has never hit himself. On 9/1/22 at 9:45AM, V53 (nurse) stated, I saw R23 come out his room with a black eye. R23's injury was consistent with being hit. R23 did not have any other injuries Nursing note dated 7/24/2022 documents: Resident (R23) was noted with swelling and discoloration to left side of his face. Resident (R23) was unable to recall events that led to the swelling. R28 has diagnoses of dementia and disorganized schizophrenia. R28's brief interview for mental status dated 7/8/22 documents cognitive skill for decision making is severely impaired. Care plan initiated 11/04/20 and 8/11/21 documents: R28 has a history of being a target of aggression from peers. Redirect when roaming into others rooms to decrease and avoid any problematic situations. R28 has wandering behaviors, R28 wanders in the hallway, dining room and other peer's room. Social service note dated 8/17/22 document: Without provocation, R16 made physical contact with another peer (R28). R28 was seen due to being a target of physical aggression. Another peer (R16) made physical contact with resident (R28). Incident report dated 8/17/22 documents: another peer (R16) made physical contact with resident (R28). No witnesses. Reportable dated 8/21/22 documents: R16 was physically aggressive toward his co-peer (R28) when R28 was found wondering into R16's room taking some of R16 personal belongings. R28 was noted to have an injury to the left side of his face.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on interview and record review, the facility failed to follow its abuse policy to prevent the misappropriation of resident's funds. This affected 6 of 6 (R6, R8, R28, R42, R43, R44) residents reviewed for misappropriation of funds. Findings include: R8 was admitted to the facility on [DATE] with diagnoses of schizophrenia, bipolar disorder and unspecified psychosis. R8's brief interview for mental status score dated 7/12/22 documents a score 9/15 which indicates moderately impaired. R8's transaction history documents: on 4/26/22 miscellaneous withdrawal of 1500.00. The facility presented two store receipts totaling 1398.26. Items purchased were a tv, pillow, two comforters, miscellaneous clothing, hygiene supplies. On 8/30/22 at 1:38PM, V69(CNA) confirmed there were no clothing items, blankets or shaver for R8 on the unit or in his room. V69(CNA) stated R8 received a tv today 8/30/22. On 8/30/22 at 2:22pm, V1(Administrator) stated they are unable to locate R8's items and unsure where they went. The facility did not get written consent from R8 to purchase items on his behalf. The facility should have gotten consent for items. Abuse Policy revised 3/1/21 documents: It is the policy of this facility to prohibit and prevent abuse, neglect, exploitation, mistreatment and misappropriation of resident property #7Misappropriation of resident property is the deliberate misplacement, exploitation or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. R28 was admitted to the facility on [DATE] with a diagnoses of dementia, hypertension, obsessive compulsive disorder, and major depressive disorder. R28's brief interview for mental status score dated 7/5/22 documents a score 99 which indicates resident was unable to complete interview. R28's transaction history documents: on 4/29/22 miscellaneous withdrawal of 2800.00. The facility presented a check dated 4/29/22 to R28's brother in the amount of 2800.00. On 9/6/22 at 3:56PM, V1 (administrator) stated that the check for R28 was mailed to his brother but was never cashed. V1 was unable to provide any consent or documentation for money to be removed out of R28's account. R44 was admitted to the facility on [DATE] with a diagnoses of schizophrenia, anxiety disorder, restlessness and agitation. R44's brief interview for mental status score dated 6/7/22 documents a score 15/15 which indicates cognitively intact. R44's transaction history documents: on 4/26/22 miscellaneous withdrawal of 500.00. On 9/1/22 at 3:50PM, R44 who was alert and oriented at time of interview stated she did not give consent for any funds to be removed by the facility for purchases. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/2/22 at 10:07AM, V19(business office) stated money was taken out of the resident account to purchase clothing but was never used. V19 presented an envelope with cash. V19 was unable to provide any consent from resident or representative for funds to be removed. R42 was admitted to the facility on [DATE] with a diagnoses of paranoid schizophrenia, anemia, major depressive disorder, dysphagia and altered mental status. R42's brief interview for mental status score dated 7/4/22 documents a score 14/15 which indicates cognitively intact. R42's transaction history documents: on 4/26/22 miscellaneous withdrawal of 1000.00. On 9/1/22 at 3:43pm, R42 who was alert and oriented a time of interview stated he did not give consent for any funds to be removed by the facility for purchases. On 9/2/22 at 10:07AM, V19 stated money was taken out of the resident account to purchase clothing but was never used. V19 presented an envelope with cash. V19 was unable to provide any consent from resident or representative for funds to be removed. R43 was admitted to the facility on [DATE] with diagnoses of schizoaffective disorder, cognitive communication deficit, and hypotension. R43's brief interview for mental status score dated 7/4/22 documents a score 3/15 which indicates cognitively impaired. R43's transaction history documents: on 4/26/22 miscellaneous withdrawal of 500.00. On 9/2/22 at 10:07AM, V19 stated money was taken out of the resident account to purchase clothing but was never used. V19 presented an envelope with cash. V19 was unable to provide any consent from resident or representative for funds to be removed. 41758 On 8/25/22 at 3:43PM, R6 who was assessed to be alert and oriented to person, place and time, stated I gave V18 (activity aide) $60.00 for taking me to the bank. On 8/25/22 at 2:49PM, V20 (assistant administrator) stated, V18 (activity aide) was terminated for accepting $60.00 from R6. Employee Disciplinary Action Form dated 7/25/22 documents: V18 (activity aide) was terminated for policy violation of Appendix A Addendum #15: requesting to borrow money or asking for tips, loans, gratuities or gift from any resident or member of resident's family.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on observation, interview and record review, the facility failed to follow their activities of daily living policy to include by not providing incontinence care at least every 2 hours and assisting residents with dressing assessed, that require staff assistance. These failures affected 3 of 3 residents (R18, R8, and R23) reviewed for activities of daily living care. Findings include: R18 was admitted to the facility on [DATE] with diagnoses of dementia, anxiety, bipolar abnormalities of gait and mobility. R18's brief interview for mental status score dated 8/4/22 documents a score 15/15 which indicates cognitively intact. R18's Minimum Data Set, dated dated dated [DATE] document under toilet use: Extensive assistance and one-person physical assist. Under urinary incontinence documents frequent incontinent. On 9/1/22 at 9:03AM, R18 was observed sleeping, laying on two bed pads with multiple dried yellow irregular shaped rings under R18's buttock and lower back. V47 (cna) stated, I did not provide any incontinence care for R18. R18 refused. R18 is soiled/soaked with urine and there are dried urine stains on R18's bed pad. V47 asked R18, if he would like to be changed. R18 replied, yes. During incontinence care, R18 was observed with two incontinent briefs, the first incontinent brief was noted with dark yellow urine in the left center side of the incontinent brief. The second incontinent brief which was on R18's skin was completely saturated and soiled with dark yellow urine. R18 who was assessed to be alert and orient to person, place and time stated, I have not been changed since last night. On 9/1/22 at 1:07PM, V2 director of nursing (DON) stated, R18 is not care planned for wearing double incontinent briefs nor should R18 be wearing two incontinent briefs at any time due to the increased risk for skin break down. R8's care plan dated 4/28/21 documents: R8 requires supervision to limited assistance with ADLS to maintain highest possible level of functioning. Interventions: Assist with dressing as needed. Care plan dated 12/17/21 did not document anything related to wearing double incontinent briefs. Toileting: Requires extensive assistance and one-person physical assist. Facility policy titled Activities of daily living dated 7/15/2010 documents: Residents are given routine daily care by nurse or CNA to promote hygiene, provide comfort and provide home like environment. ADL care is provided throughout the day at intervals that are coordinated between the care giver and the resident. ADL care of the resident includes assisting the resident in personal care such as bathing, dressing and eating. R8 was admitted to the facility on [DATE] with diagnoses of schizophrenia, bipolar disorder and unspecified psychosis. R8's brief interview for mental status score dated 7/12/22 documents a score 9/15. R8's minimum date set dated 7/13/22 documents under dressing limited assistance with one-person physical assist. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/1/22 at 3:00PM, R8 was observed in the same clothing from 8/31/22. On 9/2/22 at 11:15AM, V2(DON) stated residents should be assisted to change clothing upon getting up in the AM. V2 stated she did not receive or see any documentation regarding R8 refusing care. R23 admitted to the facility on [DATE] with a diagnoses of schizophrenia, anemia, lack of coordination, bipolar and anxiety disorder. R23's brief interview for mental status score dated 7/21/22 documents a score 5/15. R23's Minimum Data Set, dated dated dated [DATE] documents under dressing limited assistance with one-person physical assist. During the survey, on 9/1/22 at 10:09AM, observed R23 in same clothing as yesterday and confirmed by V36(Nurse). On 9/2/22 at 11:15AM, V2(DON) stated residents should be assisted to change clothing upon getting up in the AM. V2 stated she did not receive or see any documentation that R23 had refused care or changing clothing.

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F 0684 Level of Harm - Minimal harm or potential for 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** 39340 Based on interview and record review, the facility failed to follow physician orders to obtain orders for sexual transmitted disease panel, hepatitis C, lipid profile and obtaining orthotic inserts for one (R24) of three residents reviewed for physician orders. Finding include: R24 was admitted to the facility on [DATE] with diagnoses of asthma, seizures, hypertension, schizophrenia, weakness and delusional disorder. R24 's brief interview for mental status score is 15/15 which indicates cognately intact. On 8/26/22 at 1:03PM, R24 who was alert and oriented at time of interview, stated she requested laboratory tests due to a potential exposure and tests still have not been completed. On 9/2/22 at 11:15PM, V2 director of nursing (DON) stated she saw lab orders for R24 and was unsure why they had not been completed and no results in medical record. V2 stated nurses are expected to follow through with doctors' orders. On 9/8/22 at 9:30AM, V68 medical doctor (MD) stated he would expect the facility to follow through with his orders and was unsure why they were not completed. R24's physician order dated 6/2/22 documents: sexual transmitted disease panel, hepatitis C, lipid profile per patient request R24's progress notes dated 6/2/22 documents: Patient wants sexual transmitted disease panel, hepatitis C, and lipid profile ordered. Had recent sexual contact with someone with hepatitis C per patient. Plan: Continue current regimen, sexual transmitted disease panel, hepatitis C, and lipid profile ordered per patient request Facility policy titled Physician Orders undated documents: It is the policy of the facility to follow the orders of the physician. On 8/26/22 at 1:03PM, R24 who was alert and oriented at time of interview stated she has not received her shoes and she experience mild foot pain related to fallen arches which makes standing for long periods difficult. On 9/2/22 at 1:56PM, V62(Appointments) stated R24's orthotic shoes were delayed because she was unable to find a vendor/service that would provide them. V62 stated she did not have any documents related to attempts to contact other vendors or places to obtain R24's shoes. On 9/8/22 at 9:30AM, V68(MD) stated he would expect the facility to follow through with his orders and was unsure why they were not completed. R24's physician order sheet dated 3/15/22 documents orthopedic shoes (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and custom accommodative orthotic device semi-flexible cork and leather 1st and 5th met cutouts. R24's progress note dated 6/16/22 documents: V68(MD) Talked to social services about orthopedic shoes still pending.

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F 0689 Level of Harm - 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** 41758 Based on interview and record review, the facility failed to develop a plan to monitor and supervise a resident with a history of suicidal ideations and self-injurious behaviors. The facility also failed to have a plan to monitor and supervise residents with physical aggression. These failures affected 4 of (R22, R23, R27, R28) 4 residents reviewed for supervision. This failure resulted in R23 being found in the dining room attempting to hang himself from a pipe with a belt around his neck. R23 was taken down and sent to the local hospital for a psychiatric evaluation. Findings Include: R23 was admitted with schizoaffective disorder. R23's brief interview for mental status (BIMS) dated 7/21/22 documents a score of 9 which indicates moderately impaired and disorganized thinking. The facility placement assessment summary dated 4/14/21 documents: R23 is a high level for self-injurious behavior both recent and remote. R23 has a history of wanting to hurt himself. Screening assessment for evaluation self-harm/suicide risk and indicators of aggressive and/or harmful behavior dated 7/21/22 documents: R23 was a moderate risk. On 8/30/22 at 4:36PM, V35 (nurse) stated, I heard R29 screaming at 6:30AM. I ran to the dining room. R23 was hanging from a pipe with a belt tightly around his neck and the other end around the pipe. The belt gave away from the pipe causing R23 to fall to the ground. R23 was unresponsive. At the time of the incident the dining room was not being monitored by staff. On 8/31/22 at 10:52AM, V17 psychiatric rehabilitation service director (PRSD) stated, the facility placement assessment summary is used to determine psychosocial needs. R23's high level for self-injurious behavior both recent and remote and a history of wanting to hurt himself should have been a red flag. I would have processed R23 to determine if his self- injurious behavior was active or passive. Moderate risk on the screening assessments dated 7/21/22 would indicate R23 needed close observation which entails a staff member within R23's area to visually watch/monitor R23. There aren't any nursing notes that document R23 was being monitored closely. R23 was at risk for self-harm due to a history of self-destructive behavior including suicidal thought and suicidal actions, severe mental illness and recent aggressive/agitated behaviors. V17 stated residents should not be in the dining room without supervision. On 9/1/22 at 9:58AM, R29 stated, I saw R23 hanging from the pipe with a belt around his neck. R23 fell to the floor. I called the staff to hurry to come into the dining room. We did not have a monitor in the dining room. On 9/1/22 at 10:02AM, R31 and R32 where observed in the dining room, sitting without staff supervision. Nursing note dated 7/31/22 documents: 6:40AM resident alerted this nurse to come in the dining room. Upon entering resident was noted with his belt wrapped around his neck on one end and the other around a pipe in the ceiling. R23 fell to the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Standard supervision and monitoring dated 2/2/22 documents: This guideline emphasizes a proactive intervention promoting enhanced physical and psychosocial well-being. The facility recognizes supervision and guidance to the resident is an essential part of nursing care in which standard approaches are successful in meeting the resident's physical and psychosocial needs R27 has the diagnosis of violent behavior. Care plan initiated on 7/21/22 documents: R27 displayed conflictual, difficult behavior with other persons related to severe mental illness (schizophrenia and delusion disorder) and psychosis (audio, visual hallucination and disorganized delusion thoughts). Behavior: symptoms are manifested by impulsivity and unprovoked expressions of anger towards staff and peers. R27 demonstrates behavioral distress related to being challenged by mental illness. Problems: are manifested by verbal and physical abusive behaviors when agitated, alleged behavior towards peers. On 8/31/22 at 10:55AM, V17 (PRSD) stated, R27 has poor boundaries, difficulty redirecting, and refusal to process with staff. R27 is impulsive and actions where all of sudden. On 9/7/22 at 3:32PM, V21 (nurse) stated, R27 has a mental illness, unpredictable thoughts and actions and sometimes things happen with the residents that are out of our/staff control. The incident with R27 and R36 was unpredictable. I was called by staff (unable to recall which staff) to assess the situation. Incident report dated 7/21/22 documents: R36 allegedly received physical contact from peer (R27). No witnesses. Final Reportable dated 7/25/22 documents: R27 had physical contact towards her co-peer (R36). On 8/24/22 at 3:41PM, R26 (R4's roommate) who was assessed to be alert and oriented to person place and time, stated R27 entered our room, standing at R4's bedside. R4 asked R27 to get out. R27 hit R4 in the face and head multiple times. R4 tried to fight back. R27 stopped hitting R4 on her own and left our room. On 8/24/22 at 3:21PM, V17 psychiatric rehabilitation director (PRSD) stated, R27 was impulsive and difficult to deescalate. R27 has a history of being impulsive and physically/verbally aggressive. R27 became physically aggressive without any warning towards R4. On 8/24/22 at 3:30PM, V20 (assistant administrator) stated, R27 was standing at R4's bedside. R4 was trying to redirect R27. R27 made physical contact with R4. Incident report dated 7/29/22 documents: R4 received physical contact from co-peer (R27). R27 was physically aggressive towards peer (R4). Witness R26. Standard supervision and monitoring dated 2/2/22 documents: This guideline emphasizes a proactive intervention promoting enhanced physical and psychosocial well-being. The facility recognizes supervision and guidance to the resident is an essential part of nursing care in which standard approaches are successful in meeting the resident's physical and psychosocial needs. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R28 has diagnoses of dementia and disorganized schizophrenia. R28's brief interview for mental status dated 7/8/22 documents cognitive skill for decision making is severely impaired. Care plan initiated 11/04/20 and 8/11/21 documents: R28 has a history of being a target of aggression from peers. Redirect when roaming into peers' rooms to decrease and avoid any problematic situations. R28 has wandering behaviors in the hallway, dining room and other peer's room. On 8/30/22 at 3:56PM, V57 (cna) stated, R28 wanders and requires constant supervision. I have to sit outside R28's room in this chair to prevent R28 from wandering into other resident's room. On 9/1/22 at 9:09AM, R28 was observed coming out of co-peer R9's room. R9 who was assessed to be alert and orient to person, place and time stated, R28 just came in my room and sat on that bed. I did not ask R28 to come into my room nor did I want R28 in my room. Social service note dated 8/17/22 documents: R28 was seen due to being a target of physical aggression of peer R16. (R16) made physical contact with resident (R28) without provocation. Incident report dated 8/17/22 documents: another peer (R16) made physical contact with resident (R28). No witnesses. Reportable dated 8/21/22 documents: R16 was physically aggressive toward co-peer (R28) when R28 was found wondering into R16's room taking some of R16's personal belongings. R28 was noted with injury to the left side of his face. Facility reported incident dated 7/14/22 reads in part: R22 was physical towards co-peer R33. Conclusion: Per staff, they witnessed R22 wandering the dining room during mealtime and as staff was trying to redirect R22 to his table, R22 was swinging his hands and accidentally bumped into R33. R22 has diagnoses not limited to schizoaffective disorder bipolar type and dementia without behavioral disturbances. R22's Care Plan review date 1/6/21 with revision date of 7/8/22, reads in part: Socially inappropriate behavior. Resident has presented with inappropriate personal boundaries manifested by inappropriately touching peers and staff, screaming and yelling in the hallway. Interventions: Staff will continue to re-direct and offer assistance when resident is on the floor (date initiated 4/5/2021). Staff will provide redirection and place resident on close monitoring when suspected or any reports of inappropriate behavior (Revised 1/6//21). Staff will provide redirection when observed entering others room or personal area (Revision on 1/6/21). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R22 is care planned for aggressive behavior with initial date of 1/6/21 and revision date on 7/8/22). The resident has a history of aggression (physical and verbal), inappropriate, and attention-seeking. R22's history includes conflicts/altercations with others, threatening behavior, verbal /physical aggression. Interventions: Place resident on 72-hour well-being checks in order to monitor any mood and behavior changes and document accordingly (1/6/21). Remove resident from triggering environment. Motivate resident to exercise safety (initiated 11/27/21, revision on 8/31/22). Staff will monitor for aggressive behavior and redirect as necessary. Abuse and Neglect indicates: Resident is noted to have been the target of aggression from peers and to display inappropriate behaviors and aggression such as throwing things while in on the unit. These behaviors are unprovoked and unpredictable (initial date of 1/6/21 and revision on 5/12/22).Interventions: Staff will remain available for any behavioral changes (initiated 8/20/22 and revision 8/31/22). Place on 72-hour wellbeing checks when the target of aggression to further monitor any changes (imitated 11/11/21 and revision on12/5/21). Remove resident from triggering environment. Motivate resident to exercise safety. Place on 1:1 supervision (date initiated 8/20/22 and revision on 8/31/22) Staff will immediately intervene if observing resident and see signs of abuse/neglect (initiated 1/11/21 and revision on 11/22/21). On 8/26/22 at 9:45AM, V20 (Assistant Administrator) stated that V20 investigated the incident. V20 stated that V20 asked the nurse assigned on the floor what happened. The nurse reported to V20 that R22 was walking around the unit pacing and accidentally bumped into R33. R22 was walking with his hands flaring and hit R33. The nurse immediately attended to the situation. The nurse separated the residents immediately. The nurse completed an assessment on R33, no injury or pain noted. R22 was placed on one-to-one monitoring immediately. The incident was reported to [NAME] police. V20 stated the incident was physical altercation, and it was part of the 7 types of abuse, and it is the residents right to be free from abuse. V20 stated we did our diligence on our part to report and investigate the incident. R22 is noted to have the behavior of flaring his hands. V20 stated R33 was in a wheelchair in the hallway and R22 passed by and accidentally hit R33. R22 has history of accidentally hitting other residents, I cannot recall how many but more than one incident. During this incident, other staff were providing care to other residents and did not witness the resident-to-resident physical altercation. Only the nurse observed this incident. Prior to this incident, R22 was placed on one-to-one monitoring multiple times because of R22's aggressive behavior. When V20 was questioned about the location conflicts (reported to the state agency (SA)) and interview. V20 stated that incident happened in the hallway, V20 stated I apologize, if the final report says dining room, then that was where the incident happened. We have lots of incidents and I probably confused it with another incident. On 8/26/22, V23 (Dementia Care Coordinator) stated I was in the facility the day of the incident. I believe it was the nurse that informed me that R33 reported to the nurse that R22 hit him. R33 is able to report if someone hit him. I believe R22 has a history of hitting other residents. I know we do close monitoring for R22 because of R22's aggressive behavior. The incident happened it the hallway, around the corner from R33's room. If someone hit R33, I know R33 is able to report it to staff. This is the first time I heard R33 report that a resident hit him. R33 did not have any other physical abuse allegation except for this incident. R33 was not hurt, no injuries and no reported pain. We are closely monitoring R22 and redirecting R22. Sometimes R22 has the tendency to swing R22's arms and hit others unintentional and unprovoked. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/30/22 at 12:20PM, R33 stated that 3 months ago someone hit him on the back of the head. Per R33, he was watching television in the dining room, near the television. R33 noticed R22 walking in the dining room, then R22 got close to R33, and before the staff could get to R22, R22 had already hit me (R33). R22 was just walking everywhere, and no one was watching R22 at the time. R33 stated that R33 was not expecting that R22 would hit R33. R22 hit me in the head and my ear was warm for a while and painful at the time of the incident but the pain went away. Since the incident R33 has not been close to R22. On 9/7/22 at 12:45PM, V2 (Director of Nursing) stated I was not part of the investigation. An abuse allegation usually goes to the administrator. R22 is a wanderer. If R22 is having behaviors such as not redirectable or altercation with someone either verbal of physical, or if R22 becomes aggressive with staff we will do a one-to-one supervision. We will keep R22 on one-to-one monitoring for as long as R22 presents aggressive behaviors. On 8/26/22 at 2:15PM, V50 (LPN) stated I was doing rounds in the morning and R33 met me in front of R33's room and reported to me while pointing at R22 who at the time was coming out of the washroom. R33 stated R22 hit me in the head and I asked R22 what happened, R22 just muffled and walked away. I assessed R33, no pain and no injury were noted. I assessed R33 and then reported it to the administrator immediately. I observe R22 wandering on the unit majority of the time but have not seen R22's hand swinging when walking. I am not aware of any history of R22 hitting another resident prior to this incident R33 is alert and oriented and able to report if something happens to R33. It was shift change at the time the incident happened, and I am pretty sure the other staff were doing patient care, there are no witnesses. On 9/2/22 at 11:00AM, R22 was observed to be ambulating the hallway. R22 was observed walking from the dining room area to the end of the hallway where R22's room is located. R22 stayed in the hallway, paused for a short period of time and went back into the dining room. There was no staff member redirecting the resident or monitoring R22 at that time. Other residents are observed in the hallway and dining room area. One staff member observed in the nurse's station, sitting in front of a computer. On 9/6/22 at 1:00PM, R22 was observed again walking from the dining room to the end of the hallway. R22 observed would pausing for a short time then started walking back to the dining room. Other residents observed walking the hallway also. There are no staff to visually monitor the resident at the end of the hallway, close to R22's room.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 41758 Based on interview and record review, the facility failed to develop a psych-social treatment plan for a resident with a history of suicidal ideations, self-injurious behaviors and recent suicide attempt. This failure affected 1 of 3 (R23) residents reviewed for psych-social interventions. Findings include: R23 was admitted with schizoaffective disorder. R23's brief interview for mental status (BIMS) dated 7/21/22 documents a score of nine which indicates moderately impaired and disorganized thinking. Facility placement assessment summary dated 4/14/21 documents: R23 has a high level for self-injurious behavior both recent and remote. R23 has a history of wanting to hurt himself. Screening assessment for evaluation self-harm/suicide risk and indicators of aggressive and/or harmful behavior dated 7/21/22 documents: R23 was a moderate risk. Nursing note dated 7/31/22 documents: 0640 upon entering the dining room resident (R23) was noted with his belt wrapped around his neck on one end and the other around a pipe in the ceiling. R23 fell to floor. V36 (nurse) removed the belt from R23's neck, R23 was unresponsive to verbal stimuli. Sternal rub applied by V36, R23 took deep breath and began to make moaning sounds. On 8/31/22 at 10:52AM, V17 Psychiatric Rehabilitation Director (PRSD) stated, the facility placement assessment summary is used to determine psychosocial needs. R23's high level for self-injurious behavior both recent and remote and a history of wanting to hurt himself wound have been a red flag had I reviewed the Preadmission Screening and Resident Review (PASSAR). I would have processed R23 to determine if his self- injurious behavior was active or passive. Moderate risk on the screening assessments dated 7/21/22 indicates R23 was at risk for self-harm due to a history of self-destructive behavior including suicidal thought and suicidal actions, severe mental illness and recent aggressive/agitated behaviors. R23 was not care planned for his history of self-injurious behavior. R23 was not care planed after his failed suicide attempt. No interventions were put in place after R23's failed suicide attempt. On 9/1/22 at 10:09AM, V36 (nurse) stated, R23 had been withdrawn and isolative for the last two days. R23 has not been interacting with peers or participating in activity On 9/1/22 at 4:02PM, V22 Psychiatric Rehabilitation Services Coordinator (PRSC) stated, R23 was not seen by the psychiatrist after R23's failed suicide attempt. R23 was seen by the psychiatrist on 8/24/22 for a gradual dose reduction for psychiatric medication. The psychiatrist would have to read R23's progress notes in order to be updated on R23's suicide attempt. No verbal report was given to the psychiatrist about R23. I did not put in any interventions or update R23's screening assessments for evaluation of self-harm, suicide risk, and indicators of aggressive and/or harmful behavior after R23's failed attempt. I should have updated those assessments on 8/8/22. I did not chart anything about R23 not having items to prevent self-harm. I verbally told staff that R23 can't have belts. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I meet with R23 1:1 daily, I don't have any assessment tools related to suicide or use a specific tool with R23 during our sessions. I asked R23 that same question, I would ask any other residents. I asked R23, how was his day going? Have you talked to your family? Depending on R23's answers, I would ask, how does that make you feel? During my 1:1 sessions, I don't ask anything about suicide. It could be a trigger for R23. On 9/1/22 at 4:39PM, V57 (cna) stated, I am not aware of any residents (R23) that cannot have a belt. R23 was a little depressed and attempted to hurt himself. R23's care plan did not document any interventions related to suicide or self-harming behavior post hospitalization . Hospital paperwork dated 7/31/22 documents: R23 was sent for psych evaluation because of suicidal ideation with a plan. R23 was observed attempting to hang self today. R23 is depressed and tried to hang self with a belt. Psychiatry Note dated 8/24/22 and 7/1/22 documents: Medical history was reviewed with staff, any type of dose reduction at this time would likely impair R23's cognition, mood and precipitate psychiatric instability by exacerbation of underlying symptoms, psychotic delusion ideation, auditory hallucination- gradual dose reduction is contradicted a present time. (7/11/22) R23 exhibits no new symptoms or side effects. Staff report stable mood and psychotic symptoms. Social Service Behavior Monitoring Policy updated 2/2/22 documents: To assure that sufficient and appropriate social service assessment(s) and intervention (s) are provided to attain or maintain the highest practicable physical, mental and psychosocial well-being needs for each resident. #7 the social service caseworker will update the care plan with the new intervention(s). All new interventions(s) will include the date that the intervention was initiated.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on observation, interview and record review, the facility failed to ensure a resident's medication was available for administration for one (R7) of three residents reviewed for medications. Findings include: R7 was admitted to the facility on [DATE] with diagnoses of bipolar disorder, mood disorder, hypertension, hyperlipemia and human immunodeficiency virus. R7's brief interview for mental status score dated 7/5/22 is 15/15 which indicates cognitively intact. On 8/26/22 at 11:11AM, R7 stated he did not receive his Ativan today. R7 reported he has been without Ativan for a few days and was without last month as well. R7 stated he has a hard time sleeping when he does not receive his medication. On 8/26/22 at 1131AM, V25 (nurse) confirmed with surveyor that Ativan tablets were not on hand for R7 in the medication cart. V25 stated they were awaiting a new prescription for the medication so the pharmacy could send the medications. On 9/2/22 at 11:15AM, V2 (Director of Nursing/DON) stated nurses are expected to call the pharmacy when medication is not on hand and call the doctor if medication is not available for possible alternative. V2 was unable to find or provide any documentation that R7's Ativan medication was given between 7/7/22 through 7/20/22 and 8/20/22 and 8/27/22. R7's physician orders dated 4/26/22 documents: Ativan 1 mg. Give one tablet by mouth two times a day for anxiety. R7's-controlled drug receipt 6/17/22 documents: Ativan 1 mg. Give one tablet by mouth two times a day. Last dose given was 7/7/22 at 9AM with no remaining doses. R7's-controlled drug receipt dated 7/19/22 documents first dose received on 7/20/22 at 9AM. There were no other controlled drug receipts between 7/7/22 and 7/20/22. R7's-controlled drug receipt 7/19/22 documents: Ativan 1 mg. Give one tablet by mouth two times a day. Last dose given was 8/20/22 at 9AM with no remaining doses. R7's controlled drug receipt dated 8/26/22 documents first dose received on 8/27/22 at 9AM. There were no other controlled drug receipts between 8/20/22 through 8/27/22.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 41758 Based on observation, interview and record review, the facility failed to maintain an effective pest control plan by not ensuring the facility was free of brown crawling insects. This failure has the potential to affect all 28 residents who reside on the third floor. Findings include: On 8/30/22 at 9:55AM, V29 (housekeeping director) stated, we have an issue with roaches. On 8/30/22 at 3:52PM, live brown insects were seen crawling in the bathroom and hallway outside of the men's bathroom on the third floor. V57 (CNA) stated, that's a roach. Pest Control Policy: It is the policy of the facility to ensure that an effective pest control program is in place. An effective pest control program is defined as measures to eradicate and contain common household pest. These include but are not necessarily limited to roaches.